COMMUNITY CARE AND HEALTH (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Community Care and Health (Scotland) Bill introduced in the Scottish Parliament on 24 September 2001. It has been prepared by the Scottish Executive to satisfy Rule 9.3.3(c) of the Parliament's Standing Orders. The contents are entirely the responsibility of the Scottish Executive and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 34–EN.

BACKGROUND

2. The Bill drives forward a number of key policy commitments made over the last year, all of which aim to improve the delivery of care to people in Scotland. In particular, it will help fulfil commitments made in announcements by Susan Deacon MSP, Minister for Health and Community Care, in October 2000 and January 2001.

3. In October 2000 the Minister announced the *Scottish Executive's Response to the Royal Commission on Long Term Care*. That announcement set out the Executive's priorities for community care. It introduced a series of new measures to improve the delivery of care, backed up by a commitment to a substantial increase in expenditure, building up to almost £100m per year by 2003-4. The Minister also committed the Executive to introducing legislation to ensure the provision of free nursing care in all settings; to remove any remaining obstacles to joint service delivery (and enable pooled budgets, delegation of responsibilities and a broader scope for financial transactions between the NHS and local authorities); to ensure consistency of charging in non-residential settings; to allow for the value of a person's home to be disregarded from the means test for 12 weeks following admission to residential care; and to make local authority loans available so that people in residential care would not have to sell their homes to fund their care. The 12-week disregard has already been introduced by way of secondary legislation and this Bill will provide the legislative basis to implement the rest of these commitments.

4. In January 2001, the Minister announced the publication of the *Scottish Executive's Response to the Report of the Joint Future Group*; 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) and the *Response by the Scottish Executive to the Health and Community Care*

Committee's Inquiry into the Delivery of Community Care. Those responses set out key features of the Executive's plans to deliver distinctive improvements to community care in Scotland.

5. The Minister also announced the establishment of the Care Development Group to further the development of the Executive's policies. The Group's 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".

6. At the same time, the Minister announced the Executive's intention to bring forward this Bill to implement the commitments announced the previous October. The Minister stated her intention that the Bill should also provide for any further changes to the legislative framework which were needed to extend free personal care, over and above those required to fulfil the Executive's commitment to the provision of free nursing care.

7. The Scottish Ministers consulted on these proposals in a number of ways, principally by publishing the consultation paper *Better care for all our futures* in April 2001 and through the public engagement strategy of the Care Development Group. (The other consultation processes involved are set out in detail later in this document.) The comments made by the wide range of respondents informed the development of the detail of the Bill.

8. In addition, the Executive established a dedicated website for the Bill (http://www.scotland.gov.uk/health/ltc/legislation.asp) and for the Care Development Group (http://www.scotland.gov.uk/health/cdg). Links to the documents and announcements referred to above can be found on these sites.

POLICY OBJECTIVES OF THE BILL

Charging for social care

Free nursing care

9. NHS nursing care is provided free of charge in the home, in hospitals and in nursing and residential care homes. Non NHS nursing care provided in nursing homes is also free for those residents whose care is funded, depending on individual circumstances, by the local authorities or the NHS. However, some residents pay all or part of those non NHS nursing care costs, subject to a means test.

10. The Scottish Ministers agreed that the current situation was inequitable and that nursing care should be free in all settings, as recommended by the Royal Commission on Long Term Care. In the *Scottish Executive's Response to the Royal Commission on Long Term Care*, in October 2000, the Executive stated:

> "We therefore plan to act, and to legislate to ensure that nursing care is provided free of charge regardless of where the patient resides."

11. The *Report of the Chief Nursing Officer for Scotland's Group on Free Nursing Care*, published in December 2000, provided recommendations on how free nursing care could best be delivered. The Executive welcomed the approach taken by the report to the definition of nursing care and the suggested arrangements for implementation. The remit of the Care Development Group therefore included a requirement to work with the Chief Nursing Officer's Group. The approach to definition and implementation taken in the CNO's report has therefore formed a central part of the CDG's considerations.

12. The CNO's report envisaged that free nursing care would be delivered by means of flat rate payments, taking into account needs related to activities of daily living, difficult behaviours and complex clinical needs. They recommended that funds should be paid into local, jointly managed budgets for older people's services which are to be established from April 2002. These jointly managed budgets will bring together relevant local interests in NHS Scotland and local authorities.

13. If local authorities are to play a part in implementing these arrangements then a change in the law is required. This is because the Social Work (Scotland) Act 1968 requires that any care provided by local authorities to people in care homes is charged for. New provisions are therefore necessary to ensure that local authorities could help fund flat-rate payments for nursing care (provided to those in nursing homes) free of charge.

14. The part of the Bill which will assist with the provision of free nursing (and personal) care therefore allows the Scottish Ministers to prescribe in regulations that local authorities charge, or do not charge, for social care services. This will enable the Executive to fulfil the commitment given in October 2000.

Free personal care

15. The Executive is committed to bringing forward plans for the implementation of free personal care, beginning in April 2002. Consideration of this issue has been taken forward by the Care Development Group, established by Susan Deacon, Minister for Health and Community Care, in January 2001. On 28 June 2001, Angus MacKay, Minister for Finance and Local Government, announced that the Executive would provide £100 million in 2002 and a further £100 million in 2003 to fund free personal care for older people and other recommendations of the Care Development Group. These resources are additional to the package of almost £100m announced by Ms Deacon in October 2000.

16. The Care Development Group was established "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 was chaired by Malcolm Chisholm MSP, Deputy Minister for Health and Community Care. Its full remit was:

- To examine existing service provision and to identify gaps, deficiencies and duplication which may require to be addressed;
- 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;

- To provide a clear definition of what is meant by free personal care;
- To examine the current deployment of resources from all funding streams for the care of older people and make any recommendations for change that are thought to be necessary;
- To work with the Chief Nursing Officer's Group to develop a person-centred holistic needs assessment process;
- To consider the interrelationships with UK matters, notably the tax and social security benefits system and cross border movement;
- To bring forward recommendations, together with costs and possible opportunity costs, of providing sustainable changes which will meet current and projected need and likely demand; and
- To report to the Minister for Health and Community Care by August 2001 with a view to the first stage of implementation beginning in April 2002.

17. The remit of the CDG therefore extended to a much wider range of considerations than personal care alone. The implementation of free personal care and its interaction with free nursing care was, however, central to its considerations. The CDG published its report, *Fair Care for Older People*, in September 2001. The CDG's conclusions will shape the future direction of the Executive's policy for these areas and in particular its approach to implementation. The CDG's conclusions will also give an indication of the way in which the powers provided by the Bill will be used by the Executive to fulfil its commitments.

18. As explained above (in relation to nursing care) local authorities cannot currently provide free care to those in residential care. This also applies to personal care. The Executive envisages that the provisions of the Bill to assist with the implementation of free nursing care will also play a similar part in the delivery of free personal care.

19. An additional consideration for personal care is non-residential care. Currently local authorities have a wide discretion in respect of charging for such care. In practice, many local authorities have no, low or capped charges for home care which may mean that personal care is, in effect, not being charged for. However, in order to ensure that personal care is (and is seen to be) delivered in line with Executive policy, the Bill provides powers for Ministers to prescribe in regulations which aspects of social care shall not be charged for.

20. This will build on the current range of powers which Ministers will draw on to enable implementation of their commitment to free nursing and personal care, all of which will be informed by the considerations of the CDG.

Promoting consistency in charging for non-residential care

21. Most older people, including many of the very frail, live at home. Research and feedback from older people themselves confirms that, so far as possible, they want to stay there. The Executive's community care policies are designed to support people in their own homes and promote care at home where possible. One of the issues of concern to those receiving care at home is the variation in charging approaches adopted by different local authorities.

22. As indicated above, local authorities currently have considerable discretion to set charges for non-residential care (which includes care at home, day care and equipment and adaptations). As a result, there is a wide range of approaches among local authorities. A few charge the full cost of the service; others apply a maximum charge ranging from £11.30 to £88.58 per week, while in some cases services are free.

23. It is a widely held view that such wide variations in charging for non-residential care are not acceptable. Users of these services need and expect fairness. People do not understand why they should pay significantly different amounts for care depending on where they live. Free personal care will help to eliminate some of the current variations, but non-personal care costs will continue to be chargeable and the potential for variation in charging policy between local authorities will remain. The Scottish Ministers have therefore decided to legislate so that they can act to ensure a greater consistency of approach.

24. The Bill therefore gives the Scottish Ministers power to make regulations to specify which aspects of social care shall, or shall not, be charged for. The regulations may also specify the factors which local authorities must take into account in calculating a charge, if one is being levied for a service, or stipulate a maximum charge to be applied. The factors to be taken into account can include those relating to the service user's income and capital.

25. COSLA (the Convention of Scottish Local Authorities) has already indicated a willingness to take steps to address this issue and work with local authorities to produce guidance to reduce the inconsistencies in non-residential care charging. It has already produced draft guidance on the issue, in September 2000. However, this work has been on hold until the CDG reports and decisions are made about how free personal care should be implemented.

26. Therefore, the intention of the Scottish Ministers remains to hold in reserve the powers to regulate non-residential care charges provided by the Bill, at least until the outcome of COSLA's work can be evaluated.

Accommodation

Promoting choice in residential care: disregarding of resources in deciding eligibility

27. Currently, local authorities have to consider a person's capital when deciding whether to arrange care home places and must disregard any capital below the higher capital limit in the means-test for calculating contributions to care home charges. 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. However, as noted above, moves towards free personal care and deferred payment agreements put forward in this Bill will mean that for the first time, many people with capital above this limit may need to be made eligible for local authority supported care home places. To enable any doubt about local authority responsibility to be removed, the Bill includes a power to break this link with the care home charging means test.

Promoting choice in residential care: choice of more expensive care home

28. Someone whose care costs are being met by the local authority may choose to stay in a residential or nursing home that is more expensive than the local authority would normally fund, if the additional costs are paid. In such cases, it has been accepted practice for a third party (such as a relative) to make up the difference in costs, but existing legislation does not clearly grant that right, either to third parties or to individuals receiving care.

29. This issue is now important because of other changes which will mean that people with significant income and/or significant capital (above the residential care charging capital limits) will, for the first time, be eligible for local authority supported care home places. (These are the deferred payment agreements put forward in this Bill and the disregard of home value from the residential care charging means test introduced by the National Assistance (Assessment of Resources) (No. 3) (Scotland) Regulations 2001. It is also possible that moves to free personal care will have the same effect, depending on how that is to be implemented.) The Executive wants to make sure that people in this category who want to choose more expensive accommodation and who have the necessary means to fund such a top-up are enabled to do so from their own resources.

30. The Bill therefore amends the current legislation to provide for top-ups either by third parties or by residents themselves. We envisage that regulations will be made to restrict self top-ups to residents with sufficient resources to ensure that the arrangement can be sustained and that the person is not likely to be impoverished as a consequence. Third party top-ups will have wider application, to reflect current practice.

Promoting choice in residential care: cross-border placements

31. Local authorities have responsibility for arranging residential care for people assessed (under section 12A of the Social Work (Scotland) Act 1968) as needing such care under section 12 of the 1968 Act. They have similar responsibility to arrange residential care where nursing is provided under section 13A of that Act.

32. For people requiring such care it is established policy that they can request a place in a care home outside their local area and, indeed, outside Scotland. This can be important, for example, in order to be close to relatives or friends or to be close to a particular community such as an ethnic minority or faith community. Local authorities enter into such arrangements for placements outside their area and they presently retain responsibility for their funding.

33. It has been accepted practice that local authorities have power to arrange and pay for care home places without nursing in other parts of the UK but are not able to do so for care home places with nursing. This is because the relevant legislation (section 13A of the Social Work (Scotland) Act 1968) only permits local authorities to enter into arrangements to pay for nursing care in a nursing home registered under Scottish legislation.

34. Currently, where a person wishes to have a care home place with nursing outside Scotland, local authorities can only make the provision indirectly. They seek agreement with the host authority in the appropriate part of the United Kingdom to act as an intermediary in arranging and funding the person's care. Such arrangements are clearly uncertain and

administratively complex. They impose an unnecessary administrative barrier to the effective implementation of the principle of choice.

35. It has been understood that there is no similar barrier to care home placements without nursing, but existing legislation does not provide a clear power to arrange such placements outside Scotland. The Executive wants to remove these barriers to choice and remove any uncertainty. Therefore, the Bill provides a new power for Scottish local authorities to arrange and pay for care home places (both with and without nursing care) in other parts of the UK, which is to apply to both new and existing cases.

Promoting choice in residential care: deferred payment agreements

36. While the Executive is committed to ensuring that nursing care will be provided free of charge in all settings and to bring forward proposals for the implementation of free personal care, some charges will continue to be levied for "hotel costs" such as accommodation, laundry, meals, etc. which are likely to fall outside the definition of personal care.

37. The value of a person's house is taken into account in the means test to assess payments towards care home fees. In some cases, therefore, where there is insufficient income to pay the assessed level of charges or where other sources of capital are lacking or have been exhausted, some people in residential care need to sell their homes to raise sufficient free capital to fund their care. The Executive's proposals will significantly reduce the number of people who need to sell their homes to fund their care because moves to free nursing and personal care will reduce the contributions which many people will need to make to their care home fees. However, some charges will remain for "hotel costs" (i.e. basic living costs).

38. As announced in the Executive's response to the Royal Commission on Long Term Care in October 2000, the Scottish Ministers want to extend choice for people in this situation about how to fund their care. The powers in the Bill therefore make it possible for local authorities to offer deferred payment agreements to people going into care homes, so that they do not have to sell their homes to fund that care. A deferred payment agreement would be an agreement whereby during a certain period of time a resident would not be required to make payments which he or she would otherwise have been required to make from his or her capital towards the cost of his or her care. Instead, the resident would grant the authority standard security over his or her property in respect of payment, which would be recovered from his or her estate. No interest would be charged on the additional amount paid by the local authority while the agreement is ongoing.

39. Allowance has already been made (within the 3-year local government settlement allocations from April 2001) for the additional costs to local authorities of such deferred payment agreements.

40. The Bill provides a power for Scottish Ministers to make it mandatory for local authorities to make such arrangements available in certain circumstances. However, the intention is to delay using this until the scheme has been operating long enough to assess demand and the impact on local authority income and budget planning.

Direct Payments

Promoting choice in non-residential care: direct payments for care services

41. Empowering individuals to have a greater say in the management of their care is central to community care policy. Local authorities already have a power to offer eligible people direct payments, instead of arranging services, so that they can use the money to purchase for themselves the services they have been assessed as needing. Direct payments have been available to disabled people aged 18 to 64 since 1 April 1997 and to those aged 65 and over from 7 July 2000. Direct payments can increase the choice and control disabled people have over meeting their care needs, increasing independence and aiding social inclusion.

42. The Community Care (Direct Payments) Act 1996, which introduced new sections 12B, 12C and amended section 13 of the Social Work (Scotland) Act 1968, gave local authorities in Scotland the power to make cash payments for community care services to disabled people. The Community Care (Direct Payments) (Scotland) Regulations 1997 (as amended by the Community Care (Direct Payments) (Scotland) Amendment Regulations 2000) identify those groups of individuals to whom payments may be made and the associated conditions. A further extension to allow direct payments to be used to purchase children's services is included in the Regulation of Care (Scotland) Act 2001.

43. At present take-up of direct payments is low in Scotland with only half of local authorities giving disabled people the opportunity to arrange their own services. In addition some of the authorities offering direct payments are restricting access to certain client groups. The Executive is committed to promoting more widespread use of direct payments for all client groups. The provisions in the Bill will improve access to direct payments and make a more level playing field between local authorities and other providers. Extending access will extend choice for service users. For example, to assist people who require services which are sensitive to ethnicity or culture.

44. Firstly, the Bill makes it a duty, rather than a power, for local authorities to offer direct payments. It will extend the scope of direct payments legislation to include all community care client groups. Recipients of direct payments will also be able to purchase services from a local authority if they want to and local authorities will be given the corresponding right to sell their services. It will allow attorneys and guardians to consent to, set up, alter and receive direct payments. Parents will be able to use direct payments to purchase children's services on behalf of their children. Finally, there will be a provision to enable local authorities to recover the contribution a recipient has been assessed as being able to pay towards the services provided.

A "duty" for local authorities to provide direct payments

45. Under current legislation local authorities have a power to offer direct payments in lieu of services; there is no duty on them to do so. In May 2000, the Learning Disability Review (*The Same as You*) recommended that anyone who wants direct payments should be able to have them. The Bill will amend the legislation to make it a duty for local authorities to offer direct payments in lieu of arranging services direct. The Bill will ensure people in all areas of Scotland will be able to access direct payments and thus increase choices for all disabled people.

Direct payments to be available to all community care client groups

46. At present to be eligible to receive direct payments a person must be defined as a "person in need" for the purposes of section 94 of the 1968 Act. That condition is further restricted by section 2(1) of the 1997 Regulations which specifies that to be eligible to receive direct payments a person must be "disabled'. This effectively excludes all those people who receive community care services because they are frail, receiving rehabilitation following an accident or operation, fleeing domestic abuse, recovering from alcohol or drug dependency etc. The Bill will widen the scope of the Act by removing the "person in need" condition enabling all people who require community care services to access direct payments. The Bill will also enable direct payments to be used for housing support services under the "Supporting People" initiative. Certain groups of people will continue to be excluded by regulations.

Direct payments to be used to purchase local authority services

47. The Learning Disability Review also recommended that recipients should be able to use their direct payments to purchase local authority services. At present local authorities are prevented from selling their services in this way. The Executive recognises that many people are happy with the services they currently receive from the local authority but would welcome more control over the delivery of these services. The Bill will make direct payments available to people who live in more remote areas where the local authority is the only provider of a certain service. It will enable direct payments recipients to purchase services from any local authority, provided that authority agrees to the arrangement. The local authority will be expected to consider the implications of the above arrangements on the provision of services to clients residing in its area before agreeing to sell its services.

Extension to allow attorneys and guardians to receive direct payments

48. Recent research commissioned by the Scottish Executive found that there were very few people with learning disabilities or mental health problems receiving direct payments. The main obstacle appears to be the difficulty in meeting the condition that a person must be able to demonstrate that he or she can consent to receiving direct payments. A person must also appear to the local authority capable of managing the arrangements, with or without assistance. Where a person is unable to give consent, the Bill will allow attorneys and guardians, with the relevant powers, to consent to, set up, vary and receive direct payments on behalf of the person. The Adults with Incapacity (Scotland) Act 2000 contains safeguards to ensure that people are protected and that attorneys and guardians cannot abuse their powers.

Extension to allow parents to purchase children's services with direct payments

49. Section 22(1) of the Children (Scotland) Act 1995 imposes certain duties on a local authority to safeguard and promote the welfare of children and to provide a range and level of services appropriate to the children's needs. Section 22(3)(b) allows services to be given in kind or in "exceptional circumstances" in cash. However, it could be argued that "in exceptional circumstances" sets too high a test and makes it very difficult for parents to access direct payments. The Bill will make it easier for parents to arrange services for their children when it best suits the family. Appropriate safeguards will need to be established to ensure the welfare of the child at all times.

Making "gross" payments

50. To ensure fair and equal treatment between direct payments recipients and people receiving local authority services, direct payments can be made on a gross basis and the user contribution (charge) can be recovered later. Currently there is no mechanism to recover the personal contribution unless the local authority has provided the service itself. The Bill will ensure that where a local authority has determined that a person has the means to contribute to the cost of the services required it will be able to recover that charge as it does with non-direct payments users.

Carers

Improving support to carers: background

51. The Scottish Executive is committed to supporting carers – people who regularly provide voluntary care on a regular basis for relatives or friends who are unable to look after themselves because they are frail, disabled, ill or vulnerable. The Strategy for Carers in Scotland, introduced in November 1999, set out a framework to ensure that all carers are better supported than they have been in the past. Working closely with carers and their representatives, the Scottish Executive has already taken action on a number of fronts to turn the Strategy into real benefits for carers.

52. An important commitment in the Strategy was to draw up proposals for new legislation to allow carers' needs to be assessed directly in all circumstances. An independent Carers' Legislation Working Group was set up in January 2000 to consider the issues and make recommendations to the Scottish Executive. The Group included representatives of carers, people receiving support from a carer, carers' organisations, local government and Scottish Executive officials. The Group reported its conclusions to the Executive in January 2001 and the Executive has consulted widely on those recommendations.

Improving support for carers: carers' assessments

53. Currently carers can have their needs as carers assessed only if the person they care for is being assessed for the provision of community care services (under section 12A of the Social Work (Scotland) Act 1968, as amended by the Carers (Recognition and Services) Act 1995). (Carers of children are discussed below.) The UK and Scottish Carers' Strategies recognised this as an anomaly that should be amended to allow carers' needs to be considered in all cases. The law has already been amended to do this in England and Wales under the Carers and Disabled Children Act 2000 which came into force on 1 April 2001. Carers in Scotland can be given assistance under the general powers contained in section 12 of the Social Work (Scotland) Act 1968, although this involves carers being treated as persons in need of social assistance in their own right.

54. The current provision for carers' assessments was framed to protect the rights of the person being cared for by ensuring carers could not alter care arrangements without the cared-for person's consent. In practice, however, it appears that few carers are assessed in their own right, and the Executive believes a better balance needs to be struck between the rights of the cared for person and the needs of the carer, who cannot currently be assessed if the cared-for person is not

being assessed. The policy objective is to recognise the vital contribution that informal carers make to the overall provision of care to cared for persons, and to ensure carers have a legal right to a direct and appropriate assessment of their needs as carers, without having to be treated as people in need in their own right.

55. In the responses to the consultation there was overwhelming support for this recommendation amongst carers, carers' organisations and the voluntary sector. Local authorities who responded gave a general welcome to this recommendation, although they highlighted possible resource implications which in turn might influence their interpretation of who classifies as a "carer". NHS respondents also generally supported the recommendation. Respondents as a whole were concerned that the assessment should be optional, carried out in conjunction with an assessment on the cared-for person if possible, that the assessment must lead to concrete results, and that carers need to be aware of the process and get copies of the assessment.

56. The Bill gives informal carers a right to an assessment of their needs, on request to the local authority, independent of whether the cared for person is being assessed.

Improving support for carers: carers of disabled children

57. The Carers and Disabled Children Act 2000 provides for people with parental responsibility for disabled children in England and Wales to be assessed as carers (i.e. for their ability to continue to care for the child to be assessed) and for councils to take this assessment into account in deciding what services to provide to the child and family under children's legislation. This effectively extended to these carers for the first time a direct, independent right to have their own needs as carers considered.

58. In Scotland, carers of a disabled child have a right to have their own needs assessed under section 24 of the Children (Scotland) Act 1995, in the context of an assessment of the needs of the child. The Working Group recognised that the position of such carers differed in significant ways from that of other carers, but believed that they should have, as far as possible, an equivalent right to assessment as other carers.

59. Consultation responses demonstrated a general welcome for extending the proposed independent right to an assessment to carers of disabled children. This proposal was supported by most of the local authority respondents. The common view held was that all carers should have the same rights, and most respondents believed that carers of disabled children should have a right to a carer's assessment independent of an assessment of the child's needs under the Children (Scotland) Act 1995, although a minority of respondents believed that the provisions of the Children (Scotland) Act 1995 were sufficient but were not being implemented adequately.

60. The Bill extends the right to an independent carers' assessment to carers of disabled children, enabling them to have their needs assessed at any point rather than solely in the context of a child's assessment.

Joint working, etc.

Joint resourcing and management of health and social care services

61. The Executive's policy is to improve joint working across health and social care boundaries, to promote partnership between agencies in providing health and social care for communities and to remove barriers, which impede progress. *Our National Health: A plan for action, a plan for change* makes clear the Executive's commitment to strengthening links between the NHS and local authorities. The aim is for "seamless" services which are more accessible and more efficient and which deliver better outcomes for people who use them.

62. The Bill will allow for joint working across a wide range of NHS Scotland and local authority functions which are relevant to health and social care. This includes local authority functions such as housing, education and leisure. The expectation is that the new flexibilities will be made use of, in the first instance, for services relevant to adult community care, including housing. However, the Bill will allow for their extension to other service areas in the future.

63. In the Executive's response to the Royal Commission on Long Term Care, in relation to joint working, it was noted that:

> "… the Royal Commission stressed throughout its report the need for better co-ordination between the providers of care – notably the NHS and local authorities – and also the independent and voluntary sectors … We intend that by 2002, all community care services for older people will be jointly managed and jointly resourced. In the course of next year we expect every local authority in Scotland to put in place the necessary arrangements. Joint working is not only desirable in the care of older people, it is essential. We will legislate as necessary to remove any remaining obstacles to effective joint service delivery."

64. In taking forward this commitment to joint resourcing and joint management the Bill has not sought to impose a single model – this is an area where "one size" does not "fit all". The clear preference of the Executive is to provide a framework which lets local authorities and local health bodies develop approaches most appropriate for their own area which might involve alignment or pooling of budgets and a range of joint management models in pursuit of agreed outcomes.

65. The Scottish Executive Joint Future Unit will provide a strong lead and comprehensive support to agencies to help implementation locally through the issue of guidance, a new website to include promising practice examples, holding regional seminars, and co-ordinating supplementary advice on financial, human resource and other issues as necessary.

66. Although the preference was to enable rather than to prescribe, reserve powers have been taken in the Bill to enforce joint working where necessary. It is intended that these powers be used only in cases of failure where the expected service outcomes are not being delivered. In such cases, the powers will be used to intervene to speed up the pace of change and improve service delivery for the benefit of local people. It is intended therefore, that the Scottish Ministers will be able to use this power to require that local authorities and NHS bodies adopt

certain key principles, such as a single management structure, with a single budget and the delegation of functions.

Health Boards' lists

Services lists and supplementary lists for general medical practitioners

67. Island Health Boards and NHS Trusts with primary care functions ("Primary Care Trusts") are currently required to maintain lists of all doctors who undertake to provide general medical services (GMS) in their area under the National Health Service (General Medical Services) (Scotland) Regulations 1995. General medical services are provided under a contract negotiated nationally with GP representatives. The list kept is known as the medical list and doctors on the medical list are known as GP principals. A GP must be on the medical list before he or she can be contracted to provide GMS.

68. To join the medical list, a GP has to satisfy rules on suitability, including appropriate experience. Once on the list, a GP is subject to discipline procedures relating to statutory Discipline Committees and the NHS Tribunal.

69. The objective of the provisions on services and supplementary lists is to introduce enabling powers to extend the list system to all other GPs in NHS Scotland, comprising GPs who assist GMS principals (GMS non-principals) and GPs who perform personal medical services (PMS). GMS non-principals are GPs who work with GP principals. They comprise GPs employed by a principal to assist with the provision of care including:

- Assistants;
- Associates;
- GPs – known as retainees – who work up to four half days per week to keep in touch with general practice;
- GPs paid by salary under the terms of the national contract; and
- Locums brought in to fill short-term gaps.

70. Personal medical services are distinct from general medical services as they are performed (a) by independent practitioners under contracts developed locally between the Board or Trust and a GP practice to focus on specific local needs; or (b) by GPs employed directly by PMS practices or Primary Care Trusts.

71. Under the powers provided by the Bill, a new medical list system will be introduced to provide the opportunity to bring GMS non-principal GPs and GPs who perform PMS into the framework for the administration and management of general medical practitioners. Thereafter, in order to practice as a GP in GMS or PMS, a GP will be required to be on:

- the medical list – for GMS principals;
- a supplementary list – for GMS non-principals; and

- a services list – for PMS performers.

72. Accordingly, a GMS principal or PMS practitioner will not be able to practice unless he or she is on the appropriate list; and will not be able employ a GP unless that GP in turn is on the appropriate list.

Establishment of the services and supplementary list

73. As with the medical list, the services and supplementary lists will be maintained by Island Health Boards and Primary Care Trusts.

74. Reciprocal arrangements with the other health administrations in the UK will be introduced.

Entry to, control of and operation of the lists

75. The following principles will apply.

- The entry and control arrangements will, as far as practicable, contain the same requirements on individuals for the medical list and for the services and supplementary lists.
- To practice in the area of a Board or within the area of responsibility of a Primary Care Trust as a GMS non-principal or PMS performer, a GP will require to apply for inclusion on – and be accepted on – that Board or Trust's supplementary or services list as appropriate. Once accepted on a list following submission of a full application, acceptance on a parallel list held by another Board or Trust will be subject only to completion of an application form which indicates that the individual had been accepted on a list elsewhere. Acceptance on the parallel list will then be automatic once the Board or Primary Care Trust has confirmed that statement with the first Board or Trust. This process will minimise the bureaucracy for GPs, Boards and Primary Care Trusts where the GP (particularly relevant for locums) wishes to be able to practice in more than one area. An alternative whereby acceptance on one list would enable the GP to practice anywhere in Scotland would mean that it would not be possible to apply the statutory requirements relating to the NHS Tribunal in the same way as they apply to GMS principals. In particular, if acceptance on one list allowed practice nationally, local disqualification could not be an option in practice.
- At present Boards and Primary Care Trusts are required to remove from their medical list the name of any GP convicted in the UK of murder or of a criminal offence and sentenced to at least six months in prison. This requirement will be extended to services and supplementary lists.
- GP principals and PMS practitioners will be required to ensure that organisations providing deputy doctors provide only doctors on a list; and organisations providing deputy doctors will be required to provide only doctors on a list.
- The Scottish Medical Practices Committee (SMPC) has a role in the consideration of inclusion of names on the medical list. This role derives from the statutory responsibility of the SMPC under section 3 of the 1978 Act as to securing that the number of medical

practitioners undertaking to provide GMS in the areas of different Boards is adequate. The statutory responsibility under section 3 relates to GP principals and not to GP non-principals; the SMPC will have no role in relation to services and supplementary lists.

- Statutory requirements as to Discipline Committees and the NHS Tribunal will cover GPs on the services and supplementary lists. Under the National Health Service (Service Committees and Tribunal) (Scotland) Regulations 1992, reference of a GP to the Discipline Committee arises from a potential breach of the terms of service set out in Schedule 1 to the GMS Regulations. Those terms of service which concern the performance of a GP as a GMS non-principal will attach to GPs on services and supplementary lists: terms of service which relate to the performance of a GP principal as part of the management of the contract between the GP and the Board or Primary Care Trust (for example on acceptance and removal of patients from the patient list) will not attach to GMS non-principals or PMS performers.
- The NHS Tribunal will have the same powers and duties in relation to those on services and supplementary lists as it has for those on medical lists.

Pension scheme

76. The introduction of services and supplementary lists for non-principal GPs and PMS performers will increase the regulation of locum GPs. It also provides the opportunity to bring locum GPs working in the NHS into the NHS pension scheme. Once the legislation and the services and supplementary lists are in place, Scottish Ministers will make regulations to allow locum GPs to join the NHS pension scheme. The regulations will provide that membership can then be backdated to 1 April 2001.

Representations against preferential treatment

77. Section 16 extends in a minor way the jurisdiction of the NHS Tribunal in relation to practitioners providing PMS under pilot arrangements. The original role of the Tribunal was to inquire into cases where the continued inclusion of a practitioner on a family health services list would be prejudicial to the efficiency of the relevant service. The National Health Service (Primary Care) Act 1997 ("the 1997 Act") also gave the Tribunal a role in cases where practitioners had agreed to provide PMS under pilot arrangements and had therefore left the "medical list" – that is the list for the provision of general medical services. Such practitioners were to receive preferential consideration when returning to the medical list provided the Tribunal was satisfied that course would not prejudice efficiency.

78. The Health Act 1999 further extended the role of the Tribunal to enable it to inquire into cases of alleged fraud against the NHS or any other publicly-funded health service by family health services practitioners, in addition to those cases involving efficiency. There was, however, a small, unintended omission in the jurisdiction of the Tribunal to consider all cases put before it on both fraud and efficiency grounds. This related to the return of PMS pilot providers to the medical list. The effect of section 16 therefore is to enable the Tribunal to consider also if a pilot scheme provider should be prevented from returning to the general medical services list on the grounds of a finding of fraud.

Miscellaneous

Clinical Negligence and Other Risks Indemnity Scheme (CNORIS)

79. This provision will allow for the Mental Welfare Commission for Scotland to be added to the list of bodies covered by section 85(B)(2) of the National Health Service (Scotland) Act 1978. This will ensure it is offered cover by the CNORIS which was introduced by way of regulations on 1 April 2000. The Scheme provides financial risk-sharing arrangements for specified health bodies in respect of their clinical and certain other liabilities. The scheme is aimed at improving and developing Trusts' risk management procedures, so reducing the number and value of claims in the future. It is also about cash managing the situation by sharing, on a "pay as you go" basis, the financial risk of large settlements.

80. This is a technical change. The change is administrative to allow the Mental Welfare Commission to be covered by the CNORIS scheme. The Mental Welfare Commission was consulted and the proposed amendments were included in the consultation exercise, *Better care for all our futures*. The few respondents who did comment were very supportive of the change.

Amendment to the Road Traffic (NHS Charges) Act 1999

81. This provision will extend the scope of the road traffic accident charges scheme to include accidents that happen in public places as well as on the open road. The Road Traffic (NHS Charges) Regulations 1999 came into effect on 5 April 1999, and provides a Scheme that enables the NHS to recover the costs incurred from the treatment of road traffic casualties. The charges, recoverable for insurers and certain other persons, are only payable following an agreed compensation settlement. The provision is consequential on a change in the UK legislation that broadened the definition of "road" for statutory motor insurance requirements.

82. This is a technical change. UK-wide regulations broadening the definition of "roads" for statutory insurance requirements were laid on 3 April 2000. These extended the insurance requirements to include cover for incidents occurring in other public places as well as roads. Charges associated with road traffic accidents can be recovered by the NHS under the devolved sections of the Road Traffic Act 1988 and the Road Traffic (NHS Charges) Act 1999. This amendment ensures that, by extending the definition of road for the purposes of such recovery, NHS charges can be recovered in relation to incidents in a similarly wide range of locations. The proposed amendments were included in the consultation exercise, *Better care for all our futures*. The respondents who did comment were clearly supportive of the change.

CONSULTATION

Care Development Group

83. The implementation of free personal care for Scotland's older people and the associated costs and implications, including the interaction with free nursing care, were considered by the Care Development Group, chaired by Malcolm Chisholm, Deputy Minister for Health and Community Care. The group met for the first time in March 2001 and reported to the Minister for Health and Community Care in September.

84. The group undertook a wide ranging public engagement exercise. A brief open-ended questionnaire was developed which asked individuals and organisations to comment on issues related to the remit of the CDG. Just over 1,000 questionnaires were sent out following advertisements in a number of national newspapers in April 2001. The questionnaire was also posted on the Scottish Executive web site. 312 responses were received.

85. To enable the Group to engage directly with people across Scotland, public meetings were held in Ardrishaig, Edinburgh, Dumfries, Glasgow and Inverness.

86. Following a competitive tendering process, System Three and MORI Scotland, two independent survey organisations, were commissioned to conduct jointly a national telephone survey. The survey drew on a sample of individuals who had previously taken part in the most recent Scottish Household Survey. The System Three/MORI survey focussed on two groups of people from this survey: individuals over the age of 50, and individuals under the age of 50 who identified themselves as formal carers.

87. The survey took place in July 2001. In total, 2,354 individuals were interviewed. Comparisons between the achieved sample and the original Scottish Household Survey sample confirm that the survey was representative of all individuals, aged over 50 and carers under 50 across Scotland.

88. The CDG also decided that focus group work should be commissioned which would allow issues to be explored in more depth than in a telephone survey. It was also judged important that groups excluded from the survey work (particularly older people in residential and nursing home care) should be included in focus group research. Given the tight timescale, two organisations were approached, each on a single tender basis, to conduct this work. One organisation, Scottish Health Feedback (SHF), was commissioned to convene a study that involved engaging six groups of individuals, in the following categories:

- carers' organisations;
- younger people (aged 35-50);
- older people's groups.

The second organisation, the Centre for Advances in the Care of Older People at Queen Margaret University College (QMUC), was commissioned to conduct research with six further groups, in the following categories:

- older people in nursing and residential care homes;
- older people using day care services;
- older people in day hospitals.

89. The public engagement programme has resulted in a wealth of evidence. It is possible to present findings in any depth here. However, the topics addressed in the written submissions, public meetings and commissioned research were intended to be complementary.

Better care for all our futures

90. In April 2001 the consultation paper *Better care for all our futures* was widely distributed to individuals and organisations, including local authorities, health boards, professional bodies and organisations such as Age Concern, Mental Welfare Commission, Capability Scotland etc. The paper was also published on the Scottish Executive website and available in large print or Braille as well as on audiocassette. Consultees were given until 15 June to respond to the paper, although responses received until 9 July were included in the analysis.

91. Responses were received from 85 individuals and organisations, although 5 were joint responses i.e. jointly from local authorities and health boards. In these cases comments were recorded and analysed as if each body had responded separately. Respondees included 23 local authorities and 16 NHS bodies, as well as voluntary organisations, carers and carers' representative groups and other providers of services. Copies of responses are held in the Scottish Executive Library and can be viewed by appointment.

92. Full consultation took place on the direct payments provision of the Bill in *Better care for all our futures*. 64 responses were received in total, 18 from local authorities. There was general support from all who responded to the principle of making direct payments more widely available. General concerns centred on the importance of monitoring the use of the payments and to ensuring that adequate safeguards are put in place to protect children and vulnerable people. The need for strong support systems to be in place was recognised. Local authorities wanted more time to manage the "challenges" they associated with a move towards increased take up of direct payments.

93. The Executive also held a national conference to increase awareness of direct payments in October 2000. A copy of the consultation paper was sent to all delegates.

Carers' legislation consultation paper

94. The Strategy for Carers in Scotland included a commitment to consult on proposals for new legislation to improve the rights of carers. The Executive issued a consultation paper in April 2001 based on the recommendations of the independent Carers' Legislation Working Group. The Group included representatives of carers, people receiving support from a carer, carers' organisations, local government representatives and the Scottish Executive. The consultation period ran from 12 April to 6 July.

95. The paper was issued to all 32 local authorities (to Chief Executives, Directors of Finance and Directors of Social Work) and to all Health Boards and NHS Trusts (to Chairmen and Chief Executives). In addition it was sent to over 200 organisations and individuals representing: individual carers; carers' organisations and support groups; service user organisations; children's organisations and young carer representatives; organisations representing users and carers from minority ethnic groups; health professionals; community care forums across Scotland and representatives from the main churches in Scotland. The documents were also placed on the Scottish Executive Health Department website. A total of 203 responses were received, including from 17 local authorities, 10 NHS bodies, 50 responses from undisclosed sources and

over 100 responses from the voluntary sector, carers' organisations and individual carers. Other respondents included health professions and public sector organisations. The responses have been included in the analysis summarised under *Policy Objectives* above. Copies of all responses received are available in the Scottish Executive's library.

Consultation on supplementary medical lists for non-principal medical practitioners

96. In June, a consultation paper was issued to Health Boards, Primary Care Trusts, the Scottish Committee of the Council on Tribunals and a wide range of other interested bodies including the National Association of Non-principals. Copies were sent to all general medical practices in Scotland with the request that the paper be drawn to the attention of all non-principals, including locums, who worked in the practice. Discussions also took place prior to the issue of the consultation paper with the Scottish General Practitioners Committee and representatives of the Primary Care Trusts at routine "Links" meetings with Scottish Executive officials.

97. Fifty responses to the consultation paper were received and nine Primary Care Trusts attended a meeting to discuss the proposals.

98. The results of the consultation demonstrated widespread agreement to the principle that services and supplementary lists be established. On the nature of the lists, while some respondees considered that there should be a single list maintained at Scotland level, the general view supported the option favoured in the consultation paper that, as with the medical list (of principal GPs), services and supplementary lists should be maintained by Island Health Boards and Primary Care Trusts. At the consultation meeting with representatives of the Primary Care Trusts, the benefits (in terms of local control and the development of the quality agenda locally) from each Trust maintaining its own list were recognised; but there was also support for the development of a virtual (electronic) national list readily available on the web and bringing together all the individual lists. A virtual list could easily be accessed by those seeking to employ a locum urgently.

99. There was strong support for the view that admission to one list should enable a non-principal or PMS performer to work in the area of any other Board or Trust.

100. The thrust of the responses supported the proposal that the entry and control arrangements should, as far as practicable, be the same as for the medical list.

101. The proposal that, once the legislation and the services and supplementary lists are in place, Regulations should be made to allow locum GPs to join the NHS pension scheme (backdated to 1 April 2001) was widely welcomed.

102. A number of Primary Care Trusts and other consultees expressed reservations about the statement in the paper to the effect that the limited additional costs of administering the services and supplementary lists should be subsumed within existing budgets.

Consultation on representations against preferential treatment

103. The Council on Tribunals and the BMA were consulted on the original proposals to extend to fraud the grounds on which the NHS Tribunal might judge cases referred to it. The Scottish Committee of the Council on Tribunals and the Scottish General Practitioners' Committee (SGPC) of the BMA were also consulted about attracting to those practitioners on services and supplementary lists the NHS Tribunal regime. A further letter has been sent informing the Scottish Committee of the Council on Tribunals and the SGPC of the intention to correct the unintended omission in the Tribunal's jurisdiction and thus complete the original policy intention.

EFFECTS ON EQUAL OPPORTUNITIES

104. The Bill strengthens the commitments contained in *Our National Health*, the health plan for Scotland, which is founded on equal access to care for all, and contains clear undertakings to tackle inequalities wherever they arise and ensure that the healthcare needs of excluded groups are met. It states, for example, that "we need to demonstrate by our actions that people will get the care and treatment they need, when they need it and where they want it, irrespective of their age".

105. The majority of the provisions in this Bill are aimed at improving services for vulnerable groups such as older people, disabled people and carers. The greater numbers of women requiring community care services mean that the Bill's provisions are of particular relevance to women. In addition, public bodies in Scotland must comply with the requirements of the Race Relations (Amendment) Act 2000. This outlaws race discrimination in all public functions, not just those previously covered by the Race Relations Act 1976, and places a general duty on specified public bodies to promote race equality.

106. Unpaid carers of people who are frail, sick, disabled or vulnerable for whatever reason can often feel isolated and excluded from community life by the nature of their caring responsibilities which can prevent them from accessing the same employment, educational and social opportunities as others. The Scottish Executive is committed to supporting carers and to improving their quality of life. The measures contained in this Bill will further improve the support offered to carers in their important role in society. For example, it will help to ensure that their needs and capabilities are properly assessed, enabling some to help balance paid employment with their caring role and helping others to feel less isolated within their communities by allowing them time to take part in leisure, educational and social opportunities.

EFFECTS ON HUMAN RIGHTS

107. The Bill does not cut across the rights available under the European Convention of Human Rights. The Bill will rather ensure that those affected are treated with greater respect in terms of the right to respect for private and family life under article 8.

EFFECTS ON ISLAND COMMUNITIES

108. The Bill has no differential impact on the island communities.

EFFECTS ON LOCAL GOVERNMENT

109. Most of the provisions in the Bill will have an impact on local government because of their central role in delivering social work services. Free personal care could lead to increased demand for assessments for social work services. Joint working will bring about a change in organisational culture, management structures and accountability. The extension of direct payments could lead to fewer services being directly delivered by the local authority and a shift away from social work budgets being tied up in fixed resources. The right to a direct assessment of support needs for carers is likely to lead to an increase in the numbers of carers' assessments being carried out. Evidence from work with carers who have not previously been in contact with support services suggests that any increase is unlikely to be dramatic or sudden, and that many carers are not looking for high levels of support.

110. Local authorities have been consulted on the provisions contained within the Bill and were on the whole supportive of the Executive's policy objectives, although concerned about the potential resource implications of some aspects such as those noted above and the changes to charging arrangements for residential care.

EFFECTS ON SUSTAINABLE DEVELOPMENT

111. The Bill has no significant impact on sustainable development.

This memorandum relates 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

POLICY MEMORANDUM

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