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PRIME MINISTER

19 June 1989

SERVICES FOR THE MENTALLY ILL

In the debate on mental health, four points are clear.

- In theory, Enoch Powell's policy of closing down the large Victorian psychiatric hospitals was a good one. But in practice, resources released by closure have been used to boost the acute hospital sector. Money did not follow the patient.

- As a consequence, social services departments have been unable - and sometimes unwilling - to help. The homeless community has swollen. And it has been estimated that as much as one third of the male prison population could be regarded as psychiatric cases.

- To some organisations (notably MIND), mental illness can often be caused by poor social conditions. Consequently, they believe that all organised attempts to alleviate socially undesirable conditions may be considered part of community mental health. Psychiatry and drug therapy are then viewed as secondary.

- In this mode of thinking, the severe psychotic cases inevitably lose out. Malcolm Weller, consultant psychiatrist at Friern Barnet Hospital expanded on this point in last month's edition of the magazine Nature.

> "The fear of many community centres' personnel in the United States is that 'bad' patients may drive out the 'good'. Thus the psychotic are implicitly or explicitly excluded - partly because of their dishevelled appearance and social ineptitude, and partly because their illnesses are unremittingly chronic and provide little reward for therapists who like to see their patients improve."

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The decline in the quality of services for the worst cases needs to be tackled head-on. Local authorities have been unable to cope so far. I therefore believe that Kenneth Clarke's proposal to give responsibility to the NHS for arranging the social care of mentally ill patients who have been in hospital for 3 months or more, is the best solution.

The onus for the continued care of the most serious mentally ill cases (about 10% of the total) would then remain with the NHS.

RECOMMENDATION AND QUESTIONS

Accept Kenneth Clarke's proposals subject to some key questions:

- Would senile dementia be included in the 'three month rule'? If the social care of geriatric cases is included, the level of responsibility would expand enormously.

- What mechanism will be put in place to prevent health authorities discharging patients just before the 3 month deadline?

- Will NHS expenditure on health care and the social care of the mentally ill be ring-fenced to avoid the inevitable leakage?

- The Health Advisory Service ('HAS') was established in the wake of scandals. There are concerns that the HAS is now not as effective (Annex 1 of Kenneth Clarke's note). What is the progress of the Department of Health's review of HAS?

Ian Whitehead

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ANNEX A

TRANSITIONAL ARRANGEMENTS FOR SOCIAL SECURITY BENEFITS

Introduction

1. Ministers have agreed that in April 1991 there should be fundamental changes in the way public support is provided for people in residential care and nursing homes. They have also decided that the existing Income Support arrangements should continue to apply to existing residents. This paper deals with the preservation of existing entitlements and with other transitional issues; in particular the possibility of an increase in the take-up of Income Support in residential and nursing homes prior to the new "gatekeeper" being fully in place in April 1991.

Groups of residents and claimants involved

2. Various types of resident will be affected. The following groupings apply both to residential homes and nursing homes.

2.1 Existing claimants of Income Support on announcement day (over 155,000). Most are elderly but there are a number of younger, disabled or mentally ill people (about 20% of the total) whose preserved entitlements to Income Support could remain for many years.

2.2 Existing residents of eligible homes on announcement day who are not claimants at present but who have a title to Income Support were they to need it on income grounds; for example those currently living off savings.

2.3 Potential new claimants going to an eligible home for the first time after the announcement but before implementation of the new arrangements. This group includes those in newly created homes (eg residents of newly privatized LA accommodation).

2.4 New claimants post April 1991 including existing residents of homes seeking public support for the first time.

3. It is impossible to say how many of these residents would be receiving public support in a residential or nursing home under the new arrangements. The best available data (used by DSS Ministers in evidence to the Social

Services Select Committee) is that fewer than 7% of residents were judged as not needing residential care at the point of admission although a further 10% could have returned to or remained in the community if appropriate levels of support were available.

Existing Claimants at April 1991

4. Ministers have decided to make the transition as stable as possible by leaving the current Income Support system intact beyond April 1991 for existing claimants. The consequential decisions which Ministers now need to take are:

- whether entitlement to "preserved" Income Support should apply equally to other residents of eligible homes who at April 1991 are living there without public support.

- whether special rules need to be developed to stop any unusual increase in the numbers of claimants to Income Support prior to April 1991, due either to claimant behaviour or that of providers (including Health Authorities and Local Authorities).

Existing Residents at April 1991

5. Approximately 40% of the residents of homes rely on support from their savings or families and are not dependent on the state. Currently 5% of claims for the residential rates of Income Support are from people already in homes. The philosophy in Sir Roy Griffiths' report is that the care test should apply to all those needing public support for the first time, including those already in residential care. It would be consistent with this approach to treat existing residents as other new claimants; ie subject to the care test and eligible for "basic" Income Support and Housing Benefit.

6. There are arguments against this proposal:

i. Some existing residents might consider that their futures are made uncertain. To counter this, Local Authorities can be advised that they ought to show a strong prejudice in favour of leaving existing (possibly long-term) residents in familiar surroundings.

ii. When the present system of Supplementary Benefit (now Income Support) limits was introduced in 1985, the transitional protection provided for existing claimants was subsequently extended to existing residents on a discretionary basis. This sets a precedent, although under the old Supplementary Benefit scheme.

7. Against these considerations must be set the very significant practical difficulties of giving existing residents access to "preserved" Income Support. For entitlement to be established, and to prevent abuse, it would be necessary to have some sort of registration machinery or census to identify all residents in homes at the April 1991 changeover date. Social Security offices would need to identify these residents when they made a claim for Income Support and, having verified their entitlements, to allocate them to the "old" Income Support system. These would differ from the procedures needed to maintain existing claimants on preserved Income Support and, in effect, local offices would have to deal with three types of claimant in residential homes - existing claimant, existing resident, and post April 1991 resident - with consequent significant administrative costs. Moreover, extension of preserved Income Support beyond existing claimants would increase the incentive for people seeking residential accommodation before April 1991, (see paragraphs 12-16).

8. On balance, given that any hard cases will be within the remit of local authorities to sort out locally we recommend that continued income support entitlement should only apply to residents who are claimants at April 1991.

Potential New Claimants

9. The second issue is the possibility of an increase in the numbers claiming Income Support in residential care homes following the announcement but before its implementation, and whether anything could, or should, be done about it.

10. There are four separate factors to consider:

(1) Whether there is an incentive for potential claimants to go into residential care earlier than they might otherwise (ie before April 1991).

(2) Whether there is an incentive for residents already in homes to seek to claim Income Support before April 1991.

(3) Whether there is an incentive for private sector providers to expand provision to take advantage of the last few months of the present Income Support limits.

(4) Whether local authorities and health authorities will wish to bring forward the privatisation of provision.

11. Claimants. It is very difficult to gauge the effect on claimants with any precision. It is unlikely that claimants who genuinely need care will receive less public support under the new system, because the present system of limits will not carry over into LA care budgets. Claimants who did not genuinely need care would be better off now than after April 1991, though what research evidence there is suggests that very few move into a home purely on the basis of a financial calculation.

12. Residents. Some existing residents, or their families, might consider that they have an incentive to order their affairs so as to become entitled to Income Support prior to April 1991. Yet to do so would mean spending their money faster than they would otherwise; and there are already safeguards in the benefit system against deliberate deprivation of capital and shedding of income.

13. Private sector providers. The key question is whether, following the announcement of the Government's proposals, private home-owners will indulge in a dramatic short-term expansion of provision. Demographic change is already creating a burgeoning market. On the one hand, they will have no guarantee of future funding for unwarranted expansion to take advantage of the delay before implementing, particularly where they are not providing facilities that local authorities would want to use. Commercial caution might well hold them back. On the other hand, home-owners may judge that people will perceive the new arrangements as unattractive; indeed, the owners may seek to popularise this view to create a new market for residential places.

14. It is unrealistic to think of changing the rules for claimants or independent home owners since this would need legislation. There will be no time for primary legislation before the announcement. Secondary legislation to bring in benefit changes is subject to consultation with the Social Security Advisory Committee before laying and cannot of course be made retrospective.

15. The options for Government action therefore centre on getting the balance of Income Support entitlements right so as not to achieve undesirable incentives. Broadly these are:

(1) Allow all new eligible claimants who make a claim before the April 1991 changeover date entitlement to "preserved" Income Support post-April 1991.

(2) Make eligible claimants who claim after the announcement, but before the April 1991 changeover date, subject to the local authority care test after a period on "preserved" Income Support; they would then become new-style claimants.

The main practical issue is the ability of local authorities to deal sensibly and quickly with a tranche of people already resident in homes. The care test could not be introduced before April 1991. Local authorities will find it very difficult to deal with a substantial backlog of existing cases at the same time as they begin to assess new cases under the new rules. Possibly over 100,000 residents will claim IS for the first time between July 1989 and April 1991. To make their continued receipt of benefit subject to a care test would need primary legislation, which could be done by April 1991. However to attempt to withdraw benefit from a substantial number of existing cases would inevitably arouse strong opposition and could cause profound administrative and political difficulties.

16. Provided that existing non-claimant residents are not given access to preserved Income Support after the changeover date (see paragraph 7), and the majority of home owners act prudently, the announcement appears unlikely to change substantially the level of claims. Accordingly, on balance we recommend <u>that the preservation of income support entitlements applies to all new claimants who claim before April 1991.</u>

<u>Privatisations</u>

17. One effect of the announcement might be to encourage local authorities to bring forward privatisation of their own provision. The post-April 1991 arrangements will leave local authorities with a substantial incentive to dispose of homes. However, they are likely to receive more central Government support for each resident from the current Income Support scheme and the

preserved entitlements than from the new arrangements, given that they have to make a contribution to the funding of places under the new arrangements and that this will only be funded indirectly through rate support grant. Furthermore, early privatisation might also mean more help through the rate support grant for that particular authority.

18. However, such privatisation would be consistent with Ministers' general policy, reflected in their decision to leave the funding arrangements for local authority homes as they are now. Local authorities may in fact be constrained by their own planning mechanisms and political direction. The basic problem to be faced is that it would be difficult for Ministers to prevent local authority privatisations from being accelerated given that this would, in the normal course of events, be eminently desirable. To try and stop this would give some very conflicting signals.

19. Health authorities might also have an incentive to move "bed-blocking" patients out of long-stay hospital care and into private nursing homes before April 1991 in order to ensure that former patients will receive Income Support. NHS closure procedures and strategic planning systems may inhibit authorities who have not already thought of the idea from proceeding rapidly down this road in the time available. But the risk of significant transfers of patients to non-NHS accommodation remains.

20. Ministers are invited to agree that no action is taken on early privatisation.

Department of Social Security
June 1989

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ANNEX B

CONTROL OF HOUSING BENEFIT EXPENDITURE

Introduction

1. This paper discusses the control of Housing Benefit in residential care and nursing homes, now that Ministers have decided to use that benefit to meet the accommodation element of the charges for homes.

2. Housing Benefit is normally based on the actual rent charged by the landlord. There are powers (exercised by Local Authorities) to prevent benefit being paid on unreasonable rents and subsidy controls to ensure that they are used. Proper controls are needed both on public expenditure grounds and to prevent distortion to the "level playing field."

Existing Controls

3. Central government control of Housing Benefit expenditure is exercised through subsidy arrangements*. The alternative approach - to regulate expenditure through direct control of benefit levels - would be a departure from the subsidy-based approach and could weaken the local determined nature of Housing Benefit. We see no reason to make an exception for residential care and nursing homes, and the remainder of this paper is based on the assumption that overall control of expenditure will be through the subsidy mechanism.

* NOTE: Subsidy arrangements provide for the bulk of local authorities' benefit expenditure to be reimbursed to the basic (97%) rate of subsidy. For deregulated tenancies, in general no subsidy will be payable above a reasonable market rent figure determined by an independent rent officer. However a reduced rate of 50% is payable above the rent officers determination where the claimant is in a "vulnerable" group, which includes the elderly and the sick and disabled. For regulated tenancies, the basic rate of subsidy will be paid for rents which are below a threshold figure for each local authority's area. Benefit paid on rents which exceed the threshold is subsidised at 25%.

Issues

4. The present Housing Benefit system would be difficult to apply to residential homes without some modification. The basic problem is that the more discretion local authorities have to vary the eligible rent in a residential care or nursing home, the more temptation there will be to set rents high. This is because high rents mean more Housing Benefit subsidy; and an artificial "cheapening" of residential care as opposed to domiciliary care would be subsidized through Housing Benefit. The "level playing field" necessitates that the Income Support and Housing Benefit entitlement of someone in residential care should ideally be the same as if they were receiving domiciliary care. Giving even a reduced rate of subsidy on higher rents in residential care and nursing homes could distort this.

5. One approach would be to use Rent Officers to police this system, though there would be difficulties with this because they have no experience in assessing the relative weight of "care" and "accommodation" in the charge. A possibility would be to let the home owners sort this out (leaving rent officers only to assess whether the accommodation element is reasonable), but making the distinction is very much a matter of judgement. Home owners have an incentive to up the accommodation element so that their home would seem cheaper to the local authority.

6. An alternative would be to base benefit on notional rents; rents set not with regard to the actual charge levied by homes but with regard to some measure of rents elsewhere in the market. This would ensure that the playing field was as level as possible, and provide a highly effective limitation on Housing Benefit expenditure.

7. Ministers have already ruled out an approach where amounts are prescribed centrally. An alternative approach would be to express the notional rent in terms of some measure of the average rent met by Housing Benefit in the relevant area. The definition would have to be drawn fairly tightly (for example, with reference to the average rent on a particular recent date) and we would have to involve the auditors in ensuring that local authorities had proper systems in place to make the calculation. Subject to consultation with the Audit Commission and the Accounts Commission in Scotland, this could be done.

8. The most appropriate analogue needs further consideration. The Local Authority Associations will have to be consulted over the necessary changes to the Housing Benefit regulations.

9. The notional rent would vary automatically with reference to the local authority area in which the residential home was, not with reference to the authority responsible for care (either a different tier authority or a completely different authority). The variations would be much more sensitive than the very limited regional variations in the current DSS limits on Income Support; in particular they would better reflect the true cost of providing residential care in London.

10. Notional rents will ensure adequate control over expenditure both because they would act as fixed sums above which benefit could not be paid; and because if the notional rent is based on other rents met through Housing Benefit, it will itself reflect the controls imposed on other parts of the rented sector (eg the rent officer arrangements).

11. Minor amendment to the 1986 Social Security Act may be needed to provide for the fact that rent for these purposes would no longer have any relationship with the actual charge levied by the owner of the dwelling. This could be incorporated in the 1989-90 Social Security Bill.

12. The level of rent allowed for Housing Benefit purposes has a clear and direct impact on the amount of money available for transfer from DSS to the health votes; and on the future division of expenditure between DSS and LAs. These sums are for settlement in next year's Public Expenditure Survey; and there is therefore no need for the actual analogue to be settled in time for the public announcement.

Conclusion

13. The use of notional rents appears to offer a promising way forward, though it will clearly need more study. Ministers are invited to agree in principle that this approach should be adopted, subject to the satisfactory resolution of any new difficulties that may emerge in the necessary further work.

Department of Social Security

June 1989

ANNEX C

COMMUNITY CARE: SPECIFIC GRANTS

Paper by the Department of Health

At its meeting on 18 May the Prime Minister's Group decided against a general specific grant, on the basis that Government support for community care expenditure by local authorities should be provided through Revenue Support Grant. The Group concluded that there might be a case, however, for targeted specific grants designed to influence local authority decisions in particular areas where a good case could be made out. The possibility is to be further considered, and this note suggests areas in which targetted grants could be beneficial in securing outcomes that would otherwise happen too slowly, too patchily, or not at all. Three such areas are identified:

- home care
- encouraging the independent sector
- support for mentally ill people.

Home Care

2. Reports of the Social Services Inspectorate have exposed the magnitutde of the task faced by social services departments in turning existing services (home helps, meals on wheels etc) that tend to be spread very thinly, into more intensive services targetted on individuals who might otherwise have to leave their homes and enter residential care.

3. Although the new funding structure for residential care should give local authorities a financial incentive to target home care on those most at risk of going into residential homes, they will face powerful pressures the other way eg, a local political desire not to reduce the present number of recipients of some sort of service, however thinly it is spread. Also, considerable inertia is built into existing structures, focusing on services (eg home help, meals on wheels) rather than individuals' needs.

4. These services are large (costing some £700m per year and serving about three quarters of a million people) and are central in meeting the objective of enabling people to live in their own homes for as long as possible.

5. The key objective of a specific grant would be:

- to target mixed "packages" of home care services on those most likely to be at risk of having to resort to residential care.

In order to achieve this, SSDs would have to demonstrate their willingness:

- to redeploy some of the existing, thinly spread services;

- to improve the means by which they address home care needs, putting the client's and carer's interests first and tailoring services (including the provision of respite for carers) to meet them.

6. Specific targets could include

- increasing the average number of hours of help for the most highly dependent clients;

- reducing the publicly financed residential care population while allowing for demographic change;

- providing more help for carers;

- establishing necessary quality controls.

7. A grant of £60 million per year over 5 years to support expenditure of £120m per year on certain home care services (eg weekend supply of meals, home helps, increased voluntary support) and on improved case management. The grant would be payable on condition that the SSD had adequate targets, and was implementing them satisfactorily. Its availability could significantly increase the likelihood of the necessary steps being taken uniformly across the country, and with due speed.

Encouraging the independent sector

8. Moving to an "enabling role" will be a major challenge for SSDs. They will need to develop new skills in purchasing, including contract management. They will need improved budgetary, information, and quality assurance systems.

9. Again, the changes as a whole should give SSDs some incentive to meet those needs. In practice, given the varying responses and capacities of authorities, progress is likely to be patchy, and in places hesitant.

10. A specific grant would provide an opportunity to ensure that every authority addressed these needs with due urgency and commitment. £10m per year over five years, to support expenditure of £20m, payable on similar conditions to the home care grant, would provide an additional incentive to SSDs to address the means by which they would secure greater diversity of provision.

11. Key targets might include

- annual increases in the contribution of the voluntary sector;

- increasing numbers of contracts with the private sector;

- demonstrable evidence that quality assurance and management information systems were in place and working satisfactorily.

Mental Illness

12. If local authorities continue to have any responsibility for the social support of people unable to live independently as a result of mental illness, measures will be needed to ensure that that responsibility is carried out more effectively than at present.

13. The preponderance of medical and nursing care in support of mentally ill people in the community, and other high priority demands on SSDs, tend to result in poor levels of social services for the mentally ill. The changed financial structure will not directly address this issue, and there is a risk that SSDs will continue to give the needs of mentally ill people low priority.

14. The purpose of a specific grant would be to prevent that happening by giving SSDs an incentive to ensure that their services were adequate, in collaboration with health authorities, and recognising the predominant part played by health services in care of the mentally ill. A grant of £30m per year over 5 years, to support £60m of expenditure, payable on conditions similar to the other grants, could significantly re-direct LA priorities towards an area of specific Ministerial and public concern.

15. Specific targets could include

- measurable increases in the services available to seriously mentally ill peole in the community (eg numbers of drop-in centres and other forms of day care and advice);

- agreed, funded plans with health authorities to cope with effects of hospital closures;

- measurable increases in support for informal carers.

The alternatives

16. Without the leverage afforded by specific grants, Government's ability to influence LAs priorities and activities is extremely limited. LAs can in theory be required to act in accordance with circulars issued by the Secretary of State, and the Social Services Inspectorate can exert some pressure on authorities to adopt good practice. Audit Commission reports can similarly check on the economy, efficiency and effectiveness of services in relation to statutory requirements and government objectives.

17. Although these instruments can be used to exert some influence, experience of the targetted grants for training introduced recently has shown that they can be much more effective in stimulating action when encouragement and persuasion have failed.

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ANNEX D

COMMUNITY CARE: POWERS AND CONTROLS

Paper by the Department of Health

Introduction

1. Following the decisions taken at the Prime Minister's meeting on 18 May, this paper discusses:

- the shaping of local authority powers and duties
- planning and monitoring arrangements
- registration and inspection of homes

The paper addresses legislative requirements under each of those headings.

SHAPING LA POWERS AND DUTIES

2. Existing LA powers and responsibilities are variously expressed in a large number of enactments (a detailed account is in the Annex) and it might be argued that this, coupled with a comprehensive White Paper and detailed guidance would be sufficient to achieve Ministers' aspirations. A minimal change approach of this sort would simplify the legislative programme and avoid explicitly raising expectations that new services were to be provided.

3. Against this, existing powers and responsibilities are dispersed, vague and couched in general terms. They do not achieve the central Griffiths objective of delineating responsibilities unambiguously, nor have they been effective in delivering a coherent policy up to now. Unless local authority powers and responsibilities are expressed statutorily in ways which fit the new approach, there will be reason to doubt whether authorities will respond as they should.

4. Such an approach would require primary legislation explicitly to place a responsibility on LAs, in consultation with others as necessary, to arrange for the assessment of the care needs of individual applicants and keep them under review; to determine whether those needs can best be met by support at home or care in a residential setting; to take account of whether an individual or his/her carers can make a contribution towards the cost of those services; to make arrangements for packages of service to be provided; and to meet the cost of that care, with regard to the ability of individuals to pay and the availability of public funds.

5. Apart from the legislative change proposed above, other changes would have to be in place on implementation day. LAs currently have no power to meet the care costs in residential settings of elderly people in receipt of benefits; neither are they able to top up the care costs for elderly people whose income level is too high to

qualify than for benefit support, but who cannot afford the cost of residential care in full. Both these changes would require primary legislation.

6. Ministers will wish to consider how far they wish to make their legislative intentions clear in the July statement, and what they would prefer to leave to discussion in the White Paper later in the year. It might be sufficient to say in the statement that the legislative proposals would be spelt out in the White Paper.

PLANNING AND MONITORING ARRANGEMENTS

7. Sir Roy Griffiths argued for a systematic and comprehensive approach to LA planning systems and monitoring their performance, linked explicitly to his recommendation of a substantial general specific grant towards the cost of community care. Ministers have effectively rejected this approach along with the general specific grant. There are also, as mentioned in the separate paper on specific grants, other mechanisms available - ie guidance and circulars, SSI and the Audit Commission. However, these compliment rather than replace the Government's objectives of focussing on and controlling policy development and direction, for example in the areas of diversity of service provision, promoting better management and delivery of home care, developing case management, and strengthening the voice of consumers.

8. Any targeted specific grant programme would require clear arrangements for objective setting and monitoring of performance. On top of this, however, it can be argued that the enhanced role that Government is awarding to local authorities caries a commensurate responsibility for accountability; and also that the Government needs to meet the frequent criticism that its control of its own community care policy is imperfect, leading directly to the off-quoted patchy levels of performance across the country. All this implies some emphasis on developing local information systems; requiring local authorities to be explicit and systematic in, at least, producing statements of objectives and priorities, and collaborating with health authorities and other agencies to do so; and developing the role and ability of SSI to monitor these developments.

9. Ministers will wish to consider:

- whether they wish to ask LAs to produce community care plans, including specific objectives and targets, in consultation with health authorities, voluntary bodies etc

- whether they wish those plans to be open to inspection by the Social Services Inspectorate; and

- whether they wish to be able to call for reports from a LA on specific or general community care issues for which it is responsible

The second and third, at least would need toa be included in legislation. The first might be the subject of guidance, or could be a statutory requirement.

REGISTRATION AND INSPECTION OF RESIDENTIAL CARE AND NURSING HOMES

10. Monitoring of standards in residential care and nursing homes was raised by Sir Roy Griffiths and by the committee chaired by Lady Wagner which reviewed residential care. Mr Clarke outlined his views on handling these issues in his minute of 28 April.

A Unified System for Registration and Inspection of Residential Care and Nursing Homes

11. At present local authorities are statutorily responsible for registering and inspecting private residential care homes. Health authorities have parallel responsibilities for registering and inspecting private nursing homes.

12. Sir Roy Griffiths recommended bringing the two systems together under LA control. This would logically follow a decision to make LAs responsible for assessing needs for such care and meeting care costs.

13. Against this, medical and nursing interests, and private nursing home proprietors, are likely strongly to resist transfer of the existing health authority functions to LAs.

14. Also, there has been pressure to create an independent national inspectorate for residential care homes, and any change in responsibilities is likely to bring that issue to the fore, as well as raising questions about the extent to which the NHS has a responsibility for providing residential nursing care, where it is needed.

15. For all these reasons, Ministers may conclude that both the statement and the White Paper should propose leaving the existing structures in place, while not ruling out the possibility of change in the longer term.

An Even-handed Approach to Inspection of Homes in the Public and Independent Sectors

16. LA homes, unlike private and voluntary homes, are not subject to independent inspection. This, together with scandals in some LA homes had led to demands for a system that treats all homes alike (reflected in the Wagner report) and also to pressure for a national inspectorate.

17. A national inspectorate would be seen to be independent and would meet the Wagner recommendation that LAs should not inspect their own homes. It could also help in applying reasonable and uniform standards across the country. But it would mean setting up a new inspectorate, with its own overheads, that could lead to public

pressure for increased spending on homes. No form of inspection is an adequate substitute for effective day-to-day management and supervision, which should be the primary safeguard against poor standards and abuse of residents.

18. Officials have been considering ways of creating within the present statutory framework an even-handed approach to inspection of residential homes in the public and independent sectors. DH Ministers are currently considering proposals. Depending on the outcome, it might be possible to announce in the community care statement an intention to bring forward proposals for this purpose.

19. In essence, these proposals, which build on work by the Social Services Inspectorate, would entail:

- the introduction of an independent element into LAs inspection processes;

- extension of those processes to LA homes;

- continuing external oversight nationally by the Social Services Inspectorate.

The cost of the changes might be about £5m per year. Primary legislation would not be required. More radical change need not be ruled out: indeed, Ministers may wish to say that they will be keeping registration and inspection issues under review while the main post Griffiths changes are implemented.

LOCAL AUTHORITY SOCIAL SERVICES DEPARTMENTS: STATUTORY POWERS AND RESPONSIBILITIES

1. GENERAL

NATIONAL ASSISTANCE ACT 1948

Section 21-26: Confers a duty on LAs to provide residential accommodation for old, infirm and others in need of care and attention, normally resident in their area, with approval of and direction of Secretary of State. Where accommodation is provided LA must fix standard rate of charge to be paid. If person unable to pay amount can be reduced by LA to minimum set by S of S.

Authorities can provide accommodation themselves or make arrangements with voluntary bodies or persons registered under Registered Homes Act 1984.

Section 29-30: Gives LAs power to promote welfare of blind, deaf, dumb and other disabled or handicapped with approval of and direction of S of S. Their duty to exercise these powers in relation to residents in their area, covers provision of instruction re overcoming disability:

- workshops and training for work
- recreational facilities
- compiling and maintaining classified disabled register.

Section 36: Where LA fails to discharge any of their functions under the Act, or fail to comply with regulations, the Minister may make an order declaring authority to be in default. Authority must then remedy default in time specified in the order. If authority fails Minister may then make fresh order transferring authority's functions to himself.

Section 43-45: Where residential accommodation is provided LA may make application for costs to be met by person liable to maintain the person assisted, or may recover expenditure where there has been misrepresentation.

Section 47: Enables LA to apply for an order to remove person to a suitable hospital, or other place, if person incapable of looking after themselves and no-one else available to look after them. NB: Power conferred on District Council + London Boroughs.

Section 48: Lays duty on LA to safeguard moveable property of persons admitted to hospital or Part III accommodation. Includes right of access to persons residence and provision for recovery of expenditure occurred in relation to this duty.

HEALTH SERVICES AND PUBLIC HEALTH ACT 1968

Section 65: Enables LAs to give assistance by way of grant or loan to voluntary organisations.

NHS ACT 1977

Section 21 & Schedule 8: Provision of home helps and laundry facilities to elderly, mentally ill etc.

Section 22: LAs to co-operate with HAs and FPCs in promotion of welfare. Set up Joint Consultative Committees and engage in joint planning.

Section 28: Duty of LA to provide HAs with social workers necessary to enable HAs to discharge their functions under this Act.

2. DISABLED

NATIONAL ASSISTANCE ACT 1948

Section 41: States that County Councils will be registration authority for charities for the Disabled.

DISABLED PERSONS EMPLOYMENT ACT 1958

Section 3: Gives LAs power to provide facilities for registered disabled to be employed in or work on their own account as well as training for employment, with approval of and direction or S of S (for employment).

CHRONICALLY SICK AND DISABLED PERSONS ACT 1970

Section 1: Confers duty on every LA to find out the number of persons affected by their welfare provisions (Sect 29 of Nat Assist Act 1948). Also they must publish information as to services available and advise people of services relevant to their needs.

Section 2: Confers duty on every LA, where it assesses a need for services, to provide various facilities under Sect 29 of NA Act ranging from practical assistance in the home, to recreational facilities, to adaptation of premises, to supply of telephones, TVs etc. [List of facilities given in Act over 13 items]

DISABLED PERSON (SERVICES, CONSULTATION AND REPRESENTATION) ACT 1986

[NOTE: Sect 1-3 not yet in force]

Sections 1-5: States LAs shall permit authorised representatives of disabled people to act in connection with requests of provision of LA services etc. LAs shall deal with representatives as required unless they deem it to be harmful to the interests of the disabled persons. Requires assessment of needs for services to be made by LA and representations to be made by person or representative. Where disabled person leaves special education LA must assess needs.

Section 8(1): Where a person is living at home and looked after substantially on a regular basis by a carer LA shall have regard to ability of carer to continue providing this service when assessing if person needs LA services.

3. MENTAL DISORDERS

MENTAL HEALTH ACT 1959

Section 8: Enables LAs to provide residential accommodation for care or aftercare of mentally disordered people under para 2 of Schedule 8 to NHS Act 1977 and provides that Section 29 of 1948 Act applies to mentally disorderd people.

CHRONICALLY SICK AND DISABLED PERSONS ACT 1970

Section 18: Requires LAs to provide information to S of S of numbers of people under age 65 suffering from mental illness or disorder or handicap for whom residential accommodation provided in homes for over 65s.

NHS ACT 1977

"Schedule 8 para 2 - Confers powers on LAs to make arrangements subject to S to S approval and his directions to provide accommodation and services for the prevention of illness and the after care of people suffering from

illness. In LAC 19(74) approval was given to a number of services for mentally disordered people. A direction in that circular obliges authorities to make available for those people residential accommodation, training and occupational facilities, social work and certain other provision. LAC (74)28 gives blanket approval for services for a loosely defined group of sick people [ie it is not confined to people with mental disorders].

MENTAL HEALTH ACT 1983

Section 116-117: The authority to arrange visits to patients and on leaving hospital to provide necessary services in co-operation with DHA or voluntary organisations.

DISABLED PERSONS (SERVICES, CONSULTATION AND REPRESENTATION) ACT 1986

Section 7: Where a person is discharged from hospital after continuous stay of 6 months LA to make arrangement for needs assessment under welfare enactments unless person requests otherwise. Co-operation with HA essential. [Not yet in effect]

5. ELDERLY

HEALTH SERVICES AND PUBLIC HEALTH ACT 1968

Section 45: LA may make arrangements for promotion of welfare of vulnerable old people as per Section 21-26 and 29-30 of Nat Assist Act 1948. S of S approval given in Circular No 19/71 to making of arrangements for purpose mentioned in para 4 of circular to meet needs of elderly.

HEALTH AND SOCIAL SERVICES AND SOCIAL SECURITY ADJUDICATIONS ACT 1983

Section 17: Enables authorities to recover reasonable charges in respect of services provided under Sect 29 of 1948 Act, Sect 45(1) of 1968 Act, Schedule 8 to NHS Act 1977 & Sect 8 of Residential Homes Act 1980 & Para 1 of Part II of Schedule 9 to that Act.

NB. Legislation applying to disabled applies to elderly where they are disabled.

6. OTHERS

SUPPLEMENTARY BENEFIT ACT 1976

Schedule 5: Paragraph 2 of Schedule 5 gives S of S power to require social service authorities to exercise on his behalf functions of providing and maintaining resettlement units.

PUBLIC HEALTH (CONTROL OF DISEASE) ACT 1984

Section 46(2): LA may cause to be buried of cremated body of dead person resident in Part III or hostel accommodation.

Section 46(5): Allows LA to recover cost from the estate or liable relative.

REGISTERED HOMES ACT 1984

Local social service are the registration authorities for residential care homes and given powers of inspection and cancellation of registration.

HOUSING ACT 1985

Sect 71: Local housing authority may request social services authority to exercise functions regarding homeless or potentially homeless people, authority must co-operate as is reasonable.

Circulars

National Assistance Act 1948

Section 21: S of S approval and direction - DHSS circular No 13/74

Section 29: S of S approval and direction - DHSS circular No 13/74

Section 47: DHSS Circular No LASSL (78)18

HEALTH SERVICES AND PUBLIC HEALTH ACT 1968

Section 45: DHSS Circular No 19/71

NHS ACT 1977

Section 28 A - DHSS Circulars LAC (83)5, LAC(84)8

CHRONICALLY SICK AND DISABLED PERSONS ACT 1970

Section 1: DHSS Circular No 45/71

DHSS Circular No 69/71

DHSS Circular No LAC(87)6

REGISTERED HOMES ACT 1984

DHSS Circulars No's LAC (84)15, LAC 86(6) and LAC (88)15

DISABLED PERSONS (SERVICES, CONSULTATION AND REPRESENTATION) ACT 1986

Section 5 - DHSS Circular LAC(88)2

Section 8 - DHSS Circular LAC (87)6 (part vi)

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NHS ACT 1977

Schedule 8 para 2 DHSS Circular No 19/74

DHSS Circular No (74)28

Mental Health Act 1983

Section 114-115: DHSS Circular No (86)15

HASSASSA ACT 1987

Section 17 - DHSS Circular No LAC (84)7

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