



**Law  
Commission**  
Reforming the law

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**Adult Social Care  
Consultation Analysis**

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**Consultation Paper No 192 (Consultation Analysis)  
31 March 2011**

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# Adult Social Care Consultation Analysis

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# **PART 1**

## **SUMMARY**

- 1.1 This document analyses the responses received to the Law Commission's consultation paper, *Adult Social Care*. It summarises the views of consultees in relation to the 57 provisional proposals and 25 consultation questions put forward.

### **THE CONSULTATION PROCESS**

- 1.2 The consultation paper was published on 24 February 2010. The public consultation process ran from publication on 24 February 2010 until 1 July 2010. During this period, the Law Commission received 231 written responses. These were received from a wide range of consultees which included:

- (1) the Government and Welsh Assembly Government;
- (2) non-departmental public bodies, including the Equality and Human Rights Commission, Care Quality Commission and HM Inspectorate of Prisons;
- (3) professional bodies including the Local Government Association, Association of Directors of Adult Social Services, Law Society, Royal College of Psychiatrists and General Medical Council;
- (4) 26 local authorities in England and Wales;
- (5) 14 multi-agency safeguarding boards and networks;
- (6) major service providers and charities, including Age UK, Mencap, Sense, Scope, RNIB and Guide Dogs, the Royal National Institute for Deaf People, Action on Elder Abuse, the Multiple Sclerosis Society, BUPA, Leonard Cheshire Disability and Carers UK;
- (7) local service user-led organisations, carers groups and advocacy organisations;
- (8) academics, legal practitioners, and social care trainers and consultants; and
- (9) individual service users and carers.

- 1.3 A full list of formal written responses is provided in Appendix A. In addition, the Law Commission attended 72 events across England and Wales. These events covered a wide audience, including service users, carers, social workers and other local authority staff, health staff, academics, representatives from safeguarding boards and regional networks, community care lawyers, service providers and representatives from charities and campaigning organisations. A full list of events attended is provided in Appendix B.

- 1.4 We are very grateful for all those who took part in consultation events and submitted formally responses.

## **SUMMARY OF VIEWS<sup>1</sup>**

### **Part 2: Our approach to law reform**

- 1.5 Most consultees agreed with the proposal to introduce a single statute which covered both England and Wales. However, there was discussion about whether there should be a separate statute for Wales given ongoing policy developments.
- 1.6 Almost all consultees supported the proposal to introduce a three-level structure of primary legislation, statutory instruments and guidance in adult social care. Consultees argued that this would be clearer than the present situation where there is a large volume of law and guidance. For similar reasons, most consultees approved of the idea of bringing together statutory guidance in the form of a code of practice.
- 1.7 There was a range of views on the proposal to adopt a process-driven approach to adult social care. A majority of consultees agreed that this approach sufficiently captures how adult social care operates in practice. However, some consultees argued that a process driven approach might define adult social care too narrowly.

### **Part 3: Statutory principles**

- 1.8 A large majority of consultees agreed that there should be a statement of principles included in the proposed statute. It was agreed that principles could guide decision making whilst clarifying the aims of the statute as a whole.
- 1.9 A large majority of consultees supported the inclusion of the proposed principles based on maximising choice and control, dignity in care and safeguarding adults at risk. Consultees argued that these principles are essential to the provision of adult social care.
- 1.10 A smaller majority of consultees supported the principles based on person-centred planning, viewing a person's needs broadly, the need to remove or reduce future need and independent living. Consultees were of the view that these principles would be desirable in an adult social care statute.
- 1.11 A small majority of consultees disagreed that there should be a principle based on an assumption of home-based living. Many consultees argued that the wishes of service users should be the basis for determining whether a person is placed in residential accommodation.
- 1.12 Some consultees suggested alternative principles for inclusion in the statute such as principles based on non-discrimination and human rights, well-being, the UN Convention on the Rights of Persons with Disabilities and partnership working.
- 1.13 Most consultees argued that one principle should be afforded primacy over the other principles but were split on which principle should be afforded primacy.

<sup>1</sup> In the summary, when a proportion of consultees is stated this refers to the proportion of the consultees that responded to the relevant proposal or question.

#### **Part 4: Community care assessments**

- 1.14 An overwhelming majority of consultees agreed that there should be a duty to undertake a community care assessment on the appearance of social care needs. Consultees argued that the assessment process is vital because it gets potential service users into the social care system. A large majority of consultees also argued that a right have an assessment on request should be introduced to ensure that certain groups are not excluded from assessments unlawfully.
- 1.15 There was a consensus that an assessment should focus on a person's needs and outcomes. A large majority also agreed that the proposed statute should recognise co-produced self-assessments as a lawful form of assessment. However, a majority of consultees disagreed that the statute should allow for pure self-assessment for certain people or groups of people. Many consultees were of the view that it would be inappropriate to leave an individual to assess themselves with no external input from a social care professional or advocate.
- 1.16 Almost all consultees were of the view that there should be duty to make regulations which prescribe details of the assessment process since this would help standardise practice. All consultees agreed that local authorities should retain the ability to provide temporary services in urgent cases.

#### **Part 5: Carers' assessments**

- 1.17 All bar one consultee agreed that there should be a duty to undertake a carer's assessment in the statute. A large majority also agreed that this duty should apply to all carers who are providing or intend to provide care to another person, and not just those providing substantial and regular care, and that the duty should not be triggered by the carer making a request but on the appearance of needs.
- 1.18 Most consultees agreed that carers should be defined so as to include previously unpaid carers who now receive payment through direct payments received by the cared-for person, carers who are paid for only some of the care they provide and carers where the local authority believes the caring relationship is not principally a commercial one. A majority of consultees approved of a more unified assessment process for carers and cared-for people but disagreed that the carers' assessment duty should be merged with the community care assessment duty. This was on the basis that whilst a unified process would encourage holistic assessments, carers and cared-for people tend to have distinct needs which ought to remain assessed separately.

#### **Part 6: Eligibility for services**

- 1.19 An overwhelming majority of consultees agreed that the statute should require local authorities to determine whether a person's social care needs are eligible needs using eligibility criteria and provide or arrange services to meet all eligible needs. A similar majority approved of the proposal to place a duty on the Secretary of State and Welsh Ministers to make regulations which prescribe risks to independence that will call for the provision of services and the objectives to be achieved by the provision of services. Almost all consultees supported a right to re-ablement services and agreed that if it is introduced it should be included in the proposed statute.

- 1.20 Furthermore, a large majority of consultees agreed that if eligibility criteria are to be set at a national level, these criteria should be prescribed in regulations issued by the Secretary of State and Welsh Ministers. There was similar support for the proposal to introduce a mandatory national eligibility framework for carers' services and a duty to meet the eligible needs of carers.
- 1.21 A significant majority of consultees approved of the proposal that there should be a power for the Secretary of State and Welsh Ministers to make regulations which would require local authorities to allocate a personal budget to service users.

**Part 7: Section 21 of the National Assistance Act 1948 and section 2(1) of the Chronically Sick and Disabled Persons Act 1970**

- 1.22 A small majority of consultees agreed that section 21 of the National Assistance Act 1948 should be repealed and that the Government should ensure a proper scheme for the provision of residential accommodation to those who might lose their entitlement. A similar majority also agreed that if the Government does not introduce such a scheme, section 21 should be retained but only for those who would otherwise lose their entitlement. A small majority argued that if section 21 were repealed, some groups might lose their entitlement to accommodation – such as those asylum seekers.
- 1.23 A large majority of consultees were of the view that section 2(1) of the Chronically Sick and Disabled Persons Act 1970 should be removed from adult social care legislation. This was on the basis that the effect of this duty would be replicated by our proposed eligibility framework.

**Part 8: Ordinary residence**

- 1.24 Almost all consultees agreed with the proposal that there should be a duty on local authorities to provide services to those who are ordinarily resident in their area and a power to provide service to those who are not ordinarily resident in their area; in cases of urgent need, there should a duty to provide accommodation to those not ordinarily resident; and community care assessments and the provision of temporary urgent services should not be limited by the ordinary residence rules. A large majority of consultees also agreed that the local authority in which the cared-for person lives should be given responsibility for providing carers' services.
- 1.25 An overwhelming majority of consultees approved of the proposal to enable the portability of services by the introduction of an enhanced duty to cooperate when service users move areas coupled with (if these policies are implemented) a national portable needs assessment and national eligibility criteria.

**Part 9: Scope of Adult Social Care**

- 1.26 A large majority of consultees approved of the proposal to define community care services by a short and broad list of services. A similarly large majority were of the view that such a list should be on the face of the statute itself primarily on the grounds that this would provide a clear statement of what a service user could expect. Over half of consultees argued that community care services should not be left undefined in the statute.

- 1.27 A large majority of consultees agreed that there should not be a central definition of a disabled person or service user. Many said that it was unnecessary, whilst others went further by saying that a definition may be stigmatising. Most consultees approved of the proposal to leave carers services undefined in the statute on the basis that this would give local authorities flexibility.
- 1.28 The great majority of consultees agreed that there should a power for the Secretary of State and Welsh Ministers to issue regulations that could define Shared Lives schemes as being non-residential services in all cases. Consultees were of the view this would improve clarity particularly in terms of charging.
- 1.29 Over half of consultees agreed that the existing divide between health and social care should be maintained in the statute. Some consultees called for more clarity on the health and social care divide whilst others argued that whatever the division, joint working should be encouraged actively. A large proportion of consultees agreed that social services authorities should be prohibited from providing ordinary housing and connected services where these services are provided for under other legislation.
- 1.30 The majority of consultees argued that retaining the prohibition on providing services to those subject to immigration control because they are destitute would have negative effects given that people who fall within this category are particularly vulnerable. While some argued that removing this prohibition would have a severe financial impact on social services budgets, others argued that prohibition means that preventable conditions deteriorate until they are much more complicated and expensive to treat.

#### **Part 10: Delivery of services**

- 1.31 An overwhelming majority of consultees supported the proposal to introduce a statutory duty to produce a care plan for those with assessed eligible needs. Consultees argued that a care plan is fundamental to the assessment and care planning process. Consultees were also in favour of specifying the form and content of care plans in regulations.
- 1.32 The majority of consultees argued that direct payments should be extended to cover residential accommodation. Many consultees stated this would promote choice and control. However, some expressed concerns that the nature of the care home market might mean that service users would have to pay more for their residential accommodation as local authorities can negotiate lower rates.
- 1.33 Almost all consultees agreed that the choice of accommodation directions should be placed in statute law and that the additional payments regulations should be retained in secondary legislation. Consultees said this would make the legal status of the directions clear although some sought clarification over some of the conditions.
- 1.34 A large majority of consultees agreed that the direct payments provisions should be retained in their existing form in the future statute. In particular, consultees said that recent amendments to the provisions made further change unnecessary. However, some consultees said that local authorities should be required to do more to encourage the take up of direct payments.



- 1.35 A large majority of consultees agreed that there should be a regulation-making power to require or authorise local authorities to charge for residential and non-residential services. Consultees argued that this would give flexibility to local authorities although a number of consultees were concerned about the possibility of introducing a duty to charge for non-residential services. A similarly large proportion of consultees were in favour of retaining the regulation-making power which allows certain services to be provided free of charge and that these services should be listed in regulations. Consultees argued that a list would provide clarity but that such a list should not restrict the provision of free services.

### **Part 11: Joint working**

- 1.36 Most consultees agreed that the proposed adult social care statute should apply to those aged 18 and above, and the Children Act 1989 (and the Chronically Sick and Disabled Persons Act 1970) should apply to those aged 17 and below. Most agreed that this would promote greater legal clarity but some concern was expressed that distinguishing between adults and children at the age of 18 is somewhat artificial and the statute needs to accommodate those who ought to remain in children's services for longer and those who need to move to adult services earlier.
- 1.37 There was also a predominantly positive response to the proposal that local authorities should have a power to assess 16 and 17 year olds under the proposed adult social care statute and there would be a right to request such an assessment. Consultees argued that this proposal would help the transition process, although there was concern that the proposal may add to an already complex legal situation and does not oblige local authorities to plan appropriately for the transitional phase.
- 1.38 A majority of consultees were positive about the proposal that the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 should be retained and amended so that they apply only to young carers. It was argued that this would preserve the rights of young carers, although there was concern about the fragmentation that would result, as well as the fact that young carers would need to satisfy a higher threshold to qualify for an assessment.
- 1.39 A large majority of consultees agreed with the proposal that parent carers should continue to be eligible for a carer's assessment under the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 and that where a young person aged 16 and 17 is being assessed under the proposed adult social care statute, parent carers should also be given a carer's assessment under this statute
- 1.40 Consultees were asked for comments on how the well-being power is being used in practice. Many consultees highlighted that it has been used to meet social care needs that fall below the eligibility threshold, as well as allowing for early intervention to prevent needs from reaching a critical level. Some consultees indicated that the well-being power is or should be used to meet other needs that are not specifically fall within adult social care. However, some consultees stated that it is rarely used, especially in the context of adult social care.

- 1.41 A majority of consultees agreed that the delayed discharge provisions should be retained in their existing form in our statute. However, some consultees suggested that they should be amended to facilitate more co-operation between the NHS and local authorities. Some consultees were concerned that the tight timescales resulted in the local authority not carrying out a thorough assessment and also not offering the patient appropriate choice.
- 1.42 Consultees were asked for comments about whether adult social care should be extended to prisons. The majority of consultees argued that prisons should be included. Some consultees stated this as a point of principle, that prisoners should be entitled to the same social care as other members of the community. Many responses highlighted the current deficiencies in meeting the social care needs of prisoners. On the other hand, several consultees highlighted concern over the resource implications for local authorities.
- 1.43 There was strong support for the proposal that the choice of accommodation directions should cover residential accommodation provided under section 117 of the Mental Health Act 1983. Many consultees highlighted that there is no reason to differentiate between people placed under section 117 and other service users. The vast majority of consultees approved of the proposal that the additional payments regulations should cover residential accommodation provided under section 117.
- 1.44 A large majority of consultees agreed that the concept of ordinary residence should be extended to apply to after-care services provided under section 117. Some consultees argued that this would provide more clarity and consistency in this complex area. However, there was disagreement about the best way to retain the current effect of section 117.
- 1.45 A small majority of consultees agreed that the section 117 duty should be amended to clarify that the duty falls on health authorities to provide *health care after-care* and social services authorities to provide *social care after-care*. Several consultees said that this would help bring, although some consultees disagreed with the proposal arguing that it will undermine joint working between the NHS and social services. All consultees agreed that section 117 should be amended to clarify that health and social services authorities can commission after-care services. A small majority of consultees disagreed the duty should 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.
- 1.46 Just over half of consultees agreed that section 117 should be recast from a free-standing duty to a gateway provision. Many consultees argued that this would bring greater clarity and consistency to the law. Some, however, expressed concern over the increased potential for local authorities to start charging for services provided under section 117.
- 1.47 Other issues were raised in relation to section 117 included general concerns about charging for services provided under this duty, the definition of after-care services and whether section 117 should be extended to people currently or previously deprived of their liberty under the Mental Capacity Act 2005.

- 1.48 An overwhelming majority of consultees agreed with the proposal to place a general duty on a social services authority to promote cooperation between the local authority and specified relevant organisations. Many consultees argued that cooperation is central to delivering effectively adult social care services. A similarly large majority supported the proposed power to allow local authorities to request assistance from other organisations. Consultees were of the view that such a proposal would help strengthen inter-agency cooperation.

## **Part 12: Safeguarding Adults at Risk**

- 1.49 A large majority of consultees agreed that local authorities should be placed under a duty to make enquiries where there is reasonable cause to suspect that the person appears to be an *adult at risk*. Most consultees argued that this would clarify the current position and ensure that there was no room for disagreement about whether such a duty exists.
- 1.50 A significant majority of consultees agreed that the term *vulnerable adult* should be replaced by the term *adult at risk*. Many consultees criticised the term *vulnerable adult* as stigmatising and dated. Consultees preferred *adult at risk* because it focuses on the situation the individual is in rather than the characteristics of the person.
- 1.51 There was only a slim majority of support for the proposal that *adult at risk* should be defined as a person with social care needs who is at risk of significant harm. Consultees agreed that such a definition would prevent local authorities responsibilities from becoming too broad and over inclusive. Several consultees, however, argued that the phrase significant harm sets the threshold of the duty to make enquiries too high.
- 1.52 A large majority of consultees agreed with the proposal that if new compulsory and emergency powers to safeguard adults were introduced by the Government, these should be included in any future adult social care statute. However, some criticised the Law Commission for not making its own recommendations as to new powers.
- 1.53 A large majority of consultees agreed that section 47 of the National Assistance Act 1948 should be repealed. Consultees cited human rights concerns and that the power is obsolete in practice. A significant number of consultees agreed with the proposal on the basis that section 47 should be replaced with a power that is compatible with the Human Rights Act 1998.
- 1.54 Consultees were unanimous that local authorities should remain under a duty to prevent the loss and damage of a person's property when they have been admitted to hospital or provided with residential accommodation. Some consultees were of the view that this duty requires increased clarity, particularly in relation to pets and the role of family members.
- 1.55 Almost all consultees supported the proposal to place a duty on local authorities to establish adult safeguarding boards. Consultees argued that this would strengthen current arrangements and would standardise areas such as the functions and membership of the boards. A similar proportion of consultees agreed that there should be an enhanced duty to cooperate which would apply expressly in the context of safeguarding adults. .

- 1.56 An overwhelming majority of consultees agreed that *No Secrets* and *In Safe Hands*, or their successors, should be clearly linked to a local authority's statutory functions to safeguard adults. Other issues were also raised during the consultation in relation to safeguarding. These issues include the role of Guardianship under the Mental Health Act 1983, protecting those with capacity who are being ill-treated or wilfully neglected and the application of the Family Law Act 1996.

### **Part 13: Strategic Planning**

- 1.57 A significant majority of consultees agreed that the disabled persons register should be abolished. Consultees argued that such registers did not assist with strategic planning and represent an outdated approach. However, some consultees stressed that the registration can give entitlements to certain groups of service users such as those with sensory impairments.
- 1.58 A large majority of people agreed that there should not be any strategic planning provisions in our statute. Consultees acknowledged the current complexity of current strategic planning arrangements and so to add more could be counter-productive. Some consultees made the point that strategic planning should be multi-agency exercise and shouldn't be confined to an adult social care statute. .
- 1.59 Almost all consultees agreed that there should be a duty on local authorities to provide information about services available in their local area. For many this was seen as promoting choice and control as it would enable service users to make more informed choices.

### **Part 14: Other issues**

- 1.60 The Law Commission received a significant number of responses on certain issues which were not covered in the consultation paper. Consultees were clear that advocacy can have a beneficial impact across almost all areas of adult social care. A large number of consultees were of the view that the Law Commission's proposal should have included proposals on complaints and redress. Several consultees suggested the introduction of a community care tribunal.

## PART 2

# OUR APPROACH TO LAW REFORM

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

- 2.1 Of the 231 submissions which were received, 80 submissions expressed a view on the proposal that there should be a single adult social care statute for England and Wales, unless policy in Wales diverges enough to require separate statutes for England and Wales. Of those consultees, 68 agreed with the proposal, 5 disagreed, whilst 6 held equivocal positions.

### ***The need for consolidation***

- 2.2 There was broad agreement amongst the consultees who responded to this proposal that the current legal framework is in need of consolidation. For instance, Buckingham County Council stated that:

Front line social workers and service users find it difficult and confusing to navigate through the 38 or so current pieces of legislation on adult social care.

- 2.3 In addition, the Disability Law Service described the law as “convoluted and confusing for service users, and for persons seeking to assist and advise service users, to obtain the support that they require”.
- 2.4 The Learning Disability Coalition suggested that the fragmented legal framework “has led to a system heavily subject to a postcode lottery and inaccessible to many who require care and support”. Conwy Connect highlighted that because of the fragmented legal framework “a lot of time and money is spent ... and people still do not know where to find information”.
- 2.5 Some local authorities agreed with this position. East Riding of Yorkshire Council described the law as “cumbersome” and “hard to interpret”, whilst North Tyneside Council stated that:

The fact that there is currently a huge volume of legislation scattered amongst various Acts makes interpretation and application of the law complex and time consuming.

- 2.6 In addressing these problems, consultees who supported this proposal were positive about the proposal for a single statute which consolidated adult social care law. Enfield Disability Action felt that such a proposal would make the law “more accessible to the user-led organisations and therefore the people it affects”.
- 2.7 Conway Connect also highlighted the value of having all the relevant law in one place:

We think that currently providing services can be hard and you don't always look at the "rules" but if they were all in one place ... that would be beneficial and make things easier for everyone.

- 2.8 Making Every Adult Matter made the point that simplification into one adult social care statute will have positive effects for service users:

This simplification itself may go some way to ensuring that people with multiple needs and exclusions receive the services to which they are entitled.

- 2.9 This point was echoed by Citizens Advice:

A single statute would be a big step forward. It would make the responsibilities and powers of local authorities much clearer, which would make life much easier for bureaux and their clients.

- 2.10 Whilst the majority of responses to the proposal to introduce a single consolidating statute were positive, Belinda Schwehr, an independent legal and training consultant, warned that:

It is extremely difficult to consolidate existing legislation into one such statute without subtly affecting the strength of the duties owed to disabled and ill people.

### ***A single statute for both England and Wales***

- 2.11 Many responses expressly supported a single statute covering England and Wales. The Vale of Glamorgan Older People's Strategy Forum argued that a single statute would encourage local authorities to consult closely to ensure as much consistency as possible:

Citizens in England and Wales move across the borders regularly for family, work and retirement reasons and it would be confusing to encounter markedly different systems.

- 2.12 Similarly, the Practitioners Alliance Against the Abuse of Vulnerable Adults suggested that a problem of having separate statutes is that:

Separate statutes would need to address portability between the two countries, perpetuating the existing post code lottery by transforming it into jurisdiction shopping.

- 2.13 The difficulty of cross-border issues was also recognised by the Royal College of Physicians of Edinburgh:

A single adult social care statute between England and Wales is particularly important in view of the very large number of people whose residence is close to the border and whose health and social care services straddle the two geographical areas.

- 2.14 While most responses supported the proposal, a small number expressed concern, including the Welsh Assembly Government and several Welsh organisations.

- 2.15 There were broadly three themes which caused concern: developing policy divergence between England and Wales, the expected referendum in 2011 and issues about how a two-country single statute would work in practice.

#### POLICY DIVERGENCE

- 2.16 The response of the Welsh Assembly Government emphasised the likelihood that there may be an increased divergence of policy between England and Wales. It has commissioned a series of strategic policy reviews and until then wished to hold its position on whether divergence in policy will be sufficient to justify separate statutes for England and Wales.

- 2.17 This approach was shared by the Welsh Local Government Association which argued that:

There is significant scope for an increase in policy divergence between England and Wales in the coming months, which builds on the existing divergence embodied through the implementation of the Government of Wales Act, and the Assembly Government's strategy for social services, *Fulfilled Lives, Supportive Communities*.

- 2.18 The Government made a similar point:

We believe it would be preferable to have separate statutes for England and Wales ... In the longer term, we think that this will provide for clearer law if further policy divergences emerge.

- 2.19 However, some consultees argued that policy between England and Wales has already diverged to such a point that a single statute could not be justified. For instance, the Social Care Institute for Excellence stated that a single statute would be "contrary to the spirit of devolution". In particular:

England's approach to implementing personalisation policy differs from that of the Welsh Assembly Government in key respects, such as the greater use of direct payments and personal budgets to support choice, and greater reliance on the independent sector to provide the bulk of care services. Unlike England, Wales has not chosen to separate children's from adult's policy, commissioning, provision, regulation and training.

- 2.20 Other responses pointed to the different approaches in Wales to paying for care (Social Care Charges (Wales) Measure 2010), and to support for carers (Carers Strategies (Wales) Measure 2010).

- 2.21 However, Age Cymru's response recognised that current divergence in social care provision between England and Wales is not so great that it could not be covered by a single statute, but went on to make the pragmatic point that:

Policy divergence between the two nations is likely to increase over time and therefore there is a case for separating them now to save greater confusion, or having to write a Wales-only statute in the future ... A single statute would need to include significant framework powers to Wales to enact its own social care legislation policy in areas which are divergent.

#### THE 2011 REFERENDUM

- 2.22 Amongst the consultees who had concerns about a single statute for England and Wales, the key factor was the proposed referendum on the devolution of further powers to the Welsh Assembly Government.
- 2.23 The response of the Welsh Assembly Government acknowledged that the referendum creates uncertainty about whether there should be a single statute for England and Wales. In its response, the Welsh Assembly Government considered a number of legislative options which included:
- (1) a single UK Bill which makes common provision in all respects for England and Wales;
  - (2) a single UK Bill which makes some common provision but which includes parts which apply only in England and parts which apply only in Wales;
  - (3) two separate UK Bills, one for England and one for Wales;
  - (4) a single UK Bill which contains a “framework power” for the Welsh Assembly to make its own Measure on adult social care law; or
  - (5) a National Assembly for Wales Measure made under powers obtained by way of a Legislative Competence Order.
- 2.24 The Welsh Assembly Government expressed no fixed view about the merits of any option and preferred to hold its position until the result of the referendum.
- 2.25 The Welsh Local Government Association adopted a similar position to the Assembly Government. In particular, it commented that the proposed referendum, the continued implementation of the Government of Wales Act 2006, a White Paper on social services and assembly elections in May 2011 constituted “extraordinary circumstances”. It went on to say that given the existence of such factors, it would not want to provide a detailed response that sets out an immovable position.
- 2.26 The Government agreed with the Welsh Assembly Government that the issue will have to be revisited in light of the referendum. However, the Wales Neurological Alliance was less hesitant, stating that it was “deeply concerned” about the proposal for a single statute. It argued that:

The Law Commission is inadvertently taking a short term view on the devolution settlement without considering what will happen in the next 12 months ... It seems that little attention has been paid to future-proofing this legislation for Wales.



## HOW A TWO COUNTRY SINGLE STATUTE WOULD WORK IN PRACTICE

- 2.27 Some consultees also raised practical objections to the introduction of a single statute for England and Wales. Age Cymru made the point that even if policy has not diverged sufficiently, a single statute could cause confusion and difficulty if policy does diverge significantly in the future. Learning Disability Wales developed a similar point:

Wales will be disadvantaged should it wish to make changes if it has to bid for scarce Parliamentary time to alter primary legislation. The context is that Welsh social care policy is an entirely devolved matter and powers in all manner of areas are being steadily transferred to the National Assembly. It appears regressive to bind a fully devolved area into the Westminster legislative process and could delay decision taking.

- 2.28 Disability Wales made a similar point, arguing:

An Adult Social Care (Wales) Act would enable subsequent amendments to be made more easily and clearly, even if this initially uses the same wording as in England.

- 2.29 Citizens Advice also made the point that the language differences between England and Wales may be a problem when it comes to drafting a single statute:

Almost all subordinate legislation for Wales under any new Act would be made in Cardiff and bilingually. If the enabling act is in English only, that could cause some problems, as, if an exact Welsh equivalent was not available for a word, then presumably the English meaning would be given preference in interpreting the legislation. This does not seem to fit with devolution of powers and bilingual law-making.

## A SEPARATE STATUTE FOR WALES

- 2.30 Two responses proposed a separate adult social care statute for Wales. Disability Wales argued:

The NHS Act 2006 and the NHS (Wales) Act 2006 provide a clear example of how separate legislation can recognise and respect different national approaches and yet work well in practice.

- 2.31 A similar point was made by the Wales Neurological Alliance.

## **Conclusion**

- 2.32 The responses to this proposal were in broad agreement with the idea of a single statute which consolidates all of adult social care law. However, there was a greater debate about the merits of a single statute for England and Wales. For some consultees, it would seem that this aspect of the proposal is contingent upon the result of political factors which may be resolved in 2011.

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

- 2.33 Of the 231 submissions which were received, 78 submissions provided answers to the question relating to the proposed three-level structure for adult social care law. Of those consultees, 72 argued that the proposed structure is appropriate, 1 disagreed with the proposed structure, whilst 5 held equivocal positions.

***Current difficulties with the legal structure***

- 2.34 Some consultees argued that the current legal structure leads to confusion and the danger of unnecessary litigation. For example, Coventry City Council stated that:

The current source of law, which relies on Department of Health directions, approvals and circulars, policy, and practice guidance, some of which has statutory force, makes it almost impossible to navigate. This can lead to legal challenge, which has a cost implication for local authorities.

- 2.35 The use of approvals and directions was criticised by some consultees. For example, Leonard Cheshire Disability argued that:

The use of approvals and directions results in creating confusion and that a simple three tier system of primary legislation, statutory instruments and guidance is most appropriate. A principle goal for Leonard Cheshire Disability throughout this process will be to develop a social care legislative framework that is clear and understandable, and will allow disabled people to be clear about their rights and entitlements.

- 2.36 Newcastle City Council made a similar point:

We believe this structure is the most appropriate and also believe that the avoidance of local authorities' powers being subject to further direction and approvals by the Secretary of State will be beneficial and allow the law to be better known.

- 2.37 The application of statutory guidance was criticised by a number of consultees. Statutory guidance is used by the Department of Health and the Welsh Assembly Government to guide the exercise of social services functions and discretions by local authorities. As a matter of law, statutory guidance must be complied with and can only be departed from with good reason.<sup>1</sup> However, Simon Burdis, a carer, stated that:

<sup>1</sup> *R v Islington London Borough Council ex p Rixon* (1997-98) 1 CCLR 119

There is widespread concern from family carers and professionals that “statutory guidance” is routinely ignored now by local authorities in relation to family carers, children and adults with learning disabilities, autism, complex needs and disabilities. Further, little seems to be done by central government to rectify this and sanctions against local authorities are rare.

2.38 Lack of consistency can arise if local authorities ignore statutory guidance. Counsel and Care stated this was a problem they experienced on a regular basis and that “an example of this includes local authorities that ignore sections of the charging for accommodation guide: guide because it is ‘only’ guidance”

2.39 Furthermore, Cymorth Cymru highlighted the perception that guidance has a legally ambiguous status can mean that local authorities’ decisions go unchallenged. It was stated that:

Our concern in the past has been that where guidance is the preferred method, when it is not followed there seems little recourse to address this ... to endorse this three-level structure we want to be confident that the right processes are in place to ensure guidance is followed.

#### ***Benefits of a three-level structure***

2.40 Some consultees were clear that the primary benefit of a three-level structure is clarity which would lead to increased accessibility. Solicitors for the Elderly argued that:

Any law that deals with vulnerable people should be accessible to legal and non-legal professionals alike and most importantly easily understood by voluntary sector workers on whom many individuals rely as their primary source of information. If community advisers understand the obligations imposed on social care providers they are more likely to identify when there may be a need for intervention. If the three level structure does achieve this aim then it must be welcomed.

2.41 The National AIDS Trust particularly welcomed:

the proposal to set out the legal duties of local authorities on the face of primary legislation where they represent fundamental requirements or entitlements as this will make it easier for people with social care needs, including people living with HIV, to identify what duties their local authority has.

2.42 Some consultees argued that the three-level structure had an important role to play in strengthening rights and entitlements for service users. However, they stated that this depends on where rights and entitlements sit in the statutory hierarchy. For example, Counsel and Care argued that:

All rights and entitlements for older people and their carers [should be] included in primary legislation rather than in regulations or guidance. In this way, there can be no question about the strength of a particular right or the duty of the local authority to ensure that it is being met in practice.

- 2.43 Some consultees argued that rights and entitlements should exist higher up the legal hierarchy because this would mean that changes could be only authorised by Parliament. For example, Refugee Action recommended:

that the fundamental elements of the services to be covered are outlined within primary legislation. This is in order to ensure that the vital elements of this very important service cannot be altered without Parliamentary scrutiny.

- 2.44 The importance of Parliamentary oversight was highlighted by the National Youth Advocacy Service:

Care must be taken to ensure that the most important duties are enshrined in the primary legislation and, therefore, not susceptible to change without the full sanction of Parliament.

#### ***The role of directions***

- 2.45 Enfield Disability Action noted that while directions are mandatory, they are “not always issued as statutory instruments”, which “means there is no Parliamentary scrutiny”. They, therefore, suggested that regulations were preferable.

- 2.46 Ann McDonald, a social care academic, argued that while the proposed structure was appropriate, “the power to make directions and approvals is useful to emphasise national priorities”. Michael Mandelstam, a legal trainer and consultant, argued that directions have a stronger legal status than guidance and queried whether anything would be lost by excluding them.

- 2.47 The Government appeared to agree that a three-tiered system would be beneficial. However, it was argued that the directions still have a role to play in the social care system and that the power to issue directions should be retained:

both to allow the Secretary of State to deal with issues arising in individual authorities and to enable binding instructions to be issued more generally on issues relating to the exercise of social services functions not covered by a regulation-making power.

- 2.48 However, it was recognised that directions can be confusing and lack transparency. Accordingly, the Government stated that “thought would clearly need to be given as to how such directions could be made accessible to the public”.

#### ***Precedents in other areas of law***

- 2.49 Garden Court Chambers argued that there was a precedent for a legal framework with a three-level structure:

We have extensive experience of this kind of structure in housing law practice. In contrast to community care law, housing law is a relatively accessible area of law having a handful of, on the whole, well-drafted key statutes, supplemented by short statutory instruments and statutory guidance which is re-issued from time to time.

- 2.50 Solicitors for the Elderly made a similar point in relation to the Children Act 1989 and the Mental Capacity Act 2005:

Child law practice has managed to keep a grasp on guiding principles under the primary legislation ... Fleshing out the detail of the Children Act comes largely from Regulations, but there are protocols on conducting public law cases.

### ***Conclusion***

In conclusion, there was a broadly affirmative response to the question regarding a three-level structure. Consultees highlighted a number of practice issues that are caused by the current legal structure. In particular, there can be confusion about the status of some of the legal instruments used in adult social care. Several consultees argued that a three-level approach could improve this situation since it would have benefits in terms of clarity and accessibility. Most consultees agreed that directions are particularly problematic, while a small number argued that they should be retained in our structure. However, an outstanding issue remains the possible use of directions. It was said by some consultees that there are precedents for a three-level structure which indicate that such an approach can work well in practice. Accordingly, there was strong overall support for a three-level structure.

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

- 2.51 Of the 231 submissions which were received, 88 submissions provided answers to the question whether there should be a duty on the Secretary of State and Welsh Ministers to prepare a code of practice to bring together statutory guidance. Of those consultees, 80 argued that there should be such a duty on the Secretary of State and Welsh Ministers, 1 disagreed that there should be such a duty, whilst 7 held equivocal positions.

***The existing complexity***

- 2.52 A number of consultees suggested that there was too much guidance and that this produced practical difficulties. Solicitors for the Elderly argued that:

The plethora of practice guidance and level of detail currently in circulation is often ignored as, possibly because the assessor cannot be sure it has been superseded, revoked or should be followed.

- 2.53 The Law Society argued that the existing guidance needs consolidation and streamlining.
- 2.54 Several consultees highlighted the codes of practices issued under the Mental Capacity Act 2005 and the Mental Health Act 1983 as being successful examples of how guidance should be issued. For example, the Disability Law Service argued that the *Mental Capacity Act 2005 Code of Practice* should be used as a template for adult social care because it is recognised widely as an “extremely useful guide”.
- 2.55 Some consultees pointed to the practical benefits of a single code of practice. For instance, Michael Mandelstam, a legal trainer and consultant, argued that:

When people operate the Mental Health Act they take the code of practice seriously; likewise the *Mental Capacity Act 2005 Code of Practice* has not only legal status but also visibility in that it is “the” guidance. Compare adult social care with an absolute mass of half baked, half known guidance which is little known apart from *Fair Access to Care Services*.<sup>2</sup>

***Efficiencies associated with a single code***

- 2.56 A number of consultees highlighted the potential efficiency of a single code of practice. In particular, Northumberland Tyne and Wear HNS Foundation Trust argued that codifying the guidance into a single code would enable organisations to ensure that the guidance is accessible and avoids the excessive cost that occurs from having to identify where the relevant law is located if the guidance remains in multiple and dispersed formats.

<sup>2</sup> LAC(2002)13, Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care

- 2.57 The Henry Spink Foundation took this point further and stated that a single code of practice:

would provide guidance to local authorities in preparing assessments, and would enable service users to understand the basis on which eligibility has been determined, assessments have been prepared and support packages delivered. This would in itself save money and time in helping to resolve some disputes at an early stage.

### ***Accessibility***

- 2.58 Several consultees emphasised the point that a single code of practice is more accessible. The Equality and Human Rights Commission stated that:

We also support the idea of a Code of Practice to sit alongside the adult social care statute to clarify and expand the law and to give service providers, practitioners and individuals a more accessible version of their rights and obligations.

- 2.59 This was a theme that resonated with service user organisations. For example, the Spinal Injuries Association argued that:

A unified code would simplify the current legislation for users who may be daunted or confused by the number of guidance documents which currently exist.

- 2.60 The response from the National AIDS Trust noted that a single code of practice will enable service users to identify what they were entitled to in a simple way.

### ***The practicality of consolidating guidance***

- 2.61 However, some consultees expressed concern as to the practicality of consolidating all adult social care guidance in a single code of practice. For example, Garden Court Chambers stated that “there will inevitably need to be a vast amount of guidance in community care law. It would not be practical to issue it as one single code or piece of guidance”.

- 2.62 Similarly, Gateshead Council argued that:

A code of practice for the whole area of adult social care would risk being unwieldy, or too vague and general to be truly useful. It would be more helpful to have individual codes of practice for different processes under the over arching principles in the main statute.

- 2.63 The Government made a similar point and stated that whilst guidance should be in one place, formulating it as a code of practice may be “unduly cumbersome”.

- 2.64 The response of the Welsh Assembly Government also made a point about physical task of bringing guidance together:

Whilst we can see the merits of this approach we have concerns about its practicability. The sheer volume of statutory guidance that currently exists would mean that this would be a hugely resource intensive task and it would surely limit the coverage that the individual guidance currently has on a given issue unless the code was very lengthy. Given the current economic circumstances the availability of the human resources required to undertake this seems highly unlikely.

- 2.65 Furthermore, many organisations, including the Care Quality Commission suggested that the new code must be subject to periodic revision to ensure it remains relevant and up to date.

#### ***A separate code for Wales***

- 2.66 The position in Wales was touched upon by a number of consultees. A theme of the responses was that the question of a single code of practice for England and Wales would depend on whether the Law Commission recommends a single statute for England and Wales.
- 2.67 However, Conwy County Borough Council made the point that if there were to be two separate codes, “both codes of practice need to be aligned so as to avoid difficulties over cross border issues”.

#### ***Conclusion***

- 2.68 The overwhelming majority of responses to this question were in favour of a single code of practice which would bring together statutory guidance. Many consultees argued that there was too much guidance, which needs to be consolidated and streamlined. They argued that a single code would improve efficiency and accessibility. Several consultees pointed to the codes of practice under the Mental Capacity Act 2005 and the Mental Health Act 1983 as effective templates. Some consultees questioned whether a single code would work in practice, although others argued that any problems were not insuperable.



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

2.69 Of the 231 submissions which were received, 79 submissions provided answers to the question about whether a process-driven approach is sufficient to determine the scope of adult social care. Of those consultees, 56 argued that a process driven approach is sufficient, 8 disagreed that it is sufficient, and 13 held equivocal positions.

***Some benefits of a process-driven approach***

2.70 Most responses to this question were broadly positive about a process-driven approach to defining the scope of adult social care. RADAR and the National Council for Independent Living, for example, argued that a process driven approach “clearly sets out the steps that a local authority has to take in order to support disabled people, in a way that holds them accountable”.

2.71 RNIB and Guide Dogs felt that such an approach “will help to achieve fairness and equity in the system and fits with the current policy objective of personalisation”.

2.72 Indeed, a number of consultees felt that a process-driven approach exists already. Age UK argued:

For the most part a “process-driven” approach reflects existing legislation, including requirements to consider or respect entitlements and to act proportionately contained in the Human Rights Act.

***Concerns over the broad list of services***

2.73 Whilst over half of responses to this question were in favour of a process-driven approach, a significant number of consultees qualified their responses. The largest number of concerns related to the suggestion of a broad list of services.

2.74 For instance, whilst the National AIDS Trust agreed with a process-driven approach, this was:

provided that the “broad list” of services given on the statute itself is not seen as exhaustive but rather as an indication of the types of services that could be included in a social care package.

2.75 Several local authorities felt that a list of services would conflict with the personalisation agenda. For instance, Surrey County Council argued that “a list of services may be too prescriptive if a holistic approach is taken to meeting a person’s needs”. Similarly, the London Borough of Camden was:

concerned that there is not an overly prescriptive list of services ... provision of a “list” of services shifts away from the personalisation agenda and does not reflect a needs-based (rather than service-led) social care service.

2.76 On this issue, the Government argued that:

There is a balance to be struck between clarity of scope, and support for flexibility and innovation in how people's needs are met, and the [process-driven] approach will need to accommodate, rather than constrain, our desire for innovation and personalisation in the design and delivery of support.

2.77 These concerns also apply to Provisional Proposal 9-1 which considers specifically the idea that community care services should be defined by reference to a short and broad list of services. This issue is given a more detailed treatment in the analysis of Provisional Proposal 9-1. However, it was an important source of concern in relation to the question of a process-driven approach.

### ***Inconsistency with personalisation***

2.78 A number of consultees suggested that, in a general sense, a process-driven approach may not take sufficient account of personalisation. For instance, NAAPS – while broadly agreeing with a process-driven approach – argued that:

The personalisation of social care places more choice and control in the hands of the individual and over-prescribing the types of service that can be funded could have an undermining effect.

2.79 The Social Care Institute for Excellence argued away from a process-driven approach and towards a personalised approach based on rights, commenting that:

If the law is to accept and reflect a person-centred approach to social care and empower people seeking support, there should be a clear, consolidated statement of the rights and entitlements of the individual.

2.80 In an individual submission, Tessa Harding, argued that a purely process-driven approach does not go far enough towards a personalised approach and stated that:

There is a real risk that the new statute, governed by a process-driven approach, would be limited to a tidying up exercise and would not take us further forward in acknowledging and making real the rights of individuals. That would be a wasted opportunity. The new law needs to go further.

### ***Excluding those falling outside the eligibility criteria***

2.81 A number of submissions wanted a process-driven approach to be wider than simply focusing on those with assessed needs. For instance, the Spinal Injuries Association agreed with defining social care by reference to a process but also argued that "any such definition should also include areas such as advice, signposting and following up cases for those who fall just outside eligibility criteria". Parkinson's UK made a similar point:

By giving prominence to rights of those being admitted “into” the system there is less clarity on the rights of those who are “outside” the system and who are told their eligible needs are not of enough significance to warrant local authority intervention.

- 2.82 Similarly, whilst Solicitors for the Elderly felt that a process-driven approach would give sufficient definition to social care, such an approach would:

not alter the problem of local authorities limiting service provision to the legal minimum. The process often “rules out”, rather than “rules in” those who should be assessed, deemed eligible and have services provided.

### ***Conclusion***

- 2.83 The majority of responses to this question argued that a process driven approach is sufficient to determine the scope of adult social care. A significant number of responses raised concerns about a process-driven approach to adult social care. The concerns focused on the use of a broad and short list of services, the role of personalisation and whether a process-driven approach would exclude potential service users. Collectively, these concerns expressed the view that a process-driven approach may define adult social care too narrowly.

## **PART 3**

# **STATUTORY PRINCIPLES**

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

- 3.1 Of the 231 submissions which were received, 87 submissions expressed a view on the proposal that our statute should include a statement of principles. Of those consultees, 79 agreed with the proposal, 3 disagreed and 5 held an equivocal position.

### ***Clarifying the underlying aims of legislation***

- 3.2 RNIB and Guide Dogs “firmly” supported the inclusion of a statement of principles within the statute, arguing that:

In addition to the benefits outlined in the consultation document, a statement of overarching principles could have the effect of reenergising the social care sector, forcing local authorities to think about the purposes of social care and what they are trying to achieve through the provision of services/budgets.

- 3.3 ADASS agreed that the statute should include a statement of principles that will “provide guidance, articulate underlying aims of legislation and ethical standards which can be defined by the law”. Nottingham City Council considered that a “statement of principles would set out the central tenets of the delivery of the adult social care statute and what underpins it”. Similarly, the Vale Older People’s Strategy Forum and Compassion in Dying agreed that there was a strong case for including statutory principles in the proposed statute. The latter argued that:

Such an approach would allow for a clear statement of the fundamental principles underpinning adult social care legislation, and provide a useful foundation and focus for those decision makers and practitioners affected by the legislation.

- 3.4 Solicitors for the Elderly argued that:

It is easier to formulate arguments where an authority has failed to give due consideration to principles contained in an Act of Parliament and this in turn sends a message that the priority of the legislators was to ensure that all interpretation should have those principle aims and objectives at their root.

### ***Guiding decision-making***

3.5 Many consultees agreed with the proposal on the basis that principles would help guide decision-making under the Act. For example, Blackburn with Darwen, Blackpool and Lancashire Safeguarding Adult Boards agreed that a statement of principles “can be an aid to decision-making” and North Tyneside Council argued that principles are “useful in terms of aiding the interpretation and understanding of legislation”. ADASS Cymru argued that a set of overarching core principles would provide guidance that “would help guide decision-making on social care” and that this “may make the law more accessible to the layperson, and ensure that people can better understand what they are entitled to”.

3.6 A number of consultees also considered that statutory principles would help achieve consistency in decision-making. For example, the Joseph Rowntree Foundation agreed that a statement of principles enshrined in law:

will help promote the consistent application of legislation and much needed clarity, and may enable service users to feel more confident about demanding compliance with them.

3.7 The MS Society also argued that:

A statement of principles on the face of the statute could help to address the widely differing interpretations of the current legislative framework of the social care system.

3.8 Gateshead Council agreed that “simple clear statements of principle do have an important part in creating greater clarity and consistency in decision making”. Furthermore:

Courts would also have to apply these principles and that would give rise to a body of case law which would be able to evolve in the same way that human rights legislation is able to evolve whilst still giving effect to the fundamental principles in the Convention.

3.9 Liz Ball, a deafblind person, supported the idea of statutory principles and considered that “they could help to improve implementation of the law in a way that would benefit deafblind people”.

### ***The Mental Capacity Act 2005***

3.10 A number of consultees pointed to the Mental Capacity Act 2005 as providing a good example of the positive impact of statutory principles. For example, the Office of the Public Guardian argued:

Our experience of implementing the Mental Capacity Act 2005 has been that the broad principles in the statute have been widely welcomed as providing a clear framework for those working and falling within the scope of the Act.

3.11 The Care Quality Commission considered that “a statement of principles can be of enormous help to people using services, staff and policy makers” and went on to state that:

Principles have the potential to communicate complex ideas in a way that everyone understands and can help to build the currency of the legislation. The Mental Capacity Act 2005 for England and Wales for example set out five key principles and, since the implementation of the Act, we have seen these principles incorporated into practice and policy.

- 3.12 Similarly, Carers UK agreed that there should be a statement of principles on the face of the law and noted that:

We have found these extremely useful during training of professionals in mental capacity law, where they have helped to focus on what the law is there to do in the first place and to improve decision-making.

- 3.13 Counsel and Care considered that a statement of overarching principles would give the statute “strength and coherence in the same way that the Mental Capacity Act 2005 has benefited”. Furthermore, it would also “help older people and their carers to understand their key rights and entitlements and for the local authorities to adhere to their statutory duties”.

#### ***Educational value***

- 3.14 The Equality and Human Rights Commission agreed with the arguments in support of statutory principles as set out in the consultation paper but, in particular, it endorsed “the importance of the educational function of statutory principles” and went on to state that:

In our experience, statutory principles often become adopted as shorthand for the purpose of the statute itself. Experience with (for example) the Children Act 1989 suggests that if people remember only one thing about the statute, they remember the principles behind the statute.

#### ***Application of principles to carers***

- 3.15 A number of consultees argued that the principles must apply to carers as well as service users. For example, ADASS Cymru noted that the proposed principles “focus on service users, and by default excludes carers who also need to be included”. Similarly, Carers UK argued that the “rights and principles should apply equally to carers as they would to any other citizen if they are based on core values and approaches”.

#### ***Principles in statute or in guidance?***

- 3.16 A number of consultees commented on whether the principles should be on the face of the statute or set out in guidance documents, with most preferring the former. For example, Solicitors for the Elderly agreed that the proposed statute should include a statement of principles “in order to give them prominence, clarity and consistency of approach to adult social care”. They considered that principles contained in guidance are “not so accessible”, given the amount of guidance produced, and the ambiguous legal status of such guidance. Similarly, the MS Society considered that it was:

important that fundamental principles are incorporated into the guidance to set them apart from the multitude of guidance that supports this vast and complex area of the law.

- 3.17 Surrey County Council argued that principles “are more likely to be taken into account if they are in the statute”. It noted that evidence from the Mental Capacity Act 2005 is that “principles have helped interpretation”. It also noted that principles can “help to define/determine the scope of social care particularly when considering people’s rights and entitlements”.
- 3.18 Similarly, Compassion in Dying considered that “making the principles part of statute, rather than simply part of the accompanying guidance emphasises their fundamental importance”. They pointed to the statutory principles in the Mental Capacity Act 2005 as providing “a useful example”.
- 3.19 Alwyn Davies, Development and Professional Support Manager with Barnsley Adult Social Care Services, argued expressly for including the principles in the statute rather than in the code of practice, arguing that:

The Adult Social Care Act ought to prescribe *what* to do. The code of practice ought to explain *how* to do it. The statement of principles ought to help us to apply the Act and the code of practice in *individual situations*.<sup>1</sup>

- 3.20 While describing it as a matter of debate whether principles are enshrined in law or presented elsewhere such as in guidance, on balance the Care Quality Commission supported:

the case for embedding a set of principles within the new statute as a means of setting out, in the strongest possible terms, what the aims of the legislation are and making this accessible to everyone.

- 3.21 On the other hand, Newcastle City Council – while expressing generally positive views on the proposal – questioned whether the statement of principles should be in primary legislation or incorporated in guidance or policy:

There was some concern that including principles within the statute would lead to impossible conflicts which would inevitably lead to an increase in court applications - either to the Court of Protection or High Court – with consequent costs and delays.

- 3.22 Newcastle City Council expressed concern about defining certain terms in legislation (such as choice and control) and resource limitations given that statutory principles could “have potentially far-reaching cost implications”. A further point regarding future-proofing legislation was made:

Given the identified difficulties created by the current patchwork of amended legislation, how sustainable are these principles in the future and how long would it be before the primary legislation would date in relation to policy drivers?

<sup>1</sup> Emphasis in original.

### ***Concerns about how to construct principles***

- 3.23 A number of consultees raised concern about how the principles would be constructed. For example, the British Psychological Society argued that a statement of principles within the statute “is likely to be difficult to construct ... and potentially bland”. The Local Government Association argued that it will be “essential to ensure that any statement of principles is not drawn too tightly such that it becomes restrictive or reduces flexibility”.
- 3.24 Nottingham City Council – while supporting the proposal – expressed concern that “the language needs to be legally watertight to prevent, wherever possible, litigation and costs caused by vexatious claims”. Similarly, the Carers’ Resource (Harrogate and Craven, Bradford and Airedale) argued that the statutory principles “need to be precise in order to assist decision making and promote consistency”. Scope suggested that the principles should “have supporting information to clarify and define their content, perhaps with examples”.
- 3.25 Anthony Collins Solicitors expressed doubt about whether “the same degree of shared principles can be achieved in the case of social care as have been achieved in the fields of health, education or children’s care”. They argued that:

The nature of personal care will change significantly over time. If principles are established they should be capable of being changed and developed with changed social needs.

### ***Opposition to statutory principles***

- 3.26 A small number of consultees did not agree that a statement of principles was suitable. For example, BUPA Care Homes argued that:

a specific statement will not add anything by having little or no legal effect or, if it does, that it will make the law difficult to interpret and could fix the principles at a point in time.

- 3.27 They considered that the principles suggested in the consultation paper were a reflection of the current position and that a “much more appropriate place for them would be in guidance or statutory regulations”. They preferred the former, arguing that “these could then be amended more easily to cope with changes in social care practice”.

- 3.28 Belinda Schwehr, a legal and training consultant, did not consider that principles “will be of any use in relation to community care”. She went on to say that:

I think use of such principles will lead to the sort of litigation we are now seeing about disability discrimination and equalities duties – exactly how bad does the decision have to appear before a judge feels able to decide that the authority must have been completely ignorant of the obligation to turn its mind to the impact of its proposal to itself, on disabled people?



- 3.29 The Welsh Assembly Government expressed some reservations and questions about the inclusion of statutory principles in the statute “particularly around their practical application and resource implications”. For example, they were unsure what weight would be given to the principles by courts, whether there would be duplication with other legislation and how the principles would affect decision making. They also queried whether decision makers will need to evidence that the principles have been taken into account, which may have resource implications in terms of paperwork.

### ***Conclusion***

- 3.30 The majority of consultees strongly supported the proposal that the statute should include a statement of principles. Some suggested it would clarify the underlying aims of the legislation, re-energise the adult social care sector, encourage better and more consistent decision-making and generally educate people about the purpose and role of adult social care. Most consultees agreed that the principles should be in statute and not in guidance, in order to give them more prominence and force. However, a small number of consultees disagreed with statutory principles and argued that the principles should be set out in guidance.

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

- 3.31 Of the 231 submissions which were received, 83 submissions expressed a view on the question of whether there should be a principle in the statute which provides that decision makers must maximise the choice and control of service users. Of those consultees, 61 answered that this principle should be included, 7 argued that it should not be included, and 15 held an equivocal position.

***The importance of choice and control***

- 3.32 The majority of consultees agreed that maximising choice and control should be included as a principle in the statute, on the basis that choice and control are fundamental concepts. For example, Mencap stated that “this is essential in fulfilling the human rights of individuals who receive care support”. Similarly, RADAR and the National Centre for Independent Living stated that it is “vital” that disabled people are given maximum freedom over how they manage their resources:

Autonomy underpins independent living and is one of the fundamental human rights principles. Self-determination – or choice and control – are not just ends in themselves, but they may enable the individual to contribute to society through community involvement and employment.

- 3.33 Newcastle City Council recognised that “the principle of maximising choice and control was considered very positive” but also expressed some concern that “the phrase ‘choice and control’ has become jargon and has lost some meaning”. They suggested that the principle of control is “a greater concern” than that of choice, and questioned whether there would be potential conflict with “other statutes [that] effectively reduce people’s control over their lives, care and environment”.

- 3.34 Conversely, Solicitors for the Elderly argued:

Clearly for some, maximising choice where they have been treated with condescension is an important part of their self determination and expression of free will, but not everyone in need of social care shares that view or has the same need to be “in control”. For example many people leaving hospital may be happy for someone to arrange their care package so long as their needs are well met and provided for in a dignified manner.

### ***The need for informed choice***

- 3.35 Several consultees argued that informed choice, in practice, requires the availability of advocacy and brokerage. For example, Age Cymru argued that “this principle must include reference to independent advocacy, which would fill a crucial support role in enabling service users to maximise choice and control”. Similarly, RADAR and the National Centre for Independent Living stated that “of course, choice and control can only exist with genuine access to information, support and advocacy”.
- 3.36 Furthermore, RNID stated that, in practice, this proposal “will mean that decision-makers will need to ensure that brokerage is available to service users”. They referred to the Social Care Institute for Excellence’s definition “that describes support brokerage as a set of tasks to enable people to plan and arrange social care”.<sup>2</sup>
- 3.37 The Medway Older People Communication Network also emphasised the importance of information and guidance in allowing people to make an informed choice. However, they suggested that this function should be carried out by the local authority, and not by “unaccountable, albeit well-meaning, voluntary bodies”.

### ***Undue influence and coercion***

- 3.38 Several consultees, including West Berkshire Safeguarding Adults Board and the Welsh Assembly Government for example, highlighted the potential tension between the proposal and safeguarding adults from abuse. Furthermore, Robert Browning, a parent carer, expressed concern that:

Choice presumes an intellectual capacity that only very few of those with Learning Disability can hope to attain and, from personal experience, I can state that the proposition contains an inherently massive high risk of manipulation, even by parents in some instances, but more likely by others.

- 3.39 He also argued that there is a “dangerous weakness” in the promotion of choices, where a person suffering from a learning disability is unable to make a “wise choice”.
- 3.40 Similarly, Solicitors for the Elderly stated that some of their members, when acting as a deputy or attorney for a mentally incapacitated adult, have been informed that they can only receive services if they accept a direct payment. They argued that:

Not everyone has the benefit of legal advice ... and they may be befriended or groomed by others who abuse the funds received, leaving the person increasingly vulnerable to neglect and abuse.

### ***Choice and control for carers***

- 3.41 Several carers’ organisations added that the principle of choice and control should be extended to carers’ assessments and services. For example, Carers UK stated that:

<sup>2</sup> <http://www.scie.org.uk/publications/atagance/atagance12.asp>

The autonomy of carers to determine the level and type of care they provide must, we believe, also be a fundamental principle, acknowledged either alongside that of service users as one principle (our preferred model) or expressed as a separate principle. This would, of course, require, in some cases, a balancing of competing rights and interests, but advice on this could be included in the code of practice.

3.42 Similarly, the Standing Commission on Carers stated that they would prefer:

an explicit reference to carers as discussions around self-directed care and support do not reflect the preferences of carers with regard to their ability and willingness to care or the level or timescale of care that they feel able to provide. The proposed statute should acknowledge the equal, inter-dependent and inter-related relationships between carers and those to whom they offer care and support.

3.43 Furthermore, the Children's Society – while agreeing with the proposal – expressed concern that “the service user's choice and control should not be upheld at the expense of any children caring for them”. They cited the *Framework for the Assessment of Children in Need and their Families* Guidance, which states that “there may be differences of view between children and their parents about appropriate levels of care” and they added that “such differences may be out in the open or concealed”.<sup>3</sup>

#### ***The need for balance***

3.44 North Tyneside Council stated that they agreed with the policy direction of maximising choice and control, but expressed reservations about it becoming a principle in statute law because “clearly maximizing choice and control should not take priority over meeting assessed needs”.

3.45 The Royal College of Psychiatrists argued that choice and control are important but for people with a mental health problems, including those who lack capacity, “acting according to wishes and feelings is what matters most since they may in fact not wish to take control at such a time”.

3.46 Similarly, the Law Society stated that:

There is a risk of placing a mandatory duty couched in the way set out in the question in conflict with the principles applicable to those who lack capacity as set out in the Mental Capacity Act 2005. It is suggested instead that there could be a provision that decision makers should have due regard to the principle of respecting the choice and control of service users. This should take into account the fact that some people might prefer services to be arranged for them rather than receive a direct payment or personal budget.

3.47 Furthermore, Solicitors for the Elderly suggested that:

<sup>3</sup> Department of Health, *Framework for the Assessment of Children in Need and their Families* (2004).

People wish to receive adequate and affordable services. Many people our members advise opt for direct payments and “user control” because the services they were provided with were poor ... The “maximising choice and control” agenda can mask what is fundamentally an expression of dissatisfaction with services received rather than a need to exercise any freedoms of choice.

- 3.48 The Welsh Assembly Government stated that this principle may conflict with the role of the local authority as an employer:

In relation to the choice of carer and equalities legislation, for example, where a service user expresses a wish not to be cared for by a person of a particular race.

- 3.49 The North West Complaint Managers Group stated that “the term should be ‘promote’ rather than ‘maximise’ choice and control of service users”. Anthony Collins Solicitors suggested that a weaker principle might be more appropriate because “‘maximising’ threatens the ability of public authorities to discharge functions cost effectively for the benefit of the majority”.

***Equating choice and control with direct payments***

- 3.50 Some consultees suggested that local authorities have come to automatically equate choice and control with direct payments, and that these are not suitable for everyone. For example, the RNIB and Guide Dogs stated that “it is important that this is not simply taken by decision makers to be shorthand for the provision of self-administered personal budgets” and argued that people should be able to choose to have traditional services, delivered in the traditional way.

- 3.51 Similarly, Solicitors for the Elderly pointed to cases of “people being forced to accept a direct payment, where they do not have the desire or energy to arrange their own care”.

- 3.52 Furthermore, the Medway Older People Communication Network stated that:

We do not believe that providing individuals with lump sums of cash is an effective way of ensuring either that the individual gets the service they need or that it ensures cost effective services for the tax payer. Rather we fear that ... the aim of the exercise is to reduce the amount paid for a person’s services and thus ultimately providing the individual with an inferior service.

- 3.53 Furthermore, Stephen Browning, a carer, cited examples of abuse “which have only recently led to the tragic and cruel death of persons with learning disability” by their carers, and suggested that “adding large amounts of regular cash into that social mix can only stimulate the temptation for such wrong-doing”.

### ***Creating unrealistic expectations***

- 3.54 A small number of consultees expressed concern that the proposal would create unrealistic expectations amongst service users. For example, Gateshead Council stated that in relation to adaptations “people desire outcomes over and above what we would consider essential” and therefore “increasing the level of expectation of choice and control will increase the numbers of complaints”. It was suggested that this principle would be better expressed as a duty to “give effect to the service user’s wishes unless it was not appropriate to meet assessed need or not cost effective (with the ability for the service user to ‘top up’)”.
- 3.55 Similarly, the Socio-Legal Studies Association stated that “a principle maximising choice may set up unrealistic expectations amongst service users and distort the provision of services”.
- 3.56 Some consultees disagreed about the significance of financial implications for the local authority. For example, Lincolnshire Partnership NHS Foundation Trust cited “cost-effectiveness” as an important factor for decision-makers to consider. On the other hand, York Carers Centre argued that the principle:

may be undermined if there is express reference to it being subject to the cost-effectiveness of the choices available and the local authority’s view on the suitability of the choices.

- 3.57 Moreover, Michael Mandelstam, a legal trainer and consultant, stated that it is “hollow to give people a choice of what to do if the resources on offer are inadequate”.

### ***The need for further guidance***

- 3.58 Several consultees suggested that there is a need for further guidance in applying this principle. For example, Hertfordshire County Council stated that “guidance and/or [a] code of practice should make clear that this is ‘within defined personal budget/ taking into account available resources’”.
- 3.59 Compassion in Dying suggested that the accompanying guidance “be tailored to the specific needs of different client groups”.

### ***Conclusion***

- 3.60 There was a strongly affirmative response to the question of whether there should be a principle in the statute which provides that decision-makers must maximise the choice and control of service users. Many consultees emphasised the importance of choice and control, and described the principle as the cornerstone of adult social care. However, many consultees also expressed concern that the principle should be based on informed choice, away from undue influence and coercion. Moreover, some consultees argued that local authorities are abdicating their responsibilities and enforcing direct payments on people who do not want them, or on people who are incapable of administering them, therefore exposing them to a risk of abuse and neglect.

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

- 3.61 Of the 231 submissions which were received, 73 submissions expressed a view on the question whether there should be a principle in the statute based on person-centred planning. Of those consultees, 47 answered that this principle should be included, 17 argued that it should not be included, and 9 held an equivocal position.

***The importance of person-centred planning***

- 3.62 Many consultees argued that this principle should be included because of the importance of person-centred planning. For example, the National Autistic Society stated that person-centred planning “should be intrinsic to every aspect of social care: a statement to this effect would help to make this point”.
- 3.63 Compassion in Dying stated that “service users must be at the heart of planning and decision making ... [which] would enable service users and carers to plan their futures effectively”. They highlighted that person-centred planning “is already a core aim of end-of-life care”. Similarly, the Council for Disabled Children stated that:

Taking a person-centred approach is vital for disabled young people to establish a sustainable system of support that will help them move towards their aspirations, including aspirations for independent living and employment.

- 3.64 Solicitors for the Elderly also supported a statutory principle based on person-centred planning “as something to aspire to” but noted a number of practical difficulties:

Person-centred planning will often depend upon the ability to communicate one’s expectations and the skill and effort of the person undertaking the assessment and care plan. The breadth of expectations may depend on what that person is told or what they have experienced.

- 3.65 The Wales Council for Voluntary Action stated person-centred planning is:

the seminal principle for citizen-centred services and communal transactions based on reciprocity. Service users will maximise their ‘voice’, improvement and control of services by involvement in the design and planning of those services. This principle should *also* be incorporated into provisions of the legislation.<sup>4</sup>

- 3.66 The National Family Carer Network – while supporting the inclusion of this principle – warned that “not having a person-centred plan in place must not be allowed to be a block to getting support in the short term”.

<sup>4</sup> Emphasis in original.

3.67 On the other hand, Simon Burdis, a carer, stated that:

In some local authorities, person-centred planning has become meaningless: the local authority does not have the personnel with the requisite training, expertise and experience to carry it out, where it has been carried out the local authority ignores it, where a person-centred plan has been requested it is refused or the involvement of family carers is denied contrary often to the local authority's own and government's best practice guidance, even where the person concerned has severe or complex needs and family carers have a right to be involved at all stages.

3.68 The Joseph Rowntree Foundation, while supporting the inclusion of the principle, stated that:

Obstacles to person-centred planning – and more broadly to person-centred approaches to supporting people – include lack of resources, culture and attitudes of carers and families, skills and training of staff and poor inter-agency working

***Person-centred planning as a principle is unnecessary***

3.69 Newcastle City Council considered person-centred planning to be “fundamental to current practice” but argued that it should be incorporated into other provisions. Similarly, Nottingham City Council stated that establishing person-centred planning as a statutory principle is not necessary as it is “covered elsewhere in the statute”.

3.70 Cartrefi Cymru also argued that a separate principle based on person-centred planning would be unnecessary because:

Statements of principle around individual assessment, choice and control and independent living could adequately incorporate the principles of person-centred planning.

3.71 Similarly, the RNIB and Guide Dogs stated that including a principle based on person-centred planning is not necessary, especially since the term may be considered “jargon” and “therefore possibly relatively short-lived”.

3.72 The Welsh Assembly Government stated that:

In practice, this principle is unlikely to make any legal impact as it would not add to existing requirements or proposed requirements about how assessments should be carried out.

***Wording of the principle***

3.73 Coventry City Council argued that the specific use of the term person-centred planning “may not be easily understood by everyone” and therefore suggested that:

There should be a broad principle to reflect the need to ensure individuals are at the centre of assessing and designing appropriate



packages of support for themselves which is a key element of the personalisation agenda.

3.74 East Riding of Yorkshire Council expressed concern that, while they “agree that it is right that the individual should be at the heart of their assessment and involved in planning how their needs will be met”, having a principle based on person-centred planning “will be too restrictive for local authorities”. They therefore enquired whether it would be “sufficient to promote consultation with the individual during the assessment and support planning process”.

3.75 The Council for Disabled Children stated that:

It is important that [principles] are carefully worded. There is a risk that person-centred planning is seen as a one-off event that does not feed into service delivery and therefore does not improve outcomes. Rather than referring to person-centred planning it may be more helpful to refer to a person-centred approach to assessment, care planning, commissioning and delivery. What this means should then be set out in guidance.

***Too broad and insufficiently precise***

3.76 Several consultees stated that person-centred planning is too vague to form the basis of a statutory principle. For example, Michael Mandelstam, a legal trainer and consultant, argued that if you are dealing with an individual person, an assessment cannot be anything but person-centred.

3.77 NAAPS and other organisations such as the National Housing Federation and Newcastle City Council argued that person-centred planning is a process rather than a principle and is best provided for in regulations which detail the assessment duty.

3.78 The Lincolnshire Partnership NHS Foundation Trust highlighted that:

The balance between vulnerability and capacity on a day-to-day basis for practitioners is unclear and can be a cause for concern especially as capacity is often a determinative issue of safeguarding investigation conclusions ... Inclusion of a necessarily broad principle of person-centred planning may therefore serve to increase confusion in a sensitive and testing area for individuals and practitioners alike.

3.79 They provided an example where this principle may lead to potential conflict with the principle of dignity proposed below:

An individual with learning disability and mental disorder assessed as having capacity in relation to deciding the level and manner of physical care they require wishes to appear in a manner running contra to “socially accepted norms”. If the individual states they wish to sport greasy hair and wear ill-fitting clothing, the law would currently allow this providing the individual had capacity to so decide. If the incontinent capacitated individual wishes to wear soiled clothing, and live in an unhygienic or unhealthy home, the situation becomes far less clear for practitioners, especially when balancing

the rights of the individual with the concept of dignity. In very rare and extreme cases, powers under public health legislation to remove individuals from their environment have been considered.

- 3.80 Several consultees argued that further definition is required. For example, Disability North – while stating that a principle based on person-centred planning is an “excellent idea” – warned that it “may be largely valueless unless it is accompanied by some definition of what person-centred planning actually is”. Similarly, Age UK and Age Cymru stated that person-centred care is “not clear and [its] meaning is sometimes contested” and so they recommended that the statute should include a definition of the term.
- 3.81 There was some support expressed at consultation events for creating a statutory principle from certain elements of person-centred planning, such as a requirement that all decisions should be based upon the individual circumstances of the person and not blanket assumptions on the basis of, for example, their age, appearance or condition and a statutory principle which would encourage maximum participation for service users and carers in the decision making process.

#### ***Taking other people into account***

- 3.82 The Princess Royal Trust for Carers and Crossroads Care stated that they “support the personalisation of support planning” but cautioned that:

Person-centred planning could be to the detriment of better outcomes achieved through joint planning of support for the service user, carer and potentially other service users within the same family. There should be a principle that support planning should be centred on the person rather than the provider, whilst making clear that support planning can incorporate the needs of two or more related individuals.

- 3.83 The Blackburn with Darwen, Blackpool and Lancashire Safeguarding Adults Boards argued that “the presumption of person-centred planning should be balanced by the acknowledgment of a person’s relationships with significant adults in their lives.” They stated there are examples of “person-centred planning methodologies which contain prescriptive sections which do not take account of the centrality of relationships in the life of an individual”.
- 3.84 The Cardiff and Value of Glamorgan Voluntary Health and Social Care Networks stated that the term “person” in “person-centred planning” needs defining, and argued that “this should include both the cared-for and the carer”.

#### ***Overlap with other principles***

- 3.85 The Cardiff and Value of Glamorgan Voluntary Health and Social Care Networks stated that person-centred planning could be combined with viewing a person’s needs broadly into a single principle, which incorporates “physical social and emotional needs to emphasise the holistic approach in viewing an individual’s needs”. Hertfordshire County Council also stated that the principle should state “that the individual should be the centre of all assessment, care management and review” and that this could then incorporate the principle that a person’s needs should be viewed broadly.

- 3.86 Several consultees, like ADASS for example, also suggested that person-centred planning is a mechanism to achieve the principle that decision makers must maximise the choice and control of service users. Similarly, Carers UK argued that “person-centred planning is one mechanism for achieving choice and control and can be dealt with in a code of practice”.

### ***Conclusion***

- 3.87 There was a predominantly affirmative response to the question of whether there should be a principle in the statute based on person-centred planning. However, many consultees expressed concern about whether person-centred planning is suitable as the basis of a principle, and suggested that it should be incorporated into other provisions in the statute. Several consultees suggested that person-centred planning is a process rather than a principle and can therefore be a mechanism in achieving the principle of maximising choice and control. Some consultees argued that person-centred planning is vague and suggested alternative language for the proposal.

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

- 3.88 Of the 231 submissions which were received, 71 submissions expressed a view on the question of whether there should be a principle in the statute which provides that a person's needs should be viewed broadly. Of those consultees, 48 answered that this principle should be included, 17 argued that it should not be included, and 6 held an equivocal position.

***The importance of viewing needs broadly***

- 3.89 Many consultees agreed with the inclusion of this principle on the basis that it would encourage a more holistic assessment of a person's needs. For example, Mencap stated that:

Social care services are the route for many people with a learning disability to live the life that they want. This includes the provision of support for individuals to participate in recreational activities, support to get a job or support to have a family. All of which are elements of basic human rights.

- 3.90 Similarly, the National Family Carer Network stated that:

Holistic assessments should take both the physical and mental well being of the person needing care and support and the family into account. Too many people with a learning disability also have mental health problems. They are lonely and isolated because they do not have the support they need to belong to the community.

- 3.91 The National Aids Trust argued that this principle is crucial to people living with HIV whose needs are varied and include "not only physical support requirements but also psychological support due to the stigmatised nature of the condition".

- 3.92 Moreover, the Disability Law Service stated that "the principle should recognise that a person's needs will fluctuate from time to time depending on their condition". They argued that:

Views from the service user, family, carers and medical professionals (as well as other relevant people) should be taken as to how their condition can vary over time and how the extremes can sometimes require more support than the individual would ordinarily require.

- 3.93 The Children's Society stated that a person's "needs should be viewed in terms of their quality of life, and the life of their surrounding family, and not just in terms of their need for specific services". Simon Burdis, a carer, suggested that the principle that a person's needs should be "with reference to and in consultation with family carers who need and wish to be involved due to the nature or severity of the disabling condition".

### ***Increasing recognition of communication needs***

- 3.94 Several consultees, such as the RNID and the RNIB and Guide Dogs highlighted that this is of particular importance to people with communication needs. Similarly, Sense described this principle as “of critical importance to deafblind people”. They added that:

All aspects of their life should be considered and the person’s own view of what is most important should be taken into account. Whilst it could be argued that this is already the case in law, it is not how the law is implemented. We feel that giving this the status of a principle will help ensure that it is carried out.

- 3.95 Likewise, Liz Ball, a deafblind person, stated that:

Social services, in my experience, prioritise personal care over other forms of social care. It is crucial for deafblind people, such as myself, that needs relating to communication, mobility and access to information are considered. If this were made a statutory principle, it would help to ensure that all areas of life are given equal weighting

- 3.96 As an example she stated that she is allowed to use direct payments for somebody to spend five minutes, twice a day making sure that she took the personal medication, as this counts as personal care. However, she is not allowed to use direct payments to pay someone to go to the pharmacy to collect the medication and then assist her to label it in Braille so that she could take it independently, although this would take a lot less time and hence cost less.

### ***Too vague and insufficiently precise***

- 3.97 Several consultees argued that viewing a person’s needs broadly is too vague to form a statutory principle. For example, the Welsh Assembly Government stated that “this principle could not be sufficiently precisely stated to operate as a statutory principle”. The London Borough of Havering stated that, while they accept that “it is appropriate to have a holistic approach to assessing and providing for a person’s needs”, they are “not convinced that the phrase ‘viewing a person’s needs broadly’ will be sufficiently precise to achieve that end”.

- 3.98 Nottingham City Council stated that they are “totally opposed to this [principle] on the basis that it will encourage vexatious claims and has no real meaning”.

- 3.99 The Practitioners Alliance Against the Abuse of Vulnerable Adults stated that:

Structuring such a principle would be difficult and the aim may therefore be more successfully achieved where it may be dealt with in more detail. A principle that is too loosely worded may end up achieving very little or be open to wide interpretation which may even be contrary to that intended

- 3.100 On the other hand, Age UK and Age Cymru agreed with the proposal, but suggested that the statute should define what is meant by “taking a broad view”. They suggested that:

Such a definition should incorporate the conclusions of existing community care and human rights case law with regard to the need to assess social and psychological needs, to take into account the right to personal development in a social setting, and a right to dignity. As existing legislation has been developed by case law, we recommend that a definition of the areas that assessment should cover should be included in the statute itself rather than being left to guidance.

***Viewing needs broadly should be covered elsewhere***

- 3.101 Several consultees argued that this principle should be covered by other principles or provisions in the statute, or left to guidance. For example, Sunderland City Council suggested that the principle of maximising choice and control and the principle based on person-centred planning “could cover the issue of meeting a broad range of needs with some flexibility”. They further stated that the “courts have found it difficult to apply any rigid view of what should or should not be involved in the assessment process”.
- 3.102 North Tyneside Council stated that this principle “should be covered in the assessment process with sufficient guidelines offered to ensure that needs are viewed broadly”.
- 3.103 Solicitors for the Elderly questioned whether this should be a principle, and suggested that:

There is merit in having the scope of an assessment set out under domains such as “matters which be given consideration when making an assessment” and should contain a sweeping up clause such as “any other reasonable consideration as may in the circumstances be appropriate”.

- 3.104 On the other hand, Disability North stated that “the holistic nature of the assessment process should be sufficiently clear throughout the statute but a principle to consider needs broadly may be useful”.
- 3.105 Similarly, Action on Elder Abuse argued that there should be a principle which provides that a person’s needs should be viewed broadly:

Our general view is that “best practice” approaches toward the assessment and provision of social care are open to the influence of external factors such as funding priorities etc, and that, if they are crucial to the decision making process, they should be included as an explicitly stated principle.

***Conclusion***

- 3.106 There was a strongly affirmative response to the question of whether there should be a principle in the statute which provides that a person’s needs should be viewed broadly. Some consultees argued that this would emphasise the importance of viewing a person’s needs holistically, in particular, paying attention to the communication needs of people who are deaf or blind or both. On the other hand, some consultees argued that this would be insufficiently precise to include as a principle, and is best covered by other principles or provisions in the statute.

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

- 3.107 Of the 231 submissions which were received, 71 submissions expressed a view on the question of whether there should be a principle in the statute based on the need to remove or reduce future need. Of those consultees, 49 answered that this principle should be included, 11 argued that it should not be included, and 11 held an equivocal position.

***The importance of preventative services***

- 3.108 Many consultees argued that there should be a principle based on the need to remove or reduce future need on the basis that preventative services are of crucial importance. For example, the York Carers Centre “strongly” supported the inclusion of this principle, and stated that “it is long overdue”. They argued that:

In some categories of cases, the benefits will be far beyond those which accrue to the individual and their independence. Benefit could extend to greater social integration, reduced demand for help, better health (and so reduced pressure on the NHS) and other reduced pressures on public services.

- 3.109 The National Family Carer Network argued that “preventative work is essential” and stated further that:

Waiting for a crisis is bad for the individual and their family and usually costs more to the public purse in the long run. It is well recognised that a small amount of support can keep people out of needing far more support later.

- 3.110 RNID highlighted that despite the fact that the need to remove or reduce future need is seen as a policy priority:

Growing levels of demand for social care has meant that many local authorities have restricted their services to those people who have substantial or critical needs. This means that some of those people with low or moderate needs do not receive the care that would prevent their needs from becoming substantial or critical.

- 3.111 They further argued that the introduction of a statutory principle based on prevention “would ensure practitioners take this requirement seriously and also reflects the fact this is a policy priority”.

- 3.112 On the other hand, Hull City Council – while welcoming a statutory principle to remove or reduce future need – cautioned that “any legislative duty to provide care to reduce or remove future need has to be tempered with a degree of proportionality of care required and care needed”.

### ***The cost-effectiveness of preventative services***

3.113 As well as being in the interest of the service user, several consultees argued that preventative services are also a cost-effective way of meeting social care needs. For example, RNIB and Guide Dogs argued that “this not only helps to promote independence and choice but also leads to considerable cost savings in the long run”.

3.114 Similarly, Cartrefi Cymru stated that:

Early intervention to address needs before they reach acute or critical levels can delay or halt progression to more acute levels that can be both more expensive to deal with and have a greater effect on the long term independence of the individual.

3.115 The Joseph Rowntree Foundation – while suggesting that this principle could be combined with person-centred planning – stated that:

Relatively low cost, and often mainstream, universally accessible services were identified as having disproportionate benefits to people’s sense of independence and well-being and as a means of preventing more costly and intensive help later on.

3.116 The National Aids Trust expressed concern that:

In the current difficult economic environment local authorities will be tempted to direct resource to those with the most extreme needs, removing services from others which are vital for them to maintain active and fulfilling lives. This in the long term will cost rather than save money as many low-level interventions prevent people developing more severe needs that are more expensive to meet.

3.117 On the other hand, RADAR and the National Centre for Independent Living – while expressing strong support for types of services which remove or reduce the level of help required in the future – cautioned that “an increasingly popular focus on prevention may in future restrict the spending for those with existing ‘high needs’”.

### ***Autism and learning disability***

3.118 Several consultees argued that this principle is less relevant to autism and learning disability because care and support needs are unlikely to reduce with time. For example, the National Autistic Society stated that “many conditions, including autism, are lifelong and a principle to remove or reduce future need would be inappropriate”.

3.119 Similarly, Mencap stated that “as learning disability is a life-long condition, it is rare that care and support would remove or reduce” future need. However, it was acknowledged that “early intervention and prevention services can prevent individuals from being in crisis or causing family carers to reach breaking point”.



### ***Effect on eligibility criteria***

- 3.120 Some consultees were unclear about the relationship between the principle to remove or reduce future need and the eligibility criteria. For example, the Welsh Assembly Government was concerned that if this principle was capable of making any legal difference it could affect the outcome of decisions on eligibility where the person does not meet the eligibility criteria.
- 3.121 Age UK – while agreeing with the proposal – also stated that “there are considerable difficulties in describing how this should be done”, particularly with regard to “the process of allocating resources”. They stated that:

Existing statutory guidance on determining eligibility has attempted to reconcile the targeting of services at people with the highest needs with a focus on prevention.

- 3.122 They highlighted, however, that neither the *Prioritising Need* statutory guidance nor its predecessor, *Fair Access to Care Services* “are entirely clear about how this should be done”.<sup>5</sup>

### ***Other issues***

- 3.123 Several consultees, such as Age UK, argued that the current wording of the principle “assumes greater certainty about the effectiveness of interventions than actually exist”, and recommended replacing reduce with might reduce.
- 3.124 Several consultees highlighted that preventative services extend beyond social care authorities, overlapping in particular with health services. For example, ADASS Cymru stated that this is “complex particularly at the interface with health when determining eligibility and funding”. Gateshead Council suggested that the concept of prevention:

could not be addressed simply as a social care responsibility as so many of the threats to independence are caused by or linked to health related matters such as obesity, smoking and substance abuse.

- 3.125 Similarly, the Joseph Rowntree Foundation argued that “preventative services are not the same services in smaller portions at an earlier stage”, but “it’s a responsibility that extends well beyond social services”.

<sup>5</sup> Department of Health, *Prioritising Need in the Context of Putting People First* (2010) and LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*.

### ***Conclusion***

- 3.126 There was a predominantly affirmative response to the question of whether there should be a principle in the statute based on the need to remove or reduce future need. Many consultees argued that such a principle should be included on the basis that preventative services are important, and may reduce the demand on and cost of adult social care in the long run. However, some consultees were unclear about the relationship between the principle and eligibility criteria and others pointed out that health services also have some responsibilities for prevention.

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

- 3.127 Of the 231 submissions which were received, 82 submissions expressed a view on the question of whether there should be a principle in the statute based on the concept of independent living. Of those consultees, 44 answered that this principle should be included, 25 argued that it should not be included, and 13 held an equivocal position.

***Support for independent living***

- 3.128 Most consultees argued in favour of a principle based on independent living on the basis that it will ensure that people will get the support they need to achieve full citizenship. For example, the Office for Disability Issues argued that:

The adult social care statute should be based on the concept of independent living, with emphasis on: choice and control - disabled people having choice and control over the support they need to go about their daily lives; and co-production – involving those who are affected by the policy at every stage of policy development, implementation and delivery.

- 3.129 Similarly, Disability Wales argued that independent living should be “the primary principle of the legislation” so that it becomes “the first and paramount consideration whenever social services make a decision or take action”.

- 3.130 Compassion in Dying suggested that the principle of independent living is particularly important:

as a means of providing those at the end-of-life with dignity and a place to live and/or die during the last stages of life, as well as in the broader sense (for disabled people and others not approaching the end of life).

- 3.131 Some consultees argued that independent living is essential in order to engineer a move away from care home provision. For example, Regenerate RISE argued that:

Residential care should be phased out and extra-care take over. The largest number of homeless people in this country are older people because generally speaking they are removed from their home against their will and placed with people they would never choose to live with, or an environment they would never choose to live in.

- 3.132 Similarly, the National Housing Federation argued that:

This principle is necessary to end the bias towards placing people in regulated residential care homes. Currently people with very similar social care needs have a variable chance of living in a care home depending on where they live in the country. This principle is a vital link across the social care system to consideration of a person’s housing circumstances. These circumstances can make a huge

difference to a person's ability to exercise choice and control and address undignified standards of care.

- 3.133 However, other consultees, such as Southern Cross, argued that "it should be recognised that independent living is possible in a residential care environment".

***The importance of legal clarity***

- 3.134 Some consultees expressed concern that this principle is difficult to define in practice. Solicitors for the Elderly argued that the principle of independent living was too subjective and that:

Many older people choose not to receive any help because they see it as losing independence; whereas it may prevent an older person from going into a care home which would make them more dependent.

- 3.135 Similarly, Cartrefi Cymru argued that:

Given that the concept of "independent living" is so difficult to pin down and encompasses such a wide range of aims and principles we agree that it would not lend itself to a legally enforceable statement of principle.

- 3.136 Simon Burdis, a carer, disagreed with this principle on the basis that the issue is more complicated. While some service users will be independent to some degree, for others "independence must be accompanied by appropriate interdependence (different sides of the same coin)".

- 3.137 The Foundation for People with Learning Difficulties noted that:

Independent living is not universally understood – for example, it is threatening to some minority ethnic communities and cultures in which interdependence is prized, and it is misunderstood by some people as "managing without support".

- 3.138 Due to these perceived definitional problems, some consultees suggested alternative principles. For example, Blackburn with Darwin, Blackpool and Lancashire Safeguarding Adults Boards argued that:

Given that village communities for people with learning disabilities are described as offering "independent living" we suggest that the presumption might be better defined as "supporting people to live as independently as possible and be assisted to achieve greater independence if this is their wish". Most people do not live independently of others and good mental health is better maintained when people are involved in mutually supportive relationships.

- 3.139 The National Family Carer Network argued that it is important to recognise that "independent living does not mean living without appropriate levels of care and support" but that "care and support should maximise independence and enable the individual and his or her family to exercise choice and control of their lives".

### ***Independent living in family homes***

- 3.140 A small number of consultees emphasised that independent living should not prohibit the option of living in a family home. For example, the Council for Disabled Children – while supporting this principle – argued that it should not “allow a bias in favour disabled young people living in their parents ‘homes’ against independent living in supported accommodation”.
- 3.141 Carers UK expressed concern that the definition of independent living “has tended to be limited to mean disabled people living in supported accommodation and not within a family”.

### ***Relationship with the choice and control principle***

- 3.142 Some consultees expressed concern that independent living could clash with the choice and control principle if, for instance, a disabled person wanted to be cared for in a communal setting. For example, the Disability Law Service agreed that the principle of independent living should be included in our statute but “with the caveat that if a service user does not wish to benefit from the concept of independent living, then their views are respected where appropriate”.
- 3.143 Liz Ball, a deafblind person, argued that:

For me, independent living is about being able to have the support I need, when I need it, in a way that I need it, so that I can live a life that is as near to normal as possible. However, this same objective could be achieved by viewing needs broadly and by giving service users genuine choice and control ... I consider these to be a critical aspect of social care law.

- 3.144 Royal College of Physicians of Edinburgh argued that that the principle of independent living would:

restrict the principle of choice and may force some individuals into situations such as group homes which they dislike or where others may be abusive towards them.

- 3.145 The Standing Commission on Carers, while supporting independent living, recognised that:

Many service users (and carers) may need support with “inter-dependent living” In this context we feel that this principle needs clarification, i.e. that there should be a vision of maximum choice and control, but that vision should take into account the probable need of service users and carers for support in achieving this goal.

### ***Wider considerations***

- 3.146 Some consultees – even those who supported this principle – argued that it is important to balance independent living with other considerations. For example, Gateshead Advocacy Information Network argued that the independent living principle “must be viewed in the context of what is actually achievable rather than aspirational”. Similarly, North Tyneside Council argued that independent living should be “only mandated where independent living is a realistic option”.

- 3.147 A specific example was provided by Michael Mandelstam, a legal trainer and consultant, who argued that independent living is less straightforward when applied to:

older people with multiple pathology including cognitive as well as physical issues ... Basically we are talking about sometimes very sick, ill, frail, vulnerable people in their own homes (and care homes). You can remove all the obstacles in the world but the fact that is that they often in a highly dependent and, I hate to say it, helpless state.

- 3.148 Some consultees expressed concern about the cost implications of independent living. For example, West Berkshire Safeguarding Adults Board – while supporting this principle – argued that it must be clarified that:

Local authorities must be able to take into consideration costs when making a placement. For example, where an equivalent residential/nursing placement exists which meets the service user's needs and is priced lower than a package of living at home, this must be a factor in decision making.

- 3.149 Belinda Schwehr, a legal and training consultant, put this point in strong terms:

It cannot be right that a person can demand that the state takes on the burden of the person's personal choices as to where they lived, who they lived with, what animals they keep, how they maintain their property, and the very fabric and suitability of the house or flat for adaptations, when exercising its strictly safety net obligation to meet social care needs, in my view. If independent living comes to mean living in your own home, regardless of the cost, we will all have to pay much more tax, and that will have to be debated politically.

### ***Conclusion***

- 3.150 There was a predominantly affirmative response to the question of whether there should be a principle in the statute based on the concept of independent living. Indeed for some consultees this should be the primary principle in our statute. Other consultees, however, expressed concern that this principle is difficult to define in practice, should not prohibit the option of living in a family home and might clash with the choice and control principle. Some consultees – even those who support this principle – argued that it is important to balance independent living with other considerations, such as costs.

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

- 3.151 Of the 231 submissions which were received, 79 submissions expressed a view on the question of whether there should be a principle in the statute based on the assumption of home-based living. Of those consultees, 20 answered that this principle should be included, 50 argued that it should not be included, and 9 held an equivocal position.

***The importance of choice and control***

- 3.152 Many consultees disagreed with a principle based on home-based living arguing that individuals' choice and wishes should be the key factor in deciding their living arrangements. For example, the North West Complaint Managers Group argued that:

It is understood that home-based living will be the preference for many, but placing a principle of an assumption of home based living it potentially conflicts with the principle of choice.

- 3.153 The British Psychological Society argued that:

Not everyone would consider that home-based living is an appropriate option for themselves. For some older people, loneliness is the end product of being the recipient of social care.

- 3.154 Stuart Marchant, a social care lawyer, argued that an assumption of home-based living "is not consistent with the concept of maximising choice" and "in a worst-case scenario, it could be manipulated against the interests of service users". Similarly, Action on Elder Abuse argued that there is a "fundamental flaw in any argument that presumes one type of care is automatically preferable to another" as this both "negates the purpose of a community care assessment and the right to choice of the individual".

- 3.155 Some consultees suggested ways in which to combine the principles of choice and control with the assumption of home-based living. For example, the Vale of Glamorgan Carers' Forum argued that "no assumption should be made regarding the provision on care or services" and that service users and their carers should "always be asked about their wishes". However, there should be "a right for people to stay at home wherever possible if that is their wish".

- 3.156 Counsel and Care argued that the principle should be focused on supporting people to stay or move to where they want to be, especially in later life, and that moving into a care home can be a positive choice for many older people.

***Resources***

- 3.157 Some consultees pointed to the cost implications of this principle. This issue was put strongly by BUPA Care Homes:

We believe that this principle has a potential adverse costs implication and as such is a matter for policy. In our experience, many of our residents have a high level of needs requiring a high level of

care. In order to remain in their own homes, such people would require a high level of care, in many cases 24 hour care, which would be more expensive to deliver in their own homes.

3.158 Gateshead Council also pointed out that:

The present housing stock is often not suitable to provide homes for disabled people. Central and local government would have to be given corresponding duties to ensure that a proportion of both private and public housing was suitable – the greatest need being for single level housing and level access showers or “wet rooms”. Financial incentives to promote “co-living” solutions should also be put in place.

3.159 However, other consultees disagreed that financial considerations should be the overriding factor. Solicitors for the Elderly, for example, suggested that this principle might be useful to counteract “the prevalent inclination towards institutionalised care that is cheaper and more convenient to provide than home based care for older people”. They argued further that:

An interesting comparison is the principle of the least restrictive options in the Mental Capacity Act 2005 and if such a principle were adopted into the proposed social care statute it may throw up some surprising results in terms of service provision for elderly people.

#### ***Support for home-based living***

3.160 Some consultees expressed general support for the inclusion of this principle on the basis of the importance of providing home-based care. For example, the UK Homecare Association expressed strong support for this principle and that it “merits a separate principle, in addition to any choice and control principle” because:

Modern homecare is designed to cope with a range of service users’ needs from relatively straightforward assistance to more complex medical needs, and is able to support even highly dependent service users. Without a clear principle in the legislation, we fear that cash-strapped councils will be able to insist that service users who require intensive support must be cared for in a (usually cheaper) residential care environment, rather than at home.

3.161 The Practitioners Alliance Against the Abuse of Vulnerable Adults argued that there is “too often an assumption that residential care is the only option” which is best addressed by introducing an assumption of a home-based package of care, with “the option of the individual themselves overriding it”. Otherwise, they argued, “moving into a care home will continue to be seen as the easiest or cheapest option for social services”.

3.162 The York Carers Centre argued that a principle of home based care “is too important and will affect too many people to be subject to such substantial caveats” and whilst acknowledging potential drafting difficulties, they stated that “as a basic starting point the principle should be included”.



3.163 On the other hand, several consultees supported the principle but only subject to certain caveats. North Tyneside Council supported “the ethos of this principle” but argued “that there should be a caveat around this being mandated only where home-based living is a realistic option”. The Wales Council for Voluntary Action argued that this principle could only operate effectively if “a far broader range of more holistic services can be provided” at home.

3.164 Kevin Issac, a carer expressed concern about this principle because:

Many mentally handicapped people I know aspire to independent and/or home based living, and some succeed in obtaining this. However, it may place a heavy burden on both carers and service providers. These principles must be viewed in the context of what is actually achievable rather than aspirational. The boundary between the two is frequently quite hard to define.

#### ***The definition of a home***

3.165 Many consultees expressed concern about the definition of a home under this principle. For example, the National Family Carer Network stated that:

People with learning disabilities, like other citizens, want to live with maximum independence but with appropriate support. In the majority of cases, this will be in the family home or in a home of their own with support. The presumption should be that people have the right to live in ordinary homes in their local communities *unless* they wish to move elsewhere.<sup>6</sup>

3.166 Age UK also pointed out that in the future the distinction between residential care and home based living will become increasingly blurred by the development of new forms of extra care sheltered housing and community based care. RNID argued that supported tenancy schemes, can be described as both care being provided at home and care being provided in an institution.

3.167 Similarly, the Joseph Rowntree Foundation argued that the distinction made between care being provided at home and care being provided in an institution is artificial. They provided the example of Hartfields retirement village which is intended to be an independent living setting, but can accommodate people with high levels of need for care and support who would otherwise be living in residential care.

3.168 The Joseph Rowntree Foundation also argued that according to its research into extra care housing, “semi-residential settings may provide independent living *more effectively* than home-based care”.<sup>7</sup> Residents in extra care schemes were found to “enjoy a great degree of independence which was facilitated, rather than undermined, by the additional support on site being used as a safety net”. Furthermore, residential units for people with learning disabilities often gave those living there more independence than those people living with their parents.

<sup>6</sup> Emphasis in original.

<sup>7</sup> Emphasis in original.

### ***The importance of residential care***

3.169 Many consultees expressed concern that this principle might undermine the provision of residential care. Coventry City Council highlighted that residential care can be the most appropriate way of providing support to some individuals and therefore any principle “must not create too specific a presumption to allow for flexibility”.

3.170 Medway Older People Communication Network argued that there are good reasons to start from the position that service users should receive a home based package of care except if “there are legitimate reasons for favouring residential or other institutional care”.

3.171 Carers UK disagreed with an assumption of home based living since:

Residential care is appropriate, and even unavoidable, for some people and some circumstances – for example, someone who is caring for a partner with dementia and who can no longer cope even with all the available support, or who is subject to abuse by the cared-for person.

3.172 BUPA Care Homes argued that this principle would stigmatise the provision of residential care:

As with the stigma attached to certain labels, e.g. “vulnerable” ... the assumption of home-based living could stigmatise residential care. There are many categories of people who need residential care for a variety of reasons including health and social care needs, danger to themselves and others. There are also others who would actively choose residential care and who may feel discriminated against should home-based living become a principle.

### ***Conclusion***

3.173 There was a predominantly negative response to the question of whether there should be a principle in the statute based on the assumption of home-based living. Many consultees argued that maximising the choice and control of the service user should be the determining factor in deciding on residential accommodation. Some consultees disagreed with the assumption of home-based living because of the financial implications of such a principle, as well as its potential for undermining the provision of residential care, which may be important for meeting the needs of some service users. On the other hand, some consultees supported the inclusion of this principle on the basis that it would assist in counteracting what they perceive to be the current presumption in favour of residential care. Finally, some consultees questioned the distinction between home-care and residential care, in light of new forms of extra care sheltered housing and community based care.

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

3.174 Of the 231 submissions which were received, 78 submissions expressed a view on the question of whether there should be a principle in our statute based on dignity in care. Of those consultees, 62 answered that this principle should be included, 9 argued that it should not be included, and 7 held an equivocal position.

***Dignity as a key principle***

3.175 The majority of consultees argued in favour of a statutory principle based on dignity in care and a significant number – including the Equality and Human Rights Commission and NAAPS – maintained that it should be the primary principle of the statute.

3.176 Mencap put the point simply:

Everyone has the basic human right to dignity. Any care and support service that does not meet this should be immediately held to account. A principle of dignity in care must be included in the statute.

3.177 Wales Council for Voluntary Action welcomed a principle based on dignity in care because:

This again links back to the foundation of co-design and all relationships being reciprocal – services are not “done to” the recipient: all can bring something of value to the transaction. It also highlights the need to ensure that social care is seen as a worthwhile activity and valued in society: not seen as menial low level, low skilled and low paid work.

3.178 Sense took this point further and argued that:

Dignity is a core value and relates closely to some of the other values which are deemed to be important by policy makers including choice and control. Inclusion of dignity as a legal principle in the context of social care should safeguard the individual. Dignity is an invaluable interpretative tool and should help social care providers and assessors to keep their moral compass – e.g. for deafblind people, no-one could say that expecting a person to live without human contact for months at a time was consistent with human dignity.

3.179 The National Family Carer Network argued that this principle is vital because “sadly, over many years there have been appalling examples of people with a learning disability not having their rights respected”.

3.180 The Medway Older People Communication Network were of the opinion that:

Respecting human rights and treating people with dignity and respect are fundamental to social care and believe that this principle must be clearly stated in any new legislation. We are concerned that

experience shows that despite the requirements of the Human Rights Act people are not being treated in the manner required by the Act.

3.181 West Berkshire Safeguarding Adults Board argued that dignity was particularly relevant in a safeguarding context because “service users may find it easier to talk about dignity rather than in safeguarding terms”.

3.182 Compassion in Dying argued that:

The principle of dignity in care is fundamental and should *provide a foundation on which all other elements of the statute are built*. Unless service users and carers are afforded dignity in the planning and delivery of appropriate social care, services will cease to deliver effective care.<sup>8</sup>

### ***The definition of dignity***

3.183 Some consultees, like Sense, disagreed with the concerns expressed in the consultation paper that the difficulty of defining the term dignity may make it unworkable as a principle and they pointed out that the principle of dignity has been successfully applied by the courts. Furthermore, many consultees, such as Age UK, argued that although it has been developed by the courts in the context of Articles 3 and 8, the fact that dignity is not written into the ECHR was a strong argument to include it in the statute.

3.184 However, other consultees were concerned by the imprecise nature of dignity. For example, Coventry City Council argued that the principle “could generate legislative confusion as the provision of dignity is very personal to each individual”. Lincolnshire Partnership NHS Foundation Trust argued that there are objectively defined standards of dignity which are based on the views of professionals and can be in conflict with the subjective views of the service user.

3.185 The Practitioners Alliance Against the Abuse of Vulnerable Adults welcomed this principle but suggested:

It may be better achieved by describing what is intended using other words rather than the word dignity. At present there is a tendency for the word dignity to be given an interpretation that best suits the person using it and not the person whose dignity is in question.

3.186 Few responses addressed the need to narrow down the concept of dignity into a precise definition. On the other hand, some consultees, such as Action on Elder Abuse, suggested the following definition originally put forward by the Social Care Institute for Excellence:

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

<sup>8</sup> Emphasis in original

undermine, a person's self-respect regardless of any difference.<sup>9</sup>

3.187 Others, such as Age UK, objected to this definition on the basis that it sees dignity as resulting from what care staff and professionals do to service users rather than emphasising the notion of people being supported to develop their own social and community activities.

3.188 NAAPS suggested the following definition based on the Department of Health Dignity in Care Campaign:

- (1) have a zero tolerance of all forms of abuse;
- (2) support people with the same respect you would want for yourself or a member of your family;
- (3) treat each person as an individual by offering a personalised service;
- (4) enable people to maintain the maximum possible level of independence, choice and control;
- (5) listen and support people to express their needs and wants;
- (6) respect people's right to privacy;
- (7) ensure people feel able to complain without fear of retribution;
- (8) engage with family members and carers as care partners;
- (9) assist people to maintain confidence and a positive self-esteem; and
- (10) act to alleviate people's loneliness and isolation.

***Overlap with the choice and control principle***

3.189 Some consultees argued that there might be some overlap between a principle based on dignity and a choice and control principle. For example, the Royal College of Physicians of Edinburgh argued that dignity follows from the principle of choice and control, and involves taking into account the views of disabled people.

***Overlap with human rights legislation***

3.190 Nottingham City Council argued that this principle is "unnecessary" because it is covered elsewhere "as part of any commitment to safeguard adults and has also been established in case law as part of the Human Rights Act".

<sup>9</sup> Social Care Institute for Excellence, *Dignity in Care: Guide 15* (2008) p 6.

3.191 Some consultees pointed out that while dignity is a key principle, in practice it provides only for certain minimum standards of care and support. Belinda Schwehr, a legal and training consultant, while opposed to statutory principles altogether, argued that if dignity is to be turned into a principle then it would be best to consider the way in which the courts have defined the concept of inhuman and degrading treatment and reverse this so that it was clear that there was an actual minimum standard of dignity that is expected, rather than the absence of neglect or ill-treatment.

3.192 However, RADAR and the National Council for Independent Living took a more expansive approach to defining dignity:

Dignity means that local authorities need to do more than just provide the very minimum of care needed to keep a person alive – it means providing the care in a way that disabled persons’ sense of autonomy and equality are enhanced rather than violated

***Other comments***

3.193 Ann McDonald, a social care academic, suggested that the principle of dignity should also include “respect for difference and the opportunity for further personal development”.

3.194 Gateshead Council argued that this principle is unnecessary because the statutory framework of regulation for care homes covers dignity and “rigorous application of those standards by the Care Quality Commission should embed this in practice”.

3.195 Some consultees, such as Carers UK, RADAR and the National Council for Independent Living, objected to the term “in care” due to its paternalistic connotations.

***Conclusion***

3.196 There was a strongly affirmative response to the question of whether there should be a principle in our statute based on dignity in care. The majority of consultees argued that dignity is a key human right, and that it is central to the provision of adult social care. On the other hand, some consultees expressed concern that dignity is difficult to define with sufficient precision, and cannot therefore become the basis of a statutory principle.

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

- 3.197 Of the 231 submissions which were received, 68 submissions expressed a view on the question of whether there should be a principle in our statute based on safeguarding adults at risk from abuse and neglect. Of those consultees, 53 answered that this principle should be included, 11 argued that it should not be included, and 4 held an equivocal position.

***The importance of safeguarding***

- 3.198 The majority of consultees agreed that a principle based on the need to safeguard adults at risk should be included, on the basis that safeguarding adults from abuse and neglect is of crucial importance. For example, Mencap stated that “safeguarding should be an essential part of the care and support received”. Coventry City Council stated that safeguarding “is a key priority and should be reflected as an overriding principle within the statute”. Michael Mandelstam, a legal trainer and consultant, argued that this principle is “an absolute must” and is “closely linked to the dignity principle”.

- 3.199 Furthermore, Age UK and Age Cymru stated that “this is arguably the most important single proposal in the consultation”. Age Cymru went on to argue that:

It is essential that safeguarding is seen as an underpinning principle to this review, which will also send a strong message to all agencies of the importance of the need to safeguard people from abuse and neglect. Without this principle there is a risk that the other proposals under safeguarding are not given the same precedence as other parts of the proposed duties on local authorities.

- 3.200 Regenerate-RISE stated that safeguarding is “paramount” and should be at the “core” of any legislation for adult social care. They further argued that because “an estimated 500,000 older people are being abused each year” and society is failing older people “by allowing it to happen”.

- 3.201 The West Berkshire Safeguarding Adults Board supported the inclusion of this principle “so that safeguarding is given greater importance and funding from central government”. They added that “it should include not only those at risk of harm from perpetrators but also those at risk of harm by their own actions (i.e. self neglect)”.

***Balancing safeguarding with autonomy***

- 3.202 Several consultees – while acknowledging the importance of safeguarding – emphasised that it must be balanced with autonomy and the right to take risks. For example, the British Association of Social Workers (North East Mental Health) welcomed a principle based on the need to safeguard adults at risk but stated that “it might be better qualified so that the autonomy and self-determination of capable adults are respected”.

- 3.203 Several consultees, like the Northumberland Tyne and Wear NHS Foundation Trust for example, argued that qualifying the principle in this way:

would make the proposed statute more consistent with the provision of the Mental Capacity Act 2005 section 1(2) and section 1(4), that is the legal presumption of capacity and the right of a capable adult to make unwise choices respectively.

- 3.204 Similarly, Alwyn Davies, a Development and Professional Support Manager with Barnsley Adult Social Care Services, stated that:

Without qualifying the position of autonomous adults the principle could otherwise be read that it is lawful for practitioners or organisations to adopt defensive practices which run counter to the capable adult's choice and control agenda.

- 3.205 Cartrefi Cymru also argued that:

The statutory principle should make reference to the appropriate assessment and management of risk and achieving a sensible balance alongside the principles on choice, control and independence. This is particularly relevant to service users with a learning disability where many local authorities (and some providers) have traditionally adopted an unnecessarily risk averse approach.

- 3.206 Liz Ball, a deafblind person, expressed concern that:

If [safeguarding] were made a statutory principle, that it may restrict choice and control and lead to overly cautious practice. Therefore, I consider it to be more appropriate to exclude safeguarding from the statutory principles and instead to ensure that it is clearly set out elsewhere in the statute.

- 3.207 Disability Wales, while stating that safeguarding is of "vital importance", warned that it "must not be used as a reason for removing people's right to take appropriate risks:

A positive approach to risk enablement, taking individual circumstances into account rather than a blanket approach will enable people to continue growing towards achieving their full potential. Support plans should give equal importance to the need for individuals to take risks and the need for safeguarding and protection.

- 3.208 Similarly, Ann McDonald, a social care academic, argued that the principle "should be more positively framed to promote the welfare of adults at risk and minimise the need for compulsory intervention".

### ***Including carers***

- 3.209 A number of carers organisations, such as the Standing Commission on Carers, argued that this "principle should apply to both service users and carers". They noted that:



At present there is limited literature on (or knowledge of) the risk of neglect or abuse for the *carer*, although we have a number of documented cases where carers without the necessary support in managing very challenging behaviour, have had to resort to calling the police to provide emergency assistance. Such emergency assistance is not of course a long-term solution and the absence of appropriate advice and support can precipitate a demand for residential provision.<sup>10</sup>

### ***The necessity of a safeguarding principle***

- 3.210 Some consultees, like the RNIB and Guide Dogs for example, argued that such a principle is of no substantive benefit if safeguarding and adult protection are prescribed in detail elsewhere in the statute. Similarly, the Welsh Assembly Government stated that “it is unnecessary to include this as a principle since it may not add anything to the (proposed) duty to investigate”.
- 3.211 On the other hand, the Joseph Rowntree Foundation argued that it is important to differentiate between a “general principle to guide all practice” and a specific duty, which does not fulfil the same role”. In safeguarding, the duty to investigate after the event is by necessity a “retroactive” duty, and it is also important to include in the statute “the preventative, or *proactive*, concept of safeguarding”.<sup>11</sup> Moreover they argued that the safeguarding principle “should be underpinned by a wide definition of abuse – including not just physical and sexual, but also emotional and financial abuse and neglect”.
- 3.212 Action on Elder Abuse maintained that safeguarding and adult protection are two parts of the same process; with one relating to the prevention of abuse and the other relating to investigation and intervention where it is suspected that abuse may have occurred. They suggested, however, that they are “essentially different processes and so there is consequently merit in considering a statutory principle relating to safeguarding”. They argued that such a principle is particularly relevant within a personalisation agenda that includes personal assistants, direct payments and individual budgets.
- 3.213 Similarly, Lincolnshire Partnership NHS Foundation Trust argued that a safeguarding principle could interact well with other principles as a useful minimum threshold in the more complex cases where the wishes and feelings of the individual in terms of outcomes run counter to less inherently risky options available in terms of needs being met.

### ***The Welsh position***

- 3.214 The Welsh Assembly Government stated that:

Welsh Ministers have commissioned a comprehensive review of vulnerable adults’ arrangements that apply in Wales and will be considering the outcomes of that review and determining a way forward towards the end of the year. We would not feel able to come

<sup>10</sup> Emphasis in original.

<sup>11</sup> Emphasis in original.

to a definitive position in respect of this question until the outcomes from that review are known.

- 3.215 Delegates at a consultation event hosted by the Older People’s Commissioner for Wales stated that there should be a statutory principle based on the concept of safeguarding. It was generally argued that that the thinking on adult protection in England and Wales may not be identical, that Wales has the potential to do “something unique” and that “the opportunity should be taken to do so”.

***Conclusion***

- 3.216 There was a strongly affirmative response to the question of whether there should be a principle in the statute based on safeguarding adults at risk from abuse and neglect. The majority of consultees argued that safeguarding is essential to adult social care. On the other hand, many consultees – while acknowledging the importance of safeguarding – warned that the principle must be framed in a way that balances choice and control. Some consultees argued that the principle would be unnecessary in light of the duty to investigate, while other consultees argued that it at least serve the purpose of highlighting the pertinence of safeguarding work.

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

- 3.217 Of the 231 submissions which were received, 85 submissions expressed a view on the question of whether any one principle in adult social care should be given primacy over all other principles. Of those consultees, 44 answered that one principle should be given primacy; 36 argued that it should not, and 5 held an equivocal position.
- 3.218 The majority of consultees argued that a particular principle or combination of principles in adult social care should be given primacy over all over principles. However, consultees disagreed over which principle or principles should be given primacy.

***Choice and control***

- 3.219 Several consultees argued that maximising choice and control is the key principle. For example, the Spinal Injuries Association argued that their members “wish to live as independently and to have as much control over their lives as possible”. The Care Quality Commission – while expressing doubt as to whether any one principle should be given primacy – stated that “maximising choice and control is vital – everything flows from this premise”. They further argued that:

It is also important to maximise the underlying concepts as far as possible. For example, an individual’s right to self-determination represents much more than “choice and control” alone. In doing so, other principles, such as an assumption of home-based living, could be subsumed into the one overarching principle.

***Dignity***

- 3.220 Several consultees, including the Equality and Human Rights Commission, the National Aids Trust and Michael Mandelstam, a legal trainer and consultant, argued that dignity should be given primacy over all other principles. Similarly, the National Autistic Society argued that:

There should be a primary principle that people with disabilities have the same rights as everyone else to be treated with dignity and respect and to have the opportunity to achieve their full potential.

- 3.221 Dr Gregg Moore, in an individual submission, argued that dignity should be combined with fulfilment in a single overarching principle, namely that of “quality of life”. He stated that “this is not purely abstract. There are quality of life indices and indicators which attempt to make it concrete”.

***Independent living***

- 3.222 Enfield Disability Action Group argued that independent living should be given primacy “as the aspiration of disabled people”. They stated that the other principles “flow from this principle”.

3.223 Citizens Advice also suggested that choice and control, alongside supporting “individuals to lead full, independent lives and to participate in British society” should be the overarching principles.

#### ***Safeguarding adults at risk from abuse and neglect***

3.224 Some consultees, including several local authorities, argued that safeguarding adults at risk from abuse and neglect should be given primacy over other principles. For example, Hertfordshire County Council stated that “safeguarding should be the primary principle for both service users and carers”.

3.225 Some consultees argued that dignity should be combined with other principles to form the primary principle. For example, the Blackburn with Darwen, Blackpool and Lancashire Safeguarding Adult Boards argued that there are two overarching principles, namely dignity of the individual and safeguarding adults at risk from abuse and neglect. They asked “how can dignity be upheld if a person’s physical and/or emotional security is compromised or threatened by abuse?”

3.226 The Vale of Glamorgan Older Peoples Strategy Forum also stated that their primary concern is that the “key legislative principles should reflect a core emphasis on dignity, safeguarding adults and a holistic person-centred approach to people’s needs”.

#### ***Well-being***

3.227 The Social Care Institute for Excellence and ADASS each suggested that the statute could be built around a single organising principle, the counterpart for adults of the core principle informing the Children Act 1989 that “the welfare of the child is paramount”. 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 possible exception of some people without capacity, an adult would be presumed the best judge of their own wellbeing.

3.228 ADASS suggested that common elements of well-being include:

- (1) personal identity;
- (2) autonomy and self-determination;
- (3) dignity, privacy and respect;
- (4) physical and mental health;
- (5) security and freedom from abuse; and
- (6) economic and social inclusion.

3.229 Deficiencies in these areas would form the basis for individuals to be considered for support and these domains would provide the yardstick for deciding whether the support was effective. It is acknowledged that some of the elements may be in tension – for example, some forms of care might offer security, but at a high price in terms of autonomy or even personal identity – but unlike children, adults could generally expect to take part in weighing options and deciding where to strike a balance.

### ***Other suggestions***

3.230 The following suggestions were also put forward for the primary principle in adult social care:

- (1) the Medway Older People Communication Group and the Wales Council for Voluntary Action suggested that person-centred planning should be the overarching principle;
- (2) The Joseph Rowntree Foundation suggested that there should be a primary principle “to reaffirm the attainment and protection of human and civil rights within the context of adult social care”; and
- (3) Ann McDonald, a social care academic, suggested that the “welfare of the service user is paramount”; and
- (4) Mencap argued that a principle of “meeting the human rights of people who require care and support” should be given primacy.

### ***No primary principle***

3.231 On the other hand, a significant minority argued that it would not be possible nor is it desirable to give primacy to any one principle. For example, the Lincolnshire Partnership NHS Foundation Trust stated that:

It is difficult to see any obvious or direct equivalent to the paramountcy principle in the Children Act 1989 or the best interests principle in the Mental Capacity Act 2005. Both statutes are designed around the more protective and paternalistic view where capacity is lacking.

3.232 Similarly, Action on Elder Abuse rejected the idea that any single principle “was so fundamental that a failure to give it due regard would result in a detrimental effect on the person receiving care”, in a similar way to section 1(5) of the Mental Capacity Act 2005. Thus they argued that “each principle contributes to the overall objectives and it seems difficult to identify any one which should be paramount”.

3.233 Age Cymru stated that they “do not think that one principle is more important than the others, but that they work in concert”. Similarly, the National Care Forum stated that “as the principles listed overlap and are inter-related it is difficult to see how a single principle could be sufficient”. The British Psychological Society argued that “given the difficulty in developing a set of principles, prioritisation is likely to be very arbitrary”.

3.234 Moreover, ADASS Cymru suggested that there should be:

fewer principles, and all of them carry equal weighting, otherwise primacy to one principle will undermine the rationale for the inclusion of others, which are in fact inter-related.

***Conclusion***

- 3.235 A majority of consultees argued that a particular principle or combination of principles should be given primacy. The most commonly suggested principles were safeguarding, dignity and choice and control. On the other hand, a significant minority argued that no single principle can or should be given primacy, because they are all inter-related and have different significance to different people, depending on their social care needs.

## Further suggestions for principles

### ***Non-discrimination and human rights***

- 3.236 RNIB and Guide Dogs welcomed the inclusion of a principle “which recognises the importance of the provision of social care within a civilised society”. They also considered that it is important that the statute “includes a principle of non-discrimination (and that services are provided purely on the basis of need)”:

Whilst the principle of non-discrimination is clearly stated elsewhere in legislation we consider that it has never been clearly stated in relation to the provision of social care – for example, where older people are refused assistance or provided with more limited services.

- 3.237 A number of consultees emphasised the importance of referencing or founding the principles on human rights. For example, the Joseph Rowntree Foundation argued that a statement of principles should “begin with, and be framed by, explicit reference to the role of adult social care in promoting and protecting human and civil rights and entitlements”.

- 3.238 Medway Older People Communication Network argued that:

Respecting human rights and treating people with dignity and respect are fundamental to social care and [we] believe that this principle must be clearly stated in any new legislation. We are concerned that experience shows that despite the requirements of the Human Rights Act people are not being treated in the manner required by the Act.

- 3.239 Ann McDonald, a social care academic, considered that statutory principles “should refer to the need to protect and promote human rights”.

- 3.240 At a conference held by the Older People’s Commissioner for Wales, delegates agreed that statutory principles are extremely helpful and argued that they should reflect “human rights principles and be based on rights, choice, dignity and independence”. Any proposed statutory principles should be measured against the United Nations Principles for Older Persons and other similar UN Conventions.

### ***United Nations Convention on the Rights of Persons with Disabilities***

- 3.241 The Equality and Human Rights Commission also felt that suggested principles “fall some way short of reflecting the aspirations and outcomes of disabled and older people”. They therefore suggested as a platform for further development, the use of either the United Nations principles for older persons or the preliminary recitals to the United Nations Convention on the Rights of Persons with Disabilities:

We believe that either approach would aid the transformation of care and support that has been historically based on a passive definition of individual need to one based on an active conception of rights and duties in which people are enabled to be full and equal citizens.

- 3.242 Tessa Harding, a carer – while strongly supporting the proposal to include principles in the statute – argued that the principles themselves “do not need to be reinvented for the purpose of this statute”:

They should be based on the existing principles embodied in the Human Rights Act and in the United Nations Convention on Human Rights. People who need the support of social care services are no different from anyone else: they just need some help to secure the same rights as others. It is about respect for the individual and his or her dignity and autonomy and the absolute duty of the state to promote these.

***Other suggestions***

- 3.243 Alwyn Davies, a Development and Professional Support Manager with Barnsley Adult Social Care Services, suggested that the “key principle ought to be one that recognises a person’s right to self assessment of their needs as the default position, unless proved otherwise”. It was argued that this would be similar to the Mental Capacity Act 2005 “where the assumption is that people over the age of 16 years have mental capacity for decision making unless proved otherwise”.
- 3.244 The Social Care Institute for Excellence argued that the new law should affirm clearly under statutory principles “that social care is a core responsibility of the state, carried out in partnership with individuals, carers and families”.
- 3.245 East Sussex County Council agreed that there should be a statement of guiding principles within the statute, and a key principle which they suggested would be helpful to acknowledge from a local authority perspective is the “dual responsibility to assess individual’s need and also to make sure there are sufficient services to meet need across the local population”.
- 3.246 West Sussex Safeguarding Board considered that if a statement of principles is placed in statute, then it is “very important this includes a principle of multi-agency and other partnership working”.
- 3.247 The North West Complaint Managers Group argued that there should be a principle related to “the right of a service user or carer to make a complaint – similar to that contained within the NHS constitution”. They highlighted that:
- Over the years a successful system for handling complaints has been developed in social care based upon an open a thorough consideration of complaints, and the development of professionalism of the role of Complaints Managers. It is essential that service users have awareness of and confidence in the complaints system. If the right to complain is not included in a list of core principles it may compromise this area of work at a time of diminishing resources.
- 3.248 Parkinson’s UK suggested a “principle based on the concept of universal access to information, advice and advocacy”.
- 3.249 The MS Society suggested that “decision makers should respect an individual’s right to freedom of movement by striving to maximise portability of care and support packages”.



## **PART 4**

# **COMMUNITY CARE ASSESSMENTS**

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

- 4.1 Of the 231 submissions which were received, 42 submissions expressed a view on the proposal that there should be a duty to undertake a community care assessment where it appears that a person has social care needs and the power exists to provide community care services. Of those consultees, 40 agreed with the proposal, 1 disagreed whilst 1 held an equivocal position.

### ***The benefits of simplification***

- 4.2 There was broad consensus that the current legal framework is overlapping, complex and confusing. Accordingly, a number of consultees suggested that a single gateway into assessment would provide clarity and streamline this area of law. Cartrefi Cymru described the legal framework for community care assessments as “in urgent need of clarification and simplification”. The Law Society argued that:

It is vital to bring to an end the present multi-layered assessment powers and duties which have proliferated through different statutes. We therefore consider it essential that the assessment duty should be simple, direct and contained within in a single statute.

- 4.3 These views were supported by the Welsh Assembly Government and the Government.
- 4.4 Some consultees indicated that clarifying the duty would remove any doubt that local authorities had a duty to assess in certain cases. Refugee Action argued:

In our experience, a significant number of individuals with care needs currently remain without services because local authorities do not consider themselves to have a duty to assess.

- 4.5 However, Gordon Lishman from the International Federation on Aging expressed concern at placing the assessment duty on local authorities on their own:

I fear that a situation in which one professional group is seen to have the lead responsibility and duty for assessment will undermine the sense of shared responsibility for outcomes. I also have enough experience of the professions associated with older people to know that each profession tends to view each case through the prisms of their training and the resources they have available. I remember the research which demonstrated that access to meals on wheels services was often provided inappropriately because it was the only way in which an assessing professional could respond to the complex needs they had seen.

### ***Low threshold test***

4.6 A significant number of consultees commented on the trigger for the proposed duty to assess. For example Mencap argued that it is “fundamental that the threshold to trigger an assessment is as low as possible”. They also urged that the guidance accompanying the statute should “clarify in detail what can trigger an assessment”.

4.7 A number of consultees made detailed suggestions on the precise wording of the duty. For example, Age Cymru recommended that the current wording of section 47 of the NHS and Community Care Act 1990 – which provides that the duty arises where it appears to the local authority that the person “may be in need” of services – should be retained in our statute because this:

makes it clear that a local authority should only decide whether a person has needs after carrying out an assessment and should not screen people out by pre-empting the results of the assessment.

4.8 Similarly, the Law Society suggested it would be preferable to keep the current wording of section 47 “as this makes it clear that authorities cannot decide if a person ‘has needs’ without first undertaking an assessment”.

4.9 Refugee Action made a similar point:

In our view, the key is to ensure that where individuals *may* be entitled to community care services and *may* have community care needs, the duty to assess is triggered.<sup>1</sup>

4.10 The use of the word “appears” in the proposed trigger was queried by a small number of consultees. Conwy County Borough Council argued that there was a need for further definition and Hull City Council argued that such a term was too “subjective”.

4.11 The Wales Council for Voluntary Action argued that even though a low threshold is necessary, even though it may have resource implications, because:

We have to recognise that if we are to meet care needs well now and into the future, this gateway process into comprehensive planned service care is the only way to manage resources and maximise efficiencies whilst still gaining good outcomes for the service user.

<sup>1</sup> Emphasis in original.

- 4.12 Refugee Action argued that the overall costs of a broader approach to assessment might be balanced by other efficiencies:

It may be that the additional cost of assessing those who may subsequently be found not to be eligible for services could be met by the reduction in challenges to refusals of support, the reduced administration involved in identifying whether to assess, and the ability to meet needs when they are simple, rather than refusing support until those same needs become more complex and may become more expensive to meet.

### ***Refusing assessment***

- 4.13 A theme which arose in the consultation responses was whether our proposals would allow a person to refuse a community care assessment. It was the view of Age Cymru that:

This approach does mean that in some cases the local authority duty to assess or review could be triggered in situations where the person who is entitled to an assessment has not asked for one and does not want one. We are aware that some organisations of disabled people are therefore concerned that if it was open to relatives or neighbours to request an assessment this would be unduly intrusive.

- 4.14 A similar concern was raised by Regenerate RISE and the Practitioners Alliance Against the Abuse of Vulnerable Adults. Cartrefi Cymru suggested a solution to this:

Perhaps it would be appropriate to couch the duty in terms of a duty to *offer* a community care assessment, in recognition of the fact that some individuals who may appear to the local authority to be in need may not wish to avail themselves of an assessment.<sup>2</sup>

- 4.15 The Socio-Legal Studies Association gave an alternative answer to this problem:

We would like the Commission to consider whether a statute should specifically enshrine the right of an adult with capacity to refuse to be assessed. We are aware that social workers can find this a difficult area in those rare circumstances when an adult refuses help.

### ***Accommodating personalisation***

- 4.16 Several consultees wanted this proposal to explicitly take into account a personalised approach to social care. ADASS argued that:

<sup>2</sup> Emphasis in original

The current proposals are very rooted in the existing NHS and Community Care Act 1990 and as such risk enshrining an approach to “assessment” that has become in many places cumbersome and bureaucratic. Some of the proposals appear to put the individual and their family in a relatively passive position during an assessment process “carried out” by the local authority. In a new approach, assessment would no longer be primarily the first stage of a process leading to decisions on eligibility for services or resources. Instead, it is a service in its own right, with potential to become the equivalent in social care of the GP service in the NHS.

- 4.17 The Adults with Learning Disabilities Services Forum argued that a “one size fits all” approach to assessment is inappropriate because “all needs are different”. The South Yorkshire Centre for Inclusive Living agreed with this point. Accordingly, assessments should be personalised and conducted with active engagement with the individual.

#### ***Time limits***

- 4.18 The potential role of time limits was highlighted by Liz Ball, a deafblind person, who pointed out that where a specialist assessment was required there should be a limit on the time between the initial contact assessment and the full assessment:

As deafblind people need a specialist assessment this timeframe must be adequate to allow for arranging a specialist assessment, booking communication support and carrying out what may be a complex assessment but it must be short enough to ensure that people get an assessment and then services as quickly as possible. After one move, I had to wait 18 months to get an assessment, which is unacceptable.

#### ***Conclusion***

- 4.19 Almost all consultees who expressed a view agreed with this proposal. There was agreement that the current legal framework for assessments is unnecessarily confusing and can make it unclear whether a local authority has a duty to assess in certain situations. There was also agreement that a low threshold for assessment would be positive, but questions were asked about whether the proposal changed the current threshold. A number of consultees wondered whether the provisional proposal would allow individuals to refuse an assessment. Furthermore, it was queried whether the proposed approach to assessment took sufficient account of personalisation. However, the overwhelming majority of consultees agreed with the proposed approach.

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

- 4.20 Of the 231 submissions which were received, 100 submissions provided answers to the question of whether there should be a right to an assessment on request. Of those consultees, 82 agreed with the question, 12 disagreed whilst 6 held equivocal positions.

***A safety net provision***

- 4.21 A large number of consultees were in favour of a right to request an assessment on the basis that this could help rectify problems that are caused by the existing duty to assess. For example, the Equality and Human Rights Commission argued that the right to request would ensure that no-one is excluded from the assessment process:

The current assessment process could exclude certain people. For instance, local authorities are “managing” their budgets by failing to do assessments that they are legally obliged to carry out (particularly for self-funders) or by unacceptably delaying the assessment. Including a request mechanism would embed a safeguard if the Commission’s proposal does not work in practice – a necessity if people are being excluded from assessments unlawfully.

- 4.22 Parkinson’s UK made a similar point, arguing that a right to request:

will ensure that where an authority was not performing its duties there is additional recourse for the public. There is enough evidence, including from the Commission for Social Care Inspection report cited in the consultation paper (*Cutting the Cake Fairly, 2008*) to demonstrate that this would be a positive change.

- 4.23 The Joseph Rowntree Foundation highlighted research they had conducted which demonstrated that different social work teams determined eligibility for assessment differently. It was argued that a right to request an assessment would operate as a mechanism to redress this.

- 4.24 Mencap pointed out that local authorities are often not aware of a person’s care needs until a crisis situation arises. The ability to ask for an assessment would mean that potential service users could be brought into the system before their condition worsens.

- 4.25 Organisations which represent particular service user groups argued that a right to request would be beneficial for those they represent. The Foundation for People with Learning Difficulties argued that a right to request would be particularly useful for those with “invisible” disabilities, such as autism. Similarly, the MS Society argued that:

People with multiple sclerosis often have a number of hidden symptoms (such as fatigue or continence problems), and their needs can fluctuate rapidly, so it is important that people can request an assessment when required. ... People with relapsing remitting multiple sclerosis currently rarely receive care services during a relapse due to the system's lack of responsiveness.

4.26 RNIB and Guide Dogs made a similar point:

We believe that people with a sight loss are being excluded from assessment unlawfully. Whilst this can obviously be challenged, we do believe that the provision of a "right to have an assessment on request" would be useful. This effectively provides a "belt and braces" approach to ensuring the provision of an assessment.

***The position of self-funders***

- 4.27 It was argued by several consultees that a right to request an assessment would be of particular assistance to self-funders who may not be receiving assessments from local authorities. Alwyn Davies, a social care professional, argued that "the right to an assessment would reduce the inequality sometimes felt by those who would likely to be self-funding". The Office of the Public Guardian argued that such a right would allow self-funders access to an assessment which could assist in determining the appropriate level of care and support that will be purchased.

***Resource implications***

- 4.28 Several consultees expressed concerns about a right to request an assessment on the grounds that it would have resource implications for local authorities. North Tyneside Council argued that:

We have reservations that a right to request an assessment could lead to an obligation for the local authority to undertake an assessment where an assessment is not warranted. This has resource implications for local authorities.

- 4.29 Hertfordshire County Council supported this view. The Government argued that there was a general concern that "authorities' resources might be disproportionately tilted towards the process of assessment". BUPA Care Homes queried whether these likely implications meant that such a right was actually a policy matter and not a question for the Law Commission.

- 4.30 The Wales Neurological Alliance also expressed a concern that:

Local authorities would not be able to handle the number of requests for self-assessments, leading to a system where the person who shouts loudest would be assessed quicker.

### ***Vexatious requests***

- 4.31 A number of consultees asked whether a right to request an assessment would be accompanied by some method of managing unmeritorious requests. For example, Nottingham City Council did not agree that the statute include a right to have an assessment on request because “it would risk frivolous and vexatious requests creating unnecessary burdens on local authorities”.
- 4.32 This view was supported by government at both local and national level. The Welsh Assembly Government argued that a right to request would “pave the way for frivolous or vexatious requests”. The London Borough of Camden argued that there would need to be clarity about the circumstances in which a request for an assessment could be refused, in order to support professional practice.
- 4.33 Many service user organisations did not share these views. RADAR and National Council for Independent Living pointed to history and argued that:
- When the NHS first opened its doors in 1948, some GPs barricaded their doors for fear of an avalanche of patients. This avalanche never happened. Similarly we do not believe that there will be many malicious requests. If any procedure were to be set up to avoid those requests, then this should account for people with fluctuating conditions.
- 4.34 Similarly, Medway Older People Communication Network did “not believe that the likelihood of frivolous requests is high”. They considered that “in matters of health and social need it is important to err on the side of providing for need rather than risk failing to provide for needs that remain undetected”.
- 4.35 The York Carers Centre also commented that:
- It is very rare that someone seeks to involve social services in their lives or the life of someone they care for. There can be requests which seem bizarre, but these are normally where there are underlying mental health issues, which need a community assessment.
- 4.36 Dr Gregg Moore, in an individual response, considered that although ruling out requested assessments avoids misuse it also “allows local authorities to avoid the cost of care by refusing to assess”.
- 4.37 Despite these opposing views, there was a broad level of agreement that some mechanism was needed to allow local authorities to refuse a requested assessment. Several consultees – including the Welsh Assembly Government and Disability North – pointed to the system in Scotland whereby a refusal has to be accompanied by written reasons.<sup>3</sup> The Law Society described this as “an appropriate compromise”.

<sup>3</sup> By virtue of section 288, Mental Health (Care and Treatment) Scotland Act 2003.

### ***Carers right to request an assessment***

- 4.38 It was noted by the Social Care Institute for Excellence that currently carers have a right to request an assessment, while the individuals they are caring for do not. It was suggested that introducing a right to request an assessment for potential service users could rectify this apparent inconsistency.
- 4.39 However, the Government highlighted that the Law Commission has provisionally proposed that carers should not have a right to request an assessment (Provisional Proposal 5-3). Accordingly, an inconsistency would be maintained, although the position would be swapped.

### ***Conclusion***

- 4.40 A large majority of those who responded to this question supported the introduction of a right to an assessment on request. Consultees principally saw this as a protective measure which could help ensure that would-be service users are not excluded from the community care system. Furthermore, it could operate as a complaint mechanism if an individual feels that an assessment was deficient. However, concerns were raised by government at both local and national level about the resource implications, particularly because it may lead to unnecessary requests being made. To address these concerns, several consultees proposed the Scottish system whereby written reasons are provided when an authority refuses a request for an assessment.



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

- 4.41 Of the 231 submissions which were received, 77 submissions expressed a view on the proposal that the focus of a community care assessment duty should be an assessment of a person's needs and desired outcomes. All of those consultees who responded agreed with the proposal.

***An outcomes-based approach to social care***

- 4.42 Many consultees argued that community care assessments should be outcomes-focused on the basis that this would lead to a fuller picture of a person's needs. The Care Quality Commission made the point that:

For far too long people's needs assessments have been driven by the services on offer or can be provided in a particular area. Report after report demonstrates assessment and care management that is unfocused and unambitious and heavily task focused. Such an approach fails to recognise the richness and complexity of people's lives and fails to support or promote truly person-centred care.

- 4.43 Similarly, Gateshead Council stated that:

The current emphasis on "services" is not easy to reconcile with personalisation where people may choose to meet their needs by services which do not fit within the traditional definition of community care services e.g. football club season tickets.

- 4.44 By contrast, an outcome-focused approach would promote more holistic assessments and would take in account of needs beyond "pure" social care. The Northumberland Forum for People with a Learning Disability argued that:

The assessment should include not only what the person needs in terms of care but also what their aims are to lead a good, healthy and happy life.

- 4.45 The Social Care Institute of Excellence argued that an outcome-focused approach has a central role in the policy of personalisation:

Under this model of assessment, problems would be defined not in terms of existing services but in terms of people's aspirations and preferred outcomes, and the process would include the provision of information, advice, sign-posting and advocacy to enable people to find their own solutions.

- 4.46 This was supported by the Challenging Behaviour Foundation. Some consultees took this further and pointed to the practical impact of an outcome-focused approach. York Independent Living Network argued:

Outcomes are key – if you can't cook, do you need someone to come in and heat up food, support to enable you to cook, or adaptations to your kitchen to enable you to cook alone? All are potentially valid options, and in the long run may cost the same, but the difference in terms of independence is massive.

- 4.47 The Wales Council for Voluntary Action recognised that such an approach would lead to an expansion in the scope of the assessment process:

In monitoring need and informing the design and planning of services; and access to a more demand led, flexible and wider range of services that can be more tailor-made. This is going to be challenging for all service providers, but rightly challenging in better meeting need.

- 4.48 Hazel Qureshi, an adviser to the Department of Health argued that the national eligibility criteria should be based on outcomes because this:

potentially provides a good basis for defining easily-understood eligibility across different user groups, as well as for devising a common broad approach to assessment in adult social care, that would allow for individual and local variations in needs and resources.

#### ***Complementing a needs-led assessment***

- 4.49 Many consultees were of the view that needs-led assessments go hand-in-hand with an outcome-focused approach. Medway Older People Communication Network argued that:

It is important to consider all aspects of a person's needs which means assessing what are the outcomes to be desired and the means of achieving these outcomes.

- 4.50 RNIB and Guide Dogs described the combination of needs and outcomes so that the "whole person" is considered as part of the assessment process. This is distinct from a service-led approach which simply assesses a person in terms of their suitability for a service. Regenerate RISE argued that a service-led approach is inappropriate and that the proposed approach to assessments would ensure that this was avoided.

- 4.51 The Joseph Rowntree Foundation relied on their *Shaping Our Lives* project to argue that:

Looking at outcomes from users' perspectives involves taking a holistic view, and considering issues such as housing, transport, employment, income and benefits, and broader issues around discrimination and equality. ... A move to outcome and needs-based assessments would put the individual service user and their views, needs and wishes at the centre of the work, as the setting of outcomes is both a personal and subjective process.

### **Carers' assessments**

- 4.52 Organisations which represent the views of carers argued that the desired outcomes of carers should also be taken into account. The Standing Commission on Carers argued that:

It is essential that the carer's own aspirations and desired outcomes are taken into account. For example, a carer may wish to continue in paid employment or may feel that his/her own health and well-being could be adversely affected by heavy or long-term levels of unsupported physical care.

- 4.53 Carers UK argued that the principles underlying the Carers (Equal Opportunities) Act 2004 could be applied in this context. The Act requires local authorities to consider outcomes which are important to carers based on their wishes. It was highlighted that these principles have been often overlooked and, in particular, many carers are forced to choose between caring or remaining employed:

With a modern care system this is not acceptable and the majority of carers wish to continue working for as long as possible. With our current economic system, the rise in retirement age and demographic changes, the country needs carers to be working longer, and economically they will need to.

### **Practical difficulties**

- 4.54 Newcastle City Council pointed out that a focus on outcomes can mean it is difficult to accurately quantify individual need and therefore plan to provide sufficient resources:

As the recent *Savva v Royal Borough of Kensington and Chelsea* [2010] EWHC 414 (Admin) case demonstrates, the entire current community care framework is premised on quantification of need, without which an under-supplied service user has much reduced ammunition to challenge an "outcome-based" resource allocation system decision, for example. Some practitioners think that the shift to focussing on outcomes (even if incorporated into a needs-led assessment) remains a huge leap into the unknown.

### **Conclusion**

- 4.55 All consultees who responded to this proposal agreed that there should be a duty to assess needs and outcomes. There was consensus that this approach would encourage a holistic assessment of an individual and reinforce the policy of personalisation. Furthermore, it was argued that an assessment of needs and outcomes are linked and ought to be seen as part of the same process.

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

- 4.56 Of the 231 submissions which were received, 98 submissions provided answers to the question of whether co-produced self-assessments should be recognised in our statute as a lawful form of assessment. Of these consultees, 85 agreed with the question, 4 disagreed whilst 9 held equivocal positions.

***Empowerment***

- 4.57 Of those who agreed with this question, a substantial number did so on the basis that co-produced self-assessments would empower individuals to engage in the assessment process. The Joseph Rowntree Foundation argued that:

Co-produced assessments are vital in ensuring users' voices are heard and their preferences and wishes taken into account, which is fundamental to the exercise of choice and control. ... It is difficult to see how the Commission's proposal for assessments based on needs and outcomes would be feasible if service users were *not* central to assessments in defining needs and setting their own outcome.<sup>4</sup>

- 4.58 Counsel and Care argued that the views of the person being assessed should be the main focal point of the assessment:

This would encourage a permanent move away from the traditional, paternalistic and top-down approach to decision-making during a local authority assessment.

- 4.59 The MS Society pointed to research by the Social Care Institution for Excellence which shows that "co-production emphasises that people are not passive recipients of services, and empowers people who use services".<sup>5</sup>

- 4.60 The Local Government Association took this point further arguing that:

If the principles on the face of the statute either presume that people are best able to determine what is needed to support their own well-being then it is clear that the statute should recognise co-produced self assessments.

- 4.61 The Hampshire Personalisation Expert Panel reported that co-produced self-assessments produce better results for the service user:

In our experience, the information collected is of a high quality and validity compared to a "traditional" assessment process where local authority staff often inadvertently disempower the user during the process.

<sup>4</sup> Emphasis in original.

<sup>5</sup> Social Care Institution for Excellence, *Research Briefing 31: Co-production: An Emerging Evidence Base for Adult Social Care Transformation* (2009).

### ***Assessing needs accurately***

- 4.62 Several consultees emphasises the importance of ensuring that self-assessment reflects queried the needs of the service user. It was argued that whilst service users may be able to identify some of their needs, there is a risk that they might under assess their needs. For example, York Independent Living Network argued that disabled people often underestimate their needs because “no-one wants to admit to what they cannot do”.
- 4.63 The Law Society highlighted the need to make sure that individuals who understate their needs do not go without appropriate care. Conversely, if individuals overstate their needs there must be a level of scrutiny to ensure that resources are not wasted. Carers UK indicated that there was a role for self-assessments “as a way of preparing well for an assessment with a professional”.

### ***Accountability***

- 4.64 Some consultees argued that a role for the local authority ought to be maintained so that there is a clear line of accountability. For instance, a number of local authorities argued that as a minimum there should be some sort of sign-off procedure. North Tyneside Council suggested this would allow a professional to validate the assessment. Lancashire County Council argued that the assessment should be formally agreed between the individual and the authority.

- 4.65 Furthermore, RADAR and National Council for Independent Living argued that:

The local authority must remain accountable for the assessment and ensuing decisions. For example, we have evidence that a local authority has commissioned carers’ assessments to an external agency, which has confused lines of accountability and created an extra burden on those who wish to challenge assessments undertaken in this way.

### ***Flexibility***

- 4.66 A large number of consultees argued that the appropriateness of a co-produced self-assessment depends entirely on the individual who is being assessed. The Gateshead Advocacy Information Network argued that co-production could only work for people who were the “most able” mentally handicapped individuals.

- 4.67 In relation to those with a visual impairment, RNIB and Guide Dogs argued that:

People with sight loss are not a homogenous group. There will be those who have already tapped into support networks, adjusted emotionally, done their homework are very clear about what they want from life and the sort of help they need. But at the other end of the scale there are those for whom the world of sight loss is a very bewildering place and who through lack of confidence and low levels of emotional wellbeing will suppress aspirations and place self-imposed limitations on their own potential. Application of the principles of self-directed support could serve the former group well, but must not be at the expense of the latter.

4.68 Accordingly, they considered that:

A very important part of the assessment process therefore is enabling a disabled person to sit down with their social worker/rehabilitation worker to talk about their needs, the services they may require and the outcomes they seek. To take this away and simply have a person complete a questionnaire which is then considered independently by a social worker could lead to an underestimation of the needs of the person. At a time where resources are limited there would be no incentive for social workers to spend time with people discussing their needs etc. unless there were a legal requirement to do it.

4.69 Similarly, in relation to deafblind people, Sense argued:

A co-produced assessment can be very appropriate for many people who have stable long term conditions and have built up a good understanding of their needs. For these people, a minimum of professional input may be required. For those newly entering the social care system or with changing or specialist conditions, input from a specialist is essential.

### ***Opposition to the proposal***

4.70 Some consultees did not agree with the proposal. For example, Newcastle City Council argued that there was no need to have co-produced self-assessments recognised in statute as lawful “as long as the reformed law did not explicitly preclude them”.

4.71 The Care Quality Commission suggested that recognising co-produced self-assessments was a matter for guidance rather than statute:

Experience from some [Care Quality Commission] service inspections of councils suggests that, where they work well, supported self-assessments can lead to better outcomes than those attained by conventional assessments. However, some processes are over-long and, potentially, disempowering. Local experience also suggests supported self-assessments can require more staff time and result in slower assessments, contributing to delays. There is a need to both affirm the key principles of supported self-assessment and provide advice about its practical implementation.

### ***Conclusion***

4.72 A large majority of consultees agreed that co-produced self-assessments should be recognised as a lawful form of assessment. Many consultees argued that this would empower individuals and lead to better quality assessments. It was also noted that co-production follows naturally from the Law Commission’s other provisional proposals in relation to the assessment process. Several consultees considered, however, that it was important for local authorities to retain professional oversight of assessments. Comments were made that the level of co-production will depend on the individual and that in some cases local authorities will need to be more engaged in the process.

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

- 4.73 Of the 231 submissions which were received, 85 submissions provided answers to the question of whether our proposed statute should allow for a pure self-assessment for certain people. Of these consultees, 18 agreed with the question, 48 disagreed whilst 19 held equivocal positions.

***The benefits of pure self-assessment***

- 4.74 Some consultees to this question argued in favour of pure self-assessment on the basis that it would promote independence. Disability Wales argued that:

If people who self-define themselves as disabled recognise that they have low level needs to maintain their independence, they should be enabled to make a pure self-assessment.

- 4.75 Furthermore, Enfield Disability Action saw financial benefits:

Pure self assessment offers considerable savings in assessment and care management costs which could be reinvested in community care and reablement/preventative services.

- 4.76 Solicitors for the Elderly also considered that pure self-assessments would allow “for resources to be targeted both in the assessment process and the provision”. Furthermore, they gave the following reasons in support of allowing pure self-assessments:

Some older people may be reluctant to allow the state to assess their needs because fear judgments being made on how they choose to live their lives (many very old and frail people would prefer to adopt a lifestyle that others may judge as not being suitable – for example, not bathing but relying on a flannel wash or misusing alcohol to alleviate pain). Some people would prefer not to receive a full assessment, and are reluctant to seek help. They may however agree to more low-grade help to enable them to maintain the status quo. There is also concern that the local authority will want to know all about their finances, which they would prefer to keep private.

- 4.77 Counsel and Care considered that for “some people, especially those adverse to local authority involvement, a pure self-assessment may well be of positive benefit”. On the other hand, Maxwell Gillott Solicitors suggested that in such cases the answer is not to allow pure self-assessment, but rather to develop:

mechanisms for carrying out an assessment which are not too intrusive and which service users do not experience as stigmatising, rather than giving local authorities the opportunity to push all the responsibility onto the service user through a pure self-assessment process.

- 4.78 Many consultees argued that self-assessment could only really work if input from an advocate was available. Disability Wales argued that:

Third party support should be available to help facilitate this when necessary, particularly to counter the risk of individuals under-assessing their level of need.

- 4.79 RADAR and the National Council for Independent Living argued that everyone who undertakes self-assessment should be offered information and advocacy. The National Family Carer Network argued that an assessment should not mean “that vulnerable people are left to fill in forms themselves”.

#### ***Relationship with co-production***

- 4.80 A number of consultees emphasised that whilst an individual should have control over the assessment process, at some stage the local authority ought to be involved. For instance, the MS Society argued:

Pure self-assessment should not be ruled out by the new legal framework. However, realistically, local authorities will always require some element of formal sign-off in order to ensure that their resources are used wisely.

- 4.81 Hampshire Personalisation Expert Panel and North Tyneside Council also argued that a sign-off process was a minimum requirement. Hertfordshire County Council made the point that a self-assessment could form part of the assessment process and may be indicative of care needs but also argued that:

It is important to retain the requirement for professional input into the assessment process in order to ensure eligibility and resources are applied consistently, and to consider risk factors.

- 4.82 This view chimed with other consultees, such as Hertfordshire County Council, who saw self-assessment as a potential component in the assessment process rather than something which would stand in isolation.

#### ***Broad concerns***

- 4.83 A large number of consultees expressed significant concerns about the effectiveness and appropriateness of pure self-assessment. York Carers Centre set out what it saw as the main dangers:

First, those people who believe they are capable but are not. Second, those who are unduly influenced by a third party, spouse, close relative or “friend”. Third, the all too human temptation of highly pressurised social workers to allow people who are in the first or second groups to undertake pure self-assessments when, if the local authority had a degree of actual involvement they would appreciate that it was inappropriate.

- 4.84 Newcastle City Council highlighted some problems from the local authority’s position:



It is not effective from an equality basis as there is an assumption of capability and capacity which should not necessarily prevail. If pure self-assessment did become law then a mechanism would need to be established that enabled professionals to challenge these assessments. A pure self-assessment has no support framework around it and people may under-assess themselves and persist with unidentified and unmet needs. The converse is, of course, also true.

4.85 A number of consultees argued that local authority involvement was necessary to ensure an accurate assessment of someone's needs. Jill Scholl, a parent-carer, expressed this concern by analogy to healthcare: "We do not expect to diagnose our illnesses and email the GP for the medication we require".

4.86 Age Cymru suggested that a pure self-assessment "would not be suitable for many older people", and cautioned that a greater use of self-assessment may cause people "to under assess or not apply for services".

#### ***Identifying suitable groups***

4.87 A number of consultees argued that even if pure self-assessment was appropriate in principle, there would be a difficulty in establishing which groups of individuals should be allowed to self-assess. Bournemouth Borough Council suggested that groups could be defined by their level of need, although the National Family Carer Network argued that "making definitions about any group will lead to people being wrongly included or excluded". ADASS argued that this issue "could create inequalities".

4.88 The Law Society expressed doubt as to whether defining groups of people for self-assessment would be possible:

It is difficult to categorise what an appropriate group to be allowed self assessment would be. It might be possible to allow self assessment for a limited range of services either at a financial limit and/or for living aids to a financial ceiling. If this was to be a proposal then the detail should not be on the face of the statute but contained in regulations. ... Whether self-assessment is appropriate should be considered on a case by case basis, taking into account the particular background and needs of the service user in question.

4.89 Furthermore, the Care Quality Commission considered that defining a group who were entitled to self-assess may undermine the broad right to an assessment:

It is hard to conceive of to whom such a right of pure self assessment should be extended, and to whom, by implication, it could be denied. This risks, it seems, contradicting the significance of universal rights to assessment.

### ***Self-assessment for certain services***

- 4.90 Several consultees argued that pure self-assessment is only viable for a very limited range of care services. Sense indicated that self-assessment “might possibly be valid for those who need a small, one-off piece of equipment or adaptation”. However, even this presents problems because “there is a risk that by having pure self-assessment bigger issues may not be picked up”. Sense furthered this point, stating that:

Many older people who need a grab rail might also have unrecognised dual sensory loss, which they themselves assume is a natural part of the ageing process and therefore don't ask for help with. If some level of professional involvement was required then there is a greater chance of this being picked up.

- 4.91 The Royal Borough of Kensington and Chelsea argued that given the risks involved in self-assessment it should only be considered “where the cost of assessment would be greater than the cost of provision”. Age UK made a similar point:

There may be some cases where the service needed is not expensive and no one who did not need it would want it, so gate keeping is not cost effective. Under these circumstances local authorities ought to be able to accept an assessment carried out entirely by an independent person or body, including the person who wants the service.

### ***Conclusion***

- 4.92 Significant concerns were raised about the merits of pure self-assessment. Whilst some consultees suggested it was consistent with promoting independence, many other consultees highlighted numerous problems. In particular, it was argued that pure self-assessment is likely to be inappropriate for many people and identifying suitable groups would be problematic. A significant number of consultees agreed that some external input, whether from an advocate or a social care professional, should be offered whilst local authorities would need some form of sign-off procedure. Furthermore, some consultees argued that the scope of pure self-assessment is likely to be very limited, such as for small items where an assessment would cost more than the item itself.

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

- 4.93 Of the 231 submissions which were received, 64 submissions expressed a view on the proposal that our future adult social care statute should require the details of the assessment process to be described in regulations. Of these consultees, 60 agreed with the question, 3 disagreed whilst 1 held equivocal positions.

***Clarity and consistency***

- 4.94 A significant number of consultees argued that the current legal framework for assessments is in need of improvement. The No Recourse to Public Funds Network argued that “the current system is confusing and needs clarification”, whilst the National Care Forum argued that “the present system varies considerably”. Surrey County Council suggested that to leave the assessment process in guidance will mean that some authorities will not follow it and yet there is a need for consistency.

- 4.95 BUPA Care Homes argued:

The present system has evolved into a postcode lottery. It is vital that the proposed statute addresses this issue and enables people to understand the workings of the system without reference to geographical area. The system needs to be transparent, universal and fair.

- 4.96 Accordingly, many consultees agreed with this proposal because of the clarity associated with a more legally regulated assessment process. As North Tyneside Council argued, “regulations would provide both clarity and consistency in terms of the assessment process”. Similarly, the Law Society argued that having “a single point of reference for what should be in an assessment would be beneficial, and limit the opportunity for different interpretation of requirements”.

***Minimum practice standards***

- 4.97 The problems of varying standards of practice led some consultees to argue that the regulations should specify minimum requirements for the assessment process. Regenerate RISE described current standards as “very haphazard”. Mencap took this further, arguing that:

People who receive poor assessments will miss out on receiving the life changing care and support that they need. ... Mencap urges the Commission to include a minimum standard of quality expected.

- 4.98 Citizens Advice argued that minimum standards would help prevent bad practice:

We think that this is needed to provide an essential safeguard against local authorities cutting corners in assessments, for example by relying on largely telephone assessments by administrative staff, which several bureaux say is widespread.

- 4.99 Refugee Action provided an example of where specifying minimum standards has brought advantages:

We have seen enormous benefit in detailing minimum requirements for assessments in other area of service provision. For example, Local Authorities' age assessments were, prior to a legal case, very diverse in their approach.<sup>6</sup> ... As a direct result [of the judgment] we have seen an increase in the standard and consistency in age assessments.

#### ***Content of the regulations***

- 4.100 A large number of consultees made suggestions about the content of the regulations. For instance, Sense considered that the minimum requirements for an assessment should include a time limit for the assessment; the involvement of the service user and carer where appropriate; the provision of communication support and accessible information to enable this involvement; the involvement of specialists in the assessment; and that the assessment must look at all aspects of life.

- 4.101 Most consultees on this issue agreed that the regulations should require that all relevant people and organisations should be involved in the assessment process. Crossroads Care particularly emphasised the importance of carers. Mencap focused on the role of all relevant professionals as this would:

ensure all needs of the person are identified. Without this input, needs may not always be identified may not always be identified and, consequently, they may not get met.

- 4.102 A specific suggestion which arose in several responses related to a time limit that should be set for assessments. Liz Ball, a deafblind person, noted that "it can take months to get an assessment and where the individual's needs are complex the assessment process can be lengthy". RNID and Guide Dogs argued that they "were aware of people having to wait a significant period of time for any meaningful assessment". Similarly, Mencap noted that:

Service providers and family carers discussed concerns over delays in receiving a community care assessment, sharing personal experiences of "giving up" on waiting for the assessment. Mencap believes that everyone should receive an assessment within the shortest possible timescale and emergency cases should be given greater priority. We urge the Commission to provide clear guidance as to what is an expectable timescale for individuals to wait for an assessment and outline what cases should be prioritised.

- 4.103 The National Valuing Family Forum argued that timescales should be "clearly defined". Alywn Davies, Development and Professional Support Manager with Barnsley Adult Social Care Services, argued that a "framework for assessment timescales ought to be in law as a duty".

<sup>6</sup> *R (A) v London Borough of Croydon (Rev 1)* [2009] UKSC 8; [2009] 1 WLR 2557.

- 4.104 RNIB and Guide Dogs – while arguing that legislation should be more specific in relation to timescales for assessment – also considered that:

As diagnosis of sight loss is a highly emotional time, blind and partially sighted people will need time to come to terms with their diagnosis before entering the formal assessment procedure. In these circumstances social services authorities should provide any urgent services (including emotional support) and must keep in touch with these people and provide an assessment at an appropriate time and within an appropriate timescale.

### **Concerns**

- 4.105 Some concerns were expressed about the detail of the regulations. The Local Government Association argued:

Although we recognize that a duty on the Secretary of State to make regulations that prescribes the details of the assessment process may add clarity, we would be concerned to ensure that the principles of flexibility and proportionality are included in any such regulatory framework.

- 4.106 Hampshire Personalisation Expert Panel also emphasised the role of flexibility and proportionality to prevent the regulations becoming too rigid. The Care Quality Commission pointed out that flexibility will help “future proof” the legislation, as it would enable services to provide innovative solutions as new technologies develop.
- 4.107 The Approved Mental Health Professionals Leads Network expressed concern about setting the assessment process in regulations as “we fear this could make the process over bureaucratic and expensive as a result – which would not be to anyone’s benefit”.
- 4.108 Similarly, the Foundation for People with Learning Difficulties was wary about what they viewed as an overly-prescriptive approach to assessment, which can result in over-rigid systems that do not work for everyone.
- 4.109 The Government also guarded against an over-prescriptive or bureaucratic system that does not improve outcomes for individuals. It was suggested that “it may be more helpful to think in terms of a framework” which would go beyond simply identifying social care needs.
- 4.110 ADASS made a broader point arguing that a fresh approach should be taken to assessment where:

it is a service in its own right, with potential to become the equivalent in social care of the GP service in the NHS. Its focus is no longer on judgements about needs, but on how to assist the individual to achieve well-being, in identified domains, within the framework of their rights and entitlements building on their strengths and assets.

### ***Conclusion***

- 4.111 Almost all responses to this proposal were in favour of a duty to create regulations which set out the details of the assessment process. Many consultees argued that the current position is unclear and there is a wide range of practice, which varies in standard. It was argued that a defined assessment process would provide clarity and help to improve practice. Several consultees made specific suggestions as to the content of the regulations which focused on those who should be involved in the assessment process as well as arguing for a time requirement. Concerns were raised about how tightly defined the assessment process might become and emphasis was placed on the importance of flexibility.

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

- 4.112 Of the 231 submissions which were received, 62 submissions expressed a view on the proposal that local authorities should retain the ability to provide temporary services in urgent cases. All of those consultees who responded agreed with the proposal.

***The necessity of emergency powers***

- 4.113 Consultees agreed that having a power to provide emergency assistance is important. Surrey County Council argued that:

It is essential that the local authority power to provide temporary services without an assessment in cases of urgency is retained. ... Where need is critical and urgent the local authority needs to be able to leapfrog some of the assessment process (temporarily) to provide emergency services.

- 4.114 Similarly, Lancashire County Council argued that:

It is imperative that we have this ability so we can react to assist people at times of emergency and distress with whatever resources we have at our disposal and can follow up on the bureaucratic processes once the situation has stabilised.

- 4.115 Carers UK simply argued that “it would be unthinkable for local authorities *not* to be able to provide temporary services in urgent cases”.<sup>7</sup>

***Emergency powers in practice***

- 4.116 Maxwell Gillott Solicitors reported that the emergency powers provided by section 47 NHS and Community Care Act 1990 were very useful particularly in cases of destitute asylum seekers or failed asylum seekers to whom a duty pursuant to section 21 National Assistance Act 1948 may be owed”. They went on to clarify that:

We are able to argue that accommodation and support must be provided immediately pursuant to section 47(5) pending the carrying out of a full assessment. This is very important in circumstances where the local authority will need to gather together evidence from a variety of sources in order to complete the assessment process, but where the individual is street homeless at the time the request is made.

- 4.117 Newcastle City Council argued they could “vouch that the power to provide emergency services is often relied on by service users’ solicitors when threatening judicial review”.

<sup>7</sup> Emphasis in original.

- 4.118 The No Recourse to Public Funds Network made the point that emergency powers can be used to avoid destitution, which attracts the protection of Article 3 of the European Convention on Human Rights. It was highlighted that in the case of *R (Limbuella) v Secretary of State for the Home Department*,<sup>8</sup> Article 3 will be engaged where there is an imminent prospect of serious suffering caused by lack of the basic necessities of life. Accordingly, the existence of emergency powers would enable local authorities to ensure that Article 3 was not violated.
- 4.119 Refugee Action, however, noted that emergency assistance “is rarely offered without a significant level of advocacy on behalf of the applicant”. Accordingly, they argued that the proposed power should be cast as a duty. Scope and the Practitioners Alliance Against the Abuse of Vulnerable Adults also argued for a duty rather than a power to provide temporary services.

### ***Urgent cases***

- 4.120 A number of consultees sought to clarify on what amounted to an urgent case. Refugee Action argued:

We would also find it helpful if “urgent cases” was defined within the statute or the regulations, as this currently appears to be interpreted differently according to the local authority.

- 4.121 This view was shared by the Cardiff and Vale of Glamorgan Voluntary Health and Social Care Networks. On this point, Cartrefi Cymru argued that:

The statute should specify the criteria to be used in assessing if an emergency intervention is appropriate and should address the nature and level of short term risk to the individual if intervention is not actioned immediately.

### ***Conclusion***

- 4.122 There was consensus amongst consultees that local authorities should retain the ability to provide temporary services in urgent cases. Local authorities argued that such a power is a crucial tool to manage individuals in crisis situations. Furthermore, those acting for individuals often argue that this power should be used to ensure that their clients are not left destitute. A number of consultees queried whether the power should be recast as a duty and whether “urgent cases” should be defined in the statute.

<sup>8</sup> [2005] UKHL 66; [2006] 1 AC 396.



## **PART 5**

# **CARERS' ASSESSMENTS**

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

- 5.1 Of the 231 submissions which were received, 77 submissions expressed a view on the proposal that there should be a duty to undertake a carer's assessment in our future statute. Of those consultees, 76 agreed with the proposal and 1 held an equivocal position. No consultees disagreed with this proposal.
- 5.2 Of the 27 submissions overall which were received from individual carers and carers' organisations, 12 expressed a view on the proposal and all of them agreed.

### ***The need for consolidation***

- 5.3 Several responses agreed that the duties under the three separate statutes should be consolidated into a single statute setting out a duty to undertake a carer's assessment. For example, Compassion in Dying pointed to the "inadequacies of the current system, where the delivery of assessments to carers has been patchy". ADASS also stated that "the current framework is fragmented and is complex for professionals, service users and carers alike".
- 5.4 A number of consultees emphasised the importance of ensuring that the carers' assessment duty remained stand-alone and that the law is clear that carers are still entitled to a carer's assessment even if the person being cared-for is not receiving a community care service.

### ***Giving prominence to the needs of carers***

- 5.5 Several consultees stressed the importance of carers and argued that incorporating a duty to assess carers would be a better reflection of their status. For example, the Oxfordshire Sensory Impairment Teams stated that including the duty would provide "more recognition of carers and equality of service". The Learning Disability Coalition also emphasised "the importance of respecting and responding to the needs of carers as critical to supporting people with a learning disability".
- 5.6 Furthermore, Compassion in Dying also highlighted that "carers make a huge contribution to the care and support system" and argued that "it is vital and *fair* to provide carers with the support they need in order to enable them to fulfil their role to the maximum".<sup>1</sup>

<sup>1</sup> Emphasis in original.

- 5.7 Mencap supported the inclusion of a duty to undertake a carer's assessment because "it is crucial family carers get the support they need". They highlighted their 2006 report, *Breaking Point*, which found that seven out of ten families have reached or come close to *breaking point* because of a lack of short term respite services.<sup>2</sup>

### ***Proportionality***

- 5.8 The Care Quality Commission noted the struggles carers face in getting their own assessment of need and argued that a single and explicit duty to assess carers is "appealing in so far as it establishes clear rights and expectations enforceable in the courts". However, it argued that:

It is important to recognise that a full assessment is not always necessary and may be disproportionate. A blanket duty could be seen to be at odds with a more personalised approach. Often what are required are signposting services and the provision of high quality and relevant information.

### ***Focus of the assessment process***

- 5.9 The Social Care Institute for Excellence argued that the assessment should not only focus on whether the carer is able to provide and continue to provide care, but also whether he or she is *willing* to do so.
- 5.10 ADASS elaborated on the areas which they argued should be central to a holistic assessment process. These areas included the question of whether the carer is willing to continue to provide care, as well as enquiring 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 of assuming a caring role or as a result of its continuation".

### ***Conclusion***

- 5.11 There was a strong affirmative response to the proposal of including a duty to undertake a carer's assessment in the future adult social care statute. Consultees highlighted the importance of carers, and the importance of ensuring that they receive adequate support in carrying out their important role as key reasons to support this proposal.

<sup>2</sup> Mencap, *Breaking Point: Families Still Need a Break* (2006).

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

- 5.12 Of the 231 submissions which were received, 68 submissions expressed a view on the proposal that the duty to assess a carer should apply to all carers who are providing or intend to provide care to another person, not just those providing a substantial amount of care on a regular basis. Of those consultees, 52 agreed with the proposal, 4 disagreed, whilst 12 held equivocal positions.
- 5.13 Of the 27 submissions overall which were received from individual carers and carers' organisations, 11 expressed a view on the proposal and all of them agreed.

***The need for a more inclusive duty***

- 5.14 Many consultees agreed that the existing legal requirement that, in order to be eligible for an assessment, carers must provide a "substantial amount of care on a regular basis" is too ambiguous and increases the complexity of the process. The substantial and regular requirement means that carers who would otherwise be eligible for an assessment are precluded from obtaining one. For instance, in supporting the proposal, the Equality and Human Rights Commission stated:

Surveys carried out by Carers UK over the years have found that the current complex system prevents carers from accessing their rights and support. For example, 90% of surveyed carers were eligible for an assessment, but only 38% of carers had received one and only 50% of carers had been told of their right to request an assessment.

- 5.15 Sunderland City Council suggested that the "difficulty in defining 'substantial and regular' makes this an inappropriate mechanism for determining eligibility to a carer's assessment".
- 5.16 Some consultees also suggested that the test appears to require its own pre-assessment. As Surrey County Council put it, the "test of whether someone is providing regular and substantial care is only logically possible once an assessment has been carried out".
- 5.17 Imogen Vaughan, a carer, pointed out that carers may fail to satisfy the substantial and regular requirement because, although they provide care at that level it is only for intermittent periods. Alternatively, they may be providing a lower level of care but to several members of their family at the same time. She argued that "consideration of the support they need is very important".
- 5.18 Furthermore, the MS Society suggested that the substantial and regular requirement may:

unfairly exclude carers who provide care for someone with fluctuating, and often unpredictable needs, though this caring responsibility can often have a greater impact on the carer's life. MS Society research showed that nine out of ten carers are the main giver of care and

support during a relapse or sudden deterioration of their friend or family member's condition.

- 5.19 Furthermore, Jill Scholl, a parent carer, highlighted that it is important that carers' assessments are inclusive in order to identify carers for whom services are not readily available at the moment, but who may be reached once more "creative" services become available. Accordingly, she highlighted that:

In my experience, carers assisting physically disabled family members gain support readily because the services can be easily identified. However, statistically there are many more carers overseeing the lives of mentally ill relatives, and the services available for these carers are much harder to define and fulfil. This results in a very poor take-up of assessments, as the process is not hopeful for either the assessor or the carer.

- 5.20 Additionally, the Local Government Association pointed out that the regular and substantial test "puts disproportionate emphasis on the amount of time spent in a caring role as distinct from other pressures that carers face". Similarly, the Hampshire Centre for Independent Living argued that:

More recognition must be given to the invisible demands on an emotionally attached or family related carer's time and energy: intellectual demands of planning ahead, thinking/worrying for [the] cared-for [person], being continually answerable, responsible for household etc, on stand-by etc. These are time/energy consuming and restricting, debilitating demands that are not being recognised or allowed for.

- 5.21 Newcastle City Council stated that the proposal will:

Enable early intervention with carers making it possible for a trusting relationship with professionals to grow, outside that of crisis intervention, which is often when carers are currently introduced to assessments.

- 5.22 On the other hand, Solicitors for the Elderly agreed that the need to provide regular care should be removed, so that the duty to assess "covers people who are temporary carers", but suggested that "substantial could be retained as a way of gate keeping".

- 5.23 In a similar vein, the Royal College of Physicians of Edinburgh stated that a more inclusive assessment duty would be "unworkable and over inclusive" and suggested that:

It may be better to link the carer assessment with the assessment of the individual person's care needs i.e. to assess the effect on carers of the person's care needs, particularly where a carer would provide care that would in their absence be provided by statutory services.

### ***Resource implications***

- 5.24 Some consultees expressed concern that a more inclusive definition would open the floodgates and have significant resource implications for local authorities. For example, the Government stated that “as a proposal that will extend local authorities’ current responsibilities”, resource implications should be considered. Likewise, Wirral Council stated:

It must be recognised that this [proposal] will raise expectations and have significant resource implications and will not address or prioritise the needs of those carers who are vulnerable due to age or ill health.

- 5.25 Similarly, Conwy County Borough Council expressed concern about the “resource implications for social workers who would have to undertake the assessment as well as arrange for the provision of service”.
- 5.26 At one consultation event, a local authority employee suggested that the substantial and regular test is used as a screen to decide which carers need a full assessment. Consequently, it was considered that removing the substantial and regular test would place an onerous burden on local authorities and would ultimately direct resources away from services for both the carers and cared-for people.
- 5.27 Oxfordshire Sensory Impairment Team highlighted concerns that the proposal could “be detrimental to those carers providing substantial care and also the clients with complex needs”. This is based on their concern that the proposal may stretch “resources beyond what is possible”.

### ***Complementing Government policy***

- 5.28 The Government’s response highlighted that this proposal, taken together with our other proposals on carers’ assessments:

may be a better reflection of what we are trying to achieve as it addresses the impact, or potential impact, of caring, rather than setting specific criteria to be met.

- 5.29 A small number of consultees pointed out that the proposal complements the Government’s prevention agenda. For example, Newcastle City Council stated that the proposal will:

enable early intervention with carers making it possible for a trusting relationship with professionals to grow, outside that of crisis intervention, which is often when carers are currently introduced to assessments.

- 5.30 Furthermore, the Standing Commission on Carers, stated that:

If the Government’s intentions to improve prevention through earlier intervention and reablement services are to be achieved, then it is vital that [the proposal to remove the substantial and regular test] is reflected in the new legislation.

### ***Further definition needed***

- 5.31 Several consultees argued that the word *carer* required further definition, and it was therefore not enough just to remove the substantial and regular requirement. For instance, Mary Edmunds, a social care professional, stated:

Many colleges are still very unclear on what is meant by an unpaid carer and parents of young non-disabled children are frequently included in the definition. This confusion surrounding the definition was further confirmed in the Ofsted report: *Including Carers: Towards a Framework for Meeting the Needs of Carers in Further Education and Adult Learning* (Sept 2009) in which around 50% of the case studies were of parents caring for young non-disabled children.

- 5.32 Moreover, Jill Scholl stated that the word carer “is very unhelpful for the family, as it suggests to the cared-for that they are incapable of looking after themselves”. She put forward the following alternative definition:

It is when a person, relative or friend, takes on some of the responsibility for the quality of another person’s life when they are unable to do so themselves.

### ***Proportionality***

- 5.33 Some consultees highlighted the importance of ensuring that the assessments are proportional to the impact that caring has on the carer. For instance, Lancashire County Council stated:

We would welcome this proposal if it was made explicit that this assessment should be of a level of complexity commensurate with the apparent impact of their current or intended caring responsibilities on the individual.

- 5.34 Coventry City Council stated that “clear guidance would be needed over the type and length of assessment that would be required to discharge the duty to assess”. Agreeing with the proposal, Carers UK stated that the Code of Practice “should then set out risk factors based on the impact of caring on the carers’ life ranging from low to critical requiring more urgent and substantial attention”.

### ***Welsh responses***

- 5.35 The Welsh Assembly Government highlighted that:

The National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2009 defines carers by reference to those who provide a substantial amount of care on a regular basis. Therefore, any future Assembly Measure made by the Welsh Ministers will have to be made with reference to this definition.

- 5.36 On the other hand, a narrow majority of Welsh consultees who responded to this proposal agreed with removing the substantial and regular requirement (56%).

### ***Other concerns***

- 5.37 Two consultees welcomed the inclusion of people who are intending to provide care to another person, but, as highlighted by Newcastle City Council, argued that “some guidance on the meaning and timescale of ‘intention’ would be required”.
- 5.38 On a different note, the ADASS argued that there is a need to “strengthen recognition and awareness of the right to an assessment and a need for collaboration between authorities”. Thus, they stated that the duty to assess should be complemented by two other duties:

A duty to promote the recognition of caring roles being or likely to be undertaken ... [and] a duty to make available provision of information, advice, advocacy and support to facilitate the exercise of their rights by carers in relation to the duties placed on councils under the Act.

### ***Conclusion***

- 5.39 There was a predominantly affirmative response to the proposal that the duty to carry out a carer’s assessment should apply to all carers who are providing or intend to provide care to another person, and that it should not be available to just those providing a substantial amount of care on a regular basis. Many expressed the view that removing the ambiguity and complexity in the current law which arises from a lack of agreed definition of “regular and substantial” should be welcomed. It was also argued by some consultees that our proposed approach would help to identify carers whose needs may otherwise go unidentified because of the unpredictable nature of the cared-for person’s needs. However, there was also concern about the resource implications of this proposal, as well as whether it would be workable if there was a significant increase in the number of assessments required.

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

- 5.40 Of the 231 submissions which were received, 70 submissions expressed a view on the proposal that the duty to assess a carer should not be triggered by the carer making a request, but should be triggered where a carer appears to have, or will have upon commencing the caring role, needs that could be met either by the provision of carers' services or by the provision of services to the cared-for person. Of those consultees, 53 agreed with the proposal, 5 disagreed, whilst 12 held equivocal positions.
- 5.41 Of the 27 submissions overall which were received from individual carers and carers' organisations, 10 expressed a view on the proposal and all of them agreed.

***Benefits of our proposed approach***

- 5.42 Many consultees agreed that a request should not be necessary to trigger a carer's assessment. Several reasons were put forward for this. Mencap, for instance, suggested that an assessment system that is purely based on a request trigger fails those carers who are not aware of what services are available and what support they can receive. Surrey County Council considered that a trigger of the appearance of needs was "more equitable and better than basing it on a request which has been used in the past as a barrier to assessment".
- 5.43 The National Family Carer Network highlighted that many family carers "feel guilty that they need help with the caring especially if they have done it in the past and are now not able to". This may make them less likely to request an assessment. Similarly, Cymorth Cymru argued that:

Moving away from assessment by request and towards automatic assessment based on evidence of a caring role may take away the stigma attached with assessment for some.

- 5.44 Another reason for supporting the proposal was that, as the National Valuing Family Forum stated, "carers don't always identify themselves as carers". Cymorth Cymru also made this point:

Often carers will not see themselves as requiring support but often it is crucial to ensuring that they are able to care for a user, and maintain good health and wellbeing themselves.

- 5.45 Furthermore, Belinda Schwehr, a legal and training consultant, argued that:

Some carers are so exhausted that they could not be expected to stop for long enough to even consider the impact of their condition if they continue, on the more vulnerable of the two of them.



- 5.46 On the other hand, the Law Society argued that the proposal was unnecessary if carers are informed of their right to request an assessment. Thus they argued that “there must be a duty for the local authority to inform and advise any carer that they have the right to an assessment”.

***Retaining the right to request an assessment***

- 5.47 Many consultees argued that the right to request an assessment should be retained alongside our proposed trigger based on the appearance of needs. It was suggested that this may be an important safeguard for those carers who are not identified as eligible for a carer’s assessment. For example, Crossroads Care and the Princess Royal Trust for Carers argued that:

If the most common trigger for local authorities to identify people suitable for a carer’s assessment is a community care assessment of the cared-for person, carers of people who do not want or are not eligible for a community care assessment could remain unidentified.

- 5.48 Mencap argued that giving carers a right to request an assessment would:

empower carers and ensure that they can be proactive if there is a change in their circumstances, for example if the carer suffers from ill-health or the cared for individual has a change in needs.

- 5.49 Moreover, York Carers Centre suggested that:

A request for an assessment is unlikely to be made lightly and therefore the fact of that request should – not just may – be taken as an appearance of need.

- 5.50 Some consultees argued that if a right to request an assessment was introduced for cared-for people, then it should be maintained for carers, so as to be fair and consistent. For example, Leonard Cheshire Disability argued that “if the aim of the statute is to move towards a more unified assessment process for carers and cared-for people”, and “if cared-for people are going to have the right to request [an assessment]”, then “it is important the same right is extended to carers”.

- 5.51 On the other hand, the Wales Neurological Alliance, argued that request should be the only trigger, since otherwise:

carers would only be able to receive an assessment if their local authority felt their needs could be better met by support for themselves or for the person they are caring for.

- 5.52 Rather than removing the request trigger, the Wales Neurological Alliance suggested giving carers the right to:

request an assessment using the approach for service users provided in section 228 of the Mental Health (Care and Treatment) (Scotland) Act 2003, where a request does not trigger the duty to assess, but a local authority must consider a request and if it refuses to carry out an assessment it must give reasons why.

- 5.53 If the right to request an assessment is retained, Newcastle City Council argued that there would need to be a “procedure to avoid frivolous/vexatious requests”.

***Concerns over the reference to “services” in the proposal***

- 5.54 A small number of consultees criticised our proposal because the right to a carer’s assessment is linked to the provision of services. For example, Mencap argued that the assessment trigger should be “predominantly based on the needs and desired outcomes of the carer”. Similarly, the Vale of Glamorgan Carers’ Forum argued that an assessment should always be offered where a carer is identified, and that assessment should not be:

limited to those who appear to have a need that can be met by current services to the carer or the cared-for person but rather that all need which arises from caring or which has an effect on the ability to care should be considered.

- 5.55 Furthermore, Jill Scholl, a parent carer, argued that a carer’s assessment should be available on request regardless of the amount of care being provided and expressed concern that an assessment trigger linked to available services would lead to a “very poor take-up of assessments”. Furthermore, if assessments are not completed, then she argued there is no way of identifying carers “if and when more creative resources become available” – such as carers groups, mentors, and “supporting ways to ensure the carer is still living a fulfilling life, even though this may be on hold for a while”.

- 5.56 Additionally, a small number of consultees argued that carers should be offered an assessment not because they appear to be in need of services, but simply on the basis that they are carers. For instance, Tessa Harding, an individual carer, argued that carers should have a right to an assessment “wherever it appears that a person is providing continuing support to another”.

***The ability of the carer to refuse an assessment***

- 5.57 Some consultees were concerned that under our proposal a carer could be assessed even without their consent. For instance, the Blackburn with Darwen, Blackpool and Lancashire Safeguarding Adult Boards made their acceptance of the proposal conditional on assessments not being “imposed on an unwilling carer”.

- 5.58 On the other hand, the York Carers Centre accepted that there was a “balance to be struck” where there “are real safeguarding concerns”. Similarly, the Social Care Institute for Excellence stated that individual carers:

should have the right to refuse this assessment unless there are concerns about their capacity to make decisions or the safety of the care or the person being cared for.

- 5.59 Some consultees suggested that if the intention is that a carer’s assessment can be carried out in circumstances where the carer does not consent, then this needs to be clarified in legislation. Compassion in Dying felt that this point needs further clarification with particular reference to the Mental Capacity Act 2005.

### ***Resource implications***

- 5.60 A small number of consultees expressed concern about the proposal's potential resource implications, such as increased workload for social care professionals. For example, North Tyneside Council expressed "real concerns about the potential large increase in workload" and the Welsh Assembly Government expressed concerns about resource implications.

### ***Conclusion***

- 5.61 There was a predominantly positive response to the proposal that the duty to assess a carer should not be triggered by the carer making a request, but should be triggered where a carer appears to have, or will have upon commencing the caring role, needs that could be met either by the provision of carers' services or by the provision of services to the cared-for person. However, many consultees emphasised the importance of retaining the right to request an assessment alongside the proposed trigger. Also, several consultees expressed concern that carers may be assessed without their consent, and insisted on the importance of giving them a choice in the matter.

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

5.62 Of the 231 submissions which were received, 47 submissions expressed a view on the proposal that some categories of paid carers should not be excluded from the definition of a carer for the purposes of a carer’s assessment. Of those consultees, 29 agreed with the proposal, 8 disagreed, whilst 10 held equivocal positions.

5.63 Of the 27 submissions overall which were received from individual carers and carers’ organisations, 5 expressed a view on the proposal. Of those consultees, 3 agreed and 2 disagreed.

***Paid carers should not be excluded from an assessment***

5.64 Some consultees agreed with the proposal on the basis that, as the Law Society put it:

even when a family carer is being paid, it is different from a person who has chosen a career in caring. A family carer may take on the role and be paid via a direct payment ... they may then find that they have difficulties in managing and their wellbeing may be affected.

5.65 Moreover, Hampshire Centre for Independent Living argued that payment should not preclude a carer from receiving an assessment, since:

Care related payments are compensation for missing out on alternative paid employment opportunities which brings with them other social, emotional benefits as well as pension contributions, etc. Also ... paying an emotionally attached or family related carer does not recognise or include *all* the intellectual and emotional aspects of this role.<sup>1</sup>

5.66 Newcastle City Council accepted that “the receipt of money will not necessarily professionalise a carer such that they are akin to a paid or volunteer care worker”, and agreed therefore that “there are still benefits to a carer’s assessment and it should still be accessible”.

5.67 On the other hand, some consultees argued for the need to maintain a clear distinction between paid and unpaid carers. For example, the Hampshire Personalisation Expert Panel argued that:

<sup>1</sup> Emphasis in original.

Care workers/personal assistants are protected under employment law normally and therefore to assess them as “carers” potentially compromises the employer/employee relationship.

- 5.68 Similarly, Gateshead Council argued that the extension of assessment to paid carers:

erodes the distinction between an informal carer and an employee and shifts the burden of ensuring that the employee is properly trained, equipped and supported to carry out their employment duties from the employer to the local authority.

- 5.69 Conversely, Hampshire Centre for Independent Living highlighted that undertaking a carer’s assessment does not “contradict or undermine statutory employment rights and entitlements” because it “simply addresses a different relationship”. Thus they stated that there is a:

distinction between an emotionally attached or family related carer and a standard “care assistant” which is to do with the relationship, commitment and includes matters of a familial, emotional nature and issues around interdependence, etc.

#### ***Current law is sufficient***

- 5.70 A small number of consultees argued that the current law is sufficient and does not require reform. For example, Surrey County Council considered the current law to be “adequate” and current definitions “clear and effective”. ADASS stated that the current law is “probably sufficient” and argued that “the proposal may confuse the current law”. Similarly, Carers UK argued that the proposed definition would add “confusion” and suggested that “the best place to deal with these issues is in the code of practice”. Furthermore, they argued that:

The test should be based on whether caring is likely to have an impact on a carers’ life and the response is then proportionate to that – i.e. no action needs to be taken to significant action – depending on the level of risk to independence, work, health, family relationships, leisure etc.

#### ***The proposal lacks certainty***

- 5.71 A small number of consultees expressed concerns that the proposal would reduce legal certainty about who is and who is not entitled to a carer’s assessment. For example, the Wales Assembly Government argued that:

Categories (2) and (3) imply the exercise of some discretion by local authorities presumably on a case by case basis and the exercise of that discretion would potentially be subject to the complaints procedure.

#### ***Resource implications***

- 5.72 A small number of consultees expressed concern about the increased workload and resource implications of the proposal. For example, Gateshead Council argued that:

The proposed extension of the duty to assess and meet carer's needs will lead to a greatly increased demand on local authority resources and cannot be seen as "cost neutral".

5.73 North Tyneside Council considered that a consequence of the proposal was that a separate carer's assessment would be required for all carers, "as not many situations would fall outside of the stated inclusion criteria". They therefore had "resulting concerns about capacity of local authorities to undertake this increased demand".

5.74 Nottingham City Council – while agreeing with the proposal – noted that it is likely to "significantly increase the number of carers' assessments and therefore have potential financial implications, particularly as the personalisation agenda is pursued".

***Comments particular to the separate limbs of the proposal***

5.75 A number of consultees expressed views on one or more of the individual limbs of our proposal. For example, Conway County Borough Council argued that the first limb of the proposal – *that the definition of a carer does not exclude a previously unpaid carer who now receives payment for their services* – could lead to "social services departments paying twice for the same service". Similarly, Belinda Schwehr, a legal and training consultant, argued that to give a paid carer an assessment and services would be duplicating the provision of funding, since "the money is being used for eligible needs on the basis that the carer has said that they were no longer prepared to do it for free".

5.76 In relation to the second limb of the proposal – *that the definition of a carer does not exclude a carer who is paid for some but not all of the care they provide* – the Royal Borough of Kensington and Chelsea argued that "the paid and unpaid elements [should be] made explicit as it could generate some confusion". Belinda Schwehr argued that the local authority would need to make a judgement call as to whether what is still being done qualifies for a carer's assessment and Government guidance would be required on this.

5.77 Furthermore, the York Carers Centre argued that:

To try and differentiate between the care that is being paid for and that which is not being paid for, creates fine and arbitrary divisions, which will be hard (and time consuming) to make in practice.

5.78 Instead, they suggested that the starting point should be "an assumption that only people employed by an outside agency should be excluded".

5.79 Two consultees suggested that the third limb of our proposal – *that the definition of a carer does not exclude a carer where the local authority believes the caring relationship is not principally a commercial one* – is sufficient to cover the intended purpose of the proposal. For example, the Government argued that a "simpler test as represented by (3) alone would be sufficient". Similarly, the Law Society argued that a clearer alternative to the proposal would be:

To give a local authority an exceptional discretion to provide carer's services to persons providing care non-commercially to a relative

(defined to include persons already living within the same household when the care commences).

- 5.80 However, Carers UK argued that the wording of the third limb is “highly problematic” because it suggests that the right to an assessment would extend to volunteers. The Government also commented that it is important to ensure that volunteers are not inadvertently brought under the scope of carers’ assessments.

***Other concerns and suggestions***

- 5.81 The Medway Older People Communication Network argued that there is a wider issue which needs to be considered, “as to how care is provided and how persons and their carers are dealt with”. They argue that the proposal is a “very clumsy” way of dealing with the problem, which essentially stems from the “increasing tendency of Government policy to place more responsibility upon individuals for their own care”.
- 5.82 The London Borough of Havering suggested an alternative approach to the definition of a carer, which should include any “family member or person who has formed a close personal relationship with the service user prior to the need for community care arising”.

***Conclusion***

- 5.83 While most consultees agreed with the aim of the proposal, there were more mixed responses with regards to the actual wording. In support of the proposal, consultees argued that an employer-employee paradigm does not encompass the complexity of the relationship between a paid family carer and the cared-for person. On the other hand, there was concern that the proposal blurs the distinction between carers and care-workers, as well as concern about conflict with employment law.

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

- 5.84 Of the 231 submissions which were received, 71 submissions expressed a view on the question of whether our statute should encourage a more unified assessment process for carers and cared-for people. Of those consultees, 47 agreed with the question, 10 disagreed, whilst 14 held equivocal positions.
- 5.85 Of the 27 submissions overall which were received from individual carers and carers' organisations, 13 expressed a view on this question. Of those consultees, 10 agreed with the proposal, 2 disagreed, whilst 1 held an equivocal position.

***Encouraging holistic assessments***

- 5.86 Many consultees answered the question in the affirmative because they argued it would result in a more holistic assessment process. For example, the Care Quality Commission stated that it is "important to recognise the interdependencies within families and the value in having a whole family approach". The MS Society argued that it was:

important that both the needs of the carer and the cared-for person are assessed in the context of the whole family situation, and that results from each assessment should inform each other.

- 5.87 Similarly, RNIB and Guide Dogs supported a more unified assessment process, "given the intrinsic link between the needs of the cared for person and those of the carer".
- 5.88 The Foundation for People with Learning Difficulties highlighted the advantages of a unified assessment process by setting out two different scenarios that would benefit from such an approach. First, where a person who needs support themselves becomes a carer, they argued that too often "councils are slow to recognise the complex interdependencies in such relationships". Second, where a family carer has multiple caring responsibilities, they suggested that:

It is still unfortunately the case that some authorities seek to assess each individual separately, rather than looking at the whole complex family situation.

- 5.89 Similarly, Dr Gregg Moore argued that "a holistic assessment would help to avoid some issues falling between two, independent assessments". The Spinal Injuries Association stated that "a collective need may be identified which is not immediately apparent in the assessment of two individuals".
- 5.90 However, while strongly agreeing with the question, the National Valuing Family Forum argued that there is a need for some guiding principles about what is entailed in a "holistic" assessment.



### ***Retaining separate assessments***

5.91 A small number of consultees disagreed with the question because they argued that carers and cared-for people will often have conflicting needs. For example, Tessa Harding, a carer, argued that it is important that the interests of the carer and the cared-for person are considered separately, because they “are often different and may sometimes conflict”.

5.92 Other consultees emphasised that even within a more unified process, it is important to allow for separate assessments where this is more appropriate. For example, Crossroads Care and the Princess Royal Trust for Carers argued that each party should continue to retain the right to a separate assessment because:

it is feasible that the needs of carers and cared-for people could differ and both parties must be given the right to express their views. Whole family support packages/personal budgets could produce the benefit of taking a holistic view while still allowing individuals to speak freely in their own assessment.

5.93 This was also supported by Research in Practice for Adults, who stated that:

It is important for the home situation to be assessed jointly but with scope for carer and cared for to be spoken to separately without the other listening in to allow honest answers. This allows both parties to have their say and the assessor to have a more informed opinion about the needs of both.

5.94 Furthermore, the Care Quality Commission warned against going too far in pursuing a unified process, arguing that:

Experience suggests that too ready an association of carers’ interests with those of the cared-for person means, in practice, those carers’ voices are subsumed or sometimes neglected. The reverse can, of course, also be true.

5.95 Similarly, Newcastle City Council argued that where it would be “wholly inappropriate” to combine assessments, then “the authority should not only be encouraged but required to complete separate assessments”. Such situations may be, for example, “where the carer is unable to be fully candid in front of the service user”.

5.96 Furthermore, Mencap stated that:

Carer’s assessments and community care assessments should not be done jointly, or at the same appointment as this would fail to personalise the assessment. Joint assessments may prevent the individual or the carer to be honest about what they really want. However, Mencap believes the assessments should not be done in isolation as care packages could compliment each other.

- 5.97 In addition, Crossroads Care and the Princess Royal Trust for Carers argued that “local authorities may need to develop the capacity to act as mediators if the needs of the carer and the cared-for person are not aligned”. Mediation was also supported by the National Family Carer Network because “a shift from traditional services to personalisation will inevitably lead to disagreements or concerns in some cases”.
- 5.98 In addition, the Welsh Assembly Government and Stephen Ward, a mental health professional, emphasised the importance of continuing to assess the carer in situations where the cared-for has refused an assessment.

#### ***Statute law or guidance?***

- 5.99 Several consultees suggested that the issue of a more unified assessment process should be dealt with in guidance, rather than on the face of the statute. For example, ADASS argued that the “matter is best left to guidance ... because it is essentially about processes rather than rights”. Hull City Council also preferred leaving the issue to guidance, as “this will ensure opportunities to ensure appropriate safeguarding measures are made”.
- 5.100 On the other hand, Solicitors for the Elderly argued that “detail can be fleshed out through a code of guidance but matters which must be taken into account should be included on the face of the statute”.

#### ***Resource implications***

- 5.101 Some consultees argued that a more unified assessment process would increase efficiency. For example, the Disability Law Service argued that a unified assessment between carers and cared-for people would “save time and bureaucracy”. Similarly, Newcastle City Council argued that generally “completing a carer’s assessment at the same time as a community care assessment is beneficial and efficient”.
- 5.102 On the other hand, a small number of consultees expressed concern over increased workload and resource implications of a unified assessment process. For example Caerphilly County Borough Council described the concept of offering a unified assessment as “ideal” but argued it would “likely become unsustainable” because it “would in essence double the work of a care manager in terms of one situation”.
- 5.103 Furthermore, Havering London Borough Council stated that there may be situations where a unified assessment “results in a waste of resources” and therefore suggested that:

if there is a unified assessment process that this is left to the discretion of the local authority in question to devise an appropriate assessment approach.

### ***Conclusion***

- 5.104 There was a predominantly affirmative answer to the question of whether our statute should encourage a more unified assessment process between carers and cared-for people. Many consultees highlighted the importance of looking at the whole situation of the carer and the cared-for person and that this would allow for a better understanding of their needs. On the other hand, several consultees highlighted the importance of carrying out separate assessments, or at least having the discretion to do so, within a unified framework. Some responses focused on the practical implications of this question, with some arguing that a unified assessment process will increase efficiency and reduce costs, while others argued that it will increase workload and may lead to wasted resources.

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

5.105 Of the 231 submissions which were received, 58 submissions expressed a view on the question whether the carers' assessment duty should be merged with the community care assessment duty. Of those consultees, 12 agreed with the question, 39 disagreed, whilst 7 held equivocal positions.

5.106 Of the 27 submissions overall which were received from individual carers and carers' organisations, 6 expressed a view on the question. Of those consultees, 1 agreed and 5 disagreed.

***Retaining a distinction between the carer and the cared-for person***

5.107 Several consultees disagreed with the question because they argued that it is important to retain the distinction between a carer and the cared-for person. For example, Newcastle City Council stated that "there are real and necessary distinctions in assessing and providing services to service users and their carers". Similarly, Compassion in Dying argued that this "may not adequately recognise the specific role of a carer (and related needs and challenges)". Moreover, Coventry City Council pointed out that a carer's assessment may have to be carried out by "suitably trained professionals outside of the Council with experience of carer issues".

5.108 On the other hand, some consultees argued that merging a carer's assessment with community care assessment would improve the outcome for carers. For example, Disability Wales argued that this:

may help to encourage a more holistic view of service users' needs and how their desired outcomes may be met, as well as ensuring that carers' needs are adequately addressed.

5.109 Conversely, Parkinsons UK stated:

While we recognise some more unified processes could mean more prominence for carers needs in the assessment process and joined up thinking, we would be very cautious about something akin to a joint assessment as carers and cared-for people will have very different needs.

5.110 Furthermore, ADASS stated that the removal of the distinction between carers and the cared-for person would:

risk a serious loss of recognition of the unpaid caring role. It could affect the exercise of rights by carers; become resource driven; and, affected by rising demand from demographic change.

5.111 Similarly, the York Carers Centre argued that for many carers:

A legal acknowledgment of their distinctive and invaluable role precedes a wider social recognition, which helps sustain them in what

are often difficult times. In turn, that assists and supports the cared for person.

### ***Importance of knowing who is receiving services***

- 5.112 Age UK highlighted that a merged assessment duty would make it unclear who the services are for. They described the difficulties that might result from this:

It might not be clear who should be charged for services, and local authorities could potentially give services to whoever, out of the carer and the cared for person, was best able to pay. Promoting choice and control of services is difficult where it is not clear who the service user is.

- 5.113 Lancashire County Council also highlighted the importance of distinguishing who the services are provided for:

We would wish to maintain the practical distinction between which services are provided to an individual as a carer and which provided as a consequence of their own assessment. This would still be needed in order to identify which services should remain in place and which cease, if the individual were to cease their caring role.

### ***Practicality***

- 5.114 Several consultees argued that merging the carer's assessment with the community care assessment would not be workable. For example, the MS Society argued that the proposal would not be practicable because:

Carers' services often involve services for the cared-for person, and ordinary residence issues would make it difficult to decide which local authority had responsibility for providing and funding such services.

### ***Other issues***

- 5.115 Several consultees interpreted the question to mean that a carer's assessment for the carer would be carried out at the same time as the community care assessment for the cared-for person. Thus, they expressed concerns about confidentiality and conflict of interest.

### ***Conclusion***

- 5.116 The question whether the carers' assessment duty should be merged with the community care assessment duty received a predominantly negative response. The consultees highlighted two main reasons for disagreeing. First, it was argued that merging the two duties does not give enough recognition for the distinct role of being a carer. Second, it was argued that carers and cared-for people have distinct needs, which require a different assessment. Furthermore, some consultees argued that to propose that the duties are merged would not be practicable, because of ordinary residence issues, for example. On the other hand, a small number of consultees argued that merging the duties would result in a more holistic treatment of carers.

### **General issues**

- 5.117 While the previous analysis dealt with responses on specific proposals or questions, this section highlights some of the other issues that were raised by consultees in relation to carers. It was suggested that these issues should be taken into account when developing our recommendations for reform in relation to carers.

#### ***Carer's willingness to provide care***

- 5.118 Many consultees referred to the importance of considering whether a carer is willing to provide care, not merely whether they are able to. For example, the Wales Council for Voluntary Action cited Crossroads Care Wales, as arguing that "one of the inherent difficulties arising for the NHS and Community Care Act 1990 was the interpretation of a carer's 'willingness and ability' to provide care". The National Family Carer Network stated that "it must not be assumed that the family are willing ... to provide large amounts of care".
- 5.119 Furthermore, RADAR and the National Centre for Independent Living expressed concern that there may sometimes be discrimination in assuming that a carer is willing to provide care:

For example, arising from gender, as women are generally more perceived as carers (therefore a greater carers' role will be assumed for a daughter of an older parent than for their son).

- 5.120 Additionally, Mencap suggested that the carer's assessment should include a section on their housing situation, arguing that "this would help identify whether or not the carer is willing and able to continue to accommodate their son or daughter in the home". They emphasised that "no assumptions should be made that the carer is willing to continue to accommodate the cared for individual in their home".

#### ***Carer-blind assessments***

- 5.121 Several consultees emphasised the importance of ensuring that community care assessments are carried out without taking into account the input of carers in meeting the needs of the cared-for person. For example, Counsel and Care argued that:

It is ... vital that the community care assessment process is "carer-blind" and focused entirely on the needs of the person being assessed right up to the care planning process. For clarity, it would be helpful to have it specified in statute when the carer should start to be taken into account in the community care assessment process.

- 5.122 Furthermore, RADAR and National Centre for Independent Living argued that a "carer-blind assessment" would:

Ensure that assessors do not assume that the carer or the cared-for is willing to continue to provide or receive care, whilst also ensuring that the carer receives the support that they need.

- 5.123 Age UK also argued that it is also important that care plans “refer to the level of risk if the carer is ill or otherwise unable to carry out their role”. Thus, they argued that the assessment process should focus on risk as well as needs:

If, due to the carer being unavailable, the cared-for person would quickly be at critical risk, this should be in the care plan and it should be part of the local authority’s statutory duty to the individual to ensure that contingency support is provided in response to that risk.

- 5.124 They recommended that the new statute should:

ensure that risk is assessed regardless of the carer’s contribution and then, in the care plan, record how the carer addresses that risk, and what contingency arrangements are needed.

- 5.125 Similarly, the National Valuing Family Forum argued that contingency plans can benefit carers:

Assessments should acknowledge the support carers are prepared to provide with contingency arrangements also described so carers know what additional support would be available if they are unable to offer their usual assistance.

#### ***Information, advice and advocacy***

- 5.126 Some consultees highlighted the importance of offering carers information, advice and advocacy. For example, the Equality and Human Rights Commission argued that “the right information, support and advice are vital for people who provide care”. ADASS also recommended that the statute include:

A duty to make available provision of information, advice, advocacy and support to facilitate the exercise of their rights by carers in relation to the duties placed on councils under the Act.

#### ***Inter-agency confidentiality***

- 5.127 Crossroads Care and the Princess Royal Trust for Carers drew attention to the issue of inter-agency confidentiality, arguing that this issue “bears further examination”. They stated:

60% of survey respondents indicated that they were aware of situations where carers had been reluctant to request an assessment because of concerns that contact with child protection services and other services would be triggered.

## PART 6

# ELIGIBILITY FOR SERVICES

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

- 6.1 Of the 231 submissions which were received, 73 submissions provided answers to the proposal that there should be a duties on local authorities to determine whether a person has eligible social care needs and to provide or arrange services to meet all eligible needs. Of those consultees, 70 agreed with the proposal and 3 held equivocal positions. No submissions disagreed with the proposal.

### ***Improving the current complexity***

- 6.2 Many consultees who provided responses to this proposal highlighted the existing complexity of the legal framework for determining eligibility for services. The Local Government Association welcomed:

the intention to clarify the current complexity that exists between the community care legislation and the statutory guidance issued under *Fair Access to Care Services* and agree that it will be important that there should be a duty on local authorities to determine eligible needs using eligibility criteria.

- 6.3 The Equality and Human Rights Commission described the proposal as “a long-awaited reform” and stated that:

The current maze of eligibility duties, powers and guidance is the single biggest weakness of the adult social care system. It is difficult for users to understand and for frontline staff to implement. It is open to interpretation and ambiguous. This, coupled with a lack of guidance for staff on applying criteria, means that local authorities are inconsistent in making decisions with regard to eligibility.

- 6.4 The Government and Welsh Assembly Government agreed with the proposal. The latter acknowledged the current complexity and supported the proposed move to replace it with a system that is clearer and simpler for both local authorities and service users.

- 6.5 A large number of consultees argued that the provisional proposal could help remedy this situation. Garden Court Chambers suggested that the proposal would:

safeguard vulnerable adults against inconsistent application of powers exercised by different local authorities to meet their needs and ensure that provision of services vulnerable adults needs are not arbitrary or left to chance.



- 6.6 Parkinson's UK argued that accessibility of the eligibility criteria is an important consideration:

There should *also* be a corresponding duty to ensure that the authority informs service users of the eligibility criteria in operation, as the duties on authorities to perform their statutory requirements do not necessarily translate into the public being made aware of these duties.<sup>1</sup>

- 6.7 This view was also supported by Mencap:

These duties should be widely promoted, in accessible formats, to ensure every individual knows their rights and entitlements, and to be empowered to hold the local authority to account.

### ***Financial implications***

- 6.8 Some consultees argued that the proposal would have a financial impact on local authorities. The Welsh Assembly Government said that:

We would want to give further consideration to the resource implications of consolidating the duty on local authorities to provide or arrange services to meet all eligible needs.

- 6.9 Conwy County Borough Council and the Royal Borough of Kensington and Chelsea expressed similar views. The latter argued that it was important for local authorities to retain discretion in relation to their eligibility criteria. It was argued that:

Eligible needs can be met in a range of ways and local authorities, and our partners, need to have a level of discretion about how such needs are met. We cannot always meet needs in the way an individual may prefer.

- 6.10 In a similar vein, Lancashire County Council argued that:

Where another body has a duty or a power to provide for some or all of the needs identified, such as in the case of an adaptation which may be provided through a Disabled Facilities Grant which is accessed through the housing authority, then the local social service authority should be under a duty to assist the person to secure that provision. Only after exhausting such alternative methods of provision should the social services authority have a residual responsibility to meet those needs.

### ***Personalisation***

- 6.11 A number of consultees queried whether this proposal was in-step with a personalised approach to social care. The ADASS stated that:

<sup>1</sup> Emphasis in original.

We are in agreement with the Law Commission's proposal for eligible needs to be determined using eligibility criteria but we feel that providing a range of community care services that will meet those needs is contrary to the direction of personalisation. Ongoing care in relation to the way individual budgets are framed is important collectively in order to offer people individualised support planning and choice and control.

- 6.12 Some consultees expressed this concern by focusing on the language which had been adopted in the consultation paper. For instance, the Social Care Institute for Excellence stated that:

It is worth noting that both “needs” and “eligibility” are concepts rooted in the Poor Law, casting people who may need social care as supplicants, rather than individuals in control of their own lives who may require care and support to help them live their lives as they wish.

- 6.13 Similarly, the Local Government Association said that it was unclear whether the requirement to “provide or arrange services” is helpful in the context of the developing personalisation agenda.

#### ***Prevention and early intervention***

- 6.14 Several consultees argued that eligibility criteria should reflect a much stronger emphasis on the role of prevention. It was said that in the long term, prevention is a cheaper and more effective way of managing people's needs. Cymorth Cymru expressed the view that:

One concern we do have is that eligibility criteria can be focused more on crisis intervention rather than prevention, and we see prevention as a key agenda that requires much greater focus through eligibility criteria.

- 6.15 Furthermore, the Chartered Institute for Housing were “concerned that this should not constrict local authorities in the development of more preventative services in partnership with other services”.

#### ***Position of prisoners***

- 6.16 The Prisoners' Advice Service raised a specific issue in relation to the position of prisoners. It was acknowledged that local authority eligibility criteria may be framed inappropriately for the purpose of assessing prisoners in custody. This issue is considered in more detail in relation to provisional proposal 11-2.

### ***Conclusion***

- 6.17 Almost all consultees agreed with this proposal. It was recognised that the current arrangements around the eligibility framework create unnecessary confusion. Furthermore, it was accepted that this proposal would help bring clarity and would promote more consistency of practice between local authorities. Queries were raised about the possible impact on local authorities and whether the suggested approach reflected policy objectives of personalisation and prevention. However, there was broad consensus that a clearer approach to eligibility would be beneficial.

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

- 6.18 Of the 231 submissions which were received, 53 submissions provided answers to the proposal that there should be a duty to make regulations which prescribe risks to independence and objectives that are to be achieved by the provision of services. Of those consultees, 50 agreed with the proposal and 3 held equivocal positions. No submissions disagreed with the proposal.

***Promoting clarity and consistency***

- 6.19 Most consultees acknowledged that this proposal sought to elevate the eligibility framework contained in statutory guidance into secondary legislation. Many argued that this would have a positive impact on consistency of practice. In particular, Parkinson's UK said that the proposal "is a welcome development as it should lead to greater adherence to, and consistency of, interpretation and therefore fairer access to services".
- 6.20 The British Psychological Society supported the proposal and argued that the regulations should use the phraseology contained in statutory guidance as this would be helpful for practitioners who have to apply eligibility criteria on a daily basis.
- 6.21 The Office of the Public Guardian made the point that assessing a person's needs and risks to independence are sometimes at odds with the definition of services:

An example of this which the Office of the Public Guardian encounters regularly is where someone is unable to manage their money and assets due to mental incapacity. Where the person has no family or friends to assist them, and does not have resources to pay a solicitor or other professional to undertake the role of deputy, this presents a risk to independence. However, there is not a clear duty on a local authority to provide a deputyship service, and it is commonly presented as a discretionary service.

- 6.22 Accordingly, it was suggested this proposal would help bring clarity to similar situations in the future.
- 6.23 A small number of consultees went further – such as Action on Elder Abuse – and suggested that the eligibility framework was of such importance that it should be on the face of the statute.
- 6.24 The ADASS – while supporting the proposal – suggested that the objectives to be achieved "must be firmly linked to either the statement of principles" or "enshrined in an overall well-being principle".

### **Potential problems**

- 6.25 A number of local authorities pointed out that whilst elevating elements of the eligibility framework into secondary legislation may bring benefits in terms of consistency, there would be less flexibility. Newcastle City Council said that:

Placing objectives on a statutory footing would be a complex and ultimately otiose task as the identification of personalised objectives in a support plan is an inherent part of the professional role of social workers.

- 6.26 Havering London Borough Council said that the proposal would “result in a universal approach to eligibility with no power to local authorities to make variations”. Conwy County Borough Council raised a similar concern.

- 6.27 Garden Court Chambers made a related point:

We are concerned that the regulations will be overly prescriptive as to what constitutes “risks to independence”. We are concerned that a definition of independence is hard to pin down and that it will signify something different for older vulnerable adults than for young adults, for example those who are just transitioning into adulthood and those in their 20s. ...

To restrict the scope of the regulations to prescribing the risks to independence that will call for provision of services would have the real risk of leading to inadequate and unduly standardised approaches to the provision of care services and neglect some groups of people using services. Eligibility on the basis of risks to independence should consider both early intervention and preventative measures.

- 6.28 The RNIB and Guide Dogs also emphasised the role of prevention. It was argued that an approach to eligibility is incomplete unless prevention is considered together with risks to independence. Newcastle City Council also highlighted a similar point in practical terms, saying that there is:

Difficulty in marrying any duties to provide prevention and re-ablement services at the lower end of the spectrum of need with duties to meet needs at the higher end.

### **Conclusion**

- 6.29 A limited number of consultees responded to this proposal. However, of those that provided a view, almost all were unequivocally in favour and a clear theme was the benefits in terms of consistency and clarity that the proposal would bring. Since flexibility is at the heart of a personalised approach to care, a number of queries were raised about whether flexibility would be sacrificed for consistency. It was also suggested that while risks to independence are a vital consideration, prevention should also form an important part of the regulations which will form the basis of future eligibility decisions.

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

- 6.30 Of the 231 submissions which were received, 56 submissions provided answers to the proposal that a right to re-ablement services should be accommodated in our future adult social care statute if such a right is introduced. 50 agreed with the proposal, 3 disagreed and 3 held equivocal positions.

***The meaning of “re-ablement”***

- 6.31 Whilst there was a broad consensus that a right to re-ablement would be a positive addition to adult social care, queries were raised about the definition of this term. Age UK said that:

Re-ablement is a term which does not appear to be well defined. In some cases it appears to be synonymous with rehabilitation, in others it appears to be more focused on helping people to rebuild social skills and networks or confidence in their ability to carry out the tasks of day to day living, whereas rehabilitation is seen as being more related to improving physical functioning. If this distinction is drawn it becomes particularly important that older people are not excluded from access to re-ablement.

- 6.32 Hampshire Personalisation Expert Panel defined re-ablement in wide terms:

The right to re-ablement is important but should not be just about traditional “daily living” skills such as cooking, cleaning but also skills around finding and using information, assertiveness skills and personal development / empowerment skills.

- 6.33 The Local Government Association argued that whilst:

it will be helpful to have clarification about the powers to deliver services to people who do not meet eligibility criteria, greater clarity is needed about the potential impacts on the interface and integration of services funded and / or delivered by the NHS in order to ensure that arrangements are not compromised by this.

***Health and social care***

- 6.34 Some focus was given by a number of consultees to the interaction between local authorities and the NHS. It was argued that re-ablement should be viewed in terms of a joint enterprise. Newcastle City Council said that:

This proposal needed to include reference to re-ablement services being a shared responsibility with health to maximise positive outcomes for people and to ensure that funding responsibilities remain clearly defined.

- 6.35 Similarly, ADASS argued that:

The cross cutting issues with health and social care provision need to be considered further as services are offered as a preventative and enabling element which is often part of an integrated health package. If services are determined using eligibility criteria in a single statute, this may affect the way in which joint health and social care packages are offered, and may result in the withdrawal of health care funding when social care eligibility criteria is established.

### ***Relationship with eligibility criteria***

- 6.36 Some consultees, such as Newcastle City Council, requested clarity about the relationship that a right to re-ablement would have with eligibility criteria. Disability North agreed with the proposal but expressed a similar view:

Re-ablement appears to be a clear focus at the moment and it seems eminently sensible to include a right to re-ablement services in the statute. Again, how will this match with the [Fair Access to Care Services] criteria where a local authority might only be offering support to meet critical need?

### ***Charging***

- 6.37 In addition to queries about the meaning and scope of a right to re-ablement, several consultees felt that there needed to be clarity about charging for such a right. For RNIB and Guide Dogs this issue was connected with how a right to re-ablement is understood; it was highlighted that rehabilitation is often conflated with re-ablement and for some local authorities, re-ablement is:

Something to which people are entitled prior to the allocation of resources for longer-term care needs. This is provided for a period of six weeks. We are concerned that rehabilitation could also become time-limited through misinterpretation/lack of understanding at the front end or, as is already being seen to be the case, that it may only be provided free of charge for a limited period of time.

- 6.38 Sense also made this point:

Rehabilitation training for visually impaired people is often confused with re-ablement. Rehabilitation can be seen as re-ablement in the sense that it aims to provide skills which will enable the person to develop independence and reduce the need for services in the longer term. However, six weeks is totally insufficient for this type of training.

- 6.39 On charging, Belinda Schwehr pointed to the need for more clarity between health and social care:

Re-ablement needs to be defined more carefully if it is to be made free, as a health care service, or made chargeable under the Local Government Act or *Fairer Charging*.

- 6.40 There was disagreement about what impact a right to re-ablement would have on local authorities. Nottingham City Council argued that not charging for re-ablement services would have “major resource implications” but added that “evidence has shown that charging for re-ablement services does not affect take up of it”. In contrast, Sense pointed to current practice:

The entitlement to re-ablement services needs to include the entitlement to rehabilitation training without charge. Since this is currently the case in practice, adding this to the statute would not have a significant impact on local authorities.

### ***Government’s position***

- 6.41 The Law Commission’s consultation paper argued that whether a right to re-ablement is introduced is a question of policy and accordingly, it is dependant on the views of government. Both the Government and Welsh Assembly Government did not appear to endorse a right to re-ablement being included in the proposed statute. The Government said that “we do not anticipate that there will be rights to specific services stated in the statute”. Similarly, the Welsh Assembly Government said that:

Whilst a right to re-ablement services remains a policy priority for the Welsh Assembly Government it is unlikely that such a right would be introduced in advance of a new adult social care statute. If it were to be introduced, then certain issues would need to be resolved such as whether re-ablement services would be subject to the same eligibility criteria as other services.

### ***Conclusion***

- 6.42 Almost all consultees who responded to this proposal agreed that in principle a right to re-ablement was positive and so should be included in the proposed statute, if such a right was introduced. However, there were a number of queries about how such a right would be defined. In particular, it was asked how such a right would interact with health care provision and how it would relate to eligibility criteria. The definition and scope of re-ablement was seen as impacting charging arrangements for re-ablement services and there was disagreement about the resources which would needed if such services were to be provided free. Perhaps most important was the distinct lack of enthusiasm from the UK Government and Welsh Assembly Government to include a right to re-ablement in the proposed adult social care statute. It is this factor which will be determinative of this proposal.



**Provisional Proposal 6-4: If the eligibility criteria are to be set at a national level in England and in Wales, we provisionally propose that the eligibility criteria should be prescribed in regulations issued by the Secretary of State and Welsh Ministers respectively.**

***Introduction***

- 6.43 Of the 231 submissions which were received, 64 submissions provided answers to the proposal that if eligibility criteria are to be set at a national level, the eligibility criteria should be prescribed in regulations. Of those consultees, 57 agreed with the proposal, 5 disagreed and 2 held equivocal positions.
- 6.44 A large proportion of consultees who agreed with this proposal did so on the basis that they supported the introduction of national eligibility criteria. The following analysis therefore concentrates on this issue.

***Promoting consistency***

- 6.45 A large proportion of consultees argued that eligibility criteria set at a national level would improve current inconsistencies in practice. For example, the Care Quality Commission stated that it is:

concerned about the lack of fairness in the way eligibility criteria are applied, due to different approaches taken by councils. People can also be put in a position whereby they lose some, or all, of their care package when they move from one area to another due to a lack of portability.

- 6.46 The Wales Neurological Alliance argued that:

The current situation where two individuals with the same needs could be assessed differently in two different local authorities is unfair and needs to be reformed.

- 6.47 Mencap was critical of the localised approach to eligibility and argued that “a nationally set eligibility criteria will help to erode the postcode lottery”. Newcastle City Council agreed with this view, describing “the elimination of inequity across local authority areas [as] cohesive and desirable”.

- 6.48 For Parkinson’s UK, consistency was a key benefit of this proposal:

Setting national eligibility criteria should also introduce more consistency between local authorities on their approach and interpretation. This is a key aim of Parkinson’s UK, ensuring that people can get access to the social services they need, wherever they live.

- 6.49 In addition, Newcastle City Council and Disability North saw national eligibility criteria as going together with the Law Commission’s proposals on portable assessments (Provisional Proposal 8-3).

### ***The tension with flexibility***

- 6.50 A small number of consultees questioned the introduction of national eligibility criteria, arguing that local authorities should retain flexibility to determine their own eligibility criteria. For example, Garden Court Chambers argued that:

Enshrining the eligibility criteria in the form of secondary legislation is overly prescriptive and takes away any flexibility that would be necessary to adjust to the changing needs presenting in our population without it undergoing laborious debates in Parliament. ...For example, it could be that those with critical and substantial needs must have their eligible needs met. However, discretion should be left to the local authorities in question to decide whether, and extent to which, they would meet all / some moderate / low needs.

- 6.51 Some responses received from local authorities suggested that they were concerned that national eligibility criteria would inhibit their actions. For instance, Nottingham City Council said that:

We would wish to retain the ability to set local eligibility criteria in order to intervene, as appropriate, at an earlier point with individuals assessed as being “in need” so that long term dependencies and associated costs are minimised. We believe that early intervention and prevention provides the best and most efficient response to citizens.

- 6.52 Anthony Collins LLP questioned whether the introduction of national eligibility criteria would mean that local authorities would lose their autonomy to manage their own budgets. Furthermore, the Older People’s Commissioner for Wales indicated that if this was the case:

Diminishing resources would mean that local authorities would adjust eligibility criteria in other areas in order to meet the needs assessed under national eligibility criteria (“robbing Peter to pay Paul”).

### ***Suggested compromises***

- 6.53 Two consultees suggested that the tension between consistency and flexibility could be resolved. The Cardiff and Vale of Glamorgan Voluntary Health and Social Care Networks argued that there should be:

National “core” criteria with a framework that would be used by local authorities to set their eligibility, but within regulations set by the Secretary of State or Welsh Ministers.

- 6.54 Refugee Action made a similar point, arguing that:

The system must provide equal access to care for all, irrelevant of the postcode. However, this principle could nevertheless take into account the diversity of alternative service provision in different locations. For example, the local authority could be required to meet all identified needs, but enabled to provide for those needs by ensuring access to alternative local providers if feasible.

### ***The position in Wales***

- 6.55 Some consultees sought to distinguish between England and Wales in terms of eligibility criteria. The Wales Council for Voluntary Action argued for an all Wales approach to eligibility which reflected the emerging differences between the two countries. This position was supported by Cardiff and Vale of Glamorgan Voluntary Health and Social Care Networks and the Welsh Assembly Government. However, NAAPS (originally the National Association of Adult Placement Services) raised an issue concerning portability:

If eligibility criteria are determined nationally and separately by English and Welsh Ministers then this may lead to an inequality of provision and could inhibit the free movement of people with social care needs between the two countries.

### ***The Governments' position***

- 6.56 Both the Welsh Assembly Government and Government agreed that *if* it was decided that there should be national eligibility criteria then these should be prescribed in regulations. However, both Governments reserved their position on whether such criteria will actually be introduced.

### ***Conclusion***

- 6.57 Almost all consultees that responded to this proposal were in favour of national eligibility criteria due to the potential it has to bring consistency and clarity to the eligibility criteria used by local authorities. Some consultees warned that this approach may reduce flexibility for local authorities, although suggestions were made about how this could be resolved. The position of Wales was also highlighted by some consultees.

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

6.58 Of the 231 submissions which were received, 76 submissions provided answers to the proposal that local authorities may be required by regulations to allocate a personal budget to service users. Of those consultees, 60 agreed with the proposal, 6 disagreed and 10 held equivocal positions.

***Consistency with personalisation***

6.59 Many consultees agreed with this proposal on the basis that the provision of a personal budget is in-line with the principles of personalisation. For instance, Mencap argued that personal budgets are “designed to give individuals greater choice and control over their lives” whilst the Equality and Human Rights Commission took this point further by saying that:

Engaging individuals in the personalisation of services provides a powerful means of addressing and overcoming disadvantage and inequality including that faced by people who might otherwise have critical aspects of their identity, characteristics or lifestyle overlooked, such as their ethnicity, sexuality or gender.

6.60 Conwy Connect said that “having a personal budget will empower people”.

6.61 A number of consultees acknowledged the lack of any specific legal basis for personal budgets. For instance, Mencap said:

The major policy has been developed outside of the statutory framework; this has led to ambiguity and confusion over how personal budgets fit into the current law.

6.62 Furthermore, Newcastle City Council said:

Currently, the concept of personal budgets and practice in relation to them operates in a legal vacuum and it was felt that statutory regulations would be valuable.

6.63 The Law Society considered that “legislation has not kept pace with government policy in relation to personal budgets” and accordingly, “if it remains policy that personal budgets are continued this should be reflected in the statute and regulations”.

6.64 However, several consultees expressed concerns about putting personal budgets on a statutory footing at this stage. For example, North Tyneside Council – while supportive of this policy direction – argued that:

We have not sufficiently tested the ability of personal budgets to meet eligible needs in a way that allows us to confidently support this entering into the legislative framework at this stage.

### ***Choosing not to have a personal budget***

6.65 A large number of consultees argued that the logic of personalisation should extend to there being a right to refuse a personal budget. For example, Citizens Advice and Havering London Borough Council suggested there should be a duty to *offer* a personal budget to service users, but that the decision as to whether to take this up or not should be with the service user. Wirral Metropolitan Borough Council made a similar suggestion, and also argued that a service user should be “entitled to request a personal budget with local authorities being required to provide written reasons following on from a refusal to provide the same”.

6.66 The RNIB and Guide Dogs expressed a concern that personal budgets will become a default provision for all service users and said:

Choice and control should be available to everyone, the key word being choice. As noted above, people should have the right to choose *not* to have to manage a personal budget.<sup>2</sup>

6.67 Age UK took this point further, arguing that service users who choose not to have a personal budget should not be penalised by receiving a reduced level of services.

6.68 Some consultees argued that the choice to not have a personal budget could be expressed as a duty on a local authority to *offer*, rather than to provide, a personal budget. This was the position of Citizens Advice and Regenerate RISE. The latter gave an example of when a personal budget can be inappropriate:

One of our clients is now 101 years old. She did not need social care until she reached 101. She has no family and has no desire to consider all that she could do with a personal budget, she wants to simply have someone to do housework and come to the day service four times a week.

6.69 The Blackburn and Darwen, Blackpool and Lancashire Safeguarding Adult Boards expressed a concern about personal budgets becoming the norm:

We are concerned that this proposal dismisses anxieties that personal budgets immediately assume an individual should have a direct payment. Adults can be allocated a managed personal budget based on an assessment of risks and with full attention to the responsibility of organisations to safeguard a vulnerable adult. The raising of expectations which precedes the determination of direct payments often results in a harsh reality for recipients given the current financial restraints which are likely to grow.

6.70 To avoid this raising of expectations, some consultees suggested that there should be guidance on what a personal budget can or cannot be used for. The Care Quality Commission argued that such guidance would provide clarity in this area. Newcastle City Council also said that there needed to be some explicit level of constraint on the use of personal budgets, as a subscription to Sky TV, for example, could not be argued to amount to social care.

<sup>2</sup> Emphasis in original.

- 6.71 Lancashire County Council considered that there needs to be “adequate safeguards” included in any regulations on personal budgets, “to avoid fettering the discretion of the local authority and the social worker in providing services in the manner most appropriate for the individual.

### ***Resource Allocation Schemes***

- 6.72 Another strong theme amongst consultees was resource allocation schemes (RAS). These are tools used to produce an indicative budget for service users which is designed to meet eligible needs whilst balancing this against a local authority’s available resources. Increasing numbers of local authorities are using a RAS and it is a legal requirement that a local authority must make available the reasons behind an individual’s personal budget where a RAS has been used.<sup>3</sup>
- 6.73 A number of consultees argued that the relationship between the eligibility framework and how personal budgets are allocated needs to be made clearer. For example, Newcastle City Council noted that some authorities appear to have “dovetailed” the eligibility criteria and the self-assessment questionnaire used to determine a personal budget “into one single assessment”. It was therefore suggested that “there should be explicit reference on the face of the Act or in regulations that the two processes are separate”.
- 6.74 A number of consultees commented on the use of resource allocation systems to determine personal budgets. For example, Mencap pointed to the need for a personal budget to be sufficient to meet all eligible needs and emphasised that local authorities should not place a cap on personal budgets, as the budgets must reflect the true cost of services.
- 6.75 The Residential Care Providers Association argued that the resource allocation system itself should have:

Some measure of statutory supervision since this is a leading component in the eligibility process and would be at risk of being applied in different ways across the country.

- 6.76 Simon Pearce, a social care professional, said that:

The personal budgets model offers significant benefits for many users, but the mechanism of arriving at an amount, the resource allocation system or RAS, seems to have no status whatsoever, although in many cases there is considerable evidence base behind it.

- 6.77 Carers UK adopted a more critical stance, arguing that they had:

<sup>3</sup> *R (on the application of Savva) v Royal Borough of Kensington and Chelsea* [2010] EWCA Civ 1209.

very grave concerns about RASs which has been devised as a management tool to standardise artificially levels of care provision based on a crude self-assessment model which does not give any or any adequate weight to the legal requirement to take the ability and willingness of the carer into account in assessing need. It does not take an individual needs-led approach, rather imposing (sometimes as a blanket policy) pre-determined amounts of money based on points acquired in answer to multiple choice questions. ... It is the antithesis of an individual, needs led approach to adult social care for both service users and carers.

- 6.78 Sense made the point that a RAS is often applied in a very strict manner by some local authorities and there is little willingness to vary this approach. It was argued that, in particular, RASs are inappropriate for deafblind people.
- 6.79 Both Enfield Disability Action and the Residential Care Providers Association argued that RASs should be put on a statutory footing to avoid inconsistencies between local authorities and to help ensure that they are not used as a cost cutting measure.

***Concerns about cost-cutting and shifting responsibilities***

- 6.80 Some consultees expressed more general concerns that personal budgets may be used to cut costs and shift responsibilities away from local authorities on to service users. Medway Older People Communication Network said that:

It is our view that personal budgets have no place within the social care system. ...[They are] both a means of reducing expenditure on people who have needs that other people do not have and thereby avoid fully meeting those needs and a means of placing responsibility upon the person in need rather than upon local authorities as representatives of the community.

- 6.81 Inclusion South West made a similar point:

One of the consequences of introducing personal budgets is that financial risk is transferred from the local authority to the individual user in receipt of social care. Traditionally, the local authority would contract directly with providers for “x” hours of care per week. If the provider charges went up then the local authority had to pay the increase in order to preserve the “x” hours of care to meet assessed need (subject to negotiation). In a personal budget environment, the local authority can constrain the cash value of the personal budget and let the user carry the consequences of increased charges by reducing the amount of care provided.

### ***The position in Wales***

- 6.82 There is a difference in policy between England and Wales in relation to personal budgets. While the Department of Health has stated that – except in exceptional circumstances – everyone in England who is eligible for services can have a personal budget, the Welsh Assembly Government has not made a similar commitment. It was argued by the Princess Royal Trust for Carers and Crossroads Care that given this divergence in policy:

the duty or otherwise to provide a personal budget should not be set out in this new law, but in the regulations issued by the Secretary of State for England and the Welsh Ministers for Wales. This would enable each country to prescribe in regulations whether or not a local authority must offer a personal budget.

- 6.83 The Welsh Assembly Government acknowledged this policy divergence and indicated that the statute should be flexible:

Welsh Ministers have not adopted the personal budgets approach that is being rolled out in England but 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.

- 6.84 Taking a different view, the Wales Neurological Alliance stated that:

This is a clear example of the need for two separate statutes for England and Wales, and a case where the compromise option weakens the statute for both countries.

### ***Conclusion***

- 6.85 Most of the consultees who responded to this proposal were in favour of the provision of personal budgets. In particular, it was argued that a personal budget can embody the principles of personalisation such as choice and control. It was also a strong theme that choice should extend to not having a personal budget. A number of points were made about resources allocation schemes and it was argued that it may be appropriate for these to be set out in legislation. Some consultees also argued that personal budgets may be a means of cost-cutting. The policy divergence between England and Wales on this issue was acknowledged by consultees and it was suggested that if Wales decides to implement personal budgets a future adult social care statute should allow for this.



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

- 6.86 Of the 231 submissions which were received, 65 submissions provided answers to the proposal that there should be a mandatory national eligibility framework for the provision of services to carers and a duty to meet carers' eligible needs. Of those consultees, 62 agreed with the proposal, 1 disagreed and 2 held equivocal positions.

***Promoting clarity and consistency***

- 6.87 A large number of consultees were in favour of a national eligibility framework for carers on the basis that this would bring clarity to an area which is currently confusing. Garden Court Chambers highlighted this point:

We agree in principle that there should be a transparent system by which carers are able to see whether they are entitled to support from local authorities for services they provide to the cared-for. The current state of the law in this area is confusing and left to chance too much. It is not always clear whether local authorities are using an eligibility criteria and if so what that is.

- 6.88 Furthermore, the Social Care Institute for Excellence stated that "a national framework would improve consistency" and would "increase the chances of [carers] being offered a similar care package if they moved to a new area". They also suggested that service users and carers would welcome "clarity about what they were entitled to and what local authorities are required to offer". Similarly, Coventry City Council suggested that "standardising eligibility for carers would enable a clear and consistent carer offer across the country".

- 6.89 A particular concern amongst consultees was that the lack of clarity in this area creates inconsistency of practice between local authorities. Newcastle City Council made the point that guidance in this area was needed:

The absence of policy based eligibility criteria for services for carers is a notable current omission and a structure for decision making would be valued.

- 6.90 The North West Complaint Managers Group and the Social Care Institute for Excellence saw this proposal as providing a solution. The latter stated that:

A national framework would improve consistency and increase the chances of being offered a similar care package if [a service user and a carer] moved to a new area.

- 6.91 Furthermore, it was argued that carers would benefit from being able to more easily understand what they are entitled to. The Equality and Human Rights Commission also made this point:

This proposal will hopefully deliver greater clarity about the expectations of carers and families and ensure fairer access to services across the board and across care groups.

- 6.92 Most consultees indicated that a duty to meet the eligible needs of carers would flow from a mandatory eligibility framework. Indeed, for some local authorities this is the practice already. Newcastle City Council said:

There was no disagreement with the proposal for a “duty” to meet the eligible needs of carers, since it was considered that this is common and essential practice currently.

### ***Resource implications***

- 6.93 A strong theme with some consultees was that a national eligibility framework for carers has the potential to impose a significant cost increase to local authorities. Lancashire County Council made this point and added that:

If this were to be implemented there would need to be local discretion as to the threshold at which carers would be eligible to receive services and this would not necessarily be the same level as for the people they care for.

- 6.94 Similarly, Hampshire County Council considered that “a mandatory framework would remove current ambiguity” but that this was an area where “more detailed consideration would be required as there may be significant resource implications for local authorities”. Surrey County Council expressed similar concern that “consideration would need to be given to local resources”.

- 6.95 Swansea Council stated:

The proposal should reflect legislation only and should not err towards policy. Given the economic climate, legislation should not place further duties on local authorities to meet/provide an assessed need for a carer when resources struggle to meet the needs of service users.

- 6.96 Similarly, the Law Society – while agreeing with the proposal – considered that “resources would be a significant issue”.

- 6.97 Phil Steadman, a social care consultant, raised a similar concern:

Unless resources are put in place, and one has to wonder how realistic this is in the current climate, expectations of carers could be raised only to then have them dashed.

- 6.98 At consultation events arranged by local authorities, there were mixed views as to whether this proposal would have resource implications in practice. Some local authority staff confirmed that their authority used a framework, and in one case it was claimed that the local authority used an informal eligibility framework and criteria but did not make this public.

- 6.99 Both the Government and the Welsh Assembly Government reserved their position on this issue. The latter said that it would need to fully and carefully assess such a proposal due to its resource implications.

### ***Eligibility criteria***

- 6.100 Some consultees supported mandatory eligibility criteria for carers. For instance, Enfield Disability Action said:

National eligibility criteria for carers are necessary. It mirrors the approach for those in need of community care services and would assist a consistent approach to eligibility.

- 6.101 The Princess Royal Trust for Carers and Crossroads Care welcomed the proposal and also argued that it was important to maintain a focus on the services provided to carers “and not to mistake completion of processes that should produce services, such as assessments, as outcomes in their own right”.

- 6.102 Suffolk County Council pointed out that many carers are supported successfully with preventative services and support which enables them to continue in their caring role when the cared-for person does not meet the *Prioritising Need* eligibility threshold. They suggested that:

A risk to the introduction of an eligibility criteria may mean that those with the highest needs are supported to the detriment of those who are not eligible. Some carers may feel less willing to care and therefore there would be a greater demand for local authority services.

### ***The position in Wales***

- 6.103 A number of consultees from Wales argued that if there was a national eligibility framework for carers, this should be defined at the Welsh level. The Wales Neurological Alliance disagreed with the proposal and instead recommended that the statute both includes:

The proposals for carers’ strategies, carers’ information and right to consultation about the care of the person being cared for that are enshrined with the Proposed Carers Strategies (Wales) Measure, and codifies all existing carers legislation.

- 6.104 The Welsh Assembly Government also suggested that any framework for carers could be legislated in Wales using the National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2009.

### ***Conclusion***

- 6.105 Almost all consultees agreed with the proposal that there should be a mandatory national eligibility framework and a duty to meet the eligible needs of carers. It was argued that this would promote clarity on the issue and allow carers to have consistent expectations with whichever local authority provided them with services. However, it was accepted by some consultees that this proposal may have resource implications. Some consultees also supported the proposal on the basis that it would mean mandatory eligibility criteria. It was also argued by some Welsh consultees that a national eligibility framework must distinguish between England and Wales as this would allow the Welsh Assembly Government to make their own arrangements, if necessary.

## **PART 7**

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

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

- 7.1 Of the 231 submissions which were received, 53 submissions responded to the proposal that section 21 of the National Assistance Act 1948 should be repealed and that the Government should ensure a proper scheme for residential accommodation for people who may lose entitlement. Of those consultees, 28 agreed with the proposal, 14 disagreed and 11 held an equivocal position.

### ***A single eligibility criteria***

- 7.2 Several consultees, such as Newcastle City Council, agreed with the proposal on the basis that the same eligibility criteria should be used for residential accommodation as well as all other community care services. Furthermore, they suggested that:

The duty on social services to provide residential accommodation should remain a duty of last resort, so that no duty exists if the service user has their own home (or if a housing authority can provide suitable accommodation) in which their needs can be met appropriately through domiciliary services.

- 7.3 Similarly, Nottingham City council argued that the principles behind section 21 are still clearly reflected in the eligibility criteria to minimise the number of persons who may lose out.
- 7.4 Indeed, Coventry City Council argued that section 21 could be abolished without alternative residential arrangements being made because people's needs would be met through the proposed eligibility framework.

### ***People who may lose entitlement***

- 7.5 Some consultees expressed concern that the proposal would result in some people losing their rights to services. The No Recourse to Public Funds Network argued that people would lose their entitlement for support if section 21 is repealed because the essential aspect of the current test of "looking after" is that it is wider than local authority eligibility criteria. They argued against a "one size fits all policy" when it comes to eligibility for services because:

The No Recourse to Public Funds client group is a specific client group; it is extremely varied and presents unique challenges for adult social services. It is right therefore that local authorities are required

to apply a different test when assessing [these] applicants for support because the reason for the contact and referral to the council is entirely different from those who [have access to public funds].

- 7.6 The Socio-legal Studies Association argued that section 21 “provides a useful threshold below which social provision should not fall” and is:

particularly important when there is no formal constitutional protection for social and economic rights in the UK and the Commission will have to provide strong reassurance that the alternative it proposes will serve the same purpose and achieve the same quasi constitutional status.

- 7.7 The Law Society – whilst agreeing with the proposal – argued that that repeal:

should only be carried out once new legislation is passed to ensure that those vulnerable groups (albeit a small class) who rely heavily on these sections for welfare support are not left unprotected and at risk of destitution.

- 7.8 RNIB and Guide Dogs were concerned that:

social services departments may not assess a person's need for residential accommodation as substantial or critical (especially if there is a presumption of the need for home based support) either now or when looking at future need.

- 7.9 Garden Court Chambers argued that section 21 is easier to enforce than a local authority decision based on the application of eligibility criteria. The section 21 criteria are set out on the face of the statute and there is extensive authority on how this should be interpreted. Without a specific duty which can be judicially reviewed, it may be harder to establish that the local authority's decision not to provide accommodation is irrational.

***A proper scheme for residential accommodation***

- 7.10 Many consultees argued that the Government will need to ensure that an alternative scheme for asylum seekers in particular is set up. For example, the Disability Law Service stated that it was unable to agree or disagree with this proposal “until it is clear what a proper scheme for the provision of residential accommodation to those people who might lose their entitlement actually involves”.
- 7.11 Garden Court Chambers stated that it was unclear what a “proper scheme” would be. Furthermore:

It is our view that this must be a scheme which completely replicates the coverage of section 21. Thus there would be two schemes in respect of provision of accommodation to vulnerable adults with care needs. These two schemes would seem at odds with the thrust of the policy proposed by the Law Commission of simplification. In these circumstances it is our view that it would be simpler just to retain section 21 of the NAA 1948 and not repeal it.

7.12 Making Every Adult Matter disagreed with the proposal on the basis that Government is unlikely to provide a proper scheme for residential accommodation. Moreover:

Individuals presenting in the future would need to prove that they would have had rights under the repealed section 21 – in effect a test against legislation that no longer existed.

7.13 The Residential Care Providers Association argued that any gap should be filled by a combination of the use of housing legislation and a needs assessment to determine eligibility for care provision at home.

7.14 Sunderland City Council argued that the new statute “could have provision for urgent services (including accommodation), such as that under section 47(5) of the NHS and Community Care Act 1995” to ensure that people do not lose entitlement.

7.15 Refugee Action urged that the new statute should state which body (the Home Office or local authorities) would be responsible for housing:

- (1) current asylum seeking single people;
- (2) current asylum seeking families where the main applicant has care needs;
- (3) current asylum seeking families where a dependant has care needs; and
- (4) refused asylum seeking families in both situations.

7.16 The Welsh Assembly Government confirmed there are no current plans for legislative reform in Wales to require appropriate housing to be provided by other means to these groups.

### ***Retaining section 21***

7.17 Some consultees argued that section 21 should be retained or incorporated into the proposed statute. For example, Baroness Hale of Richmond argued that:

It would be unfortunate if section 21 of the National Assistance Act 1948 were left out because it looks (and maybe is) untidy: the better solution to any gap would be to ensure that all those presently eligible were included in the new eligibility criteria.

7.18 Mencap argued that “the spirit of section 21 should be included in the new statute” and furthermore that it should be strengthened “to give social services powers to provide and procure suitable housing and appropriate support, where necessary” and “ensure that social services continue to take final responsibility in the provision of housing and support”.

### ***Conclusion***

- 7.19 A majority of consultees agreed with the proposal that section 21 of the National Assistance Act 1948 should be repealed and that the Government should ensure a proper scheme for the provision of residential accommodation to those people who might lose their entitlement. Many of those consultees argued that it would be beneficial to have a single set of eligibility criteria to all community care services. However, other consultees were concerned that some people may lose their entitlement for services if section 21 is repealed, and others were concerned that a proper scheme for residential accommodation may not be forthcoming. Some responses argued that section 21 should be retained in our proposed structure.



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

- 7.20 Of the 231 submissions which were received, 41 submissions responded to the proposal that if the Government does not introduce a proper scheme for residential accommodation, section 21 should be retained but only in relation to those people who would otherwise lose their entitlement. Of those consultees, 22 agreed with the proposal, 14 disagreed and 5 held an equivocal position.
- 7.21 While the majority of consultees agreed with the proposal, they did not further elaborate on their reasons for agreeing. Therefore, this analysis will focus on the concerns of consultees who disagreed or had equivocal views.

***People may lose entitlement***

- 7.22 Some consultees expressed concerns that people may lose their entitlement as a result of this proposal. For example, RNIB and Guide Dogs expressed concern that if section 21 is retained but only in relation to those who would otherwise lose their entitlement “that local authorities may not consider the residual provision and turn away people who previously they would have assisted”.

***Retaining section 21 in full***

- 7.23 Some consultees argued that rather than retaining section 21 only in relation to those who may lose entitlement, it should be retained in full. For example, Making Every Adult Matter argued that:

Given the theory/practice difficulties ... of determining this ‘lost entitlement’ group, we think it would be more straightforward for section 21 to be retained in full as a safety net, alongside a new residential power in [the eligibility framework].

- 7.24 Similarly, Garden Court Chambers also argued that this proposal:

Would create a scheme where there may be one single form of initial assessment then confusion as to whether to use section 21 or the eligibility criteria. In these circumstances it is our view that it may just be simpler to retain section 21.

- 7.25 On the other hand, Practitioners Alliance Against the Abuse of Vulnerable Adults argued that:

If the government does not introduce an alternative then it should be assumed that government policy is that the affected groups are no longer to be entitled to such residential accommodation provision.

**Conclusion**

- 7.26 The majority of consultees agreed that if the Government does not introduce a proper scheme for residential accommodation, section 21 should be retained but only in relation to those people who would otherwise lose their entitlement. However, some consultees expressed concern that some people may lose entitlement as a result of this proposal. It was also suggested that section 21 should be retained in full.

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

- 7.27 Of the 231 submissions which were received, 41 of submissions provided comments on whether, if section 21 were repealed, any groups lose their entitlement. Of those consultees, 22 agreed argued that groups would lose entitlement, 8 argued that no groups would and 11 held an equivocal position.

***Those subject to immigration control***

- 7.28 Many consultees agreed with our suggestion in the consultation paper that asylum seekers and others subject to immigration control would be at risk if section 21 were repealed. In addition, Brighton and Hove Advice Services Strategy Group argued that:

People who would be affected include failed asylum seekers and overstayers through to persons from Eastern Europe who by reason of illness become unable to work or to seek work and who also have a need for care and attention.

- 7.29 Nottingham City Council argued that the repeal of section would affect adversely those who have no recourse to public funds. As well as asylum seekers, other cohorts include:

- (1) Those on marriage visas who have fled their marriage due to domestic abuse;
- (2) Visa overstayers; and
- (3) A8 nationals who are unemployed and have not previously worked for 12 continuous months under the workers registration scheme (this is a rapidly increasing group).

***People ineligible for housing***

- 7.30 Cate Searle of Martin Searle Solicitors pointed out that as well as asylum seekers, others would lose their entitlement if section 21 were repealed such as “individuals or families who have been deemed to be ‘intentionally homeless’” and therefore do not qualify under housing legislation but who fall below the local authority eligibility criteria:

While on the whole I see the sense of unifying the disparate duties of community care legislation, section 21 ... is ... a vital safety net not just for asylum seekers. If it is not retained it must be replaced by something as useful to those marginalised people who have nothing else to rely upon.

***Other client groups***

- 7.31 Consultees pointed out that other groups of service users may lose their entitlement if section is repealed. For example, Sunderland City Council argued that:

Other service areas such as learning/physical disabilities provide section 21 accommodation and could potentially lose that entitlement if the section is repealed.

- 7.32 Maxwell Gillott Solicitors provided the following case examples of people who have a need for care and attention for the purposes of section 21 but would lose their entitlement if section 21 were repealed. For example:

An individual might have a level of mental health needs which required some level of supervision or support, such as being reminded of appointments or having someone drop in to check on them occasionally. Another example might be someone who is able to carry out most independent living tasks but, because of a particular physical disability requires assistance to carry out the weekly shop or to carry out housework. Such a level of needs would most probably be classed as “low” or “moderate”.

- 7.33 Counsel and Care expressed concerns about the impact on:

an older person with so-called “moderate” needs who may benefit from a care home stay, perhaps for social and emotional reasons as well as due to physical needs. If a person is living in a local authority area with eligibility criteria set to meet substantial and critical needs only, there is more possibility is that they may lose their entitlement to accommodation under the proposed structure. As increasing budgetary pressures are brought to bear on local authorities, Counsel and Care is worried that more and more people with substantial needs may also find it harder to access a care home.

- 7.34 RNIB and Guide Dogs stated that:

If section 21 were repealed a specific entitlement may not be lost in theory but some individuals may find it more difficult to prove a need through the eligibility criteria etc in practice ... [for example] sight loss-related needs have traditionally been underestimated when measured against rationing criteria; the requirement for “care and attention” may in reality be an easier hurdle to meet.

- 7.35 The National Aids Trust argued that many migrants living with HIV with severe care needs who rely on section 21 support may lose entitlement if section 21 is repealed.

- 7.36 The No Recourse to Public Funds Network was concerned about the impact of repealing section 21 on parents with care needs who might need to rely on section 17 of the Children Act 1989 and pregnant and nursing mothers who are currently covered by section 21.

### ***Conclusion***

- 7.37 Most consultees argued that some groups would lose their entitlement to accommodation if our proposals were implemented. These groups included those subject to immigration control, people ineligible under housing legislation and other without any recourse to public funds or support. Other consultees expressed concern that disabled people, people with mental health problems and older people may lose their entitlement.

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

- 7.38 Of the 231 submissions which were received, 30 submissions expressed a view on the proposal that section 2(1) of the Chronically Sick and Disabled Persons Act 1970 should be removed from adult social care legislation. Of those consultees, 24 agreed with the proposal, 3 disagreed and 3 held an equivocal position.

***Legal clarity***

- 7.39 Some consultees agreed with the proposal on the basis that it would provide further legal clarity. For example, the Government agreed that the proposal “will be useful in bringing clarity and coherence to the law”. Similarly, the Lincolnshire Partnership NHS Foundation Trust agreed that repeal would be “a positive step towards the objective of legal clarity” and added that “any proposal in favour of retention must be balanced against the legal confusion caused by its presence”.
- 7.40 Furthermore, Sunderland City Council stated that there is:

Confusion, particularly for front line social care assessors, in determining the difference between services under section 47 of the NHS Act 2006 and section 2(1) of the Chronically Sick and Disabled Persons Act 1970.

- 7.41 Furthermore, the Royal Borough of Kensington and Chelsea agreed with the proposal on the basis that section 2(1) is service led and “ought to be repealed and brought within a needs led assessment”.

***Ensuring that no existing entitlements are lost***

- 7.42 Most consultees agreed that repealing section 2(1) of the Chronically Sick and Disabled Persons Act 1970 would not have a negative effect on existing entitlements to services. For example, Mencap stated that “the community care assessment, together with the broader list of services should be sufficient”. Similarly, the Association of Directors of Social Services Cymru stated that “there is a significant overlap currently with local authority duties under the NHS and Community Care Act 1990”.
- 7.43 On the other hand, several consultees expressed concern that some people may lose some of their entitlement to services. For example, the RNIB and Guide Dogs – while welcoming the legal clarity that the proposal would bring – expressed concern that:

There may still be services which are provided under section 2 which are not necessarily the subject of eligibility criteria, since resources are not necessarily taken into account by social workers when the service is provided.

- 7.44 Carers UK stated that:

The vision behind the Chronically Sick and Disabled Persons Act 1970 was to bring in equity issues for disabled people – treating disabled people as the same as people without disabilities; giving them services that others might take for granted, for example, holidays; and giving them access to the same opportunities that they would not otherwise have or find it more difficult to have, for example, having a radio affords [disabled people] the same access to programmes as non-disabled people.

7.45 Therefore they argued that “it is vital that all the new frameworks in primary and secondary legislation protect these rights”.

7.46 Similarly, Ann McDonald, a social care academic, “strongly” supported the retention of section 2(1) and “the specification of services which may be lost within a generic assessment of services”.

7.47 Conversely, the Law Society – in agreeing with the proposal – stated that:

We consider that if the statute is robust in placing duties on local authorities to meet needs, then section 2(1) of Chronically Sick and Disabled Persons Act 1970 should no longer be necessary for people to obtain their rights.

7.48 The National Housing Federation expressed particular concern in relation to assistance with aids and adaptations. They stated that:

This is additional on local authority duties to fund adaptations under housing legislation. Adaptations are a vital element of allowing a person to choose how and where they receive care services; for example a walk in shower might allow a disabled person to wash without the help of a carer. It is important that some link is retained within any new system across to the design and adaptation of people’s homes.

7.49 Several consultees, like the Welsh Assembly Government for example, agreed with the proposal but “subject to resolution of the issue regarding how disabled children should retain their existing rights to services”. This issue is discussed in more detail under provisional proposal 11-1.

#### ***Retaining the effect of existing case-law***

7.50 Belinda Schwehr, a legal and training consultant, agreed that the proposal is the only way to bring legal clarity, but emphasised that:

Any valuable case law [should] be preserved by careful analysis of what sort of wording is required to achieve the likelihood of a court saying “and nothing about substantive rights has changed despite repeal”.

7.51 Similarly, Gateshead Council stated that:

The valuable part of section 2(1) is that it makes clear, together with existing case law like *R v Gloucestershire County Council ex p Barry*,

that local authorities can take account of other means people have of meeting their needs.<sup>1</sup> This preserves the position that community care funding is a “last resort” and local authorities can expect service users to avail themselves of universal services, voluntary services and informal support.

7.52 Surrey County Council agreed that section 2(1) should be removed provided that our proposed eligibility framework achieves the same level of services and outcomes.

7.53 Michael Mandelstam argued that “replacement would have to be carefully worded to make sure any replacement duties bite” and further suggested that:

One can't help feeling that certain elements in Government could favour a section 17 Children Act 1989 approach – a general duty that lets everybody off the hook.

### **Conclusion**

7.54 There was a strongly affirmative response to the proposal that section 2(1) of the Chronically Sick and Disabled Persons Act 1970 should be removed from adult social care legislation. Most consultees agreed that this would bring legal clarity and would not result in any loss in existing entitlement to services. On the other hand, several consultees expressed concern about retaining existing entitlement to services, especially in relation to the relevance of people's resources. Two consultees argued that the effect of current case-law on section 2(1) should be retained.

<sup>1</sup> *R v Gloucestershire County Council ex p Barry* (1997-98) 1 CCLR 19.



## PART 8

# ORDINARY RESIDENCE

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

- 8.1 Of the 231 submissions which were received, 74 submissions provided answers to this proposal concerning ordinary residence. Of those consultees, 71 agreed with the proposal and 3 held an equivocal position. No submissions disagreed with the proposal.

### ***Current problems with ordinary residence***

- 8.2 Many consultees highlighted problems which currently exist with the ordinary residence rules. A strong theme was that local authorities can spend a great deal of time arguing over who is responsible for service provision, to the detriment service users. For instance, the National Youth Advocacy Service argued that "many young people are left without services because there is a dispute between two or more authorities as to their residence".
- 8.3 The National Society for Epilepsy recounted a specific example which illustrates the effects of these disputes:

We have recently had to become involved as an interested party in a costly judicial review which simply sought to establish whether two local authorities caught up in an ordinary residence dispute had a legal obligation to consult each other. Goodness only knows how much that cost the tax payer and it was clear to us that the ulterior motive of the local authority bringing the action was to stop people moving out of residential care into supported living in their area because of the financial consequences arising from the ordinary residence rules.<sup>1</sup>

- 8.4 Several consultees argued that clarity was needed because the present complexity of the ordinary resident rules is such that people who receive community care services are hesitant about moving house. For some consultees, this is a restriction of movement. Citizens Advice argued that "it is very important that there should be provision to enable frail and disabled people to move to a different local authority". The Learning Disability Coalition acknowledged this point and argued that:

<sup>1</sup> *R (Buckinghamshire County Council) v Kingston Upon Thames* [2010] EWHC 1703.

People with a learning disability and their families lose the ability to choose where they live local because of the fear that moving will result in losing their package of care, a direct result of the current ordinary residence and portability framework.

8.5 The Equality and Human Rights Commission added that:

By only giving the local authority a power to provide services to those who are not ordinarily resident, [the proposal] does fall a long way short of guaranteeing continuity of support and may, in practice, create significant obstacles to social and economic mobility.

***Benefits of the proposal***

8.6 In addressing the concerns raised in relation to the ordinary residence rules, consultees agreed that this proposal would simplify current arrangements. Cartrefi Cymru argued that the proposal “serves to simplify and clarify the nature of the duties and power of local authorities”. Furthermore, Northumberland Tyne and Wear NHS Foundation Trust argued that the proposal:

would be consistent with the stated the aim of the statute in reducing legal uncertainty and consequent time spent by practitioners, managers and lawyers and in litigation and complaints, increasing transparency for all.

8.7 Additionally, the Learning Disability Coalition argued that in relation to concerns about restricting the movements of service users the proposal would “help alleviate” this problem.

8.8 Mencap indicated that this proposal would be of assistance because:

In some cases, local authorities have left individuals without the care and support that they need, whilst they dispute with another local authority as to who will fund the service. Mencap welcomes the Law Commission’s aim to provide a single and clear duty on ordinary residence as we believe this would reduce disputes between local authorities.

8.9 However, Counsel and Care did not agree that there would be fewer disputes. Rather, a clearer legal framework for ordinary residence could change the dynamic of such disputes:

These changes won’t prevent disputes between local authorities arising due to the ongoing complexity of the system, the pressure of restricted budgets and the current postcode lottery. Nevertheless, these proposals have the potential to make it more enforceable in practice and, therefore, to resolve any debate in a more timely and appropriate manner, without the onus falling on the family to push for a resolution.

- 8.10 A number of consultees suggested that the proposal for a *duty* to provide services for people ordinarily resident in their area and a *power* to provide services for people who are not ordinarily resident in their area, already represents the law. The Government argued that “what the Commission is proposing is in line with the current law”. ADASS and Caerphilly County Borough Council explicitly agreed with this. Sense picked up on this point and commented that:

We do not believe that the problem of ordinary residence disputes is primarily one of law. We believe that in the vast majority of cases the ordinary residence of a person is clear in law. The problems come from the lack of a funding mechanism to deal with the transfer of the cost of high cost placements. The only way to solve this will be to create a funding mechanism similar to that used when the long stay hospitals closed in order to compensate local authorities for the additional costs, or to introduce a central fund for all very high cost packages so that the impact of high cost packages on local authorities is effectively capped.

#### ***Specific service user groups***

- 8.11 Several consultees argued that the ordinary residence rules should take into account the requirements of specific service user groups. These consultees sought to emphasise the position of individuals who may not have a residential status. For instance, the Law Society highlighted the position of people who are homeless and the Socio-Legal Studies Association mentioned those detained under the Mental Health Act 1983. Refugee Action emphasised the position of asylum seekers and argued that services should be provided regardless of immigration status. This issue is given a detailed treatment in relation to question 9-2. The Prisoners’ Advice Service also argued that the position of prisoners in relation to ordinary residence needs to be considered. This is considered in more detail in relation to provisional proposal 11-2.

#### ***Amendments to our proposals***

- 8.12 Whilst agreeing with our proposal, several consultees suggested amendments, for example:
- (1) Bridget Penhale, a safeguarding academic, argued that the duty to provide services where the person is not ordinarily resident should be extended to include non-residential care services in adult protection cases;
  - (2) Cymorth Cymru suggested that where individuals have an assessed need and are outside of their ordinary residence, the local authority where they are placed should be obliged “to make every effort to meet that person’s needs whether that be through the authority itself, or working to get that individual the relevant service in the area that is considered their ordinary residence”;
  - (3) North Tyneside Council argued that a time limit should be placed on the duration of temporary urgent services for those not ordinarily resident to limit the responsibility of the local authority;

- (4) Belinda Schwehr, a legal and training consultant, argued that the statute should state clearly that a local authority has no power to provide services to someone who is ordinarily resident in another area unless he or she is physically present in the local authority's area; and
- (5) The Law Society suggested that the duty to provide accommodation in cases of urgent need should expressly include those who are homeless.

### ***The need to review ordinary residence***

- 8.13 A number of consultees expressed disappointment that the Law Commission was not reviewing the meaning of ordinary residence. The English Community Care Association argued that:

In our experience, the meaning – perhaps more accurately, different interpretations – of “ordinary residence” is at the heart of many of the problems associated with out of area placements in residential care homes. We therefore very much regret that you have not considered it in your review.

- 8.14 Further, Cartrefi Cymru argued that:

Whilst accepting that detailed consideration of the meaning of ordinary residency lies outside the Law Commission's remit we feel that it is worth pointing out that arguments around the meaning of ordinary residence and the concept of intentionality not infrequently cause difficulties for both social workers and vulnerable adults. Definitive guidance in order to clarify these issues is long overdue.

- 8.15 Some consultees also suggested alternative ways of determining which local authority is responsible for service provision. For example, the National Society for Epilepsy argued that service users should have the right to choose where they live and the costs of providing the accommodation and the care needed should follow them. Others argued that the funding mechanisms that apply to the transfer of care should be reformed to allow for transitional packages of care and support.

### ***Conclusion***

- 8.16 Almost all consultees agreed with the proposal that there should be a *duty* to provide services for people ordinarily resident in their area and a *power* to provide services for people who are not ordinarily resident in their area. However, comments did not generally extend into other aspects of the proposal such as the proposed duty to provide urgent services regardless of ordinary residence. Although, similar issues were given a detailed treatment in relation to provisional proposal 4-4.

8.17 Several issues regarding the current situation were identified. These included the complexity of the rules and the tendency for local authorities to enter into disputes. It was argued that simplification that would, at the very least, improve the dynamic of these disputes. It was highlighted that the current rules can discourage service users from moving and that this represents a restriction on movement. A number of consultees pointed to service user groups who may need specific consideration if they are not to be denied community care services by the ordinary residence rules. Furthermore, there was some disappointment that the Law Commission was not reviewing the meaning of "ordinary residence" although it was suggested that this could form the basis of a further review.

**Provisional Proposal 8-2: We provisionally propose that the local authority in which the cared-for person lives should be given responsibility for providing carers' services.**

- 8.18 Of the 231 submissions which were received, 54 submissions provided answers to the proposal that carers' services should be provided by the local authority in which the cared-for person lives. Of those consultees, 51 agreed with the proposal, 2 disagreed whilst 1 held an equivocal position.

***Clarifying the law***

- 8.19 Several consultees agreed that this proposal is already reflected in practice. For example, Carers UK highlighted that:

This provision is currently in guidance and Carers UK has used it several times to advise carers about their rights, challenging both local authorities and local organisations funded to provide carers' services, who have sought to bar the carer from having services to meet their needs.

- 8.20 Lincolnshire Partnership NHS Foundation Trust argued that the proposal reflected their understanding but pointed out that practice can vary and went on to say that "if this proposal were adopted, clear guidance as to duties would be useful to reduce discrepancies in local working practice and arrangements".
- 8.21 Nottingham City Council also recognised existing variable practice and argued that this proposal "would save confusion and also protracted correspondence between local authorities when it's not clear which local authority is responsible".
- 8.22 Parkinson's UK argued that the proposal "seems to be the least bureaucratic solution for carer and service user, with only one authority to deal with rather than two". It was suggested that the code of practice could provide details about how this might work in practice.

***A unified and holistic approach***

- 8.23 A number of consultees argued that this proposal was consonant with the general approach towards a joined-up approach to service users and carers. For instance, Belinda Schwehr, an independent legal and training consultant, argued that this proposal was consistent with the approach of unifying the assessment process between service users and carers. RNIB and Guide Dogs made a similar point:

We believe that the assessment should be carried out by the authority responsible for the cared-for person and the services provided by this authority as well. This will promote a more unified assessment process.

- 8.24 Furthermore, the Princess Royal Trust for Carers and Crossroads Care expressed a point which was apparent in several responses that this proposal would "fit with an overall shift towards considering the needs of cared for people and their carers in a holistic manner".

### ***Carers living at a distance***

- 8.25 Some consultees pointed out that carers often live outside the area in which the cared-for service user lives. In relation to this, the Standing Commission on Carers argued that the proposal:

Acknowledges the growing number of distance carers who may be supporting an elderly parent or adult disabled child or other relative who lives in another authority. Distance caring (given the mobility of families) is likely to increase and places heavy burdens on the health and well-being of many carers. It can also give rise to considerable financial costs.

- 8.26 The National Family Carer Network indicated that the needs of out-of-area carers are “often ignored by all the authorities involved”. Accordingly, this proposal would ensure that even out-of-area carers could be provided with services.

- 8.27 However, the Care Quality Commission argued that our proposal may present difficulties:

Many carers, however they are defined, may live some distance from the person they care for ... The proposal appears to negate the principle of responsibility linked to place of residence and status as citizen, voter and council tax payer. What would be useful is recognition that, where the carer and the person that they care for live in different local councils, such councils should work together to secure appropriate support for individual carers.

- 8.28 In response to this point, Newcastle City Council argued that whilst there may be some practical issues “these rare incidents of potential confusion should not prevent the proposal from progressing”.

- 8.29 Lancashire County Council disagreed with the proposal in principle on the basis that some services are more appropriately supplied to a carer via the local authority for the area in which the carer lives:

Where services are of a more general nature and would be best delivered in the area where the carer lives then we consider that that area should provide them ... Adjacent local authority areas should be required to have protocols in place to ensure that this can be given effect including the sharing of information about the carer and the nature of their role where appropriate and with the consent of the carer and or the person cared for.

- 8.30 However, it was accepted that where a carer requires a service which is to be met by providing a service to the cared-for person then this should fall to local authority where the cared for person lives.

- 8.31 The Law Society pointed out that, under the Carers and Disabled Children Act 2000, the local authority in which the cared-for person lives is given primary responsibility for providing carers' services, but the local authority where the carer resides still has a secondary responsibility to provide services to the carer. This is because the duty to assess a carer arises where a local authority has a power to provide services to the cared-for person, and a local authority retains a power in some circumstances to provide services to those not ordinarily resident in its area. The Law Society suggested that our statute should clarify that the local authority in which the carer lives should be responsible for providing services where it is impracticable for the local authority where the cared-for person lives to provide services to the carer.

### ***General powers***

- 8.32 Age UK pointed out that some of the support currently available to carers is provided under general powers; for example information, advice or advocacy provided by carers. They suggested that our statute should specify that such support should be available to carers living in the local authority area as well as to those carers who care for a person living in the local authority area.

### ***Conclusion***

- 8.33 Almost all consultees were in favour of this proposal. The principal reason was that the proposal would make the responsibility for the provision of carers' services simpler and more certain. It was further argued that this proposal was in-step with a more unified and holistic approach to service provision for carers and service users. The position of out-of-area carers was highlighted and most, but not all, consultees argued that the proposal would assist that particular category of carers.



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

- 8.34 Of the 231 submissions which were received, 78 submissions provided answers to these proposals which seek to enable the portability of services. Of those consultees, 72 agreed with the proposals, 1 disagreed whilst 5 held an equivocal position.

***Freedom of movement***

- 8.35 A large number of consultees argued that current arrangements for the portability of services are so confusing and uncertain that many service users feel unable to move from their area. Disability Wales argued that “the current situation amounts to nothing less than a restriction to freedom of movement for disabled people”. Mencap referred to a consultation which they had conducted on this issue where:

Individuals and family carers told Mencap that their human rights were being ignored as they were effectively imprisoned in their local area, because packages are not portable.

- 8.36 Counsel and Care stated that this had a significant impact on some service users:

Many older people are fearful of attempting to move to an area, perhaps nearer to where their only remaining family lives, due to anxiety about whether they may lose the care and support they can currently access.

- 8.37 The National Autistic Society argued thought that portability of services:

is a critical issue and the basic principle should be that a person in receipt of services should have the same right as any other citizen to choose where to live.

- 8.38 Enfield Disability Action took this further, arguing that portability is an issue of practice as well as principle:

Portability of service provision can be a vital factor in securing independent living. A person will not move to a chosen area unless their entitlement to community care services (by way of in-house services, direct payments or personal budget) is guaranteed to be the same.

- 8.39 The Multiple Sclerosis Society summed up these concerns in the following way:

It is important that individuals’ freedom to move and choose where they live is not restricted by the fear that the care and support that they receive will be changed or lost.

### ***The stress caused by the existing framework***

- 8.40 A number of consultees went on to make the point that if a service user does make the decision to move, the current system can make this event an even more stressful experience. The British Psychological Society argued that:

We feel the stress associated with a potential move within England and Wales should not be exacerbated by the additional stress of being subject to a further assessment, and potential loss of services in the interim, while this is undertaken. It would be wrong for people's personal relationships to be limited by the failure of bureaucratic processes to "move" with them.

- 8.41 Disability Wales pointed to the stress of re-assessment when a person moves:

There should be no need for disabled people and other service users to undergo repeated assessments simply as a consequence of moving from one local authority area to another.

- 8.42 Mencap also made this point:

Where individuals have moved, they and family carers had to battle to get the care and support that they need, often settling for a lower package. They face endless bureaucracy and countless assessments.

- 8.43 Several consultees argued that the proposal would help improve the situation. The Equality and Human Rights Commission captured the tone of responses:

In addition to promoting human rights, co-operation between local authorities to facilitate freedom of movement through the "portability" of care and support packages is likely then to help increase the economic participation of those requiring care and support and their families, as well as optimising the role of informal networks of support by enabling people to move to be near them.

### ***Enhanced duty to co-operate***

- 8.44 Many consultees argued that an enhanced duty to co-operate is vital to ensure effective portability. Mencap argued that "one of the greatest barriers to moving is the failure of local authorities to work with each other".

- 8.45 The Law Society supported this view:

Our members are aware of much anecdotal evidence that some hard pressed local authorities are less than forthcoming with support or information to assist in assessing someone who has moved into or is proposing to move into their area.

- 8.46 Enfield Disability Action made the point that a service user is unlikely to know whether they are going to receive the same care package in a new area until the receiving authority undertakes their own assessment. It was argued that an enhanced duty would ensure that such an assessment would happen.

- 8.47 The Local Government Association agreed that a duty would be useful but went on to state that:

Further clarity is needed about the potential flexibilities in relation to this in order that “receiving” authorities are not unduly subject to eligibility criteria of their neighbours.

- 8.48 Newcastle City Council reported that at a meeting where this issue was discussed:

the introduction of an enhanced duty to co-operate was universally welcomed and it was generally acknowledged that the process for eligible people moving across local authority boundaries is currently challenging and can result in delays in decision making by the receiving local authority... It was considered that the proposal would reduce the risk of distress and delay for eligible people who decide to move house and also reduce the likelihood of lack of engagement and squabbling between Local Authorities.

- 8.49 RNIB and Guide Dogs argued that an enhanced duty is essential and emphasised the role of a code of practice which would provide further information about how the duty would operate in practice. It was argued that detail on this point would prevent situations where:

Authorities simply considered co-operating but then took no real steps to co-operate in reality or simply delayed co-operating, leaving a disabled person “in limbo”.

- 8.50 Some consultees argued that the proposal did not go far enough. For instance, Liz Ball, a deafblind person, stated that:

When I have moved to a new area I have had to wait months for an assessment whilst no service is provided. The duty to co-operate may help with this but does not go far enough. There should be a duty to assess somebody’s needs if they have a firm intention to move.

- 8.51 The Royal National Institute for Deaf People pointed out another problem:

The “receiving” local authority may refuse to conduct an assessment on the basis that the service user does not appear to be in need of community care services because their needs are already being met in the residential care setting... RNID believes that any guidance should be explicit that the type of situation described above constitutes a move (even though the service user is not physically transferring from one local authority area to another) and that the enhanced duty to co-operate applies in this type of situation.

### **Portable assessments**

8.52 Consultees were largely in favour of the proposal that if the Government introduces nationally portable assessments they should be included in the Law Commission's proposed statute. Most people supported the proposal because they wanted portable assessments. In service user feedback provided by Mencap the point was put quite simply: "you should expect to have the same services in a new place".

8.53 However, some consultees disagreed over whether a portable assessment should deliver the same care package for the service user. Sunderland City Council, for example, argued that a national portable assessment "would ensure that the same 'level of service' is received but not that the same 'services' are received".

8.54 Mencap favoured a consistent *level* of support stating that:

We believe that the level of support that they received should also be portable, so that an individual does not face losing support because they have moved areas.

8.55 However, BUPA Care Homes argued that this would not be sufficient and that instead, the local authority should:

be able to give a service user the same package, as that is the important issue to them when relocating. For example, one local authority may offer a full package of care whereas another may just offer funding.

8.56 A number of consultees raised an issue of whether a receiving local authority should be able to reassess service users even though the initial assessment is meant to be nationally portable. Newcastle City Council argued that:

A national portable needs assessment would not necessarily result in consistent quality of assessment across different local authorities. As such, the right of receiving local authorities to reassess is crucial, to ensure good outcomes for eligible people and reduce the risk of high quality practice in assessment and provision being compromised by decisions taken by another local authority.

8.57 The Henry Spink Foundation agreed with this but on different grounds:

The receiving authority should have the right to carry out a new assessment if it wishes, with any significant amendments to the previous assessment and support package being clearly explained in writing. This allows for local outcomes to support packages resulting from assessment.

8.58 The Princess Royal Trust for Carers and Crossroads Care suggested how this might work in practice:

Portability could be achieved quickly through a change in practice if local authorities are presumed to accept existing support levels pending any new assessment that they may wish to conduct.

- 8.59 The Disability Law Service suggested that if a person wishes to move from one area to another, then the local authority where the person is moving from should agree to fund a temporary package (for example, 3 months) to allow the person to move areas. The receiving authority should then take over responsibility for the care once the temporary funding from the previous council runs out. Similarly, Sense argued for transitional arrangements, whereby until the new local authority has carried out an assessment the person should receive services as close as possible to those they received in the previous local authority.
- 8.60 Coventry City Council argued that any portable assessment must give some flexibility to the receiving authority to allow it to question the quality and appropriateness of a current assessment, within a given timescale.
- 8.61 Belinda Schwher, a legal and training consultant, and Nottingham City Council both made the point that a consequence of having easily portable assessments is that service users will inevitably gravitate towards certain areas, such as desirable retirement areas. It was argued that this should be recognised and the relevant local authorities should be given more resources to avoid imposing a disproportionate burden.
- 8.62 The Henry Spink Foundation and Princess Royal Trust for Carers and Crossroads Care argued that a framework for portability could be created without the need for primary legislation, “if local authorities are presumed to accept existing support levels pending any new assessment that they may wish to conduct”.

***National eligibility criteria***

- 8.63 Most consultees supported the proposal that if the Government introduces national eligibility criteria they should be included in the Law Commission’s proposed statute. The agreement was on the basis that they supported the introduction of national eligibility criteria. Disability Wales argued that:

The existing situation in which each local authority takes its own approach to eligibility creates a postcode lottery. Furthermore, eligibility criteria discriminate against people who have needs that local authorities deem as “low” and “moderate”, simply because they say they cannot afford to provide them. This rationale leads to deteriorating impairments and health conditions which later require interventions that could have been avoided or delayed and are likely to be more costly.

- 8.64 Mencap agreed with this point and argued that:

We have long called for a nationally set eligibility criteria to remove this injustice. We agree that if nationally determined, the eligibility should be included in the future statute.

- 8.65 The Law Society suggested:

We would positively endorse the special educational model that allows for transfer of responsibilities upon relocation and also for reassessment if deemed necessary.

- 8.66 Some consultees argued that an assessment process and eligibility criteria which was governed nationally would have significant funding implications. For instance, East Sussex County Council stated that:

We feel that unless there is a national funding regime in place portability of services cannot work, as local authorities have to be able to determine eligibility within the context of local circumstances which inevitably vary across the country.

- 8.67 ADASS made a similar point but in rather wider terms:

We are concerned about how the introduction of a national eligibility scheme, which removes the local authority's ability to determine who is eligible for services, impacts on the democratic accountability and raises legal and constitutional issues that would require careful assessment. The Commission will be familiar with case law that confirms and have prescribed the grounds on which the local authority can take resources into account in structuring its response to meeting local needs.

- 8.68 Caerphilly County Borough Council argued that the variation of services which are provided locally could be problematic:

Introducing such a concept could potentially raise expectations for individuals wishing to make use of a portable assessment, only to find that support and services are not replicated in a different area. Each authority throughout England and Wales will have their own issues regarding eligibility and resources will which in turn will influence the type of services they are in a position to develop.

### ***Possible savings***

- 8.69 Some consultees argued that if a national portable assessment was implemented, this could lead to savings. The Henry Spink Foundation argued that:

Introduction of portability would save money and time in hard pressed social service departments. Assessment and care management, which includes the process of receiving referrals and assessing need, cost £2bn in 2008-9.<sup>2</sup> Reducing this element of cost by even a small percentage would result in substantial savings.

- 8.70 The Princess Royal Trust for Carers and Crossroads Care made a similar point:

Reducing the need for reassessment, as occurs when moving between local authorities, would save time for local authorities cutting costs and enabling more to be spent providing services.

<sup>2</sup> NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England 2008-9*, table 2.3 (2010).

### ***Conclusion***

- 8.71 Almost all consultees agreed with this proposal. A principal difficulty caused by the current portability arrangements is that service users can feel anxious about whether they will receive the same services if they were to move to another area. This can cause them to restrict their movements. Furthermore, if a service user chooses to move, this can be a stressful experience. It was argued that this proposal could help alleviate both these problems. It was argued that an enhanced duty to co-operate would ensure that local authorities would communicate with each other if a service user wished to move areas. Most consultees felt a national system of portable assessments and eligibility criteria could produce consistency even though there may be some practical issues to be resolved. However, some consultees argued that such an approach could help reduce costs as reassessments might be needed less frequently.

## PART 9

# SCOPE OF ADULT SOCIAL CARE

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

- 9.1 Of the 231 submissions which were received, 72 submissions expressed a view on the proposal that community care services should be defined by a short and broad list of services. Of those consultees, 52 agreed with the proposal, 7 disagreed and 8 held an equivocal position.

### ***The need for clarity***

- 9.2 Several consultees highlighted the need for clarity in the meaning of community care services which they argued would be met through this proposal. For example, Newcastle City Council argued that the current definition of community care services is “unclear, repetitive and sometimes linked to particular groups of people and that a general ‘spring-clean’ of these definitions is long overdue”.
- 9.3 The Medway Older People Communication Network agreed with the proposal because they were concerned “that unless something is explicitly stated authorities will tend to disregard that need”. Similarly, Northumberland Forum for People with a Learning Disability argued that a list “would help people to know what is available and to decide what they want”. Additionally, Research in Practice for Adults stated that “services should be clearly defined, as this helps service users and carers to take action”.
- 9.4 Age UK – while expressing concern that defining services “goes against the spirit of personalisation” – highlighted a particular example of where the listing of a service assisted service users to challenge the action of a local authority. Thus they stated that a list of services “might be useful in relation to *Fairer Charging Policies for Home Care and Other Non-Residential Social Services* guidance”, which states “that a person’s income should not be reduced below a minimum level”.<sup>1</sup> They argued that:

sometimes local authorities circumvent this by treating services such as transport as being outside of the guidance enabling a further charge to be levied on top of the one which the person is already paying. The fact that transport for the purposes of using a service arranged under section 29 of the National Assistance Act 1948 is explicitly listed as a Chronically Sick and Disabled Person’s Act 1970 service is useful in challenging such an approach.

- 9.5 Coventry City Council – while agreeing with the proposal – also suggested that it “would also assist local authorities if the legislation clearly describes what social care will not provide”. Counsel and Care also argued that this would be useful.

<sup>1</sup> Department of Health, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services* (2003).



- 9.6 On the other hand, the Blackburn with Darwen, Blackpool and Lancashire Safeguarding Adult Boards disagreed with the proposal “since there is a danger of such lists becoming dated”. They gave the example of intermediate care which they stated was “unheard of 10 years ago”.
- 9.7 Moreover, the Welsh Assembly Government stated that – while they agree with the principle of replacing the current lists of services with a much shorter and broader list – the financial implications of this proposal will need to be considered.

#### ***Balancing flexibility with clarity***

- 9.8 Several consultees suggested that a short and broad list of services strikes the right balance between allowing flexibility, while also informing service users of what services they may be entitled to. For example, the Standing Commission on Carers argued that the proposal would help ensure legal certainty:

We would not want to limit the increasingly personalised and innovative range of services providing support in the community through personal budgets and direct payments through unnecessarily prescriptive categorisation within primary legislation. But we consider the risks greater if there is no definition of what community care services cover, with users and carers (and local authorities themselves) uncertain about their rights and duties.

- 9.9 Furthermore, Counsel and Care argued that “best possible compromise” between defining community care services or leaving them undefined would be the provision of a short and broad list of services:

Such a short, but broad list of community care services would provide a framework for decision makers while also still allowing for innovation in the care market and future growth in the range of different care and support mechanisms available for meeting an older person’s assessed eligible needs and agreed outcomes.

- 9.10 Similarly, the North West Complaint Managers Group argued that this proposal would “provide guidance without stifling innovation in meeting people’s needs”. North Tyneside Council – in agreeing with proposal – stated that “a more detailed definition may result in exclusion and reduce flexibility”. The Law Society also agreed with this proposal and argued that a prescriptive list “would mean that some people would not be able to meet their care needs in the way they consider to be most suitable to them”.

#### ***A holistic approach to adult social care***

- 9.11 Several consultees agreed with the proposal because it encourages a holistic approach. For instance, ADASS Cymru argued that the proposal encouraged a “whole person approach” to adult social care. Similarly, the Royal National Institute for Deaf People agreed with the proposed list, in particular the inclusion of “social, leisure, communication, education and training activities”. They argued that:

the inclusion of this broad list will highlight the requirement for councils to take a wide view of service users' needs and provide services which meet peoples' social, as well as their personal, needs.

- 9.12 The Wales Council for Voluntary Action also supported a short and broad list on the basis that:

a broad definition recognises that a more individually tailored care plan utilising a wider range of services in the community provided by a mixed economy of provision can best meet the person's needs and wished for outcomes.

***An indicative rather than exhaustive list***

- 9.13 Some consultees highlighted that the proposed list should be indicative, rather than exhaustive. For example, the Residential Care Providers Association agreed with the proposal subject to the caveat that the statute should make it clear that the list is indicative only, thereby leaving open the opportunity for "innovation based on the changing needs of society". Hull City Council also expressed concern that an exclusive list "may stifle any innovation associated with personal budgets".

- 9.14 Similarly, while agreeing with the proposal, the Vale of Glamorgan Older Peoples Strategy Forum stated that the list:

Should not be formulated in such a way which hinders new forms of service developing in the future or which would enable social care authorities not to provide a service because it is not specifically on the list.

- 9.15 The Chartered Institute of Housing stated the list should be "phrased in such a way as to give flexibility for the development of new and preventative services, which may be delivered in partnership".

- 9.16 BUPA Care Homes argued that "a definitive list, however broadly worded, could be confusing to the service user". Additionally, "if [the service user] had a unique need which appears to fall outside or the edge of the bands listed, they may experience problems in obtaining funding".

***Suggested additions to the list***

- 9.17 Some consultees – while supporting the proposed general approach to defining services – suggested amendments to the list. For example:

- (1) Enfield Disability Action and Sibs suggested the express inclusion of "advocacy services";
- (2) Camphill Families and Friends suggested that the whole range of housing, support and care options (including intentional communities as at present) be included;
- (3) Carers UK argued that "it is critical that there is clarity about giving disabled parents sufficient services to be able to parent well". They stated that:

Where parents do receive sufficient support for their role as parents, they say that this enhances their independence, well-being as well as control over their lives;

- (4) Maxwell Gillott Solicitors argued that the list “appears completely to miss out services which might be provided to those with mental health difficulties”. For example, they suggested that:

service users who suffer from memory difficulties as a result of post-traumatic stress disorder may require reminders to attend important medical and other appointments;
- (5) Mencap suggested that residential accommodation be defined further in statute law to clarify that it includes ordinary housing as well as care homes and supported living arrangements;
- (6) the National Autistic Society suggested that brokerage services should be added to “recognise that some individuals in receipt of individual budgets need support to exercise choice”;
- (7) Regenerate RISE argued that there should be specific reference to “outreach services”;
- (8) Sense and Liz Ball, a deafblind person, argued that specific mention is needed of the following services which are currently specified in the deafblind statutory guidance:
  - (a) rehabilitation for visually impaired people and deafblind people; and
  - (b) specialist one-to-one deafblind support (communicator guides and interveners);
- (9) RNIB and Guide Dogs recommended the addition of a separate category of “specialist skills training/equipment in the home and in the community for the retention or reacquisition of independence”;
- (10) Garden Court Chambers suggested the express inclusion of “assistance with mobility and personal care outside the home” which is not necessarily linked to any particular social or leisure activity, and emphasised the importance of this service:

We have experience of this kind of need not receiving adequate attention when needs are assessed, leaving a person with a very low quality of life, one very far removed indeed from that of a non-disabled person, and leading to exacerbation of other problems such as depression;
- (11) the Law Society argued that “assistance and facilities in the home”, should include a reference to appropriate adaptations and that “transport services” should be included within the list; and
- (12) the Office of the Public Guardian suggested that financial management

services, such as deputyship, should be added to the list.

- 9.18 Citizens Advice argued that “there should be a power to amend the list by affirmative resolution regulations (to allow for changes in the future as technology develops)”.

***The need for supplementary guidance***

- 9.19 Several consultees suggested that a fuller list, or examples of services under the broad list, could be provided in guidance. For example, the Standing Commission on Carers suggested that the list should be interpreted in guidance as including:

Short breaks; a range of facilities in the family home such as home help and laundry services; telecare; assistance in arranging home adaptations and sitting or other services. Training could include assistance in taking advantage of educational activities and preparation or support for moving to (or returning to) employment. In the case of young carers, it could include support to regularly attend school and participate in related activities.

- 9.20 The Law Society also accepted the proposal “subject to the provision of clear guidance as to interpretation of the categories”. Mencap also argued that guidance should clarify that:

Local authorities should use this as a list to base service provision, but the overall aim of the personalised system should continue to be the goal facilitated by good quality community care assessments.

- 9.21 The Practitioners Alliance Against the Abuse of Vulnerable Adults agreed with the proposal “if provision is made for a more detailed list to be provided from time to time by regulations”.

***Reflecting the range of social services functions***

- 9.22 ADASS argued that the approach of defining the scope of adult social care through defining services requires “rethinking” since it has the potential to be:

counter productive, contrary to the interests of citizens requiring support, and likely to introduce rigidity when flexibility is needed in order to personalise services.

- 9.23 They highlighted that social care “takes a holistic approach, focusing on individuals and their families and social situations within the context of the community” and it is difficult to define because of the nature of the functions involved. Not only does social services encompass “an important residual function” but it also performs another key function:

In helping people “navigate” the complex web of services they have to deal with in the modern welfare state. This requires in depth understanding of statutory, voluntary, private and commercial services. Many service users also have social care needs and significant and continuing health care needs. Many people also experience issues with housing and also have to engage with employment, benefits and pensions agencies. Younger people and

those of working age may be involved with education, training, work experience and volunteering, as well in some cases the courts and criminal justice system. A core role for social care staff is helping people understand these systems and provide a care coordination function.

- 9.24 Therefore, they argued that “social care requires permeable boundaries and scope for detailed interaction with allied functions and services”.
- 9.25 Similarly, the Foundation for People with Learning Difficulties stated that they would prefer “discussion of scope to focus on outcomes rather than to try to list types of services”.

### ***The impact of personalisation***

- 9.26 Several consultees questioned whether a list of services was appropriate in light of the policy of personalisation. Stephen Corlett, a social care professional, stated that whilst historically the function of a list may have been to define the scope of adult social care, this function can no longer be achieved since the introduction of personal budgets because:

the philosophy is that people can use them to pay for things very *unlike* our traditional list of services, the principles determining how much support people are entitled to cannot sensibly be based on whether services on the list would meet their needs.<sup>2</sup>

- 9.27 The Social Care Institute for Excellence also stated that “limiting services to a set list does not appear consistent with a personalised approach, which should be focused on needs”. They stated that:

Personalisation and self-directed support imply that individuals can put forward imaginative support packages that may go well beyond what is usually thought of as a mainstream or specialised care or support service. The key is that it should be possible to make a direct connection between an individual’s needs and their desired outcomes.

- 9.28 Similarly, the Northumberland Tyne and Wear NHS Foundation Trust argued that, given the implementation of personalisation across adult care:

The proposed list of community care services, albeit broader than those in the previous community care legislation, fits uncomfortably with the drive to innovative working, self help, enabling /re-ablement and building community capacity.

- 9.29 Additionally, the Local Government Association stated that:

Given the policy drivers towards personalised support and care open up the potential for an ever expanding range of “services” it is difficult to see how community care services might be defined in a future adult social care statute.

<sup>2</sup> Emphasis in original.

- 9.30 Although they argued that a list “does not seem appropriate”, they went on to say that “if it proves necessary to determine services in this way, then there would be a preference for a short and broad list”.

***An outcomes-based approach***

- 9.31 A number of consultees put forward an alternative approach to the definition of community care services, based on outcomes rather than a list of services. For example, NAAPS (originally the National Association of Adult Placement Services) considered the:

Current lists identified in the consultation as out of date both in terms of language and substance and that a better approach may be to make the definitions fit the activity and desired outcomes.

- 9.32 Similarly, the Princess Royal Trust for Carers and Crossroads Care stated that they would prefer to see:

Community care defined in terms of services and interventions designed to achieve relevant outcomes, such as: living independently; participation in family life; participation in community life; overcoming barriers to employment; and providing unpaid care.

- 9.33 Inclusion South West argued that rather than use a short but broad list of services as a definition, “it would be better to use the Department of Health’s Green Paper, *Independence, Well being and Choice* and in *Putting People First*”.<sup>3</sup> They suggested that the best definition of social care is based on the notion that it is “all activities, equipment and services that contribute to achieving social care outcomes that are not prohibited by statute”.<sup>4</sup>

- 9.34 The Care Quality Commission suggested that services should be defined in a way that is compatible with the regulated activities prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2010, so that a read across between the two sets of legislation is possible.<sup>5</sup> It argued that this would be helpful for it in its regulatory role.

<sup>3</sup> Department of Health, *Independence, Well-being and Choice* (2005) Cm 6499 para 3.7 and HM Government and others, *Putting People First* (2007) pp 2 to 3.

<sup>4</sup> Emphasis in original.

<sup>5</sup> Health and Social Care Act (Regulated Activities) Regulations 2010, reg 9(1)(b).

### ***Conclusion***

- 9.35 There was a strongly affirmative response to the proposal that community care services should be defined by a short and broad list of services. Many consultees argued that this provides clarity; achieves the right balance between allowing for flexibility and innovation; and informs people with community care needs of what kind of services are available. However, many consultees – while agreeing with the proposal – emphasised that the list must be indicative rather than exhaustive so as not to hinder innovation. On the other hand, several consultees argued that a short and broad list of services is inconsistent with personalisation, and instead advocated an outcomes focused approach. Finally, a small number of consultees argued that definition of community care services is not an appropriate way to attempt to define the scope of adult social care.

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

- 9.36 Of the 231 submissions which were received, 46 submissions expressed a view on the proposal that the list of community care services should be set out on the face of the statute. Of those consultees, 39 agreed with the proposal, 6 disagreed and 1 held an equivocal position.

***The importance of clarity***

- 9.37 Many consultees agreed with the proposal on the basis that it provides greater clarity. For example, the Law Society stated that “for clarity and certainty the list should be included in the guidance”. RNIB and Guide Dogs considered that – as long as the list is not too prescriptive – it should be included on the face of the statute:

From a sight loss perspective, there would be clear benefits to having rehabilitation services recognised at this level. Equally the failure to provide for such services may only serve to reinforce the poor provision currently “enjoyed” by people with a sight loss.

- 9.38 Similarly, the Royal Borough of Kensington and Chelsea argued that:

In principle there is a necessity for a facility listing specific services as they can be seen as examples of how people might utilise resources to support independence and enhance quality of life. In particular people with impaired cognition may benefit for something concrete.

- 9.39 Ann McDonald, a social care academic, also agreed with this proposal as it “will enable potential service users to decide what to ask for”. Belinda Schwehr, a legal and training consultant described this as “essential”.
- 9.40 Several consultees, such as the Welsh Assembly Government, agreed with this proposal on the basis that the list is “short and broad”. They stated that “if a more prescriptive list were to be used then this would be best placed in regulations so that it could more easily be amended and updated”. The Royal Borough of Kensington and Chelsea also expressed reservation about too much detail being included on the face of the statute.
- 9.41 Anthony Collins Solicitors agreed with the proposal, “provided there is also a list of excluded services”.

***A list of services in regulations***

- 9.42 A small number of consultees disagreed with the proposal and argued that the list should be included in regulations. For example, Sunderland City Council argued that “the list should be accommodated in regulations to allow greater flexibility should circumstances change in the future”.
- 9.43 Furthermore, Garden Court Chambers recommended that the list is set out in regulations:



The list will inevitably to one degree or another inform the areas of focus of community care assessments (whether or not that is intended). There needs to be scope for considered adjustment over time to reflect the greater understanding of people's needs and how to achieve disability equality that will be gained through experience.

- 9.44 They argued that a list “would inevitably become outmoded” and emphasised that “it is very important in this area of law ... that concepts and phraseology move with the times and are adapted to match needs as they are perceived over time”.
- 9.45 On the other hand, the Practitioners Alliance Against the Abuse of Vulnerable Adults stated that the list should be included on the face of the statute, and regulations could provide a more detailed list from time to time. Similarly, the Chartered Institute of Housing stated that “where more detail is required this should be included in the guidance”.
- 9.46 Alternatively, Lancashire County Council suggested that, “given the pace of change of technology and the changing expectations of society” the Secretary of State should be able to add to a list included on the face of the statute through regulations, “merely to keep the list of services up to date”.

#### ***A list of services in guidance***

- 9.47 The ADASS recommended that, “defining or describing services if it must be done, may be a matter best left to guidance”. They argued that:

the underlying difficulty in specifying services within legislation is that it may be problematic to future proof them in the context of change; personalised responses to needs; and the interface with universal community services that can be of equal relevance to meeting needs. Definition also risks perpetuating a focus on service-led rather than outcome-led care. It may restrict creative support planning and action in response to individual adult social care needs unless some provision is made for “*such other services, information or support as seems appropriate to their assessed needs*”.<sup>6</sup>

#### ***Conclusion***

- 9.48 There was a strongly affirmative response to the proposal that the list of community care services should be set out on the face of our future adult social care statute. Some consultees highlighted that this would provide more clarity for potential service users as to what services they may be entitled to. On the other hand, several consultees argued that the list should be included in guidance because it will soon become outdated, and regardless of how broad it is, the outmoded terminology used may continue to inform the focus of community care.

<sup>6</sup> Emphasis in original.

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

- 9.49 Of the 231 submissions which were received, 62 submissions expressed a view on the question whether community care services should be undefined in the future adult social care statute. Of those consultees, 20 answered that it should be undefined, 37 argued that it should be defined, and 5 held an equivocal position.

***The need for clarity and consistency***

- 9.50 Many consultees argued that community care services should be defined so as to provide some clarity and/or consistency. For example, the National Aids Trust supported defining community care services through the inclusion of a broad list “in the interests of clarity”. Nottingham City Council argued that to leave community care services undefined “would go against the grain of what is hoped to be achieved by introducing a single statute framework that is clear, consistent and modern”. They argued that it would “lead to uncertainty, especially among service users”.

- 9.51 Similarly, Deafblind UK argued that leaving such services undefined could:

lead to ambiguity in whether services are or can be provided. Such ambiguity would remove much of the benefits of having a national and portable needs assessment and eligibility criteria.

- 9.52 Drawing a parallel with the lack of definition of carers’ services, Counsel and Care expressed concern that the latter has “encouraged a subsequent lack of clarity about what specific services a carer may be entitled to”. Thus they recommended – while recognising the possible down-falls – that community care services should be defined through a short and broad list.

- 9.53 Garden Court Chambers stated that a short list broad categories set out in regulations is the better option:

This will inform people’s expectations (which might otherwise be too low or too high), help structure decision making, and at the same time, allow for adjustment over time to ensure that the services that people need and want can be provided.

***The danger of litigation***

- 9.54 Solicitors for the Elderly argued that without some definition it would be more difficult to claim breach of statutory duty. The Law Society argued that this approach would produce confusion and litigation over what constitutes a social care service. Similarly, Lancashire County Council argued that to leave community care services undefined “would open the door to a number of challenges as to what services could be considered appropriate or not to meet an assessed need in a novel way”. For example, they argued that:

It is not unlawful for a service user to pay for sex and sex is undeniably a basic human need. However, it would probably be considered inappropriate for a local authority to fund this activity.

### ***Cuts in services***

- 9.55 Parkinson's UK argued that "due to the financial pressures that will exist on authorities for the foreseeable future" they would prefer to see a short and broad list of services on the face of the statute, "if only to give an indication as to the services that are within the scope of local authority social care services should authorities seek to cut back on what they provide". Furthermore, they argued that:

Leaving the list undefined could risk ongoing battles of interpretation and, given the rationale for the review is clarity on the face of the law so everyone is aware of entitlements and scope, it could be counter-productive to leave matters undefined. It may also increase the burden on the NHS if the lack of definition leaves authorities able to cut back on what they provide under the community care "banner".

- 9.56 Similarly, the Royal College of Physicians of Edinburgh argued that it is important that community care services remain defined "as local authorities might find it tempting to disinvest in services that are undefined".

### ***Postcode lottery***

- 9.57 Leonard Cheshire Disability acknowledged the risks associated with defining community care, for example "ending up with overly narrow, prescriptive services with little room for innovation". However, they highlighted that "there are also risks to not defining services through considerable local variations and some people getting one service and others being denied it". They did, however, emphasise the importance of the "need to define the more outcome-focused aspects of what social care is actually there to achieve".

- 9.58 Similarly, the ADASS Cymru – while acknowledging the difficulty of defining community care services – stated that:

If community care services remain undefined it may lead to inconsistencies in how different local authorities interpret what is and is not a community care service, creating further difficulties when service users want to move from one area to another.

### ***Consistency with personalisation***

- 9.59 Newcastle City Council highlighted a range of views as to whether definition would "conflict with the policy drive towards creative use of direct payments and personal budgets under the personalisation agenda", but concluded that:

It was ultimately agreed that some structure was desirable to focus local authority responsibilities but also to enable actual or potential beneficiaries of community care services to understand their entitlements.

- 9.60 RADAR and the National Centre for Independent Living stated that "very broad" definition is needed so that a person with social care needs is "not restricted to 'traditional services'". They argued that they would want guidance to provide that community care services "might include more flexible and innovative ways of meeting social care needs".

### ***The need to encourage innovation***

- 9.61 On the other hand, some consultees argued that community services should be undefined so as to allow for flexibility and avoid stifling innovation. The Multiple Sclerosis Society, for example, argued that a list of services could be interpreted restrictively as an exclusive list, and could “stifle creativity and innovation in terms of the type of care and support offered”. Furthermore, over time, “as care and support continues to diversify and become increasingly personalised, a static list, though short and broad, could rapidly become outdated”.
- 9.62 Similarly, the Joseph Rowntree Foundation argued that with the advent of personal budgets and more innovative approaches to supporting people in the community, “it would seem dated for service users and commissioners to have a pre-set menu of services from which to choose”.
- 9.63 The Wales Council for Voluntary Action argued strongly that community services should be undefined in order to:

Encourage and enable more flexible and innovative community care service development: the approaches of co-design and co-delivery and of citizen directed services; the placing of social care services within the wider holistic approach of community services creating sustainable service models.

- 9.64 The London Borough of Camden argued that leaving community services undefined would allow for:

Locally determined services to be offered, including alternative provision (i.e. universal offer outside of social care services) and a broader range of provision through personalisation.

- 9.65 Similarly, the Care Quality Commission suggested that “the merit and significance” of proposals to define community care services are “debatable”. They argued that listing of community care services may be “very broad, and so open to varied interpretations, or more comprehensive and vulnerable to becoming quickly outdated”. Or in other words, “a ‘definition’ of community care services is likely to be either so broad as to be fairly meaningless or so specific as to invite exclusion”. They emphasised that whatever approach is taken, “new thinking should not require new legislation”.

### ***An outcome-focused approach***

- 9.66 Several consultees argued that community care services should be undefined in the statute, because to attempt to define them with be inconsistent with an outcome-focused approach. For example, the Joseph Rowntree Foundation stated that, given the proposed focus of assessments on needs and outcomes rather than eligibility for specific services, “it would seem incongruous to have such a form of assessment, which then needed to be fitted into a list of services”.
- 9.67 Similarly, Cymorth Cymru stated that given the move towards outcomes focused assessments, a list of adult social care services is not required:

We understand that we need to remain realistic about what services can be provided, but it is important that we have a full and open

discussion about how much we want to adopt an outcomes-focused approach as this will impact on how prescriptive we are regarding what services can be provided.

9.68 Cartrefi Cymru argued that an outcomes-based approach would:

Allow for greater flexibility on the part of commissioners and providers alike to meet need and would be likely to result in a more effective and efficient use of public resources.

9.69 Similarly, Suffolk County Council stated that:

As self-directed support progresses and more people assume control of their support planning (whether or not they take a direct payment) the “allowable” uses of local authority funding should expand to allow more of a focus on outcomes and “joined up thinking” about the use of public money. Defining “community care services” may well restrict this realignment of thinking.

9.70 Surrey County Council also argued that community services could remain undefined on the basis that:

The introduction of self-directed support and personalisation have broadened the definition of a service, and what support will provide the best outcome to meet a person’s assessed needs.

9.71 Gateshead Council argued that the proposed short and broad list is “in fact a half way house that does little legal work and could be limiting to the principle of choice and control”. They argued that needs identified through the eligibility criteria should have no “artificial limits” set on them, and that what is needed instead is an outcome-focused approach, “whereby the local authority must be satisfied that the means chosen of meeting a need is capable of meeting that need and, on review, that it is in fact doing so”. They suggested that guidance “is urgently needed” to provide more detailed provisions about the practical applications of this, citing in particular “facilitating the taking of holidays”.

### ***Meeting a diverse range of needs***

9.72 Several consultees argued that leaving community services undefined in the statute would facilitate meeting a diverse range of needs. For example, Jane Cave, an individual consultee, stated that this would “ensure that the widest range of services are eligible and thus the most effective ways of a person meeting needs and attaining their goals is available”. Similarly, the Spinal Injuries Association argued that:

Given the broad ways in which a user may receive care to meet their needs, a definitive list may allow for certain, unconventional services to slip outside of the regulations. By leaving the term undefined, an individual is free to argue that such services form a legitimate part of their care provision.

- 9.73 The Joseph Rowntree Foundation argued that “by defining *any* list of services that have to meet needs and outcomes in all their diversity, it is likely the list will fall short”.<sup>7</sup> They argued that their research with disabled parents illustrates how a list approach could result in people missing out on vital services:

Disabled parents require social care support and assistance in the home to help them with parenting tasks. Yet in practice local authorities are unsure whether assistance with parenting is an adult social service or whether it should fall under children’s social care ... The broad list [proposed] could still leave this particular issue unaddressed.

- 9.74 Scope expressed an equivocal view on the issue of definition. They highlighted that, on one hand, “local authorities could dismiss their responsibility by claiming a person’s needs do not count as a community care service”. On the other hand, they argued that “definitions are by their nature restrictive and could impact on what needs can be met”. Sense Cymru strongly emphasised that community care services should be defined and should be done so in wide terms. Examples were given of people who were denied important services because they were not defined as “community care services”.

### **Conclusion**

- 9.75 There was a predominantly negative answer to the question of whether community care services should be undefined in the proposed adult social care statute. The majority of consultees argued that there should be a definition of community care services, either in line with the earlier proposal of a short and broad list, or an alternative definition based on outcomes. Many consultees argued that definition is required in order to provide clarity to both the potential service user and local authority as to what types of services may be offered to meet an eligible need. On the other hand, a significant number of consultees argued that attempting to define community services would inevitably stifle innovation and may limit the range of services that could be provided to meet eligible needs.

<sup>7</sup> Emphasis in original.

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

- 9.76 Of the 231 submissions which were received, 73 submissions expressed a view on the proposal not to include a central definition of a disabled person or service user in our statute. Of those consultees, 52 agreed with the proposal, 14 disagreed and 2 held an equivocal position.

***A central definition is unnecessary***

- 9.77 The majority of consultees supported this proposal on the basis that including a central definition of a disabled person or a service user is unnecessary. Age UK and Age Cymru stated that there does not appear to be any need for any additional definition related to a person's disability because the proposed statute includes:

Definitions referring to entitlement to assessment and local authority care and support, which are based on appearance of need, and inclusion within the scope of safeguarding guidance and legislation, based on risk of abuse.

- 9.78 Similarly, Cymorth Cymru argued that no central definition is required because "what should define whether someone is a service user is whether they are eligible to receive social care services".

- 9.79 Furthermore, the Law Society argued that:

If the new statute is to resolve the complexity and confusion that pervades adult social care law, it is essential that no central definition of a disabled person or service user is set out.

- 9.80 ADASS also noted that the statutory guidance on eligibility criteria in England "does not refer to user groups nor the traditional, and in the main 'functional', definitions of user groups. Rather it looks to needs and risks to independence".

***The removal of barriers to adult social care***

- 9.81 Some consultees agreed with the proposal on the basis that any central definition of a disabled person or a service user would be exclusionary. The Law Society argued that, besides giving rise to complexity, "more importantly, to continue with an overly restrictive approach will only serve to exclude as many as it includes from accessing services". Similarly, Newcastle City Council stated that "the difficulty with a central definition is that there is the potential for exclusion". Phil Steadman, a social care consultant, also argued that definitions like those in the Disability Discrimination Act 1995 create "artificial boundaries that may be useful in law but not so much in practice". The Equality and Human Rights Commission argued that:

The care and support system must be focused on the needs of the people who use it, rather than categorising them into a user group definition which would undoubtedly restrict eligibility.

9.82 The Wales Neurological Alliance highlighted that they represent 26 organisations including some representing people with “conditions which would face some difficulty fitting within a classic definition of disability, even though their members are disabled”. Similarly, the National Youth Advocacy Service highlighted that the current requirement of disability has:

Given rise to many difficulties for some individuals in establishing eligibility for services especially for those with “hidden” disabilities such as some forms of autism.

9.83 Surrey County Council also argued that “categories of ‘client groups’ can lead to discrimination in the provision of services between different client groups”.

9.84 The Royal College of Psychiatrists agreed that our statute should not include a definition of disability and “strongly” opposed the use of the Disability Discrimination Act 1995 definition, which they argued “continues to cause a barrier for some people with a short-term mental illness”.

9.85 On the other hand, a small number of consultees expressed concern that there may be a lack of clarity as to who would be entitled to services. NAAPS (originally the National Association of Adult Placement Services) – while agreeing with the proposal – expressed concern that “the absence of a definition could ... lead to local authorities specifying which people they are prepared to assist or indeed to deny assistance”.

9.86 Furthermore, the Care Quality Commission argued that if the new statute does not include its own definition of disability, then there will be a tendency for people to refer to other existing legal definitions instead, such as the definition contained in the Disability Discrimination Act 1995.

### ***The importance of not categorising people***

9.87 Some consultees agreed with the proposal on the basis that people should not be labelled or categorised. For example, the Northumberland Forum for People with a Learning Disability stated that “you should not have to be labelled to get a service, it should only matter that you need the service”.

9.88 Similarly, the Wales Council for Voluntary Action agreed with the proposal “in order to move away from stigmatising language and assumptions of dependency and deficiency”. ADASS also noted that the removal of a central definition of a disabled person “means the post-war definitions and dated language currently provided under section 29 of the National Assistance Act 1948 would disappear”. However, they pointed out that other definitions of disability in other legislation would remain.

9.89 Newcastle City Council stated that it is “apparent that the acceptability of language changes and definitions of people by condition can date horribly”. They also suggested that existing statutory definitions be repealed, “removing some anachronistic definitions of people who may be eligible for community care services including ‘mothers lying-in or nursing’ for example”. Furthermore, they welcomed the proposal because:



such an approach would “normalise” the experience of receiving community care services, as at some point in their lives, anyone could have a need to receive such support.

- 9.90 Parkinson’s UK also strongly supported the proposal, and stated that this is in line with “the principle of person-centred planning where it is individual needs that give rise to support, not a blanket classification based on notions of disability”. Similarly, the British Psychological Society welcomed “the move away from diagnostic criteria/labelling process to obtain services”. Moreover, Mencap argued this proposal “is fundamental for the move towards personalisation”.

***Suggested definitions of disabled person or service user***

- 9.91 Some consultees suggested there should be a *social model* of disability in our statute. For example, the Joseph Rowntree Foundation argued that in addition to a community care assessment service users should be required to meet the *social model of disability* recommended by the Office for Disability Issues. This definition states that:

Disability is the loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers.<sup>8</sup>

- 9.92 On the other hand, Cartrefi Cymru cited the social model of disability as a reason for supporting the proposal not to include a central definition of disabled person. They argued that since the social model of disability “takes the view that individuals are disabled by the barriers imposed by society and societal attitude rather than by any personal conditions”, then “strictly speaking therefore, the term ‘disabled person’ has no meaning”.
- 9.93 Alternatively, the Chartered Institute of Housing – while agreeing that the language in legislation is outdated – argued that “there is value in some broad definition of service users”. They suggested that a list of service user groups should be provided in statute, which includes “persons who by reason of age and frailty require services to maintain their safety and secure their independent living”.
- 9.94 Similarly, RNIB suggested there should be a list of categories of user groups, in the interest of “clarity and consistency”. They further argued that “there are strong arguments for adding people with a sensory impairment to the list of user groups”. On the other hand, Newcastle City Council highlighted that the lack of reference to people with sensory impairment in the illustrative list suggested in the consultation paper “emphasises the risk of actual or perceived exclusion using a set definition”.
- 9.95 RNIB also argued that older people should be included in a list as a distinct category of service users because:

not all older people living with impairment define themselves as being disabled and so are perhaps less vocal than other sections of the

<sup>8</sup> Office of Disability Issues, *Delivering Inclusive Policy* (2010).

disabled population. Secondly, the vast majority of people with visual impairment are over retirement age.

- 9.96 On the other hand, Solicitors for the Elderly argued that “it would be stigmatising to identify older people as a user group per se because older people can be self-caring and well right up until the end of their lives”. They suggested that the preamble to the statute could be used to describe to whom it is intended to apply, namely:

Anyone with a disability or condition which affects their well-being and who need services for the improvement of, or to prevent deterioration in, their well-being.

- 9.97 Similarly, Carers UK suggested that a definition in the statute:

Could refer to someone’s physical and or mental condition giving rise to risks to independence and well-being. The assessment would then establish the level of need and risk to independence. Eligibility criteria following that would then decide whether the person was eligible to receive services.

### ***Conclusion***

- 9.98 There was a predominantly affirmative response to the proposal that the adult social care statute should not include a central definition of a disabled person or a service user. Most consultees agreed that such definition is unnecessary because potential service users would have to satisfy the eligibility criteria in any case. Some consultees also argued that the proposal would ensure that people with community care needs are stigmatised, or excluded from receiving services to meet their needs because of artificial categories. On the other hand, some consultees advocated that a social-model definition of disability should be included in the statute. Alternatively, a broad list of service users was suggested by one consultee to draw attention to particular groups that may be overlooked.

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

9.99 Of the 231 submissions which were received, 49 submissions expressed a view on the proposal that carers' services should remain undefined in the future adult social care statute. Of those consultees, 37 agreed with the proposal, 9 disagreed and 3 held an equivocal position.

***The need for flexibility***

9.100 Most consultees agreed with this proposal on the basis that it would allow for flexibility in the provision of carers' services. For example, Disability North argued that it is "far better for the local authority to have the flexibility to provide the right services for the particular situation". Similarly, RNIB and Guide Dogs stated that they "recognise the breadth of services which may be necessary in order to support an individual in their caring role and so recognise the merit of this approach".

9.101 The Joseph Rowntree Foundation agreed with the proposal because it allows for the flexibility required to meet the needs of such a diverse group:

Research shows that carers are a diverse group in terms of age, socio-economic status, relationship with those being cared for, and the type of care and support being provided. Carers may have to balance their caring role with a job, with education, or with caring for their own children. As such, carers will need a wide range of support to meet their specific situations.

9.102 Carers UK argued that this approach has led to a more creative delivery of services. They also stated that:

it is important that the focus remains on outcomes. Too often a response is service-led rather than outcome-led and the assessment becomes heavily process driven.

9.103 The Cardiff and Vale of Glamorgan Voluntary Health and Social Care Networks agreed with the proposal as long as it is explained that services are not being defined because of "the wide range of individual carer's circumstances and needs". On the other hand, Belinda Schwehr, a legal and training consultant, accepted the proposal:

Subject to acknowledgement that the range is still limited by reference to principles of legality, harm and reputational damage to local authorities, as they are spending public money.

### ***Lack of clarity about carers' services***

9.104 Several consultees disagreed with the proposal on the basis that it results in a lack of clarity about carers' services. For example, the London Borough of Havering argued that "currently there is a lack of clarity over what these [carers' services] could include and the whole area needs more definition". Furthermore, East Riding of Yorkshire Council stated that as a result of the lack of definition, there may be differences in provision between different authorities, leading to inconsistency. Furthermore, ADASS stated that:

people need to have some idea about what might be available and what might help them. Awareness of this aspect can be a critical factor in seeking an assessment.

9.105 Enfield Disability Action cited research which found that:

local authorities have adopted policies of not providing certain low level services, e.g. housework, that are often of high importance to a carer and in maintaining the caring role.

9.106 They, therefore, suggested the provision of a list of services in the statute based on those services which are listed in the practice guidance on the Carers and Disabled Children Act 2000.<sup>9</sup> Similarly, the Disability Law Service suggested the inclusion of a broad list of carers' services, but stated that "it should be made clear that this is not an exhaustive list and that there is additional room for additional services where they can be justified in the circumstances".

9.107 Parkinson's UK stated that "for the foreseeable future local authorities will be controlling their expenditure closely". They therefore argued that a broad definition of carers' services is needed on the face of the statute in case local authorities "use the lack of definition to tighten up their interpretation of what they should provide".

9.108 Similarly, the Wales Neurological Alliance suggested that Welsh Ministers should be given the power to define what carers' services are, particularly in a financial climate that might see such services withdrawn.

9.109 The Princess Royal Trust for Carers and Crossroads Care argued that a broad definition based on desired outcomes would further personalisation.

### ***The need for consistency***

9.110 Several consultees – including ADASS and the Care Quality Commission – argued that there should be consistency in the approach taken to the definition of carers' services and the definition of community care services.

9.111 The Standing Commission on Carers also proposed that the same short and broad list of services that was proposed for community care services should also define carers' services.

<sup>9</sup> Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001).

- 9.112 The Law Society argued that “that flexibility is not always practically exercised by local authorities and other services providers in the exercise of discretion” and they therefore suggested “a broad list of services to mirror that already proposed for service users themselves”.

***Further guidance***

- 9.113 Several consultees argued that irrespective of whether carers’ services are defined in the statute or not, further guidance is required. For example, Parkinson’s UK – while disagreeing with the proposal – stated that alongside a broad definition:

the accompanying code of practice could reiterate the need for innovation and wide interpretation so that services develop and modernise according to the carer’s support agenda.

- 9.114 Suffolk County Council agreed with the proposal but also stated that “a code of practice would be helpful in giving some further guidance”.

***Conclusion***

- 9.115 There was a predominantly affirmative response to the proposal that carers’ services should remain undefined in the future adult social care statute. Most consultees argued that this would provide local authorities with the required flexibility to meet this diverse group’s broad range of needs. On the other hand, some consultees argued that defining carers’ services would provide carers with more clarity as to what services they may be entitled to in order to support them in their caring role, as well as ensuring consistency between service users and carers.

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

- 9.116 Of the 231 submissions which were received, 38 submissions expressed a view on the proposal that the future adult social care statute should allow for regulations to be issued that are capable of defining Shared Lives schemes as being non-residential services in all cases. Of those consultees, 34 agreed with the proposal 3 disagreed and 1 held an equivocal position.

***Legal clarity***

- 9.117 Several consultees, such as the Law Society, welcomed the proposal on the basis that clarity as to the legal status of Shared Lives is required. Furthermore, the ADASS Cymru stated that:

a lack of a definition of Shared Lives schemes has led to difficulties in knowing which charging regime to apply and the fact that a person cannot obtain direct payments to pay for residential accommodation.

- 9.118 On the other hand, Nottingham City Council argued that “such a specific, but confusing issue needs the force of statute to provide clarity”.

***Support for Shared Lives schemes being non-residential***

- 9.119 Several consultees, like the Lincolnshire Partnership NHS Foundation Trust for example, supported Shared Lives being identified as non-residential because they argued that it would reflect current practice. Similarly, Newcastle City Council stated that:

this is already the practice in Newcastle as it allows the service user to enjoy the benefits of a tenancy (which is not possible for contracted residential accommodation), housing benefit and direct payments where appropriate.

- 9.120 Furthermore, the Care Quality Commission argued that identifying Shared Lives as non-residential is in keeping with the registration regulations whereby “Shared Lives schemes are seen as providing ‘personal care’ only and not ‘accommodation for persons who require personal care’”.

***The negative impact of defining Shared Lives as residential***

- 9.121 NAAPS (originally the National Association of Adult Placement Schemes) agreed with the proposal and also supported Shared Lives being defined as non-residential. They stated that current position in relation to Shared Lives is “somewhat confused” and highlighted that where local authorities treat placements as residential and use the funding and charging model for residential care:

the negative impact of this is that people using shared lives on this basis are denied access to a range of social benefits including

Housing Benefit and are left with only pocket money which denies them the opportunity to live ordinary lives as part of a family.

- 9.122 Mencap also stated that they would like to see Shared Lives defined as non-residential, on the basis that it “would ensure that the individual placed in a Shared Lives arrangement would have more control over the place [where] they live”.

### ***Shared Lives and residential services***

- 9.123 Several consultees commented on the residential elements of Shared Lives schemes. For example, the Government agreed with the proposal, but stated that:

it would be important to ensure that all such services are treated as non-residential rather than preventing them from including a residential element. We would not want to do anything that prevented both current and future users from selecting this option.

- 9.124 On the other hand, Belinda Schwehr, a legal and training consultant, stated that some people in Shared Lives schemes “will need accommodation and personal care in one and the same package of services” and this should be considered residential care, and should therefore trigger registration as a care home. She disagreed with the proposal because it would be wrongly describing it as a “non-residential service, when it is the essence of what a residential placement *is*”.<sup>10</sup>

- 9.125 The Welsh Assembly Government also disagreed with the proposal on the basis that:

in recent years the nature of the services that are provided under Shared Lives schemes has continued to broaden. The possibility that these schemes may well in the future seek to extend their service provision into what would normally be regarded as residential services therefore cannot be completely excluded.

### ***Conclusion***

- 9.126 There was a strongly affirmative response to the proposal that the future adult social care statute should allow for regulations to be issued that are capable of defining Shared Lives schemes as being non-residential services in all cases. Some consultees argued that it would offer more clarity. Many consultees interpreted the proposal as recommending that Shared Lives schemes are defined as non-residential, and they argued that this reflects current practice, where Shared Lives are treated as a non-residential service, as well as being in the interest of the service user. On the other hand, a small number of consultees highlighted that the broad range of services provided under Shared Lives schemes could not be delineated or should not be limited by such a definition.

<sup>10</sup> Emphasis in original.

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

- 9.127 Of the 231 submissions which were received, 49 submissions expressed a view on the proposal that the existing divide between health and social care service provision should be maintained in the future statute. Of those consultees, 33 agreed with the proposal, 5 disagreed and 11 held an equivocal position.
- 9.128 While the majority of consultees agreed that the existing divide between health and social care service provision should be maintained, many did not further elaborate on their reasons for agreeing with the proposal. Therefore, this analysis will focus on the views of consultees who expressed concerns.

***Lack of legal clarity***

- 9.129 Several consultees highlighted that the proposal does not provide the necessary clarity in this difficult area of the law. For example, Carers UK stated that “this is a welcome opportunity to clarify legal rights and obligations and not simply to reproduce current confusion”. Moreover, Ann McDonald, a social care academic, stated that “this is an opportunity to clarify boundaries which should not be lost”.
- 9.130 Similarly, the National Autistic Society stated that clarity would be welcome because “the respective funding responsibilities of local authorities and the NHS are often confused and confusing for some people with autistic spectrum disorders”. Likewise, Parkinson’s UK stated that clarity is very important because:

the interface between NHS and social care funded accommodation is an area of law which is one of the most perplexing and contentious for individuals in the receipt of care services.

***The terminology of the prohibition***

- 9.131 Moreover, some consultees pointed out that the proposal has replicated the confusing terminology used in the National Assistance Act 1948 to describe the division between health and social care. For example, some participants at consultation events criticised as unnecessarily obscure the use of the term *under* to signify services that are authorised by the NHS Acts 2006 by way of guidance or directions. It was argued that this concept could be explained more clearly on the face of the statute without changing its meaning. Others suggested that the terms *authorised* and *required* were confusing and should be replaced by 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.



### ***NHS target duties***

- 9.132 Some participants at consultation 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 in practice be difficult to distinguish between services that are required and those that are authorised. Moreover, the provision of NHS services can also be subject to eligibility criteria developed locally (such as the provision of secondary mental health care), which can obscure further the identification of a power and a duty.
- 9.133 In addition, many duties and powers must be discerned from a range of circulars and guidance from central government; for example, the primary health care need approach is only set out in guidance and directions and does not appear in statute law.<sup>11</sup> This not only creates difficulties in identifying and locating the relevant documents but it is often not clear from the language used in the documents whether a power or a duty is being established.

### ***The limits of social services responsibilities***

- 9.134 Some consultees expressed concern that our proposals fail to clarify the limits of what a local authority can lawfully provide. For example, the Royal Borough of Kensington and Chelsea expressed concern “that this proposal suggests a continued lack of clarity between what a local authority can legitimately commission/provide and what the NHS is required to do”. Similarly, Enfield Disability Action stated that:

The wording of the proposals (authorised or required) follows section 21(8) of the National Assistance Act 1948 which was closely considered by the Court of Appeal in *R v North and East Devon Health Authority ex parte Coughlan*.<sup>12</sup> However, despite that case, entitlement to NHS Continuing Healthcare remains unnecessarily obscure and local authorities continue to fund cases which are the responsibility of health bodies and to charge people for what should be free NHS care.

- 9.135 Therefore, they suggest amending section 49 of the Health and Social Care Act 2001 to reflect the *quantity and quality* test established in *Coughlan*.
- 9.136 However, representatives from the Local Government Association at a consultation event expressed concern about the operation of the *quantity and quality* test. They argued that this test does not fit easily with the concept of a primary health need because logically *primary* suggests 51% or more, but *incidental or ancillary* cannot be regarded as 49%.

<sup>11</sup> NHS Continuing Healthcare (Responsibilities) Directions 2009, direction 2(7) 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.

<sup>12</sup> *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213.

- 9.137 It was further argued that 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 a *social care need* and moreover, the nature of social services cannot be extrapolated from the lists of services contained in the community care statutes because they are too broad and imprecise. Some participants at consultation events argued further that the proposal to replace these lists with a single short and broad list of services would perpetuate this difficulty.
- 9.138 Representatives from the Local Government Association proposed that the *quantity and quality* test should be replaced with a requirement placed 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 needs.<sup>13</sup>
- 9.139 A small number of consultees asked for additional guidance. For example, the Multiple Sclerosis Society stated that “it would be helpful if the Secretary of State were given a power to issue guidance around the interface between these services”.

#### ***The gap between health and social care***

- 9.140 Some consultees highlighted that there is a possibility of a gap between health and social care for some people. Participants at consultation events argued that our proposed statute should clarify this matter by ruling out altogether the legislative possibility of a gap. This could be achieved, for example, by placing the *primary health need approach* on the face of statute law and therefore making it clear that any need beyond the *quantity and quality test* must be met by the NHS. Additionally, representatives from the Local Government Association proposed that the proposed statute should require 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 needs.
- 9.141 It was also argued at consultation events that Government policy needs to change in order to eradicate the gap between health and social care. It was suggested that the *primary health need* approach as explained in the *NHS Continuing Healthcare Framework* and *Decision Support Tool* places the bar too high for qualifying for NHS continuing healthcare. One participant at a consultation event pointed out that the *nutrition domain* does not contain a priority band, only a severe band, meaning that a person unable to take food or drink by mouth, making intervention inappropriate or impossible, cannot be deemed on this basis to be eligible for NHS continuing healthcare (in that they are not a *priority* under the *Decision Support Tool*).

<sup>13</sup> Department of Health, *Decision Support Tool for NHS Continuing Healthcare* (2009).

- 9.142 A further problem identified by consultees was that increasingly assessors are adopting a narrow understanding of a primary health need by looking only at the health elements when completing the *Decision Support Tool*, and then asking whether the need is primarily for *health services*.

### ***Disputes***

- 9.143 The Law Society expressed concern that the proposal does not address any period in time when there may be a gap in service provision whilst a decision is made as to primary responsibility. They suggested that:

the statute address this issue by directing that the agency who first became aware of an individual's need to be responsible for the provision of services until a formal decision is made without prejudice to their position that the agency may not be the appropriate long term agency to provide services.

### ***Joint working***

- 9.144 For several consultees – including some who agreed with the proposal – the key issue was not establishing clear boundaries but recognising the fluidity and inter-working relationship between health and social care. For example, the Joseph Rowntree Foundation stated that the Law Commission “needs to recognise the increasing overlap between these two realms, particularly for people with high-level support needs”. They argued, in particular, that “nursing care which is required to be provided by a registered nurse’ should be recognised as a fluid concept”. They referred to pilots which up-skilled residential care staff to complete basic clinical tasks and argued that this “potentially challenges the assumption that some tasks need always be carried out by a registered nurse”. While they accepted that the distinction between health and social care should be maintained in the statute, they argued that it:

should be described in a context where increased integration and joint working of these two realms should be standard practice and encouraged to promote more positive outcomes.

- 9.145 Similarly, Cartrefi Cymru highlighted that “there is an increasing (and in our view, practical and appropriate) blurring of responsibilities at the interface between the two sectors”. For example, they stated that social care providers often undertake tasks that would previously have been considered the province of nursing or medical staff, such as the administration of medication and some aspects of medical care. They suggested that “perhaps it would be more appropriate to draw the exclusive divide by reference to the defining factor being ‘medical’ rather than ‘health’ interventions”. Moreover, they suggested that:

the development of the new statute should include a form of words which would promote partnership working and the pooling of budgets (particularly at the interface as described above) across social care and the NHS.

- 9.146 In a similar vein, the Royal College of Physicians of Edinburgh noted that:

many tasks currently done by carers at home would need a nurse in hospital e.g. administration of injections, such as insulin, and that the division between residential and nursing home registration required by current legislation seems completely arbitrary.

- 9.147 They concluded that “it would be much more desirable to change the care provided than force the individual to have to change the place where their care is received”.
- 9.148 Scope also argued that “there needs to be recognition of greater future joint-working between health and social care” and suggested that “maintaining the existing divide between social care and health may require subordinate legislation to ensure effective joint-working”.

### ***Personalisation***

- 9.149 Some consultees highlighted problems in providing joined up personalised services between health and social care. For example, the Adults with Learning Disabilities Services Forum stated that “there are difficulties of co-ordinating different funding streams, but individual budgets must be comprehensive, covering all aspects of an individual’s needs”.
- 9.150 The Hampshire Centre for Independent Living stated that, since direct payments cannot be given for health care, this proposal is “highly problematic” for people who qualify for NHS Continuing Healthcare funding and are therefore “*forced* to abandon their long established local authority direct payments scheme and accept staff scheduled by a care agency”.<sup>14</sup> They stated that this “is an infringement of the right to choose how service is delivered ... and *must* be addressed”.<sup>15</sup>

### ***Other issues***

- 9.151 The Wales Neurological Alliance disagreed with the proposal and stated that “this is an area which clearly needs further debate in Wales following the recent restructuring of the NHS and the abolition of the internal market in health”.
- 9.152 Citizens Advice highlighted that because the current boundary between health and social care is so hard to delineate, “health and social care authorities were encouraged by the last government to get round the problem by establishing Partnership Trusts”. While acknowledging that this probably outside the Law Commission’s remit, they argued that this proposal:

would not grasp the nettle of giving those trusts a single legislative basis. Nor would [it] sort out the awkward differences over charges, with NHS service free and adult social care charged for.

<sup>14</sup> Emphasis in original.

<sup>15</sup> Emphasis in original.

### ***Conclusion***

- 9.153 There was a predominantly affirmative response to the proposal that the existing divide between health and social care service provision should be maintained in the future adult social care statute. On the other hand, many responses on this issue pointed to the need to introduce greater clarity to the interface between health and social care services, not least with regard to the limits of what local authorities are able to provide. Moreover, some consultees argued that even if the distinction between health and social services is maintained, it must be worded in a way that encourages joint working. A small number of consultees suggested that the statute should ensure that any possible gaps in provision between health and social care are covered.

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

- 9.154 Of the 231 submissions which were received, 32 submissions expressed a view on the proposal that social services authorities should continue to be prohibited from providing ordinary housing and connected services, if these services are authorised or required to be provided by or under other legislation. Of those consultees, 29 agreed with the proposal, and 3 disagreed with the proposal. There were no equivocal views.
- 9.155 While the majority of consultees agreed with the proposal, they did not further elaborate on their reasons for doing so. Therefore, this analysis will focus on the views of consultees who expressed concerns.

***The importance of joint working***

- 9.156 Several consultees highlighted the importance of joint working between social services and housing authorities. In particular, the Chartered Institute of Housing – while agreeing with the proposal – stated that:

the legislation should be able to support and facilitate the development of greater joint working across these and other partners, in order to meet the increased needs, to focus on prevention and early intervention, and to respond properly to a system that is truly person centred, maximising choice and control over services that contribute to desired outcomes.

- 9.157 Similarly, RNIB and Guide Dogs – while agreeing with the proposal – stated that “there is an intrinsic link between the provision of housing and the provision of social care services” and therefore welcomed “measures that require departments to co-operate”. Likewise, Cartrefi Cymru stated that:

Access to suitable housing is ... recognised as a significant determinant of health and well-being and a necessary prerequisite for meaningful community and social integration/involvement.

- 9.158 They stated therefore that the relationship between social services and housing would benefit from the same partnership arrangements that exist between social services and the NHS, for example by promoting partnership working and the pooling of budgets.
- 9.159 Moreover, the Care Quality Commission stated that it “firmly believes that the process of joining up (or integrating) care will improve people’s experiences and outcomes of care”. They therefore cautioned “against territorial approaches which can stifle innovation and change”.

### ***Ensuring housing needs are met***

- 9.160 Several consultees argued that the mechanisms currently in place to protect service users who are judged to be intentionally homeless must be strengthened. For example, Belinda Schwehr, a training and legal consultant, argued that greater co-operation was needed between social services and housing departments “so as to avoid situations where vulnerable individuals are left unsupported in accommodation that they cannot manage”. She also argued that individuals should not be deemed to have acted intentionally where issues of disability or capacity are relevant. Finally, she suggested that local authorities should use the well-being power to set up a rent deposit scheme to assist those found intentionally homeless, rather than require they are accommodated through adult social care legislation.
- 9.161 Newcastle City Council – whilst agreeing with the proposal – expressed concern that disabled people often needed to be admitted into residential care where such provision was not “clinically required” because:
- housing services had either refused to accommodate people who were deemed to be intentionally homeless or who had exhibited high-risk behaviours or simply because homeless accommodation was inaccessible.
- 9.162 They argued that this “appears to be a gap in the legislation” which:
- presents a number of problems in terms of funding responsibility and also in terms of risks posed to other residents who often exhibit higher vulnerabilities than the individual in question.
- 9.163 Furthermore, Carers UK argued that the dividing line between social care and housing should be redrawn since:
- having a disability is different to a family living in overcrowded accommodation. For example, disabled people can be trapped in one room with no prospect of adaptations. If this does not render them statutorily homeless, then they would be subject to the vagaries of local housing transfer policies.
- 9.164 Age UK and Age Cymru warned that “the divide should not act as a barrier to social services providing housing in order to meet community care needs” where other authorities choose not to exercise their powers to provide housing.
- 9.165 Moreover, Belinda Schwehr argued that guidance is needed to help local authorities differentiate between a person whose community care needs do impact upon or are exacerbated by their housing situation; this distinction was suggested recently in *R (Mwanza) v the London Borough of Greenwich*.<sup>16</sup>

<sup>16</sup> [2010] EWHC 1462 (Admin).

### ***Conclusion***

- 9.166 There was a strongly affirmative response to the proposal that social services authorities should continue to be prohibited from providing ordinary housing and connected services, if these services are authorised or required to be provided by or under other legislation. On the other hand, several consultees highlighted the importance of encouraging joint working between social services authorities and housing authorities, and its impact on people with social care needs. Moreover, several consultees expressed concerns that the current dividing line between social care and housing is having a negative impact on service users, in particular those deemed intentionally homeless.



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

- 9.167 Of the 231 submissions which were received, 46 submissions responded to the question of what are the likely consequences of retaining the prohibition on adult social care services to those subject to immigration control solely because they are destitute or because of the physical or anticipated physical effects of being destitute.

***The exclusion of vulnerable asylum seekers from support***

- 9.168 The majority of consultees pointed to the negative impact of the existing prohibition on the provision of services. Some consultees suggested that a review of Government policy is required to ensure that the social care needs of vulnerable people are met. In particular, Still Human Still Here argued that “refugees and asylum seekers are a particularly vulnerable group of people whose access to social care should be facilitated rather than restricted”. It was argued that the current legal framework “excludes thousands of refused asylum seekers” and that retaining the prohibition means that “this group of asylum seekers will continue to suffer extreme hardship”.
- 9.169 Coventry City Council argued that retaining the prohibition would mean that “groups of people who may reasonably be considered to be at risk will be excluded from access to support”. They suggested this would be unacceptable to anyone “exercising its duty of care as normally understood”.
- 9.170 North Tyneside Council argued that the effect currently of the prohibition is that “the health of those who are ineligible may deteriorate to such an extent that services must be provided in order to prevent a breach of human rights”. However, on balance and in light of case law which provides that only very extreme situations will constitute a breach of human rights – “such a consequence is likely to occur infrequently”.
- 9.171 More generally, Enfield Disability Action stated that “the consequences will be recourse to the black economy, prostitution, slave labour etc. leading to deteriorating health and well-being”.

***People with mental health problems***

- 9.172 Many consultees highlighted the negative impact that the prohibition has on causing or exacerbating mental health problems. For example, Still Human Still Here cited a report which estimated that between five and 30 per cent of asylum seekers have been tortured and suggested that many asylum seeking women, as well as some men, have been victims of rape.<sup>17</sup> Furthermore, they cited a 2009 report published by Mind, which stated that:

<sup>17</sup> A Burnett and M Peel, *The Health of Survivors of Torture and Organised Violence* (2001) p 322.

restrictive policies on healthcare, education, accommodation, welfare support and employment are functioning to socially exclude and marginalise refugees and asylum-seekers, both exacerbating existing mental health problems and causing mental distress. ... Immigration policy creates an environment which is having a devastating impact on the mental health, well-being and long-term integration prospects of refugees and asylum-seekers.<sup>18</sup>

- 9.173 Furthermore, Maxwell Gillott Solicitors argued that the way in which the physical effects of destitution or anticipated physical effects of being destitute are connected to mental health problems and can exacerbate these is “extremely complex”. They argued that the prohibition can:

operate to exclude those with mental health difficulties which appear, at least on their face, to be mainly linked to some feeling of security and certainty in respect of their accommodation, particularly in light of the traumatic experiences that such individuals may have suffered in their country of origin.

- 9.174 Lincolnshire Partnership NHS Foundation Trust stated that retaining the prohibition will mean:

It is more likely than not that asylum seekers, who have suffered trauma and who are then subjected to destitution, will suffer deterioration in their mental condition thereby bringing them within the eligibility range for residential care.

### ***People living with HIV***

- 9.175 The National Aids Trust argued that the prohibition on adult social care services to those subject to immigration control means that some of those most in need are deprived of services. They further stated that:

HIV disproportionately affects black African communities and we are aware that many migrants that require social care support to manage their condition struggle to access this support. Many rely on voluntary sector services or support that officially they should not be able to access from local authorities (but that local authorities continue to provide), putting all concerned in a difficult position. This means that the type of support provided can be ad hoc and often takes the form of crisis interventions.

### ***Protecting carers***

- 9.176 The Children’s Society argued that retaining the prohibition would continue to “place a heavy burden on their surrounding families, specifically their children, to care for asylum seekers and children’s rights would be put at risk”. They stated that this is an especially pressing issue because:

<sup>18</sup> Mind, *A Civilised Society: Mental Health Provision for Refugees and Asylum Seekers in England and Wales* (2009)

a large proportion of asylum seekers tend to have social care needs, potentially arising from the experiences within home country and during migration such as post-traumatic stress and mental ill health. They may also have disabilities and long-term illnesses including communicable diseases.

### ***Legal confusion***

- 9.177 Still Human Still Here suggested that the prohibition further complicates the assessment process:

Trying to decide what a vulnerable person's needs are and how they are best met is an extremely difficult task. Adding complex immigration eligibility criteria to this, which social work decision-makers are not properly trained to understand, leads to confusion, is administratively burdensome and may result in a significant number of vulnerable people being denied the care they need and are entitled to.

- 9.178 They drew a parallel with the problems of applying immigration eligibility criteria in relation to the NHS in recent years, where they stated that despite guidance that immediately necessary treatment, such as maternity care, must never be withheld, confusion about entitlement remains widespread. The result of this was that "urgent and immediately necessary treatment was wrongly denied to numerous refused asylum seekers on the basis that they were not entitled to free treatment". They argued that:

The same confusion around eligibility criteria is likely to exist in relation to accessing social care and may lead to many asylum seekers and refugees not seeking assistance from local authorities or being wrongly denied social care services because of their immigration status.

- 9.179 They therefore suggested "the introduction of a simplified gateway for accessing social care based on needs, not immigration status".

### ***Resource implications***

- 9.180 Several consultees argued that the current prohibition should be retained because of the financial implications that removing it would have for local authorities. For example, Nottingham City council argued "strongly" that the prohibition on adult social care services being provided to those subject to immigration control solely because they are destitute or because of the physical or anticipated physical effects of being destitute should be retained. They suggested that any change to the law would be "seriously financially disadvantageous" to local authorities, especially in the context of budget cuts and budgetary pressures on social services from an ageing population. Finally, they argued that the support of asylum seekers should remain a responsibility of Central Government, although they "recognised that there are significant gaps in support within the current system".

9.181 Similarly, Solicitors for the Elderly argued that to remove the prohibition “would seriously affect the sustainability of the adult social care system”. However, the London Borough of Camden argued that maintaining the current system will lead to continued pressure on the adult social care budget to support such people with accommodation and food as well as care support.

9.182 On the other hand, Still Human Still Here argued that retaining the prohibition would result “in very significant indirect cost implications for local authorities” and further stated that:

the denial of social care on eligibility grounds which consequently leads to a person becoming “destitute-plus” and needing higher and more expensive levels of care later on, is cost ineffective and causes unnecessary distress to the individual involved and their families.

9.183 They illustrated the difference in cost between meeting low-level needs and having to wait until someone’s needs become “destitute-plus”:

Hospital inpatient attendance for those requiring mental health services are £532 for intensive care, £268 for acute care and £257 for rehabilitation (all costs are national averages per bed day). Compare this against the cost of NHS Trust day care for people with mental health problems which averages £65 per day (not including evenings) or weekly Cognitive Behavioural Therapy session which costs £58 per session.<sup>19</sup>

9.184 Similarly, the National Aids Trust argued that:

Without a more sustained source of support some people’s health deteriorates, leading to the need for emergency medical care which is more expensive in the long run than providing reliable low level social care support.

9.185 Likewise, the Royal College of Physicians of Edinburgh stated that:

If [asylum seekers] are prohibited from social care and become destitute, then there is a risk of physical ill health occurring. The physical ill health leads to a consumption of health care resources, and may ultimately be more expensive than providing social care.

### ***The risks associated with reform***

9.186 Several consultees argued that any reform was not necessary or that it should be approached with caution. For example, Havering London Borough Council stated that the current “destitute-plus” test “appears to be working reasonably well in practice and probably does not need any further clarification or amendment”.

<sup>19</sup> L Curtis, *Unit Costs of Health and Social Care 2008* (2008) pp 81, 53 and 57.

9.187 Similarly, Nottingham City Council argued that “there is vast case law available under the existing law that is able to bring clarity to individual cases and circumstances”. They expressed concern about “how far the Human Rights Act would impact on any changes if brought in by statute” and that this may therefore “open the flood gates” for legal challenges.

***A matter for Government policy***

9.188 Some consultees pointed out that any changes to the prohibitions are appropriately a matter for Government policy rather than law reform. For example, the Care Quality Commission stated that “these are matters of policy” but went on to argue that “policy in this area is in need of review as evidence suggests that people’s needs are frequently overlooked”. They referred to the Social Care of Institute for Excellence report on the social care needs of refugees and asylum seekers.<sup>20</sup>

9.189 Similarly, the Law Society argued that this is a “matter for Government policy”, but it is their view “that as a matter of principle the Government should enact provisions outside of the adult social care statute to deal with this group”.

9.190 Bath and North East Somerset Safeguarding Board agreed that the Law Commission’s review does not extend to considering the merits of Government policy in relation to the interface between adult social care and immigration and asylum law.

***Conclusion***

9.191 The majority of consultees suggested that retaining the prohibition on adult social care services to those subject to immigration control solely because they are destitute or because of the physical or anticipated physical effects of being destitute would lead to negative consequences for the asylum seekers involved. Many consultees argued that asylum seekers are particularly vulnerable and should therefore have their needs met by local authorities where necessary. Several consultees, however, argued that the cost implications on local authorities would be severe if the prohibition was removed. Conversely, however, some other consultees argued that to have to wait until the needs of someone subject to immigration control satisfied the “destitute-plus” test would in fact be more expensive for social services and health authorities in the long term.

<sup>20</sup> Social Care Institute for Excellence, *The Social Care Needs of Refugees and Asylum Seekers* (2006).

## **PART 10**

### **DELIVERY OF SERVICES**

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

- 10.1 Of the 231 submissions which were received, 93 submissions provided answers to the proposal that there should be duty to produce a care plan, supported by a duty to make regulations concerning their form and content. Of those consultees, 87 agreed with the question and 2 disagreed, whilst 4 held an equivocal position.

#### ***Support for a clear statutory requirement***

- 10.2 There was strong support for the proposal that there should be a duty to produce a care plan for people who have assessed eligible needs. Some consultees felt that the absence of such a duty causes problems of consistency. For example, Maxwell Gillott Solicitors argued that local authorities sometimes fail to produce care plans or produce inadequate care plans. Similarly, the Vale of Glamorgan Older People's Strategy Forum commented that "at present, care plans are used very patchily for different adult groups".

- 10.3 Liz Ball, a deafblind person, stated:

I have only once seen my care plan and this bore absolutely no resemblance to my needs – it omitted mention that I am a wheelchair user, it stated that I have a carer which I do not, and it listed my needs and the support I could get incorrectly.

- 10.4 Reflecting on these problems, Age UK recognised the importance of care plans arguing that:

a care plan is the main way in which entitlements are communicated to the person who needs care. Without this it is difficult for someone who is not receiving the care and support that they need to challenge the process of assessment and care planning.

- 10.5 A number of consultees supported the point that if care plans had a specified form, service users and carers could challenge their care plans more effectively. For instance, Parkinson's UK argued that such an approach would "strengthen user and carer rights particularly in holding services to account as to delivery against the plan and its outcomes".

- 10.6 Being able to challenge the local authority was seen by some consultees as particularly important where a service user is in receipt of a direct payment. Age UK pointed out that until the case of *R (on the application of Savva) v Royal Borough of Kensington and Chelsea*, there was no recognised legal requirements to provide information about how a direct payment was calculated.<sup>1</sup> However, this is not a statutory duty:

This unsatisfactory state of affairs appears to have arisen because legislation relating to assessment and care planning has not been updated to keep pace with the development of individual budgets.

- 10.7 The view of Age UK, which was shared by the Law Society, was that legislation should require the information received in a care plan to be clear and specific enough to enable the service user to contest their level of payment.
- 10.8 However, the Welsh Assembly Government raised a concern that a duty to provide a care plan could present a risk as “this could lead to more legal challenges to the lawfulness of care plans”.

### ***Universal services***

- 10.9 Others suggested that the plan would be a useful way of providing information about the availability of universal services and ensuring prevention services are provided to those who currently have low level needs. In some local authority areas – such as Suffolk County Council – it was reported that this function had been contracted to local advocacy services.

### ***The importance of co-production***

- 10.10 Many consultees felt that care plans needed to be created in a specific way – in particular, through active involvement with the service user. For instance, Disability Wales recommended that, “the duty spells out that local authorities are required to produce a care plan *with*, and not just *for*, people who have assessed needs”.<sup>2</sup>
- 10.11 The Office for Disability Issues stressed the role of co-production between the local authority and the service user. This point was captured by Cymorth Cymru which stated that:

we would like to see an explicit emphasis on the role of the service user in developing a care plan. Services should be centred around their needs and aspirations and the outcomes they want to achieve and as such any care plan should fully reflect their input.

<sup>1</sup> [2010] EWHC 414 (Admin). Upheld on appeal: *R (on the application of Savva) v Royal Borough of Kensington and Chelsea* [2010] EWCA Civ 1209.

<sup>2</sup> Emphasis in original.

### ***The importance of multi-agency working***

10.12 Several consultees felt that co-production should go wider to include all relevant agencies and, where relevant, carers. Regenerate RISE argued that a care plan “should have input from all agencies that care for the person (if there are several agencies involved) – particularly including the voluntary sector”.

10.13 This was supported by the Government which emphasised the role of multi-agency working:

If we were to adopt this approach, it will be important to consider how any duty for a local authority to produce a care plan inter-relates with other agencies also providing services to an individual so that this legal duty does not lead to multiple care plans that impede a multi-agency approach.

### ***Incorporating the policy of personalisation***

10.14 A number of consultees queried how this proposal would fit with the policy of personalisation. For instance, the Local Government Association felt that:

it is not clear that producing a “care plan” properly reflects the nature of how personalised care is likely to be designed and arranged in the future. It will be important therefore that support planning is not overly prescribed or rigidly defined in regulation but is focused on the outcomes people wish to achieve and the means through which this will be supported.

10.15 Indeed, East Sussex County Council described care plans with a prescribed form and content as “a step too far”.

10.16 A looser approach to care plans was suggested by a few consultees who felt that the duty should be to *ensure* that a care plan is produced. Crossroads Care made this point:

Given the implications of personalisation and the intention for individuals to retain more control, it could be more appropriate for the statute to clarify that the local authority has a duty to ensure that an appropriate plan is produced rather than being responsible for actually producing a plan.

10.17 Inclusion South West made a similar point:

Experience shows that when given the opportunity people (or their representatives) come up with person specific proposals that are, in many cases, unique to them. It is quite possible that social services staff will not be involved in the production of such a support plan. ... The duty should be phrased in terms of them having a duty to make sure that something happens, but not them necessarily actually executing the requisite duty directly. The less local authorities do themselves, the more cost effective and personalised will be the end result.



### ***Relationship with support plans***

- 10.18 Whilst most of the responses to this proposal were in favour of a duty to produce a care plan, a large number of consultees argued that the term *care plan* should be replaced with the term *support plan*. For instance, The Care Quality Commission argued that the term:

“Care plan” is, in some circles, deemed a rather outmoded expression and one thought largely inappropriate for carers. It may be better to refer to “care and support plan” or “care or support” plan. “Support plan” might better describe the content of many such plans, particularly with the advent of more self directed support.

- 10.19 However, some consultees went further and felt that the term “support plan” reflects a different approach to the relationship between local authorities and service users. ADASS argued:

A duty on the local authority to "produce a care plan" is outdated and disempowering for all except those who completely lack capacity. The onus must be on assisting individuals (where required) to define and continually refine their own support plan.

- 10.20 The argument was taken further at several consultation events, where it was suggested that the introduction of support plans marks a radical shift in practice away from the paternalistic approach associated with a care plan. It was argued that the key characteristic of the support planning process is the importance attached to the service user's ownership of the support plan. Even where it is not possible for the service user to prepare their own support plan, it was argued that their views must guide the preparation of the plan as far as possible. In effect, a support plan was seen at consultation as indicative of a personalised approach to adult social care.

- 10.21 However, there was little agreement about the precise distinction between care plans and support plans. For instance, Simon Pearce, a social care professional, suggested that:

a care plan sets out the areas, which are eligible for service and how, broadly that service will be met. ... A support plan would be a much more personal diary-type document. The care plan would identify needs and how they would be met; a support plan would detail the daily practicalities. ... Care plans are as it were official documents, supports plans are more personal. I am not sure that the same document can always do both things, although I do think both things need to be done.

### ***Carers' rights to a care plan***

- 10.22 Carers' organisations argued that the duty to produce a care plan should also apply to carers. The Princess Royal Trust for Carers and Crossroads Care viewed an individual duty to produce care plans for carers as a new development and a positive move. Carers UK also supported this approach.

- 10.23 However, the Standing Commission of Carers argued that a service user's care plan "should be accompanied by a care plan for the carer". The Commission went on to state that:

we have been concerned to see some personal budgets that presume the carer will be willing to provide often high levels of support but without any proper reflection of other commitments such as employment, caring responsibilities for other family members or of the financial implications of providing such care. In the majority of cases, there will of course be no difference of opinion between carers and the person cared for. But expectations should be clear and a care plan will ensure that all concerned have common expectations and goals.

***The form and content of the care plan***

- 10.24 A number of consultees felt that the proposed statute should go further than simply setting out the form and content of the care plan in regulations. The Practitioners Alliance Against the Abuse of Vulnerable Adults argued that "a broad outline of what a care plan should contain should be in the statute", whilst Cartrefi Cymru suggested that "certain aspects of the care plan should be enshrined in statute". They argued that this should include:

the requirement to place service users and/or their carers at the centre of devising their care plan and specifying the personal outcomes that the plan is designed to achieve.

- 10.25 In their response, Sense argued that the function and content of a care plan is slightly different depending on whether the local authority is providing services or the service user has a direct payment. Accordingly:

Where a local authority is responsible for delivering services then it is critical that the service user has a detailed outline of what they can expect to be provided with and in what way. ... The critical element is that the person is dependent on the local authority to provide the service, so a clear outline of what is to be provided is essential. ... Where the care or support plan is to be delivered through a direct payment we still feel there should be a requirement to have a written plan setting out the expectations of the local authority for the service. Where there are restrictions on how a direct payment may be spent these need to be clear to the service user. ... Without this there is a risk of disagreement or misunderstanding between the local authority and the service user over the use of the funds.

- 10.26 Such an approach implies a parallel set of requirements depending on a person's funding stream.

### **Conclusion**

- 10.27 Almost all consultees agreed with the proposal that there should be a duty to produce a care plan. However, many consultees questioned the extent to which such care plans would be in-step with the policy of personalisation. In particular, some consultees wanted care plans to be produced with the active engagement of service users and carers and it was argued that the content could be tailored to desired outcomes. An issue remains about how detailed primary legislation ought to be, whilst consultees were in favour of the explicit inclusion of carers in the duty to produce a care plan. Some consultees favoured using the term *support plan* rather than *care plan*, and for many, the introduction of support plans represents a radical shift in practice towards a more personalised approach to adult social care.

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

- 10.28 Of the 231 submissions which were received, 83 submissions provided answers to the question on whether direct payments should be extended to cover residential accommodation. Of those consultees, 52 agreed with the question, 16 disagreed, whilst 15 held an equivocal position.

***Promotion of choice and control***

- 10.29 The primary reason given for supporting this proposal was that it would promote choice and control for service users. For instance, Sense argued that:

if we are to have a statute that makes no assumptions about the best way to deliver care, allowing the individual maximum choice and control, then it follows that direct payments should be an option for any type of service.

- 10.30 Similarly, Cartrefi Cymru argued that:

extending direct payments to cover residential care would serve to extend the level of choice and control available to service users and [we] can see no good reason why this should not happen.

- 10.31 Some consultees suggested that there is already choice and control by virtue of the choice of accommodation directions and extending direct payments would reinforce this approach. It was the view of Michael Mandelstam, a legal trainer and consultant, that this gives rise to another principled argument for extending direct payments because “residential care is an important choice, just as much as non-residential services”.

- 10.32 However, some consultees argued that because choice and control already exist, extending direct payments would be unnecessary. Sunderland City Council made this point:

It is unclear how direct payments would add any value for people needing residential care who would have a choice of accommodation under the current system.

***Cost implications for service users***

- 10.33 There was a significant number of consultees who doubted whether extending direct payments would be appropriate. A key issue was the potential impact that there might be on value for money for service users. Pauline Thompson, a social care academic and former Age Concern policy officer, explained the source of this problem:

There are already considerable differences between what those funding themselves are charged and what local authorities are charged. ... If everyone is left to commission their own care with a care home what happens to the market given that many people will not have the sort of negotiating skills developed by local authorities to fix a reasonable price?

- 10.34 Parkinson's UK pointed out that presently most local authorities negotiate their supply of residential accommodation with care home providers and authorities can use their increased buying power to agree a lower rate and other contractual terms. Accordingly, service users who are placed in residential accommodation by a local authority will be paid for at a lower rate than if the service users had arranged the same accommodation for themselves. Similarly, Age UK observed that:

Care homes routinely charge self payers more than they charge local authorities, so a direct payment set at the local authority rate would probably be inadequate to meet the rate for self payers so the person's relatives would have to top it up.

- 10.35 Some consultees viewed an increased reliance on top-ups as a necessary consequence of extending direct payments to residential accommodation. Counsel and Care expressed this as a concern:

We are extremely worried whether the amount provided to each individual in a direct payment to fund their care in a care home will be realistic and reflective of the current market value, and how this will be monitored. Older people must not be forced to request a top-up from a family member in order to ensure that their direct payment covers the full cost of the care home fees.

- 10.36 Age UK suggested that the only way to avoid this would be to place a duty on local authorities "to meet the market rate for self payers" and to demonstrate that this rate is *in fact* the usual rate that it pays. However, Counsel and Care made the point that if local authorities were placed under a duty to meet the *market rate*, then:

it is vital that it coincides with an injection of more funding into the system to make it workable rather than encourage more families and carers to pick up the tab between the amount that the local authority will pay and the rate that the care home charges.

***Increased burden on service users***

- 10.37 Some consultees pointed out that placing people into residential care should remain an option of last resort and that direct payments would not be appropriate in such circumstances. Regenerate RISE described the typical situation:

If people have to go into residential care, it is generally because they are unable to look after themselves anymore and that includes the mental health of the client – direct payments would be an added stress and unnecessary worry.

- 10.38 Kate Chapman, a carer, disagreed with the proposal on the basis that "it would mean another fight for exhausted families".

- 10.39 Gateshead City Council made the point that:

Many elderly and more vulnerable people cannot or do not want to manage direct payments or the contractual relationships with a care home. ...it is an important safeguard for the most vulnerable individuals that the local authority can set contractual standards and procedures for ensuring that standards are maintained.

10.40 Nottingham City Council expressed a similar worry:

We are concerned about the contractual responsibilities this would place on often elderly and vulnerable people. These contracts would involve large sums of money often outside the norm of direct payments. We would have concerns about recipients using Direct Payments in this manner getting into financial difficulties.

### ***Conclusion***

10.41 The responses to this question highlighted a division between those who were in favour of the principle of extending choice and control to include direct payments for residential accommodation and those who expressed concerns about what this would mean in practice. Many consultees argued that the realities of the care home market meant that service users would probably be worse off if they used direct payments to fund their accommodation. This is because local authorities are able to negotiate lower rates. A suggested consequence was an increased reliance on top-ups. Furthermore, some consultees felt that this proposal would place increased and unwanted burdens on service users.

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

- 10.42 Of the 231 submissions which were received, 50 submissions provided responses to the proposal that the choice of accommodation directions should be placed in statute law and that the additional payments regulations should be retained in secondary legislation. Of those consultees, 46 agreed with the proposal, 2 disagreed, whilst 2 held an equivocal position.

***Legal clarity***

- 10.43 Some consultees suggested that the existing status of the choice of accommodation directions can create legal uncertainty. Therefore, the National Autistic Society made the point that placing them in statute law would “bring greater clarity to individuals’ right to choose”. Dr Gregg Moore, in a written response, indicated that elevating the directions “would indeed be helpful in order to avoid local authorities circumventing them”.

- 10.44 However, the Welsh Assembly Government, disagreed saying that:

we are not convinced that the rationale for doing this is strong enough. We have no evidence at present of uncertainty about the legal status of the directions and thereby their effectiveness. Placing the directions in statute law would create restrictions on the ability to amend them.

***Consistency***

- 10.45 The Care Quality Commission saw this proposal as ensuring consistency. Similarly, Nottingham City Council argued that this proposal was in line with extending direct payments to cover residential accommodation (see Question 10-1). Furthermore, NAAPS (originally the National Association of Adult Placement Services) argued:

If the choice of accommodation directions were placed on a statutory footing it would bring greater consistency with direct payments and the exercise of choice and control by service users.

- 10.46 Accordingly, it was argued that this proposal confirms the principle of choice and control at the statutory level. However, ADASS argued that this is unnecessary:

The choice of accommodation directions become irrelevant if the statute properly supports personalisation which gives all individuals choice and control within the available resources to meet the described needs.

***The “usual cost” of the preferred accommodation***

- 10.47 Several consultees raised a concern about one of the conditions for the provision of preferred accommodation set out in the choice of accommodation directions. Direction 3(b) states that the local authority shall only make arrangements if:

the cost of making arrangements for him at his preferred accommodation would not require the authority to pay more than they would usually expect to pay having regard to his assessed needs.<sup>3</sup>

10.48 Age UK argued that this provision creates problems because:

the vague wording of the current directions ... makes it difficult for the service user to challenge or dispute the figure that the local authority claims is its usual price.

10.49 Carers UK made a similar point:

We agree that the principles in the choice directions should be included in primary legislation, but stress the need to clarify the definition of “usual cost” and prohibit the use of blanket figures that are not referable either to individual needs or the real market costs of care provision in the relevant LA area.

### ***Additional payments regulations***

10.50 The majority of responses to this proposal focused on the choice of accommodation directions and few made specific reference to the additional payments regulations. However, those who did were positive. Solicitors for the Elderly argued regulations “should be made to flesh out the statutory basis of contributions”.

10.51 Carers UK commented that:

we have no objections to the detail of additional payments being reserved to secondary legislation, but think that a prohibition on seeking an additional payment in circumstances where there has been no offer and subsequent refusal of a place suitable to meet the individual’s assessed needs at the “usual cost” should be included in primary legislation. The concept of usual cost and additional payments are inextricably linked as two sides of the same coin.

10.52 However, Medway Older People’s Communication Network questioned whether it was appropriate to rely on secondary legislation if the aim is to have everything in a single document.

### ***Other comments***

10.53 Louise Molina from Projex Health expressed concern that those eligible for residential care must be able to be housed in the home of their choice:

<sup>3</sup> National Assistance Act 1948 (Choice of Accommodation Directions) 1992 and in Wales, the National Assistance Act 1948 (Choice of Accommodation) Directions 1993.



This would, of course, always be the preferred option, but it should not be statute. As we know, many people are moved to long term residential care straight from hospital. Some families already exploit social services and health services by refusing to let their family member be discharged to a suitable home, because it's not the one of their choice, and sadly this can be down to wanting to delay entry to a residential home, where fees are involved. I have witnessed this happening on numerous occasions. Such an approach already causes delayed transfers of care, blocks hospital beds and costs social care services money in reimbursement costs. A statutory right to choose a residential home would make the situation worse. People should have the right to state their preferred choices and have them considered first, and every attempt made to secure residency in their preferred choice, but it should not be a statutory right in my view."

### **Conclusion**

- 10.54 Almost all responses to this proposal were positive about placing the choice of accommodation directions into statute law and retaining the additional payments regulations in secondary legislation. In relation to the directions, consultees felt that this proposal could bring benefits in terms of clarity and consistency. However, concerns were raised about the *usual cost* provision in the directions. In particular, it was seen as unhelpfully vague. In relation to the proposal on additional payments, those who expressed a detailed view were largely in favour. However, the number of consultees who gave a reasoned response on this was limited.

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

- 10.55 Of the 231 submissions which were received, 50 submissions provided responses to the proposal that direct payment provisions should be retained. Of those consultees, 42 agreed with the proposal, 7 disagreed, whilst 1 held an equivocal position.

***Recent amendments***

- 10.56 Several consultees agreed with this proposal on the basis that there was little point in changing the framework for direct payments given the recent amendments which have been made to the direct payments regime by the Health and Social Care Act 2008. These amendments extended the provision of direct payments in England to people who lack capacity, certain patients subject to the powers of the Mental Health Act 1983 and people subject to certain criminal justice orders.<sup>4</sup>
- 10.57 Disability North picked up on this point and argued that “the direct payments legislation has undergone major recent revisions which everyone seems clear on now, so there is no point in changing them.” This proposal does not seek to change the direct payments provisions. Rather, it seeks to bring current arrangements within the Law Commission’s proposed statute.

***Limiting the provision of direct payments***

- 10.58 A number of consultees argued that our proposal needed to go further and that the legislation should recognise expressly that direct payments may not always be appropriate. For instance, RNIB and Guide Dogs argued that “we would welcome regulations which clearly required authorities to enable service users to choose *not* to receive a direct payment”.<sup>5</sup>
- 10.59 Similarly, the National Autistic Society noted that:
- local authorities quite often give individuals the impression that they do not have the choice to decline direct payments, interpreting the “duty to provide” as a “duty to insist”.
- 10.60 Gateshead City Council argued that local authorities should have a wider discretion in relation to the duty to provide, stating that:
- it would be helpful if local authorities are given an explicit power to refuse direct payments if they are satisfied that they are being used in ways that do not promote the safeguarding of a service user who has capacity... the local authority should be able to refuse the direct payment if it has reasonable grounds to do so.

<sup>4</sup> Community Care, Services for Carers and Children’s Services (Direct Payments) (England) Regulations 2009, SI 2009 No 1887.

<sup>5</sup> Emphasis in original.

### ***Further points of criticism***

- 10.61 There were some further points of criticism raised by consultees. For instance, some consultees wanted local authorities to do more to promote direct payments. For instance, Cartrefi Cymru argued that:

there is considerable variation in the way that the “right” to be offered a direct payment is interpreted by local authorities and we would welcome a stronger “encouragement” to ensure that all those entitled to the offer of a direct payment actually receive it and have access to appropriate support in order to make a decision and manage their payment.

- 10.62 Disability Wales gave statistics on this point:

Currently only 3% of eligible service users in Wales have a direct payment. We suggest that the main reason for this is that local authorities are ambivalent about direct payments. Evidence shows that where local authorities invest in direct payment co-ordinators, the take up is much higher. This suggests that insufficient encouragement is given to people to opt in to direct payments.

- 10.63 However, the Direct Payments Support Scheme Network emphasised that whilst encouraging service users is important, service users should be given the opportunity to make an informed choice.

- 10.64 On a different point, Sense argued that there can be a lack of information about direct payments and quoted a service user who described direct payments as:

a great option if you know someone already or are looking for bog standard personal care at home. It's a nightmare if you need specialist support and know no-one.

- 10.65 Carers UK made a point about how direct payments are administered:

There is a very important practical need to reduce some of the bureaucracy surrounding direct payments. In some instances, the bureaucracy and time taken in managing staff and direct payments is the equivalent to a full time job for carers. ... A significant proportion of carers find this burden of administration excessive.

- 10.66 Anthony Collins Solicitors held the view that reform of the existing direct payments law is required:

The provisions relating to direct payments for individuals without capacity are inadequate and lack the necessary detail. For instance the local authority ought to be under a duty to ensure the representative is appropriate and competent and has been offered suitable guidance on the role and its responsibilities before the role is taken up.

### ***Conclusion***

- 10.67 Most consultees agreed with the proposal that the direct payment provisions should remain in their existing form. A reason for this is that reviews into direct payments have recently amended the provisions and this proposal would support these changes. However, several consultees felt that some local authorities could do more to encourage the take up of direct payments, whilst others should be more willing to accept a service user's refusal of direct payments. Other concerns were raised which related to how direct payments operate in practice. In the main, however, consultees were positive about this proposal.

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

10.68 Of the 231 submissions which were received, 57 submissions provided responses to the proposal that local authorities may be required or authorised to charge for residential and non-residential services. Of those consultees, 50 agreed with the proposal, 4 disagreed, whilst 3 held an equivocal position.

***Flexibility of the proposal***

10.69 Consultees cited the flexibility of this proposal as a reason for agreeing with it. Surrey County Council described it as sensible to allow for future changes in Government policy. The Government argued that such a regulation-making power “would give Government greater flexibility and avoid the need for primary legislation if Government wished to change the charging rules in the future”.

10.70 Similarly, the Wales Council for Voluntary Action was of the view that “it is important that this proposed statute be able to cater for future changes in policy”.

***Requiring local authorities to charge***

10.71 However, a significant number of consultees expressed a concern regarding the possibility that this proposal could *require* local authorities to charge for non-residential services. For instance, the Standing Commission on Carers argued:

We are firmly against any proposals that would *require* local authorities to charge for non-residential community care services. At present there is wide variation in charging policies, with some local authorities choosing not to charge for certain services such as short breaks, but others charging for everything.<sup>6</sup>

10.72 Carers UK took this point further:

We would see this as yet another tax on disabled people and their families. Some services are still provided free by local authorities and they have the discretion to do this because they believe it would be counter-productive or more expensive to charge for services. ... Charging for these services would hit the poorest hardest and prevent take-up of these services – which is counter-productive.

10.73 Parkinson’s UK questioned the value of charging for non-residential services:

<sup>6</sup> Emphasis in original.

There have been a number of reports which analyse the reasonableness of charges for non-residential services, which in some cases can be well over the actual cost of providing the service and vary hugely between different authorities ... we believe the proposals should maintain the status quo i.e. should be a power for authorities to recover the costs of non residential care, rather than a *requirement* for them to do so, as this may exacerbate the existing problems that people experience with charges levied.<sup>7</sup>

- 10.74 A number of consultees sought clarity about which services would be subject to a charge if this proposal were implemented. The Local Government Association argued:

In relation to charging it will be helpful for there to be greater clarity about what services are charged for and not and the rationale behind these in order that people are clear about what is available to them and at what cost.

- 10.75 Research in Practice for Adults highlighted this issue as pointing “to the need to agree how adult social care will be funded in the medium to long term”.

#### ***Suggested duty to provide guidance***

- 10.76 A theme that was apparent in some responses was a perceived lack of openness about local authorities’ charging structures. For instance, the Standing Commission on Carers recommended that:

all councils should have transparent charging policies ... service users, carers and the public should understand the purpose of local charging policies and the criteria used to determine levels of charging for particular services.

- 10.77 Furthermore, the Multiple Sclerosis Society recommended that our proposal:

should be accompanied by a duty to provide guidance as to how local authorities should determine their charges, in order to encourage more consistency and fairness of charges for social care across the country.

#### ***The Law Commission’s remit***

- 10.78 Consultees accepted generally that the Law Commission’s remit does not extend to altering the rules on charging for services. However, some consultees felt that this proposal *would* change the rules. The North West Complaint Managers Group argued:

The remit [of this review] does not extend to [altering] charging for services, yet this proposal seems to travel at least half way down this path. Without further national debate, this proposal should not be advanced.

<sup>7</sup> Emphasis in original.

10.79 Similarly, the Welsh Assembly Government argued that:

the proposal would appear to establish a default position whereby local authorities could not charge unless they were required or authorised by regulations to do so. This would be a change to the existing position and may not be an appropriate default position in relation to both residential and non residential care.

10.80 However, the Government acknowledged that this proposal “does not intend to alter existing arrangements”.

### ***The position in Wales***

10.81 The Welsh Assembly Government explained the situation in Wales whereby the power to charge for non-residential care will be subject to the provisions of the Social Care Charge (Wales) Measure 2010. This means that Welsh Ministers will be able to be more prescriptive as to what local authorities can charge for.

10.82 The Welsh Assembly Government held the view that this proposal “would appear to be pointing towards a far more restrictive regime” because a duty to require a local authority to charge for services would, it suggested, remove their current discretion to not charge for services. The Welsh Assembly Government also suggested that this proposal will be contingent on the findings of the Commission on the Funding of Care and Support.

### ***Conclusion***

10.83 Most consultees agreed with this proposal on the basis that it is important to allow flexibility in the proposed statute as this would allow future policy developments to be accommodated. However, several consultees argued that the proposed regulation-making power could be used to require local authorities to charge for non-residential services – which, it was argued, would be a negative change. Some consultees questioned whether this proposal might actually amount to a change in the current charging regime, and so would lie beyond the remit of the Law Commission’s review. An unresolved issue remains the funding of adult social care and it was suggested that the use of the proposed regulation-making power will be dependant on the findings of the Commission on the Funding of Care and Support.

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

10.84 Of the 231 submissions which were received, 44 submissions provided responses to the proposal that the existing regulation-making power, which enables certain community care services to be provided free of charge, should be retained. Of those consultees, 42 agreed with the proposal and 2 held an equivocal position. No consultees disagreed with this proposal.

***Listing free services***

10.85 Several consultees were in favour of this proposal on the basis that it would promote clarity regarding which services must be delivered for free. For instance, Disability North argued that “a clear list of services that cannot be charged for would be helpful for everyone”.

10.86 However, a number of consultees were critical of this proposal on the basis that local authorities may feel restricted to providing the services listed for free. The RNIB and Guide Dogs expressed concern saying that:

this could lead to an overly prescriptive approach whereby local authorities charged for everything that was not on the prescribed list and did not or could not exercise any discretion not to charge. Technology is constantly advancing in the area of sight loss-related equipment, and so having a prescribed list might mean that as new equipment becomes available, the regulations will need to be changed to allow/require local authorities to provide such equipment free of charge.

10.87 The Care Quality Commission argued that:

It will be important to maintain flexibility in what people using services are expected to pay. This proposal will serve to clarify which services are provided free of charge and is welcome. However, the Care Quality Commission cautions that new services will emerge in the future and the proposal could prove limiting.

10.88 The Law Society suggested a solution to this problem:

We agree [to this proposal] subject to the proviso that the regulations should make it clear that just because a particular service does not appear on the list of free services does not mean that the local authority must make a charge for the service.

10.89 These concerns tended to reflect similar concerns raised in relation to Provisional Proposal 9-1 which suggested a short and broad list of community care services. Many consultees to that proposal argued that it should be emphasised that such lists should be illustrative and non-exhaustive.



***The need for this proposal***

10.90 The Welsh Assembly Government was unclear about this proposal. This was because:

if local authorities could only charge for what they were authorised or required to charge for you would not need to do anything in relation to these community care services.

10.91 The logic of the Welsh Assembly Government's position appears to be that, under this proposed structure, all services will be free apart from those where charging is authorised or required. This position depends upon the implementation of Provisional Proposal 10-4.

***Conclusion***

10.92 Almost all consultees unequivocally agreed with this proposal to retain the existing power to provide community care services for free and to list free services in regulations. There were some concerns raised about whether a list would cause local authorities to restrict the provision of free services. Several consultees argued that community care services develop over time and so a fixed list would be inappropriate. However, it was argued that a possible solution to this problem would be an explicit recognition that the list was illustrative and non-exhaustive.

## **PART 11**

### **JOINT WORKING**

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

- 11.1 Of the 231 submissions which were received, 43 submissions expressed a view on the proposal that our statute should apply to those aged 18 and above. Of those consultees, 37 agreed with the proposal, 4 disagreed and 2 held an equivocal position.

#### ***Legal clarity***

- 11.2 Many consultees supported this proposal on the basis that it will promote legal clarity. For example, both ADASS and Carers UK agreed that the Children Act 1989 should be the principal, if not the only, mechanism for assessing the needs of children and young people up to the age of 17.
- 11.3 The Care Quality Commission argued that “improved legal clarity and a more flexible approach to assess and provide services to young people are needed”. They pointed to the inconsistency between different agencies as to when adolescence ends and young adulthood begins and strongly endorsed the “simple overarching definition of an adult being 18 or over” put forward in the proposal.

#### ***Effect on transition***

- 11.4 On the other hand, several consultees expressed concern about the effect that the proposal would have on transition from children’s services to adult social care. For example, the Hampshire Centre for Independent Living argued that treating different age groups differently “leads to differences in the services received and make for huge problems at *transition*”.<sup>1</sup> They stated that they are “not convinced that it is necessary to legislate separately for children and young people and adults” and suggested that the matter should be for practice rather than statute law.
- 11.5 Similarly, NAAPS argued that the problems of transition are “confounded by the cliff edge effect at the age of 18 and further by the shift of the children’s service from social services to education”. Thus they suggested “a completely separate legislative framework from 16 to 25 ... designed to help young people through transition from childhood to adult life”. This is necessary they suggest because:

Transition from childhood to adulthood is a continuous and variable process which happens over a long period of time and it is important that any legislation attached to this should be flexible enough to accommodate both those who are ready to move into adult services

<sup>1</sup> Emphasis in original.

at 16 or 17 and those that may need to remain with children's services beyond the age of 18

- 11.6 Furthermore, the Lincolnshire Partnership NHS Foundation Trust – while agreeing with the proposal – stated that it does not “specifically address the transition problems, which have been highlighted in case law”. They also added that the proposal “does not take into account capacity implications” and that this, “together with the change in social care staff and uncertainty can make transition fraught”.

### ***Preserving disabled children's rights***

- 11.7 Several consultees agreed that it is important to ensure that children did not lose their existing enforceable rights to services under the Chronically Sick and Disabled Persons Act 1970, and thus agreed that this statute should continue to apply to those under 18. For example, Enfield Disability Action highlighted that the duty under the 1970 Act is stronger because “the duty under section 2 of the 1970 Act is an enforceable duty but the duty under section 17 Children Act 1989 is a target duty”.
- 11.8 Other consultees went further and saw our review as an opportunity to simplify children's legislation. The London Borough of Havering, for example, argued that it would be appropriate to repeal the whole of the 1970 Act and to “reincorporate these provisions in an amended Children Act 1989”. Similarly, Anthony Collins Solicitors argued that it would be “better to amend the Children Act 1989 than retain the Chronically Sick and Disabled Persons Act 1970”.
- 11.9 The National Autistic Society, while supporting the proposal, questioned whether the proposed legislation would affect the funding responsibility for education from 18 onwards, including residential accommodation, because they argued that local authorities currently have a duty to provide education to people with learning difficulties to age 25.
- 11.10 The Law Society also suggested that “attention will also need be given to other legislation” which applies to children “such as services under the NHS Act 2006 Schedule 20 paragraph 3 (home help and laundry facilities)”.

### ***Other issues***

- 11.11 The Welsh Assembly Government agreed in principle but wanted to explore further with stakeholders whether it might cause bureaucratic delays or internal local authority disputes.

### ***Conclusion***

- 11.12 There was a predominantly affirmative response to the proposal that the future statute should apply to those aged 18 and above, and the Children Act 1989 (and the Chronically Sick and Disabled Persons Act 1970) should apply to those aged 17 and below. Many consultees highlighted that this would clarify the current position, and encourage consistency between different agencies. However, some concern was expressed that distinguishing between adults and children at the age of 18 is somewhat artificial and the statute needs to accommodate those who ought to remain in children's services for longer and those who need to move to adult services earlier.

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

- 11.13 Of the 231 submissions which were received, 52 submissions expressed a view on the proposal that local authorities should have a power to assess 16 and 17 year olds under our statute and young people aged 16 and 17 would have a right to request such an assessment. Of those consultees, 38 agreed with the proposal, 8 disagreed and 6 held an equivocal position.

### ***Transition planning***

- 11.14 Many consultees supported the proposal on the basis it would improve transition. Mencap, for example, highlighted that inadequate transitional planning can have “very serious consequences” for a young person’s health and well-being and argued that the proposal would go some way in improving the transition process. Moreover, the National Autistic Society argued that it would help to ensure “timely planning and care provision for the transition process”. The Welsh Assembly Government stated that the proposal “would seem to strike a balance between the aim of rationalising and clarifying the law and creating a link and a vehicle for transition”. The Government also stated that the proposal “reflects the need to improve transitional arrangements”.
- 11.15 Additionally, Nottingham City Council argued that the lack of clarity about existing transition arrangements has led to bureaucratic delay, internal disputes and judicial review challenges.
- 11.16 On the other hand, a minority of consultees argued that the proposal would not improve the transition from children’s services to adult services. For example, the Refugee Council argued that transferring 16 and 17 year olds to adult social care legislation “would fail to be in their best interests, both in terms of current levels of support, and the impact on Children Act leaving care services”. The Joseph Rowntree Foundation argued that our proposals could lead to young disabled people being forced to move out of residential accommodation because while policy for children “is moving in the direction of enabling children in care to remain in their placements longer”, policy for adults is moving in the opposite direction.
- 11.17 Furthermore, the Law Society expressed concern that the proposal adds to a currently complex legal situation and “may lead to confusion around responsibilities generally and for certain children’s needs falling to children’s services in particular”.

### ***A duty to assess young people***

- 11.18 A number of consultees supported the idea of assessing 16 and 17 year olds under our statute, but argued that the proposal should be strengthened to establish a duty rather than a power. For example, the Foundation for People with Learning Difficulties suggested that a duty is required because:

We remain very concerned about poor handling of the transition from children’s to adult services; some authorities leave it far too late to start planning with a young person and their family.

11.19 Similarly, the Law Society argued that:

From a policy perspective we believe it is justified to change the power to a duty and to prioritise resources to this age group which could be said to be especially vulnerable.

11.20 Furthermore, the Council for Disabled Children and the Transition Information Network argued that if local authorities refuse to assess this must only be for prescribed reasons and families should be told why and given information on other ways of meeting their needs.

11.21 Additionally, the Standing Commission on Carers suggested that if an assessment of a 16 or 17 year old is being carried out by adult social care there must be a duty on the relevant children's department to contribute to that assessment and that the young person (and his or her parents) should be given all relevant information.

### ***Encouraging autonomy***

11.22 The General Medical Council welcomed the proposal on the basis that:

It is important that young people should be enabled, through the legislation, to make decisions for themselves where they wish to do so and have the necessary maturity and understanding.

11.23 They suggested that problems often arise for service users and doctors because, in law, young people are presumed to be autonomous adults in some situations but not in others. For example:

In health care, young people of 16 and 17, or younger children, where they have sufficient maturity and understanding, are entitled to consent to, or to refuse, medical treatment. In contrast, the Children Act and other legislation defines as a child everyone under 18, and no direct provision is made for young people, who are developing capacity, to make decisions for themselves.

11.24 Scope argued that, as well as a right to request an assessment under adult legislation, young people should be given "the right not be assessed as adults if they do not wish to".

### ***Inter-agency working***

11.25 The Law Society argued that "many problems that arise upon the age of transition appear to stem from a lack of multi-agency cooperation" and suggested that "how the new legislation may assist in improving this situation should be addressed".

11.26 Furthermore, ADASS argued that the proposal:

risks moving away from joint approaches to the task of transition planning with clarity around lead roles and responsibilities to be found in council protocols, and risks duplication of pathways.

- 11.27 In addition, they argued that the proposal needs to include the transition to adult health care within the NHS and the transition responsibilities of the NHS. Alternatively, they suggested that:

Strengthening joint responsibilities for young people in this age group and for ensuring effective and appropriate transfers to adult social services, including for support of carers, may be more preferable and sustainable.

***Further clarification***

- 11.28 Several consultees stated that aspects of the proposal needed further clarification. For example, ADASS 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.
- 11.29 Furthermore, Carers UK and RNIB and Guide Dogs raised concerns about how the charging regime for services would operate under our proposals. In particular, they argued that local authorities are more likely to charge for services under community care legislation than for services provided to children, and therefore some young people may be affected adversely by our proposals.

***Opposition to the proposal***

- 11.30 ADASS argued that many of the issues relating to transition may be better tackled through guidance and that the proposal risks moving away from joint approaches to the task of transition planning.
- 11.31 Caerphilly County Borough Council opposed the proposals on three grounds:
- (1) the transition process at the age of 14 may be delayed on the basis that an assessment under adult social care legislation will be available;
  - (2) the majority of adult services do not cater for the needs of children; and
  - (3) potential overlap issues concerning safeguarding responsibilities and *variation orders* under the Children Act 1989.

***Alternative proposals for transition***

- 11.32 The Law Society put forward an alternative proposal to assist transition planning. First, they suggested that a duty should be placed on local authorities to assess young people when there is evidence that they lack capacity and this is likely to persist into adulthood, and the failure to assess would place them “at risk of harm or neglect, or where harm or neglect is already occurring”. They argued that this group is particularly vulnerable and therefore, both the law and resources should be focused on their needs during the transition from children’s to adults’ services. Second, where a disabled child is likely to need services beyond the age of 18, the local authority should be under a duty to assess them under adult social care legislation “at a reasonable time before they reach their eighteenth birthday”.

- 11.33 Alternatively, the National Youth Advocacy Service suggested that a duty should be placed on local authorities to “undertake full transition planning for vulnerable young people over 16”.
- 11.34 Mencap and the Wales Neurological Alliance suggested that those aged 14 years and over should be given the right to be assessed as adults.
- 11.35 NAAPS argued that consideration should be given for “a completely separate legislative framework from 16 to 25 which is designed to help young people through transition from childhood to adult life”.

### ***General comments***

- 11.36 Many consultees highlighted difficulties in the current transition process from children’s services to adult social care. For example, the National Autistic Society argued that the transition “is often problematic and unsatisfactory, leaving young people with a sense of being ‘dumped’”. The Joseph Rowntree Foundation argued that the transition to adulthood for young disabled people is:

characterised by poor liaison between different agencies and professionals in children and adult social work teams, a failure to involve young people in transition planning and a failure to cover the issues of most importance to them and their families (such as maintaining friendships and having a role within their family and community).

- 11.37 Mencap stated that:

Young people with a learning disability and their families are not being well supported in their transition to adulthood. Local authorities are failing to ensure every young person has a personalised transition plan.

- 11.38 Moreover, the Nottingham City Adult Safeguarding Partnership stated that “it is widely accepted that young adults in transition are particularly vulnerable to abuse”.

### ***Conclusion***

- 11.39 There was a predominantly positive response to our proposal that local authorities should have a power to assess 16 and 17 year olds under our proposed adult social care statute and young people aged 16 and 17 would have a right to request such an assessment. Some consultees argued that this proposal would provide the required flexibility to improve the transition process, as well as ensuring timely planning. On the other hand, there was concern that the proposal may add to an already complex legal situation, does not go far enough in obliging local authorities to plan appropriately for a transition, and fails to encourage inter-agency working.

**Provisional Proposal 11-3: We provisionally propose that the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 should be retained and amended so that they only apply to young carers.**

- 11.40 Of the 231 submissions which were received, 39 submissions expressed a view on the proposal that the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 should be retained and amended so that they only apply to young carers. Of those consultees, 26 agreed with the proposal, 9 disagreed and 4 held an equivocal position.

***Legal clarity and consistency***

- 11.41 Some consultees suggested that our proposal might promote legal clarity. For example, Learning Disability Wales stated that the proposal would help to “clarify and simplify when statutes relate to children or to adults and ... recognise the position of young carers”.
- 11.42 However, both the Law Society and Surrey County Council pointed out that under our proposals there would be a higher threshold for the provision of a young carer’s assessment, who would continue to be required to provide *substantial and regular care* and request an assessment, compared with our proposals for adult carers. Carers UK and Newcastle City Council emphasised that if the threshold for a carer’s assessment is lowered in the adult social care statute then this should be reflected in provisions for young carers.
- 11.43 Furthermore, some organisations, such as Carers UK for example, expressed concern about retaining these Acts as “rump legislation” giving different levels of entry and entitlement depending on age and the caring situation. Nottingham City Council, while supporting the proposals, had concerns about the need to cross reference different pieces of legislation when carrying out a carer’s assessment “when the purpose of this exercise is to reduce duplication and provide clarity”.

***The position of young carers***

- 11.44 There was some disagreement about how the law should cater for the needs of young carers. For example, Ann McDonald, a social care academic, argued that our proposal resulted in “unnecessary duality” and suggested that “young carers could be treated in the same way as any other carer”. However, where age appropriate services are required for the young carer, these needs could be met through a link to child in need provisions under the Children Act 1989.
- 11.45 The Princess Royal Trust for Carers and Crossroads Care argued that there would be a danger that young carers will be assessed increasingly under section 17 of the Children Act 1989, which in many cases will mean that young carers will not receive an assessment until their needs have deteriorated to the extent that they become *children in need*.



- 11.46 Taking the opposite view, RADAR and the National Centre for Independent Living opposed the proposals on the basis that children with caring responsibilities should be considered first and foremost as children and therefore entitled to support under the Children Act 1989. This in their view would ensure “that children should be children and not disadvantaged by having a disabled sibling or parent”.

***Joint working between adults’ and children’s services***

- 11.47 Other organisations suggested that our proposals should go further. In particular, the Children’s Society questioned whether the proposal would be necessary, and argued that if a child was “providing a substantial amount of care on a regular basis” then it is “time to look to adult social care to improve service provision to the users rather than offering a carer’s assessment to a child and so sustain the caring role”. They stated that:

Above all, any change in statute should be working towards a *significant decrease* in children in need assessments for young carers ... we will be failing in our responsibilities if a child becomes a “child in need” simply and only because of excessive and inappropriate caring responsibilities which is a direct result of lack of effective adult social care provision.<sup>2</sup>

- 11.48 They therefore suggested that:

the presence of a young carer should always constitute an appearance of need for the family and should *automatically trigger a community care assessment* of the person they care for ... a new adult social care statute would provide the perfect opportunity to introduce this as a trigger for assessment within a legislative framework.<sup>3</sup>

- 11.49 They further stated that a “*whole family pathway* or whole family assessment process is key and this process should be prescribed in regulations”.<sup>4</sup> On the other hand, they accepted that there may be a case for young carers aged 16 and 17 to continue to be eligible for a free-standing assessment which did not depend on the cared-for person being simultaneously assessed “if this is their informed choice and it is not impacting on their own well-being and personal development”.

- 11.50 Similarly, ADASS argued that where a child becomes or is likely to become a carer due to the unmet needs of their parent, there should be a duty to inform adult social care, for adult social care to undertake an assessment and for both authorities to work together to meet unmet community care needs.

<sup>2</sup> Emphasis in original.

<sup>3</sup> Emphasis in original.

<sup>4</sup> Emphasis in original.

- 11.51 Furthermore, Carers UK called for strengthened guidance to ensure that where there is a disabled parent, “the primary duty and response is with adult social services to *prevent* inappropriate caring responsibilities for children”.<sup>5</sup> The Hampshire Centre for Independent Living similarly argued that “society should *not* accept a situation where a young person is providing a substantial amount of care”.<sup>6</sup>

### ***Alternative proposals***

- 11.52 Some consultees put forward alternative proposals. The Wales Neurological Alliance suggested that:

A young carer who becomes a carer before the age of 18, should be treated as a young carer until they were 25, and their services would be defined by the Carers (Recognition and Services) Act 1995, Carers and Disabled Children Act 2000 and the Proposed Carers Strategies (Wales) Measure, whilst someone who became a carer after the age of 18, would be covered by the proposed Welsh statute.

- 11.53 Similarly, Scope suggested that a young carer who becomes a carer before the age of 18 should be treated as a young carer until they were 25 “because of the complexities of the situation and additional barriers they may face”.

### ***Conclusion***

- 11.54 There was a largely positive response to the proposal that the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 should be retained and amended so that they only apply to young carers. It was argued that this would clarify and simplify the law, whilst also preserving the rights of young carers under these two statutes. However, there was concern about the fragmentation that would result, as well as the fact that young carers would need to satisfy a higher threshold to qualify for an assessment.

<sup>5</sup> Emphasis in original.

<sup>6</sup> Emphasis in original.

**Provisional Proposal 11-4: We provisionally propose that parent carers should continue to be eligible for a carer’s assessment under the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000. We also propose that where a young person aged 16 and 17 is being assessed under our proposed adult social care statute, parent carers should also be given a carer’s assessment under this statute.**

11.55 Of the 231 submissions which were received, 36 submissions expressed a view on the proposal that parent carers should continue to be eligible for a carer’s assessment under the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000. Of those consultees, 29 agreed with the proposal, 4 disagreed and 3 held an equivocal position.

11.56 While the majority of consultees agreed with the proposal, many did not further elaborate on their reasons for agreeing. Therefore, this analysis will focus on the concerns of consultees who disagreed or had equivocal views.

***The need to consolidate children’s legislation***

11.57 Carers UK expressed concern that parent carers “would effectively be left with residual or ‘rump’ legislation covering their rights”. Also, while agreeing with the proposal, the London Borough of Havering argued that “it would be a lost opportunity if the current legislation were not simplified and brought into one consolidating piece of legislation”. They suggested that bringing it under the Children Act 1989 might be the appropriate.

11.58 Similarly, ADASS argued for an “integrated framework” and suggested that:

It would be more appropriate for the responsibility to assess needs of parent carers, other than those with adult social care needs, to be included within the Children Acts on the same basis as for adult carers or adults with social care needs under the proposed social care legislation. This would be consistent with responsibilities under that legislation and guidance to support and promote parenting capacity.

11.59 However, Carers UK expressed concern that parent carers are currently not being given appropriate recognition, and that consolidating the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 into the Children Act 1989 may perpetuate this problem:

Although any service can, effectively be provided, under the Children Act 1989, the total focus on the child often overlooks the needs of the parent which can also be very hard for the parent to articulate since [they] place their needs second.

### ***Legal clarity and consistency***

11.60 The Law Society highlighted that as a result of this proposal, parent carers would have to meet the higher threshold of the *regular* and *substantial* test, and argued that “having a more stringent test for certain groups of carers would need to be justified”. Similarly, the Care Quality Commission emphasised that “it will be crucial for the new statute to be truly equitable between different groups of carers across the system”.

11.61 Carers UK emphasised that:

There is an urgent need to ensure that parent’s rights to a life outside caring outside caring for their disabled child are also achieved and aligned with the rights of adults caring for adults.

### ***Assessing parent carers under the adult statute***

11.62 Caerphilly County Borough Council agreed with the first limb of the proposal, but disagreed with the second on the basis that local authorities should not have the power to assess 16 and 17 year olds under the adult social care statute, “as until the age of 18 they are not an adult”.

11.63 On the other hand, Carers UK agreed that if a disabled young person is assessed under adult community care legislation, then parents should be assessed under the equivalent parts. However, they pointed out that:

There should also be some recognition in the assessments that legally, the parent will still retain some legal parental responsibility for the young person until they are 18.

### ***Other concerns***

11.64 The Princess Royal Trust for Carers and Crossroads Care pointed to the need to have a consistent definition when referring to a *parent carer*. They pointed to the Job Centre definition as an example where the parent of a non-disabled child is labelled a *parent carer*.

### ***Conclusion***

11.65 There was a predominantly positive response to the proposal that parent carers should continue to be eligible for a carer’s assessment under the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000; and the proposal that where a young person aged 16 and 17 is being assessed under our proposed adult social care statute, parent carers should also be given a carer’s assessment under this statute. However, a number of consultees expressed concern 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 statute.

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

- 11.66 Of the 231 submissions which were received, 35 submissions provided comments on how the well-being power is being or should be used in practice.

***Meeting social care needs***

- 11.67 Several consultees, like the Welsh Assembly Government for example, highlighted that the well-being power is or should be used to meet the needs of people who fall below the eligibility threshold. Similarly, Lancashire County Council also stated that the well-being power does have a role in:

meeting lower level needs for the population as a whole and enabling individuals to maintain their independence without reliance on social care services.

- 11.68 Several consultees stated that the well-being power is useful in relation to enabling early intervention. For example, Parkinson's UK stated that the well-being power could be "used to establish preventative services ... or services that are innovative" and welcomed it as "enabling authorities to establish an ability to progress with projects and initiatives quickly".

- 11.69 NAAPS stated that they "strongly believed that the well-being power is one that should be retained". They argued that:

Provision of low key flexible preventative services (and their coordination) can do much to prevent or slow down the progress of the more vulnerable members of the community into more formal services.

***Meeting other community needs***

- 11.70 Several consultees highlighted ways in which the well-being power is or should be used in relation to needs that are not specifically covered by adult social care. For example, the Welsh Assembly Government highlight that, in implementing the Strategy for Older People in Wales, "Welsh local authorities have been using the well-being power innovatively but not as a basis for specifically providing adult social care".

- 11.71 Ann McDonald, a social care academic, stated that the well-being power is a "useful power to provide collective as opposed to individual services". Similarly, NAAPS argued that the well-being power is useful:

to fund new and innovative services such as local micro services and community initiatives is highly important in terms of achieving sustainable and healthy communities.

- 11.72 RADAR and the National Centre for Independent Living argued that a good use of the well-being power "would be to look holistically at the local community and bring together various funding streams that support individuals". They highlighted that:

People who need social care support do not live their lives in a vacuum. They have other needs that may be funded by other programmes such as housing, learning or employment support. Very often the need for social care support diminishes when all aspects of life opportunities are considered. The well-being power can do much to foster independent living which is not confined to how social care support is provided but is about a whole way of life.

- 11.73 Leonard Cheshire Disability argued that “disabled people are massively more likely to live in poverty than non-disabled people” and suggested that local authorities should “use their well-being power to better bring together services to challenge disability poverty and social exclusion in their local areas”.
- 11.74 Hertfordshire County Council provided three examples of how the well-being power is being used in practice: the first contact checklist; community agents; and health trainers. The first contact checklist is a multi-agency checklist for frontline staff and volunteers to access, through a single gateway, a range of preventive services. Community agents are paid staff supported by volunteers who provide face to face information and support to people over 50 and to other socially isolated and vulnerable adults in the locality. Finally, health trainers support individuals aged 50 plus to make informed choices regarding healthier lifestyle and behaviour changes.
- 11.75 Two other local authorities provided examples of how the well-being power is used. Coventry City Council stated that the well-being power is being used in a range of ways “to support the reduction of health inequalities in Coventry”. Sunderland City Council stated that the well-being power is currently used in the city “to give financial assistance to voluntary sector agencies. The grants must be used for specific projects and the outcomes for people are monitored”.
- 11.76 Carterfi Cymru suggested extending and strengthening the well-being power to:
- include a duty to engage in community development work related to the inclusion and integration of excluded or low status groups and the promotion of active citizenship.

***Limited use of the well-being power***

- 11.77 A number of local authorities, such as the Royal Borough of Kensington and Chelsea for example, stated that they rarely use the well-being power. Newcastle City Council stated that the well-being power is hardly ever used in the context of adult social care:
- We are aware that In Control proposed its use to overcome restrictions in direct payments regulations, but we chose not to pursue that avenue, as in our minds the current regulations are explicit and should not be avoided through legal sophistry.
- 11.78 Nottingham City Council stated that the well-being power is only used “in the setting of broad commissioning strategies priorities or in the governance and scrutiny of overall services”.

- 11.79 Wirral Metropolitan Borough Council stated that “the well-being power is currently under used and further guidance in relation to its application in the field of community care law would be appreciated”.
- 11.80 Similarly, Solicitors for the Elderly argued that the power is rarely used except where “the person has an advocate who is aware of its existence and asks for the power to be exercised in a particular case”.

#### ***Overlap between well-being power and adult social care law***

- 11.81 Several consultees, such as the Office of the Public Guardian for example, commented on the overlap between the well-being power and adult social care, although most went on to argue that neither can replace the other. For example, Lancashire County Council stated that they do not “consider that the well-being power should be used routinely to provide adult social care services”. The Welsh Assembly Government stated that they would prefer to have “a single and comprehensive adult social care statute” rather than providing adult social care through the well-being power:

We would strongly oppose any proposal to require the well-being power to be used for particular purposes (such as the provision of social care). That would undermine the whole purpose of the power, which is deliberately very broad and totally discretionary. It seems that the whole thrust of the consultation paper is about clarifying and codifying people’s universal entitlements to care. That would be rather at odds with securing their provision through a power which gives local authorities very wide discretion. If there is a need to expand or alter local authorities’ powers and duties as regards adult social care, then that needs to be addressed on its own terms.

- 11.82 The Care Quality Commission stated that it is a matter of debate “whether the well-being power could be developed as an alternative to adult social care law” but argued that “there are cogent reasons in favour of a single and comprehensive adult social care statute”. Similarly, Conwy County Borough Council argued that the well-being power is “too wide and vague, could lead to confusion and also has resource implications”.
- 11.83 On the other hand, Age UK argued that the well-being power should be used as a “means to discharge duties imposed by community care legislation but not as a means to circumvent such legislation”.

#### ***Other issues***

- 11.84 In relation to charging for well-being services, the Welsh Assembly Government argued that the well-being power:

can’t be used if the primary purpose is to raise money (e.g. to set a local sales tax). If the money raised is ancillary to a service provided under the well-being power (e.g. an entry fee) then there’s no problem.

- 11.85 However, they acknowledged that “the well-being power probably couldn’t be used to introduce charges for ‘core’ social care services”.

### ***Conclusion***

- 11.86 Most consultees indicated that the well-being power is useful and should be retained. They highlighted that it has been used to meet social care needs that fall below the eligibility threshold, as well as allowing for early intervention to prevent needs from reaching a critical level. Some consultees highlighted that the well-being power is or should be used to meet other needs that are not specifically fall within adult social care. On the other hand, a number of consultees stated that it is rarely used, especially in the context of adult social care. Furthermore, several consultees argued that, while there is overlap between the well-being power and adult social care, the latter is best dealt with under a single and comprehensive adult social care statute.



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

***Introduction***

- 11.87 Of the 231 submissions which were received, 42 submissions expressed a view on the proposal that the delayed discharge provisions should be retained in their existing form in our statute. Of those consultees, 25 agreed with the proposal, 7 disagreed and 10 held an equivocal position.

***Retaining the current provisions***

- 11.88 The majority of consultees agreed with the proposal, including the Government, the Welsh Assembly Government and the vast majority of local authorities. For example, Surrey County Council considered that the:

law on hospital discharges needs to be retained and possibly strengthened to ensure good practice is consistent across all hospitals.

- 11.89 Furthermore, the Royal College of Physicians of Edinburgh argued that “from a health service point of view, this proposal is important as it retains provisions whereby social services are charged for delayed discharges”.

- 11.90 Those consultees who disagreed with our proposal did so mostly on the basis that they did not support the delayed discharge provisions. For example, Belinda Schwehr, an independent legal and training consultant, disagreed with the approach of imposing a penalty for non-performance of a statutory duty and argued that a better alternative would be to apply general public law principles about the obligation to discharge all duties within a reasonable time.

- 11.91 Similarly, Conwy County Borough Council argued that “fines being imposed in this economic climate [are] impractical, leading to health being protected whilst local authority social service departments are facing cuts”.

***Negative consequences of the delayed discharge procedures***

- 11.92 Several consultees expressed concern over the consequences of the delayed discharge provisions. For example, the Law Society – while agreeing with the proposal – stated that “the issue of the increase in emergency re-admissions should be addressed”.

- 11.93 Similarly, Age UK expressed concern that the delayed discharge provisions “might have resulted in increased emergency re-admissions”. They explained that pressure on hospitals to discharge older patients as quickly as possible “makes it difficult for older people to make decision about their future based on consideration of different options and adequate information”. They stated that although there are ways to alleviate these problems, for example, through adequate transitional arrangements:

in practice the very tight timescales involved provide an incentive for local authorities to take the simplest course of action, which in many cases will be removing someone to a care home. In extreme cases

we have encountered examples of abuse involving older people being moved to care homes against their wishes.

- 11.94 Solicitors for the Elderly – while agreeing with the proposal – suggested that the procedures can lead to a lack of choice in practice for service users arguing that:

Patients are often being told they have to leave hospital and that the patient has to go to a particular nursing home without the patient exercising any real choice or exploring alternatives. This was clearly not the legislative intention of the [Community Care (Delayed Discharges etc) Act 2003] but is another example of the problems of looking at a problem outside the context of a resource stretched service unable to meet targets for discharge at the same time as providing choice to the patient.

- 11.95 They suggested that patients should “be better informed in the future” about circumstances in which the delayed discharge procedures are used.

- 11.96 Similarly – while agreeing with the proposal – the Practitioners’ Alliance Against the Abuse of Vulnerable Adults warned that one effect of the delayed discharge provisions is “harassment of family members to agree to arrangements that are not entirely suitable because they are presented as the only option”.

- 11.97 On the other hand, RADAR and the National Centre for Independent Living disagreed with the proposal and considered that there was a “genuine need to revise the delayed discharge provisions” because “the provisions can place local authorities in an impossible position in meeting the support needs of people who really should remain in hospital”.

- 11.98 The English Community Care Association stated that Primary Care Trusts often prefer to defer the assessment of care needs until the individual has settled into the home, which “is potentially disruptive on a number of levels for both the resident and the home”.

***The need to update the delayed discharge provisions***

- 11.99 A number of consultees, including the Government, pointed to recent developments in delayed discharge policy and the need to ensure that our statute reflected these developments. For example, Carers UK and the Standing Commission on Carers argued that the provisions will need to be updated in light of the new Government’s policy that health bodies would bear greater responsibilities for re-admission within 30 days of discharge.<sup>7</sup> Similarly, ADASS supported the proposal but argued that “recent proposed changes in responsibilities” are taken into account.

<sup>7</sup> The Delayed Discharge (Continuing Care) Directions 2009 (for hospital discharge situations) and the NHS Continuing Healthcare (Responsibilities) Directions 2009.

### ***The need for a review***

- 11.100 A small number of consultees argued that the delayed discharge provisions should be reviewed. For example, Citizens Advice stated that they are “concerned about the huge burden placed on local authorities currently and consider that there should be a review of the delayed discharge provisions”. Similarly, the Care Quality Commission stated that “any steps to refine or simplify delayed discharge arrangements, or alternative models, would be welcome”.
- 11.101 The English Community Care Association suggested a wider review, arguing that hospital discharge procedure should not only be considered in the context of delayed discharge, but also in the context of continuing healthcare.
- 11.102 A number of consultees pointed to the need to have greater inter-agency co-operation in making the decision to discharge a patient from hospital. For example, RNIB and Guide Dogs argued that in their experience hospitals are “frequently insistent that a patient is discharged and there is often no multi-disciplinary element to the discharge decision”. Rather, “social services are expected to make the necessary arrangements”. They suggested that one of the consequences is that social services:
- simply decide to reinstate a person's previous care package (which is insufficient and may have led to the admission in the first place) and patients and their relatives are left in the unenviable position of having to insist that they remain in hospital pending a proper assessment even though they clearly just want to go home.
- 11.103 Consequently, they argued that the delayed discharge provisions should: reinforce the “multi-disciplinary requirements of the decision” and also require “authorities to give full consideration to the package of care that is necessary to enable a person to return home safely”.
- 11.104 Similarly, Enfield Disability Action suggested they had seen cases “where the persons have been discharged to the community without ensuring that a need for community care services is met”. They argued that “it should not be open to an NHS body to act unilaterally in this way and restrict itself to identifying the patient’s responsible social services authority” and therefore suggested the delayed discharge provisions should be amended “to ensure that both the NHS and the social services authority must agree a safe discharge within an agreed time scale”.
- 11.105 ADASS suggested that the structure of the delayed discharge provisions needs “more recognition of the social care/health interface” because “it is not always easy to define a social care need [versus] health care need and more regulation means less room for discretion”.

### ***Extension to other groups***

- 11.106 A number of consultees commented on the exclusion of mental health patients from the delayed discharge procedures. For example, Lincolnshire Partnership NHS Foundation Trust argued that current arrangements on discharge from mental health hospitals should be addressed in the delayed discharge provisions “so as to align with principles of independence and choice”. Similarly, the Royal College of Psychiatrists argued that the exclusion of mental health facilities from the delayed discharge provisions has “significant negative repercussions for inpatients in acute mental health care”. They highlighted that a delayed discharge means that individual mental health patients are “inappropriately living in a hospital facility instead of in the community with the risks of social exclusion, institutionalisation, and marginalisation”.
- 11.107 On the other hand, Newcastle City Council argued that “it is essential to maintain the current mental health exemption from the provisions”. They also suggested that the provisions should be expanded so that self-funders were included, “thereby allowing them to enjoy the same benefits of a fast and structured discharge”.

### ***Rights of carers***

- 11.108 Carers UK stated that “it is vital that cares are assessed prior to discharge and these protections are clearly retained within the statute”. Similarly, the Standing Commission on Carers argued that “it is vital that carers’ engagement and rights are recognised within the new statute”. They recommended the procedures set out in the *Memorandum of Understanding on Hospital Discharge* as a framework for good practice which offers “local flexibility; is not overly prescriptive, but avoids the current concerns about inappropriate levels of care being placed on some carers”.<sup>8</sup>

### ***Disputes***

- 11.109 Age UK and Age Cymru pointed to a gap in the law regarding “what happens if the NHS discharges a patient but they refuse to leave”. Age UK argued that patients may refuse to leave “because they believe the care that the local authority has offered is inadequate or unsafe” and commented that:

Whilst it is not for this statute to address this gap we recommend that it should ensure that there is an adequate mechanism for resolving disputes ... [which] should recognise the right of people with care needs to refuse services provided their refusal is not unreasonable.

- 11.110 Age UK also suggested that some of the problems highlighted do not relate directly to the Community Care (Delayed Discharges etc) Act 2003 but to the fact that the original statutory guidance on hospital discharge was replaced with non-statutory practice guidance. They therefore recommended that our statute should require the Secretary of State to publish statutory guidance on hospital discharge.

<sup>8</sup> ADASS, *Memorandum of Understanding, Carers as Partners in Hospital Discharge: a Review*, ADASS (2010).

### ***Conclusion***

- 11.111 There was a largely positive response to the proposal that the delayed discharge provisions should be retained in their existing form in our statute. However, some consultees suggested that they should be amended to facilitate more co-operation between the NHS and the relevant local authority. There was also concern that the tight timescales resulted in the local authority not carrying out a thorough assessment and also not offering the patient an appropriate choice in what care they will receive.

**Question 11-2: We welcome comments about whether prisons should be included or excluded from adult social care.**

- 11.112 Of the 231 submissions which were received, 60 submissions expressed a view on whether prisons should be included or excluded from adult social care. Of those consultees, 31 argued that prisons should be included in adult social care, 17 argued that prisons should be excluded, whilst 12 held equivocal positions.
- 11.113 All the consultees that are concerned mainly with prisoners, namely, the Prisoners' Advice Service, HM Inspectorate of Prisons, Health in Justice, the Older Prisoner's Action Group, and the Howard League for Penal Reform, agreed that prisons should be included in adult social care. Out of the 14 local authorities who expressed an opinion, 10 argued that prisons should be excluded.

***The significance of social care needs in prisons***

- 11.114 Some consultees highlighted the importance of clarity on this issue, on the basis that prisoners may be particularly vulnerable. For example, the Howard League for Penal Reform argued that prisoners "are some of Britain's most vulnerable people". They stated that 32% of those in prison suffer from two or more mental disorders; 7% of men and 14% of women in prison suffer from a psychotic disorder; and 66% of male and 55% of female prisoners have a drug problem. They went on to consider that:

Social welfare is designed to provide a safety net for those most in need. Social welfare cannot be said to function if it excludes the most vulnerable in our society. A large percentage of this vulnerable population are in the prison system and we should be cautious about anything that allows the state to break the connection between social welfare and a large group in need of support.

- 11.115 Similarly, the Royal College of Psychiatrists argued that "prison populations are full of individuals with significant social care needs, relating to their offending behaviour or arising from their term in prison".

***The legal framework for adult social care in prison***

- 11.116 Several consultees argued that the current legal framework for adult social care in prison requires clarification. For example, the Government highlighted that "the provision of social care in prison is a complex area" and that "the law is currently unclear where responsibility lies". The Welsh Assembly Government also agreed that clarification is required, and argued, in accordance with the findings of HM Inspectorate of Prisons, that "in the absence of clarity the reality is that prisoners can be excluded from social care provision by default". The National Aids Trust argued that "it is currently unclear how the adult social care legal framework accounts for prisoners", and welcomed "greater clarity on this and best practice guidance about how prisoners' social care needs are met".
- 11.117 Similarly, the Care Quality Commission argued that a "firm policy decision is needed about the responsibilities councils have with regard to social care in prisons" and noted that:

Meeting the healthcare needs of people in prison settings has benefited from a clear and unequivocal policy position whereby there is an entitlement to equivalent NHS provision as available outside the prison system. Offenders who have social care needs cannot point to an equivalent expectation in relation to their social care needs.

- 11.118 Age UK also argued that “in practice, the limited reference to prisoners made by existing legislation has led to very limited in-prison provision of social care”. They therefore recommended that “in future, legislation should outline this commitment on the part of local authority adult care services specifically and clearly”.
- 11.119 The Howard League for Penal Reform argued that it would be illegal to exclude prisons from adult social care. They pointed to case-law, legislation and guidance to support this view. For example, they highlighted that Prison Service Order 2300 – which they argued provides mandatory instructions and long-term policy guidance to governors and staff – mentions the necessity of a community care assessment for disabled and elderly prisoners. They also argued that any attempt to exclude prisons from adult social care would “breach a number of legislative obligations under the various anti-discrimination legislation”, as well as the Equality Act 2010.
- 11.120 Similarly, RNIB and Guide Dogs stated that:

If prisoners are covered by the Disability Discrimination Act 1995 and the Human Rights Act 1998 then it would be anomalous for them not to be covered by any future social care statute. By providing prisoners with services under the community care legislation, authorities also meet their [duties under the Acts].

***The importance of including prisons in adult social care***

- 11.121 Some consultees highlighted the importance of including prisons in adult social care on the basis that the mere fact of being a prisoner should not exclude them from such basic rights. For example, Ann McDonald, a social care academic, argued that prisoners should be included “as recognition of citizenship”. Similarly, the Prisoners’ Advice Service argued that “social care services are not a privilege but engage fundamental rights which are not circumscribed by the fact of a custodial sentence”. The Howard League for Penal Reform also strongly endorsed that prisoners should continue to be included in adult social care:
- It is dangerous to treat prisoners as a separate group for the purpose of social care. It will further marginalise people who require social care support to prevent them from returning to prison.
- 11.122 Furthermore, RADAR and the National Centre for Independent Living argued that it is “a matter of equality and human rights” that prisoners have access to social care, and “a disabled prisoner should not be subject to more degrading treatment than other prisoners by virtue of not having their support needs recognised”. Similarly, the Spinal Injuries Association argued that “by excluding prisoners from social care they would be additionally punished as they would no longer be able to function on the same level as their peers”.
- 11.123 The Law Society highlighted that:

There is a considerable growth in the number of older prisoners and it seems right that they should be able to access the same services as non-prisoners to meet their needs.

11.124 The Prisoners' Advice Service argued that prisoners should remain included in adult social care and that this position should be made explicit in future legislation. They provided three reasons as follows:

- (1) the duty on the Prison Service under the Disability Discrimination Act 1995 to provide reasonable adjustments and care services to prisoners does not place a sufficiently explicit and effective positive obligation upon prisons to assess and provide for prisoners care needs, particularly as the Prison Service does not have the expertise in social care required to undertake assessments and care-planning;
- (2) the principle which underpinned the decision to transfer responsibility for the provision of prison healthcare services from the Prison Service to the Department of Health – that prisoners are entitled to have access to health services of the same range and quality as the general public receives in the community – applies to social care services. Placing responsibility for assessing and providing social care to prisoners with the Prison Service would run counter to the lesson learnt in relation to health; and
- (3) the purpose of section 47 of the NHS and Community Care Act 1990 is to ensure that there is a single gateway assessment process for access to care services. An arrangement that imposed a duty upon the Prison Service to conduct prisoner care assessments would undermine the purpose of section 47, add unnecessary complexity to the adult social care system, and deny prisoners the benefit of the extensive case law in the community care field.

11.125 HM Inspectorate of Prisons argued that it is important for local authorities to be involved in providing social care for prisoners, for various reasons. First, they stated that, for disabled and elderly prisoners, reasonable adjustments, such as motorised wheelchairs, could be difficult to achieve where they are not funded through “planned expenditure from local authority budgets following assessment”. Second, they stated that their thematic review found that “few prisons put in place care plans for prisoners with a disability or older prisoners”. Furthermore, they described instances where assistance with social care is simply not provided, such as an example of a prisoner who had not had a shower for over a year, or where prisoners with mobility problems have been located upstairs or being given a top bunk.

11.126 Furthermore, the Lincolnshire Partnership NHS Foundation Trust argued that prisons “should be included particularly in the context of the Care Programme Approach and section 117 [of the Mental Health Act]”.



### ***Service provision by prison and health authorities***

11.127 On the other hand, several consultees, while not necessarily discounting a role for social services, argued that the Prison Service or health authorities should take the lead in providing services to prisoners with social care needs. For example, Health in Justice stated that:

In practice, the maintenance responsibilities for social care may in many cases be assumed by the prison (acting under its duty of care through Prison Service Orders) and/or by the Primary Care Trusts through its responsibilities for meeting health needs. The local authority role would then become a form of backstop, as well as ensuring overall that the provision of social care was being properly addressed.

11.128 Similarly, the Howard League for Penal Reform argued that:

The Prison Service has primary duties towards vulnerable prisoners, under the Prison Act 1952, the Prison and Young Offenders Institute Rules, and under distinct legislation such as the Disability Discrimination Act 1995.

11.129 However, they argued that “there should not be a limit on a prisoner’s access to adult social welfare support when it is needed”.

11.130 Similarly, Belinda Schwehr, a legal and training consultant, drew an analogy between the prison regime and continuing care:

It should not be possible that the well-being of people in the hands of the state can ever get to the point where eligibility for social care is triggered, and the primacy of the prison service’s responsibility should be underlined with prohibitions which extend to services provided under duties or powers in prisons legislation.

11.131 Alternatively, Nottingham City Council argued that “health rather than social care should lead in prisons”. Conversely, HM Inspectorate of Prisons argued that “often ... reliance on social care needs being met by healthcare staff means that prisoners are unnecessarily located in healthcare with restricted access to the regime”. The Prisoners’ Advice Service provided a case example of a prisoner who developed mobility problems as a result of a stroke being located in the prison healthcare unit, despite having no ongoing clinical needs, because there was no care support available within the prison. They stated that “the restricted and isolated regime within the healthcare unit deepened the depression he was experiencing following the stroke”.

11.132 The Howard League for Penal Reform noted that an “integrated model of care is not generally available to older people in prisons”. They noted the findings of a 2008 report by HM Prisons Inspectorate which had found little evidence of “multi-disciplinary working” and had expressed disappointment “that the social care needs of older and disabled prisoners were still considered the responsibility of health services only”.<sup>9</sup> They suggested that removing social care from adult prisoners “will make appropriate care as regards elderly prisoners more difficult”.

### ***Carer-prisoners***

11.133 HM Inspectorate of Prisons, Health in Justice and the Prisoners’ Advice Service argued that carer-prisoners should be equally included within adult social care. HM Inspectorate of Prisons stated that, in their experience:

Local authorities are not usually engaged in assessing or care planning for the needs of prisoners or of the carer-prisoners who may assist them. In the case of the latter often prisoners fill the role of carer without adequate safeguards being considered.

11.134 Health in Justice argued that offenders should benefit from measures which apply to the wider community such as “entitlements to assessments, including for offenders acting as carers”.

11.135 The Prisoners’ Advice Service argued that:

There is a need for explicit recognition in statutory guidance that prisoners retain the full rights of carers in the community, to the extent that they are relevant in the prison context.

11.136 Moreover, the Prisoners’ Advice Service emphasised that the relevant authority must not assume that prisoner-carers are willing to continue caring, because:

Many prisoners find themselves in the position of caring for fellow prisoners, such as cell mates, that they may barely know as a result of a compassionate response to their fellow prisoner’s otherwise neglected need for assistance, rather than by true choice.

11.137 They therefore suggested:

A duty to ensure that prisoner-carers only provide services which would otherwise be provided by local authorities under community care legislation or the prison under the Disability Discrimination Act 1995, where they have provided their express consent to do so.

<sup>9</sup> HM Chief Inspector of Prisons for England and Wales (2008) ‘Older Prisoners in England and Wales: A follow up to the 2004 thematic review’ London HMIP

11.138 The Prisoners' Advice Service highlighted the position of prisoner-carers through a case example where a carer-prisoner asked to defer his own categorisation review so that he could remain at the prison to care for a fellow prisoner for whom there was no care support available. The prison agreed to this "despite the fact that [the carer-prisoner] was expected to gain a transfer to open conditions as a result of the review, and deferral would therefore be detrimental to his preparations for release".

11.139 Finally, the Prisoners' Advice Service argued that the prisoner who is being cared for "should have the right to choose that care professionals should provide for their care needs rather than a fellow prisoner" because:

Carer-prisoners are part of their enforced and confined community, and – in addition to issues regarding training and risk of harm to both parties – obvious concerns regarding confidentiality and dignity may arise.

### ***Practice difficulties***

11.140 Health in Justice argued that the law "may well be adequate in theory for the meeting of needs but it is in the implementation that problems arise". They argued that clarification of respective responsibilities between HM Prison Service and local authorities under the law is required "so that arrangements are made that are both effective and practical". HM Inspectorate of Prisons agreed that:

While the law may be adequate, the implementation of adult social care in prisons is being undermined – we regard it as deficient – and this requires clarification at policy level.

11.141 They highlighted some of the practice difficulties that may arise, including that:

prison staff may not fully appreciate the duties placed upon local authorities; prisoners are disinclined to be involved in protracted and intrusive assessment processes with social services.

11.142 The Prisoners' Advice Service referred particularly to the duty on prison, probation and healthcare workers to refer prisoners to a community care assessment under section 47 of the NHS and Community Care Act 1990. They noted that the guidance in this area is "scant" and "vague", and that it does not make any reference to the duty to refer prisoners who are in need of care services during their custodial sentence for a section 47 assessment. They argued that lay officers "can generally be assumed to have no knowledge of the operation of section 47 of the National Health Service and Community Care Act 1990". Therefore they suggested that there is a need for clear guidance or training, as well as suggesting that "clearly identified role holders should take responsibility for making referrals". They names seconded and home probation officers, prison Disability Liaison Officers, and prison Healthcare Managers as possible candidates for the role.

11.143 Some consultees pointed to difficulties with the types of services that can be provided to prisoners. For example, Havering London Borough Council argued that prisons “seem to fall into a different category given the totally different regime”. They argued that holiday breaks, for example, would be “completely inappropriate for people in custody”. Similarly, the Prisoners’ Advice Service highlighted that self-assessment and direct payments are not suitable in the prison context, because of factors including:

prison service control over service provision arrangements; restrictions in the management of prisoners’ personal finances; barriers to researching service provision options; and the problems faced by vulnerable, disabled and potentially illiterate prisoners in exercising informed choice over service provision.

11.144 Similarly, Belinda Schwehr expressed concern that arrangements such as direct payments for prisoners would “likely undermine the reward or work schemes operating in many prisons” and could place vulnerable prisoners who are in receipt of direct payments “at greater risk within the prison population”.

11.145 On the other hand, RADAR and the National Centre for Independent Living argued that, as long as care provisions meet the needs of the individual, “it may be appropriate that care is provided without the same degree of choice and control afforded to people in the community”.

#### ***Resource implications***

11.146 Several consultees expressed concern about the resource implications of including prisons within adult social care. For example, Belinda Schwehr argued that including prisons in adult social care would “place an unnecessary burden on local authorities and add unnecessary duplication of provision”.

11.147 Moreover, the Welsh Assembly Government argued that “including prisoners within adult social care will have resource and delivery implications for local authorities which we would need to explore further”.

11.148 Similarly, the Blackburn with Darwen, Blackpool and Lancashire Safeguarding Adult Boards – while acknowledging “the strong case for this extension of responsibility” – expressed great concern about resource implications if prisons were included within adult social care. They stated that “in Lancashire there are currently 20,000 people in prison, an unknown proportion of whom have social care needs”. In addition, “given the acknowledged existence of abuse within the prison system, adult safeguarding could arguably be overwhelmed with referrals”. Consequently, they suggested there is “arguably an issue concerning the sharing and equalisation of resources”. For example, if implemented, “a possible basis for funding could be the previous residence of an individual prisoner”.

11.149 The London Borough of Camden, argued that prisons should be excluded from adult social care because:

Given the 24 hour containment of prisoners, and the fact that they are located in specific geographical areas, it would place an undue pressure on the relevant local authorities to provide the appropriate

social care for the inmates, unless appropriate resourcing was made available to them to carry out this function.

### ***Eligibility criteria***

- 11.150 The HM Inspectorate of Prisons noted that eligibility criteria had not been developed with prisoners in mind. Similarly, The Older Prisoners' Action Group argued that "eligibility criteria have to be viewed slightly differently within prison as opposed to planning for release". They highlighted that the nature of needs within a prison are different to what they may be outside:

The work on the Isle of Wight and in Staffordshire suggests that it is areas of personal care, such as an inability to wash or bathe oneself, that are the critical areas of need.

- 11.151 The Prisoners' Advice Service also expressed concern that "local authority eligibility criteria may be framed inappropriately for the purpose of assessing prisoners in custody" but stated that there is "no obvious solution". They suggested that:

Eligibility concerns could, however, be mitigated by the Disability Discrimination Act 1995 which, in our view, would place a duty on the Prison Service to provide for needs identified during a section 47 assessment [under the National Health Service and Community Care Act 1990], which do not meet a local authority eligibility threshold. Indeed, this is another reason why it is essential that the section 47 duty continues to apply to prisoners in custody.

### ***Ordinary residence***

- 11.152 Several consultees highlighted the issue of ordinary residence as an area requiring further consideration. For example, the Older Prisoners' Action Group argued that ordinary residence "is clearly an obstacle to taking this agenda forward for many prisoners". Similarly, Health in Justice argued that "the overwhelming reason" for the lack of consistency and fairness in offenders' entitlement to adult social care is that "in practice it is not clear which local authority is responsible for the care of offenders in prison and this often leads to a void".

- 11.153 The HM Inspectorate of Prisons argued that ordinary residence was not designed with prisoners in mind, and prisoners may not wish to or be unable to return to their pre-imprisonment places of residence. It noted that this

may lead to disputes over obligations for funding between local authorities as ordinary residence and eligibility criteria are open to a number of potential interpretations.

- 11.154 The Prisoners' Advice Service also pointed to the additional practical difficulties for prisoners, in comparison to those living in the community, in seeking to establish ordinary residence status:

Finding appropriate legal representation can be very difficult, particularly for vulnerable and disabled prisoners; a high proportion of

prisoners have learning disabilities and/or poor literacy; prisoners often have little if any domestic documentation upon them within prison to help to establish their former ordinary residence status; they may have little or no support on the outside, particularly if they are a long term prisoner.

11.155 Health in Justice expressed the view that:

It makes practical sense to align this with the responsibilities of commissioning Primary Care Trusts. This would mean that social care services in prisons would be commissioned by the local authority with social care powers for that geographical area.

11.156 Similarly, the Disability Law Service considered that “the local authority where the prison is located, should have responsibility for organising services for prisoners in their area”.

11.157 On the other hand, Solicitors for the Elderly argued that:

Like hospital admission, a prisoner’s place of ordinary residence should be where they last resided before they were taken into custody; and only if they were homeless should their place of ordinary residence be where the prison is situated. Not only does this provide parity but also it may encourage more preventative work being carried out by social services and health at a local level.

11.158 The Prisoners’ Advice Service argued that where ordinary residence cannot be established in the pre-custody home area, “the prisoner should be found to be ordinarily resident in the local authority in which the prison is located”. This would mean that the prisoner would be “entitled to services from that authority on the same basis as non-prisoner residents”.

11.159 Both the Older Prisoners’ Action Group and the Prisoners’ Advice Service argued that there should at least be a duty on the local authority a duty to carry out an assessment where it has a power to provide services.

11.160 In relation to prisoners who are due for release from prison and were not ordinarily resident in any area prior to being sentenced, and do not have a permanent place to live on release, Prisoners’ Advice Service argued that:

Given the vulnerability of prisoners in need of social care services leaving prison, and the public interest in prisoners having a home and appropriate care support services upon release due to the evidence that this reduces their risk of reoffending, it is our view that the responsible local authority should have a duty [rather than a power] to provide to all prisoners who fall within [these] circumstances.

11.161 Similarly, in the case of a prisoner who is moving to a new authority area on release under the supervision of probation, the Prisoners’ Advice Service argued that:

The local authority for the probation area in which they will be living on release should be under a clearly specified duty to provide social care services for that prisoner.

- 11.162 More generally, the Care Quality Commission argued that portability should be the key principle in tackling the issue of residence. Furthermore, they argued that “there is a risk that ‘host’ local councils will assume disproportionate burdens, which need to be recognised in resource settlements”. Therefore, they stated that “there will be a need for clear assignment of responsibilities between respective local councils – those ‘hosting’ prisons and those in which individuals habitually live”.
- 11.163 The Vale of Glamorgan Older People’s Strategy Forum argued that there may be a need for “enhanced co-operation between two social services authorities”, because “many prisoners may be accommodated long distances from their place of ordinary residence”.
- 11.164 The Care Quality Commission argued that the inclusion of prisons further illustrates why it is problematic to place the responsibility for carers’ services on the local council where the cared-for person lives.

***Social care needs upon release from prison***

- 11.165 Many consultees highlighted social care needs upon release from prison as a pertinent issue. For example, HM Inspectorate of Prisons highlighted “resettlement as a key concern” for older and disabled prisoners, “in particular the need to identify and meet social care needs of these vulnerable groups on release”. They argued that in their thematic review in 2008, they found that the needs of older prisoners were not being adequately considered prior to release, and that “in many cases local authority’s community services will not accept that they have a responsibility to provide social care for prisoners returning to their area”.
- 11.166 Additionally, the Howard League for Legal Reform highlighted resettlement as a particularly significant issue for young adults. They cited high reconviction rates – 74.8% of those released from prison in 2004 were reconvicted within two years of release – as mostly resulting from the “lack of suitable support and accommodation available and provided for these young people”. They argued that the cases of young people that they represent “demonstrate the necessity for *more* co-ordinated work between the Prison Service and social services, rather than less”.<sup>10</sup>
- 11.167 Similarly, the Royal College of Psychiatrists argued that “preparation for rehabilitation in the community would be improved if they had equal access to social care while in prison”.
- 11.168 Age UK suggested argued that “the transfer of duty of care between local authorities when a prisoner is returned to a community away from the prison presents challenges”, and suggested that:

<sup>10</sup> Emphasis in original.

There should be clear duties upon both prison authorities to notify a receiving local authority about a forthcoming move of this kind, upon the original local authority to transfer records as appropriate, and upon the receiving local authority to carry out an assessment of needs immediately upon notification.

- 11.169 The Vale of Glamorgan Older Peoples Strategy Forum argued that the following changes could be considered to achieve better coordination:

enabling assessments to be made whilst a person is in prison and applying normal eligibility criteria at the point of discharge. It is known that more prisoners are older now and who may well have social care needs on release from prison.

- 11.170 On the other hand, Lancashire County Council disagreed that prisons should be included within adult social care, but suggested that “there should be a duty for the Prison Service to share information with the relevant local authority prior to discharge”.

- 11.171 Similarly, Gateshead Council argued that rather than including prisons in adult social care, there should be “a duty to cooperate to ensure appropriate planning for discharged prisoners with community care needs”. Belinda Schwehr suggested that needs that are specific to prisoners – such as “when they come out of prison with mental health and other independent living issues” – should be “explicitly covered in any social care guidance accompanying the new legislation”.

#### ***Other issues***

- 11.172 The Care Quality Commission and the Law Society argued that prisons are currently excluded from the Care Quality Commission’s regulatory remit, and that this may require amendment. Similarly, the Health in Justice noted that particular attention should be given to ensuring that offenders benefit from and are protected by measures which apply to the wider community including, amongst other things, inspection of social care functions.

- 11.173 The Prisoners’ Advice Service argued that if Parliament determines that there is a dual responsibility for both the Prison Service and local authorities to provide social services, then:

There is a need for a dispute resolution procedure comparable to the referral of ordinary disputes between local authorities to the Secretary of State for determination.

- 11.174 However, they emphasised that, as with local authority ordinary residence disputes, “it should be made clear that where a determination is sought, the provision of services ... should not be delayed as a result”.



### ***Conclusion***

- 11.175 The majority of consultees argued that prisons should be included within adult social care. Some consultees stated this as a point of principle, that prisoners should be entitled to the same social care as other members of the community. Some consultees highlighted the current deficiencies in meeting the social care needs of prisoners, and argued that the express inclusion of prisons within adult social care, and providing clear duties and responsibilities, is essential to meeting these needs. On the other hand, several consultees highlighted concern over resource implications, especially for local authorities “hosting” the prisons, emphasising the risk of placing a disproportionate burden on them.

**Provisional Proposal 11-6: We provisionally propose that the choice of accommodation directions should cover residential accommodation provided under section 117 of the Mental Health Act 1983.**

11.176 Of the 231 submissions which were received, 42 submissions expressed a view on the proposal that the choice of accommodation directions should cover residential accommodation provided under section 117 of the Mental Health Act 1983. Of those consultees, 34 agreed with the proposal, 1 disagreed and 7 held an equivocal position.

***Equal treatment of different service users***

11.177 Many consultees suggested that there was no reason why section 117 service users should be treated any differently to other service users. For example, the Local Government Association stated “it is not at all clear why people placed under section 117 should not have the same opportunities as others to exercise choice”. Similarly, ADASS stated that:

There is no reason why the views, wishes and feelings of people placed in accommodation under section 117 should not be taken into consideration, as they would be for anyone else placed under general social care legislation.

11.178 Likewise, ADASS Cymru stated that “it is not acceptable for individuals subject to section 117 to be treated less favourably than other service users needing residential accommodation”. The Government described the exclusion of residential accommodation provided under section 117 from the choice of accommodation directions as “anomalous”.

11.179 Furthermore, Enfield Disability Action argued that the proposal is “necessary to ensure that the personalisation policy is not denied to those who have been detained under the Mental Health Act 1983”.

11.180 On the other hand, while welcoming “the extension of people’s rights and choices when using mental health services”, the Care Quality Commission stated that:

It needs to be established whether the principles set down in the choice of accommodation directions are compatible with the “direction” of people on statutory mental health aftercare, which can necessarily involve constraint of choice.

***Current practice***

11.181 Some consultees argued that the proposal reflects current practice, but disagreed about whether, as a consequence, to support the proposal or not. For example, ADASS argued that:

In fact in practice we believe that the majority of people receiving section 117 services are not treated any differently, and are given equal choices, but extending rights to choice in law will ensure that there is no risk of different treatment.

11.182 On the other hand, Belinda Schwehr, a legal and training consultant, suggested that this change is unnecessary because people can already negotiate to top-up their preferences for section 117 services by applying human rights principles. In addition, authorities acting under section 117 “must take on board the wishes and feelings of all clients anyway”. Furthermore, she argued that extending the choice of accommodation directions may undermine the free-standing nature of the section 117 duty.

11.183 Additionally, the Lincolnshire Partnership NHS Foundation Trust and the Welsh Assembly Government suggested that the extension of the choice of accommodation directions might cause delays to placements which would secure the discharge of individuals from hospital. However, the Welsh Assembly Government argued that “suitable guidance could be used to minimise the risks of adverse delays”.

#### ***Patients who are not free to choose***

11.184 Several consultees, including the Government for example – while agreeing with our proposal – pointed out that “there will be certain people in receipt of section 117 after-care are not free to choose their own accommodation”. Furthermore, Nottingham City Council argued that:

Choice should be encouraged but not as a right as some residential care under section 117 needs to be provided within a prescribed route due to issues of risk or vulnerability.

11.185 The Law Society provided the example of a patient who is subject to a Community Treatment Order under the 1983 Act (and is consequently eligible for section 117 services) and who may be required as a condition of that order to reside in a particular place.<sup>11</sup> The Law Society queried how this would work alongside the choice of accommodation directions, but went on to note that:

Under the current Directions one of the conditions that must be met before the local authority is under a duty to accommodate the person in a care home of their choice, is that the accommodation must be “suitable”.

#### ***Other issues***

11.186 The National Housing Federation, while supporting the extension of the choice of accommodation directions to residential accommodation arranged under section 117, suggested the directions should also be extended further to give people the choice of location for non-registered supported housing. They argued that the provision on non-registered supported housing for people with enduring mental health problems has expanded over the past few years and this form of specialist provision provides an important stepping stone for an increasing number of people leaving institutional care. They argued that:

People with an entitlement to aftercare services provided in supported housing should have the same right to choose the location within England and Wales as someone living in a care home.

<sup>11</sup> Mental Health Act 1983, s 17B.

### ***Conclusion***

11.187 There was a strongly affirmative response to the proposal that the choice of accommodation directions should cover residential accommodation provided under section 117 of the Mental Health Act 1983. Many consultees highlighted that there is no reason to differentiate between people placed under section 117 of the Mental Health Act and other service users. Some consultees argued that while the proposal reflects current practice, it is better to confirm it in legislation to ensure that there is no risk of differential treatment. On the other hand, some consultees expressed concern that sometimes choice is not appropriate for a person under section 117 because of risk or vulnerability, or because a patient is subject to a Community Treatment Order. A small number of consultees also expressed concern that the extension of the choice of accommodation directions might cause delays to placements which would secure the discharge of individuals from hospital.

**Provisional Proposal 11-7: We provisionally propose that the additional payments regulations should cover residential accommodation provided under section 117 of the Mental Health Act 1983.**

11.188 Of the 231 submissions which were received, 36 submissions expressed a view on the proposal that the additional payments regulations should cover residential accommodation provided under section 117 of the Mental Health Act 1983. Of those consultees, 32 agreed with the proposal, 1 disagreed and 3 held an equivocal position.

***Clarity and consistency***

11.189 Both the Government and the Welsh Assembly Government agreed that such a change would provide greater clarity and certainty. ADASS also argued that the proposal is “essential to clarify the power to charge service users and third parties for any additional payments”.

11.190 Furthermore, Slough Borough Council stated that “the lack of clear regulation means that different local authorities are adopting different practice”. They therefore agreed with the proposal in “interests of consistency, and of allowing choice to service users receiving section 117 aftercare”.

11.191 Several consultees saw this proposal as being a logical consequence of the extension of the choice of accommodation directions to include section 117. For example, Newcastle City Council agreed with extending the choice of accommodation directions “on the proviso” that the additional payment regulations were also extended to accommodation provided under section 117. Furthermore, they argued that the regulations should be extended so that either a third party or the actual section 117 patient should be able to pay any necessary top-up. This was considered appropriate given what they described as “the improved financial position of a section 117 patient compared to the standard community care service user”.

11.192 ADASS Cymru, also stated that if we extend the choice of accommodation directions, that it follows that the additional payment regulations should also be extended because “otherwise service users subject to section 117 are not able to choose accommodation that is above the local authority rates and this limits choice and access”.

***Concerns about implementation***

11.193 A number of consultees were concerned about how this proposal may be implemented in practice. For instance, the Practitioners Alliance Against the Abuse of Vulnerable Adults argued that it would result in “some people paying when they do not do so at present” because local authorities would “lose sight of section 117 and simply treat them the same as everyone else, which in practice is to expect third party top-ups”.

11.194 Similarly, Solicitors for the Elderly – while agreeing with the proposal – argued that the current regulations are “frequently and routinely misapplied” and the effect of our proposal will be that section 117 service users “will run the risk of being asked to pay for care which should, in fact, be provided free of charge”. Furthermore, they noted that:

Our members’ experience shows that those cared for under s117 have more extensive care needs and it follows is more expensive than under the usual residential accommodation contracts. As such, the regulations should provide that the cost must meet the needs as assessed, rather than the usual contract rate.

11.195 The Law Society proposed that it is particularly important for authorities to take into account the view expressed by the Local Government Ombudsman:

In the absence of specific guidance or case law on the subject of “top-up” payments related to section 117 aftercare, local authorities need to take care when reaching decisions on individual cases. A council should be able to show that it has: considered all relevant factors including the particular circumstances of the individual case; reached a reasoned decision without undue delay; and considered any representations that it receives with an open mind.<sup>12</sup>

### ***Conclusion***

11.196 There was a strongly affirmative response to the proposal that the additional payments regulations should cover residential accommodation provided under section 117 of the Mental Health Act 1983. Several consultees argued that it would provide clarity and consistency, and others stated that it would follow logically from the extension of the choice of accommodation directions to include section 117. On the other hand, a small number of consultees expressed concern that this provision might be misapplied by local authorities.

<sup>12</sup> Complaint against North Yorkshire County Council, 2007.

**Provisional Proposal 11-8: We provisionally propose that the concept of ordinary residence should be extended to apply to after-care services provided under section 117 of the Mental Health Act 1983.**

11.197 Of the 231 submissions which were received, 32 submissions expressed a view on the proposal that the concept of ordinary residence should be extended to apply to after-care services provided under section 117 of the Mental Health Act 1983. Of those consultees, 25 agreed with the proposal, 1 disagreed and 6 held an equivocal position.

***Clarity and consistency***

11.198 Several consultees argued that the proposal would improve the current situation. For example, the British Psychological Society considered the proposal as “bringing coherence to the area”. Nottingham City Council agreed with the proposal “for the purpose of clarity”.

11.199 Suffolk County Council welcomed the proposal because they argued that the current arrangements are “not helpful in ensuring a consistent approach and response to this area”. Similarly, Swansea Council argued that the definition of ordinary residence needs clarification “as it increasingly is becoming an issue of dispute between local authorities”. It suggested that “simplification of ordinary residence, and consistency in its application would greatly improve the current situation”.

11.200 On the other hand, ADASS – while agreeing with proposal – warned that “this is a complex area of law already” and there will need to be clarity about “how section 117 is included and any exceptions, so that the change is helpful rather than providing further complications”. Lincolnshire Partnership NHS Foundation Trust argued that if this proposal is to work “very clear guidance incorporating judicial interpretations to date would be essential”. They suggested that “this might produce a notable cost saving nationally”.

***Extending the concept of ordinary residence***

11.201 Most consultees agreed that the current effect of the existing rules for section 117 should be retained. However, there was disagreement about whether the best way to achieve this would be to adopt separate rules to apply to all section 117 services, or only in circumstances where a section 117 patient is being discharged to a new local authority and residential care is not being provided.

11.202 ADASS argued that the option adopted should be “that which keeps the inclusion of section 117 within the ordinary residence rules as simple and straightforward as possible”, which in its view was for a separate rule to apply to all section 117 services. Similarly, Nottingham City Council argued that “the rules should apply to all section 117 services for the purposes of clarity”. While not putting forward a decided view, the Royal College of Psychiatrists also considered that adopting separate rules to apply to all section 117 patients “might be clearer and involve less confusion for those administering the law”. They emphasised that their main concern in this area is to prevent “any opportunity for delayed discharges or duplication of activities/assessments in different authorities, both of which can be detrimental to services and patients”.

- 11.203 Other views expressed at consultation events suggested, however, that it may 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.
- 11.204 On the other hand, Stephen Ward, a social care professional, disagreed that maintaining the current position is the best solution, since “this can make it impossible for someone with section 117 entitlement to move to a new area”. He suggested that a possible alternative may be that “where someone is to be discharged to a new area, not into residential care, their ordinary residence should be the new area, as it would in all other cases”.
- 11.205 Similarly, RADAR and the National Centre for Independent Living expressed concern “that it may not be in [people with section 117 entitlements] best interests to make the authority where the patient lived before admission responsible for after-care”. They argued that “consideration would need to be given to the circumstances in which admission took place which may be related to the area in which they were living” and that “the patient should have the freedom to choose where they want to live”.

***Differences between ordinary residence and section 117 residence***

- 11.206 The Government argued “on closer inspection, the fit between section 117 and the ordinary residence rules as they operate under the National Assistance Act 1948 is more complicated” than suggested in the Law Commission’s consultation paper. It highlighted that there are at least two scenarios in which the application of the ordinary residence rules would produce a different result to section 117 as it stands, in addition to those identified in the consultation paper:

The first is where someone has been placed in a care home by local authority A in the area of local authority B, and is then detained under section 3 of the 1983 Act. Under the National Assistance Act 1948 ordinary residence rules, local authority A would retain responsibility for residential accommodation requires on the patient’s discharge, because the patient would be “deemed” still to be ordinarily resident in local authority A. however, under section 117, the deeming rules do not apply, so local authority B would be responsible if the patient had, as a matter of fact, become resident in its area by virtue of living in the care home. The second is where someone who is in receipt of section 117 after-care voluntarily moves from one local authority area to another. Under ordinary residence rules, that move would normally change the local authority responsible – under section 117 it does not.

- 11.207 The first area was also raised by a number of consultees, with ADASS, for example, requesting that legal clarity be provided about which authority is responsible. Referring to the recent decision of *R (M) v London Borough of Hammersmith and Fulham*,<sup>13</sup> which suggests it is the host area that is responsible, it was argued that:

<sup>13</sup> [2010] EWHC 562 (Admin).



It may be more consistent with the existing rules for first detentions if consideration is given to the inclusion of deeming provisions as currently included in section 24 National Assistance Act 1948. Then if a local authority makes a placement in a care home in another area, they will remain the responsible authority under section 117, even if further detentions subsequently take place.

11.208 Some participants at consultation events suggested that the effect of this decision should be retained since it would ensure that service users had an increased chance of support from care managers who work for the local area and are aware of locally available services.

11.209 Newcastle City Council recognised two opposing views. First, it noted the argument that there should be “consistency with standard residential accommodation rules so that the originating authority retained responsibility throughout”. On the other hand, it noted the view 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.

11.210 Swansea Council argued that there is increasing pressure to take on the care management of people who become ordinarily resident in their area by default. They highlighted the difficulty of working in partnership with other local authorities that place someone in their area and then “abrogate their responsibilities”. It argued that:

There needs to be clarification and definition between a person who has *chosen* to move to another area as opposed to someone who has been *placed* by their former local authority.<sup>14</sup>

### ***The need for a general review of Government policy***

11.211 Given the differences between section 117 and the ordinary residence rules as they operate under the National Assistance Act 1948, the Government suggested 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”.

### ***Conclusion***

11.212 There was a predominantly affirmative response to the proposal that the concept of ordinary residence should be extended to apply to after-care services provided under section 117 of the Mental Health Act 1983. Some consultees argued that this would provide more clarity and consistency in this complex area. However, there was disagreement about the best way to retain the current effect of section 117. The Government and the Welsh Assembly Government highlighted that a new policy decision is required to bring coherence to this field.

<sup>14</sup> Emphasis in original.

**Provisional Proposal 11-9: We provisionally propose that section 117 should be amended to clarify that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care*. We also propose that section 117 should be amended to clarify that health and social services authorities can commission after-care services.**

11.213 Of the 231 submissions which were received, 41 submissions expressed a view on the proposal that section 117 should be amended to clarify that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care*, and the proposal that section 117 should be amended to clarify that health and social services authorities can commission after-care services. Of those consultees, 26 agreed with the proposal, 7 disagreed and 8 held an equivocal position.

***Clarifying the current law***

11.214 Several consultees agreed with the proposal to clarify that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care* because they argued that it would be helpful to clarify the current situation. For example, Counsel and Care agreed with the proposal and stated that:

An injection of clarity is urgently needed here in order to avoid ongoing disputes between the NHS and social care as to who should provide or commission a particular required aftercare service.

11.215 Similarly, the No Recourse to Public Funds Network welcomed the clarity that this proposal would bring:

For people with no recourse to public funding this would mean greater consistency in care and support arrangements. Additionally this would provide consistency across all regions and clarity regarding roles and responsibilities.

11.216 Moreover, Suffolk County Council stated that this proposal “will assist in case management, planning and delivery of services to those subject to section 117”.

11.217 On the other hand, Belinda Schwehr, an independent legal and training consultant, argued that the proposal was unnecessary because the Court of Appeal had already clarified that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care* in *R (Watson) v Richmond upon Thames London Borough Council*.<sup>15</sup> However, she stated that there may be merit in making the position clear on the face of the Mental Health Act 1983.

<sup>15</sup> (2000) 3 CCLR 276.

### ***Effect on multi-agency working***

- 11.218 There was disagreement between the consultees about the effect of the proposal to clarify that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care*. For example, Lincolnshire Partnership NHS Foundation Trust argued that it would not undermine existing partnership arrangements between NHS and local social services because the key issue was the quality of the underlying relationship:

In areas where there are good partnership relationships any change should not make much difference and any contractual variations arising from the change could be negotiated fairly, and in areas where there are bad relations, any change would serve to clarify and assist.

- 11.219 While strongly agreeing with the proposal, Deafblind UK highlighted that:

As a section 117 order can only be commenced on the authority of a psychiatrist we believe that a lead psychiatrist should be appointed to lead on after-care across both health and social care, as without a singular lead then section 117 offers service users little protection.

- 11.220 On the other hand, a large number of consultees disagreed with the proposal and many of these did so on the basis that it does not promote, and in many cases may undermine, multi-agency working. For instance, the Royal College of Psychiatrists expressed “significant reservations” about this proposal on the basis that:

Any provision that encouraged turf wars about what is “social care” and what is “health care” would be ... regrettable (given also the breadth of the concept of the notion of “treatment” in the Mental Health Act 1983). The greater flexibility of working arrangements, the diversity of commissioning arrangements and private or voluntary sector providers also makes this distinction difficult.

- 11.221 The Welsh Assembly Government also expressed concerns that this proposal may undermine existing policy which encourages “joint working between health and social care” and seeks to “provide a service to the individual that is seamless at the point of delivery”. They argued that mental health service users with complex and enduring needs often require both health and social after-care:

This places demands on services that no one discipline or agency can meet alone, and it is therefore necessary to have an integrated system of effective assessment, planning, delivery and review, so that all services can work together for the benefit of the service user.

- 11.222 Similarly, the Law Society expressed concern that “highlighting a split between health and social care might undermine the important emphasis so far on joint working”. Furthermore, Carers UK argued that splitting health and social after-care is “unnecessary and is a false distinction”. Likewise, Newcastle City Council strongly disagreed with the proposal on the basis that:

Splitting health and social after-care would simply open up the area to already perennial conflicts as to what is social care and what is health

care and such debates are potentially more invidious in the field of mental health.

- 11.223 Similarly, Gateshead Council, disagreed with the proposal, arguing that attempting to separate *health* after-care and *social* after-care “could be fraught with difficulty and likely to lead to increased confusion and contention”. They also argued the proposal would undermine the current direction of policy because:

The “old” dichotomous thinking of “health” care and “social” care might not always be useful to the “new” context of recovery and personalisation in mental health after-care.

- 11.224 They highlighted that personalisation requires that patients are empowered to define those services that best contribute to their own “recovery action plan”:

These services may be an imaginative combination of “health” service e.g. counselling, talking therapies, or social care e.g. personal assistants, home treatment or support and recovery workers as well as social and employment opportunities. Attempting to create a clear split between what elements of a service users recovery plan is “health” and which is “social” may very often be difficult and contentious to meaningfully unravel in this context.

- 11.225 Furthermore, ADASS argued that splitting after-care as suggested in the proposal “might result in partners seeing people’s needs differently and not in the spirit of whole systems or holistic assessment”.

- 11.226 Newcastle City Council also expressed fears that splitting section 117 would allow NHS Trusts to “unilaterally withdraw support; creating real difficulties for local authorities, as currently occurs with NHS continuing healthcare patients”. This concern was also expressed by Slough Borough Council, who – although agreeing with the proposal – went on to argue that:

It seems important that both authorities should be involved and agree on the decision, to prevent the danger of one agency inappropriately leaving the other with inappropriate levels of responsibility.

- 11.227 The Practitioners Alliance Against the Abuse of Vulnerable Adults opposed the proposal because it “would make unnecessary much of the existing partnership working” but argued that the proposal may be “acceptable if [it] related to funding rather than provision”. On the other hand, Gateshead Council argued that the proposal could:

lead to confusion and contention between health and social care funding agencies trying to define which elements of the recovery plan is “their” responsibility, with associated uncertainty for the service user.

***NHS continuing healthcare and section 117***

- 11.228 ADASS suggested that there is an issue where someone eligible for section 117 after-care is also assessed as eligible for continuing healthcare funding. They suggested that:

In this situation some primary care trusts seem to believe that having section 117 status precludes the person from being eligible for continuing healthcare funds. Clarity for health services on this matter would be welcomed, perhaps as part of clearer guidance about section 117 duties, roles and responsibilities overall.

11.229 They also stated that in other circumstances:

Once continuing healthcare funding has been approved the primary care trusts have no further involvement in the section 117 reviewing process, leaving this to the local social services.

11.230 Slough Borough Council also highlighted the issue of funding continuing healthcare for people with section 117 entitlement “as a contentious issue” where clarification would be welcomed “particularly if the relative roles and responsibilities can also be clarified”.

#### ***Effect on charging rules***

11.231 Furthermore, RADAR and the National Centre for Independent Living expressed concern that this proposal would lead to “regression for existing users, who may then have to pay for part of the care that was previously provided free”. Similarly, Carers UK expressed concern that “this provision would introduce charging for social care services which has always been resisted within mental health as having a negative impact of service users”.

#### ***Commissioning after-care services***

11.232 The second limb of the proposal – that section 117 should be amended to clarify that health and social services authorities can commission after-care services – was accepted by all consultees who commented on it. For example, Slough Borough Council agreed that the language of section 117 should be amended to indicate that commissioning of after-care services is appropriate and acceptable. The Government and the Welsh Assembly Government also argued that the proposal would bring greater legal clarity.

#### ***Conclusion***

11.233 Overall, there was an affirmative response to this proposal. Several consultees argued that the first limb of the proposal, that section 117 should be amended to clarify that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care*, will help to bring clarity to a complex area. On the other hand, some consultees disagreed strongly with the first limb of the proposal. They argued that it is based on an artificial dichotomy between “health” and “social” after-care, and that it will undermine joint working between the NHS and social services. All consultees who commented on the second limb of the proposal agreed that that section 117 should be amended to clarify that health and social services authorities can commission after-care services.

**Question 11-3: If the section 117 duty should be split between health and social services authorities, should the termination of the duty also be split so that, for example, *social care after-care* ceases when the social services authority is satisfied that the person no longer needs social care after-care; or should both authorities be involved in the decision?**

11.234 Of the 231 submissions which were received, 43 submissions expressed a view on the question whether, if the section 117 duty was split between health and social services authorities, the termination of the duty should also be split, or whether both authorities should be involved in the decision. Of those consultees, 8 agreed that the termination of the duty should also be split, 23 disagreed and argued that both authorities should be involved in the decision, and 12 held an equivocal position.

***The importance of joint decision-making***

11.235 Most consultees disagreed that the decision to terminate should be split, and highlighted the importance of joint decision-making in the context of terminating after-care. For example, Counsel and Care, despite agreeing that the section 117 duty should be split between health and social services authorities, argued that “in order to encourage partnership working, both the local authority and the NHS should be required to come to a joint decision as to when the duty is to end”.

11.236 Similarly, Deafblind UK – while also agreeing that the section 117 duty should be split between health and social services authorities – argued that:

The termination of the duty cannot be split as section 117 applies simultaneously to both health and social aftercare. We believe that as only a psychiatrist can place a service user on a section 117 after-care order, that psychiatrist (or psychiatric team) should be the overall lead for the after-care order. Neither authority should be able to end their part of a section 117 after-care order without agreement and involvement from the other authority. If any dispute arises the psychiatrist should have the final decision as the order is based on a mental health treatment order.

11.237 Furthermore, the Lincolnshire Partnership NHS Foundation Trusts acknowledged that “expertise in relation to function properly lies with the relevant authority” but stated that “having both authorities involved in the decision may assist in ensuring needs are met”.

11.238 Furthermore, Belinda Schwehr, an independent legal and training consultant, argued that both authorities should be involved in the decision to terminate “as the integration of the significance of each kind of service for the outcome is likely to be complex”. This point was also reflected in the submission by the No Recourse to Public Funds Network:

For people with no recourse to public funds, the greatest impact will be on the provision of accommodation support. It is important that if social services terminate accommodation support, the potential impact on the individual’s mental health needs to be assessed by the

health authorities and a joint decision made as to the suitability of this option for the individual.

11.239 ADASS also argued that there should be “joint involvement and agreement at the beginning of provision, review stages and termination”. Similarly, the Medway Older People Communication Network argued that “what is important is that there is close co-operation between local authority and the NHS to ensure that the needs of each person are fully met”.

11.240 Moreover, Regenerate-RISE suggested that joint working should also involve the voluntary sector. They recommended that “a card should be produced listing the agencies involved in the person’s care to enable us all to work together for the good of the patient/client”.

***The need for greater clarity***

11.241 The Welsh Assembly Government stated that the Law Commission may wish to consider further the issue of termination of the duty:

We are aware that there are a number of conflicting views on the termination of the duty within health and social care services, despite the Codes of Practice for England and for Wales, and case law on this matter.

11.242 Similarly, ADASS stated that they would:

welcome greater clarity in legislation about the circumstances in which section 117 after-care can be terminated, as there is a great deal of room for interpretation in the current guidance and a broad range of responses across the country in local authorities’ section 117 procedures.

11.243 Bournemouth Borough Council also stated that clearer guidance is needed regarding “thresholds and endings of after-care”.

***Involvement of service users***

11.244 Several consultees highlighted the importance of involving the service user in the decision to terminate. For example, RADAR and the National Centre for Independent Living urged that a “duty can be terminated only after agreement of both authorities – and that this happens with the full involvement of the service user”. The Law Society also suggested that “some mechanism for taking account of patients’ views before termination is important and necessary”.

11.245 Furthermore, ADASS Cymru argued that:

Ideally the mechanism for either organisation to discharge section 117 should involve a Care Partnership Approach and a section 117 review with the service user and agreement reached to discharge section 117 individually or jointly.

### ***Duty to consult or inform***

- 11.246 Several consultees agreed with the proposal, but stated that there should be a duty to consult the other authority, or to inform them. For example, Sunderland County Council stated that “the decision to terminate one duty should be made by the authority concerned but there should be a duty to inform the other authority of the decision”. Furthermore, the Royal Borough of Kensington and Chelsea argued that:

There ought to be consultation on this [the decision to terminate] but each body needs to be able to make a decision for itself if there is no consensus; we would [also] need to have a duty to inform each other.

### ***Other issues***

- 11.247 There was some confusion at consultation on whether a person can be discharged from section 117 if their mental health condition is *stable*. Some argued that this approach was common, whilst others argued that section 117 focuses on a patient’s need and that a need can continue to exist even though it is being met successfully.

### ***Conclusion***

- 11.248 The majority of consultees disagreed that the termination of the section 117 duty should 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. They insisted on the importance of joint-working in reaching the decision to terminate and therefore argued that both authorities should be involved in the decision. In addition, a significant number of consultees who supported the proposal to split the section 117 duty also opposed the suggestion that the termination of the duty should also be split. On the other hand, some consultees argued that the termination decision should be split, and instead, there should be a duty to consult or at least inform the other authority.



**Question 11-4: Should section 117 be recast from a free-standing duty to a gateway provision?**

11.249 Of the 231 submissions which were received, 38 submissions expressed a view on the question whether section 117 should be recast from a free-standing duty to a gateway provision. Of those consultees, 21 agreed that it should be recast as a gateway provision, 9 disagreed and 8 expressed an equivocal position.

***Legal clarity and consistency***

11.250 Several consultees agreed that section 117 should be recast as a gateway provision to bring greater clarity and consistency to this area. For example, Nottingham City Council and NAAPS agreed with the Law Commission's assertion that the effect of recasting section 117 as a gateway duty would be to remove the current uncertainties, complication and anomalies.

11.251 Furthermore, ADASS Cymru stated that:

By making it a gateway provision it gives clarity as to what constitutes a section 117 aftercare service, i.e. a service we already have a power to provide under other legislation.

11.252 The London Borough of Camden, for example, argued that this will "further help to define what counts as an aftercare service and the scope of responsibilities under this section". Gateshead Council argued that this change would be more consistent with the *effectiveness, efficiency and equity principle* in the *Mental Health Act Code of Practice*, "enabling people receiving 117 aftercare to access and receive the same types of support available to other mental health service users".

11.253 ADASS agreed that making section 117 a gateway provision "would simplify all the other changes such as the choice of accommodation directions, additional payment regulations, and ordinary residence rules".

11.254 Furthermore, although they held an equivocal position overall, the Lincolnshire Partnership NHS Foundation Trust argued that "this would provide consistency of legal statutory interpretation and application, furthering the objectives of this project".

11.255 On the other hand, Bournemouth Borough Council stated that if section 117 is recast as a gateway duty, then:

the statute and guidance would need to be clear regarding which services or provisions could be accessed. Our experience has been that ambiguities regarding section 117 have led to uncertainty about the use of resources, and potential over commitment by the local authority.

### ***Effect on charging rules***

- 11.256 Most of those who were opposed to section 117 becoming a gateway did so on the basis that it could make it easier for charges to be introduced for section 117 services. For example, the London Borough of Havering expressed concern that there may be some confusion as to the charging regime that might apply. Lancashire County Council also stated that they “would be concerned to ensure that the power to charge for section 117 services would be disapplied”. Counsel and Care argued that this change would “encourage the greater likelihood of these services becoming chargeable in the future” and insisted that “it is important to keep the onus on the local authority to cover the full cost of care”.
- 11.257 Additionally, both Newcastle City Council and ADASS agreed that section 117 should be recast as a gateway “on the premise” that the power to charge would be disapplied. Similarly, Enfield Disability Action argued that “what is paramount for a service user is that no charge for the services can be made by local authorities”.
- 11.258 On the other hand, Belinda Schwehr, a legal and training consultant, suggested that charging is a logical consequence of recasting section 117 as a gateway duty. Therefore she argued that section 117 should remain freestanding “unless there is the political will now to make it chargeable”.

### ***Effect on other existing rights and entitlements***

- 11.259 Some consultees expressed concern that recasting section 117 as a gateway duty would weaken the current protections afforded to section 117 service users. For example, Carers UK argued stated that they see “this as a watering down of rights held by the individual and, as such, would significantly impact on carers”. Similarly, Ann McDonald, a social care academic, stated that “section 117 is crucial for recovery and so should be a free-standing – and therefore a ring-fenced – duty”.
- 11.260 Furthermore, Stuart Marchant, a social care solicitor, argued that:
- The arguments in favour of recasting section 117 as a gateway provision do not outweigh the difficulties that would be caused by authorities not accepting responsibility for a patient on discharge.
- 11.261 The Law Society accepted that the Law Commission had made a strong argument for recasting section 117 as a gateway provision but were concerned to ensure that children and young people would not lose their existing entitlements to after-care services. This point was also made by the Government:
- It would be necessary also to address the interface with the statutory framework for children’s services, as section 117 applies to people of all ages.

- 11.262 At consultation events, it was also 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.<sup>16</sup> It was noted that this aspect of section 117 needs to be retained if the duty is to become a gateway provision.
- 11.263 The Lincolnshire Partnership NHS Foundation Trust expressed uncertainty about “the actual national impact on individuals as a result of such a change” and thus suggested that “perhaps this warrants further clarification before substantive changes are made”.
- 11.264 Solicitors for the Elderly argued that there are currently problems with joint-working, which include issues such as “social services gate-keeping for primary care trusts” or “by analogy, NHS staff may overestimate what social services can and will do in practice”. They stated that there is a need to place a specific duty on social services to provide the social care aspect of a section 117 order, and that this would be “far more effective than a gateway duty or on the duty to co-operate”.

### ***Conclusion***

- 11.265 There was a predominantly affirmative response to the question whether section 117 should be recast from a free-standing duty to a gateway provision. Many consultees argued that this would bring greater clarity and consistency to the law. Several consultees agreed with the submission that the main advantage 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. On the other hand, some consultees expressed concern over the increased potential for local authorities to start charging for services provided under section 117. There was also some concern about whether children or those subject to immigration control would be adversely affected by this change.

<sup>16</sup> Schedule 3 to the Nationality, Immigration and Asylum Act 2002 does not apply to section 117 services.

### **Other issues relating to section 117**

- 11.266 This section highlights issues that were raised by consultees in relation to section 117 of the Mental Health Act 1983 which do not relate to a specific proposal or question in the consultation paper. It was suggested that these issues should be taken into account when developing the recommendations for reform in relation to section 117.

### ***Charging for section 117 services***

- 11.267 A range of views were expressed at consultation about the requirement that section 117 services must be provided free of charge. Some participants at consultation argued that it was inequitable that, for example, 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 (*the adjacent beds argument*).
- 11.268 The *adjacent beds argument* was used by some participants at consultation events as being a reason for abolishing the duty to provide 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.
- 11.269 Belinda Schwehr, a legal and training consultant, argued that legislation should enable charges to be made for section 117 services where people qualify for certain welfare benefits that are used to pay for service provision. It was suggested that particular difficulties arise when section 117 service users with dual diagnosis qualify for enhanced benefits and wish to spend their money on, for example, drugs or alcohol which lead to battles with social services appointees.

### ***The definition of after-care services***

- 11.270 Many consultees pointed out that, since the publication of the Law Commission's consultation paper, the decision of the Administrative Court in *R (Mwanza) v the London Borough of Greenwich* has added to the uncertainty over the definition of section 117 after-care.<sup>17</sup> In this case, 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.<sup>18</sup> 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 was the more appropriate provision for seeking assistance.

<sup>17</sup> [2010] EWHC 1462 (Admin).

<sup>18</sup> [2010] EWHC 1462 (Admin) at [67] and [75] to [76].

- 11.271 The Royal College of Psychiatrists while welcoming the confirmation that after-care services includes accommodation, was concerned by the suggestion that “bare accommodation” may rarely fall within the section:

It is important to realise that section 117 provides for a package of care and that the components of that care should be seen together as constituting the person’s needs. Absent accommodation it may be impossible to provide the other elements of the package effectively.

- 11.272 Furthermore, at a consultation event members of the Local Government Association expressed concern that the judgment in *Mwanza* 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 readmission to hospital based on the specific circumstances of the last compulsory hospital admission under section 3. Alternatively, section 117 could include services aimed generally at preventing any type of readmission to a psychiatric hospital in the future – including an informal admission or an admission for a new condition not related to the previous admission(s). Members of the Local Government Association argued that the latter interpretation would make it almost impossible to discharge a patient from section 117 after-care and would mean that free services would have to be provided to meet people’s needs even though they are unconnected to previous hospital admissions; for example, a young person who was detained under section 3 of the 1983 Act for depression would continue to be eligible for free care services in later years (if they had not been discharged from section 117) if they, for example, develop dementia and require a care home admission.

***Extending section 117 to the deprivation of liberty safeguards***

- 11.273 The Royal College of Psychiatrists argued that section 117 services should apply to those who have been deprived of their liberty under the Mental Capacity Act 2005, “to prevent them being so deprived again”. They raised this “as a matter of importance for the proper care of vulnerable people and those at risk” and stated that this is “an excellent opportunity to bring together legislation and iron out anomalies”.

**Provisional Proposal 11-10: We provisionally propose that our future adult social care statute should place a general duty on each social services authority to make arrangements to promote co-operation between the local authority and specified relevant organisations.**

- 11.274 Of the 231 submissions which were received, 60 submissions expressed a view on the proposal that there should be a general duty on each social services authority to make arrangements to promote co-operation between the local authority and specified relevant organisations. Of those consultees, 54 agreed with the proposal and 6 held an equivocal position. No consultees disagreed with the proposal.
- 11.275 Many consultees agreed with this proposal on the same basis as the proposal that a local authority can request certain authorities to assist in a number of circumstances, and that the request authority would be under a duty to give due consideration to the request. Consultees considered the latter to be a specific instance of the former and therefore there was much overlap in the responses to both of these proposals.

***The need to promote co-operation***

- 11.276 Many consultees agreed with this proposal on the basis that they views joint working as a crucial element in meeting service users' needs. For example, Mencap argued that:
- Joint working, and the failure to do so, has an impact on all parts of a person's life. It can make the difference between someone being enabled to live independently or losing his life.
- 11.277 Furthermore, Parkinson's UK strongly supported greater co-operation between authorities on the basis that "this should aide integration and cost effectiveness of services".
- 11.278 Research in Practice for Adults argued that this proposal "is perhaps the most important item" in the Law Commission's consultation paper. Similarly, the Cardiff and Value of Glamorgan Voluntary Health and Social Care Networks argued that "references/proposals for joint working/co-operation should be emphasised at the beginning of the document, not towards the end". Enfield Disability Action cited a briefing paper given by Professor Luke Clements, that the case for statutory obligations in relation to multiagency working "is overwhelming".<sup>19</sup> Similarly, the Hampshire Centre for Independent Living described current joint working arrangements as "disappointing" and "insufficient".
- 11.279 Furthermore, Parkinson's UK strongly supported greater co-operation between authorities on the basis that "this should aid integration and cost effectiveness of services". In addition, the National Autistic Society stated that:

<sup>19</sup> L Clements, The Need for New Legislation (2007): [http://lukecllements.co.uk/downloads/PDF\\_Sep08\\_04.pdf](http://lukecllements.co.uk/downloads/PDF_Sep08_04.pdf) (last visited 4 February 2010)

This [proposal] would be very helpful in promoting a joined up approach between the various agencies to achieve a comprehensive solution to meet an individual's needs.

- 11.280 On the other hand, Belinda Schwehr, a legal and training consultant expressed doubt as to the “value of duties to co-operate in relation to the cost-benefit analysis and the impact that such co-operation has or does not have on the public”. Similarly, Sunderland City Council agreed with the proposal in principle but questioned “whether placing a duty on social services would make any difference”.

***The application of the duty***

- 11.281 Several consultees commented on who the duty should apply to. For example, Buckinghamshire County Council suggested that the legislation should “provide a list of ‘relevant organisations’, such as local housing authorities, education authorities, health authorities and specified others”. Similarly, Sense provided a list of the authorities that they argued should be included:

- (1) health services;
- (2) education authority;
- (3) children’s and adult’s social services;
- (4) housing;
- (5) the police; and
- (6) service providers.

- 11.282 The Joseph Rowntree Foundation argued that the duty should apply to:

all statutory services that could support someone with support need, reflecting the very wide range of needs and outcomes that may be identified. Joseph Rowntree Foundation’s *Shaping Our Lives* project clearly indicated that service users considered issues such as housing, transport, employment, income and benefits, and broader issues around discrimination and equality holistically ... and it would be incongruous for some service areas to be better integrated with social care than others.

- 11.283 They also rejected the idea of having a pre-determined list of services with whom social services would have a duty to cooperate since this would be too restrictive. Furthermore, they suggested that some groups – such as disabled parents and people with dual diagnoses – require “specific types of joint working” which would not potentially be reflect by providing a list of specific organisations.

### ***Information sharing***

- 11.284 Several consultees highlighted information sharing as a potentially difficult area of practice which should be addressed in the proposed duty to co-operate. For example, Cartrefi Cymru – while “wholly in favour” of the proposal – highlighted the issue of information sharing as “particularly problematic”. Similarly, the Older People’s Commissioner for Wales stated that “timescales for co-operation information sharing need to be set”, highlighting that:

There is still a tendency for local authorities and independent organisations to hide behind the Data Protection Act 1998. Any new code of practice should make it clear that data protection is for the protection of the individual and not the organisation that holds the data.

- 11.285 The Royal College of Psychiatrists recommended:

There should be a duty to share information needed by another authority; both information needed by social work departments which could be provided by the NHS, but also the local authority should share information with the NHS when they make their assessment. This would include a requirement to notify the GP and provide the assessment of care needs.

- 11.286 On the other hand, the General Medical Council – while agreeing with the proposal – highlighted the importance of confidentiality between doctors and patients:

It can be very difficult for doctors to gain a patient’s trust, and enable patients to make frank disclosures about their lifestyle, sexual, alcohol, mental health or other problems, if information cannot be held in confidence because the doctor, or their employing or contracting body, is required to disclose it to another, or possibly several other, agencies.

- 11.287 They therefore suggested that any duty to co-operate which relates to information sharing of health records is made “subject to consent or an overriding public interest test, in cases involving adults with capacity”. They suggested that any such duty to obtain consent “need not be onerous – and could be a simple verbal agreement, recorded in the patient’s medical notes”.

### ***Involving the voluntary and private sector***

- 11.288 Regenerate RISE argued that it is “paramount to include the voluntary sector agencies involved in a person’s care”. Similarly, the Older People’s Commissioner for Wales that the duty to “share and co-operate should not be confined to local authority agencies and departments. It should extend to other relevant independent organisations”.

- 11.289 Furthermore, the Lincolnshire Partnership NHS Foundation Trust suggested that the proposal “could be extended to those bodies carrying out functions of a public nature on behalf of [the specified] authorities”. On the other hand, they also argued that “there is inherent difficulty in firstly identifying whether private sector bodies would fall within the oft-times thorny legal definition”. They suggested that:



Any lack of cooperation from involved organisations contracting/working with education, housing, health and other local authorities could be written into existing agreements in a manner to suit the local arrangement eg formal variation to indemnify for specified loss as a result of any breach of duty. This would also have the benefit of keeping the proposed statutory duty to co-operate simple and effective, avoiding lacunae as a result of attempting an all-inclusive overarching duty.

- 11.290 Similarly, the National Offender Management Office stated that, while they currently participate in local arrangements on a flexible basis:

Further work would be required before making a decision on legislating to impose a duty to co-operate because of the potential resource implications for agencies made subject to that duty.

#### ***Extending the obligation to other agencies***

- 11.291 Some consultees argued that as well as local authorities, other agencies should be placed under an obligation to promote co-operation. For example, Making Every Adult Matter suggested that this would ensure that a range of different organisations would have a duty to promote co-operation and to engage in such work. Disability North stated that, from their experience, “the local authority is good at trying to work with other organisations” but it is “other organisations that are less willing to co-operate”.

#### ***Conclusion***

- 11.292 There was a strongly affirmative response to the proposal that there be a general duty on each social services authority to make arrangements to promote co-operation between the local authority and specified relevant organisations. Many consultees highlighted the importance of co-operation in efficiently meeting the needs of service users. Some consultees argued that there should be a list of relevant agencies, while one consultee argued that this would be incompatible with a person-centred approach where a different set of agencies may be required to co-operate in order to meet a person’s needs. Several consultees suggested that the voluntary and private sector should also be included, while others warned about the resource implications on those organisations if they were required to co-operate. Several consultees highlighted the importance of information sharing, while one consultee emphasised the importance of confidentiality.

**Provisional Proposal 11-11: We provisionally propose that our future adult social care statute should specify that a local authority can request certain authorities to assist in a number of circumstances, including when an assessment of a service user or carer is taking place and in providing services to a service user or a carer. In such cases, the requested authority would be under a duty to give due consideration to the request.**

11.293 Of the 231 submissions which were received, 50 submissions expressed a view on the proposal that a local authority can request certain authorities to assist in a number of circumstances, and that the requested authority would be under a duty to give due consideration to the request. Of those consultees, 45 agreed with the proposal, 1 disagreed and 4 held an equivocal position.

11.294 Some consultees treated this proposal as a specific instance of the proposal that there should be a duty to each social services authority to make arrangements to promote co-operation between the local authority and specified relevant organisations. Therefore, there was much overlap in the responses to both of these proposals, and some consultees merely referred to their reasons for supporting the latter as a basis for supporting this proposal.

#### ***The importance of joint working***

11.295 Many consultees agreed with this proposal on the basis that they viewed joint working as a crucial element in meeting service users' needs. For example, the Standing Commission on Carers considered that:

These new duties would be particularly helpful when the carer and the person needing care and support live in different authorities or where the individual requires a complex package of support which cannot be provided by one authority.

11.296 Furthermore, an analogy was drawn to section 10 of the Children Act 2004 which they argued has:

improved co-operation between authorities and other agencies and the related guidance gives examples of some of the arrangements that could be made, such as pooled budgets and staff, shared information or providing particular types of goods and services.

#### ***Strengthening the obligation on the requested authority***

11.297 Several consultees expressed an equivocal opinion on the proposal on the basis that it does not go far enough in obliging the requested authority to co-operate. This was the position of the Parliamentary and Health Services Ombudsmen who submitted a joint response with the Local Government Ombudsman. Ann McDonald, a social care academic, argued that "the other authority should be required to carry out its statutory duty (if a duty exists)".

11.298 Alternatively, Belinda Schwehr, a legal and training consultant, stated that she would agree with the proposal only if “it is expanded to include written reasons for declining such invitations [to assist in a number of circumstances]”. Similarly, Sense stated that if the requested authority is not willing to give the requested assistance then they should be required to provide reasons:

If the requested authority is able to simply not respond to the requesting authority then this will mean that in the most difficult situations where this power is most needed, such as transition of people with high support needs, there is a risk that authorities will simply not respond.

11.299 Likewise, the Law Society argued that:

Compulsion to give reasons would positively support inter-agency co-operation and prevent authorities from evading their responsibilities, which we are aware occurs too frequently.

11.300 Similarly, the Welsh Assembly Government – while agreeing with the proposal – noted that:

The proposed Carers Strategies (Wales) Measure goes beyond “due consideration” by placing specified duties on relevant authorities including NHS authorities in respect to carers.

11.301 The proposed Carers Strategies (Wales) Measure provides under section 2(1) that the “Welsh Ministers may by regulations require two or more relevant authorities to prepare and publish a strategy setting out how they will work together” to achieve certain tasks, such as providing appropriate information and advice to carers and ensuring that a carer is consulted before a decision is made as to what services (if any) are to be provided to or for the carer or the person cared for.

11.302 Moreover, the Older People’s Commissioner for Wales argued that the duty to give duty consideration “lacks teeth”. They suggested that instead there should be:

a penalty imposed on agencies that do not co-operate or refuse to provide information without reasonable excuse. Timescales for co-operation and information sharing need to be set.

### ***Other issues***

11.303 Making Every Adult Matter argued that the duty should also require social services authority to co-operate with other agencies at their request too. Similarly, the Social Care Institute for Excellence suggested that there should be “mutually binding obligations on the statutory agencies to collaborate with one another in applying agreed strategies, priorities, procedures and information-sharing protocols”.

11.304 Sense suggested that the particular instances when other authorities must co-operate should include:

- (1) where an assessment is taking place;
- (2) where a person's ordinary residence is changing;
- (3) where a person is making a transition from children's to adults' services;  
and
- (4) where there are safeguarding concerns.

11.305 The Office of the Public Guardian considered that the local authority should be required to co-operate with the Public Guardian on the basis that where:

a safeguarding concern relates to the actions of a deputy or a person acting under a registered power of attorney, [such a duty would] ensure that there is a link between the relevant local authority and the Public Guardian's duty to investigate under section 58(1)(h) of the Mental Capacity Act 2005.

### ***Conclusion***

11.306 There was a strongly affirmative response to the proposal that a local authority can request certain authorities to assist in a number of circumstances, and that the request authority would be under a duty to give due consideration to the request. Many consultees agreed with this proposal on the same basis as the previous proposal that each social services authority to make arrangements to promote co-operation between the local authority and specified relevant organisations, and considered it to be a specific instance of the latter. On the other hand, several consultees held an equivocal position because they did not feel that the proposal went far enough in obliging the requested authority to respond to the request for assistance. Many of these consultees argued that required authority should at least be required to provide written reasons if they refuse to co-operate.

### **General comments about joint working**

- 11.307 In addition to responses to particular proposals, several consultees highlighted the general importance of joint working between different agencies providing services to people with social care needs. For example, Mencap stated that people who took part in their consultation called for greater joined-up working:

Too many are tired of rigorous form filling, telling their story to dozens of key workers and being given conflicting advice. Joint working, and the failure to do so, has an impact on all parts of a person's life. It can make the difference between someone being enabled to live independently or losing his life.

- 11.308 Furthermore, the Local Government Association stated that:

In further developing proposals relating to the scope of adult social care services and proposals relating to joint working it will be important both to achieve greater clarity in relation to the interfaces between social care and health services and similarly to better represent the interfaces with other statutory areas – for example in relation to benefits, employment and training.

- 11.309 On the other hand, the National Care Forum – while also supporting greater integration between social care and health provision – warned that:

There is an inherent danger that full integration brings with it a risk that time and resources are absorbed in encouraging different professionals with different perspectives and priorities to work together. What matters to service users is effective co-ordination. The experience of a seamless set of services need not necessarily be one of complete integration.

- 11.310 They suggested that “a new regulator with responsibilities across health and social care may bring some benefit in terms of an integrated set of provision”.

## **PART 12**

# **SAFEGUARDING ADULTS AT RISK**

**Provisional Proposal 12-1: We provisionally propose that our future adult social care statute should place a duty on local authorities to make, or cause to be made, such enquiries as it considers necessary where it has reasonable cause to suspect that a person appears to be an adult at risk and consider whether there is a need to provide services or take any other action within its powers in order to safeguard that person from harm.**

- 12.1 Of the 231 submissions we received, 89 submissions expressed a view on the proposal that our statute should place a duty on local authorities to make enquiries where it has reasonable cause to suspect that a person appears to be an adult at risk and consider whether it necessary to provide services or take action. Of those consultees, 74 agreed with the proposal, 6 disagreed, and 9 held an equivocal position.
- 12.2 All of the local authorities (13) and safeguarding boards (10) who responded to this proposal agreed with it.

### ***Clarification and strengthening of the current law***

- 12.3 Some consultees agreed with this proposal on the basis that it clarifies the current law. For example, Bath and North East Somerset Safeguarding Board supported this proposal since “it serves to clarify the existing and somewhat ambiguous legal position within the NHS and Community Care Act 1990 (the duty to carry out an assessment)”, and agreed that the community care assessment duty is often an unsatisfactory mechanism for dealing with adult protection cases.
- 12.4 Newcastle City Council also agreed with this proposal and emphasised a lack of investigatory powers in the current law. The Royal Borough of Kensington and Chelsea considered that:

Whilst there is a range of legislation that can be applied in adult abuse cases ... having a statutory duty enshrined in one piece of legislation would give local authorities a clear direction on the response required.

- 12.5 Both the Welsh Institute for Health and Social Care and Ann McDonald, a social care academic, argued that the proposed duty should have the same legislative status and priority as protecting children.
- 12.6 In contrast, both the British Association of Social Workers and Northumberland Tyne and Wear NHS Foundation Trust disagreed with the proposal, arguing that the “duty to assess under section 47(1) of the [NHS and Community Care Act 1990] is at such a low threshold it is questionable why a specific duty to investigate abuse is needed”.

### ***Difficulties with the statutory guidance***

- 12.7 Several consultees reported that the duty to investigate contained in the statutory guidance *No Secrets* and *In Safe Hands* is unclear and/or often improperly or ineffectively used.<sup>1</sup> For example, the Care Quality Commission argued that not all councils accept that *No Secrets* requires local authorities to investigate actual or alleged abuse of service users:
- Some would contend that *No Secrets* gives councils the lead on establishing and co-ordinating the local multi-agency procedures but not for the investigation of individual cases.
- 12.8 An anonymous carer questioned in a written submission questioned whether guidance was the appropriate location for such an important legal provision and that “local authorities ... are completely free to breach the guidance in *No Secrets* and in reality are under no obligation to carry out any meaningful investigation”.
- 12.9 BUPA Care Homes fully agreed with this proposal and argued that there is a “lack of a prescribed process in the current system which leads to a lack of consistency and misuse of the principles of *No Secrets*”.
- 12.10 Furthermore, Enfield Disability Action pointed out that the scope of the statutory guidance is too limited and:
- only extends to people described as vulnerable adults who are or may be in need of community care services and cannot protect themselves from significant harm.

### ***A multi-agency duty to investigate***

- 12.11 Some consultees queried whether local authorities should be given the lead investigation role in all safeguarding cases. For example, Caerphilly County Borough Council argued that:
- If there were to be a “duty” placed on local authorities as proposed *in this consultation paper*, rather than on all *other statutory agencies*, then it should follow that local authority should lead the response to *all* referrals. This would mirror child protection arrangements. If other statutory bodies such as the Health Boards in Wales are to retain their role to coordinate the response to referrals of abuse in hospital, then the “duty” should apply equally. It appears that clarity is required as to the lead and supporting roles before the “duty” can be determined.<sup>2</sup>
- 12.12 The Law Society argued that there needs to be consideration of whether this duty should be placed upon other agencies that have contact with adults at risk:

<sup>1</sup> Department of Health and Home Office, *No Secrets* (2000); National Assembly for Wales, *In Safe Hands* (2000).

<sup>2</sup> Emphasis in original.

This would have an inevitably positive impact on joint working and multi-agency co-operation. A prime candidate for inclusion under the duty is the health service.

- 12.13 Newcastle City Council recognised that many people supported placing a duty to investigate on health bodies and “considered that many health bodies have not fully appreciated their safeguarding responsibilities”. .
- 12.14 Gateshead Council argued that there must be a corresponding and enforceable duty on other authorities to respond to any request for enquiries to be made, “notably police, health services including GPs, and private sector care providers”.
- 12.15 Both the British Association of Social Workers and Northumberland Tyne and Wear NHS Foundation Trust, in disagreeing with the proposal, were concerned that, by imposing this duty solely on local authorities, “other organisations might be tempted to pass responsibility to the local authority”, especially since “resources are stretched”. RADAR and the National Centre for Independent Living also argued that:

There is a danger that the duty lifts responsibility from the shoulders of criminal justice agencies and moves it to social care services who are unlikely to be equipped and accountable in taking appropriate action.

- 12.16 The Government expressed its commitment “to a whole system approach that brings together a number of key partners”. It continued by observing that:

Local authorities currently have the lead co-ordinating role in relation to adult safeguarding. The Government is actively engaged in developing a coherent approach to adult safeguarding.

- 12.17 However, a significant number of consultees argued that it is important for clear lines of responsibility in safeguarding cases and that it was important to give a single agency the lead responsibility in such cases. The National Offender Management Service, for example, considered that:

Lead responsibility must always sit with the local authority and cannot be delegated to prison or probation services. A duty to investigate needs to reflect and be complementary to existing investigative mechanisms within other agencies.

### ***Inter-agency co-operation***

- 12.18 A large number of consultees emphasised the importance, in general terms, of multi-agency work in safeguarding cases. The Practitioners’ Alliance Against the Abuse of Vulnerable Adults argued that the duty to investigate “may also need to include a requirement for other agencies to co-operate”. The National Care Forum and BUPA Care Homes made a similar point. The latter argued that:

There should be an obligation of co-operation on other organisations, for example, banks in the case of financial abuse investigations, and medical professionals, especially where assessments of capacity are required.



12.19 Both Bridget Penhale, a safeguarding academic, and the Eastern Region Adult Safeguarding Leads Group considered that if a duty to investigate is placed on local authorities then there must be an equivalent duty to co-operate with enquiries placed on other agencies. The Council for Disabled Children also argued that the law should allow the “scope for community care services to work with other agencies to manage [the risk of abuse].”

12.20 The Care Quality Commission explained that:

In many cases there will be joint investigations or investigations coupled with regulatory activity. It is therefore important that the operation of such a new duty is lodged in a system where co-operation between agencies is established. This also requires some clarity about the purpose of the investigation so the territory is clearly defined – for example, the police will have a focus on whether a crime has taken place, the regulator on compliance with the regulatory framework etc.

12.21 In addition, West Sussex Safeguarding Board considered that:

It is also very important that local authority duties are also set in the context of multi-agency partnership working. Safeguarding investigations require the input, co-operation and investigative expertise, knowledge and skills of a wide range of professionals and disciplines.

### ***Interaction with the criminal justice system***

12.22 Several consultees highlighted the importance of local authorities working in partnership with the police in safeguarding cases. For example, the Hampshire Personalisation Expert Panel disagreed with the proposed duty to investigate but did support the idea that there should be a duty to co-operate closely with any police investigation. They went on to argue that

In most cases, abuse is a criminal act and should be treated as such and investigated by the police. We would be wary of any implications that just because the victim is a disabled person, there would be an investigation by social services rather than the police.

12.23 Buckinghamshire County Council also noted that a joint approach with the police may be in appropriate in some circumstances.

12.24 East Sussex County Council argued that:

This new obligation to investigate needs to include what is meant by “investigative powers” and how they interact with police powers to investigate criminal matters. This introduction should be distinct from any powers the police have.

12.25 In contrast, BUPA Care Homes reported that, in its experience:

The criminal justice process is allowed to take precedence over the requirement to conduct a swift investigation and to take immediate

steps to stop abuse from occurring. Swift and effective investigation and intervention by service providers is key to safeguarding people who are being or who are at risk of being abused. This process is regularly sidelined to allow the criminal investigation to take place.

### ***Safeguarding adults with capacity***

12.26 Many consultees recognised that the proposed duty to investigate would potentially apply to people with decision-making capacity. The Older People's Commissioner for Wales Conference Report expressed support for the proposed duty and particularly welcomed the fact that it would extend protection to adults with capacity who may be at risk of harm but who are not protected under existing legislation.

12.27 On the other hand, Wolverhampton Safeguarding Board argued that:

Consideration should also be given to an individual's personal autonomy if they have been assessed as having mental capacity in certain areas to make "unwise decisions" as per the Mental Capacity Act 2005 and be able to refuse enquiries by the local authorities.

### ***Safeguarding carers***

12.28 Some consultees supported the proposed duty to investigate on the basis that it would apply to carers. Carers UK welcomed the proposal on the basis that such a duty to investigate would, in some cases, protect carers where they are at risk. The Carers' Resource also raised the point that often carers themselves are at risk. In addition, the Standing Commission on Carers argued that carers "may also be adults at risk without appropriate help and advice".

### ***New safeguarding powers***

12.29 A small number of consultees suggested that a duty to investigate might be insufficient on its own without the addition of new safeguarding powers. For example, the Law Society agreed with this proposal but suggested "it could go further":

It is apparent that a very real gap exists in the current legal framework whereby a local authority is under a duty to assess an adult at risk under the NHS and Community Care Act 1990, but is under no common law duty of care to protect an adult at risk against acts by a third party.

12.30 The West Sussex Safeguarding Board argued that "there are currently difficulties in how local authorities can gain access to make enquiries". They stated that:

Current legal avenues for accessing people in these circumstances are very much "work arounds", e.g. gaining access to a residential care home if the proprietor refuses this, as it is private premises, is very difficult unless there is a reason to believe there is a life and limb risk or access under the Mental Health Act 1983. Both these scenarios require extreme circumstances and negate opportunities to work in a preventative way.

- 12.31 Baroness Hale went further, and argued that “there is little point in imposing an investigatory duty without any powers to back it up”. Similarly, Worcestershire Safeguarding Adults Board argued that there was “a need for new powers, including powers of entry and access to information”. They expressed particular concern “about those people who are often in coercive relationships who may have the mental capacity to make decisions”.

***A duty to investigate or make enquires?***

- 12.32 Several consultees commented on the use of the terms “investigation” and “enquiries” in a safeguarding context. For example, Blackburn with Darwen, Blackpool and Lancashire Safeguarding Boards proposed that the word “investigate” should be used and not “enquiries” and that the words ‘at risk of harm and neglect’ should be included”. Similarly, Nicolette Barry, an adult protection co-ordinator, considered that “it would be very useful if we could have the term ‘investigate’ put into legislation as it is different to assessing a situation ... and does require different skills”.
- 12.33 However, some participants at consultation events argued that the term *investigate* should not be used because it would lead to confusion and overlap with the role of the police. A similar point has been made to us informally by a Department of Health official. It was suggested that our statute should, therefore, enable local authorities to undertake *enquires* and the police to carry out *investigations*. Several consultees pointed out that the Adult Support and Protection (Scotland) Act 2007 and section 47 of the Children Act 1989 use the word “enquiries” to describe the local authority duty.

***Practice issues***

- 12.34 A number of consultees pointed to practice issues or put forward solutions to address practice issues that might arise under the proposal. The Northumberland Forum for People with a Learning Disability argued that further clarification was needed regarding the triggers for a “reasonable cause to suspect” and Mencap requested clarification regarding the manner in which an investigation should take place. In addition, both Bridget Penhale and the Eastern Region Adult Safeguarding Leads Group argued that further clarification is required as to how “enquiries” will be defined.
- 12.35 Age Cymru advised that the duty to investigate should be “carried out within clear timescales so that people are safeguarded at the earliest opportunity”. Similarly, the Care Quality Commission argued that consideration should be given to “what further guidance is needed to support the implementation of such a duty such as triggers and timescales”.
- 12.36 Age UK recommended that in addition to a duty to investigate, local authorities should also be under “a duty to make an assessment of risk and to further review the situation after an appropriate period” in cases where enquiries reveal that an adult, although not at immediate risk, is likely to become so in the future. They further suggested that duties should be imposed upon local authorities to “take steps to ensure that the [Director of Adult Social Services] has the powers/resources necessary to encourage a culture of vigilance against the possibility of adult abuse”.

- 12.37 The Approved Mental Health Practitioner Leads Network suggested that including a duty to investigate in our future adult social care statute would require specialist training of the social care workforce.

***Information sharing***

- 12.38 Many consultees raised the specific issue of information sharing in relation to the proposed duty to investigate. BUPA Care Homes highlighted that there are situations where, as care providers, they are “actively excluded from the [safeguarding] process and there is a blanket refusal to share information with us, without explanation of justification”. They suggested that failure to share information with the care provider “is ultimately a detriment to the adult concerned” because the care provider “is usually the only agency which is in a position to take steps to stop or prevent abuse in the care home environment”.

- 12.39 On the other hand, the GMC raised concerns about confidentiality:

It is not clear whether the duty to make enquiries would include powers to access health records, or to receive information about a person’s health. If this were the case, we would again recommend that ... the person concerned gives consent, or there is an overriding public interest in the disclosure, and possibly restricted to circumstances where, unless a disclosure were made, a third party would be at risk of serious (or significant) harm or death.

***Further points raised***

- 12.40 Sense – while agreeing with the proposal – argued that there should also be a duty on workers to report suspected abuse and that furthermore:

Where someone paid to provide support to an individual could reasonably be aware that abuse may be occurring and fails to report this, this should be an offence.

- 12.41 Learning Disability Wales and the Welsh Assembly Government both referred to the review of the safeguarding vulnerable adults arrangements in Wales, as commissioned by Welsh Ministers. Both stated that any consideration of this proposal should only be made once this review has been concluded.

- 12.42 The Government noted that “there are a number of definitional challenges in terms used in the proposal, such as ‘adult at risk’, ‘duty to investigate’, ‘make enquiries’ and ‘significant harm’”.

- 12.43 The National Youth Advocacy Service disagreed with the proposal. It was concerned about the meaning of “reasonableness” and believed that a “code of practice should clarify what enquiries have to be made in order to meet the standard of reasonableness”. It also argued that a duty on local authorities to investigate “is unlikely to afford any protection”.

### ***Conclusion***

- 12.44 The large of consultees agreed with the proposal that our statute should place a duty on a local authority to make enquiries where it has reasonable cause to suspect that a person appears to be an adult at risk. Many consultees argued that a statutory duty to investigate would give legitimacy to enquiries, clarify differences of approach that exist nationally, afford greater protection to adults at risk, raise the status and profile of the abuse of adults at risk, and promote the safety of adults at risk without being over-protective.
- 12.45 In contrast, some consultees considered the current law sufficient and did not think that there is a need for a distinct duty to investigate. In addition, many consultees – both who agreed and disagreed with this proposal – believed that a corresponding duty to co-operate with other agencies is required. There was some concern in respect of placing this duty solely on local authorities; several consultees suggested imposing the duty on other agencies as well. Comments were also made about the terminology and definitions employed and a number of suggestions were put forward regarding the scope, form and applicability of the duty to investigate.

**Provisional Proposal 12-2: we provisionally propose that the term vulnerable adult should be replaced by adult at risk for the purposes of the duty to make enquiries.**

- 12.46 Of the 231 submissions we received, 82 submissions expressed a view on the proposal that the term vulnerable adults should be replaced by adult at risk for the purposes of the duty to make enquiries. Of those consultees 63 agreed with the proposal, 9 disagreed, and 10 held an equivocal position.
- 12.47 All of the local authorities (12) and safeguarding boards (7) who responded to this proposal agreed with it.

***Criticisms of the term “vulnerable adult”***

- 12.48 Many consultees - including the Standing Commission on Carers, Carers UK, and the Multiple Sclerosis Society - criticised the term “vulnerable adult” as “stigmatising”, “dated”, “negative” and “disempowering”. The Office for Disability Issues argued that the term “vulnerable adult” perpetuates “outdated and discriminatory concepts of disability” and Mencap argued that it implies “an inherent vulnerability and even culpability on the part of disabled people”.
- 12.49 On the other hand, the Standing Commission on Carers reported that some of its members who care for young people “associate the term ‘at risk’ with child protection procedures” and therefore preferred the term “vulnerable adults”.
- 12.50 Furthermore, some consultees expressed concern that the use of the word “risk” needs further clarification so that it does not interfere with a person’s right to take risks. For example, Disability Wales argued:

It is vital that the needs for safeguarding and risk-taking are given equal weighting to avoid inappropriate restrictions on individual freedom and decision making that occurs in risk-averse cultures.

- 12.51 Similarly, the National Forum for People with Learning Difficulties – while recognising the reasons why this change of terminology has been proposed – expressed concern that “people can get very focussed on possible risks and how ‘risk assessments’ are used”. They argued it would be helpful for people with learning difficulties if “a risk enablement process could be included into [their] support plans”.
- 12.52 Similarly, the Social Care Institute for Excellence stated that:
- Risk is an inherent part of adult life, and increasing people’s ability to control their own lives means enabling, and if necessary supporting, them to take, assess and manage their own risks.

***The need to focus on the situation not the person***

- 12.53 A number of consultees – including the Bath and North East Somerset Safeguarding Adults Board, Age Cymru, Caerphilly County Borough Council and the Equality and Human Rights Commission – argued that the term “adult at risk” was preferable to “vulnerable adult” because it focuses on the situation causing the risk to the adult, rather than the inherent characteristics of the adult concerned. The Care Quality Commission considered that:

The term “adult at risk” as a replacement is an improvement on the term “vulnerable adults” as it can encompass a multiplicity of factors that give rise to the risk rather than implying that it is intrinsic to the person. Whilst the label of “vulnerable adult” tends to be one that sticks with the person, a person may no longer be an “adult at risk” where effective strategies or interventions are put in place to manage the risk.

- 12.54 On the other hand, Inclusion South West argued that changing the term “vulnerable adult” to “adult at risk” would be “a mistake, because risks can arise at any time and are not always predicable. It is the vulnerability that is the concern”.
- 12.55 Similarly, the National Family Carer Network argued that the term “vulnerable adult” more accurately describes the status of people with a learning disability:

[Those with learning disabilities] are vulnerable to many risks but it does not mean that they are living “at risk”. There is a danger that if they are not “at risk” they will be excluded from services even though they are very vulnerable if not supported.

- 12.56 The Middlesbrough Department of Social Care agreed with the proposed redefinition since it was noted for its clarity.

***The inclusivity of the term “adult at risk”***

- 12.57 Consultees expressed differing views about whether the term “adult at risk” is over-inclusive or under-inclusive, and whether inclusivity is to be welcomed. For example, the Law Society considered that:

The term “adult at risk” is necessarily wider and more inclusive than the term “vulnerable adults” thus preventing adults who require protection from falling through the net simply because of, say, inherent characteristics.

- 12.58 In contrast, Solihull Safeguarding Board was concerned that “adult at risk” may be “interpreted too widely, thus making the implementation of this term unmanageable”. Equally, Conwy Council, who disagreed with this proposal, thought that “the term ‘adult at risk’ can describe anybody”.
- 12.59 Conversely, Mencap perceived the term “adult at risk” to be somewhat exclusive, rather than inclusive:

Many people with a learning disability receiving care services may not be defined as an adult at risk because they live in a safe environment.

However, their parents felt their need for care and support makes their sons and daughters vulnerable.

### ***Practical difficulties***

- 12.60 Some consultees pointed to practical difficulties that might arise as a result of the proposal. For example, Conwy Connect argued that because there are existing procedures and policies referring to the protection of *vulnerable adults*, “changing terminology would make it confusing”.
- 12.61 Northumberland Tyne and Wear NHS Foundation Trust disagreed with the proposal and set out the following comments:

From “adult protection” to “vulnerable adult” to “safeguarding adult” and now to “adult at risk” – cost of reprinting leaflets/policies – practice struggles to meet some of the basic standards let alone cope with another change in name.

### ***Alternative suggestions***

- 12.62 Sense suggested that the term “adult at risk due to abuse or neglect” should be used instead because:

Using the term “adult at risk” fails to make it clear that the risk we are talking about here is the risk of abuse or neglect. Where a person has capacity, they should be able to make decisions about the risks they are happy to face in their own lives.

- 12.63 Suffolk County Council supported this proposal but advised that “the language is cross-referenced with other guidance”.

### ***Conclusion***

- 12.64 The majority of consultees agreed with the proposal that the term “vulnerable adult” should be replaced by “adult at risk” for the purposes of the duty to make enquiries. Many consultees welcomed “adult at risk”, especially because it focuses on the situation causing the risk rather than the characteristics of the adult concerned. On the other hand, there was some concern that a change in terminology would present definitional challenges and lead to confusion, and that practice would struggle to cope with the change.



**Provisional Proposal 12-3: We provisionally propose that an adult at risk should be defined in our statute as anyone with social care needs who is or may be at risk of significant harm.**

- 12.65 Of the 231 submissions we received, 83 submissions expressed a view on the proposal that an adult at risk should be defined in our statute as anyone with social care needs who is or may be at risk of significant harm. Of those consultees 46 agreed with the proposal, 13 disagreed, and 24 held an equivocal position.

***The inclusivity of the definition***

- 12.66 There was much overlap between the responses that consultees provided for the proposal above –, to replace the term “vulnerable adult” with “adult at risk” – and their responses to the proposed definition. Many of those who argued that term “adult at risk” is over-inclusive went on to argue that the definition should limit who this term applies to. For example, RADAR and the National Centre for Independent Living agreed with this proposal, “as long as it’s not automatically awarded to anyone receiving social care”. In their view, “vulnerability can happen to anyone in a variety of situations which do not necessarily apply to adults needing support”.
- 12.67 On the other hand, consultees, who argued that the term “adult at risk” may exclude some people, went on to argue that the definition should be broad enough to encompass anyone who may otherwise be excluded. For example, Mencap stated that because “adult at risk” may exclude some people:

Therefore, whilst welcoming the change in terminology, it is felt that the scope of the definition needs to be sufficiently broad in order to ensure that all at risk groups are adequately protected. It was felt that by changing the term in the proposed statute, local authorities would seek to reduce the number of individuals they have to cover under safeguarding services.

***Health needs***

- 12.68 Many consultees were concerned that the proposal appears to exclude those with other needs, in particular health needs, from protection. For example, Solihull Safeguarding Board argued that the proposal “alienates health care” and stated:

The Board supports the Law Commission’s proposal that the “term” to be used should be defined in statute but *must* not be specifically social care defined *but* must include health.<sup>3</sup>

- 12.69 Ann McDonald, a social care academic, agreed with the proposal but also suggested that “the exclusion of those with solely health needs would leave some unprotected”.

<sup>3</sup> Emphasis in original.

- 12.70 The Office of the Public Guardian was equally “concerned about continuing to define safeguarding in relation to social care needs and hence perpetuating the difficulties with *No Secrets*”:

If local authorities are the lead agency for safeguarding, and local safeguarding boards comprising a range of representative organisations are established on a statutory basis, we cannot see the rationale in defining the duty too narrowly in terms of social care and potentially excluding people at risk in health provision, for example.

- 12.71 Baroness Hale observed that:

Safeguarding measures may be necessary to protect people who need health rather than social care – what about the elderly person with a broken arm whose carer will not let anyone in?

- 12.72 Wolverhampton Safeguarding Vulnerable Adults’ Board, whilst agreeing in principle with not extending local authorities’ responsibilities into the health arena, expressed concern that the proposal could restrict any investigation in respect of an adult at risk in a health service setting or investigation of neglect by a health care service.

- 12.73 The Care Quality Commission argued that in reality there is considerable overlap between health needs and social care needs and these categories do not always correspond to neatly defined agency responsibilities. For example:

There are situations in practice where similar care and support needs are met in some instances by a health care service and others by a social care service (for example with regards to people living with dementia or people who use illicit drugs). Equally, primary care trusts rather than councils may be commissioning care in a social care setting such as a nursing home to meet the person’s needs.

- 12.74 The Royal Borough of Kensington and Chelsea observed that joint NHS and social services safeguarding teams already exclude those with “only social care needs” from their services, especially those with low level mental health needs, learning disabilities, personality disorders and substance misuse problems. They argued that our definition would perpetuate this trend.

- 12.75 West Sussex Safeguarding Board argued that the limitation of the definition to those with social care needs “would be unworkable in practice” because the majority of investigations will involve individuals with a wide range of needs, including health and mental health needs, as well as housing and finances. They stated that:

The approach should be focused on the person rather than on the services they receive to avoid a lack of coordinated approach to investigation that in turn could place or leave vulnerable adults at risk.

- 12.76 Moreover, Bridget Penhale, a safeguarding academic, argued that this proposal “does not sufficiently recognise the important role of partnerships in safeguarding” because:

The inclusion of “social care needs” within the definition may mean that in practice non-social care agencies will be provided with an opportunity not to participate in safeguarding arrangements.

- 12.77 Similarly, Safeguarding Teams in Birmingham stated that separating safeguarding for those who have social care needs from those who have health needs “would lead to parallel systems of investigations to concerns regarding possible harm” and would therefore be “a retrograde step in the recent advances in multi-agency working and totally disregard the recommendations made in the valuable work of *No Secrets*”.

### **Significant harm**

- 12.78 Our proposal that the person must be at risk of *significant harm* in order to fall within the definition of an *adult at risk* divided opinion at consultation. Many 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. The National Autistic Society went further and argued that the definition should be further restricted to cases where there is an “imminent risk of significant harm”.
- 12.79 Several consultees disagreed with the requirement of *significant harm* in the proposed definition of adult at risk. For example, Action on Elder Abuse stated that:

Introducing the word “significant” influences and affects the understanding of the word “harm” and implies that there is a threshold of damage, injury, impairment or hurt which someone in a vulnerable situation must reach in order to receive assistance. And, as this is an undefined threshold, it allows localised and/or subjective interpretation which then inevitably results in victims receiving different responses to similar needs or circumstances.

- 12.80 Age Cymru argued that the term *significant harm* appeared to create “an unacceptable hierarchy of abuse” and argued it would undermine preventative measures. The Care Quality Commission pointed to the Steven Hoskin serious case review where it was found that intervention in response to lower level safeguarding alerts could have prevented the tragedy.<sup>4</sup>
- 12.81 Cartrefi Cymru expressed concern that a definition based on those “who may be at risk of *significant harm*” indicates “that a judgement needs to be made as to the level of risk, and nature of the harm to which the individual may be exposed”. They went on to argue that “it is difficult to see how such a proper judgement could be made without some assessment and/or investigation of the relevant circumstances”. They further suggested that:

The significance of any risk of harm, and therefore its *impact on a person’s wellbeing*, will largely be a matter of subjective perception by the individual involved.

<sup>4</sup> M Flynn, *The Murder of Steven Hoskin: A Serious Care Review* (2007).

- 12.82 Similarly, Age UK argued that if the requirement of *significant* harm is retained, then “it should be supported by a definition that ensures that the concept encompasses all forms of harm that the victim might consider to be significant”. Others warned of a resulting “postcode lottery” for adult protection if the term was not defined precisely.
- 12.83 Some social workers who participated at consultation events warned that the definition of “significant” in section 31(9) the Children Act 1989 had not led to consistency in practice and was still reliant, to a large degree, on individual judgment. Many were doubtful whether a precise definition of “significant” could ever be constructed given the wide range of circumstances it would need to cover.
- 12.84 Several consultees argued that the requirement of significant harm would hinder preventative action. For example, Cartrefi Cymru stated that:
- The earlier a perceived risk is addressed, and action taken to manage it, the less likely it is to reach a level of significance that will impact negatively upon the wellbeing of the individual.
- 12.85 Similarly, Age Cymru argued that the *significant* harm requirement would:
- adversely enable social care services to put preventative measures in place where the only abuse presented and proven was lower level but where there could be a risk of escalating abuse – preventative interventions are crucial to stop any escalation of abuse from occurring.
- 12.86 Inclusion South West considered that the duty to make enquiries should be extended to “lower-level abuse situations where formal safeguarding procedures are not relevant or appropriate”.
- 12.87 Participants at a conference organised by the Older People’s Commissioner for Wales stated that the threshold for the duty to investigate should be low because “crossing it triggers only a duty to investigate”. They suggested that “further criteria could be put in place when considering whether or not to intervene following an investigation”. On the other hand, some delegates argued that the *significant* harm requirement should be retained “since there is concern about the resourcing of investigations and the accompanying workload”.
- 12.88 Moreover, there was disagreement among consultees about whether the word “significant” would have to be further defined. The Vale of Glamorgan Older Peoples Strategy Forum stated that “although the term ‘significant harm’ is itself open to interpretation, experience in the children’s services indicates that it is a concept that works in practice”.

- 12.89 Many consultees argued that the threshold of *significant harm* – for the purposes of the definition of a “vulnerable adult” in *No Secrets* and *In Safe Hands* – was being ignored by practitioners or applied inconsistently. A number of safeguarding teams reported that their criterion for referrals was set much lower than *significant harm*. Also, the Law Society argued that the High Court sets a much lower threshold for intervening in cases of abuse and neglect under its inherent jurisdiction and that consideration should be given to aligning this threshold with the definition of an *adult at risk* in our statute.

### ***The definition of harm***

- 12.90 Several consultees argued that there should be a broad definition of harm. For example, the Law Society referred to the definition of harm included in the Department for Constitutional Affairs report of *Who Decides*, which stated that:<sup>5</sup>

“Harm” should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development.

- 12.91 Furthermore, they were concerned that the reference to “unlawful conduct” in the consultation paper would “require social workers to check with their legal advisers that certain action was unlawful before referring a matter to safeguarding”, and that “there are aspects of financial abuse where it is almost impossible to prove a financial crime but it is still constitutes abuse”. The Law Society therefore recommended removing the word “unlawful”.
- 12.92 Age UK argued that the definition should include reference to financial abuse and be linked to the Human Rights Act 1998 and concepts of “dignity” and “respect” whilst Making Every Adult Matter argued that it should include the impairment of “well-being” as well as impairment to health or development or unlawful conduct.
- 12.93 Several consultees, such as Newcastle City Council for example, stated that there should be clarity as to whether harm should include self-harm and self-neglect. Jill Scholl, a parent-carer, argued that self-harm and self-neglect should be included.

### ***The inclusion of self-funders***

- 12.94 A number of consultees supported the inclusion of self-funders within the definition of adults at risk, as proposed in the consultation paper. For example, Age Cymru welcomed the inclusion of self-funders and those on direct payments – “who are very often the most vulnerable people” – within the definition of “adult at risk”.
- 12.95 Similarly, the West Sussex Safeguarding Board argued that “it is important that any definition of ‘adult at risk’ does not discriminate on the grounds of where funding for support for needs comes from” and therefore welcomed “clarification that this includes self-funders”.

<sup>5</sup> Department for Constitutional Affairs, *Who Decides? Making decisions on behalf of mentally incapacitated adults* (1997).

### ***People with low level needs***

- 12.96 Many consultees supported the express inclusion of people who fall under the local authority eligibility criteria within the definition of adults at risk, as proposed in the consultation paper.
- 12.97 On the other hand, the Office of the Public Guardian queried whether this would be achieved in practice:

The proposed definition would potentially exclude those who have refused social care services, those with low level needs such as moderate or mild learning disabilities, those experiencing low level but persistent abuse, and others at risk in the wider community at risk such as those at risk of forced marriages, etc.

- 12.98 Worcestershire Safeguarding Adults Board argued that any reference to the bands in the *Fair Access to Care Services* statutory guidance should be omitted from the detailed definition proposed in the consultation paper, because the criteria can be “confusing and too wide”.

### ***The appearance of social care needs and harm***

- 12.99 Many consultees argued that the definition of an adult at risk should be broad and encompass people who are known to have social care needs or be at risk of significant harm, but also people who appear to have social care needs or be at risk of significant harm. For example, John Howard, an adult protection manager, argued that the definition should extend to those who *may have* or *reasonably appear to have* social care needs because this would ensure that the definition covered people who were previously unknown to services, awaiting an assessment or the outcome of an assessment and have difficulty in accessing services.
- 12.100 Other consultees argued that the duty to make enquiries should apply where the local authority had a reasonable belief that the person *might be at risk of significant harm*, since establishing whether significant harm has taken place should be the purpose of the investigation and not the trigger. Others argued that this approach would encourage prevention services.
- 12.101 However, Gateshead Council raised concerns that this would require local authorities to undertake enquiries on people who were previously unknown to them and would have resource implications.

### ***People who can safeguard themselves***

- 12.102 West Berkshire Safeguarding Adults Board argued that the proposed definition is too broad and may include those who have social care needs but who are able – either by themselves or with the help of others – to protect themselves. They suggested that a more appropriate definition would be:

someone who is at or may be at significant harm but is unable to take the necessary steps to protect themselves, whether by themselves or with others.

### **Carers**

- 12.103 Many consultees agreed that carers should be included within the definition of an adult at risk. For example, Carers UK argued that this would ensure protection where the cared-for person is violent or the carer's health is close to breakdown because of the levels and intensity of care provided.
- 12.104 However, individual carers at consultation events expressed concern that they could become the subject of a safeguarding investigation inappropriately (some suggested examples of this happening now); and queried whether the definition of an adult at risk should cover carers in the same way as service users. For example, one carer argued that if she had suffered significant harm through an accident at work, which had nothing to do with her role as a carer, it would be inappropriate to require social services to investigate her as an *adult at risk*. West Sussex Safeguarding Board argued that the definition of an adult at risk should include carers but only those who are at risk by virtue of their caring role.

### **Other groups**

- 12.105 Some consultees argued that certain groups should be included or excluded from the definition of an adult at risk. Suffolk County Council and the London Borough of Havering were concerned that victims of domestic violence and gang violence should not be included within the definition. It was considered that the inclusion of these groups within the remit of social services authorities – as opposed to the police – could have significant workforce implications.
- 12.106 The Royal Borough of Kensington and Chelsea argued that responsibility for domestic violence needs to remain with community safety teams and the Multi-Agency Risk Assessment Conference, and adult safeguarding teams need to liaise with these bodies if the victim meets the definition of an adult at risk.
- 12.107 However, West Sussex Safeguarding Board argued that the definition must include asylum seekers, those on probation, homeless people and victims of domestic violence where they have some social care, healthcare or other needs.

### **The relationship with a community care assessment**

- 12.108 At consultation, it was argued that our statute needed to clarify the relationship between the community care assessment and the duty to investigate an *adult at risk*. For example, a social worker who participated at a consultation event suggested that – in accordance with the principle of the least restrictive form of intervention – a safeguarding investigation should only take place if all attempts to provide community care services had failed or if the provision of such services was inappropriate.

### **Further definition**

- 12.109 Some consultees argued that the proposed definition should be accompanied by a list of examples of people who would be considered to be adults at risk. The GMC suggested that the definition should:

combine a restricted list of situations in which adults might be vulnerable, coupled with the requirement that that person is, or may

be, also at risk of significant harm [in order] to define people within this group.

- 12.110 Age UK considered that the legislation should make clear that “this definition would need to take into account personal circumstances as well as individual characteristics”. It therefore recommended the inclusion of “a short, indicative but non-exhaustive list of factors that might result in a person being considered an adult at risk”.

### ***Alternative definitions***

- 12.111 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.

- 12.112 Birmingham safeguarding teams proposed the definition originally put forward in ADASS safeguarding guidance:

Every adult “who is or may be eligible for community care services” (NHS and Community Care Act 1990) and whose independence and well-being is at risk due to abuse or neglect.<sup>6</sup>

- 12.113 Others suggested a situational approach to the definition. For example, the GMC suggested:

a restricted list of situations in which adults might be vulnerable, coupled with the requirement that that person is, or may be, also at risk of significant harm to define people within this group.

- 12.114 Similarly, Worcestershire Safeguarding Adults Board stated that “many members of the Board agreed that a ‘situational’ definition rather than one just based on a person’s vulnerability was more appropriate”.

- 12.115 Whilst we appreciate the Law Commission’s objective is to ensure adult social care responsibilities are clearly defined in statute, we believe that it will prove challenging to resolve this before Government policy on safeguarding is settled.

- 12.116 Action on Elder Abuse questioned whether health or social care needs are the appropriate “filter” to apply in safeguarding cases. They reported that – according to the evidence from their helpline – health and social care needs are not automatically a factor in every case of abuse, such as financial abuse of some older people. It was, therefore, suggested that a “silo approach” towards safeguarding should be avoided and that instead, the definition of an *adult at risk* should encompass adult abuse in its entirety, including domestic violence. 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: (a) experience abuse; and (b) cannot protect themselves without outside assistance”:

<sup>6</sup> Association of Directors of Adult Social Services, *Safeguarding Adults: A National Framework of Standards* (2005) p 5.



Safeguarding (in terms of creating environments, circumstances, situations etc that reduce the potential for abuse to happen) should apply equally to *all* adults within society, and not just to those who are more vulnerable to abuse, although it should clearly be informed by the experiences of victims. Intervention itself should only occur where someone experiences abuse (or is likely to experience abuse) and cannot take independent action to protect themselves.

12.117 They argued that the challenge in defining when to intervene is in ensuring:

that it captures those circumstances in which people are unable to make informed choices as a consequence of undue influence, coercion or some other incapacitating factor, while at the same time supporting the right of individuals to make unwise – or apparently harmful – decisions.

12.118 To illustrate this they provided an example of two circumstances that “are abusive and would be covered by the definition, but the intervention and protective strategies should be different”: On one hand, an older woman who makes an informed choice to allow a niece to continue stealing £10 from her purse each week because she chooses to benefit from the weekly companionship, where they deem her to be “making what is essentially a ‘best interest’ decision from her perspective”. On the other hand, the “the older woman who hands over the weekly £10 because she is fearful of the consequences”.

### **Conclusion**

12.119 The majority of consultees agreed with the proposal that an adult at risk should be defined in our statute as anyone with social care needs who is or may be at risk of significant harm, arguing that it would ensure that social services’ responsibilities in safeguarding cases do not become too broad and over-inclusive. Consultees also welcomed the inclusion of all those who have social care needs, and not only those who receive services. On the other hand, there was considerable concern amongst some consultees that the focus on people with social care needs will exclude those with health or other needs, and will obstruct rather than facilitate multi-agency working in the context of safeguarding. Many consultees also objected to the requirement of *significant* harm, and argued that it sets the threshold for the duty to investigate too high and will obstruct preventative action.

**Provisional Proposal 12-4: We provisionally propose that if the Government in England or the Welsh Assembly Government decides to introduce new compulsory or emergency powers to safeguard adults from abuse and neglect then these will be included in our future adult social care statute.**

- 12.120 Of the 231 submissions we received, 54 submissions expressed a view on the proposal that if the Government or the Welsh Assembly Government decides to introduce new compulsory and emergency powers, these will be included in our statute. Of those consultees 38 agreed with the proposal, 10 disagreed, and 6 held an equivocal position.
- 12.121 However, these figures should be treated with caution. It is possible that a number of consultees misinterpreted the proposal as suggesting that new safeguarding powers should be introduced. For example, seven out of the 38 consultees who agreed, and seven of the 10 consultees who disagreed, appear to have done so on the basis that they assumed from the wording of the proposals that new emergency and compulsory powers were being proposed. Seven of the nine adult safeguarding boards who responded to this proposal said that they agreed with it. However, three of those who agreed and both who disagreed may also have misinterpreted the proposal.
- 12.122 While the majority of consultees agreed with the proposal, they did not further elaborate on their reasons for agreeing. Therefore, this analysis will focus on the concerns of consultees who disagreed or had equivocal views.

***Criticism of the Law Commission's approach***

- 12.123 Some consultees disagreed that the remit of the Law Commission's review should not include new safeguarding powers. Baroness Hale was critical of the Law Commission's reluctance to make proposals for new powers for safeguarding adults at risk, asserting that, while it is for Parliament to legislate and Government to decide whether or not to promote legislation:

this has never deterred the Law Commission from developing proposals where the law is clearly in need of improvement and the subject matter is particularly suitable to the Commission's methods and strengths.

- 12.124 Referring to a number of Law Commission and Scottish Law Commission papers on this area, Baroness Hale observed that "this subject has already been considered eminently suitable to their methods and strengths by both Law Commissions". Baroness Hale went on to argue:

The Government did not implement the Commission's earlier proposals because it wished to see how effective statutory guidance would be. It has now recognised that guidance may not be enough and that legislation may be required.

- 12.125 Action on Elder Abuse also queried why the Law Commission was not seeking to build upon its recommendations in its 1995 final report on mental incapacity:

We would prefer to receive unambiguous recommendations from the Law Commission, or a re-evaluation of those put forward in 2005 in the light of the Scottish experience, in order to ensure a full debate on these matters can take place within Parliament.

- 12.126 Equally, Ann McDonald, a social care academic, argued that “the Commission should be entitled to express an opinion on the need for compulsory or emergency powers”.

***Problems with the current law***

- 12.127 Many consultees argued that the existing legal framework for safeguarding adults is inadequate and in need of review and/or reform. Action on Elder Abuse, in disagreeing with the proposal, observed that:

Existing powers under Section 17 of the Police and Criminal Evidence Act 1984 are often not sufficient for the cases that regularly come to the attention of safeguarding processes. This power however could usefully be developed to cover the majority of safeguarding cases.

- 12.128 Furthermore, Baroness Hale considered that:

The existing powers in the Mental Health Act 1983 and the National Assistance Act 1948 are patchy and outdated. There is nothing equivalent to sections 115 and 135(1) of the Mental Health Act in the Mental Capacity Act 2005 and such is the differentiation between the client groups that those working with mentally incapacitated people in the community may not realise that those sections could also apply to their client group. There is nothing applicable to other adults who may be at risk.

- 12.129 Baroness Hale argued further that such powers have an impact, not only on the willingness of individuals to co-operate, but also on the priority given to such work by social services and other professionals:

“Statutory work” tends to take priority over softer obligations. It is for this reason that adult safeguarding has been described as a “poor relation” to child protection.

- 12.130 An adult protection professional, in a written submission, provided anecdotal evidence to support the need for a review of safeguarding powers:

We have had a few cases where we have not been able to access a vulnerable adult who we suspect of being abused. One case involved a referral from a neighbour to say that an elderly lady was being financially abused by her family, to the extent that she was not able to go out as she did not have a coat etc. We tried to access her but her son refused the social worker access, and we did not have grounds to get police assistance. So it would have been useful to have powers of access in this case.

- 12.131 Bath and North East Somerset Safeguarding Board argued that the introduction of new powers would assist the safeguarding of those adults at risk who fall outside the Mental Health Act 1983 and the Mental Capacity Act 2005 – that is, individuals who do not have a mental disorder or who have capacity. East Riding of Yorkshire Council also made the point that “not everything is covered under the Mental Capacity Act 2005”.
- 12.132 Royal Borough of Kensington and Chelsea argued that “compulsory powers would be advantageous when considering last resort options”.
- 12.133 Several consultees argued that further consideration and/or more extensive consultation on the need for compulsory or emergency safeguarding powers was required. For example, the Care Quality Commission believed that further detailed enquiry is needed in respect of gaps in the existing legislation, particularly concerning powers to gain entry to premises for an assessment. It also considered that “it would be appropriate to reflect any decisions on this made by Government and to reflect the experiences in Scotland”.
- 12.134 The Law Society argued that “any future adult social care statute should contain new compulsory or emergency powers to safeguard adults” but only after a thorough review and consultation has taken place.
- 12.135 Bridget Penhale, a safeguarding academic, argued that “the introduction of new compulsory powers should be subject to further consideration by government”.
- 12.136 The Welsh Assembly Government is currently carrying out a review of adult safeguarding policy and therefore it responded by stating that this proposal would require further consideration after considering the outcome of the review.

### ***UN Disability Convention***

- 12.137 Consultees suggested that a review of safeguarding powers is necessary in the light of the UK's recent ratification of the UN Convention on the Rights of Disabled Persons. Article 16 requires States 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”. In her response, Baroness Hale argued that any new safeguarding powers must be reconciled with Article 3 of the UN Convention but “supporting autonomy and protecting from abuse do not have to be seen as opposites and can go hand in hand” and “translating this into legislative form is not an easy task, but it is one which no-one is better qualified than the Commission to undertake”.

### ***Scotland's approach***

- 12.138 Some consultees pointed to the Adult Support and Protection (Scotland) Act 2007 as providing a template for reform. Baroness Hale observed that the Scottish Law Commission's proposals were very similar to the Law Commission's 1995 proposals and have been implemented, with appropriate modifications in the light of later thinking and developments, in the Adult Support and Protection (Scotland) Act 2007.<sup>7</sup> She concluded that it is "difficult to understand why the Scots should be in need of such measures and the English and Welsh not".
- 12.139 BUPA Care Homes disagreed with the proposal and pointed to the approach taken in Scotland, stating that:

We are not aware of any problems which have arisen because of this change, but we recommend that a review of the Scottish system should be undertaken and that the proposed statute should mirror but also learn from and reflect the problems encountered in Scotland.

### ***New powers***

- 12.140 Some consultees put forward specific proposals for new safeguarding powers. It was argued that additional safeguarding powers to deal with two distinct problems. The first is the refusal by a service user of help and support when without them they will no longer be able to live an independent life in the community. For example, it was suggested that getting access to an adult at risk to enable a proper assessment to take place was often the key issue to address before deciding whether any compulsory action is needed. Consultees, therefore, argued that a local authority should have a power to apply to a court to carry out a compulsory assessment, enabling staff to enter premises by force if necessary, but without removing the person from their home.
- 12.141 The second problem is where it is believed that a service user is being abused or neglected by a third party, such as someone with whom the service user is living, and that third party refuses access to the person or refuses the provision of services to them. Some consultees argued that, in these circumstances, to remove the victim of abuse or neglect from their home but not the perpetrator was unreasonable and amounted to punishing the victim for the abuse they had suffered. Therefore, they argued that a local authority should have a power to apply to the court for an order to ban a named abuser from a specified place for a limited period of time.

### ***Conclusion***

- 12.142 The majority of responses to this proposal were positive. However, many consultees may have misinterpreted the proposal. There was some criticism of the Law Commission's reluctance to make proposals for new procedures for safeguarding adults at risk, especially in light of the approach taken in Scotland. Some consultees argued that the current law was insufficient in this regard, and that recent developments in the law highlighted the need for the Law Commission to undertake the task of translating these developments into legislative form.

<sup>7</sup> Report on Vulnerable Adults (1995) Scot Law Com No 158.

**Provisional Proposal 12-5: We provisionally propose that section 47 of the National Assistance Act 1948 should be repealed.**

- 12.143 Of the 231 submissions which were received, 79 submissions expressed a view on the proposal that section 47 of the National Assistance Act 1948 should be repealed. Of those consultees, 56 agreed with the proposal, 7 disagreed and 16 held an equivocal position.
- 12.144 Out of all consultees, 43 consultees wanted section 47 repealed entirely whilst 25 wanted section 47 either amended or replaced.

***Human rights concerns***

- 12.145 A large number of consultees agreed with this proposal on human rights grounds. For example, NHS Leeds stated that:

We agree with the concern relating to human rights breaches whereby section 47 could be used to detain people of sound mind, suffering from grave chronic diseases.

- 12.146 Some consultees noted that service users are sometimes arbitrarily removed from their homes without proper legal authority or regard for their human rights. NAAPS reported that:

This is particularly the case in Shared Lives households where an allegation of abuse or even just malpractice has been made but not substantiated. We strongly feel that the statute should be explicit in stating that proper consent or legal authority must be obtained before such action can take place.

- 12.147 Sense raised a particular concern in relation to deafblind people giving the example of a deafblind man, living at home, whose condition had progressed to such a degree that he was no longer able to receive formal communication by any means:

The local authority had concerns about his welfare living at home and so wanted to place him in residential care. There was no reason to think he lacked capacity but it was not possible to get his consent to residential care. Section 47 was therefore used to remove him from his home and place him in a care home.

***Obsolete in practice***

- 12.148 A large number of consultees noted that section 47 is rarely used in practice. Nicolette Barry, an adult protection co-ordinator with Worcestershire County Council, noted that she has only ever used the provision once.
- 12.149 West Berkshire Safeguarding Adults Board agreed that section 47 is infrequently used and can be confusing for social care staff who do not understand its use, while maintaining that:

It is a useful option still available to a Local Authority where the service user has capacity but needs to be removed from their home

and is useful in that it is available as a local option. People should treat everyone as individuals, and not make decisions because a rule says they can.

***Alternative legal powers***

12.150 Several consultees argued that the majority of people who could come under section 47 would be covered by alternative powers. John Howard, a social care professional, argued that:

Powers already exist under the Mental Health Act 1983 to remove individuals who have a mental disorder to a place of safety (sections 135 and 136) and the Mental Capacity Act 2005 provides a statutory framework for decision making for individuals who lack capacity.

12.151 Similarly, NHS Leeds stated:

Our experience confirms that ... [i]n many instances other more suitable legislation could be used where section 47 could be invoked (e.g. the Mental Health Act 1983).

12.152 Suggested alternative powers include an application to the Court of Protection, which North Tyneside Council said provides the most appropriate legal remedy. In addition, Anthony Collins Solicitors argued that its position turned on whether the inherent jurisdiction of the High Court amounted to an alternative residual power in this area. It was argued that if the inherent jurisdiction remains even for people with capacity, section 47 has no place on the statute books.

12.153 The Approved Mental Health Professional Leads, pointed out that 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”. Others argued that the Mental Capacity Act 2005 provided a much more effective legal framework for dealing with most people for whom section 47 is intended to apply.

12.154 However, other consultees argued that some people would be left unprotected if section 47 were repealed. Stephen Ward, a social care professional, made the point specifically in relation to the Mental Health Act 1983:

[Section 135 Mental Health Act 1983] will not be available in all circumstances and limitations on section 6 of the Mental Capacity Act 2005 mean it may not be sufficient where someone is resisting being removed from their property. This only leaves an application to the Court of Protection (assuming the person lacks capacity) which is an expensive procedure and may leave local authorities unwilling to take action.

- 12.155 Furthermore, the Welsh Assembly Government expressed some reservations on the repeal of section 47 because “there may be circumstances in which it could be used which would not be covered by the Deprivation of Liberty Safeguards” under the 2005 Act. Moreover, some local authorities argued they are reluctant to rely on the Deprivation of Liberty Safeguards to detain a person to a place of safety who is currently living at home. *DCC v KH* confirmed that a standard authorisation would be sufficient to return an individual from “contact sessions” to their place of residence, where doing so would entail a deprivation of liberty. However, some consultees suggested that the principle does not apply to the initial journey to admit the person to the residence.<sup>8</sup>
- 12.156 West Berkshire Safeguarding Adults Board argued that section 47 – while used rarely – is a useful safeguarding option where the service user has mental capacity but needs to be removed from their home and no other legal option is available. Gateshead Council argued that something similar to section 47 is needed to cover situations where a vulnerable person needs removing urgently from a situation that is causing them significant harm, and it is not clear if they lack capacity.
- 12.157 The British Psychological Society argued that repealing section 47 would leave unprotected individuals who by virtue of their psychological difficulties did not acknowledge and did not accept that they might require assistance. They argued that new legislation would be needed to protect people who have capacity, but whose lifestyle creates significant nuisance for themselves and others.
- 12.158 At consultation events with approved mental health professionals it was suggested that mental health and mental capacity legislation is not used to protect all potential section 47 cases. For example, the use of the Mental Health Act 1983 is in practice limited to people who need to be detained in hospital, even though the 1983 Act does not always require this. Thus, the compulsory removal power under section 135(1) of the 1983 Mental Health Act 1983 is normally used to assess a person at a place of safety for detention in hospital, rather than its wider purpose. 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.
- 12.159 Consultees also suggested 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.

<sup>8</sup> *DCC v KH* (2009) COP 11729380.



12.160 Belinda Schwer, a legal and training consultant, argued that alternative environmental health powers are ineffective as they fail to ensure that a sophisticated social work value based decision is made about what to do with vulnerable persons in the way section 47 does. The British Psychological Society described the Public Health Act 1936 as “arcane” and argued that any increase in its use, if section 47 were repealed, would be a “retrograde course to follow”. At consultation events, it was argued further 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. Furthermore, Belinda Schwehr argued that separate environmental health powers fail to ensure that “a sophisticated social work value based decision is made about what to do with the person with a complex compulsive behaviour disorder”.

***Practical difficulties***

12.161 Several consultees practical difficulties with the use of this power. For example, mental health practitioners at consultation events suggested that the police are 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 has been given not to social services authorities, but to district councils, who usually allocate an environmental health officer to the role. It was argued that such officers are not best suited to seeing this as a power for the protection of adults at risk.

12.162 Currently, section 47 requires that in order to be detained a 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 cause practical difficulties because they set the bar unrealistically high for the use of this power and the reference to “insanitary conditions” confuses this power with alternative public health powers.

12.163 Furthermore, in several local authority areas consultees reported that they had been unable to identify the medical officer of health in their area or that the role had 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, people with mental health problems or who need safeguarding.

12.164 Some consultees argued that magistrates' courts are not the most appropriate forum for considering the compulsory removal of an adult at risk. It was suggested that, since they are generally viewed as criminal courts, it is inappropriate for magistrates courts to consider cases which will often not involve any criminal activity and that the person for whom the order is being sought may be stigmatised as a result. Some consultees raised concerns about entrusting to lay magistrates the decision to detain adults at risk and suggested this was not an effective safeguard. Similarly, it was argued that magistrates lack the necessary expertise to deal with cases involving self neglect and mental health issues in general; whereas the appropriate level of expertise was available in other courts, such as the mental health tribunal and the Court of Protection. Others pointed to existing delays in hearing cases at magistrates' courts and suggested that if as a result of our reforms, applications for compulsory removal powers were to increase, the courts would find it difficult to cope.

***Replacing section 47***

12.165 Some consultees agreed with the proposal but only on the basis that section 47 is replaced with a similar power. The Law Society reflected this point saying that there was agreement with the proposal but this is:

subject to the proviso that new legislation is enacted to protect that group of people for which this section is the only safety net and that it provides access to otherwise inaccessible care and support services.

12.166 Suffolk County Council's response argued that special provision should be made to safeguard certain individuals:

There are concerns that repealing this legislation may mean a small number of individuals would be at risk, but recognise the concerns raised by the European Court of Human Rights. We would therefore recommend that alternative proposals are considered to safeguard the small minority of individuals who may remain at risk.

12.167 Bath and North East Somerset Safeguarding Board supported the proposal on the basis that "this is replaced with a provision to protect the welfare of individuals residing in insanitary and/or verminous conditions".

12.168 Some consultees opposed our proposal on the basis that section 47 should be retained, albeit in a modified form. Baroness Hale stressed that compliance with human rights should be at the heart of a proper approach:

The Commission may think that it makes little sense to recommend repeal of section 47 of the National Assistance Act 1948 without considering whether there is a need to replace it with a more Convention-compliant process.

12.169 Swansea County Council saw utility in retaining the power:

The use of section 47 is rare but it does cover individuals who do not come under mental health or [mental capacity] legislation but there remain grave concerns about the person and their living conditions. The present arrangements that the local authority is the lead in

applying to the Court under section 47 should remain as this is far more practicable than previous guidance that a Community Physician makes the assessment and application to court.

- 12.170 Some consultees predicted an upwards trend in the use of section 47. Gateshead City Council argued that:

Historically this section has not been used often. However, as the emphasis on safeguarding increases, it (or something like it) will be needed to cover situations where a person who cannot be said to lack capacity urgently needs removing from a situation that is causing them significant harm.

***Conclusion***

- 12.171 Most consultees agreed with the proposal that section 47 of the National Assistance Act 1948 should be repealed. This included those who wanted section 47 repealed altogether and those who wanted it to be replaced. Most consultees agreed that section 47 should be repealed on the basis that it does not comply with the Human Rights Act 1998 and is obsolete in practice. Several consultees argued that the majority of people who could come under section 47 would be covered by alternative powers. However, other consultees argued that some people would be left unprotected if section 47 were repealed.

**Provisional Proposal 12-6: We provisionally propose that a local authority should continue to be under a duty to prevent the loss or damage of a person's property when they have been admitted to hospital or provided with residential accommodation.**

12.172 Of the 231 submissions which were received, 57 submissions expressed a view on the proposal that a local authority should continue to be under a duty to prevent the loss or damage of a person's property when they have been admitted to hospital or provided with residential accommodation. All 57 responses agreed with the proposal.

***An important safeguard***

12.173 A large number of responses stressed the important role this duty plays in the protection of the property of service users. For example, Bath and North East Somerset Safeguarding Board argued that the duty "serves to provide an important safeguard when a person's property is at risk particularly when compulsory powers have been used".

12.174 Furthermore, the Care Quality Commission suggested that the duty to protect property "seems a useful fallback to safeguard a person's property where there are no other suitable means".

***The need for greater clarity***

12.175 Several consultees argued that local authorities' responsibilities in this area ought to be clarified. For example, the Law Society argued that further thought was needed as to "how individuals may enforce such rights and also to the extent of the duty upon local authorities to prevent loss".

12.176 In addition, West Sussex Safeguarding Board, RADAR and the National Council for Independent Living suggested that further consideration should be given to how local authorities access property in these circumstances and to what extent the loss or damage to an empty home should be balanced against the right to privacy.

***Protection of pets***

12.177 Belinda Schwehr, a legal and training consultant, argued that more guidance is needed on how local authorities should carry out this duty in relation to pets, since there is a real difference between protecting pets who will have ongoing needs and preventing damage to, for example, pictures or furniture.

12.178 Furthermore, Blackburn with Darwen, Blackpool and Lancashire Safeguarding Adult Boards expressed concern about the excessive costs that can arise in looking after pets under this duty:

It should be noted that should there be a requirement to care for pets the cost may be prohibitive. Is there a rationale for adult social care services to bear this considerable expenditure?

### ***Responsibilities of family members***

- 12.179 ADASS and Worcestershire Safeguarding Adults Board argued that the duty should apply only where other family members or others are prevented from fulfilling this function.
- 12.180 The Eastern Region Adult Safeguarding Leads Group and Bridget Penhale, a safeguarding academic, suggested that the duty should apply only if local authorities are satisfied that there is no other person who can act in the individual's interests:

The continuation of this section appears appropriate. However a clause could perhaps be added which is similar to the Mental Capacity Act 2005 provisions, for the use of Independent Mental Capacity Advocates in safeguarding cases. This would indicate that local authorities would only have this duty where they are satisfied that there is not other person who can act in the individual's best interests.

- 12.181 Worcestershire Safeguarding Adults Board 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.

### ***Other comments***

- 12.182 Some consultees, for example, RADAR and the National Centre for Independent Living stressed the need to balance the duty to prevent loss or damage to an empty home against the right to privacy as protected by article 8 of the European Convention on Human Rights.
- 12.183 Worcestershire Safeguarding Adults Board agreed with the proposal but suggested that the duty should be time limited.
- 12.184 Some consultees also emphasised that local authorities should continue to have the power to recover costs from the service user for any expense occurred. For example, Worcestershire Safeguarding Adults Board and Newcastle City Council arguing that the duty should be expressly one of last resort and that costs should be recouped where appropriate.
- 12.185 East Riding of Yorkshire Council queried why this duty should apply only to local authorities and suggested that the NHS should also bear some responsibility.

### ***Conclusion***

- 12.186 All consultees agreed with the proposal that a local authority should continue to be under a duty to prevent the loss or damage of a person's property when they have been admitted to hospital or provided with residential accommodation. However, some argued that greater clarity was needed about what the local authority's responsibilities are in this area, and specific provision was needed to ensure that pets are protected appropriately. A small number of consultees suggested that the duty needed to be modified to take into account family members who can perform this duty.

**Provisional Proposal 12-7: We provisionally propose that our future statute should place a duty on each social services authority to establish an adult safeguarding board and should specify the functions and membership of the board, the requirement to share information and a duty to contribute to serious case reviews.**

- 12.187 Of the 231 submissions which were received, 82 submissions expressed a view on the proposal that our future statute should place a duty on each social services authority to establish an adult safeguarding board and should specify the functions and membership of the board, the requirement to share information and a duty to contribute to serious case reviews. Of those consultees, 77 agreed with the proposal and 5 held an equivocal position. No consultees disagreed.

***Statutory safeguarding boards***

- 12.188 The majority of consultees supported the idea of statutory safeguarding boards. The reasons were summed up by Sunderland City Council:

The placing of the Adult Safeguarding Boards on a statutory basis will ensure engagement from relevant partners, a consistency of approach across the country, and support better outcomes for people who are identified as needing safeguarding

- 12.189 Furthermore, Bridget Penhale, a safeguarding academic, argued that putting safeguarding boards on a statutory basis would “give the board a greater clarity as to its remit, function, membership and constitution”. Nottingham City Adult Safeguarding Partnership Board suggested that this “would provide national consistency and raise the profile of boards”.

- 12.190 The Royal Borough of Kensington and Chelsea also agreed with the proposal:

Putting adult safeguarding boards on a statutory footing would undoubtedly strengthen the local governance arrangements by setting out the functions and membership of the board, requirements to share information, and a duty to contribute to serious case reviews. It would also give the Care Quality Commission a clearer benchmark on how to assess the performance of boards during safeguarding inspections as at present there seem to be a lot of variability as to what the standards are and a lot of variability in the effectiveness of safeguarding boards across the country.

***The duty on the local authority***

- 12.191 Most consultees agreed that the local social services authority should be given the lead role in establishing adult safeguarding boards. For example, the Equality and Human Rights Commission – while recognising the need to ensure multi-agency working – argued that a single agency should be charged with co-ordinating the adult safeguarding board and that the local authority should be given this role.

12.192 Several consultees argued that social services should be given this role because they already have the lead co-ordinating role for safeguarding adults by *No Secrets* and *In Safe Hands* and therefore, have the necessary experience of safeguarding adults at risk and encouraging multi-agency working.

### **Functions**

12.193 Most consultees agreed that the functions of adult safeguarding boards should be specified on the face of the statute. Many consultees, such as the Wolverhampton Safeguarding Vulnerable Adults' Board, argued that the functions specified should be the same as those contained in the Adult Support and Protection (Scotland) Act 2007:

- (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;
- (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 committee's functions.<sup>9</sup>

12.194 Furthermore, Action on Elder Abuse suggested adult safeguarding boards should be given a strategic role to monitor and research levels of abuse and neglect in their area and identify any trends in referrals to adult safeguarding teams, including gaps and over-representation in relation to certain groups or certain types of abuse. They 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.

### **Membership**

12.195 Most consultees agreed that the local authority, the 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:

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

<sup>9</sup> Adult Support and Protection (Scotland) Act 2007, ss 42(1) and 46.

- 12.196 Action of Elder Abuse suggested that our recommendation should go further than address representation at meetings, but should place a duty on agencies to “collaborate, actively participate at a senior level, and work together” and the appointment of representatives should rest with chief constables and the chief executives of relevant agencies. Nicolette Barry, a safeguarding professional, argued that legislation is needed to ensure that people take an active role in the board and at the correct level in their organisation.
- 12.197 Newcastle City Council suggested that if an individual or institution was invited to a safeguarding meeting and was unable to attend then there should be some requirement that a report would be submitted instead.
- 12.198 Moreover, both Age UK and Solihull Safeguarding Board suggested that the boards should be required to appoint an independent chair.
- 12.199 The Care Quality Commission, however, urged caution on specifying the membership of the board, since this would either be done at a level which is so broad as to be of dubious value or, if more detailed, be unduly prescriptive and possibly constrain local action. Furthermore, the names and roles of specific agencies will change with time, meaning that the list of members would need updating periodically.
- 12.200 The National Offender Management Service agreed with the proposal to specify membership but argued that its officers should not be required to attend because often the agenda will have little relevance to offender management and to require attendance at every meeting of every safeguarding board would have significant resource implications. Similarly, the Office of the Public Guardian argued for flexibility for agencies, such as itself, that have legal responsibilities and an interest in specific safeguarding issues but, due to the extent of their jurisdiction, it would not be practical to sit on all local safeguarding boards.

***Duty to share information***

- 12.201 The Care Quality Commission, Equality and Human Rights Commission and Blackburn with Darwen, Blackpool and Lancashire safeguarding adult boards supported the introduction of a duty on members of the safeguarding board to provide the committee with any information that the committee may reasonably require in order to carry out its functions.
- 12.202 Wolverhampton Safeguarding Vulnerable Adults’ Board also proposed that this duty should be widened to incorporate a requirement to share information in any investigation concerning an adult at risk.

***Duty to contribute to serious case reviews***

- 12.203 Several consultees argued that adult safeguarding boards should commission serious case reviews and that there should be a duty to contribute to these reviews.



- 12.204 Nottingham City Adult Safeguarding Partnership and Belinda Schwehr, a training and legal consultant, suggested that our proposals could go further and argued that the serious case reviews criteria and procedures should be national and not local. Some participants at consultation events considered that 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.

#### ***Other suggestions***

- 12.205 Action on Elder Abuse suggested that statute law should require Government to provide adequate funding for adult safeguarding boards and establish a standardised data monitoring and collection system on adult protection referrals and outcomes and to establish clear timescales for investigation and intervention.
- 12.206 Age UK suggested that safeguarding boards should have powers to apply for a court order to protect a person from harm by excluding the abuser through an enforceable order, changing door locks and putting in place emergency care support if necessary.
- 12.207 The Law Society supported, “in principle, the mandatory statutory provision for the establishment of adult safeguarding boards” but were concerned however “as to the resource implications of such a proposal”. They noted in this regard “that local safeguarding children boards have faced funding difficulties since their establishment under the Children Act 2004”.

#### ***Conclusion***

- 12.208 The majority of consultees agreed that that our future statute should place a duty on each social services authority to establish an adult safeguarding board and should specify the functions and membership of the board, the requirement to share information and a duty to contribute to serious case reviews. Most consultees agreed that the local social services authority should be given the lead role in establishing adult safeguarding boards and that the functions of adult safeguarding boards should be specified on the face of the statute. 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. Several consultees argued that board members should be placed under a duty to share information and that adult safeguarding boards should commission serious case reviews and that there should be a duty to contribute to these reviews.

**Provisional Proposal 12-8: We provisionally propose that the enhanced duty to co-operate, as proposed in Part 11 of the consultation paper, should include specific provision to promote co-operation between the organisations in safeguarding adults from abuse and neglect.**

- 12.209 Of the 231 submissions which were received, 75 submissions expressed a view on the proposal that the enhanced duty to co-operate, as proposed in Part 11 of the consultation paper, should include specific provision to promote co-operation between the organisations in safeguarding adults from abuse and neglect. Of those consultees, 72 agreed with the proposal and 3 held an equivocal position. No consultees disagreed with the proposal.

***Lack of existing joint working***

- 12.210 A large number of consultees endorsed the proposal to incorporate a specific duty to promote co-operation between the organisations in the statute on the basis of the current lack of co-operation in information sharing between agencies. As the Law Society's response put it:

Safeguarding is a shared responsibility, even if in reality, local authorities take the lead. The Society fully supports this proposal and understands that the introduction of such an enhanced duty is widely supported by many agencies and organisations who work with vulnerable adults.

- 12.211 Several consultees added that the proposal harmonises the adult social care regime with existing Local Safeguarding Children's Board and *Multi Agency Public Protection Arrangements* and *Multi-Agency Risk Assessment Conference* requirements. This point was made by Action on Elder Abuse:

We believe that the legislative duty to co-operate already in place for *Multi Agency Public Protection Arrangements*, and also for safeguarding children under section 11 of the Children Act 1989, needs to be placed upon those from whom co-operation is sought and expected for safeguarding adults. A duty to co-operate could relate to different people in statutory Agencies at different times and in different circumstances.

***Safeguarding vulnerable adults***

- 12.212 Several responses argued that a specific provision to promote co-operation between the organisations was vital to protecting the ability of vulnerable adults to control their lives. Conwy Connect considered that:

We think there is a gap between those who are offered learning disability services and those offered mental health services. We think that some people fall though the "gaps" in services.

- 12.213 Mencap highlighted the cases of Fiona Pilkington and Brent Martin, arguing that they reflect the failure of statutory agencies to work together to intervene in cases of abuse:

Mencap acknowledges the benefits of early intervention in identifying situations of risk and preventing serious neglect and abuse. It sees the greatest possibility for early intervention arising from closer co-operation between agencies.

***Clarification of the duty***

- 12.214 Several responses made suggestions as to how the duty should be defined. The Law Society considered that:

The placement of multi-agency co-operation and information sharing on a statutory footing ... should extend to non-local authority agencies such as NHS Trusts and the Police.

- 12.215 John Howard, a social care professional, argued that the position in Wales should be carefully considered and that the provision should include:

duties respectively to investigate, to co-operate and to share information within a clear statutory framework for inter-agency working. This would be more than that suggested [by the proposal], "to promote co-operation." Past experience suggests that promoting and obtaining co-operation and partnership working remain a long way apart with much time used unproductively in terms of outcomes.

- 12.216 The West Sussex Safeguarding Board argued that the provision should detail arrangements for the provision of professionals:

Enhanced co-operation should also specify the need for agencies to have plans in place for the commissioning, training and availability/provision of appropriately trained professionals and practitioners to undertake safeguarding investigatory work where requested by the local authority.

- 12.217 The Social Care Institute for Excellence argued that:

There should not only be a duty on local authorities to co-operate with other agencies and to request their assistance, but also mutually binding obligations on the statutory agencies to collaborate with one another in applying agreed strategies, priorities, procedures and information-sharing protocols.

- 12.218 In addition, some consultees asked whether agencies that failed to accord with the duty (if implemented) would be subject to sanctions. Hull City Council made the point thus:

This proposal places a duty to co-operate on the multi-agencies involved in adult social care. This is welcomed, though it is unclear if there are to be any sanctions placed on agencies that are considered not to be co-operating in the spirit of the law.

### ***Expansion of duty***

12.219 Several consultees argued that the enhanced duty should be expanded. For example, Nottingham City Adult Safeguarding Partnership suggested that the duty to co-operate in safeguarding cases should be expanded and that health authorities should have specific responsibilities to identify health risks and contribute to the safeguarding assessment process. Age UK suggested that the duty should also apply to individual general practitioners.

12.220 Age UK also argued that the current guidance should be replaced with legislation that is binding on all public bodies (including social services):

We recommend that the proposed duty should be supplemented by a duty to make referrals to the local authority where abuse is suspected.

12.221 Making Every Adult Matter's response echoed this point:

This duty should apply not only to other agencies cooperating at the request of the social services authority but to the social services authority cooperating with other agencies at their request too.

### ***Other comments***

12.222 In addition, the following suggestions were put forward by consultees:

- (1) Action on Elder Abuse recommended that the duty should apply to: chief officers, in terms of their participation at strategic management level; to those delegated to participate in adult safeguarding boards; and to others, in terms of their employment responsibilities to co-operate with investigations and comply with outcome decisions;
- (2) The London Borough of Havering suggested that the duty to co-operate should also include a power to share information;
- (3) Hull City Council suggested that sanctions could be placed on agencies that are considered not to be co-operating in the spirit of the law;
- (4) Mencap recommended that the duty to co-operate should be accompanied by guidance on existing policies, such as the Caldicott guidelines, in order to balance safeguarding with a right to privacy; and
- (5) Age UK recommended that the proposed duty should be supplemented by a duty to make referrals to the authority where abuse is suspected.

### ***Conclusion***

12.223 There was overwhelming support for the proposal that the enhanced duty to co-operate, as proposed in Part 11 of the consultation paper, should include specific provision to promote co-operation between the organisations in safeguarding adults. No consultees disagreed that there should be an enhanced duty to co-operate in the safeguarding context. A large number of consultees saw such a duty as an important part of effective safeguarding. Some consultees made specific suggestions about how the duty should be defined, with some consultees arguing for an approach which expanded beyond the provisional proposal.

**Provisional Proposal 12-9: We provisionally propose that *No Secrets* and *In Safe Hands*, or their successors, are linked clearly to a local authority's statutory functions to safeguard adults from abuse and neglect, as set out in our future adult social care statute.**

12.224 Of the 231 submissions which were received, 47 submissions expressed a view on the proposal that *No Secrets* and *In Safe Hands*, or their successors, are linked clearly to a local authority's statutory functions to safeguard adults from abuse and neglect, as set out in our future statute. Of those consultees, 44 agreed with the proposal and 3 held an equivocal position. No consultees disagreed with this proposal.

### ***Legal Clarity***

12.225 Many consultees argued that this proposal would assist legal clarity. For example, Bath and North East Somerset Safeguarding Board argued that this proposal:

Serves to create a clear link between *No Secrets* and *In Safe Hands* and the local authority's statutory functions comparable to similar links that already exist between the Children Acts and Working Together to Safeguard Children and the Mental Health and Mental Capacity Acts and their respective Codes of Practice.

12.226 On the other hand, the Care Quality Commission – while agreeing with the proposal – argued that this should not mean any delay in the revision of *No Secrets* pending the introduction of new legislation.

12.227 Moreover, Age Cymru argued that this proposal should not be seen as a replacement for further debate on the need for separate safeguarding legislation.

### ***Other comments***

12.228 The Law Society agreed that “formal guidance as contained in *No Secrets* and *In Safe Hands* should be clearly linked to a local authority's statutory functions” but emphasised that it must be “abundantly clear that it is the new legislation that local authorities should primarily rely upon even if such guidance becomes statutory guidance in due course”.

12.229 Mencap argued that this proposal would place “policy at the heart of the legal framework of social care”.

### ***Conclusion***

12.230 The majority of consultees agreed with the proposal that *No Secrets* and *In Safe Hands*, or their successors, should be linked clearly to a local authority's statutory functions to safeguard adults from abuse and neglect, as set out in our future statute. Most consultees argued that such a link would have benefits in terms of legal clarity whilst others pointed to the importance of primary legislation to guide the actions of local authorities.

### **Other issues raised at consultation**

- 12.231 While the previous analysis dealt with responses on specific proposals or questions, this section highlights some wider issues that were raised at consultation in relation to safeguarding. It was suggested that these issues should be taken into account when developing our recommendations for reform in relation to safeguarding.

### ***Guardianship***

- 12.232 The Approved Mental Health Professionals Leads Network recommended 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”.<sup>10</sup>
- 12.233 The Approved Mental Health Professionals Leads Network argued 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”.
- 12.234 They argued that removing the qualification would 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***

- 12.235 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.<sup>11</sup> Proceedings can be instituted by the Director of Public Prosecutions or by a local social services authority with the Director’s consent.<sup>12</sup>

<sup>10</sup> Mental Health Act 1983, s 1 (2A) and (2B).

<sup>11</sup> Mental Health Act 1983, s 127 and Mental Capacity Act 2005, s 44.

<sup>12</sup> Mental Health Act 1983, s 130.

- 12.236 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 nor lack mental capacity. For example, one participant at a consultation event suggested that a situation could arise whereby three adults at risk have been placed in a care home where they suffer 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.
- 12.237 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.

### ***The Family Law Act 1996***

- 12.238 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.
- 12.239 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 the 1996 Act allows authorities to apply for forced marriage protection orders.<sup>13</sup> There is provision in 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.<sup>14</sup>

<sup>13</sup> Family Law Act 1996, Part 4A (as amended by the Forced Marriage (Civil Protection) Act 2007).

<sup>14</sup> Family Law Act 1996, s 60. The representative is not defined but can be prescribed in the relevant court rules.

## **PART 13**

# **STRATEGIC PLANNING**

**Provisional Proposal 13-1: We provisionally propose that the disabled persons register should be abolished.**

- 13.1 Of the 231 submissions which were received, 57 submissions expressed a view on the proposal that the disabled persons register should be abolished. Of those consultees, 38 agreed with the proposal, 11 disagreed whilst 8 held an equivocal position.

### ***Difficulties with the disability register***

- 13.2 A large number of consultees agreed with this proposal on the basis that disability registers are difficult to compile and maintain. Disability North described the situation:

Despite having been a legal requirement for several decades, local authorities have found it difficult, if not impossible to establish disabled persons registers. Different definitions of “disability” and different criteria for registration across impairment groups contribute to the complexity of establishing registers. The issue of who informs the Council when someone moves out of the area or dies compromises local authorities’ ability to maintain accurate registers.

- 13.3 Several consultees doubted the value of disability registers because they are often not kept up to date, whilst people have the choice as to whether or not their name is included on a register. The Government stated that:

these registers are very variable in quality and scope. This is, in part, because many disabled people choose not to register. Registers do not produce good data on the numbers of disabled people in England even at a strategic policy level. Moreover, registers of disabled people do not offer the best tool for local authorities in planning services.

- 13.4 Given these problems, a number of consultees argued that the disability register is not a good use of valuable resources. Nottingham City Council described the register as “an unnecessary burden at a time of financial rectitude”.

### ***Outdated approach***

- 13.5 Some consultees argued that disability registers represent an outdated approach. The Multiple Sclerosis Society described the registers as “potentially stigmatising”, whilst the Care Quality Commission stated that they have no place in contemporary planning of services. The Northumberland Forum for People with a Learning Disability made this point:



Writing down how a disabled person is different from another person is a bad idea and we do not agree. It should be about not being different; we don't think that it is fair to be labelled "disabled". Everyone with a disability might as well wear a sticker that says they're different. This doesn't need to be pointed out to other people. It should be about supporting us to be able, not about labelling us as unable.

### ***Unintended consequences***

- 13.6 A number of consultees expressed concern that abolishing the disability register may have unexpected consequences. The Vale of Glamorgan Carers' Forum argued that:

careful consideration needs to be given to whether there is any benefit to any of the groups on the register and if there is, provision needs to be made to ensure this is not lost.

- 13.7 Amongst consultees, there was a strong theme that abolishing the disability register should not leave people worse off. For example, RADAR (originally the Royal Association for Disability Rights) and the National Council for Independent Living stated that:

steps must be taken to ensure that this does not disadvantage disabled people who need registration as proof of their entitlement. In particular, local authorities need to alter their procedures in relation to blind and partially sighted people so that they do not rely on registration as proof of impairment. This also applies to Her Majesty's Revenue and Customs who currently required blind people to be registered with a local authority in order to claim the blind person's tax allowance.

### ***Retaining the disability register***

- 13.8 A significant number of consultees argued that the disability register should be retained and improved. The Standing Commission on Carers stated that:

effective strategic planning must include a database or register to provide as accurate as possible information on current and likely future need. ... We are aware of the challenges of setting up and very importantly updating and maintaining a database or register. ... But where it has worked well (invariably with cooperation between health and social care services), it has led to better strategic planning and the avoidance of crisis management over situations that could have been avoided with earlier intervention. Many of the earlier registers (including the Registers of People with a Learning Disability) failed because of their complexity. We suggest that a simpler database could work well.

- 13.9 Several responses echoed the theme that whilst disability registers may have several flaws, this means that the registers should be developed rather than abolished. Mencap made this point:

The register of disabled people ... has not in practice been implemented. Many local authorities fail to maintain true records of disabled people. However, Mencap has strong evidence of the benefits for keeping registers of people with a learning disability.

- 13.10 In their response, Mencap gave a case study from Lambeth which described a learning disability register which is run by Register Services (an initiative set-up by NHS Merton and Sutton Primary Care Trust). The argued that since the register is properly maintained, it has allowed effective planning to take place.
- 13.11 Consultees who argued for the retention of the disability register highlighted the potential value of such registers. Hull City Council asked the question: “whilst the register is not currently a useful tool for strategic planning, would it be better to improve the register rather than remove it?”
- 13.12 At a consultation meeting, Anne Bowman, Head of Register Services at NHS Sutton and Merton, argued that registers can be made to operate successfully in practice. *I Count* is a register of adults with a learning disability and disabled children. This is a joint initiative by health and social services and provides registers across several different local authority areas. People are encouraged to register by offering incentives such as the *I Count card* which can be used to access a range of concessions. The registers are updated each year and include a wide range of data on the individuals. A wide range of data is collected which are used for planning services, monitoring specific groups, data for research and mail shots. They are also used as a means to identify problems that may require attention by health and social services. GPs also have access to the register, for example for the purposes of fulfilling the Directed Enhanced Services contract to identify patients with learning disabilities and provide an annual health check.

### ***Possible solutions***

- 13.13 A number of consultees suggested solutions to the problems currently associated with disability registers. For instance, the National Family Carer Network suggested a role for technology as a means of simplifying the current system. The Social Care Institute for Excellence argued that:

some service users and carers have suggested that individuals could be automatically registered as disabled at the time of assessment, and could then have the choice of whether to opt in or out of the register.

- 13.14 Some consultees also argued that there should be a stronger requirement on local authorities to maintain a database. For example, Cartrefi Cymru queried whether there should be a stronger duty to compile a database.

### ***People with sensory impairments***

- 13.15 A strong theme amongst consultees related to the position of those with sensory impairments. This is because those with visual impairments can use the disability register to establish entitlement to certain benefits or services. Liz Ball, a deafblind person, argued:

The registers of blind and partially sighted people are valuable. In many circumstances being registered blind gives entitlement to concessions or services. If blind people were no longer registered, their eligibility would have to be proven every time.

- 13.16 RNIB and Guide Dogs listed benefits and concessions which registration confers on a blind or partially sighted person in addition to those mentioned in the consultation paper. These include concessionary travel passes; free postage on items marked "articles for the blind"; entitlement to devices and equipment, including permanent loan of radios and audio players; free NHS sight test for those under 60; help with NHS costs such medical prescriptions and vouchers towards the cost of glasses; discounted rail travel; and council tax disability reduction. They went on to say that:

a desire to streamline the law, should not lead to "throwing the baby out with the bath water". Simply because it does not necessarily fit easily with the approach adopted by the Commission in its proposed social care statute does not mean that registration (for sight loss) has no place in a new social care system. Without specific guarantees that future legislation would retain the advantages of the registration system, and considering the prospect that local authorities will further ration and streamline social care, we have to take a rather more practical view.

- 13.17 Other consultees made the point that sight-loss registers can be used for strategic planning. Sense argued that:

we also feel that there is merit in the continuation at the very minimum of the blind and partially sighted register. The numbers of visually impaired people who choose to register is high enough to make this worthwhile.

- 13.18 The Royal College of Ophthalmologists agreed with this point. The RNIB and Guide Dogs noted that whilst only around 20% of disabled people are registered, up to 80% of sight-impaired people are registered. This, it was argued, makes strategic planning for this user group a viable exercise:

Registers, when maintained effectively, should assist local authorities with predicting demand for rehabilitation and other forms of training and support. And whilst the registers only provide information by impairment and not need, they do give an indication of what that need might be.

### ***Conclusion***

- 13.19 Most consultees agreed with the proposal to abolish the disability register. Consultees recognised that registers do not currently assist with strategic planning and would be costly to maintain properly. Some consultees went further, saying that disability registers are outmoded and can stigmatise the disabled. However, there were a substantial number of concerns raised. A number of consultees warned that abolishing the disability register may have knock-on effects for service provision and that some service users could lose their entitlements. Some consultees felt that the flaws in the disability register pointed to a strong argument to keep and improve the register and ways to achieve this were suggested. Arguments were made on behalf of those with sensory impairments since the register can act as a gateway to entitlement for certain benefits, whilst the numbers of those registered are high enough to enable effective strategic planning. In the main, however, consultees agreed that the disability register requires at least some modification to be a useful tool in the future.

**Provisional Proposal 13-2: Provisionally, we do not propose to include any strategic planning provisions in our future adult social care statute.**

- 13.20 Of the 231 submissions which were received, 40 submissions provided answers to our proposal not to include any strategic planning provisions in our statute. Of those consultees, 32 agreed with the proposal, 7 disagreed whilst 1 held an equivocal position.

***The need to avoid additional complexity***

- 13.21 Many consultees agreed with this proposal because it was acknowledged that the volume of current strategic planning provisions is such that further provisions are unnecessary. Newcastle City Council expressed the point in the following way:

Placing further strategic planning responsibilities on social services departments over and above those already existing (including joint strategic needs assessments, local performance frameworks, sustainable community strategies and local area agreements) would be otiose and there is real argument for streamlining the current surfeit.

- 13.22 Many consultees agreed that streamlining strategic planning provisions would be desirable. Nottingham City Council argued further additions would be “likely to create uncertainty and complexity”. It was also argued that strategic planning is a wide area which goes beyond adult social care. Accordingly, to create further provisions in isolation would be inapposite.

- 13.23 Some consultees expressed an expectation that the coalition government will undertake a review of current strategic planning responsibilities. Age UK anticipated “fundamental change under the new government”. RNIB and Guide Dogs concluded that:

until this process is undertaken, it does not seem sensible to add to the complexity of current arrangements by introducing strategic planning provisions in the proposed adult social care statute.

- 13.24 However, several consultees argued that further strategic planning provisions *are* required. Carers UK argued that “research has shown that some local authorities are consistently poor in planning strategically”. The Standing Commission on Carers took this point further and argued:

We would be concerned if there were no strategic planning duties within the proposed statute. Taking account of the present economic situation, we cannot see how local authorities can make best use of current services and plan for future provision without strategic planning. We would welcome any requirement to plan strategically also emphasizing the importance of cooperation with other public services and partners.

- 13.25 The Care Quality Commission also expressed concerns:

The wish to avoid specific provision in this area is understood, but to suggest no reference to the general duty on local councils to inform themselves of the nature of local need for adult social care services seems neglectful. Local councils should be expected to periodically appraise themselves of such need, and plan to meet such needs as they identify.

***Proposed further duties***

- 13.26 A number of consultees suggested further duties which could help facilitate better strategic planning. For instance, Mencap emphasised the benefits of strategic planning as a useful tool to enable joint-working. Accordingly it was argued that there should be a duty on local authorities to produce a strategic plan, which would be reviewed by central government and accompanied by guidance.
- 13.27 RADAR (originally the Royal Association for Disability Rights) and the National Centre for Independent Living argued that there should be a duty on local authorities to “manage the market and ensure there are a range of quality services” and a duty to engage with user-led organisations because they are “vital to the success of any new care and support system”.
- 13.28 The Standing Commission on Carers and Carers UK both argued for a strategic duty to plan to ensure a sufficient level of care services. It was highlighted that by virtue of the Children Act 2004, a similar duty exists in the context of child social care which helps to support carers. The Standing Commission for Carers made the point that:
- Many carers currently find to their alarm that when their disabled child moves to adult services, they lose the resources of the Children Act 1989 and also the wider range of short breaks (some of which may provide replacement care for working carers).
- 13.29 They also argued for a strategic duty “to address the importance of short breaks” and that:
- without a strategic approach to developing a range of local opportunities in partnership with local carers, we cannot see the provision of such services increasing.

### ***Conclusion***

- 13.30 Most of the consultees to this proposal agreed that further strategic planning provisions should not be included in a future adult social care statute. Consultees recognised that strategic planning is a confused and complicated area, and to add further provisions would only exacerbate these problems. Furthermore, since effective strategic planning requires multi-agency collaboration, it was argued that to create provisions in an adult social care statute, in isolation from other relevant policy areas, would not work. However, several consultees expressed concerns and argued that many local authorities do not engage in effective strategic planning. Accordingly, further provisions are required. Some consultees went further and argued for specific duties which would be aimed at ensuring improved levels of service. However, the majority of consultees agreed that instead of adding to the current plethora of strategic planning provisions, this area should be streamlined. Some consultees expressed a hope that the coalition government will undertake this process.

**Provisional Proposal 13-3: We provisionally propose that our future adult social care statute should place a duty on a local social services authority to provide information about services available in the local area.**

- 13.31 Of the 231 submissions which were received, 64 submissions provided answers to the proposal that our statute should place a duty on local social services authority to provide information about services available in the local area. Of those consultees, 58 agreed with the question, 2 disagreed whilst 4 held equivocal positions.

***Promoting choice and control***

- 13.32 A significant number of consultees who were in favour of this proposal argued that a duty to provide information was in-step with a personalised approach to social care. Mencap argued that:

information is a cornerstone of personalisation. Every local authority should have accessible information on all services available. We therefore welcome a duty to be placed on all local authorities to provide information about services available in the local area.

- 13.33 Liz Ball gave her perspective as a service user:

Information about services is crucial if people are to make choices, have control, and benefit from services. As a deafblind person it is difficult for me to search for information and so this failure leaves me struggling to manage. Information needs to be provided about both specialist and mainstream services and it needs to be at a level that is appropriate.

- 13.34 Disability Wales made the point that effective access to information has positive consequences for all those involved in social care and is:

an essential means of enabling service users, social workers and others to identify the local resources available to achieve agreed outcomes, and thus to support decision making about appropriate methods of administering care packages. Accurate information about available services will also enable commissioners to identify gaps in provision and plan effectively for community based Citizen Directed Support.

- 13.35 Several consultees highlighted the benefits that improved access to information would have for self-funders or those in receipt of direct payments. Agreeing with this proposal, the Royal National Institute for Deaf People argued that:

this will become increasingly important as a greater number of people receive their social care in the form of direct payments. These people will require reliable information in order to make informed choices regarding their social care.

- 13.36 Taking this point further, Sense argued that:



There are many self-funders and those with direct payments who need help to find suitable services in their area. Indeed one of the major impacts of dual sensory loss is that individuals have less access to information. Too often we hear of cases where individuals learn about services by chance or because they have been lucky to meet someone who is well informed.

13.37 Sense illustrated this by quoting a deafblind person: “I wasn’t told about [the existence of the local] blind club, my daughter lived opposite a man who went, that’s how I found out about it”.

13.38 The Joseph Rowntree Foundation reflected a similar point and identified the lack of information as:

A significant problem for older people in managing their resources effectively, who report relying on word of mouth due to a lack of official sources of basic service information.

### ***Resource implications***

13.39 A small number of consultees mentioned potential resource implications that a duty to provide information may have. Nottingham City Council argued that:

By creating a duty we feel this is creating an unnecessary burden or pressure on an already pressured work environment which may also leave local authorities open to challenge.

13.40 The Welsh Assembly Government queried whether local authorities would have capacity to implement the proposed duty:

Whilst we recognise that it is good practice for a local authority to publicise its own services clearly, and to provide “signposts” to those provided by others this could become very burdensome if, for instance, a local authority were required to provide information about every relevant service provided by the NHS and the third sector.

13.41 The Association of Directors of Social Services Cymru argued that if this duty was to be properly implemented “authorities would need additional resources to ensure consistency and quality”.

### ***The need for advocacy***

13.42 Several consultees argued that to properly implement the duty to provide information there must be also be a duty to provide advocacy services. The Joseph Rowntree Foundation argued that:

Several Joseph Rowntree Foundation studies have pointed to the fact that information in itself is not enough. Older people clearly state that they often need more than “signposting”: they also need guidance and support. Whilst the term “advocacy” is not well understood by service users, the concept – having someone to speak on your behalf and take more hands-on action to sort things out above providing advice – is valued.

- 13.43 The Equality and Human Rights Commission argued that without a parallel duty to provide advocacy services, the duty to provide information will not work for many people. The National Care Forum took this point further and argued for “a national integrated system for information and advice”.

***The format of information***

- 13.44 A significant number of people argued that a duty to provide information must also ensure that if is provided an appropriate format. Disability North made the point that local authorities tend to provide most of their information on websites and that this can make information inaccessible to many service users and carers.

- 13.45 The National Family Carer Network argued that having information in an appropriate format is particularly important to people with a learning disability:

As many people with a learning disability are both service users and carers, both carers information and service users information needs to be in formats that they can understand and support to understand it should be made available.

- 13.46 The Royal National Institute for Deaf People made a similar point on behalf of those with hearing impairments:

Appropriate communication support, such as a British Sign Language interpreter or a speech-to-text reporter, should be provided where spoken information is being communicated. In addition, any written information should be provided in British Sign Language clips and in plain English.

- 13.47 Sense referred to deafblind statutory guidance to illustrate the variety of formats that may be appropriate. The guidance requires local authorities to provide information in an accessible format and it lists the following formats: various sizes of large print; Braille; Moon; audio; video (subtitled or signed); computer disk or use of e-mail; text-phones and type-talk. It was argued that a duty to provide information must recognise the importance of the format which information is provided in.

- 13.48 RNIB and Guide Dogs recognised that there are already provisions from which a duty to provide accessible information can be derived such as the general duty under section 49A of the Disability Discrimination Act 1995 and the specific duty under section 20(6) of the Equality Act 2010. However, it was argued that local authorities often do not comply with these duties and that “placing such a duty within the proposed social care statute would reinforce to social services their obligations in this respect.”

### ***Conclusion***

- 13.49 Almost all responses to this proposal were in favour of introducing a duty to provide information about services available in the local area. Many consultees argued that proper information services are central to the personalisation of social care because it enables service users to make informed choices. Consultees also acknowledged that those in receipt of direct payments would benefit greatly from more accessible information. There were a small number of responses which queried the resource implications of this proposal. Other responses focused on the need for advocacy services to assist service users when making their decisions. There were a large number of responses which focused on the practical point that the format of information is key to ensuring increased accessibility. It was argued that our statute would be a suitable place to emphasise the need make appropriate adjustments in this area.

## **PART 14**

### **OTHER ISSUES**

- 14.1 Amongst the responses which were received, a large number of consultees raised specific issues which in formal terms fell outside the scope of the Law Commission's consultation. Amongst these issues, two strong themes were apparent: the importance of advocacy and dissatisfaction with the current system for complaints and redress.

#### **ADVOCACY**

- 14.2 Many consultees argued for a legal right to advocacy. This permeated almost all areas of the Law Commission's consultation. The main areas are discussed below.

#### ***Statutory principles***

- 14.3 Several consultees indicated that advocacy should not be overlooked in relation to the proposed statutory principles in our statute. For example, the Gateshead Advocacy Information Network argued that:

there should be a principle in the statute that provides that a person should have access to advocacy services to ensure that all eight principles are maximized. This principle should ensure that there is a duty to promote advocacy services to ensure the individual has the opportunity to speak up about their own social care needs, and that their voice is heard and listened to.

- 14.4 Other consultees gave particular focus to the proposed principle of choice and control (question 3-2). Age UK argued that:

the concept of choice and control is broader than the need to take account of a person's wishes and feelings as described in the consultation. The way that the principle is expressed is welcome as it brings out the need for decision makers to act pro-actively to make choice a reality, for example by making advocacy, advice and information available.

- 14.5 Age Cymru put the point this way:

This principle must include reference to independent advocacy, which would fill a crucial support role in enabling service users to maximise choice and control.

- 14.6 RADAR (originally the Royal Association for Disability Rights) and National Council for Independent Living argued that:

Choice and control can only exist with genuine access to information, support and advocacy. For this purpose we would want to see a duty in the new statute to provide independent information, support and advocacy. Local user-led organisations – i.e. organisations run for and by disabled people – would be best placed to deliver this function but must be set up and resourced to that effect.

### ***Assessment process***

- 14.7 Several consultees argued that a right to advocacy would be supportive of the proposals made on the assessment process in part 4 of the consultation paper. For instance, Mencap said that:

it is crucial that people with a learning disability have the opportunity to access independent advocacy to support them in the assessment process and ensure their needs are understood and goals and aspirations heard. This may be particularly important for people with profound and multiple learning disabilities who are unbefriended. There need to be advocates available who are trained in non-instructed advocacy techniques which are needed for advocacy with people with profound and multiple learning disabilities.

- 14.8 Disability Wales supported this view:

A right to independent advocacy should be included in the statute. As well as supporting people to make informed choices and decisions about their care and support, independent advocacy is vital for some people to ensure that their voice is heard in decision making processes, to enable them to access appropriate services and to support them to address failings in provision.

- 14.9 The Social Care Institute for Excellence argued that advocacy should be integrated in a new way of thinking about assessment where:

problems would be defined not in terms of existing services but in terms of people's aspirations and preferred outcomes, and the process would include the provision of information, advice, sign-posting and advocacy to enable people to find their own solutions.

- 14.10 The enabling quality of advocacy was emphasised in responses relating to self-assessment (questions 4-2 and 4-3). For example, Parkinson's UK stated that:

If there is a principle to allow self assessment then this should really be for all individuals and the process should empower them by having advocacy to help everyone self-assess, particularly those groups who are less empowered or find there is little advocacy provision locally.

- 14.11 Similar views were adopted by the British Psychological Society and the Social Care Institute for Excellence.

- 14.12 Enfield Disability Action viewed advocacy as supporting the proposal for a right to an assessment on request (question 4-1), whilst the National Family Carer Network argued that advocacy should be made available, where appropriate, to allow tailored assessments.

***Scope of adult social care***

- 14.13 A number of consultees argued that the scope of adult social care, as discussed in part 9, should be extended to include a right to advocacy. SIBS argued that “community care provision should include advocacy which is distinct from advice and support”. Enfield Disability Action made a similar point.
- 14.14 Counsel and Care said that “if a short, but broad list of community care services is provided in statute ... the list must include ‘advice, information and advocacy’”.

***Delivery of services***

- 14.15 The points made in relation to the importance of advocacy to enable a service user’s involvement were also made in relation to the proposal to impose a duty to create a care plan (provisional proposal 10-1). For instance, Mencap argued that:

every individual should have a care plan for the care and support they receive. They should also have choice and control in where they live. ... We urge any supporting guidance to be clear as to what is expected from a care plan and the role of the local authority in its formulation. The guidance should also set out the local authority’s role in ensuring the individual is at the centre of the process by promoting advocacy, accessibility and involvement of family and carers of friends in supporting guidance.

- 14.16 Parkinson’s UK made a similar point in relation to direct payments (question 10-1):

There are challenges faced by some in accessing direct payments and using them to the best effect. The lack of advocacy services in the community may be a particular problem for those already in residential care, who may not find it easy to access information and advice.

***Provision of information***

- 14.17 Several consultees made the point that the proposed duty to provide information would go together with a right to advocacy (provisional proposal 13-3). For example, the Equality and Human Rights Commission asserted that:

we support the duty on local authorities to provide information about services available in their local area. We urge the Commission to extend this proposal to include independent advocacy otherwise the approach taken will not work for many people. ... We are concerned however that the proposal fails to include independent advocacy in the information function.

- 14.18 The Joseph Rowntree Foundation (JRF) dealt with this point in some detail:

JRF welcomes a duty for local authorities to provide information about the availability of services ... Several JRF studies have pointed to the fact that information in itself is not enough. Older people clearly state that they often need more than “signposting”: they also need guidance and support.<sup>1</sup> Whilst the term “advocacy” is not well understood by service users, the concept – having someone to speak on your behalf and take more hands-on action to sort things out above providing advice – is valued.

Advocacy in particular – including peer advocacy and collective advocacy through user-led organisations – is essential if “information and advice” and ‘personalised care and support’ are to be effective and meaningful to people using services.<sup>2</sup> By including a duty to provide information, advice and advocacy, the Commission would be taking a significant step in helping to meet this need, but would also be supporting the principle of choice and control by enabling more service users to have their voices heard through an advocate. This would be particularly important for those service users who are least able to express their preferences and needs for themselves.

### **Conclusion**

- 14.19 At consultation many individuals and organisations argued that a new legal right to advocacy was needed, and provided us with background information on advocacy and graphic examples demonstrating how advocacy has helped people to make their views and wishes heard. Arguments in support of a right to advocacy were raised in relation to most parts of the consultation paper.

### **COMPLAINTS AND REDRESS**

- 14.20 A second theme which was apparent in the responses to the consultation related to the efficacy of the current system for complaints and redress. Whilst this area was not covered in the consultation paper, a substantial number of responses addressed this issue.

#### ***Failure to address this issue***

- 14.21 A number of consultees were dissatisfied that this issue had not been addressed in the consultation paper. For example, the Local Government Association argued that the failure to address issues relating to the ways in which people might seek redress “is an omission”. Similarly, Hull City Council noted that “there appears to be a lack of potential dispute resolution within the prescribed legislation” and suggested that this can lead to “costly challenges”.

<sup>1</sup> C Horton, *Creating a stronger information, advice and advocacy system for older people*, Joseph Rowntree Foundation Solutions (2009).

<sup>2</sup> Ibid; M Godfrey, J Townsend and T Denby, *Building a good life for older people in local communities*, Joseph Rowntree Foundation (York) (2004).

### ***A community care tribunal***

14.22 Several consultees put forward the idea of a community care tribunal. For example, having identified the absence of dispute resolution procedures in our statute, Hull City Council went on to argue that:

it would be welcomed if a tribunal could be set up supporting claimants and local authorities to find resolution quickly and easily. Service users (or where appropriate their representatives) should be encouraged / supported to have advocacy to enable their cases to be presented succinctly and accurately.

14.23 A number of other consultees also suggested that a tribunal should be established, with several arguing that a tribunal was needed because of the problems with the current local authority complaints process. For example, the Disability Law Service argued that the local authority complaints procedure is “an unsatisfactory way for an individual to challenge their local authority’s social services department” and suggested that there “should be a national tribunal service set up to consider service users’ concerns”.

14.24 Similarly, Pauline Thompson, a social care academic and former Age Concern policy officer, argued that there is “still a lack of independence in the first stage of a complaint”, and considered that a tribunal system would be “a simple way of avoiding protracted and expensive systems of either going to the Ombudsman or pursuing the complaint through the courts”. Inclusion South West pointed to the limitations of the current system of redress and argued that an independent, merits-based review process should be introduced.

14.25 Other consultees suggested a tribunal was necessary because of the limitations of judicial review in this area. Citizens Advice noted that the judicial review process is not ideal, as it is:

expensive and work intensive for both applicant and local authority, and can sour the relationship between local authority and the individual and Citizens Advice Bureau involved.

14.26 Citizens Advice therefore argued that the legal framework should also include “specific procedures for individuals to challenge decisions by local authorities which they consider to be wrong”. Similarly, the Henry Spinks Foundation argued that it is “accepted by professionals, including social workers, that resolution of disputes in a tribunal is far less confrontational than through judicial review”. They suggested that this was “important when the local authority and the complainant have to continue to work together after the complaint is resolved”. They pointed out that another limitation of using judicial review in this area is that it is expensive and is concerned with procedural rather than factual matters.



14.27 The Henry Spink Foundation considered the issue of a social care review tribunal in some detail. They noted that the resolution of disputes between local authorities and service users takes up considerable amounts of time and money within social service departments, with local authorities spending nearly £16 million in 2007-08 in dealing with complaints relating to personal social services expenditure.<sup>3</sup> Given the problems and costs of the existing system, the Henry Spink Foundation suggested that there should be a tribunal for the resolution of disputes relating to social services assessments, including eligibility and the detail of support packages. They argued that “operating a tribunal to resolve disputes would save considerable amounts of money in place of each local authority resolving disputes in-house”. In support of this argument, they compared the cost of local authority complaints systems with the annual running costs for the Special Educational Needs and Disability Tribunal, which they argued was the “nearest parallel for the proposed social care tribunal”. The information they provided is set out in the table below:

14.28

	2003-04	2004-05	2005-06	2006-07	2007-08
	Costs of local authority complaints procedures <sup>4</sup> (£ million)				
England	11,786	12,383	13,269	15,521	15,834
	Total annual running costs for the Special Educational Needs and Disability Tribunal (including departmental overheads, except 2005-06) <sup>5</sup> (£ million)				
England	6.476	6.376	5.136	6.558	5.633

14.29

### ***Other suggestions***

14.30 A final suggestion put forward in relation to complaints and redress was the introduction of penalties for non-performance of statutory functions. For example, Camphill Families and Friends – while accepting that complaints and redress were outside the scope of the Law Commission’s review – queried whether the proposed statute could consider administrative sanctions or penalties to ensure that local authorities give out correct information about assessments and services.

<sup>3</sup> The Henry Spink Foundation referred to the following source: Written Parliamentary Question by Phil Hope MP, then Minister in the Dept of Health, Hansard 22 Apr 2009 : Column 721W

<sup>4</sup> This information is taken from Written Answer, *Hansard* (HC), 22 April 2009, vol 491, col 721W.

<sup>5</sup> This information is taken from Written Answer, *Hansard* (HC), 6 May 2009, vol 492, col 226W.

### ***Conclusion***

- 14.31 A large number of consultees argued that the quality of local authorities' complaints procedures is such that proposals for reform should be made in this area. Within this theme, a number of consultees argued in favour of a tribunal to resolve complaints and disputes. In particular, it was argued that such a system would save money since local authority complaints procedures were shown to be more expensive than operating a tribunal.

# APPENDIX A

## INDEX OF SUBMISSIONS

Number	Organisation/ individual	Category
01	Regenerate-RISE (Mo Smith)	NGO – service user organisations – other
02	People First/Dawn Price	NGO – service user organisations - user-led
03	Michael Mandelstam	Individual – professional
04	Louise Molina, Projex Health	NGO – service provider
05	Gordon Lishman	Individual - professional
06	NHS Leeds	Statutory services – health authorities
07	Mary Edmunds	Individual - professional
08	People First/Dawn Price	NGO – service user organisations - user-led
09	Nicolette Barry, Adult Protection Co-ordinator	Individual - professional
10	Sue (Carer)	Individual - carer
11	Phil Jones (Merthyr Tydfil CBC)	Individual – professional
12	Stephen Corlett	Individual – professional
13	John Wallace	Individual – carer
14	Nottingham City Adult Safeguarding Partnership	Statutory service – safeguarding
15	Mr Browning, parent	Individual – carer
16	Phil Steadman, consultant	Individual – professional
17	Mencap service users	Individuals – service users
18	Nathan Meredith	Individual – professional
19	Wales Neurological Alliance	NGO – professional organisations – health – Wales
20	West Berkshire Safeguarding Adults Board	Statutory service – safeguarding
21	Kate Chapman, parent carer	Individual – carer
22	Direct Payments Support Scheme Network	NGO – professional organisations – social care – Wales

23	Still Human Still Here	NGO – Asylum
24	National Autistic Society	NGO – service user organisation
25	Jerry Macmurray, carer	Individual – carer
26	Foundation for People with Learning Difficulties	NGO – service user organisation – others
27	Health in Justice	NGO – prison
28	Philip Jones, Seren Group	Individual – professional
29	Mary Jacobs	Individual
30	Nottingham City Council	Statutory service – local authority
31	BANES Safeguarding Board	Statutory service – safeguarding
32	Simon Pearce	Individual – professional
33	Wolverhampton Safeguarding Board	Statutory service – safeguarding
34	Gareth Metford	Individual – professional
35	Stephen Ward	Individual – professional
36	Dr Gregg Moore	Individual – professional
37	Kaye Iveson	Individual – professional
38	South Yorkshire Centre for Inclusive Living	NGO – service user organisation
39	Inclusion South West	NGO – professional organisation
40	Safeguarding Teams, Birmingham	Statutory service – safeguarding
41	Coventry City Council	Statutory service – local authority
42	Hazel Qureshi	Academic
43	Solicitors for the Elderly	Legal & advice
44	Steve Embleton	Individual – professional
45	National Valuing Family Forum	NGO – carers organisations
46	The Henry Spink Foundation	NGO – service user organisation
47	Slough Borough Council	Statutory service – local authority
48	The Welsh Institute for Health and Social Care	Academic

49	Regenerate RISE (Mo Smith)	NGO – service user organisation - other
50	Anonymous parent/carer	Individual – carer
51	Medway Older People Communication Network	NGO – service user organisation
52	Bridget Penhale	Academic
53	Worcestershire Safeguarding Adults Board	Statutory service – safeguarding
54	The Royal College of Ophthalmologists	NGO – professional organisation – health
55	Skills for Care	NGO – professional organisation – social care
56	English Community Care Association	NGO – professional organisation – social care
57	BUPA Care Homes	NGO – service providers
58	Esther Hack	Individual – professional
59	Royal College of General Practitioners	NGO – professional organisation – health
60	Graham Faulkner, National Society for Epilepsy	NGO – service user organisation
61	Tessa Harding	Individual – carer
62	Pauline Thompson	Individual – professional
63	Lancashire County Council	Statutory service – local authority
64	Citizens Advice	Legal & advice
65	Research in Practice for Adults	NGO – professional organisation
66	Registered Care Providers Association Ltd	NGO – professional organisation – social care
67	Care Quality Commission	Government
68	Royal Borough of Kensington and Chelsea	Statutory service – local authority
69	Conwy Connect	NGO – service user organisation – Wales
70	Compassion in Dying	NGO – service user organisation
71	Newcastle City Council	Statutory service – local authority
72	Northumberland Forum for People with	NGO – service user organisation

	a Learning Disability	
73	National Family Carer Network	Carers organisation
74	North West Complaint Managers Group	NGO – professional organisation – social care
75	Jill Scholl, Parent carer	Individual - carer
76	HM Inspector of Prisons	Government
77	North Tyneside Council	Statutory service – local authority
78	Sensory Impairment Teams Oxfordshire	Statutory service – local authority
79	Refugee Council	NGO - asylum
80	East Riding of Yorkshire Council	Statutory service – local authority
81	Camphill Families and Friends	NGO – Carers organisation
82	Rescare	NGO – Carers organisation
83	Mencap	NGO – service user organisation – major service provider
84	Office of the Public Guardian	Government
85	Middlesbrough Department of Social Care	Statutory service – local authority
86	Hampshire Personalisation Expert Panel (SCIL)	NGO – service user organisation – user led organisation
87	Eastern Region Adult Safeguarding Leads Group	Statutory service – safeguarding
88	Disability Wales	NGO – service user organisation – Wales
89	Social Care Institute for Excellence	NGO – professional organisation
90	UK Home Care Association	NGO – professional organisation – social care
91	Alwyn Davies	Individual – professional
92	Gateshead Advocacy Information Network	NGO – service user organisation
93	Kevin Isaac	Individual – carer
94	Enfield Disability Action	NGO – service user organisation
95	Anthony Collins LLP	Legal and advice

96	Vale Older People's Strategy Forum	NGO – service user organisation – Wales
97	Bournemouth Borough Council	Statutory service – local authority
98	Blackburn with Darwen, Blackpool, Lancashire Safeguarding Boards	Statutory service – safeguarding
99	Disability Law Service	Legal & advice
100	Vale of Glamorgan Carers Forum	NGO – Carers organisation – Wales
101	Irwin Mitchell LLP	Legal & advice
102	Disability North	NGO – service user organisation – user led
103	Foundation for People with Learning Disabilities Online Network (Robert Browning)	Individual – carer
104	Thomas Simcock, parent carer	Individual - carer
105	Sunderland City Council	Statutory service – local authority
106	East Sussex County Council	Statutory service – local authority
107	Wales Council for Voluntary Action	NGO – service user organisation – Wales
108	HCIL	NGO – service user organisation
109	Sense	NGO – service user organisation – major service provider
110	Self Unlimited	NGO – service user organisation
111	Cardiff and Vale of Glamorgan Voluntary Sector Health and Social Care Networks	NGO – service user organisation – Wales
112	Age UK	NGO – service user organisation – major service provider
113	Liz Ball	Individual – service user
114	John Howard	Individual – professional
115	Refugee Action	NGO - asylum
116	London Borough of Camden	Statutory service – local authority
117	NAAPS	NGO – professional organisation
118	Making Every Adult Matter	NGO – service user organisation
119	Stuart Marchant, solicitor	Legal & advice

120	Imogen Vaughan	Individual - carer
121	Marion Price	Individual - carer
122	Practitioners' Alliance Against the Abuse of Vulnerable Adults	NGO – professional organisation
123	Simon Burdis	Individual – service user
124	Belinda Schwehr, National Home Care Council	Individual – professional
125	Spinal Injuries Association	NGO – service user organisation – user-led
126	Ann McDonald	Academic
127	Crossroads Care & Princess Royal Trust for Carers	NGO – carers organisation
128	In Control	NGO – service user organisation
129	The Carers' Resource	NGO – carers organisation
130	Reach	NGO – service user organisation – other – Wales
131	ALDS Forum	NGO – service user organisation
132	Cartrefi Cymru Cyf	NGO – service user organisation – major service providers - Wales
133	Surrey County Council	Statutory service – local authority
134	West Sussex Adult Safeguarding Board	Statutory service – safeguarding
135	Windsor and Maidenhead Safeguarding Adults Board	Statutory service – safeguarding
136	Action on Elder Abuse	NGO – service user organisation
137	Deafblind UK	NGO – service user organisation
138	Age Cymru	NGO – service user organisation – major service provider - Wales
139	AMHP Leads Network	NGO – professional organisations – social care
140	Suffolk County Council	Statutory service – local authority
141	Mersey Care – Guy Soulsby	Individual – professional
142	RNIB and Guide Dogs	NGO – service user organisation – major service provider



143	RNIB and Guide Dogs – re register	NGO – service user organisation – major service provider
144	Gateshead Council's Director of ASC	Statutory service – local authority
145	Older People's Commissioner for Wales	Government - Wales
146	Socio-Legal Studies Association	Academic
147	British Association of Social Workers	NGO – professional organisations – social care
148	Darlington Association of Social Workers	NGO – professional organisations – social care
149	Buckingham County Council	Statutory service – local authority
150	Havering London Borough Council	Statutory service – local authority
151	Joseph Rowntree Foundation	NGO
152	National Aids Trust	NGO – service user organisation – major service provider
153	Bristol LINK	NGO – service user organisation – other
154	National Housing Federation	NGO - service provider
155	NRPF Network	Statutory services – partnerships
156	Council for Disabled Children	NGO – service user organisation – other
157	Monty Exile	Individual
158	Cymorth Cymru	NGO – service user organisation - Wales
159	MS Society	NGO – service user organisation – major service provider
160	Prisoners' Advice Service	NGO - prisons
161	National Youth Advocacy Service	NGO – service user organisation
162	Hertfordshire County Council Adult Care Services	Statutory service – local authority
163	Garden Court Chambers	Legal & advice
164	Older Prisoners' Action Group	NGO - prisons
165	Hampshire County Council	Statutory service – local authority
166	Parkinson's UK	NGO – service user organisation – major service provider

167	Hull City Council	Statutory service – local authority
168	ADASS	NGO – Professional organisation
169	Royal College of Physicians of Edinburgh	NGO – professional organisations - health
170	National Offender Management Service	Government
171	Leonard Cheshire Disability	NGO – service user organisation – major service provider
172	Sibs	NGO
173	Scope	NGO – service user organisation – major service provider
174	Learning Disability Coalition	NGO – service user organisation – other
175	Care and Support Alliance	NGO
176	Scottish Refugee Council	NGO - asylum
177	Southern Cross	NGO – service provider
178	Wirral Council	Statutory service – local authority
179	Alzheimer Society	NGO – service user organisation – major service provider
180	Challenging Behaviour Foundation	NGO – service user organisation – other
181	Jan Cave	Individual
182	Radar and NCIL (joint response)	NGO – service user organisation – major service provider
183	Cate Searle	Legal and advice
184	Learning Disability Wales	NGO – service user organisation – major service provider – Wales
185	National Care Forum	NGO – carers organisation
186	Carers UK	NGO – carers organisation
187	Caerphilly Borough Council	Statutory service – local authority - Wales
188	Office for Disability Issues (DWP)	Government
189	Swansea Council	Statutory service – local authority - Wales
190	The Children's Society	NGO – service user organisation – major service provider

191	Dinny and Richard Cope	Individuals – carers
192	Sheffield Safeguarding	Statutory service – safeguarding
193	Slough Safeguarding Board	Statutory service – safeguarding
194	Veronica Hopkins	Individual - carer
195	PHSO and LGO	Statutory service
196	Nottingham Safeguarding	Statutory service – safeguarding
197	Paula Keedy	Individual
198	RNID	NGO – service user organisation – major service provider
199	Counsel and Care	NGO – service user organisation – other
200	Chartered Institute of Housing	Professional organisation - Housing
201	Simon Cramp	Individual – service user
202	National Forum for People with Learning Difficulties	NGO – service user organisation – other
203	Law Society	Legal & advice
204	Thomas Simcock (2)	Individual - carer
205	York Carers Centre	NGO – carers organisation
206	Howard League for Penal Reform	NGO - prisons
207	Lincolnshire Partnership NHS Foundation Trust	Statutory services – health authorities
208	Maxwell Gillott	Legal and advice
209	Hampshire Personalisation Expert Panel	NGO – service user organisation – user led organisation
210	Berni Vincent, Hampshire Personalisation Expert Panel	Individual – professional
211	Equality and Human Rights Commission	Government
212	Local Government Association	NGO – professional organisation?
213	Northumberland Tyne and Wear NHS Foundation Trust	Statutory services – health authorities
214	Law Reform Committee, Bar Council of England and Wales	Legal & advice

215	Brighton and Hove Advice Services Strategy Group	Legal and advice
216	British Psychological Society	NGO – professional organisation – health
217	Baroness Hale of Richmond	Legal & advice
218	York Independent Living Network	NGO – service user organisation – user led organisation
219	Conwy County Borough Council	Statutory service – local authority - Wales
220	ADSS Cymru	NGO – professional organisation – Wales
221	Welsh Local Government Association	NGO – professional organisation – Wales
222	Royal College of Psychiatrists	NGO – professional organisation – health
223	Sense Cymru (Wayne Lewis)	NGO - professional organisation - Wales
224	Andy McGowan	Individual
225	General Medical Council	NGO – professional organisations - health
226	Solihull Safeguarding Adults Board	Statutory service – safeguarding
227	Deputy Minister for Social Services, Welsh Assembly Government	Government - Wales
228	K M Julier, carer	Individual - carer
229	Housing Law Practitioner Association	Legal & advice
230	Standing Commission on Carers	NGO – Carers organisation
231	Department of Health	Government

# APPENDIX B

## INDEX OF CONSULTATION EVENTS ATTENDED

No	Event	Date
1.	Assess for Care event	22 January 2010
2.	Law Society's Wills and Equity Committee	27 January 2010
3.	Law Society's Mental Health and Disability Committee	2 February 2010
4.	Princess Royal Trust for Carers	16 February 2010
5.	In Control Management Meeting	24 February 2010
6.	ADASS Executive Meeting	26 February 2010
7.	Sense user group consultation event	13 March 2010
8.	In Control Big Event	16 March 2010
9.	HSCWB Network meeting	16 March 2010
10.	NAAPS meeting in Oldham	22 March 2010
11.	CCLR	23 March 2010
12.	Matrix workshop	24 March 2010
13.	Solicitors in Local Government workshop	25 March 2010
14.	Slough Safeguarding Vulnerable Adults Partnership Board	26 March 2010
15.	Bolton Safeguarding Board	26 March 2010
16.	Older People's Commissioner for Wales	29 March 2010
17.	SLSA Conference	30 March 2010
18.	Advisory Group Meeting	1 April 2010
19.	Eastern region adult safeguarding leads	15 April 2010
20.	DH Safeguarding Conference	19 April 2010
21.	Meeting with Children Society	19 April 2010
22.	Meeting with Jeff Jerome	26 April 2010
23.	Welsh Health and Social Care Facilitators Network	26 April 2010
24.	Law Society's Mental Health and Disability Committee, Law	29 April 2010

	Society	
25.	Personalisation meeting – Richmond	5 May 2010
26.	Safeguarding seminar – Birmingham	7 May 2010
27.	Sense visit	10 May 2010
28.	ADASS meeting	12 May 2010
29.	Sense meeting	12 May 2010
30.	Learning Disability Wales	13 May 2010
31.	Southampton Centre for Independent Living	14 May 2010
32.	Standing Commission of Carers	17 May 2010
33.	Icount	18 May 2010
34.	Social Work Seminar AMHP Leads	19 May 2010
35.	Mencap	20 May 2010
36.	Wales Safeguarding Seminar	21 May 2010
37.	ADASS meeting – Leeds	21 May 2010
38.	National Valuing Families Forum	24 May 2010
39.	Regenerate-Rise	26 May 2010
40.	SCIE	27 May 2010
41.	AMHP Leads	28 May 2010
42.	LGA	1 June 2010
43.	DWP Right to Control	1 June 2010
44.	Asylum Group	3 June 2010
45.	LAWDIG	3 June 2010
46.	All Wales Direct Payments Forum	7 June 2010
47.	Reach	7 June 2010
48.	National Children Bureau	8 June 2010
49.	Maxwell Gillott Solicitors	9 June 2010
50.	Conwy Connect for Learning Disabilities	10 June 2010
51.	Ordinary residence meeting	10 June 2010

52.	Southeast Regional Safeguarding Leads	10 June 2010
53.	Turning Point	14 June 2010
54.	Suffolk County Council	14 June 2010
55.	Centre 404	15 June 2010
56.	In Control (London) seminar	15 June 2010
57.	Hackney Council	16 June 2010
58.	National Housing Federation meeting	16 June 2010
59.	In Control (York) seminar	17 June 2010
60.	South Yorkshire Centre for Inclusive Living	17 June 2010
61.	Northumbria University	18 June 2010
62.	Camphill Carers	19 June 2010
63.	Manchester adult safeguarding board	22 June 2010
64.	NW Local Govt ASC Lawyers	22 June 2010
65.	Law Society	23 June 2010
66.	Peterborough Council	24 June 2010
67.	Sussex/ADASS	25 June 2010
68.	Young Carers Festival	26 June 2010
69.	Cardiff and The Vale Parents Federation	28 June 2010
70.	Bristol University	28 June 2010
71.	Swansea Social Services Directorate	29 June 2010
72.	National Forum for People with Learning Difficulties	7 July 2010