

# **COMMUNITY CARE AND HEALTH (SCOTLAND) BILL**

---

## **EXPLANATORY NOTES**

### **(AND OTHER ACCOMPANYING DOCUMENTS)**

#### **CONTENTS**

1. As required under Rule 9.3 of the Parliament's Standing Orders, the following documents are published to accompany the Community Care and Health (Scotland) Bill introduced in the Scottish Parliament on 24 September 2001:

- Explanatory Notes;
- a Financial Memorandum;
- an Executive Statement on Legislative Competence; and
- the Presiding Officer's Statement on Legislative Competence.

A Policy Memorandum, also prepared by the Scottish Executive, is printed separately as SP Bill 34-PM.

## **EXPLANATORY NOTES**

### **INTRODUCTION**

2. These Explanatory Notes have been prepared by the Scottish Executive in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

### **SUMMARY AND BACKGROUND**

4. The Bill takes forward a number of the Scottish Executive's policy commitments on the care of people in Scotland, made over the last year. In particular, these commitments were made in:

- *The Scottish Executive's Response to the Royal Commission on Long Term Care* (October 2000);
- *The Scottish Executive's Response to the Report of the Joint Future Group* (January 2001);
- *The Response by the Scottish Executive to the Health and Community Care Committee's Inquiry into the Delivery of Community Care* (January 2001); and
- the Executive's acceptance of the findings of the *Report of the Chief Nursing Officer for Scotland's Group on Free Nursing Care* (December 2000).

The Bill also implements the Scottish Executive's commitment in the *Strategy for Carers in Scotland*, published in November 1999, to legislate to extend the rights of carers to assessment.

5. The Scottish Ministers have consulted on their proposals in a number of ways, feedback from which has informed the development of the provisions contained in the Bill. The Executive has published three separate documents for consultation:

- *Better Care for all our futures* (April 2001)
- *Carers' Legislation Consultation Paper* (April 2001)
- *Supplementary Medical Lists for Non-principal General Practitioners* (June 2001)

6. Ministers have established the Care Development Group, a group of experts in the care of older people, which has consulted as part of its remit to make recommendations on the implementation, costs and "cross-border" issues of providing free nursing and personal care for all Scotland's older people. The Group published its report, *Fair Care for Older People*, in September 2001.

7. In summary, the Bill:

- enables implementation of free nursing care (in care homes which provide nursing)
- enables implementation of free personal care
- enables regulation of charging for non-residential social care;
- enables both residents and third parties to make additional payments towards care home fees so that the resident can enter more expensive accommodation than that which the local authority would normally pay for;
- enables provision of care home places in other parts of the UK;
- enables deferred payment agreements so that residents may have their care home fees paid by the local authority so that they do not need to sell their home in their lifetime;
- provides for expansion of access to direct payments for non-residential service users, giving people the ability to purchase their own services;
- provides for an extended right to assessment for informal carers;
- enables expansion of joint resourcing and management of health and social care services between NHS Scotland and local authorities;
- enables extension of the medical list system to cover all GPs working in NHS Scotland;
- provides for extension of the jurisdiction of the NHS Tribunal to enable it to disqualify from the medical list, on grounds of fraud, providers of personal medical services under pilot schemes seeking preferential consideration to return to that list;
- provides for extension of the provisions which enable the recovery from third party insurers of expenses incurred by the NHS in treating casualties of motor vehicle accidents which occur on a road to now include other public places such as a car park; and
- provides for inclusion of the Mental Welfare Commission as a member of the Clinical Negligence and Other Risks Indemnity Scheme.

## **PART 1 – COMMUNITY CARE**

### **Charging for social care**

#### *Section 1 – Regulations as respects charging for social care*

8. This section gives the Scottish Ministers power to make regulations which can require local authorities to charge, or not to charge, for social care and to specify the factors which local authorities must take into account in determining the amount of any charge. The use of this power will override current provisions relating to local authorities' charges for social care (in section 87 of the Social Work (Scotland) Act 1968).

9. The section provides the legislative means for the implementation of free nursing and personal care. It also provides powers to regularise charges for non-residential care ('home care'). The power given to the Scottish Ministers is a general power which enables them to have regard to a wide variety of circumstances.

10. Subsection (1) enables the Scottish Ministers to define in regulations which aspects of social care (defined in section 19) are or are not to be charged for. It also provides the flexibility for the regulations to specify the amount that should be charged or the factors to be considered in determining the amount of the charge. Where regulations require that no charge is to be made, they may qualify that requirement in such ways as Ministers see fit.

11. Subsection (2) amplifies the flexibilities provided in subsection (1). It expands on those powers to make clear that regulations may require the capping of charges and may also specify how a person's means should be taken into account as part of the charging process.

12. Subsection (3) amends the 1968 Act to disapply section 87(1) and (1A) of that Act where charging for social care is regulated under section 1 of the Bill. This ensures that charges for relevant aspects of social care are not levied under both this Bill and the 1968 Act but only under one or the other. (Regulations under section 2 of the Bill will clarify which of the two Acts will apply as respects the particular aspects of social care in residential care settings.)

## **Accommodation**

### *Section 2 – Accommodation provided under 1968 Act*

13. Section 2 enables the Scottish Ministers by regulations to determine what is and what is not to be regarded as accommodation chargeable under the 1968 Act and for the purposes of the definition of social care – and so for the purposes of section 1 of the Bill.

14. Accommodation provided under the 1968 Act comprises more than simply board and lodgings. In general, what is provided is a wider package of residential care which includes both the board and lodging element of accommodation and the social care aspect of accommodation. At present, the provision of the whole package is charged for under the 1968 Act. To enable implementation of free personal care, it is necessary to separate out the social care element from the board and lodging element in the provision of accommodation – and so in the provision of the residential care package.

15. Section 2 of the Bill enables the Scottish Ministers by regulations, therefore, to determine what elements of the package will remain subject to the charging provisions of the 1968 Act, and what elements will not, being subject instead to section 1 of the Bill and regulations made under it. Those regulations will not affect the definition of accommodation for the purposes of provision of services under the 1968 Act.

### *Section 3 – Disregarding of resources when determining whether to make available assistance by providing residential accommodation*

16. Currently, local authorities must disregard £18,500 of a person's capital when determining whether to provide a care home place for that person. This is the effect of section 12(3A) and (3B) of the Social Work (Scotland) Act 1968 Act, which requires authorities to disregard capital equal to the capital limit of the residential care means test or below, currently £18,500. Thus local authorities are precluded from deciding not to provide residential accommodation to someone simply because he or she has a certain level of capital, if that is below £18,500. The implication of this is that where someone has capital over £18,500, there is

some doubt as to whether a local authority can refuse to arrange accommodation for him or her. (The implication is that the capital exceeding £18,500 could be used to meet care costs.)

17. Section 3 of the Bill replaces section 12(3A) and (3B) of the 1968 Act with new provisions which enable the Scottish Ministers to specify in regulations what resources of a person, and how much of those resources, should be disregarded when deciding whether to provide residential accommodation. The regulations can break the link with the capital limit and can be made to apply differently for different cases.

18. The power is wide. If it is decided to make local authorities responsible for everyone who is eligible for a care home place as a means of providing their nursing and personal care free, section 3 can achieve that. Also, if it is decided to direct local authorities to make a deferred payment agreement available to any eligible person (see section 6), section 3 will be necessary to remove any doubt about local authorities' discretion to decide not to arrange accommodation for that person because of the capital value of his or her home.

#### *Section 4 – Accommodation more expensive than usually provided*

19. Currently, it is not clear whether people provided with accommodation by local authorities can themselves pay the extra required for them to be provided with more expensive accommodation than the local authority would usually expect to pay for. It has been accepted practice that a third party (such as a relative) can make up the difference in costs, but the legislation does not clearly grant that right, either to third parties or to individuals receiving care.

20. Section 4 enables regulations to be made to specify how, and in what circumstances, top-up payments can be made, either by third parties or by residents themselves. Restrictions on the right of a resident to make top-up payments may be imposed – these might relate to his or her available resources, to ensure that the arrangement can be sustained and that the resident is not likely to be impoverished as a consequence.

#### *Section 5 – Local authority arrangements for residential accommodation outwith Scotland*

21. Currently, Scottish local authorities have no power themselves to arrange for residential accommodation with nursing anywhere other than in Scotland. It has been accepted practice that there is no similar restriction on arranging for residential accommodation without nursing but the legislation does not provide a clear power to arrange such placements outside Scotland.

22. Subsection (1) of section 5 enables the Scottish Ministers to permit or require, as appropriate, local authorities to make such arrangements for residential accommodation, both with and without nursing. These arrangements would be made in fulfilment of the local authority's duties under sections 12(1) and 13A(1) of the Social Work (Scotland) Act 1968.

23. Subsection (2) enables the Scottish Ministers by regulations to modify the way in which any of the provisions of the Social Work (Scotland) Act 1968 would apply to a placement under this section. An example of the type of modification would be section 12A(3) of the 1968 Act. Under section 12A(3), a local authority notifies and liaises with a health authority in the place where accommodation is proposed to be provided, where it appears to the local authority that there might be a need for the provision of health services there to the person. Modification

would be needed for the purposes of a placement under this section, to refer to the appropriate equivalent health body in the other parts of the UK.

24. Subsection (3) recognises that arrangements have already been made for residential accommodation outside Scotland, on the understanding that this was possible under section 12(1) of the Social Work (Scotland) Act 1968. It makes sure that any such existing arrangements are on a sound legislative footing by bringing them under section 5.

25. For placements made under this section, subsection (4) removes the requirement under section 13A(2) of the 1968 Act for residential accommodation with nursing to be in care homes registered under Scottish legislation. Subsection (4) also removes the requirements of section 13A(3) of the 1968 Act from premises where someone is to be placed under this section. This serves to clarify that the inspection provisions of section 6 of the 1968 Act do not apply. The accommodation will not be in Scotland and inspection arrangements will be secured through the appropriate regime in the place where it is situated.

26. The accommodation which may be arranged in Scotland under sections 12 and 13A of the 1968 Act must meet certain requirements and, in the case of section 13A(1), must be of a certain type. Section 5(5) of the Bill, read with section 5(6), defines what is an “appropriate establishment” in which residential accommodation outside Scotland may be arranged. Paragraph (a) specifies the equivalent for England and Wales of residential accommodation without nursing and allows for such establishments in Northern Ireland, the Channel Islands and the Isle of Man to be specified in regulations under subsection (1). Paragraph (b) provides similar definitions for residential accommodation with nursing.

27. The same type of restrictions therefore apply for placements in England and Wales, and the Scottish Ministers, by regulations, are able to secure such restrictions where appropriate as regards Northern Ireland, any of the Channel Islands or the Isle of Man.

#### *Section 6 – Deferred payment of accommodation costs*

28. The effect of this section is to make it possible for people already in care or going into care to defer selling their homes in order to pay for their care. In effect, where a deferred payment agreement is in place, the local authority will pay part of the resident’s contribution to his or her care home fees. The authority will ultimately recover the money either from the estate when the resident dies or from the resident if he or she decides to make a full repayment during his or her lifetime.

29. Subsection (1) gives local authorities the power, in accordance with regulations made by the Scottish Ministers, and enables Ministers to require them to enter into deferred payment agreements. Such an agreement may be made with someone for whom a local authority is already providing or securing the provision of residential accommodation under the 1968 Act or section 7 of the 1984 Act, or is proposing to do so, in circumstances where the person would be liable to make a financial contribution towards the cost. The power applies whether the financial contribution would be towards the cost which the local authority would usually expect to pay, or whether it would be a top up payment by the person by virtue of section 4 of the Bill. A deferred payment agreement will have to comply with the provisions of the regulations.

30. Subsection (2) sets out the nature of the deferred payment arrangement. In essence it is an agreement whereby during a certain period of time a resident will not be required to make a portion of the payments that he or she would otherwise have to make under the means testing regime and/or an agreed top-up. Instead, the resident will grant the authority a standard security over his or her property.

31. Under the agreement, payments will be deferred from the date on which the agreement takes effect until the expiry of 56 days after the date of death of the person or the earlier date of termination of the agreement by the person. Interest will not become due on the amount secured until that amount becomes payable and is then due at such rate as the authority may determine in accordance with directions by the Scottish Ministers. A deferred payment agreement is competent only where the person grants a standard security in favour of the authority securing the authority's estimate of the total amount of the payments deferred and the amount of interest likely to be due from the date the payments become due. In essence, therefore, the person must have property of a value sufficient to secure the portion to be deferred of the amount that he or she would otherwise be liable to pay for his or her residential care during his or her lifetime.

32. Subsection (3) allows for the portion of the payment to be deferred to be specified in regulations. The intention is, through those regulations, to ensure that the agreement defers responsibility for a person to make that part of his or her contribution which would come from the capital value of his or her home.

## **Direct payments**

### *Section 7 – Direct payments*

33. Section 7 and paragraph 1 of the schedule amend sections 12B and 12C of the Social Work (Scotland) Act 1968 (“the 1968 Act”). Those sections were inserted by section 4 of the Community Care (Direct Payments) Act 1996. They give local authorities, responsible for providing (or arranging the provision of) community care services, the power to make direct payments to disabled people to enable them to arrange their own community care services.

34. The Community Care (Direct Payments) (Scotland) Regulations 1997 (SI 1997/693) and the Community Care (Direct Payments) (Scotland) Amendment Regulations 2000 (SI 2000/183) specify the persons to whom direct payments may be made under the 1968 Act.

35. Local authorities at present may not make direct payments to disabled children. This is because the definition of “community care services” for the purposes of sections 12B and 12C at present excludes services to children (see the definition in section 5A(4) of the 1968 Act). However, section 51 of the Regulation of Care (Scotland) Act 2001 includes provision which will give the term “community care services” a different meaning for the purposes of sections 12B and 12C of the 1968 Act. Once commenced this will allow direct payments to be made to disabled children of a description specified in regulations under section 12B to enable services available under section 22(1) of the Children (Scotland) Act 1995 to be purchased. At the same time, the 1997 Regulations will be amended to specify that direct payments may be made to children aged 16 and 17.

36. Section 7 of the Bill further widens the availability of direct payments.

37. Section 7(a) amends subsection 12B(1) in three ways. Firstly, it removes the requirement that a person must be a “person in need” under section 94 of the 1968 Act to receive direct payments. Secondly, it reverses the present approach in section 12B(1)(b) whereby only persons of a description specified in regulations made under section 12B(1) of the 1968 Act are eligible to receive direct payments. All persons will now be eligible except those specified by such regulations. This will widen the scope of the direct payments scheme to all community care client groups including, for example, people who are frail, require rehabilitation treatment following an accident or operation, are fleeing domestic abuse or are recovering from drug or alcohol addiction.

38. Subsection (1) is further amended to convert what is presently a power on the part of local authorities to offer direct payments to a duty. A local authority will have a duty to offer direct payments as an alternative to arranging services itself.

39. Section 12B(2) of the 1968 Act details how local authorities can make payments on a net basis i.e. assess the person's ability to contribute to the cost of the services required and deduct this charge before making the direct payments. However, the new subsection (1A), inserted into section 12B by section 7(b) of the Bill, will enable local authorities also to make gross payments to recipients i.e. without first deducting the amount a person is assessed as being able to contribute. This will give them equality of treatment with non-recipients of direct payments, who receive the full services required with recovery of their assessed contribution taking place later. While the 1968 Act does not preclude gross payments, section 7(b) (which inserts new subsection (1A) into section 12B) will put it beyond doubt that local authorities can make payments in this way.

40. Local authorities have a power (and will have a duty) to give direct payments only if that person gives his or her consent to the arrangement. No one can be forced to take such payments. At present if it appears to a local authority that a person is unable to consent to the arrangements, the local authority cannot offer that person direct payments. Section 7(b) inserts new subsection (1B)(a) and (b) into section 12B, which allows for a person to consent to direct payments arrangements on behalf of a person whom the local authority is satisfied is unable to give consent. That person can then do anything that is required to secure the services needed on behalf of that person. Subsection (1B) allows for regulations to be made to specify who can receive direct payments on behalf of the person needing the services. This will enable the Scottish Ministers to make regulations to specify that attorneys or guardians can receive direct payments on behalf of someone who may be unable to give consent, for example a person with dementia.

41. Presently recipients are unable to use their direct payments to purchase services from a local authority. Section 7(b) inserts new subsection (1C) to allow services to be bought from any person, including any local authority, provided that authority and the consenting person are in agreement.

42. Section 7(c) inserts new paragraphs (b) to (e) into section 12B(4) and provides new examples of what a power to make regulations may do. Paragraph (b) allows for regulations to impose conditions on an authority selling its services. Paragraph (c) makes provision to specify circumstances, relating either to the person or the service or both, in which the authority is not



required to make direct payments. Under paragraph (d) regulations can specify when local authorities must or may discontinue payments. Paragraph (e) enables regulations to authorise payments to be made to another on behalf of the person entitled to them, e.g. to the service provider.

43. An authority can assess a person's ability to contribute towards the cost of the services required. However, there is currently no mechanism in the 1968 Act to allow a local authority to recover that contribution if it has not provided or arranged the services itself. Section 7(b) above will give a local authority the power to make direct payments on a gross basis. Section 7(d) inserts new subsection (5A) to ensure that when direct payments are made on a gross basis, a local authority has a power to recover any amount which it considers appropriate.

## **Carers**

*Section 8 – Amendment of 1968 Act: assessment of ability to provide care*

*Section 9 – Amendment of Children (Scotland) Act 1995: assessment of ability to provide care for disabled child*

44. At present, under section 12A of the 1968 Act a local authority is required, if requested by a carer of an adult, to carry out an assessment of the carer's ability to care only if the authority at that time is also assessing the needs of the cared-for person for community care services. "Community care services" are defined in section 5A(4) of the 1968 Act. Similarly, under section 24 of the Children (Scotland) Act 1995 a local authority's duty, if requested by a carer of a disabled child, to carry out an assessment of the carer's ability to care applies only where the authority at that time is assessing the needs of the cared-for child for children's services. Children's services are those services provided under section 22 of the Children (Scotland) Act 1995.

45. Sections 8 and 9 of the Bill amend and add to these provisions, and give carers of adults and carers of disabled children an independent right to request assessment that does not depend on whether the authority is also assessing the needs of the cared-for adult or the needs of the cared-for child. This applies to all carers.

46. At present, a local authority must have regard to the results of the assessment of a carer when deciding what services should be provided to the cared-for person or cared-for child. A local authority may also give a carer assistance directly in the form of information or advice, or by supporting organisations which help carers. Where carers have needs in their own right due to their own health or other circumstances, a local authority may assess the carer for community care services under section 12A of the 1968 Act, and may provide any necessary support in the form of community care services. The changes made by sections 8 and 9 which extend the circumstances in which carers may request an assessment do not affect the courses of action open to a local authority following that assessment, namely to provide support to carers directly, or through the services it provides to the cared-for person or child.

## **PART 2 – JOINT WORKING, ETC.**

47. The provisions of this Part of the Bill provide for the expansion of joint resourcing and management of health and social care services between NHS Scotland and local authorities.

*Section 10 – Payments by NHS bodies towards certain local authority expenditure*

48. Section 10 allows for an NHS body to make payments to a local authority towards certain of the local authority's functions. The payments must be in accordance with any conditions prescribed in regulations by the Scottish Ministers, such as requirements on accounting and auditing or requirements for associated outcome agreements. The relevant local authority functions are those which are prescribed in regulations and which, in the opinion of the NHS body, fall into categories specified in paragraph (a), (b) or (c). Such payments can be towards revenue or capital expenditure and can only be paid after consultation with the local authority. "NHS body" and "local authority" are defined in section 19.

49. The powers which section 10 provides to NHS bodies have some similarity to those under section 16A of the National Health Service (Scotland) Act 1978. That section also allows for payments by NHS bodies to local authorities for certain functions, but the new powers can potentially apply to a broader range of functions. The new section 10 is not intended to replace or supersede powers under section 16A of the 1978 Act. It is one element of a package of measures put forward in this Bill to remove barriers to joint working between NHS Scotland and local authorities.

*Section 11 – Payments by local authorities towards expenditure by NHS bodies on prescribed functions*

50. Section 11 provides a reciprocal power to section 10. It allows for a local authority to make payments to an NHS body towards certain of the NHS body's functions. The payments must be in accordance with any conditions prescribed in regulations by the Scottish Ministers, such as requirements on accounting and auditing or requirements for associated outcome agreements. Payments can be made only if, in the opinion of the local authority, they would improve the way in which the local authority's functions are exercised. The NHS body functions towards which payment can be made are those functions which are prescribed in regulations by the Scottish Ministers. Payments can be towards capital or revenue expenditure. "NHS body" and "local authority" are defined in section 19.

*Section 12 – Delegation etc. between local authorities and NHS bodies*

51. Section 12 allows NHS Scotland and local authorities to work together in new ways by enabling them to pool their resources and delegate functions and resources to one another so that a single body can provide both health and local authority services. In so doing, it removes some of the legal barriers to joint working which currently exist. The measures set out in this section are intended to allow NHS bodies and local authorities to agree jointly who is best placed to carry out their functions and how resources might be used more efficiently.

52. Section 12 removes some of the barriers to joint working by allowing:

- NHS bodies and local authorities to pool resources; and allowing staff from either agency to develop packages of care suited to particular individuals irrespective of whether health or local authority money is used;
- NHS bodies and local authorities to delegate functions to one another, to allow, for example, one of the partner bodies to provide all mental health or learning disability

services locally. It is expected that this will also reduce the costs associated with having two agencies providing services for the same group of people.

53. Subsection (1) allows both NHS bodies and local authorities to enter into arrangements to delegate some of their functions to the other partner (paragraph (a)) and to transfer resources in connection with the delegation arrangement (paragraph (b)). Paragraph (c) allows for the creation of a pooled budget in connection with these arrangements. Subsection (1) also provides for the Scottish Ministers to make regulations setting out how and in what circumstances these powers can be used. “NHS body” and “local authority” are defined in section 19.

54. Subsection (2) provides that only functions prescribed in regulations by the Scottish Ministers can be delegated.

55. Subsection (3) ensures that a NHS body or local authority may enter into such arrangements only if, in its opinion, doing so would lead to an improvement in the way its functions (prescribed by regulations under subsection (2)) are exercised. It makes clear that “improvement” in this context includes better outcomes for users of services.

56. Subsection (4) gives examples of provisions which may be included in regulations which the Scottish Ministers can make under subsection (1), setting out how and in what circumstances these arrangements can be made.

57. Subsection (4)(c) allows for regulations to make provision for staff to be provided under the section 12 arrangements, including the transfer and secondment of staff. Significant upheaval of staff is not anticipated under the new joint working arrangements. It is not intended to make provision for the transfer of staff in the short term between agencies, but agencies will be required to draw up a statement of intent, agree a training and development plan and set up Local Staff Partnership Forums to discuss longer term issues. Nationally, the Integrated Human Resources Working Group is examining long-term issues – different conditions of services, pay and pensions, discipline procedures, training etc. The Group is due to report by April 2002. Section 13 of the Bill sets out the legal effect of staff transfers and provides protection for staff who transfer.

58. Subsection (4)(g) allows for regulations to make provision as to the monitoring and supervision of the joint arrangements and can include requirements on accounting and auditing, associated outcome agreements or reporting lines and committees.

59. Subsection (5) ensures that delegation arrangements do not relieve an NHS body or a local authority from liability, e.g., in negligence, in relation to the exercise by the delegate of the delegated functions. It also provides that the NHS body or local authority which has delegated functions is not thereby prevented from exercising the functions itself. It may need to do so to protect itself from such potential liability. The subsection also ensures that although a joint service (hosted by one partner) may collect charges on behalf of one of the other partner organisations, those charges remain payable to the latter partner who must ultimately receive the funds.

*Section 13 – Transfer of staff*

60. Section 13 sets out the legal effect of any transfer of staff to the employment of another body under a partnership arrangement allowed under section 12 and provides protection for staff who are transferred. (Section 12(4)(c) allows for regulations to govern the provision, transfer and secondment of staff in a joint arrangement.)

61. Subsection (2) describes how a person's contract of employment transfers with that person. Subsection (3) specifies how the rights, powers, duties and liabilities of the transferring authority transfer to the receiving authority. It also describes how any actions of the transferring authority in relation to the employee or his or her contract shall be deemed to be actions of the receiving authority. (The terms "transferring authority", for the current employer, and "receiving authority", for the new employer, are introduced by subsection (1)).

62. Subsection (4) qualifies subsections (2) and (3) to ensure that an employee's right to terminate his or her contract are protected.

63. Subsection (5) ensures that section 13 applies to people who have entered into contracts with the transferring authority which have not yet come into effect on the date of transfer.

64. Subsections (2) to (5) therefore ensure that staff contracts, terms and conditions are not affected by such a transfer

*Section 14 – Scottish Ministers' power to require delegation etc. between local authorities and NHS bodies*

65. Section 14 establishes powers for the Scottish Ministers to direct a local authority or NHS body to enter into any of the joint arrangements set out in section 12. "NHS body" and "local authority" are defined in section 19.

66. Subsection (1) provides that this power can be used by Ministers if, in their opinion (having consulted with the local organisation concerned):

(a) any function of the local organisation, which is prescribed under section 12(2) as being within the scope of the joint working arrangements of section 12, is not being exercised adequately; and

(b) the direction to use the section 12 arrangements would be likely to lead to an improvement in the exercise of that function.

67. The directions under subsection (1) can apply to the function which is not being exercised adequately as well as other functions as described by subsection (2). This enables the directions to specify other functions to be included in the joint arrangement where, in the opinion of the Scottish Ministers, their inclusion would lead to an improvement in the way in which the original function (mentioned in subsection (1)) is exercised.

68. Subsection (3) ensures that the term “improvement” has the same meaning in this section as in section 12. That means that improvement of the exercise of a function in this context is taken to include better outcomes for users of services.

69. Subsection (4) allows the Scottish Ministers to make a “secondary direction” to another local authority or NHS body where they consider it appropriate to make the joint arrangement work.

70. Subsection (5) ensures that any joint arrangements which are entered into because of a direction must comply with all the requirements of that direction, as well as all requirements of regulations made under section 12(4).

### **PART 3 – HEALTH**

#### **Health Boards’ lists**

##### *Section 15 – Services lists and supplementary lists*

71. This section gives the Scottish Ministers power to make regulations to extend the medical list system to cover all general practitioners (GPs) working in NHS Scotland. Currently the system only covers GP principals, the GPs who undertake to provide general medical services (GMS) in their area under a contract negotiated nationally with GP representatives. To join the medical list, a GP principal has to satisfy rules on suitability and once on the list a GP is subject to discipline procedures relating to statutory Discipline Committees and the NHS Tribunal. The lists system does not currently cover GPs who perform personal medical services (PMS) either as independent contractors under contracts developed locally between the Health Board (in practice, each Island Health Board and each NHS Trust with primary care functions (“Primary Care Trust”)) or as GPs employed directly by a PMS practice or a Board. Nor does it cover GPs who assist GMS GP principals. The section is linked with paragraphs 2(3) to 2(9) of the schedule, which make amendments to sections 29, 29A, 29B, 30, 31, 32A and 32D of the National Health Service (Scotland) Act 1978 (“the 1978 Act”) to attach provisions on the NHS Tribunal to GPs on services lists and supplementary lists.

72. Subsection (1) provides the power in relation to GPs performing PMS. Subsection (2) provides the power in relation to GPs who assist GP principals in the provision of GMS.

73. Subsection (1) inserts new section 17EA in the 1978 Act. This provides an enabling power so that Regulations may be made concerning the establishment of services lists of medical practitioners approved to perform PMS. Section 17EA has five subsections.

74. Subsection (1) of section 17EA is the enabling power and provides that regulations may make provision for the preparation and publication by each Board of one or more lists of medical practitioners approved by the Board to perform PMS. PMS is provided under permanent contracts under the 1978 Act or on a pilot basis under the National Health Service (Primary Care) Act 1997 (“the 1997 Act”). Subsection (1)(a) relates to the permanency option (PMS provided in accordance with arrangements under section 17C of the 1978 Act); and *subsection (1)(b)* relates to pilot schemes (PMS provided in connection with the provision of PMS under a pilot scheme made in accordance with Part I of the 1997 Act).

75. Subsection (3) of section 17EA provides that, unless his or her name is included in the Board's services list as that of a person approved to do so, a medical practitioner may not perform PMS in the Board's area, whether in accordance with the permanency option or in connection with a pilot scheme.

76. Subsection (4) of section 17EA enables regulations made in connection with medical lists of GMS principals to be applied to PMS performers; and/or regulations to be made for PMS performers analogous to regulations in connection with medical lists.

77. Under subsection (4)(a) of section 17EA, the regulations may make provision for the application (with such modifications as the Scottish Ministers think fit) to services lists or to persons who are, have been or seek to be included in a services list of any regulations made under the 1978 Act in relation to medical lists or to persons who are, have been or seek to be included in a medical list.

78. Further, under subsection (4)(b) of section 17EA, the regulations may, in relation to such lists or persons, make provision analogous to any provision made by regulations under the 1978 Act in relation to medical lists or to persons who are, have been or seek to be included in a medical list.

79. The regulations under subsection (4) of section 17EA may make provision in terms of either or both subsections.

80. Thus, subsections (4)(a) and (4)(b) of section 17EA provide the Scottish Ministers with the power to apply to PMS performers, with modifications as necessary, the same requirements as apply from time to time to GP principals on the medical list. The Scottish Ministers will have two options to do this: by applying regulations which relate to medical lists also to services lists of PMS performers; and/or by making new regulations on service lists which are analogous to regulations which relate to medical lists.

81. Subsection (2) makes similar provision in connection with medical practitioners approved to assist in the provision of general medical services (GMS non-principals) as subsection (1) does in connection with medical practitioners approved to perform personal medical services.

82. Subsection (2) inserts new section 24B in the 1978 Act. It provides the enabling power so that regulations may be made concerning the establishment of supplementary lists of medical practitioners approved to assist in the provision of general medical services.

83. Subsection (1) of section 24B is the enabling power and provides that regulations may make provision for the preparation and publication by each Health Board (in practice, each Island Health Board and Primary Care Trust) of one or more lists of medical practitioners approved by the Board to assist in the provision of general medical services.

84. Subsection (3) of section 24B provides that a medical practitioner whose name is not included in the Board's medical list, being a GMS non-principal, may not assist in the provision

of general medical services in the Board's area unless his or her name is included in the Board's supplementary list.

85. Subsection (4) of section 24B enables regulations made in connection with medical lists of GMS principals to be applied to GMS non-principals; and/or regulations to be made for GMS non-principals analogous to regulations in connection with medical lists.

86. Under subsection (4)(a) of section 24B, the regulations may make provision for the application (with such modifications as the Scottish Ministers think fit) to supplementary lists or to persons who are, have been or seek to be included in a supplementary list of any regulations made under the 1978 Act in relation to medical lists or to persons who are, have been or seek to be included in a medical list.

87. Further, under subsection (4)(b) of section 24B, the regulations may, in relation to such lists or persons, make provision analogous to any provision made by regulations under the 1978 Act in relation to medical lists or to persons who are, have been or seek to be included in a medical list.

88. The regulations under subsection (4) of section 24B may make provision in terms of either or both subsections.

89. Thus, subsections (4)(a) and (4)(b) of section 24B provide the Scottish Ministers with the power to apply to GMS non-principals, with modifications as necessary, the same requirements as apply from time to time to GP principals on the medical list. The Scottish Ministers will have two options to do this: by applying regulations which relate to medical lists also to supplementary lists of GMS non-principals; and/or by making new regulations on supplementary lists which are analogous to regulations which relate to medical lists.

#### *Section 16 – Representations against preferential treatment*

90. Paragraphs 3(1) of Schedule 1 to the National Health Service (Primary Care) Act 1997 (“the 1997 Act”) is amended to add “fraud” to the grounds on which a Health Board may refer to the NHS Tribunal a case involving a PMS provider who wishes to cease providing PMS under pilot arrangements and receive preferential consideration to return to the medical list.

91. Paragraph 4(1) of Schedule 1 to the 1997 Act is amended to add “fraud” to the grounds on which the NHS Tribunal may direct the disqualification from the medical list of a PMS provider who wishes to receive preferential consideration to return to that list on ceasing to provide personal medical services under pilot arrangements.

#### **Miscellaneous**

#### *Section 17 – Amendment of Road Traffic Act 1988 and Road Traffic (NHS Charges) Act 1999: payment for treatment of traffic casualties*

92. This amendment is consequential on a change in UK legislation that broadened the definition of “road” for statutory motor insurance purposes. It amends sections 157(1)(a) and 158(1)(a) of the Road Traffic Act 1988 and section 1(1)(a) of the Road Traffic (NHS Charges)

Act 1999 to the same effect to cover accidents that happen in public places as well as on the open road.

93. The Road Traffic (NHS Charges) Regulations 1999 (SI 1999/785), which came into effect on 5 April 1999, provides a scheme that enables the NHS to recover the costs incurred as a result of the treatment of road traffic casualties. The charges, recoverable from insurers and certain other persons, are payable only following an agreed compensation settlement.

*Section 18 – Amendment of 1978 Act: schemes for meeting losses and liabilities etc. of certain health bodies*

94. The amendment adds the Mental Welfare Commission for Scotland to the list of bodies covered by section 85B(2) of the National Health Service (Scotland) Act 1978. Section 85B provides for the establishment of schemes to meet specified losses and liabilities of the duly listed health bodies.

95. The amendment will enable the Mental Welfare Commission to be covered by the Clinical Negligence and Other Risk Indemnity Scheme (CNORIS), which was introduced by the National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000 (SSI 2000/54) on 1 April 2000. The scheme provides financial risk sharing arrangements for specified health bodies in respect of their clinical and certain other liabilities.

**PART 4 – GENERAL**

*Section 19 – Interpretation*

96. This section clarifies the meaning of various expressions used in the Bill. “Social care” does not include the provision of accommodation (subsection (2)). The note on section 2 of the Bill discusses how the provision of accommodation can include both board and lodging and other services. It is intended that such services can be excluded from the definition of accommodation so that they may constitute social care for the purposes of the Bill. Regulations under section 2 will achieve this.

*Section 20 – Regulations*

97. This section sets out the procedure applying to regulations and orders to be made under the Bill. It provides that such regulations can be annulled by a resolution of the Scottish Parliament. It allows the Scottish Ministers to make different provision for different cases, services or persons in the regulations that may be made.

*Section 21 – Transitional provisions, etc.*

98. This section allows the Scottish Ministers by order to make such incidental, supplementary, consequential, transitional, transitory or savings provisions as they consider necessary or expedient for the purposes of or in consequence of this Act, or any order or regulations made under it. Such an order may amend or repeal primary legislation.



*Section 22 – Minor and consequential amendments*

99. Section 22 brings into effect the schedule, which makes a number of amendments to existing legislation, which are minor and consequential to the provisions of the Bill.

*Section 23 – Guidance and directions*

100. This section allows the Scottish Ministers to issue guidance and directions as to local authorities and NHS bodies as to how they should undertake their functions under the Bill. The section does not affect the other relevant powers to issue guidance and directions listed at paragraphs (a), (b) and (c).

*Section 24 – Short title and commencement*

101. This section enables the Scottish Ministers to bring sections of the Bill, except section 24 itself, into force by order. Such an order may make appoint different days for different provisions and for different purposes.

## **SCHEDULE**

*Paragraph 1*

102. Sub-paragraphs (2) and (3) make minor amendments to sections 12B(7) and 12C(2) of the 1968 Act. They are consequential to the direct payment provisions in section 7 of the Bill.

103. Sub-paragraph (4) is to correct an error in the text of section 13A(2) of the 1968 Act.

104. Sub-paragraph (5) makes a minor amendment consequential to section 3 of the Bill. It amends section 94(1) of the 1968 Act to ensure that prescription under the new section 12(3A) of that Act is by order.

*Paragraph 2*

105. Paragraph 2(2) of the schedule amends section 16A of the National Health Service (Scotland) Act 1978, which allows health boards to make payments to certain organisations for certain purposes. The amendment makes it clear that section 16A is without prejudice to section 10 of the Bill, which allows health boards to make payments to local authorities. The relevant amendments to the National Health Service (Scotland) Act 1978 which are set out in paragraph 2(3) to (7) of the schedule are to that Act as amended by the Health Act 1999 (section 58 and Schedule 4 paragraph 49).

106. These amendments to the 1978 Act will bring GMS non-principals and GPs performing personal medical services (PMS) within the jurisdiction of the NHS Tribunal which may direct the disqualification (either local or national) or conditional disqualification (either local or national) of a practitioner on grounds of fraud and efficiency and may direct his or her interim suspension on similar grounds. The Tribunal may additionally declare that the practitioner is not fit to be engaged in any capacity in the provision of the relevant services. The amendments will also enable interim suspension, disqualification and conditional disqualification provisions imposed by a Health Authority in England and Wales or an equivalent body in Northern Ireland to be applied to the same non-principal or PMS practitioner in Scotland. They also provide for a

health authority in England and Wales or an equivalent body in Northern Ireland to seek review by the Scottish Tribunal of a conditional disqualification. Referrals to the Tribunal are made by the Health Board or Boards holding the list(s) on which is included the name of the practitioner who is the subject of the referral.

107. Section 29(6) of the 1978 Act is amended to extend to a GMS non-principal or GP performing personal medical services (PMS) the first condition for disqualification by the NHS Tribunal from inclusion on a list held by a Health Board. The condition is that the continued inclusion of the person on the relevant list(s) would be prejudicial to the efficiency of the services in question.

108. Section 29(8)(a) of the 1978 Act is amended to include supplementary lists in the lists held by a Health Board from which practitioners may be disqualified by direction of the NHS Tribunal.

109. A new paragraph (aa) is inserted into section 29(8) to include a services list of performers in pilot and permanent PMS schemes in the lists held by a Health Board from which practitioners may be disqualified by direction of the NHS Tribunal.

110. Section 29A(3) of the 1978 Act is amended to extend to PMS performers' liability where a lack of diligence by the performer has resulted in a fraud being perpetrated by another member of staff.

111. A new subsection (3A) is inserted into section 29A to extend liability as described in section 29A(3), as amended, to GMS non-principals also.

112. Section 29B is amended to enable the NHS Tribunal to disqualify a practitioner from all medical, supplementary and services lists of any Health Board (section 29(2)(b)(i)).

113. Additionally, section 29B(3), as amended, provides for PMS performers to be included in the categories of person about whom the NHS Tribunal may make a declaration of unfitness when making a national disqualification. As amended, the NHS Tribunal may now declare that the person subject to national disqualification is unfit to be engaged in any capacity in the provision or performance of the services associated with the lists from which he or she has been disqualified.

114. Section 30(4) of the 1978 Act is amended to include performers of PMS in the categories of persons whose conditional disqualification a Health Authority in England and Wales or an equivalent body in Northern Ireland may request the NHS Tribunal in Scotland to review.

115. Section 31 of the 1978 Act relates to equivalent disqualification provisions in England and Wales or Northern Ireland. It provides that a person disqualified in England and Wales or Northern Ireland is disqualified for inclusion in lists in Scotland.

116. Subsection (1)(a) of section 31 is amended to extend to lists of GMS non-principals and PMS performers those lists in Scotland to which a disqualification from equivalent lists in England and Wales or Northern Ireland may relate.

117. Subsection (2) of section 31 is amended to enable Scottish Minister to impose conditions on provision or performance of services by non-principals and PMS performers equivalent to those already imposed on practitioners who are conditionally disqualified under provisions in England and Wales or Northern Ireland.

118. Section 32A(6)(a) is amended to extend to lists of PMS performers and GMS non-principals those lists from which a person shall be deemed to be disqualified where a Health Board has applied for interim suspension of that person.

119. Section 32D of the 1978 Act is amended to extend to GMS non-principals and performers of PMS the provisions that suspend and disqualify a person who, under corresponding provisions in England and Wales or Northern Ireland, has been suspended and disqualified for inclusion in a list in England and Wales or Northern Ireland.

---

## **FINANCIAL MEMORANDUM**

### **INTRODUCTION**

120. This Bill paves the way for a number of significant expenditure commitments made by the Executive and includes provisions to enable the more effective use of existing resources.

121. In October 2000, the Minister for Health and Community Care, Susan Deacon MSP, announced an additional £25m per annum to cover the costs of making nursing care provided by care homes free. This was one element of a package amounting to almost £100m per year, announced as part of the Executive's response to the Royal Commission on Long Term Care. In January 2001, Susan Deacon announced the establishment of the Care Development Group, whose aim was "to ensure that older people in Scotland have access to high quality and responsive long-term care, in the appropriate setting, and on a fair and equitable basis". The Group's remit included the requirement "to bring forward proposals for the implementation of free personal care for all, along with an analysis of the costs and implications of so doing". On 28 June 2001, the provision of an additional £100m per annum to enable the implementation of free personal care was announced by the Minister for Finance and Local Government, Angus MacKay MSP. The Care Development Group published its report, *Fair Care for Older People*, in September 2001.

122. The Bill will assist the implementation of free nursing and personal care by means of regulations. A number of the other provisions in the Bill are enabling legislation which do not in themselves impose significant direct costs. The detail of subordinate legislation made under

these provisions will influence the overall costs of the Bill in due course. This will be taken into account when the relevant orders and regulations are made.

## **COSTS ON THE SCOTTISH ADMINISTRATION**

123. A number of the elements of the Bill will enable the delivery of significant new funding commitments by the Executive. The key elements are the costs of free nursing and personal care. Details of the resources to be made available have already been announced as set out above.

124. The Scottish Executive will incur short-term administrative costs in terms of staff and related costs associated with the provisions of the Bill. These will be incurred in the preparation of regulations and in providing support and guidance on implementation of changes. The Executive will also continue to bear significant costs in support of local authorities and NHS bodies in the delivery of community care and health services. These responsibilities are not as a consequence of the Bill but the way in which some of them are delivered will be affected by the Bill.

### **Community care: charging for social care**

125. The Executive intend to make use of the powers provided by this part of the Bill to assist with the implementation of free nursing and personal care in the light of the conclusions of the Care Development Group. As made clear above, funds totalling £125m per annum have already been announced to fund these changes.

126. The powers provided by this section will also provide the Executive with the means to fulfil its commitment to regularise charges for non-residential care. The Confederation of Scottish Local Authorities (COSLA) is working with local authorities to address the issue of inconsistency across Scotland in charging for non-residential care. The Executive is therefore committed to hold the use of powers to regularise such charges in reserve, but will be prepared to regulate on the issue if necessary. If, in due course, the Executive concludes that it should intervene in this matter then any cost implications of the regulations to be proposed will be considered at that time.

### **Accommodation: deferred payment agreements**

127. Allowance has already been made (within the 3-year local government settlement allocations from April 2001) for additional costs to local authorities of providing deferred payment agreements. This falls into the allocation of £6m this year, £12m for 2002-03 and £12m for 2003-04 (which also covers the cost of changes to the residential care charging means test and the care management costs of people who currently have “preserved rights” to residential care through social security). It was announced as part of the Executive’s response to the Royal Commission on Long Term Care in October 2000. The cost implications of deferred payment agreements are discussed in more detail under *Costs on Local Authorities* below.

## **Joint working**

128. The main costs to the Scottish Executive will be in producing regulations and guidance and providing support for local organisations developing joint arrangements, although the costs arising from the Bill itself are difficult to separate out from existing commitments. Support and guidance is already underway, for moves towards joint working within the existing legislative framework. The intention is that this will be adapted and extended as legislative changes come into effect.

## **Health: services lists and supplementary lists and representations against preferential treatment**

129. The inclusion of locums in the NHS pension scheme will lead to additional costs through extra employers' contributions. These costs are difficult to calculate as they will depend on the percentage of locums who elect to join the pension scheme and on the activity in whole-time equivalent terms of such locums. On the basis of the limited information available, the Executive's best estimate is that the cost may be of the order of £650,000 per year. The costs will be met from the demand led general medical services (GMS) budget which is controlled at Scottish Executive level.

130. There will be an increase in the number of cases referred to the NHS Tribunal, with accompanying costs. These will be limited, however, as referrals to the Tribunal, which is the ultimate disciplinary body for family health service practitioners, are rare and should continue to be so. The Executive's best estimate is that extending the Tribunal's jurisdiction to non-principals, PMS performers on service lists and PMS pilot providers wishing preferential consideration on seeking return to the medical list could require an additional £3,000 – £4,000 per year on top of the £12,000 which is currently allocated to sittings of the Tribunal.

## **Miscellaneous: amendment of Road Traffic Act 1988 and Road Traffic (NHS Charges) Act 1999**

131. The change serves to increase the scope under which costs can be recovered from insurers. However, the fact that the original regulations failed to cover "public places" was an oversight. Therefore, any financial implications would have been taken into account at the outset when the financial appraisal was prepared. This change will not have any new financial implications.

## **Miscellaneous: Amendment of 1978 Act**

132. It had always been intended that the Mental Welfare Commission for Scotland would be a member of CNORIS and the financial consequences of this, which are *de minimis*, were included in the original exercise. Therefore, the change now in the regulations is a technical change which will place no additional financial burden on the system.

## **COSTS ON LOCAL AUTHORITIES**

133. Most of the elements in this Bill will impact to some extent on the way that local authorities deliver social care. Additional expenditure will be involved, particularly in the

delivery of free nursing and personal care. Extra funds have been committed by the Executive as set out in this Financial Memorandum.

134. Other elements of the Bill are concerned with the way in which local authorities deliver services, in particular those where there is an element of partnership with the NHS. The objective of these elements is to provide local authorities with the means to deliver a more effective and efficient service within the level of their current resources.

#### **Community care: charging for social care**

135. As set out above, the provision of free nursing and personal care will involve major new resources. The extra funds required to enable local authorities to deliver these services have already been announced.

136. As made clear above, the Executive does not intend to use the new powers to regulate non-residential care charges in the first instance. Any cost implications of regulating for this would be considered when such regulations were brought forward.

#### **Accommodation: disregarding of resources**

137. This change is a technical consequence of other provisions in the Bill on charging for social care and deferred payment agreements and therefore does not have separate costs in its own right.

#### **Accommodation: more expensive accommodation**

138. This provision will extend choice for individuals to top-up their contribution towards fees for more expensive accommodation. The intention is, through regulation, to ensure that this is only an option where it would not be expected to lead to a resident using up the resources which the means tests are designed to protect. It is therefore not expected that the change will lead to people requiring additional financial support from local authorities.

#### **Accommodation: deferred payment agreements**

139. A deferred payment agreement would be an agreement whereby during a certain period of time a resident would not make part of the payments he or she would otherwise have been required to make towards the cost of his or her care. The intention is, through regulations, to ensure that the agreement defers responsibility for a person to make that part of his or her contribution which would come from the capital value of his or her home. Instead, the resident would grant the authority a charge over his or her home in respect of payment, which would be recovered from his or her estate (or from him or her if he or she chooses to terminate the agreement sooner).

140. Although deferred charges will ultimately be recovered, there will still be an initial loss of revenue to the local authority. In addition, the interest free arrangements mean that the money recovered will not cover any lending costs incurred by the local authority.

141. Deferred payment agreements will therefore have an associated cost to local authorities. Allowance has already been made (within the 3-year local government settlement allocations from April 2001) for any additional costs to local authorities of such agreements. (This falls into the allocation of £6m this year, £12m for 2002-03 and £12m for 2003-04, announced as part of the Executive's response to the Royal Commission on Long Term Care in October 2000. This also covers the cost of changes to the residential care charging means test and the care management costs of people who currently have "preserved rights" to residential care through social security.)

142. Costs to local authorities are difficult to estimate because they depend on demand and also on how free nursing and personal care are to be implemented. The Executive expects that one of the effects of free nursing and personal care will be to significantly reduce the costs of providing deferred payment agreements. Therefore, the Executive's intention is to delay using the power which the Bill provides to give people a right to such arrangements until the scheme has been operating long enough to assess demand and the impact on local authority income and budget planning.

### **Direct payments**

143. The Bill will place a new duty on local authorities to offer direct payments in lieu of arranging services themselves. This, coupled with other measures in the Bill which will widen the field of eligibility for direct payments, is likely to increase the demand for direct payments. The knock on effect of this is that it is possible that, over time, demand for local authority resources, such as day centres, may fall. Local authorities anticipate costs associated with the move away from "fixed" local authority services as more people take up the offer of arranging their own services. Any move away is however likely to be gradual and a provision in the Bill to allow local authorities to sell their services will give them a level playing field with private services providers. This means that local authorities will need to ensure that their services can compete with private providers not only in terms of quality and price but also flexibility. Local authorities also anticipate start up costs associated with providing information to clients, training staff and publicising the availability of direct payment schemes.

144. Recent research, *Direct Payments: The Impact on Choice and Control for Disabled People*, (October 2000) commissioned and published by the Executive, found that time invested in setting up a scheme could be recouped in the mid to longer term. It also reported that budgetary gains are possible in the long term. This is consistent with experiences elsewhere that costs can fall if people are given the resources to organise their own care.

145. In response to authorities' concerns about managing the changes to direct payments, the commencement of the provisions will be delayed to allow them more time to put in place a mandatory scheme and an extension to all community care client groups. No firm decision on a timetable for implementing these changes will be taken until the recommendations of the Care Development Group have been fully considered.

146. The Direct Payments research found that a successful scheme is built on the foundations of a strong support system. In recognition of the report's findings and to help address concerns about start-up costs, the Executive has committed £530,000 over 2001-02 and 2002-03 to put in

place the support systems needed by recipients, supporting organisations and local authorities. The project will help improve awareness and take up of direct payments in Scotland. The project will also provide training at local levels. In addition a three-year project grant of £65,000 per annum, which started in April 2001, has been allocated under section 10(1) of the Social Work (Scotland) Act 1968.

### **Carers: amendment of 1968 Act and amendment of Children (Scotland) Act 1995**

147. The main impact of the provisions to give carers an independent right to assessment, and to extend that right to young carers under 16 and parent carers of disabled children, is likely to be an increase in the numbers of carers' assessments carried out by local authorities. As a consequence of these assessments, there is likely to be an increase in support provided by local authorities to carers and/or the people they care for. It is impossible to estimate the likely rate of any increase with any degree of accuracy.

148. We believe such increases are likely to be limited in scale and gradual. Work in Scotland by the Princess Royal Trust for Carers to identify "hidden" carers found that only a third of those identified required practical support, and only a very small minority of these carers wanted an assessment. The development of alternative approaches to assessment, particularly self-assessment by carers, and the fact that many carers already have their needs assessed as part of a wider assessment of the person they care for, should further contain the resource impact on authorities. We believe local authorities will be able to meet any increased demand from the increasing resources they are receiving to support carers and provide respite care, which are rising from £5 million in 1999-2000 to £21 million by 2003-04.

### **Joint working**

149. The powers in the Bill are mainly to remove barriers to joint working and do not, as such, have a cost attached. Indeed, one of the principle intentions is to improve flexibility to aid efficiency. There is a clear expectation that local organisations will move towards joint arrangements. There may be short-term transitional or development costs as agencies re-configure their structures and management arrangements. In their financial settlement for 2001-2004, local authorities can access the additional resources for modernising community care (now £10m per annum). Ultimately the moves to joint arrangements will lead to improved and more cost-effective services.

### **COSTS ON HEALTH BOARDS, PRIMARY CARE TRUSTS AND GENERAL MEDICAL PRACTICES**

#### **Joint working**

150. As is the case for local authorities (see above) there may be short-term transitional or development costs as agencies re-configure their structures and management arrangements. NHS unified budgets which include NHS Primary Care Trusts (and thus Local Health Care Co-operatives) allow significant headroom for development and improvement of systems and services. Ultimately however, the moves to joint arrangements will lead to improved and more cost-effective services.



**Health: services lists and supplementary lists and representations against preferential treatment**

151. In headcount terms, there are about 3,700 GP principals and a further 430 GP non-principals (excluding locums) and personal medical services performers. It is estimated that there are up to 700 GP locums. Accordingly the effect will be to add some 1,100 names across the country as a whole to the lists managed locally, an increase of some 30%. For this purpose, and cases which are referred to the NHS Tribunal, Boards and Trusts will incur limited administration costs to be subsumed within their overall resources.

152. General Medical Practices will incur limited additional costs through having to ensure that all non-principal GPs whom they wish to employ are included on the services and supplementary list for their area and through other administrative tasks involved in the operation of the list system. On the other hand, they will save costs through having available for reference a list of GPs who are approved for appointment when they wish to employ a non-principal GP. Practices will also incur costs in answering any representations made to the NHS Tribunal. In general these would be met by membership of defence bodies. Also, the Tribunal has power to award expenses.

**COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES**

**Accommodation: deferred payment agreements**

153. The provision of interest-free deferred payment agreements for payment of care home fees would be expected to have limited impact on those businesses offering equity release against the value of a person's home.

**Health: services lists and supplementary lists and representations against preferential treatment**

154. Individual non-principal GPs and personal medical services performers will incur limited additional costs through having to apply for inclusion on a services or supplementary list. For locums in particular, these costs should be set against the fact that, once on a supplementary list, they will more readily be able to demonstrate to a prospective employer that they are approved for appointment.

155. Some costs will be incurred by the defence bodies of those non-principals and performers of PMS who are referred to the Tribunal and who wish to engage legal representation. These will depend on the length of the hearing and the type of legal representation engaged.

*These documents relate to the Community Care and Health (Scotland) Bill (SP Bill 34) as introduced in the Scottish Parliament on 24 September 2001*

## **EXECUTIVE STATEMENT ON LEGISLATIVE COMPETENCE**

156. On 24 September 2001, the Minister for Health and Community Care (Susan Deacon) made the following statement:

“In my view, the provisions of the Community Care and Health (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

---

## **PRESIDING OFFICER’S STATEMENT ON LEGISLATIVE COMPETENCE**

157. On 21 September 2001, the Presiding Officer (Sir David Steel) made the following statement:

“In my view, the provisions of the Community Care and Health (Scotland) Bill would be within the legislative competence of the Scottish Parliament.”

*These documents relate to the Community Care and Health (Scotland) Bill (SP Bill 34) as introduced in the Scottish Parliament on 24 September 2001*

# **COMMUNITY CARE AND HEALTH (SCOTLAND) BILL**

## **EXPLANATORY NOTES**

### **(AND OTHER ACCOMPANYING DOCUMENTS)**

© Copyright The Scottish Parliamentary Corporate Body 2001

EDINBURGH: THE STATIONERY OFFICE

Printed in the United Kingdom by The Stationery Office Limited

Applications for reproduction should be made in writing to the Copyright Unit, Her Majesty's Stationery Office, St Clements House, 2-16 Colegate, Norwich NR3 1BQ. Fax 01603 723000.

Produced and published in Scotland on behalf of the Scottish Parliament by  
The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliament publications.