



RESEARCH PAPER 01/02
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Care Trusts and Long Term Care in the *Health and Social Care Bill*

Bill 9 of 2000/01

This Paper deals with Parts III and IV of the Bill. Research Paper 01/01 covers the other Parts of the Bill.

The measures covered in this Paper are based on proposals in the NHS Plan, Cm 4818, July 2000 volumes I and II, which included the Government's Response to the Royal Commission on Long Term Care.

The measures cover the formation of Care Trusts designed to extend joint working between NHS bodies and local authorities in their health and health-related functions; and a number of measures relating to the funding of long-term care, such as the provision of free nursing care in nursing homes.

Except for provisions on Preserved Rights, which apply to Scotland as well, the measures described in this Paper apply to England and Wales.

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Summary of main points

Part III of the Bill provides for Care Trusts based on partnerships between NHS bodies and local authorities. These would be able to commission and provide integrated services. They would be either voluntary, or compulsory. Compulsory Care Trusts would only be formed where an NHS body or local authority was failing to perform adequately.

Part IV of the Bill would:

- remove local authorities' powers to provide or arrange nursing care by a registered nurse. Nursing care is defined as "services by a registered nurse and involving a) the provision of care, or b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse". The Explanatory Notes on the Bill say that it is intended that the NHS will provide or arrange nursing care by a registered nurse free of charge under existing legislation.
- provide for local authorities to take over responsibility for people with *Preserved Rights* and abolish the *Preserved Rights* system. (People who entered care homes before April 1993 have *Preserved Rights* to Income Support towards the home's fees)
- empower the Secretary of State in England and the Welsh Assembly to use Directions to require local authorities to enter into legal charge/loan arrangements, to be known as *deferred payment agreements* recoverable when the care homes resident dies or leaves the care home.
- enables Regulations to make provision for residents and others, including liable relatives, to make additional payments for meeting all or part of the difference in cost between the actual cost of the accommodation and what the local authority would normally expect to pay for a person with the assessed needs of the resident.
- enables Regulations to make provision for local authorities in England and Wales to make and pay for residential care placements in Scotland, Northern Ireland, Channel Islands or the Isle of Man.
- Enables Regulations that would require local authorities to make Direct Payments, subject to certain conditions.

Except for the provisions on Preserved Rights, which apply to Scotland as well, the measures described in this Paper apply to England and Wales.

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I Care Trusts

A. Introduction

Part III (Clauses 45-47) of the Bill is concerned with the creation in England and Wales of new organisations called *Care Trusts*, which are designed to bring health, social services and other local authority health-related services together.

The Government's intention to create these Care Trusts was announced in the NHS Plan for England¹ published on 27 July 2000. Care Trusts were one of a set of measures in the Plan designed to encourage joint working between the NHS and local authority social services.² Others included extra government investment in new *intermediate care* and related services;³ a new ring-fenced grant to reward improved social services joint working arrangements, focused initially on intermediate care performance;⁴ and joint Best Value inspections of health and social care arrangements. These do not require primary legislation and are therefore not part of this Bill.

The Prime Minister's statement on the NHS Plan particularly mentioned the need for such joint working:

The next major reform is to remedy the incredible situation where at one time thousands of older people are in the wrong place for their needs - stuck in hospital when they could be better cared for in their own homes. So, for the first time, social services and the NHS will in every area use pooled budgets and new arrangements which ensure they work together for the good of the patient. And where local councils and Primary Care Trusts want to go further and merge into one organisation we will enable them to do so, creating new Care Trusts that will deliver one-stop care, with an entirely unified budget. Where partnerships persistently fail to deliver, we will require health and social services to join together in a new Care Trust.⁵

In Wales, the NHS Plan was welcomed by Jane Hutt, Health and Social Services Secretary of the Welsh Assembly, who had set out her plans for health services in Wales in a statement she had made to the Assembly two weeks before, on 12 July. In a press notice on the NHS Plan she stressed that breaking down "the old barriers ... between health and social services" was also one of the priorities for the Welsh Assembly.⁶

¹ *The NHS Plan*, Cm 4818, July 2000, paragraphs 7.09 - 7.12

² *The NHS Plan*, as above, Chapter 7

³ An extra £900 million by 2003/4

⁴ £50 million from April 2001 and a fund of £100 million from April 2003.

⁵ HC Deb 27 July 2000 c 1258

⁶ The National Assembly for Wales Press Notice, *A Good Day For The NHS In Wales Says Jane Hutt*, W00824-Hlt, 27 July 2000

The Care Trusts, which are the subject of this Bill, can thus be seen against the background of other, existing and proposed, measures designed to encourage joint working between health and social services.

B. Background

1. NHS Structure

Current concerns about partnership between health and social services stem from the fact that historically they have developed separately, under separate legislation, and are organised on a different basis. Social services are organised by local authority area and are partly the responsibility of elected local councillors. The NHS is divided into local Health Authorities but these do not necessarily have the same boundaries as local authority areas and elected local councillors do not have control over them. NHS structures are also more complex in that they include various statutory bodies other than Health Authorities.

NHS structures have been subject to major reorganisation under both the previous and present Governments and they are still in the process of change. In relation to Care Trusts, a major feature of the changes is to bring the organisation of community health services, such as district nurses, closer to the practice of GPs, whereas previously they were part of the system under which hospitals are organised.

Not all of the changes have required legislation although legislation has played a major part. Under the previous Government, changes brought in under the *NHS and Community Care Act 1990* were designed to help create an "internal market" within the NHS and under the present Government changes being introduced under the *Health Act 1999* are part of plans to abolish the "internal market" as well as to reorganise the service in other ways.

A brief definition of the main NHS structures that will underlie the new Care Trusts is set out below.⁷

NHS Trusts: These were introduced by the *NHS & Community Care Act 1990* and reformed by the *Health Act 1999*. They took over responsibility for hospitals from Health Authorities. Nearly all hospitals are now run by NHS Trusts, with the general exception of smaller "community hospitals", which are increasingly run by Primary Care Trusts. NHS Trusts were initially designed to compete with each other for orders for their

⁷ Unless otherwise stated, this outline is drawn from information in the Explanatory Notes to the current *Health and Social Care Bill* and from Library Research Paper 99/39,⁷ both of which provide further details.

services placed by Health Authorities although in recent years emphasis has been more on co-operation and collaboration.

Health Authorities: These are relevant to Care Trusts insofar as Primary Care Groups are legally committees of Health Authorities. The role of Health Authorities is covered by the *NHS Act 1977* and was substantially altered by amendments in the 1990 Act and again in the 1999 Act. Their functions include purchasing or commissioning health care on behalf of local populations from providers, which include NHS Trusts. Health Authorities can also purchase health care from private sector institutions. The whole of England and Wales is covered by Health Authorities. The development of Primary Care Trusts (see below) is partly intended to free them from their purchasing/commissioning role so as to be able to take a more strategic view.

Primary Care Groups: These came into being in England in April 1999 as bodies made up of GPs and certain other health professionals such as community or practice nurses, to take on the role of commissioning from NHS Trusts, with the ultimate aim of becoming free-standing Primary Care Trusts. They were introduced as part of the reforms designed to abolish the internal market and GP fundholding, and were formed without the need for legislation as they are legally committees of Health Authorities. They were described in the White Paper on the NHS in England⁸ and a series of Circulars from the Department of Health covers their development. As well as health professionals and certain others, their executive includes a social services officer and a lay member.

The English White Paper envisaged that they would act initially as advisory bodies to the Health Authority, which would retain responsibility for agreeing contracts with NHS Trusts. They would be expected to move through a series of stages, taking over practical budgetary responsibility from the Health Authority for commissioning hospital and community services (although the Health Authority would remain legally responsible for the budget). They would at a later stage become free-standing Primary Care Trusts. These might in turn start by taking legal responsibility for the budget. They could then develop to a further stage where they would take over the provision of some community services such as district nursing in addition to providing general medical (GP) services and commissioning hospital and community services.

The NHS Plan said that Primary Care Groups were up and running in every area of England and controlling £20 billion - two thirds of local NHS budgets.⁹ Primary Care Groups do not exist in Wales although the Local Health Groups, originally described in the Welsh White Paper on the NHS¹⁰ perform similar functions. Their performance was praised in statement made by Jane Hutt, Health and Social Services Secretary of the Welsh Assembly to the Assembly on 12 July 2000.

⁸ *The New NHS, Modern, Dependable*, Cm 3807 December 1997

⁹ The NHS Plan, as above, paragraph 6.7

¹⁰ Welsh Assembly, *The NHS Wales: Putting The Patient First*, January 1998

Primary Care Trusts: These were introduced by the *Health Act 1999* (which inserted new sections into the *NHS Act 1977*) and are also subject to detailed guidance issued in Circulars from the Department of Health. They have a similar composition to Primary Care Groups and can be seen as extensions of such Groups (see above).

The following description of their role is a summary of the Explanatory Note to the 1999 Act written at the time that the Act received the Royal Assent in 1999 before the first Primary Care Trusts came into being in April 2000:

Primary Care Trusts would arrange the provision (or "commissioning") of health services, a function then exercised by Health Authorities and GP fund-holders. In addition, they might become providers of hospital and community services, a function then performed by NHS trusts. But it was envisaged that, at least initially, provider Primary Care Trusts would provide only GP and dental services or community health services (ie not hospital services). They would be able to exercise some of the Health Authority's functions in relation to general medical services, for example deploying cash-limited funds to improve general practice infrastructure and support practice staff costs.

They would be established as corporate bodies with their own budget for local health care. The population coverage of a Primary Care Trust was likely to vary from place to place but typically, in England, a Trust was likely to serve a population of at least 100,000 and have a budget of around £60 million or more. They would be accountable to the local Health Authority and subject, like other NHS bodies, to directions given by the Secretary of State. As well as the local health professionals and managers, their membership would include a Chairman and lay members appointed by the Secretary of State.

The NHS Plan published in July 2000 said that the first 17 of these Trusts had been established in England as from April 2000.¹¹ At the time of the publication of the Explanatory Notes to the current Bill in December 2000, none had yet been established in Wales as relevant provisions of the 1999 Act had not yet been brought into force in Wales.

2. Working in Partnership

Before the changes introduced by the present Government there were some legal powers for NHS bodies and local authorities to work together but these were relatively limited. There also appear to have been problems using such powers as did exist.

For example, under the *NHS Act 1977*, Health Authorities did have power to make some payments for purchasing social services (as well as education for disabled people and

¹¹ The NHS Plan, as above, paragraph 6.7

housing). But social services did not have power to purchase or provide health services. A Department of Health Circular issued in 1992 to accompany the introduction of the community care reforms following the *NHS & Community Care Act 1990* did draw attention to the existing power. It particularly mentioned its use in the context of hospital discharge and suggested that the NHS might pay "dowries" to people leaving hospital for the provision of social services.¹²

However, in practice hospital discharge arrangements have been problematic because of disagreements over the respective responsibilities of the NHS and social services in relation to long-term care.¹³ Such disagreements were highlighted by the Coughlan case, where, among other things, the High Court decided that local authorities did not have the power to provide nursing services. The Court of Appeal then reversed that part of the decision by deciding that local authorities could be required under social services legislation to provide nursing care "incidental or ancillary to the provision of accommodation." They could thus be responsible for funding people in nursing homes (although the court of Appeal decided that Pamela Coughlan herself was the responsibility of the NHS).¹⁴

Disagreements between health and social services authorities have had implications not only for the authorities themselves, that is which one would be responsible for funding the care of an individual, but also for the individual. Services provided by the NHS are funded out of general taxation and are free to the individual. But nursing or residential home care provided or arranged by local authorities is subject to a means test, so that the individual may have to pay or contribute directly to the cost of the service (see the section of this Research Paper on Part IV of the Bill).

The present Government's general desire to encourage joint working between the NHS and local authorities over health and health-related functions (social services in particular) has been expressed in a number of documents, such as the Health Service White Papers for England and Wales and the respective Social Services White Papers.¹⁵ Of the changes already introduced to encourage joint working, some have been changes to legal powers and some have taken other forms.

Among the latter is the Partnership Grant to local authorities, which is paid to local authorities for their community care services partly on condition that they work with the

¹² Department of Health Circular HSG (92) 43

¹³ See, for example, the Prime Minister's statement quoted in the Introduction to this Section.

¹⁴ Times Law Report 20 July 1999; Independent Law Report 20 July 1999; R v North Devon Health Authority ex parte Coughlan [2000] 3 All ER 850, [2000] 2 WLR 622. See also Section II C of this Paper.

¹⁵ Department of Health, *The New NHS, Modern, Dependable*, December 1997; Welsh Office *NHS Wales: Putting Patients First*, Cm 3841, January 1998; and Department of Health, *Modernising Social Services*, Cm 4169, November 1998; National Assembly for Wales, *Building the Future*, July 1999

NHS.¹⁶ Among the former are provisions in the *Local Government Act 2000*, which contains powers to enable local authorities to improve their partnership working arrangements more generally.¹⁷

Section 2 of the *Local Government Act* gives local authorities a broad power to do anything that they consider is likely to achieve any one or more of the following objects: (a) the promotion or improvement of the economic well-being of their area; (b) the promotion or improvement of the social well-being of their area; and (c) the promotion or improvement of the environmental well-being of their area.

Section 4 of the Act requires every local authority to prepare a strategy (referred to as a community strategy) for promoting or improving the economic, social and environmental well-being of their area and contributing to the achievement of sustainable development in the United Kingdom. In preparing or modifying their community strategy, a local authority must (a) consult and seek the participation of such persons as they consider appropriate, and (b) have regard to guidance issued by the Secretary of State.

Guidance on preparing community strategies issued by the Department of the Environment, Transport and the Regions in December 2000 included NHS bodies among those that would need to be involved:

The public bodies that should be involved in preparing community strategies may vary from one authority area to another. At the least, however, an effective community strategy would need to involve the key public sector organisations that operate at the local level and control the majority of the resources going into the local area: health authorities (particularly when there are shared aims/objectives around reducing inequalities), primary care groups and trusts, police authorities, education (at all levels including higher/further education, the Employment Service and Benefits Agency – and from 2001, the Working Age Agency – New Deal delivery partnerships and so forth...¹⁸

Care Trusts will deal specifically with health and health-related functions. The changes most relevant to them are contained in the *Health Act 1999*, which reformed not only the structure of NHS bodies, as described in the section above, but also their powers, in order to enable them to work more closely with local authorities. It also made some changes to the powers of local authorities. The *Health Act 1999* changes to powers of joint working are described in Section I. 4 of this Paper below.

¹⁶ See Department of Health Circular LAC (2000) 6 for the conditions on which it is available.

¹⁷ Department of Environment, Transport and the Regions, *Preparing Community Strategies*, Statutory Guidance on the Local Government Act 2000, paragraph 40.

¹⁸ *Preparing Community Strategies*, as above paragraph 38.

3. Partnership in Action – Government Consultation

The consultation document for England, *Partnership in Action*, published by the Department of Health in September 1998, provided the thinking behind the changes in the *Health Act 1999*.¹⁹ It set the proposed legislative changes within the context of the Government's strategic agenda:

to work across boundaries to combat social exclusion, encourage welfare to work, tackle inequalities between men and women and other groups and improve health in local communities.²⁰

The consultation document also made clear that effective working between the NHS and local authorities should not be restricted to the latter's social services functions. The Paper concentrated on the needs of frail older people, adults or children with mental health problems, learning or physical disabilities, who required support from both health and social services because of the changing and ongoing nature of their needs. But it said that the Government would pave the way for more flexible ways of working to apply to a wider range of services in the future.²¹

The consultation document rejected major structural change, such as setting up new statutory health and social services authorities, but said that joint working was needed at three levels: strategic planning, service commissioning and service provision. Its proposals were set out in the Executive Summary:

2.1 For the right services to be delivered to local people at the time they need them, health, social services and other parts of local government must work together in partnership. Our proposals will put the needs of users and carers firmly at the centre of health and social services provision and make working together much easier.

2.2 The Government will remove barriers to joint working by introducing powers, as soon as a legislative opportunity arises, to enable:

- Pooled Budgets - health (Health Authorities or Primary Care Trusts) and social services to bring their resources together into a joint budget accessible to both to commission and provide services. This will make it easier for staff in either agency to pull together a comprehensive integrated package of care for users;
- Lead Commissioners - one authority (Health Authority, Primary Care Trust or Social Services Authority) to transfer funds and delegate functions to the other to take responsibility for commissioning both health and social care.

¹⁹ The Welsh Assembly also issued a document, *Partnership for Improvement* in September 1998

²⁰ Department of Health, *Partnership in Action*, September 1998 paragraph 1.2 of the Introduction

²¹ As above, paragraphs 1.3 and 1.9

This will put the needs of patients and users at the heart of commissioning and eliminate wasteful overlaps and gaps;

- Integrated Provision - an NHS Trust or Primary Care Trust (that provides as well as commissions services) to provide social care services beyond the level possible under current powers. Or a social services in-house provider to provide a limited range of community health services, for example, chiropody and physiotherapy in contract with the NHS. This would have the great advantage of offering an integrated service from one provider rather than many.

2.3 Incentives to encourage more joint working will be introduced to improve all aspects of health, including preventative measures that may lessen the need for intervention by the health service. This includes:

- extending the scope of Health Authority powers under Section 28A of the 1977 NHS Act to transfer money to support a wider range of local authority services (within the context of the local Health Improvement Programme (HImP));
- enabling Health Authorities to delegate to Primary Care Trusts the power to make transfers under Section 28A of the 1977 NHS Act;
- a reciprocal power for Local Authorities to transfer funds to NHS bodies to support objectives set out in HImPs;
- Health Authorities' Joint Finance special allocations to be incorporated in their new unified budgets with indicative benchmarks for resource transfers under Section 28A of the 1977 NHS Act established for a transitional period.

2.4 New measures to monitor and review joint working will be introduced by:

- issuing joint national priorities guidance for both the NHS and social services;
- developing and implementing new performance frameworks for the NHS and social services;
- exploring how health and social services could jointly review their services at the interface; considering how central bodies, such as the Commission for Health Improvement, Social Services Inspectorate and the Audit Commission, might jointly inspect services at the interface.

2.5 Finally, the Government plans to bring existing collaborative arrangements into line with new proposals for joint working by removing the legislative requirement to have a Joint Consultative Committee in place once HImPs are fully operational - local authorities and voluntary organisations will have an important role to play in HImPs.²²

²² Department of Health, *Partnership in Action*, September 1998. Executive Summary

4. **The Health Act 1999**

Sections 26-31 of the *Health Act 1999* introduced a number of these changes. The provisions to enable joint working in Section 31, in particular, pave the way for Care Trusts although the other provisions are also relevant. For example, a Care Trust might also use the more limited powers in Section 29 and 30 for health and local authorities to effectively purchase a service one from the other.

In summary:²³

Section 26 contains an explicit duty of co-operation between bodies within the NHS.

Section 27 (amending Section 22 of the *NHS Act 1977*) requires NHS bodies and local authorities to co-operate with one another, “*in order to secure and advance the health and welfare of the people of England and Wales.*”²⁴ This extends the previous requirement to co-operate, which referred only to Health Authorities and Special Health Authorities.)

Section 28 requires Health Authorities to prepare local plans both for improving the health of the local population and for providing health care to it. This gives statutory force to the requirement to prepare Health Improvement Programmes (HImPs), a policy that the Government had already introduced through guidance. The process is intended to engage local communities and voluntary bodies, employers, educational establishments and others. Local authorities are required to participate in the preparation or review of a plan.

Section 29 (amending Section 28A of the 1977 Act) extends the powers of Health Authorities to transfer money to local authorities so that they can fund any local authority health-related function. The powers are also applied to Primary Care Trusts, which, like Health Authorities must be satisfied that the purpose of the transfer is related to NHS functions or the health of individuals and (under the old legislation) that such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure in the NHS.

Section 30 (inserting a new Section 28BB into the 1977 Act) contains a reciprocal power for local authorities to make payments to health authorities or Primary Care Trusts. Only the prescribed NHS functions may be funded. The English Regulations exclude a range of

²³ Unless otherwise stated, the following summary draws on the Explanatory Note to the Act, Regulations under the Act for England: SI 2000/617 and 618; and Department of Health Circulars issued on the Act: Commencement of sections 29 and 30 of the *Health Act 1999*, HSC 2000/011/ LAC 2000/10, 31 March 2000; Implementation of Health Act Partnership Arrangements, HSC 2000/010/ LAC (2000) 9 and associated guidance <http://www.doh.gov.uk/jointunit/guidance.htm> .

²⁴ The *Health Act 1999* Section 27

services, for example, surgery, radiotherapy, termination of pregnancies, invasive treatments and emergency ambulance services.²⁵

Section 31 allows the NHS and local authorities to work together in new ways by enabling them to pool resources and to delegate health and health-related functions from one party to another (in the form of lead commissioning or integrated provision). The arrangements relate only to prescribed functions and must be likely to lead to an improvement in the way in which the relevant functions are exercised. They leave existing charging arrangements in place. There is provision for more detail to be set out in Regulations.

Examples of health authority functions that can be included in Section 31 partnership arrangements in England are hospital accommodation, medical, dental, nursing and ambulance services and various facilities, including rehabilitation services and services intended to avoid admission to hospital. There are exclusions such as surgery, radiotherapy, termination of pregnancies, invasive treatments and ambulance services.²⁶

Health-related local authority functions include most social services functions for children and adults (with some exclusions, such as charges for accommodation) education functions, certain housing functions (grants for private sector housing renewal, housing allocations and homelessness), and various other functions, such as public libraries, youth service, environmental health, and transport.²⁷

Under these powers NHS or social services staff could, for example, develop a package of care suited to a particular individual irrespective of whether health or local authority money is used. One of the partner bodies could commission all mental health or learning disability services locally. Support involving both domiciliary and community nursing care could be arranged from a single managed provider. Various wider cross-cutting initiatives, such as Sure Start could also be made easier.²⁸

In England the partnership arrangements in Section 31 (and Section 29 and 30) came into effect on 1 April 2000. Secondary legislation and guidance in Wales are the separate responsibility of the Welsh Assembly. The relevant Regulations came into effect in Wales on 1 December 2000.²⁹

The NHS Plan (published at the end of July 2000) said that Health Act schemes covering budgets of over £200 million were in operation. The Government did not think this was adequate:

²⁵ SI 2000/618

²⁶ SI 2000/617

²⁷ SI 2000/617

²⁸ <http://www.doh.gov.uk/jointunit/guidance.htm> paragraph 5

²⁹ Welsh Assembly Press Release, *Jane Hutt Launches New Partnership Opportunities For Health And Social Services* W001234-Hlt, 29 November 2000

But only a small minority of patients are benefiting. In future, therefore, we will make it a requirement for these powers to be used in all parts of the country rather than just some. The result will be a new relationship between health and social care. In turn it will bring about a radical redesign of the whole care system. In future, social services will be delivered in new settings, such as GP surgeries, and social care staff will work alongside GPs and other primary and community health teams as part of a single local care network. This co-location of services will make easier the joint assessment of patients' needs. The assessments will form part of the new personal care plan which older patients and others will now receive.³⁰

5. Care Trusts

The NHS Plan's proposal for Care Trusts is set out below:

7.9 We now propose to establish a new level of primary care trusts which will provide for even closer integration of health and social services. In some parts of the country, health and social services are already working together extremely closely and wish to establish new single multi-purpose legal bodies to commission and be responsible for all local health and social care. The Government intends to build on the establishment of primary care trusts so that all those localities who want to follow this route can do so. This will require changes to the governance arrangements for primary care trusts to ensure representation of health and social care partners. The new body will be known as a 'Care Trust' to reflect its new broader role.

7.10 Care Trusts will be able to commission and deliver primary and community healthcare as well as social care for older people and other client groups. Social services would be delivered under delegated authority from local councils. Care Trusts will usually be established where there is a joint agreement at local level that this model offers the best way to deliver better care services.

7.11 Where local health and social care organisations have failed to establish effective joint partnerships – or where inspection or joint reviews have shown that services are failing – the Government will take powers to establish integrated arrangements through the new Care Trust.

7.12 The establishment of Care Trusts will obviously have to take account of the roll out and capacity of primary care trusts. The first wave of Care Trusts could be in place next year.

³⁰ NHS Plan, as above paragraph 7.3

C. Provisions on Care Trusts in the Bill

In summary, the Bill provides that:

- Care Trusts based on partnerships between NHS bodies and local authorities would be able to commission and provide integrated services.
- Care Trusts would be either voluntary, by application to the Secretary of State or the National Assembly for Wales on the initiative of the partners, or compulsory, as directed by the Secretary of State or the National Assembly for Wales.
- Compulsory Care Trusts would only be formed where an NHS body or local authority was failing to perform adequately.
- Care Trusts could include, in addition to their health functions, a wide range of health-related local authority functions
- The Secretary of State and the National Assembly would also have powers to direct NHS bodies and local authorities to enter into certain other partnership arrangements.
- The Government is not anticipating additional expenditure overall although it says that there may be some initial start-up costs.

Clause 45 provides for voluntary Care Trusts. It provides that:

- the relevant authority (the Secretary of State in England and the Welsh Assembly in Wales) may designate a Primary Care Trust or an NHS Trust as a Care Trust where it is of the opinion that Care Trust status is likely to promote effective exercise of a local authority's health-related functions together with the Trust's NHS functions.
- all partners to the proposed Care Trust must make the application. The NHS partner could be a Primary Care Trust or NHS Trust. The Explanatory Notes say that this would include a Health Authority where a proposed Care Trust is to be based on an existing Primary Care Group.
- the Secretary of State or Welsh Assembly may direct that any of the functions specified be exercised in parts of a local authority area even though the Care Trust does not exercise any NHS functions in that area. The Explanatory Notes say that this is to create some flexibility to deal with the different populations covered by local authorities and health bodies; it would mean that a Care Trust could have responsibility for either health functions only or local authority health-related functions only for some sections of the population covered.
- the designation of a Care Trust may be revoked by application from any of the parties to it or on a motion of the Secretary of State or the Welsh Assembly.

- a Care Trust must be designated by order, either amending the establishment order of an existing Primary Care Trust or NHS Trust, or by creating a new body. The Notes say that the last would be where a Primary Care Group is involved.
- Regulations may be made in connection with Care Trusts, covering in particular the application process and the governance of such a Trust. The Notes say that the intention is to include local authority members on the Boards of Care Trusts and to increase the representation of social services professionals.
- Care Trust status shall not affect that body's NHS functions, rights or liabilities.
- where an NHS body is designated as a Care Trust and exercises social services functions, it is to act in accordance with the same directions and guidance as would apply to a local authority exercising those functions.
- a local authority's "health-related functions" has the same meaning as in section 31 of the *Health Act 1999*. This says that the term means functions which "in the opinion of the Secretary of State (i) have an effect on the health of any individuals (ii) have an effect on, or are affected by, any functions of NHS bodies, or (iii) are connected with any functions of NHS bodies".

Clause 46 provides for compulsory partnership arrangements and for compulsory trusts. It provides that:

- the Secretary of State for Wales or the Welsh Assembly can direct local authorities and NHS bodies (defined as a Health Authority, a Primary Care Trust or NHS Trust) to enter into pooled fund or delegation arrangements,³¹ with details of the arrangements specified in the Direction, where a local authority or NHS body is failing to deliver its functions adequately and where the relevant authorities are of the opinion that the delegation or pooled fund arrangement would be likely to lead to an improvement.
- functions other than the failing one(s) may also to be included in the Direction with a view to improving the way that they are exercised.
- in the case of local authorities, these powers of compulsion can only to be triggered by a failure to perform (health-related) social services functions adequately.
- where the above powers of compulsion are used, the Secretary of State or the Welsh Assembly may also designate a Primary Care Trust or NHS Trust as a Care Trust.
- as in Clause 46, local authority health-related functions may be performed by a Care Trust in specified areas where it has no health functions.

³¹ See description of Section 31 of the Health Act 1999 above.

- the Secretary of State or the Welsh Assembly may, but is not required to, revoke the Care Trust status when the Direction is revoked. According to the Notes this means that a compulsory Care Trust could continue as a voluntary one
- Regulations may be made for various purposes (as in the case of voluntary Care Trusts).

Clause 47 makes further provisions relating to powers of the relevant authorities to direct the formation of Care Trusts.

D. Responses to the provisions on Care Trusts

Below are responses received in the Library at the time of going to press.

Local Government Association (preliminary view)

LGA is keen to see further steps taken to enhance the levels of integration across services enjoyed by users and recognises and supports the general drive to better partnership working between local government and the NHS. There are, however, a range of issues about the specific approach outlined in the Bill which we will want to consider. These include:

- the proposed arrangements for an application to the Secretary of State, not only at the stage of setting up of the Trust but also at the point that partners wish to revoke the arrangement.
- the only option for this new enhanced status seems to be as health bodies. We might have preferred the creation of a truly jointly accountable body with equal responsibilities lying with both “parent agencies”. We are concerned that the current proposals may leave councils as the junior partner, rather than fully drawing on the strengths and expertise of local government.
- the current proposals may effectively bring a huge community-based service – focused on supporting people in their own homes and communities - into a service essentially dominated by treatment and ill-health. This may weaken the link to other essential community services and put at risk priority funding for social care. It may make the hard-won user and community-based policies of social care harder to sustain. The decision to expand the options open to the Secretary of State (to deal with authorities facing difficulties) to more than just Trust Status is welcome – although great care will be needed to ensure that appropriately balanced action is taken only after a thorough assessment of the “failing” arrangements.

BMA

The BMA welcomes the idea of closer working between social services and the NHS. However, we feel that it would be unhelpful to force them to work together by combining them if they fail to work together voluntarily. This could be counter productive.

The BMA's preferred route would be voluntary recognition at local level that a Care Trust is the best way forward for local service development. Care Trusts should build on pre-existing success in service development and a proposals for the creation of a Care Trust should be able to demonstrate the added value from Care Trust status that cannot be achieved within existing structures, such as a Primary Care Trust. The compulsory establishment of a Care Trust as a response to local service failure will tend to negate the possibility of partnership working which will be so essential to the development of a successful Care Trust. The BMA would expect the Secretary of State's reserved powers to be used only in the most exceptional circumstances.

The BMA has serious concerns about the timescale as the NHS Plan proposed that some new Care Trusts should be introduced in 2001.

Registered Nursing Home Association

Part III of the Bill appears to attempt to put some action into the 'joined up thinking' which led to the introduction of that part of the national Health Service Act 1999 which enables joint budgets and joint funding by social services departments and health authorities. Unfortunately, it has the appearance of trying to remedy a fault rather than introduce a concept.

Royal College of Nursing

The response of the RCN was not ready at the time of going to press but its website <http://www.rcn.org.uk> contains a note on partnership working in general, which says:

In principle the RCN supports partnership working and was involved in discussion with the Joint Health and Social Care Unit within the Department of Health who were responsible for developing guidance to both Health and Local Authorities in respect of these new arrangements. The relationship between health and Local Government is also a key area the RCN will be focusing on over the coming months as part of our response to the NHS Plan.

II Long Term Care

A. Introduction

Part IV (Clauses 48 - 58) of the Bill on social care deals with issues relating to long term care, most of which were raised in the Government's Response to the Royal Commission on Long Term Care, published as Volume II of the NHS Plan.³²

Following complaints about the system of funding residential and nursing homes, the Government announced in December 1997 that it was setting up a Royal Commission on the funding of long term care under the chairmanship of Sir Stuart Sutherland.³³ This was in fulfilment of its General Election Manifesto commitment to set up a Royal Commission "to work out a fair system of funding long-term care for the elderly".³⁴ The remit of the Royal Commission was wider and included younger disabled people in need of such care as well as the elderly.

The Royal Commission's report, *With Respect to Old Age*, was published on 1 March 1999 with a dissenting note by two of its members and three accompanying volumes of research and analysis.³⁵ In May 1999, two months after the Royal Commission's Report, the Health Select Committee published a report on the Royal Commission's recommendations, supporting the Commission general approach on the question of funding personal care out of general taxation and requesting the Government to take action as a matter of urgency.³⁶

When the Government announced the publication of the report, it did not make definite commitments with respect to the report's major recommendations.³⁷ In a debate on 2 December 1999, it did give some indication of the issues in which it was particularly interested. It said that the Royal Commission had raised six issues that the Government was examining in particular detail. These included three of the areas that are covered in the current Bill although not necessarily in the form originally proposed: providing nursing care free, abolition of *preserved rights* and the power of local authorities to place a legal charge against the resident's former home rather than force sale.³⁸

³² Cm 4818 - II

³³ HC Deb 4 December 1997 c 489W

³⁴ Labour Party General Election 1997 Manifesto, *New Labour: Because Britain Deserves Better*, page 27

³⁵ *With Respect To Old Age: a Report by the Royal Commission on Long Term Care*, Cm 4192, March 1999

³⁶ Health Select Committee, *The Long Term Care of the Elderly*, HC Paper 318 of 1998/99

³⁷ HC Deb 1 March 1999 c 741-3

³⁸ HC Deb 2 December 1999 c 452

The NHS Plan, published in July 2000, set out the Government's formal response to the Royal Commission. Although some of its recommendations were accepted, a central one, that all personal care should be provided free to the individual out of general taxation, was not accepted. The proposal on nursing care in the current Bill was a second-best recommendation of the Commission's report and was closer to the views expressed in the Dissenting Note of the Commission's report.³⁹

The NHS Plan said that the Government's general aim was to promote independence so that people could remain in their own homes wherever possible:

...However, for some people, residential or nursing care is the right option. When this is necessary, we must ensure that the funding of long-term care is fair and promotes rather than obstructs good partnership working across health and social services.

However, this is not the case at present. The present system of funding long term care is confusing, complicated and anomalous. People who need nursing care in nursing homes may have to pay for it whereas it is free in every other setting. Many people fear having to sell their homes to pay for their care. Rather than promoting independence, the present rules often reinforce an older person's dependency.⁴⁰

Many of the proposals in the Government's Response do not require primary legislation and are therefore not included in the Bill. These include several that affected the means-test for residential and nursing home care, such as disregarding the value of a person's home for the first three months in a residential or nursing home (to be implemented from April 2001). A second is to restore the capital limits to their 1996 value⁴¹ and to keep them under review (from April 2001). A third is to transfer the Residential Allowance to local authorities for new cases (from April 2002). Various other proposals include statutory guidance to local councils to reduce "unacceptable" variations in charges for care in people's own homes and a consultation on the regulation of long term care.

The measures that are in the Bill are listed below. These also include provisions that were not in the NHS Plan. They are discussed in Sections C - H below.

- Free nursing care in nursing homes
- Preserved Rights
- Legal charge on the care home resident's own home

³⁹ The Appendix to this Paper shows a list of the Royal Commission's recommendations next to the Government's Response to them (reproduced from the Response).

⁴⁰ NHS Plan, Volume 1, as above paragraphs 15.16-17

⁴¹ 1996 was the year that they were last updated.

- Paying for accommodation that is more expensive than the local authority's standard rate
- Cross border placements
- Direct Payments

These measures apply to England and Wales. The provisions on preserved rights also apply to Scotland by amending devolved legislation. The Explanatory Notes says this was at the request of the Scottish Executive and by the approval of the Scottish Parliament.

B. An outline of the current system of paying for residential and nursing home care

In April 1993 major changes to the system of funding residential and nursing home care were introduced by the *NHS & Community Care Act 1990*.⁴² These involved a shift in funding from the Department of Social Security to local authorities and changes in local authority responsibilities. NHS responsibilities were left unchanged.

Leaving aside the people who can afford to fund their own long-term care, and some who may be able to put together a package based on disability benefits, the three main sources of funds for an individual needing long-term care are the NHS, local authorities, and Income Support for those who entered residential or nursing home care before April 1993.

From the point of view of the individual receiving long-term care, services provided by the NHS are free. When in hospital or a nursing home funded by the NHS, this includes board and lodging. Services provided in people's own homes by social services (local Councils) may be free but are increasingly being charged for.⁴³ Help for residential and nursing home fees from social services and through Income Support are both means-tested and based on the premise that residents have to pay the charge unless their income and capital are low enough to qualify for this means-tested help.

The means-test rules are complex and only the barest outline is described here. Further points are in the relevant sections of this Paper below. For more detail, the Explanatory Notes to the Bill provide an account of existing social care legislation. Other sources include the Department of Health's *Charges for Residential Accommodation Guide* and

⁴² The 1990 Act included a number of relevant changes, including amendments to *the National Assistance Act 1948*.

⁴³ Under the *Health and Social Services and Social Security Adjudications Act 1983*, local authorities can charge what they like as long as it is "reasonable".

Facsheets by *Age Concern*. The latter are available from Age Concern's helpline 0800 808 6060 or from its website: <http://www.ace.org.uk/>.

Before April 1993, local authorities were, as now, responsible for funding those who entered residential own homes run by local authorities themselves. Local authorities could not, and cannot, run nursing homes themselves. People who entered independent sector residential or nursing homes before April 1993 were entitled to special, higher rates of Income Support towards the care home's fees. They did not have to be assessed as needing such care (although they were subject to a financial assessment if they wanted to receive Income Support).

These special rates of Income Support for independent sector care home residents were abolished for people who entered homes after April 1993. But those who entered before then have *preserved rights* and are treated under the old system. Under that system, people in nursing homes are entitled to higher rates of Income Support than are people in residential homes. The distinction between these types of home lies in the way that they have to be registered under the *Registered Home Act 1984* (which is being replaced by the *Care Standards Act 2000*). Both types have to be registered but there are different provisions and different Regulations covering each. For example, a registered medical practitioner or a qualified nurse has to be in charge of a nursing home.

Since April 1993, local authorities have been responsible for placing and, if necessary funding, people who need residential or nursing home places, subject to a test of need and a test of means. This includes placing them either in the independent sector or in local authorities' own homes. Where a local authority has assessed someone as needing permanent residential or nursing home care, it must apply a standard charge representing the full cost of the accommodation to the authority.⁴⁴ The rules for means-testing this charge are covered by Regulations⁴⁵. Although social services policy is a devolved matter and was the subject of separate legislation in Scotland even before devolution, at the moment the *Social Work (Scotland) Act 1968* applies the same rules in Scotland. The Welsh Assembly has power to issue its own Regulations but has not so far done so.

For the purposes of the means-test, a few types of income are disregarded but otherwise income is taken into account in full except for a small amount that is allowed to residents for personal expenses (currently £15.45 a week in 2000/2001). Capital of £10,000 or less is disregarded. Residents with capital over £16,000 have to pay the full fee. Amounts of capital in between these amounts are converted into weekly income at the rate of £1 for every £250 or part of £250. These capital rules (like many of the other rules) are similar to the capital rules under the *preserved rights system*.

⁴⁴ The *National Assistance Act 1948* Section 22

⁴⁵ The main Regulations are the *National Assistance (Assessment of Resources) Regulations, SI 1992/2977*

Subject to certain exceptions (eg when a spouse lives there) capital includes the value of the person's home (if s/he is a home owner). The resident is not required to sell the home if s/he can raise the money in other ways (for example by letting the home). But in practice selling the home is often the only way of raising the money to pay the fee. Councils do have the power to place a *legal charge* on a person's home and to recoup the money owed to them at a later date (eg when the care home resident dies) but are not required to do this.⁴⁶

Although local authorities cannot run nursing homes themselves, they have been placing and funding people in them. Department of Health guidance on the *NHS & Community Care Act 1990* says that it requires local authorities to obtain health authority consent before placing people in nursing homes, except in an emergency and that: "It is expected that the health authority approval will normally be obtained through participation in the assessment process."⁴⁷

The power of local authorities to place people in nursing homes was called into question by the Coughlan case (see also Section 1 of this Paper). The High Court decided that they could not provide nursing care but the Appeal Court decided that they could take responsibility for the general nursing care of an individual, depending on whether the nursing services were merely (i) incidental or ancillary to the provision of accommodation which a local authority is under a duty to provide and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide.⁴⁸

C. Free nursing care in nursing homes

[Clause 48]

1. Background

Of the Royal Commission's recommendations, the most controversial was the proposal that all personal care provided in residential, nursing, or people's own, homes should be paid for out of general taxation and provided free to those who need it, attracted most press attention. The Government's initial statement expressed concern about the cost,⁴⁹ which many press commentators took to mean that it was opposed to the proposal. This eventually turned out to be correct (see below) and the issue continues to be controversial

⁴⁶ *Health and Social Services and Social Security Adjudications Act 1983* Section 22

⁴⁷ Department of Health, *Community Care in the Next Decade and Beyond*, 1990 paragraph 3.38

⁴⁸ Times Law Report 20 July 1999; Independent Law Report 20 July 1999; R v North Devon Health Authority ex parte Coughlan [2000] 3 All ER 850, [2000] 2 WLR 622

⁴⁹ HC Deb 1 March 1999 c741-743

as some press reports suggest that there is still a strong body of opinion in favour of free personal care.⁵⁰

The report's recommendation involved splitting the costs of long-term care between living costs, housing costs and personal care. The last was to be available after assessment, according to need, and paid for from general taxation. The rest was to be subject to a co-payment according to means. The Commission's definition of personal care, which it considered to be on the tight side, included nursing care plus any other care that directly involved touching a person's body, such as helping someone to have a bath. Nor did it cover housing costs, the provision of meals or help in the home such as gardening and cleaning.⁵¹

The Royal Commission's recommendations were based on its views of the current system:

The Commission is clear about the strong lack of trust in the current system. There are pronounced feelings that Government was meant to underwrite the system in some universal sense through taxation, and it has not done so. People are not clear as to what they should expect. There is a linked feeling that the Health Service is abnegating its responsibility for care and making people rely on their own resources. Delivery at the sharp end is by Local Government, with its less centrally controllable (and more locally variable) system of finance, which produces variations in the implementation of the funding system, which also contributes to unease. The feeling is that a contract with the people has been broken. The reality is that there never really was one and, incrementally, rules were changed without people understanding what this meant. The result is a sense of betrayal, a lack of trust and a genuine sense of helplessness.⁵²

The immediate cost of this proposal, was estimated at the time to be in the range of £800 million to £1 billion (at 1995 prices). The two dissenting members of the Royal Commission (Joel Joffe and David Lipsey) argued that the money could be better spent on improving long term care in other ways. They did, however, support the proposal that nursing care should be funded from general taxation, subject to an assessment of need.⁵³ This option was also discussed in the main report,⁵⁴ which concluded that it had much merit and recommended that it should be implemented: "It could stand alone, but in practice would be subsumed by the wider restructuring of the means-testing system we propose."⁵⁵

⁵⁰ See, for example, "Grey Backlash Prompts Elderly Care Rethink", *The Times* 1 January 2001 and the section on responses to Part IV of the Bill in this Paper.

⁵¹ Paragraphs 6.43 –6.48 of the report (as above, Cm 4192)

⁵² As above, paragraph 4.34

⁵³ See the dissenting note published at the end of the Royal Commission Report (as above, Cm 4192)

⁵⁴ Royal Commission Report, as above paragraphs 6.22 – 6.26

⁵⁵ As above paragraph 6.26

The NHS Plan Volume II set out the Government's objections to the Royal Commission's proposal:

2.6 The main report of the Royal Commission recommended that "personal care", which includes nursing care and some social care tasks such as help with bathing, should be funded from general taxation, subject to an assessment of need. At the moment, this is usually provided on a means-tested basis through local councils, so people who are least able to pay receive it free. As a result, three quarters of those in residential or nursing care already get some or all of their personal care costs met from public funds. Making personal care free for everyone carries a very substantial cost, both now and in the future. It would consume most of the additional resources we plan to make available for older people through the NHS Plan. Yet it would not necessarily improve services as the Note of Dissent to the Royal Commission's report makes clear. It does not help the least well off. We have not followed this recommendation because we believe our alternative proposals to improve standards of care and fair access to services will generate more important benefits of health and independence for all older people, now and in the future.

2.7 Our investment in intermediate care services and in other preventive and rehabilitative services, such as community equipment, is fundamentally geared towards restoring older people's independence, particularly after an acute illness, or a fall, or some other crisis. This major investment will mean that more people will be able to continue living independent lives in their home communities rather than entering residential care. Where people need to enter residential care for a short time, our intended changes to the charging rules will help ease the pressure on people to sell their own homes against their wishes and will lessen the burden of care costs. This targeting of resources will provide a sustainable framework for future generations. It will ease the financial burdens on older people and their families, and drive up standards for everyone.

The Plan said that new investment in intermediate care and associated services would rise to £900 million a year by 2003/4 and on top of this the Government would be targeting additional resources, rising to £360 million a year by 2003/04 to tackle the anomalies and inequities of the present funding system for long term care (including the free nursing care proposal), together with a set of reforms to make the system more logical and more responsive to the changing needs of the individual (paragraph 2.4).

The NHS Plan proposed free nursing care for people in nursing homes. This would include people who now fund themselves, those funded by local authorities and those funded under the preserved rights system (who, under separate provisions of the current Bill, will be transferred to local authority funding). The proposal would leave non-nursing costs, including board and lodging to be treated under present arrangements (as amended by other proposed changes in the NHS Plan).

The NHS Plan said:

2.8 There can be no justification for charging people in care homes for their nursing costs. We will make nursing care available free under the NHS to everyone in a care home who needs it. Both the report of the Royal Commission and the Note of Dissent to it supported this. It will require primary legislation and we will introduce this as soon as possible. The change cannot apply retrospectively but we intend to introduce free NHS nursing care in all nursing homes by October 2001.

2.9 In the future, the NHS will meet the costs of registered nurse time spent on providing, delegating or supervising care in any setting. This is a wider definition of nursing care than proposed in the Note of Dissent to the Royal Commission report, which suggested it should include those tasks that only a registered nurse could undertake.

2.10 Therefore people identified as needing nursing home care will no longer have to meet any of the costs for the registered nurses involved in their care, or for the specialist equipment used by these nurses. Instead, the NHS will meet these costs. People who can afford to do so will still have to make a contribution towards their personal care and accommodation costs while in a nursing home.

2.11 This change will benefit around 35,000 people at any time. They could save up to around £5,000 for a year's stay in a nursing home.

2.12 The introduction of free nursing care in every setting will provide the right incentives to the NHS and social services to work together to provide the modern quality care that people need. It will encourage the NHS to provide rehabilitation services that people are able to benefit from. It will reduce the perverse incentive to discharge people too early to social services funded care. It will create a fairer system, where people can receive the nursing care they need wherever they live, paid for or provided by the NHS. It will end the most obvious inconsistency in the funding of long term care.

The NHS Plan's rejection of free personal care was greeted with a chorus of disapproval from voluntary organisations concerned with old people and people with disabilities, as well as their carers. The King's Fund said that it would penalise old people and continue to create insecurity for younger people.⁵⁶ The Royal College of Nursing was concerned about the lack of clarity over the definition of nursing care.⁵⁷ Others have also been critical, such as the BMA and the Association of Directors of Social Services.

Details of the plans for free nursing care in nursing homes remain to be decided. A Written Answer in November 2000 said in response to a question about models of assessment of people's care needs:

⁵⁶ "Government Provokes Fury by Rejecting Royal Commission Proposals" *Community Care* 28 July 2000

⁵⁷ "Nurses reject elderly care bill", *The Guardian* 1 September 2000

In line with the National Health Service Plan, we aim to introduce a single assessment process for health and social care for older people by April 2002, with protocols to be agreed locally between health and social services. Initially this will be introduced for those older people who are most vulnerable, for example those living alone, or recently discharged from hospital or entering residential or nursing care. Work on developing the assessment process is being taken forward as part of the development of the National Service Framework for older people.

With regard to nursing care, the NHS will make an assessment of the nursing care requirements of nursing home residents. The Department is working in close consultation with a number of organisations on a standardised approach for this part of the assessment process, which will be ready for implementation in October 2001. There are a range of nursing assessment tools currently available, though each is likely to require some development to deliver the outputs needed.⁵⁸

Another Written Answer later in the month shows how the proposal might link in with the partnership arrangements described in Section I of this Paper on Care Trusts. It said:

Responsibility for the payment of the nursing costs will be with the National Health Service – this could be discharged through a contract between the NHS and the care home, but in areas where the NHS and social services are using the Health Act flexibilities this may be handled through pooled budgets and lead commissioning by the local authority.⁵⁹

2. The Bill

Clause 48 removes local authorities' powers to provide or arrange nursing care by a registered nurse. Nursing care is defined as "services provided by a registered nurse and involving a) the provision of care, or b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse".

The Explanatory Notes say that it is intended that the NHS in pursuance of its powers and duties under the 1977 Act will provide or arrange nursing care by a registered nurse and such care will, in accordance with the 1977 Act, be free of charge. The Notes also say that the Department of Health is currently working with the Royal College of Nursing and other key stakeholders to develop a tool to be used across the country for assessing nursing care. NHS staff would be trained in the use of this tool in time for the introduction of free nursing care.

⁵⁸ HC Deb 8 November 2000 c 267W

⁵⁹ HC Deb 27 November 2000 c 472W

On the financial effects of the proposed changes, the Notes say that the additional full year cost of providing nursing care are expected to be £165 million although initial costs will be higher as existing recipients of local authority commissioned nursing care will need to be assessed. This figures is additional to existing public expenditure on nursing care by local authorities and of the Department of Social Security for people with Preserved Rights.

On the regulatory impact, the Notes say that there will be no direct costs to business providing health and social care but the proposal for free nursing may mean that District Nursing services take on some of the care needs of people in residential care, or in other cases the NHS will simply contract with the Nursing Home for the nursing elements of the resident's care.

D. Preserved Rights

[Clauses 49 –51]

These Clauses also apply to Scotland.

1. Background

Those who are in an independent sector home now but entered before April 1993 generally continue to be funded under the old system and are said to have *preserved rights* to Income Support.⁶⁰ This system has been widely criticised and would be abolished by the Bill. Indeed, some commentators have said that *preserved rights* is a misnomer as most of those with such rights are in practice at a disadvantage compared with care home residents supported by local authorities or the NHS.⁶¹

As described in section B above, people with *preserved rights* are generally entitled to special, higher rates of benefit for residential and nursing home care. Although there is a test of means, their need for care does not need to be assessed. They use the money received from Income Support to pay the home's fees. Although arrangements can be made for the Income Support to be paid directly to the home in certain circumstances, the arrangements are essentially private ones between the home and the resident.

These vary according to circumstance as well as by type of home. For example, up to £225 a week is payable for someone in a residential home on the grounds of old age, and up to £343 a week is payable for someone in a nursing home on the grounds of mental handicap (in 2000/01). *Preserved rights* generally apply even if the person was not

⁶⁰ References in this Paper to *preserved rights* to Income Support also apply to income-based Jobseeker's Allowance.

⁶¹ William Laing, *People with Preserved Rights: a socially excluded minority*, Joseph Rowntree Foundation, 2000

actually getting Income Support before April 1993, for example, because s/he had too much capital but has now run it down.

Where a home's fees are more than the limits set by Income Support, relatives or charities would be allowed to top up the help given by income support but in the case of elderly people, the local authority is prevented by law from topping up or taking responsibility for many of those with preserved rights.⁶² There are some exceptions to this general rule but, in the case of old people, these are particularly limited.⁶³

Shortfalls are the major problem of the *preserved rights* system; there can be a gap between the level of the care home fee and the amount covered by Income Support that no-one is able to meet. This was an issue even before the community care reforms came into effect.⁶⁴ Shortfalls have continued to be a problem. Indeed, there is evidence to suggest that the problem has got worse because the annual uprating of the Income Support limits has not kept pace with the rise in care home fees.⁶⁵

The Royal Commission on Long Term Care recommended that the Government should consider the abolition of *preserved rights* or whether some other solution could be found to address the shortfall in funding experienced by the group of people with such rights.⁶⁶ Following Alan Milburn's speech highlighting the points in which the Government was particularly interested,⁶⁷ the Government issued a consultation document on *Preserved Rights to Income Support and the Residential Allowance* in April 2000, requesting responses by 31 May 2000.⁶⁸

The result of the consultation was given in the Government's response to the Royal Commission in the NHS Plan. It said:

2.26 People who were already in residential care on 31 March 1993 have had a Preserved Right to receive a special, higher rate of Income Support from which they can purchase their care. The concept of Preserved Rights was introduced to reassure people already in care homes that they could remain there, and it avoided councils suddenly having to assume responsibility for a quarter of a million care home residents *en masse*.

⁶² The *National Assistance Act 1948* Section 26A (inserted into the Act by the *NHS & Community Care Act 1990* Section 43) and Department of Health Circular LAC (93)6

⁶³ The *Residential Accommodation (Relevant Premises, Ordinary Residence and Exemptions) Regulations SI 1993/477*

⁶⁴ See Health Select Committee, *Community Care Funding from April 1993*, HC 309 of 1992/93 paragraphs 66-78 and Social Services Committee, HC 257 of 1989/90

⁶⁵ People with Preserved Rights, as above, JRF 2000

⁶⁶ Royal Commission on Long Term Care, as above, paragraph 4.30

⁶⁷ See Section A above.

⁶⁸ (1) *Preserved Rights Income Support* (2) *Residential Allowance Consultation Paper*, Department of Health, 14 April 2000 <http://www.doh.gov.uk/scg/prraconsult.htm> ; and Charges For Residential Accommodation Consultation Paper, Department of Health <http://www.doh.gov.uk/scg/reschcon.htm>

2.27 A decade after the arrangements were designed, there are some 65,000 people in England in receipt of Income Support at preserved rights rates. Of these, around 40,000 are over pension age and around 25,000 are younger disabled people, including people with learning disabilities. Many concerns have emerged. Some of the younger disabled people with preserved rights probably should not be in residential care at all. Our priority is that, wherever possible, people should be encouraged and supported to live more independent lives and have real choices about the options open to them. Some of the people with learning disabilities who have preserved rights might find their needs could more appropriately be met in supported accommodation. However as a result of the preserved rights system they do not get offered this opportunity.

2.28 There are also concerns about a shortfall between the fees charged by care homes and the weekly benefit income of residents. DSS data shows that about 45% of residents with preserved rights may be experiencing such a shortfall. This can lead to very difficult circumstances in which people on preserved rights have no income of their own, lose all their capital or become dependent on family or charity to pay the extra costs of care. In some cases, people have even been evicted from the care home because of the extent of the benefit shortfall.

2.29 The Government has concluded that the time has come to wind up the preserved rights scheme. If it were to continue, we would eventually be in the position in fifty years time or more where there were still some people with disabilities on preserved rights, and still constrained by assumptions about care delivery that are already out of date. We will therefore legislate as soon as Parliamentary time allows to give councils responsibility for the assessment and care management of everyone with preserved rights. We aim to make this change in April 2002, helping up to 65,000 people.

2.30 We recently consulted service users, their carers and families, care providers and councils on the impact of the abolition of preserved rights and the transfer of the residential allowance to councils (see paragraphs 33-37). We received over 240 responses. It was clear from these that many people share the Government's concern about the current arrangements, in particular the preserved rights shortfall. We accept, however, that the prospect of changes to both schemes also worries some people. They feel that preserved rights entitlement provides security and independence through the guarantee of social security benefits and by allowing individuals to buy residential care services of their choice. There are also concerns that some people with preserved rights might have to leave their existing care home under the new arrangements.

2.31 We understand these concerns and will ensure that the new arrangements do not disadvantage people who have previously had preserved rights or who would have received the residential allowance. The Government will therefore issue guidance that people must not be moved against their will out of their existing care homes unless there is a compelling reason why they should move. When the money is transferred, we will ensure that it continues to be spent on the client groups which currently benefit from the preserved rights. We will also require

councils to offer the option of direct payments to anyone who meets the prescribed conditions so that they have the opportunity to move out of residential accommodation and exercise more choice and control over the support they receive.

2.32 Later this year, we will be consulting with councils on the best way to distribute the money which is transferred from DSS. In the meantime we will change the regulations later this year to give councils powers to help people with preserved rights to pay the fees of their residential care home if they would otherwise face eviction from that home. This will give people reassurance that they can remain where they are, provided that the home is able to meet their care needs and provided that that is where they want to stay.

2. The Bill

Clauses 49-51 provide for local authorities to take over responsibility for people with *Preserved Rights* and abolishes the *Preserved Rights* system. In more detail:

On the financial impact, the Explanatory Notes say that the £528 million that the Government would expect to spend on social security benefits for people with *Preserved Rights* would be made available to local authorities in 2002/03. A further £86 million would also be made available to local authorities to cover the shortfall between *Preserved Rights* benefits levels and the actual costs of care, together with the costs of assessment and case management.

On the regulatory impact, the Notes say that transfer of *Preserved Rights* cases to local authorities could prove of assistance to providers as *Preserved Rights* payments have not kept pace with the fees paid under local authority contracts in recent years. (Research published by the Joseph Rowntree Foundation suggests that this is likely to vary by region. For example, in the South fees tend to be higher than the *Preserved Rights* payments but in some parts of the North, the position is the other way round.⁶⁹)

Clause 49

- repeals the provisions that prohibit local authorities from taking responsibility for people with *Preserved Rights*.⁷⁰

⁶⁹ William Laing, *People With Preserved Rights*, as above.

⁷⁰ Section 26A the *National Assistance Act 1948* and Section 86A of the *Social Work (Scotland) Act 1968*,

- requires local authorities to provide to people with Preserved Rights who are "ordinarily resident" in their area such community care services⁷¹ as appear to the local authority to be appropriate, having regard to the person's assessed needs.⁷²
- requires local authorities to do this on the day that the prohibition is removed or as soon as "reasonably practicable" thereafter.
- requires local authorities to use "their best endeavours" to identify qualifying people and to carry out the assessments.
- provides that the private arrangements between the care home and the person *with Preserved Rights* cease on the day that person is provided with community care services.
- provides that where the local authority does not provide the person with community care services on the day that the prohibition ends, it becomes liable for making for the person's payments to the home until such time as it does provide the services (and takes on responsibility that way) or the person notifies the local authority that s/he does not want them.
- provides that the local authority may recover from the person concerned such amount (if any) of the payment as may be prescribed; and for Regulations to apply all or parts of the existing local authority means test
- provides that Regulations may exclude people of a prescribed description from the above provisions..
- provides for Regulation-making powers covering the meaning of "ordinarily resident";
- defines certain terms used in the Clause.

Clause 50 is about identifying and locating people with Preserved rights by using records held by the Department of Social Security. It allows the disclosure of relevant information to local authorities or to any person providing services to, or authorised to exercise functions of, such authorities and applies the same rules about unauthorised to disclosure of such information by them as apply under social security legislation.

Clause 51 requires the Secretary of State to exercise his powers under social security legislation⁷³ to abolish the special, higher rates of Income Support payable under the *Preserved Rights* system.

⁷¹ These are defined in Section 46 of *the NHS & Community Care Act 1990*. They include, for example, residential care, domiciliary care, such as home helps and meals on wheels, day care and laundry services, as provided for in various other statutes.

⁷² This means assessed under Section 47 of the *NHS and Community Care Act* or Section 12 of the *Social Work Scotland Act 1968*

⁷³ Section 135 of the *Social Security Contributions and Benefits Act 1992* (applicable amount in relation to income-related (1) and Section 4 (5) of the *Jobseekers Act 1995* (amount payable by way of Jobseeker's Allowance).

E. Legal charge on the care home resident's own home

[Clauses 52 and 54]

1. Background

Under the current rules for local authority means-testing, if a resident has property which has been taken into account in the financial assessment, but is not willing or able to sell that property, the local authority has the power to place a legal charge on the property. This power exists under Section 22 of the *Health and Social Services and Social Security Adjudication Act 1983* and enables the local authority to recover the debt when the property is sold or the resident dies.

Where a charge is placed on a resident's property in this way, the local authority contributes towards the cost of the resident's residential or nursing home fees until the property is sold or the resident dies. The amount contributed by the local authority depends on the income and capital (other than the value of the property) held by the resident. Under the 1983 Act, local authorities cannot add interest to a legal charge while the resident is alive but it can be added from the day the resident dies. Where the provision is applied, it is effectively an interest free loan. But according to the NHS Plan (see below), this power is applied inconsistently.

The Royal Commission considered the issue of extending these provisions but rejected the idea:

6.8 As a possible alternative to option 1 the Commission have considered whether a system of loans, underwritten by the state, might offer relief to people with assets above the means test limit from the pressure of having to sell their homes. This is technically possible now, in that a Local Authority can choose to take a charge on a house which is only realised at death. This approach is clearly convenient for the client. However, it is discretionary and depends on the circumstances of the client and of the individual authority.

6.9 Ultimately, such a scheme would aim to be cost neutral. However, there would need to be an initial outlay of potentially between £1bn and £2.8bn if the aim were to meet from loans all care costs of people with more than £16,000 in capital. The scheme would soon start to bring in receipts from repayments, and as a result costs to the public sector would reduce. But if it were to be fully cost neutral, Local Authorities would need to fund transaction costs and charge interest on loans.

6.10 Government attempts to interest the private banking sector in this sort of scheme have a chequered history. The Commission think it unlikely that renewed interest would emerge in this area. Moreover, the scheme would be complex to establish, and to administer, probably very expensive initially and would leave the state with an uncertain liability. If Local Authorities administered it, they

might be left with a complex burden of assets which would differ greatly from one part of the country to another. The Commission consider there little overall benefit to be gained from such a scheme. We do not recommend it.

Following Alan Milburn's speech highlighting the points in which the Government was particularly interested,⁷⁴ the Government issued a consultation document on the provisions for charging for residential care in April 2000. (This was in addition to the consultation document on Preserved Rights and the Residential Allowance mentioned in Section D of this Paper.) The consultation covered a number of issues relating to charges for property, of which the legal charge/loan provision was one. Responses were requested by 19 May 2000.

The NHS Plan published in July 2000 said:

2.18 From October 2001 councils will be given additional financial help through a special ring fenced grant to become more active in covering the costs of care for those people who would otherwise have to sell their homes. Councils have current powers to place legal charges on homes and to recoup their costs at a later stage once the house is sold, but the use of these powers is inconsistent. The new grant will help support councils in extending these schemes. This will benefit around 5,000 people at any time and help them avoid having to sell their home against their wishes.

2.19 On top of this, we will keep under review the issue of giving homeowners without significant other assets, the right to request that their care costs be met by councils through a loan until their homes are sold. This could reassure people that they will not be forced into selling their homes during their lifetimes to meet the costs of their care.

2. The Bill

The Bill makes it possible for the Secretary of State in England and the Welsh Assembly to use Directions to require local authorities to enter into legal charge/loan arrangements, to be known as *deferred payment agreements* recoverable when the care homes resident dies or leaves the care home.

Clause 54

- enables local authorities to enter into *deferred payment arrangements* with people in or entering care homes arranged or provided by the local authority.
- allows Directions to be made setting out the circumstances in which an authority must enter into these arrangements.

⁷⁴ See Section A above.

- defines a *deferred payment arrangement* as consisting of an *exempt period* at the end of which the total of contributions that would have been due during the *exempt period* become payable and of a charge in the authority's favour of land belonging to the resident.
- defines the *exempt period* as beginning with the agreement and ending 28 days after the resident's death or any earlier agreed date.
- provides for Directions (to local authorities generally) to be made by the Secretary of State and the Welsh Assembly to cover *deferred payment agreements* and charges on land.
- provides that the agreement and charge may be terminated by notice on payment of the amount owed by the resident.
- provides for the exempt period to be interest free and for interest to be payable after that date.

Clause 52 enables the Secretary of State to specify in Regulations that local authorities should ignore certain capital, as specified in Regulations, for the purposes of determining whether care and attention is "otherwise available" to the person.

The Explanatory Notes say that under that Section 21 of the *National Assistance Act 1948* local authorities can only support people in residential accommodation who are in need of care and attention which is "not otherwise available to them". This means that local authorities may be able to refuse to support a person who has capital in excess of £16,000 (which is the current upper capital limit) if that person has the capacity to make his/her own arrangements, the implication being that the capital in excess of £16,000 could be used to meet the care costs. The Clause allows for Regulations to break the link with the capital when determining whether care and attention is otherwise available so that more people would be able to take up the offer of a charge against their home. The provision will apply where limit where a person has less than £16,000 in assets other than their main home.

On the financial implications, the Explanatory Notes say that there will be a substantial initial cost to this policy, which will reduce over time as charges start to balance the costs of new resident's care. To help local authorities meet these costs a special grant of £15 million/£30 million /£40 million is to be provided in each of the next three years.

F. Paying for accommodation that is more expensive than the local authority's standard rate

[Clause 53]

1. Background

Under current legislation care home residents can in certain circumstances choose to be placed in a care home that charges higher fees than the local authority's standard rate. One

of the conditions is that there is a third party willing and able to make up the difference between what the local authority will pay and the care home's fee. There has been some question whether a resident can act as his/her "own third party" and, if s/he has £10,000 of disregarded capital, use it to top up the local authority's contribution. The Department of Health's view is that the current law does not allow this. The Bill provides for Regulations to change the law to enable care home residents (as well as third parties) to do their own topping-up.

Following some years of confusion about the legal position,⁷⁵ in 1998, the Department issued note clarifying its view.⁷⁶ The following paragraphs are a summary of this note.

The *National Assistance Act 1948* Section 22 requires local authorities to recover the full cost of accommodation subject to a means test set out in Regulations under that Act. It does not expressly forbid the local authority reaching an agreement with the person whereby he should pay part of the costs of the accommodation. But such an agreement would run contrary to the authority's duty either to charge at the full rate or determine a lower rate in accordance with the Regulations. There is no provision for an exception to the local authority's duties to charge the person at the full or the means-tested rate.

The legal position reflects the fact that, when legislation was passed in 1948, the intention was that the means test required residents to contribute what resources they could reasonably afford to spend on residential care to meet the authority's charges; and that the assessment of resources should be tightly prescribed to safeguard the person's interest. Thus under the residential charging system, no matter where a person lives, if they cannot afford the full charge, the system ensures that they are left with a standard amount for their personal expenses, and a nationally set amount of capital.

Topping up first emerged as an issue following the *National Assistance Act 1948* (Choice of Accommodation) Directions 1992. The Directions provide that a local authority, when placing a person in residential accommodation, must make arrangements for that person at the place of his/her choice within England and Wales (called *preferred accommodation*), subject to certain conditions. These are that s/he has indicated his wish for preferred accommodation; that the local authority considers the accommodation to be suitable for that person; and that the cost of the preferred accommodation does not require the local authority to pay more than it would usually expect to pay, having regard to the person's assessed needs.

⁷⁵ Department of Health Circular LAC (92) 27 had said that liable relatives and residents themselves could "top up" but a later Circular LAC (98) 8 said that the Department of Health considered that the current legislative framework did not allow residents to top up from their own resources the cost of more expensive accommodation.

⁷⁶ Department of Health, *Topping Up By Residents In Residential Care/Nursing Homes To Pay For More Expensive Accommodation*, deposited in the House of Commons Library, 31 July 1998

The Directions make no provision for a resident to make up the difference in cost from their own disregarded resources or personal expenses allowance. They only allow for local authorities to arrange more expensive accommodation than they would usually expect to pay if a third party can make a contribution towards a person's *preferred accommodation*. This provision does not apply where the third party is a liable relative.

These Directions do not apply if the local authority itself decides to place a resident in more expensive accommodation because, for example, there is no suitable accommodation available at that particular time. A local authority cannot insist that a third party contributions be made in these circumstances.

In a consultation document issued in 1996, the previous Government considered whether there should be a change in the topping up rules and also drew up a draft Bill with a clause on the provision of accommodation costing more than the local authority's usual limit.⁷⁷ The consultation document described the existing situation, taking the view that current legislation did not allow topping up and said:

However, as a result of the increase to £10,000 in the amount of capital totally disregarded by the means test,⁷⁸ some residents will have substantial sums of capital at their disposal which will never be taken into account by the means test. Some will have still more if a partnership scheme is introduced.⁷⁹

Against that background, there may be a case for changing the legislation to allow residents to use any capital they have which is wholly disregarded by the means test ... to make up the difference in cost between the care which their local authority is prepared to arrange and the care they themselves choose.⁸⁰

The present Government's view is contained in the Explanatory Notes to the current Bill:

Under the new arrangements - the three month disregard and the charges scheme - greater numbers of people will be effectively supported by the local authority and many of these people will have some resources. It would be perverse and unpopular to state that people have to go into a cheaper home for the first three months of their care where after this period they will be paying the full cost of their care. Equally, it would be difficult to justify a situation where individuals whose basic care costs were being met by the local authority through a charge against their property could not choose their preferred home and contribute extra resources towards it. [Paragraph 240]

⁷⁷ Department of Health, *A Consultation Draft Of A Community Care (Residential Charges) Bill*.

⁷⁸ This lower limit was raised from £3,000 to £10,000 in April 1996.

⁷⁹ This was a proposal for a scheme with the insurance industry that would entitled those who took out relevant policies to keep more of their own capital. It was never introduced and the present Government rejected the idea soon after it came to power (HC Deb 330 July 1997 c 341W)

⁸⁰ Department of Health, *A New Partnership For Care In Old Age*, Cm 3242, May 1996 Paragraphs 6.2 - 6.5

2. The Bill

Clause 53 provides that Regulations may make provision for residents and others, including liable relatives, to make additional payments for meeting all or part of the difference in cost between the actual cost of the accommodation and what the local authority would normally expect to pay for a person with the assessed needs of the resident. It also provides that Regulations may specify the resources on which the resident can draw.

G. Cross border placements

[Clause 55]

1. Background

The Explanatory Notes to the Bill say that existing legislation does not allow local authorities in England and Wales to make and pay for residential care placements in Scotland, Northern Ireland, Channel Islands or the Isle of Man.

2. The Bill

Clause 55 enables Regulations to be made to allow this and provides that the Regulations may specify conditions that have to be satisfied before a local authority may make such arrangements.

The Explanatory Notes say that the intention is to allow people needing residential care to have care closer to their families when their families have moved away.

H. Direct Payments

[Clauses 56 and 57]

1. Background

Direct Payments were introduced on 1 April 1997 under the *Community Care (Direct Payments) Act 1996*. The Act enables, but does not require, local authorities to make payments to individuals where the local authority would otherwise have provided services. The individuals then use the payments to buy themselves services equivalent to the ones that the local authority would have provided but from the independent sector. The Bill makes provision for Regulations that would require local authorities to make Direct Payments, subject to certain conditions.

There are various rules governing Direct Payments. For example, individuals are not compelled to receive them if they would prefer a service provided or arranged by the local authority; the payments cover most community care services but not long-term residential care; certain categories of people such as family members are excluded from providing services for which these payments may be made; and where a local authority makes a Direct Payment for a service it can "charge" for it by reducing the payment in a parallel way to the way that it would charge for a service that it provided or arranged.

Direct Payments are described in more detail in the Library Research Paper 00/10 on the *Carers and Disabled Children Bill*. That Bill is now an Act, which is due to come into force in 2001.⁸¹ The Act extends Direct Payments to services for carers (which the Act also introduces), to parents of a disabled child and to 16 and 17 year old disabled children. Direct Payments did not initially cover people over age 65 but have been extended by Regulations under the present Government to include this age group.⁸²

The present Government announced a review of Direct Payments on 24 April 1998. The Social Services White Paper published in November 1998 announced that the Government would be removing the age limit so as to make people aged 65 or over eligible for Direct Payments. It also referred to the possibility of making it mandatory for local authorities to offer such payments:

We will also be seeking to ensure that more authorities are offering this opportunity to service users in their areas. We will be conducting a further survey to see whether direct payments schemes are being offered, and to find out from those councils who have no plans for a scheme where the obstacles lie. If the case is strong enough, we will consider making it mandatory for all authorities to operate schemes, to ensure equity of opportunity across the whole country.⁸³

The NHS Plan mentioned Direct Payments in the context of abolishing *Preserved Rights*:

...We will also require councils to offer the option of direct payments to anyone who meets the prescribed conditions so that they have the opportunity to move out of residential accommodation and exercise more choice and control over the support they receive.⁸⁴

The Association of Directors of Social Services (ADSS) conducted a survey in summer 2000 into the prevalence of Direct Payments schemes. It received responses from all 171 local authorities in England and Wales. Its published results show that 80% of local authorities had introduced Direct Payments schemes. There was some regional variation,

⁸¹ HC Deb 21 November 2000 c 167

⁸² The Community Care (Direct Payments) Amendment Regulations SI 2000/ extending Direct Payments to people aged 65 or over came into force on 1 February 2000.

⁸³ Department of Health, *Modernising Social Services*, Cm 4169, November 1998

⁸⁴ NHS Plan, Volume II, as above Paragraph 2.31

the figure being 94% in London and 66% in Wales. The ADSS took the results as a good sign, saying that it was mostly the new, unitary authorities that had not yet introduced Direct Payments.⁸⁵

A report by the Department of Health's Social Services Inspectorate in October 2000 was more critical. The report, based on inspections from ten local authorities, said that most disabled people were still being offered services in a fragmented way, with no obvious consideration of whether services would promote independent living. The report said that schemes were taking off slowly but there was still ambivalence towards them some councils and staff.⁸⁶

2. The Bill

The Bill enables Regulations to be made in connection with requiring or authorising local authorities to make Direct Payments instead of services. The provisions enable Regulations covering the categories of people who are due to become entitled to Direct Payments entitled this year under the *Carers and Disabled Children Act 2000* as well as those already entitled. As now, the recipient's consent would be required. The Bill provides for the Regulations to cover various connected matters, such as circumstances where Direct Payments would not be required, for "charging", for misspent money etc. Clause 56 deals with services for adults and Clause 57 with services for children.

I. Responses to the Social Care Aspects of the Bill

The responses below are those received in the Library at the time of going to press.

BMA

The BMA's view is that the NHS should remain responsible for funding long term health care, including both medical and nursing care wherever this is provided. If individuals have to pay for this increased level of personal care it is akin to a tax on being sick. This is contrary to the ethos of the NHS.

Age Concern (Press Notice on Health and Social Care Bill)

Following the publication of the Government's Bill on Health and Social Care today, Age Concern England pledged to continue the fight for free personal care.

⁸⁵ ADSS Website: <http://www.adss.org.uk>, *Getting Going On Direct Payments*

⁸⁶ "Services To Aid Independent Living For Disabled People Are Too Fragmented", *Department of Health Press Notice 2000/0610*, 24 October 2000

The charity believes that in a move to enable older people to borrow against the value of their Home rather than be forced to sell to pay for their care, the Government has whitewashed the issue.

Gordon Lishman Director General of Age Concern England said: "The Government is continuing to dodge the issue of principle – that personal as well as nursing care should be free. The system will continue the anomalies about what is nursing care in a nursing home setting. Under the definition in the Bill if an ulcer is dressed by a nursing assistant under the supervision of a nurse it will still count as 'social care' and have to be paid for.

"The proposed loans system is being used as a smokescreen for the Government's decision not to implement the recommendations of the Royal Commission. It does not get away from the fact that older people still have to use the value of their home to pay for their care eventually. Indeed it means that people will need clear, independent advice about the pros and cons of the loans.

"The only fair and equitable way of providing long term care is by providing both free personal and nursing care."

Appendix: Summary of the Government's Response to the Royal Commission Recommendations, NHS Plan Volume II pages 8-9

Recommendations	Government Response
<p>1. Personal care should be available after an assessment, according to need and paid for from general taxation</p>	<p>The Government is making an unprecedented new investment over the next three years in improving older people's services making them more responsive and more fairly funded. The Government's investment would fund the cost of the Royal Commission's recommendation. However the Government, does not believe that making personal care universally free is the best use of these resources.</p>
<p>2. The Government should establish a National Care Commission</p>	<p>Broadly accepted in December 1999 with the announcement of a single National Care Standards Commission, now enshrined in the Care Standards Act 2000.</p>
<p>3. The Government should ascertain precisely how much money goes to supporting older people in residential settings and in people's homes</p>	<p>Any division between acute and long term health care spending would be somewhat arbitrary. The Government believes that it is more important to get the right incentives in the system to promote older people's independence and to provide care closer to home. This is what the proposals in the NHS Plan on intermediate care and associated services aim to do.</p>
<p>4. The value of the home should be disregarded for up to three months after admission to care in a residential setting and the opportunity for rehabilitation should be included as an integral and initial part of any care assessment</p>	<p>Both elements accepted in this response. Value of home will be disregarded for up to 3 months from April 2001, benefiting around 30,000 people a year.</p>
<p>5. Measures should be taken to bring about increased efficiency and improved quality in the system, including a more client centred approach</p>	<p>Accepted. Proposals in the NHS Plan for personal care plans and closer working between health and social care. Quality Strategy for Social Care to be published next month.</p>
<p>6. Other changes to the current system, such as changing the limits of the means-test, or making nursing care free (subsumed by recommendation 1)</p>	<p>Many suggestions accepted – free NHS nursing care from October 2001, benefiting around 35,000 people. Capital limits to be updated to restore 1996 value from April 2001, benefiting around 20,000 people.</p>

7. The resources which underpin the Residential Allowance in Income Support should be transferred to local authorities	Accepted – will be implemented from April 2002.
8. The Government should consider whether "preserved rights" payments in social security should be brought within the post 1993 system of community care funding	Accepted – will be implemented from April 2002, benefiting up to 65,000 people.
9. The Government's proposals on pooled budgets should be taken further, with pooled budgets being implemented nationally	Broadly accepted in the NHS Plan, with proposals for strengthening partnerships between health and social care.
10. Budgets for aids and adaptations should be included in and accessible from a single budget pool and Local Authorities should be enabled to make loans for aids and adaptations for individuals with housing assets	Accepted in principle for aids and minor adaptations. Potential for use of pooled budgets using Health Act 1999 flexibilities.
11. The system for making direct payments should be extended to the over 65s	Accepted and implemented from February 2000.
12. Further research on the cost effectiveness of rehabilitation and the development of a national strategy on rehabilitation	Accepted in principle. Research is being undertaken on cost effectiveness of rehabilitation, and the National Beds Inquiry and NHS Plan proposals on intermediate care provide the context for developing a national framework for rehabilitation.
13 and 23. Further longitudinal research is required to track the process and outcomes of preventive interventions	Accepted in principle. Work with the Office for National Statistics on proposal for a longitudinal survey of ageing.
14. It should be a priority for Government to improve cultural awareness in services offered to black and ethnic minority elders	Accepted as important in the NHS Plan and will be addressed as part of the National Service Framework for Older People. Reinforced for social care by project work with individual councils and inspection reports.
15. The role of advocacy should be developed locally, with backing from central Government	Accepted as important. Chapter 10 of the NHS Plan sets out our new proposals for patient advocacy services in the NHS.

<p>16. There should to be wider consultation on the provision of aids and adaptations and on what should be free and subject to a charge</p>	<p>Broadly accepted. New powers in Care Standards Act 2000 will enable statutory guidance to cover fairer charging arrangements for services provided at home.</p>
<p>17. Better services should be offered to those people who currently have a carer</p>	<p>Accepted in principle. Additional resources for carers' services provided in the Spending Review.</p>
<p>18. The Government should consider a national carer support package</p>	<p>Accepted, as above, and through the Government's National Carers' Strategy</p>
<p>19. The National Care Commission should be made responsible for making and publishing projections about the overall cost of long-term care</p>	<p>Agreed that this is an important task, but it is not central government's responsibility. The Department of Health has commissioned the Personal Social Services Research Unit at the LSE to make projections.</p>
<p>20. The Government should set up a national survey to provide reliable data to monitor trends in health expectancy</p>	<p>The Government agrees that a national longitudinal data may be valuable for measuring trends in health expectancy. Approval for this is being considered.</p>
<p>21. The Government should conduct a scrutiny of the shift in resources between various sectors since the early 1980s</p>	<p>The Government believes joint commissioning has developed significantly and that the new partnership arrangements (including pooled budgets) in the Health Act 1999 are also changing the allocation of resources and therefore remove the need for such scrutiny</p>
<p>22. A more transparent grant and expenditure allocation system should be established</p>	<p>Accepted. The Government intends to issue a Green Paper in September 2000 on improving the way funding is allocated to local government.</p>
<p>24. The Government should consider how the provision of care according to need would relate to Independent Living Fund provision for the personal care needs of younger disabled people</p>	<p>This recommendation relates to recommendation 1.</p>