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Care Bill [HL]

Bill No 123 of 2013-14

RESEARCH PAPER 13/71 11 December 2013

The *Care Bill* would consolidate existing legislation for adult social care in England into a single framework, and introduce reforms to the way care and support is accessed and funded. It also includes reforms to the regulation of health services and care standards, and would establish Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental public bodies.

The Bill was introduced in the House of Lords. This paper has been written for its Second Reading debate in the House of Commons on 16 December 2013.

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Summary

The *Care Bill* was introduced in the House of Lords as HL 1 and had its First Reading on 9 May 2013. The Bill had its First Reading in the House of Commons as Bill 123 on 30 October 2013.

The Bill includes provision for:

- A new legal framework for the provision of adult social care and support in England (Part 1)
- The reform of quality and safety regulation for healthcare providers, providing the Government's main legislative response to the recommendations of the Francis Inquiry into the failings at Mid-Staffordshire Foundation Trust (Part 2)
- The Establishment of Health Education England (HEE) and the Health Research Authority (HRA) as non-departmental public bodies (Part 3)

Part 1 of the Bill would consolidate existing legislation for adult social care in England into a single framework, and introduce reforms to the way care and support is accessed and funded.

The Bill would place broad duties on local authorities in relation to care and support, focusing on the promotion of 'individual well-being'. Duties would also be imposed on local authorities to

- prevent care and support needs arising;
- promote the integration of care and support services with health services;
- promote diverse and quality care services; and
- to co-operate with relevant partners, such as local NHS bodies, in providing care and support.

The Bill would provide for the assessment of adults who may be in need of care and support and what should happen once an assessment had been completed, such as the creation of a care and support plan. It would also provide for the assessment of carers' needs for support and relevant next steps. It would stipulate that care and support must be maintained when a person receiving those services, and their carer if appropriate, move from one area to another.

The Bill would provide the basis of a system for charging for care, including a new cap on care costs. It would also introduce a legislative basis for personal budgets for social care, and independent personal budgets for people whose care and support needs are not being met by a local authority.

The Bill would set out conditions under which direct payments for social care services could be made, and also for deferred payments for social care, through which people would not have to sell their home to pay for care in their lifetime.

The Bill would introduce a statutory framework for adult safeguarding from neglect or abuse, including the establishment of Safeguarding Adults Boards, which would conduct reviews of cases of serious abuse or neglect involving an adult, including where the adult concerned has died.

The Bill would require that providers of care and support services would be considered to be exercising a public function under the *Human Rights Act 1998*, meaning that all care and support providers who are regulated by the Care Quality Commission would be required to act in a way that is compatible with the *European Convention on Human Rights*.

The Bill would create a statutory duty for local authorities to ensure that an adult's care and support needs, and the support needs for a carer, are met if the business providing them fails. It would also introduce a new regime of market oversight, operated by the Care Quality Commission, to monitor the financial position of the most 'difficult to replace' care providers in England and inform the relevant local authorities when a provider is likely to fail.

The Bill would include provision for local authorities to assess the care and support needs of children and their carers, and also young carers, who may need support after they turn 18, to facilitate the transition to adult social care.

Part 2 of the Bill would allow for the introduction of an "Ofsted-style" rating system for hospitals and care homes, create a single regime to deal with financial and care failures at NHS hospitals, introduce a duty of candour for health and social care providers and make it a criminal offence for care providers to give false and misleading information about their performance.

Part 3 of the Bill would establish Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental bodies (NDPBs). These measures are intended to strengthen the independence of the two recently created bodies, which lead national systems for the education and training of health care professionals and that regulate health and social care research respectively.

1 Introduction: Social care reform in the face of an ageing population

The impact of demographic change, including an expanding and ageing population and changes in the willingness of family members to provide informal care for elderly relatives, has placed a strain on social care services and resulted in an increased demand for residential care.

Successive Governments have published a number of policy documents seeking to address the challenges for social care posed by a changing and aging population. The Library standard note *Social Care Reform: Funding for the Future*,[1] provides detail on developments under the previous Labour Government and in the build-up to the 2010 General Election.

Projections of the elderly population with health needs up to 2030 have been produced based on the University of Kent's Personal Social Services Research Unit (PSSRU) model and another micro-simulation model known as CARESIM. The table below shows estimated projections for those with formal and informal care needs.

Older adults in England with care needs (thousands): 2010 and 2030

	2010	2030	% change
Informal care	1,900	3,000	58%
Formal care:	1,945	3,175	63%
Formal non-residential care	1,600	2,600	63%
Residential care	345	575	67%

Source: Wittenberg et al, 2011

1.1 Developments under the Coalition Government

In the 2010 Queen's Speech, the Government acknowledged the need to reform the current care system and announced plans to set up a commission to consider long term funding for social care:

> The Government recognises that urgent reform of the social care system is needed to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face. This is one of the biggest challenges faced by society today.
>
> The Government will establish an independent Commission to consider how we ensure responsible and sustainable funding for long-term care. It will ensure that there is a fair partnership between the state and the individual, which takes into account the vital role of families and carers. The commission will report within a year.
>
> The Government will also take decisive steps to accelerate the pace of reform so that older people and disabled people get the care they need and have more choice and control over how their needs are met. The Government will take steps to accelerate the pace of reform so that older people and disabled people get the care they need, ensuring:
>
> - services are personalised to individual needs, with personal budgets offered by all councils giving people choice and control over how their needs are met;

[1] SN/SP/6391

- preventative support is given to people when they most need it, such as after discharge from hospital, with health and social care working together to help people stay independent at home;

- carers are helped to provide care and support for friends and family members, with direct payments and other support for their own needs as well as those they care for.[2]

The intention was repeated in the Coalition programme document:

> We will establish a commission on long-term care, to report within a year. The commission will consider a range of ideas, including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a partnership scheme as proposed by Derek Wanless.[3]

The Coalition Government's proposals for reforming the adult social care system have been informed by two independent social care reviews. The first review, by the Law Commission, examined reforms to social care legislation.[4] The second report, by the Care and Support Commission, was commissioned by the Government to explore options for funding social care in the future.[5] .

Law Commission report: The legislative framework for social care

The legislative framework for social care has developed piecemeal since the enactment of the *National Assistance Act 1948*. Many provisions of that Act are still in force and underpin the provision of residential and non-residential adult social care services. Following a scoping project in 2008, the Law Commission announced its intention to consult on proposals to reform what was regarded as an outdated framework for adult social care.

The Law Commission's consultation report, published in May 2011, recommended a wholesale overhaul of the current fragmented social care system and the enacting of a single social care statute.[6] The report recommended the consolidation of existing law into a single, unified statute for adult social care:

> 3.2 The legislative framework for adult social care is a confusing patchwork of conflicting statutes, built up over the past 60 years. There is no single modern statute to which local authorities, service users, carers and others can look to understand whether services can or should be provided. The consultation paper proposed that the best way to achieve a simple and consistent legal framework would be to introduce a unified adult social care statute. This would mean that the existing provisions under which adult social care is provided would be consolidated and reformed into a single piece of legislation. This includes the relevant provisions in the National Assistance Act 1948, the Chronically Sick and Disabled Persons Act 1970, the NHS and Community Care Act 1990 and carers' legislation.[7]

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2 Queen's speech- social care, Tuesday 25th May 2010

3 HM Government, *The Coalition – Our programme for government*, May 2010; Sir Derek Wanless, *Securing Good Care for Older People*, March 2006

4 The Law Commission, *Adult social care report*, (Law Com No.326), May 2011

5 Care and Support Commission, *Fairer Care Funding – The Report of the Commission on Funding of Care and Support*, July 2011

6 Law Commission, *Adult social care*, May 2011

7 *Ibid.*, p8

A Government response to the Law Commission report was published in July 2012, as one of a series of documents published alongside the draft *Care and Support Bill*.[8]

Dilnot report on social care funding

The Care and Support Commission, led by Andrew Dilnot, published its report[9] in July 2011 (the 'Dilnot report'). The Commission explained that while hosted by the Department of Health, it was independent of both the Department and Government. It was chaired by Andrew Dilnot, with Lord Norman Warner and Dame Jo Williams as fellow Commissioners.[10]

The Care and Support Commission reported the following key findings about the current state of the funding of adult care and support:

- The current adult social care funding system in England is not fit for purpose and needs urgent and lasting reform.
- The current system is confusing, unfair and unsustainable. People are unable to plan ahead to meet their future care needs. Assessment processes are complex and opaque. Eligibility varies depending on where you live and there is no portability if you move between local authorities. Provision of information and advice is poor, and services often fail to join up. All this means that in many cases people do not have good experiences.
- A major problem is that people are unable to protect themselves against very high care costs. The current availability and choice of financial products to support people in meeting care costs is very limited. There is great uncertainty and people are worried about the future.
- Most people are realistic about the need for individuals to make some contribution to the costs of care in later life, but they want a fairer way of sharing costs and responsibility between the state and individuals and they want to be relieved of fear and worry. There is consensus on the need for reform.[11]

In response, the Commission's main recommendations included:

- A cap on the adult social care costs any individual must pay (the Commission recommended a level of £35,000);
- Means-tested support to be introduced for those with greater means than is currently the case;
- That people should contribute a certain amount towards their general living costs, such as food and accommodation (recommended to be set between £7,000 and £10,000 per year);
- Standardisation of the system of deferred payments;

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8 Department of Health, *Reforming the law for adult care and support: The Government's response to Law Commission report 326 on adult social care*, 11 July 2012

9 Care and Support Commission, *Fairer Care Funding,* July 2011

10 *Ibid.*

11 *Ibid.*, p5

- A national eligibility criteria for care and support, set at the current 'substantial' level.[12]

The Commission estimated that while 'under the current system someone who has lifetime care costs of £150,000 could lose up to 90% of their accumulated wealth', their proposals (namely the combination of the capped cost model, with the cap set at £35,000, and the extended means test) would 'ensure that no one going into residential care would have to spend more than 30% of their assets on their care costs'.[13] Accordingly, the proposals, if adopted, would not mean that individuals would no longer have to sell their homes to pay for care. Those with assets of less than £100,000 (including property) would, however, qualify for state help, whereas currently the threshold is set at £23,250.

In terms of the cost of their proposals, the Commission stated that 'we estimate that our recommended changes to the funding system would cost from around £1.3 billion for a cap of £50,000 to £2.2 billion for a cap of £25,000'. The Commission's proposed cap of £35,000 'would cost the State around £1.7 billion'.[14]

The Library standard note *Social Care Reform: Funding for the Future*[15] provides more detail on Dilnot's proposals. Information on the current local authority means-tests for residential care funding is set out in the Library standard note, *Financing care home charges*.[16]

On presenting the Dilnot report to Parliament, the then Health Secretary, Andrew Lansley, said that the Government would be responding to the Law Commission and the Dilnot report in early 2012 when a white paper on reform would also be published.[17]

1.2 Social care white paper and the progress report on funding reform

The white paper was published on 11 July 2012, alongside a progress report on funding reform and a draft *Care and Support Bill*,[18] which would provide a draft framework to implement a number of the Law Commission's recommendations for legislative change.[19]

The Care and Support white paper

The *Caring for our future: reforming care and support*[20] white paper set out a number of actions the Government proposed to take to 'deliver a re-engineered care and support system that shifts resources towards prevention and early intervention'.[21] These included:

- Ending the current system of locally determined eligibility criteria for care by introducing a national minimum eligibility threshold by 2015. The standardising of eligibility criteria was one of the key recommendations made in the Dilnot report.[22] The white paper provides:

> In setting the level of the national threshold, the Government will need to review the eligibility position of local authorities and the resources available, and take into

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12 Care and Support Commission, *Fairer Care Funding,* July 2011
13 *Ibid.*, p7
14 *Ibid.*, p8
15 SN/SP/6391
16 SN/SP/1911
17 HC Deb 4 Jul 2011 c1234
18 *Draft Care and Support Bill*, Cm 8386, July 2012
19 *Ibid.,* p63
20 HM Government, *Caring for our future: reforming care and support*, Cm 8378; July 2012
21 *Ibid.,* p63
22 Further information on the current eligibility criteria is set out in the Library standard note: *Domiciliary care: eligibility criteria*, SN/SP/6067

> account work to develop options for a potential new assessment and eligibility framework. **Given the commitment to a national threshold, and the funding in this Spending Review, there should be no need for local authorities to tighten current eligibility thresholds.**
>
> These changes will mean that people's entitlements to care and support will be much clearer and fairer, reducing the variations in access that currently exist between local authorities. We think it is right that people's individual care and support plans continue to be determined by their needs and circumstances, so that care and support does not become a 'one size fits all' service. However, introducing more consistency to access will help people to plan for their future with much greater certainty. **It will give people using services, and carers, greater confidence that they can move around the country without losing access to care and support.**[23]

- Legislating to ensure portability of assessments. Local authorities will be required to continue to meet the previously assessed needs of a person who moves into their area until a new assessment has been carried out. The change is designed to ensure continuity of care for persons who move for example to be near family members. The Government stated:

> We believe that it is right for people to be reassessed by their new local authority when they move home, as their needs, goals and ambitions may change. However, we will place a duty on local authorities to provide a written explanation if the result of the new assessment is different from that of the previous local authority. The draft Care and Support Bill also sets out new duties on the local authorities involved to share information to encourage a smoother transition. This will include the ability for people to request an assessment before they move home.[24]

- Piloting the use of direct payments in residential care. At present direct payments cannot be used to pay for residential care services except on a short term basis.[25]

- Legislating to give people an entitlement to personal budgets. Personal budgets are an allocation of funding given to users after a social services assessment of their needs. They do not currently have a legislative basis. The draft *Care and Support Bill,* published alongside the white paper, contained provisions which provide a statutory foundation for personal budgets.

- Exploring the use of 'Social Impact Bonds' – a type of payment by results tool – in care and support to help people live independently.[26]

- Testing the use of supportive time share initiatives such as time banks to allow people to build up a 'bank' of care by caring for others that they can later draw on for themselves.

- Improving mechanisms for the early identification of carers and legislating to provide carers with an entitlement to support. In addition, the proposed national eligibility threshold for support would also be extended to carers services.[27]

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23 HM Government, *Caring for our future: reforming care and support*, p32
24 *Ibid.*, pp32-33
25 Further information on Direct Payments for social care is set out in the Library standard note SN/SP/3735
26 HM Government, *Caring for our future: reforming care and support*, p26

- Legislating to introduce Local Safeguarding Adult Boards.[28]
- Consulting on options to ensure better oversight of the social care market including:

  - ending prescriptive commissioning practices, for example contracting care by the minute;

  - when care provider businesses fail.[29]

- Greater investment in the social care workforce by training more care workers and appointing a new Chief Social Worker by the end of 2012.[30]

Progress report on funding reform

A separate document published alongside the white paper, *Caring for our future: progress report on funding reform*,[31] set out the Government's response to the Care and Support Commission's recommendations to reform the way people pay for care services in the future. In addition to the introduction of national eligibility thresholds for adult social care accepted in the white paper, the progress report provided that the Government would adopt in principle the Care and Support Commission's funding model of capped costs and an extended means-test.[32] The progress report also proposed adopting a further recommendation – the introduction of a universal system of deferred payments for residential care – which was also proposed by the previous Labour Government.[33]

The Office for Budget Responsibility has estimated that public spending on long-term social care will increase from 1.3% of GDP in 2017/18 to 2.4% of GDP in 2062/63. The lifetime cap on certain long-term social care costs will increase public spending on social care by 0.3 per cent of GDP by 2062-63.[34]

2 Pre-legislative scrutiny: The draft *Care and Support Bill*

2.1 The draft Bill

The draft *Care and Support Bill* was published on 11 July 2012 alongside the White Paper, the progress report on funding, and the Government response to the Law Commission report. The notes accompanying the draft bill set out its aims, which reflected the Law Commission's proposals accepted by the Government and also sought to enact the aspects of the *Caring for our Future* white paper that required legislative change. The notes to the Bill document discussed the aims of the draft Bill and also the provisions intended to achieve them. It stated that:

> In summary, the draft Bill will:
>
> - **modernise** care and support law so that the system is built around people's needs and what they want to achieve in their lives;

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27 *Ibid.,* pp34-5
28 *Ibid.,* pp43-4
29 *Ibid.,*pp45-48
30 *Ibid.,*pp49-52
31 HM Government, *Caring for our future: progress report on funding reform*, Cm 8381; July 2012
32 Information on the current means-test for residential care is set out in the Library standard note *Financing care home charges*, SN/SP/1911
33 HM Government, *Shaping the Future of Care Together*, Cm 7673; July 2009, p19-20
34 OBR Fiscal Sustainability Report 2013

- **clarify** entitlements to care and support to give people a better understanding of what is on offer, help them plan for the future and ensure they know where to go for help when they need it;

- **support** the broader needs of local communities as a whole, by giving them access to information and advice, and promoting prevention and earlier intervention to reduce dependency, rather than just meeting existing needs;

- **simplify** the care and support system and processes to provide the freedom and flexibility needed by local authorities and care professionals to innovate and achieve better results for people; and

- **consolidate** existing legislation, replacing law in a dozen Acts which still date back to the 1940s with a single, clear statute, supported by new regulations and a single bank of statutory guidance.

The draft Bill will therefore include the following key provisions:

- new statutory principles which embed the promotion of individual wellbeing as the driving force underpinning the provision of care and support;

- population-level duties on local authorities to provide information and advice, prevention services, and shape the market for care and support services. These will be supported by duties to promote co-operation and integration to improve the way organisations work together;

- clear legal entitlements to care and support, including giving carers a right to support for the first time to put them on the same footing as the people for whom they care;

- set out in law that everyone, including carers, should have a personal budget as part of their care and support plan, and give people the right to ask for this to be made as a direct payment;

- new duties to ensure that no-one's care and support is interrupted when they move home from one local authority area to another; and

- a new statutory framework for adult safeguarding, setting out the responsibilities of local authorities and their partners, and creating Safeguarding Adults Boards in every area.[35]

Pages 8-13 of the draft Bill document provided an overview of how the social care clauses of the Bill were intended to put these principles into place. More detailed, clause-by-clause notes were provided in Annex B of the document.[36]

2.2 Health provisions

The draft Bill did not include any of the measures around care standards and the regulation of health services that are currently found in Part 2 of the Bill, which were introduced at various stages following the publication of the Francis Report in February 2013.[37] The draft legislation, published in July 2012, contained the following proposed measures relating to medical education and research:

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35 Draft *Care and Support Bill*, Cm 8386, p6
36 *Ibid*., p113-117
37 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Francis Report), 6 February 2013

- To establish Health Education England (HEE) as a non-departmental public body (NDPB) to provide national leadership for the planning and commissioning of education and training for the health workforce. HEE was set up as a Special Health Authority in June 2012 to oversee an education and training budget of around £5 billion.

- To Establish Health Research Authority (HRA) as an NDPB. The HRA was set up as a Special Health Authority in December 2011, in order to promote the interests of patients and the public in health and social care research, as well as to streamline the research approvals process and encourage investment in research.

- Amending the *Public Bodies Act 2011* to allow for the abolition of the Human Fertilisation and Embryology Authority (HFEA) and Human Tissue Authority (HTA). Liberating the NHS: Report of the arm's-length bodies review (July 2010) set out proposals to transfer functions from these two bodies to the Care Quality Commission (CQC) and the Health Research Authority (HRA).[38]

While the provisions relating to HEE and the HRA were included in the Bill introduced to the Lords in May 2013, the Government decided to retain the HFEA and HTA, subject to a further review of their functions. This followed a consultation where the majority of respondents made it clear they did not favour a transfer of HFEA and HTA functions.[39]

2.3 Pre-legislative scrutiny: Joint Committee report

In November 2012, a Committee of both Houses was appointed to undertake pre-legislative scrutiny of the draft *Care and Support Bill*, chaired by the Rt Hon Paul Burstow MP. The Committee published its report on 19 March 2013.[40]

The Committee's press notice announcing publication set out the report's key recommendations, which called for:

- A national campaign to raise awareness of what the national care and support offer is, how people can plan and prepare for their own care needs, and what rights they have to care and support.

- Information and advice for all (including self funders) about support, care planning and housing options.

- Provision of independent financial advice about the different options available to pay for care, including deferred payment arrangements.

- A new power to mandate joint budgets and commissioning across health, care and housing, such as support for the frail elderly, making it simpler for NHS and local councils to pool budgets.

- A greater emphasis on assisting people to prevent and postpone the need for care and support.

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38 HM Government, *Draft Care and Support Bill*, Cm 8386 (July 2012). Pages 14-18 provide an overview of the health measures in the Draft Bill. There are also impact assessment and equality analysis documents for the establishment of HEE and HRA.

39 Department of Health, *Consultation on proposals to transfer functions from the Human Fertilisation and Embryology Authority and the Human Tissue Authority* (June 2012); DH, *Government response to the consultation* (January 2013); see also DH, *Response to the report of the independent review of the HFEA and HTA by Justin McCracken* (April 2013).

40 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, HL 143, HC 822, Session 2012-13

- Fast-tracking of care and support assessments for terminally-ill people
- An end to 'contracting by the minute' whereby care workers sometimes spend just fifteen minutes with the person being cared for.
- New legal rights for young carers to protect them from inappropriate caring responsibilities and ensure they get the support they need.
- An obligation on the Secretary of State to take into account the draft Bill's well-being principle when designing and setting a national eligibility threshold.
- Stronger measures on safeguarding, including explicit responsibilities for local authorities to prevent abuse and neglect.
- Independent resolution of disputes over decisions about care and support - and costs that count towards the cap – through a Care and Support Tribunal.

The notice further set out the Committee's recommendations to improve health research and the education and training of NHS workers, including:

- Strengthening the Health Research Authority responsibilities by ensuring full disclosure of research data
- Supporting greater integration of health and social care by ensuring more common training of care staff who often switch between the two sectors
- Strengthening the duties of Health Education England to give clinical experience to managers.[41]

2.4 Government response to pre-legislative scrutiny and the *Care Bill*

The Queen's Speech in May 2013 announced legislation to reform how long term care is paid for.[42] The *Care Bill* was published on 9 May 2013.[43] Alongside it, the Government published *The Care Bill Explained*, which includes responses to the public consultation on the draft *Care and Support Bill* and also the Government's response to the Joint Committee's pre-legislative scrutiny report.[44]

The recommendations of the Committee, and the Government's response, are discussed in more detail later in this paper (in relation to the appropriate sections of the Bill).

3 The Bill

3.1 Purpose

The *Care Bill* includes provision to:

- Bring together existing care and support legislation into a new, modern set of laws and build the system around people's wellbeing, needs and goals.
- Set out new rights for carers, emphasise the need to prevent and reduce care and support needs, and introduce a national eligibility threshold for care and support.

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41 Joint Committee on the Draft Care and Support Bill, *Greater focus on prevention and integration essential to improve Care & Support Bill, warn Peers and MPs*, 19 March 2013

42 The Queen's Speech, 8 May 2013

43 Department of Health, *Government publishes Care Bill*, 10 May 2013

44 Department of Health, *The Care Bill Explained: Including a response to consultation and pre-legislative scrutiny on the Draft Care and Support Bill*, Cm 8627, 10 May 2013

- Introduce a cap on the costs that people will have to pay for care and set out a universal deferred payment scheme so that people will not have to sell their home in their lifetime to pay for residential care.

- Allow for the introduction of Ofsted-style ratings for hospitals and care homes so that patients and the public can compare organisations or services and make informed choices about where to go.

- Establish a unified regime for detecting and intervening in failures in care quality and financial performance at NHS hospitals.

- Introduce a statutory "duty of candour" for health service providers and making it a criminal offence for providers to supply or publish false or misleading information.

- Establish the Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental public bodies.[45]

The Care Bill Explained set out the Bill's intentions relating to social care:

> It is over six decades since the foundations of social care law were put in place, based on principles that are no longer relevant in today's society. We need new laws that reflect modern standards, modern expectations and modern practices. The first part of the Care Bill is a critical step in reforming care and support and achieving the aspirations of the white paper, *Caring for our Future*. It also introduces a cap on the costs that people will have to pay for care in their lifetime, as recommended by the Commission on the Funding of Care and Support. The Bill pulls together threads from over a dozen different Acts into a single, modern framework for care and support. But it is far from being a mere compilation – it fundamentally reforms how the law works, prioritising people's wellbeing, needs and goals so that individuals will no longer feel like they are battling against the system to get the care and support they need. It highlights the importance of preventing and reducing needs, and putting people in control of their care and support. For the first time, it puts carers on a par with those for whom they care.[46]

The Care Bill Explained also set out the purpose of the healthcare related provisions in part 2 and 3 of the Bill:

> The second part of the Bill takes forward elements of our response to the unacceptable failings in care at Stafford Hospital. The quality of care and people's experience should be the basis on which providers of health and care are judged and this Bill takes a step towards that. It will allow for Ofsted-style ratings for hospitals and care homes that will allow patients and the public to compare organisations or services in a fair and balanced way, so they can see which they prefer and where they want to go. The Bill will give the new Chief Inspector of Hospitals the power to instigate a process to tackle unresolved problems with the quality of care more effectively than before. And it will make it a criminal offence for providers to supply or publish false or misleading information.
>
> Part 3 of the Bill establishes Health Education England as a statutory body which will assist local healthcare providers and professionals to take responsibility for educating and training their staff. It also establishes the Health Research Authority in the same way, strengthening its ability to protect patients' interests in health and social care

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45 Department of Health, *Government publishes Care Bill*, 10 May 2013
46 Department of Health, *The Care Bill Explained*, p5

> research whilst promoting research and streamlining the approvals process. Both of these bodies will be independent of the Department of Health, giving them the impartiality and stability they need to carry out their vital roles. Improving the quality of education and training and encouraging research that is both safe and ethical will support improved care for patients.[47]

3.2 House of Lords stages

The Bill was introduced into the House of Lords as HL Bill 1, and had its First Reading on 9 May 2013. The Second Reading debate was held on 21 May 2013.[48] The Bill was considered in Committee on 4, 10, 12 June and 3, 9, 16, 22 and 29 July; an amended version of the Bill was published on 30 July as HL Bill 45. Report Stage took place on 9, 14, 16 and 21 October. The Third Reading debate took place on 29 October.

The Bill had its First Reading in the House of Commons on 30 October 2013, as Bill 123 of session 2013-14.

Issues discussed during Committee and Report Stage

The Library standard note *Lords Stages of the Care Bill: Social care provisions*,[49] provides an overview of developments during Committee and Report Stage relating to social care, including a summary of the areas discussed and the most important amendments made. A further standard note, *Lords Stages of the Care Bill: Health provisions*,[50] sets out developments relating to health policy.

4 Part 1: A new legal framework for adult social care in England

4.1 Introduction and a Note on Extent

Part 1 of the Bill (clauses 1-79), sets out a new legal framework for the provision of adult social care and support in England. While Part 1 of the Bill extends to England and Wales generally, it applies only to local authorities in England because social care is a devolved matter.

There are several exceptions to this broad position: the Bill's provisions in relation to cross-border placements (clause 39(8) and Schedule 1) and certain provisions on provider failure (clauses 50 to 53) extend to the whole of the United Kingdom. The duties under clauses 50 to 53 apply to local authorities in England and Wales and to Health and Social Care trusts in Northern Ireland.

While the Law Commission's report on adult social care made recommendations in relation to both England and Wales, the Welsh Government has produced its own legislative proposals, the *Social Services and Well-being (Wales) Bill*.

4.2 General Responsibilities of local authorities

Individual well-being

Clause 1 of the Bill would establish that local authorities must promote the well-being of an adult in carrying out their care and support functions. Designed to "embed individual well-being as the driving force for care and support...the first clause of the Bill sets the context for all the provisions which follow."[51]

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47 *Ibid*.
48 HL Deb 21 May 2013 c746
49 SN/SP/6753
50 SN/SP/6769
51 Department of Health, *The Care Bill Explained*, p11

'Well-being' is not strictly defined in the Bill, but section 1(2) states that it is intended to indicate a person's well-being relating to any of the following:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional well-being;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support, or support provided to the individual, and the way in which it is provided);
- participation in work, education, training or recreation;
- social and economic well-being;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.

Section 1(3) provides a further list of factors that local authorities must consider when carrying out their care and support functions, including the individual's views, wishes, feelings and beliefs; the need to ensure that decisions about the individual are made having regard to all the individual's circumstances; and the importance of the individual participating as fully as possible.

Pre-legislative scrutiny and House of Lords stages

In its pre-legislative scrutiny report, the Joint Committee was positive about the well-being principle and stated that all references that had been made to it in the evidence it heard were supportive of the clause's intentions.[52] However, the Committee recommended that the definition of well-being should be "enlarged [from its original drafting] to include the dignity of the adult, and the availability of safe and settled accommodation."[53] The Government accepted these recommendations.[54]

The Committee also recommended that the Bill should be amended to include a provision requiring the Secretary of State, when making regulations or issuing guidance to local authorities about carrying out their functions under the Bill, to have regard to the general duty of local authorities under clause 1 to promote individual well-being.[55] The Government rejected this recommendation, stating: "Local authorities are responsible and accountable for social care. We believe that creating new duties for the Secretary of State would distort these clear lines of accountability."[56] However, during Report Stage in the House of Lords, a Government amendment was agreed to provide that the Secretary of State must have regard to the general duty of local authorities relating to well-being when issuing relevant guidance and making regulations.[57]

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52 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 68
53 *Ibid*., para 74
54 Department of Health, *The Care Bill Explained*, p61
55 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 83
56 Department of Health, *The Care Bill Explained*, p61
57 HL Deb 16 Oct 2013 c625

During Committee Stage and Report Stage in the House of Lords, amendments were discussed relating to what individual well-being would mean in practice, including consideration of a person's spiritual well-being, the ability to keep pets, and the maintenance of a person's dignity and respect.[58] The position of adult carers of disabled children was also discussed.[59] A new clause, subsequently withdrawn, was moved by Lord Warner to ban employment practices inconsistent with the Bill's well-being principle.[60]

During the Third Reading debate, Lord Hamilton moved an amendment to provide that 'spiritual needs' be included in the definition of 'well-being'.[61] The House divided on the amendment. It was disagreed to by 271 votes to 96.[62] A Government amendment, moved by Earl Howe, to include 'feelings and beliefs' in the definition was agreed without a vote.[63]

Preventing needs for care and support

Clause 2 would require local authorities to take steps intended to prevent, reduce or delay the need for care and support for all local people including adults and carers. Following concerns raised during pre-legislative scrutiny,[64] the Government revised the Bill to (in addition to this duty) more clearly link the prevention duty to the Bill's provisions on local authorities' market-shaping role (clause 5), and also local authorities' role in the provision of information and advice (clause 4).[65] Similarly, the Bill was revised to require that, when assessing needs and care and support plans, local authorities consider whether other help available in the local community could help to prevent or delay future needs, and to provide relevant information (clause 9).[66]

Promoting integration of care and support and health services

Clause 3 would place a duty on local authorities to carry out their care and support services with the aim of integrating those services with local NHS and other health services. The clause is intended to reflect the similar duties placed on the NHS Commissioning Board (known as NHS England) and clinical commissioning groups by sections 13N and 14Z1 of the *National Health Service Act 2006*.[67]

In its pre-legislative scrutiny report, the Joint Committee recommended that housing should be added to the 'health-related provisions' in the clause as originally drafted, as an area where integration was appropriate.[68] In response, the Government stated that housing:

> ...already falls within the definition 'health-related', and therefore there is already a duty on local authorities to ensure integration between care and support, health, and housing provision, that we will clarify in guidance.[69]

However, during Report Stage in the Lords, a Government amendment was agreed that, for the purposes of the Bill's provision to promote the integration of care and support with health services, housing would be considered a health-related provision.[70]

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58 PBC Deb 3 Jul 2013 c1258-1274 and HL Deb 9 Oct 2013 c82-88
59 *Ibid.*, c1304-1311 and HL Deb 9 Oct 2013 c82-88
60 PBC Deb 29 Jul 2013 c1602-1605
61 HL Deb 29 Oct 2013 c1453
62 *Ibid.*, c1461
63 *Ibid.*, c1464
64 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 140-142
65 Department of Health, *The Care Bill Explained*, p61, p12
66 *Ibid.*, p12-13
67 Explanatory Notes, para 50
68 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 124
69 Department of Health, *The Care Bill Explained*, p64
70 HL Deb 9 Oct 2013 c113

Information and Advice

Clause 4 would require local authorities to provide an information and advice service in relation to care and support for adults, and support for carers. This service is to be:

> [...] available to all people in the local authority's area regardless of whether they have needs for care and support, or whether any needs they do have meet the eligibility criteria. The information and advice service should, where it is reasonable, also cover care and support services that, while physically provided outside the authority's area, are usually available to its local population.[71]

Following concerns raised in public consultation and during pre-legislative scrutiny,[72] this duty would include the requirement that local authorities must seek to ensure that people should be able to access independent financial advice on the range of financial options available relating to their care and support needs.[73]

Promoting diversity and quality in the provision of services

Clause 5 would place a duty on local authorities to promote a diverse and high quality range of care and support services for people in their area, including prevention services.

The Joint Committee made several recommendations on the version of this clause included in the draft *Care and Support Bill*, including that the Bill should:

- Explicitly clarify that local authorities must involve service providers, service users and carers in their market shaping activity;
- Include a duty similar to the that in the *Childcare Act 2006*, which would require local authorities not only to develop a local market but also to monitor the match between supply and demand in their areas, and report publicly on the sufficiency of care and support services in their area;
- Include a requirement that local authorities properly take into account the actual cost of care when setting the rates they are prepared to pay providers;
- Include an explicit link between this duty and the CQC's essential standards of quality and safety, and to NICE quality standards.[74]

The Committee also recommended that the Government consider introducing an independent adjudicator to settle disputes between local authorities and providers over the cost of care.[75]

In its response, the Government stated that it would amend the clause to ensure that local authorities consider how to ensure the sufficiency of local services to meet local need, and that this would be focused on services available to those in their area, whether or not the services themselves were in their area.[76] However, it rejected the recommendation for authorities to publish a report on their assessment of local services as a disproportionate burden.[77]

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71 *Care Bill* Explanatory Notes, para 52
72 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 88-93
73 Explanatory Notes para 54; Department of Health, *The Care Bill Explained*, p14
74 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 107-117
75 *Ibid*., para 114
76 Department of Health, *The Care Bill Explained*, p15
77 *Ibid*.

The Government accepted the Committee's recommendation on consideration of the actual cost of care, and amended the section of the Bill on personal budgets (see section 4.5 of this note) to provide that a personal budget is equal to the amount it will take to meet identified care and support needs.[78] The Government also stated that it would not stipulate a link to the CQC's essential standards or NICE quality standards in legislation, but that it would consider whether it would be appropriate to provide further information in guidance.[79]

The Government further stated that it would consider the Committee's proposal on an independent adjudicator as part of its consultation on funding reform.[80]

Commissioning services and the length of care visits: Lords debate

During Report Stage in the House of Lords, Baroness Meacher tabled amendments which provided for regulations to be made about how care services are commissioned. The amendments aimed to ensure a sufficient level of quality for the individual, and also that home visits should not be normally commissioned for less than 30 minutes' duration.[81]

Responding for the Government, Earl Howe stated:

> [...] we need to move away from overly prescriptive commissioning practices that focus on price and time-slots, to consider how local authorities can deliver better outcomes and quality care. None the less, there is more that we can and will do to tackle poor commissioning practices. There is a role for regulation. We are therefore proposing an amendment that will make it clear that the CQC may, with approval from both Secretaries of State of DH and DCLG, undertake a special review of local authority commissioning of adult social services in cases of systematic failure. Subsequent to any such review, CQC could issue an improvement notice in the event of a non-substantial failing and recommend special measures to the Secretary of State in the event of substantial failings.
>
> We also intend to issue statutory guidance specifically on local authority commissioning. This will be a valuable opportunity to influence local practice. In particular, we will include in this guidance clear examples of high-quality and poor-quality commissioning practices to support local authorities to develop and improve their own approach.[82]

Although Baroness Meacher withdrew her amendments, she reiterated the need for visits to be of an appropriate length of time.[83]

Duty to co-operate

Clause 6 of the Bill would require local authorities and their relevant partners to co-operate in exercising their respective care and support functions. **Clause 7** would supplement this general duty with a duty to co-operate in specific cases where an individual has care and support needs.

Subsection 7 of Clause 6 provides a list of 'relevant partners':

- Where the authority is a county council for an area for which there are district councils, each district council;

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78 *Ibid.*, p63
79 *Ibid.*
80 *Ibid.*
81 HL Deb 9 Oct 2013 c113 c149
82 *Ibid.*, c161
83 *Ibid.*, c162

- Any local authority, or district council for an area in England for which there is a county council, with which the authority agrees it would be appropriate to co-operate under this section;
- Each NHS body in the authority's area;
- The Minister of the Crown exercising functions in relation to social security, employment and training, so far as those functions are exercisable in relation to England;
- The chief officer of police for a police area the whole or part of which is in the authority's area;
- The Minister of the Crown exercising functions in relation to prisons, so far as those functions are exercisable in relation to England;
- A relevant provider of probation services in the authority's area;
- Such person, or a person of such description, as regulations may specify.

In pre-legislative scrutiny, the Joint Committee recommended that the list of 'relevant partners' be extended to cover registered housing providers, including housing associations and registered social landlords.[84] The Government responded that it believed "co-operation with independent, private and voluntary sector housing providers is better achieved through commissioning and contractual means, as well as through the market-shaping duty in clause 5, rather than inclusion in the 'relevant partner' list."[85] However, during Report Stage in the House of Lords, a Government amendment was agreed to clarify that local authorities would required to co-operate with providers of services, including registered providers of social housing.[86]

During Committee Stage in the House of Lords, a Government amendment was agreed to extend the requirement to co-operate in specific cases to include the needs of young carers.[87]

4.3 Assessing and Meeting Care Needs

How to meet needs

Clause 8 would provide an indication of what a local authority may do to meet care and support needs. The Joint Committee described this clause in its draft form as the "nearest the draft Bill gets to an explanation of what is meant by care and support."[88] The Explanatory Notes to the Bill state that the list provided by clause 8 is not intended to be exhaustive, but to provide a partial list for clarification.[89] The Joint Committee described the list as "a radical departure from existing social care legislation since it is illustrative rather than exhaustive."[90]

The examples of what may be provided to meet needs listed in subsection 1 are:

- Accommodation in a care home or in premises of some other type;

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84 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 119
85 Department of Health, *The Care Bill Explained*, p17
86 HL Deb 9 Oct 2013 c107-109 and 163
87 PBC Deb 9 Jul 2013 c251
88 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 166
89 Explanatory Notes para 71
90 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 167

- Care and support at home or in the community;
- Counselling and other types of social work;
- Goods and facilities;
- Information, advice and advocacy.

Subsection 2 states that these needs might be met by:

- The authority arranging for a person other than it to provide a service;
- The authority itself providing a service;
- Making direct payments.

The Joint Committee recommended that the Explanatory Notes as originally drafted, and any subsequent guidance, be amended to make it clear that the list of what may be provided to meet needs is "not intended to limit the ways in which a local authority might meet any eligible needs or agreed outcomes," a point it felt was ambiguous in the original drafting.[91] The Government accepted this recommendation and revised the Explanatory Notes to reflect this aim.[92]

Assessments of need: Carers and Care recipients

Clauses 9-13 of the Bill would provide duties for local authorities to make the assessments of need necessary to carry out their care and support functions. **Clause 9** would provide a duty for local authorities to carry out assessments of adults who it appears may have needs for care and support; **Clause 10** would create a duty to assess carers' needs for support. **Clause 11** would set out information on when assessments might be refused by an adult or carer. **Clause 12** would provide for regulations to be made about needs assessments and carers' assessments, and how these are to be carried out. **Clause 13** would require local authorities to assess whether the needs identified through assessments made under clauses 9 or 10 are 'eligible needs' for care and support purposes.

Care and support needs assessments

Under **Clause 9**, a local authority would be required to make an assessment of a person's care and support needs, regardless of their financial resources or whether the authority believed their needs were 'eligible needs' for care and support services, wherever it appeared an adult *may* have needs for care and support. The clause brings together a number of existing powers and duties to create a single legal basis for assessment.[93] The assessment would focus on how the person's needs impacted on their well-being and the outcomes they wish to achieve in day-to-day life (such as living independently), and whether care and support could help them to achieve those outcomes.[94] The clause would also require that the adult being assessed, their carer, and anyone else the adult requests, be involved in the assessment; where the adult being assessed lacked capacity, any person who appeared to be interested in the adult's welfare must be involved in the assessment.[95]

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91 *Ibid*., para 170
92 Department of Health, *The Care Bill Explained*, p68
93 Explanatory Notes para 79
94 *Ibid*., para 74-75
95 *Ibid*., para 76

During pre-legislative scrutiny, the Joint Committee expressed concern that the clause as originally drafted (and also clause 10 on assessments of carers' needs) did not include a requirement that, if an authority making an assessment thought that the individual being assessed had a health, housing, or other relevant need, the authority must bring that need to the attention of the relevant authority, and recommended that the clause be amended to state this clearly.[96] The Government responded that it agreed with the "sentiment of the Joint Committee's recommendation, but we believe that the Bill already achieves it," citing the requirements on local authorities to co-operate with relevant partners (clauses 6 and 7), and stating that it would "underpin this requirement with guidance."[97]

The Joint Committee also raised concerns that the clause's list of those who must be consulted by a local authority carrying out a needs assessment if the person being assessed lacks capacity did not include those concerned with the person's care and well-being, as is the case under the *Mental Capacity Act 2005*.[98] The Government responded that the provisions in the 2005 Act already required local authorities to consult those persons and that there was no need to duplicate this provision in the Bill.[99]

Assessment of a carer's needs for support

Clause 10 would require a local authority to carry out an assessment where it appears a carer has support needs, or might do so in future, and if so what those needs might be. This is a new requirement on local authorities, and in its pre-legislative scrutiny report the Joint Committee noted its agreement with Dr Moira Fraser of the Carers Trust that the clause represented "a huge step forward."[100] As with assessments of need under clause 9, this duty would apply regardless of a carer's financial resources or whether the authority believed their needs were 'eligible needs'.[101] In *The Care Bill Explained*, the Government noted that some respondents to the consultation on the draft Bill had argued that the clause on a "carer's assessment should focus more clearly on the impact of caring and on the outcomes that a carer wants to achieve," and that the clause had been reworded with this objective in mind.[102]

The clause sets out several factors that must be considered in a carer's assessment, which include:

> ...the carer's ability and willingness to provide care and support, both now and in the future; the impact of caring on the carer's wellbeing; and the outcomes that the carer wishes to achieve in day to day life. In carrying out the assessment the local authority must also have regard to whether a carer works or wishes to work, or participates in, or would like to participate in, education, training or recreation.[103]

Refusal of an assessment

Clause 11 would set out what must happen when an adult or carer refuses an assessment of their needs. In most instances, such a refusal would simply mean that the assessment is not carried out. Subsection 2 lists two exceptions to this: firstly where the adult who has refused a needs assessment under clause 9 lacks the capacity to agree to an assessment and the

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96 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 176
97 Department of Health, *The Care Bill Explained*, p68
98 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 179
99 Department of Health, *The Care Bill Explained*, p68
100 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 177
101 Explanatory Notes para 83
102 Department of Health, *The Care Bill Explained*, p18
103 Explanatory Notes para 84

authority is satisfied that it is in their best interests, and secondly where that adult is at risk of harm or physical abuse.[104]

Where a local authority believes the situation has changed, either for an adult or a carer, it must again seek to carry out an assessment, but that assessment can continue to be refused providing that the exceptions listed in subsection 2 do not apply.

Needs Assessments and Carer's Amendments: Further issues

Clause 12 would require the Secretary of State to make regulations about how a needs assessment or a carer's assessment is carried out. It would also provide that a local authority may combine a needs assessment or a carer's assessment with another assessment (for instance, an adult's needs assessment and the carer's assessment of the person who cares for them) if the persons involved agree. It would further provide that local authorities may work jointly with, or on behalf of, other bodies who are carrying out assessments of a person, for instance NHS bodies.[105]

In its pre-legislative scrutiny report, the Joint Committee recommended that the clause be strengthened to make clear that, in carrying out a needs or carer's assessment, a local authority must have regard to the need to prevent children carrying out inappropriate caring responsibilities.[106] The Government agreed with the Committee's position and stated that this would be set out in regulations and guidance.[107]

The Joint Committee also recommended that the clause be amended to provide for needs assessments for terminally ill people to be fast-tracked.[108] The Government responded that it would set out in statutory guidance that needs assessments for terminally ill people should be fast-tracked, and noted that clause 19(3) of the Bill would provide for urgent needs to be met without a full assessment being carried out.[109] During Report Stage in the House of Lords, a Government amendment to clause 19 was agreed to make it explicit that where an adult is terminally ill, local authorities may treat their case as urgent.[110]

Needs Assessments and Carer's Assessments: Lords stages

The Bill's provisions on assessments of an adult's care needs, and on a carer's need for support, were discussed at some length during Committee Stage in the House of Lords.[111] During Report Stage, the Government moved a series of amendments to clauses 9, 10, and 12, subsequently agreed, to address concerns that had been raised on:

- Potential misinterpretation of the Bill by local authorities on the levels of assistance that might be provided by friends and family rather than the local authority;
- Sufficient support in the clauses for the Bill's focus on the prevention of need;
- That an adult's needs assessment can be combined with a young carer's assessment.[112]

Further Government amendments were also agreed to require that assessments were carried out by people with sufficient expertise.[113]

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104 Explanatory Notes para 88
105 *Ibid.*, para 91-92
106 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 182
107 Department of Health, *The Care Bill Explained*, p18
108 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 181
109 Department of Health, *The Care Bill Explained*, p69
110 HL Deb 14 Oct 2013 c288
111 See PBC 9 July 2013 c173-188 and 16 July c665-670
112 HL Deb 14 Oct 2013 c279-280

Eligibility criteria

Clause 13 would require local authorities to determine, following a needs or carer's assessment, whether a person's assessed needs are 'eligible needs' for local authority support. Currently, local authorities can decide to provide assistance to those with care and support needs at one of four levels of need: low, moderate, substantial or critical.[114] The clause would replace this system with a national minimum threshold for eligibility, to be set out in regulations. Draft regulations have been published that set out the Government's proposed threshold, which is intended to be broadly similar to the 'substantial' level of care need currently in use.[115] Clause 13, however, provides for such regulations to be made rather than setting that threshold itself. Speaking for the Government during Committee Stage in the House of Lords, Earl Howe confirmed that a formal consultation on the eligibility threshold would be run in spring 2014.[116]

As well as providing for regulations to be made, clause 13 would provide that, if a person does have eligible needs, the local authority must establish their residence and consider how to support those needs.[117] In the case of a needs assessment, the clause would further require that the local authority find out whether the person concerned wants to have their needs met by the local authority, which would allow those who do not to start their care account (see the following section of this paper) and to begin to receive an independent personal budget (see section 4.5).[118]

Where a person's needs do not meet the eligibility criteria, the clause would require the local authority to provide them with advice on what services are available in the community to meet the needs they do have and which may prevent or delay their need for care and support.[119]

The Joint Committee, in its pre-legislative scrutiny report, recommended that the clause be amended to ensure that, when making these regulations, the Secretary of State must have regard to local authorities' duty to ensure individual well-being.[120] The Government rejected the recommendation, stating that this new duty on the Secretary of State would distort the lines of accountability for social care, for which local authorities are "responsible and accountable."[121]

The Joint Committee welcomed the national eligibility threshold, and recommended that clause 13 be amended to make its establishment clearer than, in its view, was the case in the clause as originally drafted.[122] The Government accepted this recommendation.[123] The Committee also recommended that the Government consider whether this clause provided an opportunity to clarify the boundaries between local authority care and NHS Continuing Care,[124] a recommendation the Government rejected, stating that the *National Framework for*

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113 *Ibid.*, c280
114 A discussion of this system can be found in the Library standard note *Domiciliary Care: Eligibility Criteria*, SN/SP/6067
115 Department of Health, *Draft national eligibility criteria for care and support*, June 2013
116 PBC 16 July 2013 c683
117 Explanatory Notes para 95
118 *Ibid.*, para 96
119 *Ibid.*, para 97
120 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 188
121 Department of Health, *The Care Bill Explained*, p69
122 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 191
123 Department of Health, *The Care Bill Explained*, p69-70
124 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 191

NHS continuing healthcare and NHS-funded nursing care[125] already sets out when Continuing Care should be provided.[126]

Charges, Assessing Financial Resources, and the Cap on Care Costs

Clauses 14-17 of the Bill would provide the basis of a system for imposing care charges, and also to introduce a cap on care costs, and clause 29 would provide for a care account to record an adult's progress towards that cap. **Clause 14** would provide a general power for local authorities to charge, at their discretion, for care services. **Clause 15** would provide for a limit to be imposed on the amount a person may spend on care in their lifetime, and **Clause 16** would allow for annual adjustments to that limit. **Clause 29** would establish care accounts, for adults who are paying care fees building towards the care cap. **Clause 17** would provide the basis for a system of assessing financial resources to pay care charges.

Local authorities' power to charge

Clause 14 would provide local authorities with the discretionary power to charge for certain care and support services. Charges of this kind are not new. An overview of the current system for charges for care services received outside of residential care is available in the Library standard note, *Domiciliary Care Charges: Background and Department of Health Guidance*.[127] The Government has stated that the aim of the clause is to provide transparency on the powers and rules for charging, so that people know what to expect.[128]

In its pre-legislative scrutiny report, the Joint Committee raised concerns about the drafting of clause 14. It noted that current primary legislation states that a local authority cannot charge more for a service than it appears to them to be 'reasonably practicable' for the person to pay, and that this wording is not reproduced in clause 14.[129] The Committee also raised concerns that the clause could allow for carers to be charged for support that, at present, they are not charged for. In evidence the Department of Health stated that there was no intention to change current the position, which is that local authorities have a power to charge carers for the support they receive, although they mostly do not do so, in recognition of the critical role played by carers.[130]

The Joint Committee recommended that clause 14 be amended to state that charges be 'reasonably practicable' for the person to pay and to clarify that local authorities cannot charge the carer for services provided to the person cared for.[131] The Government rejected both of these recommendations. It stated that regulations would define a minimum level below which an adult's level of income should not be reduced by local authority charges, which should ensure that charges do not exceed a reasonably practicable level to pay.[132] (Subsection 7 of clause 14 provides for such a level to be set in regulations.) The Government further stated that it believed the existing powers in the Bill would not allow a carer to be charged for a service provided for the person they care for.[133]

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125 Department of Health, *National Framework for NHS continuing healthcare and NHS-funded nursing care*, updated 1 November 2013
126 Department of Health, *The Care Bill Explained*, p70
127 SN/SP/3774
128 *Ibid*., p19
129 s17 *Health and Social Services and Social Security Adjudications Act 1983*; Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 192
130 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 195
131 *Ibid*., para 196
132 Department of Health, *The Care Bill Explained*, p70
133 *Ibid*.

The cap on care costs

Currently, there is no limit on the amount that a person may pay for their care. **Clause 15** would provide for a limit to be put in place on the amount that a person could spend on care costs in their lifetime. The clause would provide regulation-making powers for the Secretary of State to set and amend the cap, and to set a different cap for different age groups, to allow the Government to ensure that people who have eligible care needs when they reach 18 years of age receive free care and support. The clause would also provide that 'daily living costs', to meet expenses of room and board for those in residential care, would not count towards the care cap, in the same way that expenditure on rent or utilities would not count towards the cap for a person receiving care in their home.[134]

The Government ran a consultation on social care funding reform between 18 July and 25 October 2013.[135] This consultation included the proposed level of the cap, intended to be set at £72,000 for those of state pension age and over, which is planned to be introduced in April 2016. *The Care Bill Explained* states that the 'daily living costs' in residential care, exempt from building towards the cap, are expected to be around £12,000 annually in 2016/17.[136] The Government intends to set these levels out in regulations and they are not included in the *Care Bill*.

Clause 16 provides for an annual adjustment in the level of the cap, to keep pace with inflation, although it does not prohibit more substantial changes being made to regulations. The clause would also provide that a person's accrued care costs are adjusted in the same way as the cap, so that a person who is 50% of the way to the cap remains 50% of the way there after the annual adjustment for inflation is made.[137]

The Joint Committee recommended that the Bill should provide that regulations governing the level and indexation of the cap, any subsequent changes to the cap falling outside of the defined measure, and arrangements for indexing the care account be subject to the affirmative resolution.[138] The Government responded that:

> When we establish the level of the cap in regulations for the first time, this will be subject to the affirmative resolution. This includes the differing levels of cap for working age adults. Any future substantial changes that are not part of the annual indexation will also be subject to the affirmative resolution. The Bill provides for this.[139]

Care Accounts

The cap on care costs requires that a record of an adult's expenditure on care costs be maintained. **Clause 29** would require local authorities to keep an up-to-date record of an adult's total accrued care costs and progress towards the care cap. This latter is required because, as provided for in clause 16, a person's progress towards the cap must be kept constant so that when the cap is annually adjusted for inflation, that person's progress is also adjusted.

The clause would also provide that the account specify which of the care recipient's costs are classified as living costs, and so do not count towards the cap, and also that the account holder would receive regular statements on their progress towards the cap (to be specified in

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134 Department of Health, *The Care Bill Explained*, p19-20

135 Department of Health, *Caring for our Future: Consultation on reforming what and how people pay for their care and support*, July 2013

136 Department of Health, *The Care Bill Explained*, p20

137 *Ibid*.

138 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 37

139 Department of Health, *The Care Bill Explained*, p56

regulations, although the Explanatory Notes indicate that the Government intends for this statement to be provided annually).[140]

Assessment of Financial Resources

Clause 17 would require that if a local authority exercises its power to charge for a care and support service, it must carry out an assessment of the person's ability to pay. The details of how this assessment would be made would be set out in the regulations made under this clause. The clause includes provision for regulations to set a maximum amount of financial resource an adult may have, above which a local authority will not contribute towards an individual's care and support costs, and daily living costs.[141] The Government's consultation on care funding states that this level is intended to be set at £118,000 from April 2016, but this level is not set out in the Bill.[142]

4.4 Duties and powers to meet needs for care and support

Clauses 18-23 of the Bill would set out the relevant rules where local authorities have either a duty or power to meet the needs of a care recipient or a carer, and also several exceptions to these duties and powers. **Clause 18** would provide for instances where local authorities have a duty to meet an adult's care and support needs, and **clause 19** would provide where they have a power to do so. **Clause 20** would provide duties and powers to meet the support needs of carers. **Clause 21** would provide exceptions for persons subject to immigration control. **Clause 22** would require that local authorities do not provide healthcare services that are the responsibility of the NHS, and in doing so set the boundary between NHS care and local authority care. **Clause 23** would provide that local authorities do not provide support in relation to housing where they, or another local authority, already have duties to do so.

In *The Care Bill Explained*, the Government stated that, in the past, different legal tests and duties for care have caused confusion, and that "one of the key aims of [the Bill] is to remove "anomalies and differences resulting from the type of care or setting, and provide a single route through which consistent entitlements to care and support can be established."[143] This group of clauses aims to establish that single route.

Duties to meet needs for care and support

Where an adult is assessed as having 'eligible needs' for care and support, and they have not already reached the cap on care costs after which their care and support needs would be met by the local authority, local authorities would have a duty under **clause 18** to provide care and support if any one of three conditions are met:

- The adult does not have financial resources greater than a maximum amount, to be set out in regulations (see clause 17), above which a local authority will not contribute to their care and support costs; or

- The adult does have financial resources above the maximum amount, but requests that local authorities meet their care needs, which they will fund entirely themselves (often referred to as 'self-funding'). If an adult lacks capacity, someone acting on their behalf may make a request of this kind for them; or

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140 Explanatory Notes para 187
141 *Ibid*., para 118
142 Department of Health, *Caring for our Future: Consultation on reforming what and how people pay for their care and support*, July 2013, p13
143 Department of Health, *The Care Bill Explained*, p21

- The adult lacks mental capacity to arrange care and support and no one else is available to arrange it on their behalf.[144]

The clause would further provide that local authorities would be under a duty to provide care and support to adults who are ordinarily resident in their area, and have eligible needs whose assessed care costs would exceed the care cap.

The clause would include provision that local authorities would have the discretion not to charge for a service if they did not wish to. It would also provide that no charge may be levied by a local authority where particular regulations prohibit it, and that no charges may be made for services being provided for an adult by a carer.

During pre-legislative scrutiny, the Joint Committee stated its belief that the provision for authorities to have a duty to meet the needs of self-funders, if they request that the authority does so, was likely to have significant resource implications for local authorities, although the Committee did not make recommendations in this area.[145]

Powers to meet needs for care and support

Clause 19 would provide powers for local authorities to meet care and support needs that they would not be under a duty to meet, although an assessment would need to be carried out to ensure that duties to provide support under clause 18 did not apply. The clause would also provide for local authorities to meet care and support needs in urgent cases, without having first carried out the required assessments. During Report Stage in the House of Lords, a Government amendment to clause 19 was agreed to make it explicit that where an adult is terminally ill, local authorities may treat their case as urgent.[146]

Duties and powers to meet a carer's need for support

Clause 20 would provide duties and powers, intended to be equivalent to those in clause 18 and 19 for adults in receipt of care, for local authorities to meet a carer's needs for support. *The Care Bill Explained* describes the clause as carers' "first ever legal entitlement to public support, putting them on the same footing as the people for whom they care."[147]

The clause sets out conditions that must be met for the duty to support a carer to apply, in addition to ordinary residence in a local authority's area (or having no settled residence but being present in their area), and the carer being assessed as having eligible needs for support:

- The support is being supplied to the carer, whose financial resources are at or below the financial limit; or

- The support is being supplied to the carer, whose financial resources are above the limit but the carer asks the local authority to meet those needs; or

- The support would involve provision of care and support to the person they are caring for, and the carer's financial resources are at or below the financial limit, and the person being cared for agrees to this; or

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144 Explanatory Notes para 118
145 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 200
146 HL Deb 14 Oct 2013 c288
147 Department of Health, *The Care Bill Explained*, p21

- The support would involve provision of care and support to the person they are caring for, and the carer's financial resources are above the financial limit, but the person being cared for asks the authority to meet those needs by providing care and support to them.

If a local authority has decided not to charge for support services for a carer, no further conditions would need to be met for a service to be provided.[148]

If the authority has decided to charge, then one of four conditions further would need to apply for support to be provided:

1. If the support required to meet the carer's needs was to be provided directly to carer, and they were assessed as being unable to meet any charges assessed as being due;

2. If the support required to meet the carer's needs was to be provided directly to the carer, and they had the financial resources to pay for that support, but nevertheless asked for the local authority to provide it;

3. If the support required to meet the carer's needs was to be provided to the adult they care for, and that the adult concerned both did not have sufficient financial resources to pay any charge which was assessed as due, and agreed to receive such support;

4. If the support required to meet the carer's needs was to be provided to the adult they care for, and that adult did have the financial resources to pay for that support, but requested that the local authority provide it.[149]

The clause would further provide a power for local authorities to meet the needs of carers whose needs have been assessed and decided not to be eligible. Those might include providing care to the adult being cared for, provided that adult agrees. It would also provide for support to be given to a carer where support might ideally be provided direct to the adult with care needs, but it has not been possible to do so, for instance if the adult concerned refused.[150]

Exceptions for persons subject to immigration control

Clause 21 would provide that local authorities may not meet the care and support needs of an adult subject to section 115 of the *Immigration and Asylum Act 1999* which arise solely because the adult is destitute, or because of the physical effects or anticipated physical effects, of being destitute.

Section 115(9) of the *Immigration and Asylum Act 1999* provides that a 'Person Subject to Immigration Control' (PSIC) is not entitled to most social security benefits and tax credits, except in certain limited circumstances. A person is a PSIC if they are not a European Economic Area (EEA) national and they -

- require leave to enter or remain in the UK but do not have it; or

- have leave to remain subject to the condition that they have "no recourse to public funds"; or

- were given leave to remain as a result of an undertaking for another person to maintain them during their stay; or

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[148] Explanatory Notes para 133
[149] *Ibid*., para 135-138
[150] *Ibid*., para 139

- have leave to remain solely because they are appealing a decision refusing a variation of their previous leave.

Exception for provision of health services: The boundary between NHS and social care

Clause 22 would provide that local authorities may not provide healthcare services which are the responsibility of the NHS. In *The Care Bill Explained*, the Government stated that:

> In effect, therefore [the clause] sets the boundary between the responsibilities of local authorities for the provision of care and support, and those of the NHS for the provision of health care. This clause seeks to reproduce the effect of the current limitations on what a local authority may provide by way of health care and it is not the intention to change that boundary.[151]

In its pre-legislative scrutiny report, the Joint Committee devoted lengthy consideration to this clause.[152] It stated that "since the earliest days the existing boundary between health care, which is free at point of use, and social care, which is not, has been highly problematic. Clarity over the boundary is of fundamental importance."[153] The Joint Committee noted that movement of the boundary could, depending on the direction it moved, lead either to more people paying for their care or to increased free NHS care, with substantial financial implications for the taxpayer.[154]

The existing test for determining whether a person's primary need is a health need, and must be treated by the NHS, is described in section 2.2 of the Library standard note *NHS Continuing Healthcare in England*.[155]

In its report on reforming social care law, the Law Commission recommended that, while the existing boundary should be retained, the wording of the prohibitions on local authorities to carry out healthcare functions should be "reviewed and where appropriate simplified."[156] The Committee raised concerns that the revised language the Government proposed in the draft *Care and Support Bill* would have the unintended effect of moving the boundary so that fewer people qualified for NHS Continuing Healthcare funding.[157] It recommended that the clause be amended to allay this concern:

> Whatever reassurance [the Government] may seek to give us, a court is likely to take the view that any change in wording which goes beyond bringing the drafting into the 21st century implies a change in the intended meaning of the provision. We therefore expect the Department [of Health] to redraft the clause to put the question beyond doubt.[158]

In response, the Government revised the clause and stated that:

> We welcome the Joint Committee's observations, and have looked again at the clause in the light of our clear intention to retain the existing legal boundary between local authority care and support and the NHS. We are satisfied that the revised clause (now clause 22) enables us to maintain the existing boundary between care and support and

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151 Department of Health, *The Care Bill Explained*, p22
152 N.B. In the draft *Care and Support Bill*, this provision was clause 21, and so the Joint Committee's report refers to it in this way.
153 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 52
154 *Ibid*.
155 SN/SP/6128
156 The Law Commission, *Adult social care report*, recommendation 51, p151-152.
157 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 54-55
158 *Ibid*., para 57

> NHS continuing healthcare, and that it is as clear as it can be without returning to the unhelpful and confusing language used in the past.[159]

The clause would also provide for regulations to be made about the types of services that local authorities may or may not provide, and in what circumstances, and for other matters that could be provided for in regulations, such the process for dealing with disputes between local authorities and NHS bodies regarding who should provide care in an individual case.[160]

The clause would also provide that a local authority could not provide or arrange the provision of nursing care by a registered nurse, although the local authority might arrange the provision of accommodation which included the provision of nursing care by a registered nurse provided it has first obtained the agreement of the relevant NHS body or, in urgent cases, obtained agreement as soon as possible afterwards.[161]

Exception for provision of housing

Clause 23 would provide that local authorities would be prevented from providing services which they or another local authority are required to provide under the *Housing Act 1996*. As with clauses 21 and 22, this clause aims to clarify the circumstances in which adult care and support may not meet needs, because the responsibility rests with another organisation.

4.5 Next steps after assessments

Clauses 24-36 would set out what local authorities must do after assessments have been completed, both when the authority is going to meet a person's needs and when it is not. They would provide the legislative basis for personal budgets, direct payments, and also deferred payments.

Clause 24 would provide the immediate next steps for a local authority to take after a needs or carer's assessment is completed. **Clause 25** would provide the requirements for information to be included in a care and support plan for an adult with care needs, or a support plan for a carer. **Clause 27** would require local authorities to review care and support or support plans, when reasonably requested to do so, to ensure they are up-to-date.

Clause 26 would define a personal budget and set out the financial information that must be included in its statement. **Clause 28** would establish the concept of an independent personal budget for those who have eligible needs but do not want those needs to be met by the local authority.

Clause 30 would provide a basis for the rules, to be further developed in regulations, where an adult who requires accommodation for their care needs, for instance in a care home, expresses a preference about where they would like to be accommodated.

Clauses 31, 32 and 33 would specify conditions that must be met for a direct payment to be made to meet care needs.

Clause 34 would provide for deferred payment agreements and loans, where care and support charges are recovered from an adult or their estate at a later date. **Clause 35** would make additional provisions associated with direct payments, including administration charges and the imposing of interest. **Clause 36** would provide for alternative financial arrangements to deferred payments, that would carry out a similar function without interest charges being attached.

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[159] Department of Health, *The Care Bill Explained*, p60
[160] Explanatory Notes paras 145 and 148
[161] *Ibid*., para 146-147

Immediate next steps after assessment: Care and support plans, and support plans

After assessment: What the local authority must do

Clause 24 would provide that, once a needs assessment or carer's assessment, and where relevant a financial assessment, are completed, the local authority must:

- Where it has a duty, or has exercised discretion, to provide care and support:
    - Prepare a care and support plan for the adult with needs, or a support plan for a carer;
    - Inform the adult of the needs that the authority will meet and when direct payments may be used;
    - Help the adult decide how those needs will be met.
- Where it has no duty, and has not decided, to provide care and support:
    - Provide a written explanation of the reasons why;
    - Provide written information on how an adult may meet or reduce their needs independently, including information on prevention.
- Where the adult has eligible needs for care and support but the local authority will not be providing those services (for instance because the adult does not want the authority to do so), prepare an independent personal budget.[162]

Care and support plans; Support plans

Clause 25 would provide that certain information would be required to be included in a care and support plan, or a support plan. This would include:

- The adult's assessed needs and whether these are eligible needs;
- The needs the local authority will meet and how it will meet them;
- The outcomes the person wishes to achieve in daily life;
- The adult's personal budget;
- Information and advice about how to prevent, delay or reduce the adult's needs for care and support or the carer's need for support;
- Which needs, if any, are to be met by direct payment, and the amount and frequency of that payment.[163]

The clause would also provide for the involvement of all relevant persons in the preparation and agreement of a plan, and for plans to be combined if the relevant parties (for instance an adult and their carer) agree, or where one party is a child who lacks capacity or is not competent to agree, the local authority is satisfied that combining the plans is in the child's best interests. The Explanatory Notes to the Bill state that this provision is intended to "allow

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[162] *Ibid*., para 154-157
[163] *Ibid*., para 159-160

for a combined care and support plan, for instance to reflect the needs of a family more holistically."[164]

In *The Care Bill Explained*, the Government stated that respondents to consultation had felt that this clause as originally drafted placed too much emphasis on local authorities' role, and that it had redrafted subsection 5 of the clause to make it clear that "in involving an adult or carer to prepare the care and support plan, the local authority must take all reasonable steps to reach agreement."[165]

The Joint Committee expressed concerns in its pre-legislative scrutiny report that the provisions in this clause relating to direct payments and how they were used were not sufficiently clear, and recommended that it should be made clear in the Bill that individuals can spend direct payments as they like to achieve the agreed outcomes in their plan.[166] The Government accepted this recommendation.[167]

Clause 27 of the Bill would provide that local authorities must review plans and keep them as an up-to-date reflection of the adult or carer concerned's needs and aims, and that where an adult with care needs, or a carer, makes a reasonable request that their plan be reviewed, the authority must do so. It would further provide for relevant parties to be involved in any such revision, and that local authorities must make a revised plan, following the appropriate assessments, if it believes that a person's needs or financial position has changed sufficiently that their existing plan is no longer an accurate reflection of their needs or financial means.

Personal budgets and Independent personal budgets

Personal budgets

Personal budgets are an allocation of funding given to users after a social services assessment of their needs. Users can either take their personal budget as a direct payment, or – while still choosing how their care needs are met and by whom – leave councils with the responsibility to commission the services, or they can have a combination of the two.

Clause 26 would provide for a definition of a personal budget as a statement which specifies:

- The cost to the local authority of meeting the adult's needs it is required or has decided to meet;
- The amount which, based on the financial assessment, the adult must pay towards that cost;
- The amount which, similarly based on the financial assessment, the local authority must pay towards that cost.

This is the first time personal budgets have been included in law,[168] although they are currently in use in some parts of England; section 3 of the Library standard note *Direct payments and personal budgets in social care*,[169] provides further information. The Bill would provide (see previous section) that personal budgets must be included in a person's care and support plan.

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164 *Ibid.*, para 166
165 Department of Health, *The Care Bill Explained*, p23
166 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 210
167 Department of Health, *The Care Bill Explained*, p71
168 *Ibid.*, p23
169 SN/SP/3735

The clause would also require that the personal budget include a breakdown of the amount of the cost to the local authority of meeting an adult's needs that counts as living costs, and therefore does not count towards the cap on care costs. Additionally, the clause would provide that the budget may specify other areas of public money available to the care recipient to spend on other subjects, such as housing.

In its pre-legislative scrutiny report, the Joint Committee recommended that that the Bill should make it clear that "the amount of a personal budget should be equivalent to the reasonable cost of securing the provision of the service concerned in that local area."[170] The Government accepted this recommendation and sought to make clear in clause 26 that "the personal budget *is* the cost to the local authority of meeting the needs it is required or has decided to meet."[171]

Independent Personal Budgets

Clause 28 would require local authorities to prepare a personal budget for a person who has eligible care needs, but has chosen that those needs not be met by the local authority. Since the local authority is not meeting their needs, it would not be required to prepare a care and support plan for them, which would include a personal budget. This requirement means that people who have chosen to have their needs met by other providers than their local authority are made aware of what it would have cost the authority to meet those needs. *The Care Bill Explained* states:

> This 'notional' cost is used to ensure consistency between the independent personal budget and the personal budget in the care and support plan, so that people who choose to spend more on their care do not reach the cap more quickly. It will clearly separate out the general living costs from the care costs so that people can clearly see the care costs that are contributing to their progress towards the cap. This clause also requires the local authority to review the independent personal budget on a regular basis, to ensure that it is up to date.[172]

Preferred accommodation

Clause 30 would provide a basis for certain rules relating to an adult with care needs' choice of accommodation. It would set out firstly that regulations may require a local authority to meet an individual's preference for accommodation, for instance if they would like a place in a care home in another area that is closer to their family, subject to certain conditions that regulations might impose, such as that the accommodation preferred is suitable for that persons needs.

Secondly, the clause would provide that, where the care recipient would prefer accommodation that is more expensive than the amount specified in their personal budget as meeting their needs, they or another individual may make 'top-up' payments to cover the difference. In its pre-legislative scrutiny report, the Joint Committee emphasised its belief that independent financial advice for those who might make such top-up payments was highly important.[173] In response, the Government stated that it had revised its original draft of clause 4 (see section 4.2 of this paper) to include the particular importance of access to financial information within local authorities' duties to provide information and advice.[174]

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170 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 208
171 Department of Health, *The Care Bill Explained*, p89
172 *Ibid.*, p23
173 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 206
174 Department of Health, *The Care Bill Explained*, p61

Direct payments

Direct payments are cash payments made in lieu, either fully or partly, of services from local authority social services. Direct payments were first introduced in 1997 under the *Community Care (Direct Payments) Act 1996*, and have progressively increased in their use as a means of meeting care needs since. The Library standard note *Direct payments and personal budgets in social care*[175] provides information on the development of the payments and their use.

Clauses 31, 32, and 33 would provide for conditions under which direct payments could be made.

Clause 31 would provide that a direct payment may be made if an adult with capacity has needs whose costs the local authority must contribute to, and that the adult makes a request for a direct payment to be paid to them or someone they have nominated. The clause goes on to set out four conditions which, if all were met, would require a local authority to agree to make a direct payment:

1. The adult has capacity to make a request for a direct payment, and any person they nominate to receive that payment agrees to do so; and

2. Regulations do not prohibit a direct payment being made (as they might, for instance, if the adult or their nominated recipient was receiving certain types of drug treatment); and

3. The authority is satisfied that the adult or their nominated person can manage the direct payment on their own or with available help (for instance from family members); and

4. The authority is satisfied that direct payments are an appropriate way of providing support.

Clause 32 would provide that a direct payment must be made in regard of an adult without capacity to make a request for one if an authorised person, such as someone who is authorised under the *Mental Capacity Act 2005* to make decisions about the adult's needs for care and support, makes a request for direct payments, subject to certain conditions, including that the authorised person is capable of managing the direct payment and will do so in the interest of the care recipient.

Clause 33 would provide for further regulations to be made by the Secretary of State regarding when direct payments can be made, that direct payments may only be used for the purposes outlined in a care and support plan, and that a local authority must stop making direct payments if the conditions set out in clauses 31 or 32, or in regulations, cease to be met.

In its pre-legislative scrutiny report, the Joint Committee questioned whether an existing rule relating to direct payments, that they cannot be used to purchase services directly from the local authority, was consistent with the Bill's well-being principle, and the duty on local authorities to provide diversity and quality in the provision of services. The Committee stated:

> People in receipt of a direct payment should be in control and able to exercise choice... The Department of Health should lift the ban on direct payments being used to pay for local authority direct services if the individual so chooses.[176]

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[175] SN/SP/3735

[176] Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 211

The Government rejected this recommendation:

> In our view, it should be more efficient for the local authority to provide this to the person as part of a managed service, rather than as a direct payment. Current guidance allows people to receive services as a mixed package (i.e. a council-provided service along with a direct payment) and our intention is to continue this in updated guidance that will be produced to complement the Bill.[177]

Deferred payments

Since October 2001, local authorities in England have had the discretion to enter into 'deferred payment arrangements' with care home residents.[178] This scheme helps those whose property is taken into account by the means-test for residential accommodation but who do not wish to sell their homes, or cannot do so, in order to meet their care costs. The scheme, however, is only a way of postponing paying the full cost of care home accommodation; the deferred payment will eventually be recouped by the sale of the property either during or after the care home resident's lifetime.[179] The only people eligible for deferred payments are those who have insufficient income and other assets, other than the value of their main or only home in which they have a beneficial interest, to meet the care home's charges.

The *Care Bill* includes provision to make deferred payment arrangements available across England. The Government intends that the "introduction of this 'universal deferred payment scheme' will mean that people will not have to sell their home in their lifetime to pay for care."[180]

Clause 34 of the Bill would provide for deferred payment agreements and loans, and for regulations to provide when such an agreement or loan may or must be offered. The clause would also provide that agreements would not require the sum owed to the local authority to be repaid until a specified time; that the loan may include provision for services that are not necessary to meet a person's need; and also that regulations may specify what would constitute security on a deferred payment (the Explanatory Notes indicate that this may include a person's property or a guarantee from a third party).[181]

Clause 35 would provide for further conditions on deferred payment agreements to be specified in regulations, including that interest may be allowed or required to be charged on a deferred sum; which costs (including administrative costs) interest might be charged on; and that regulations may set a maximum rate of interest that local authorities could charge. It would also provide for further regulations to be made about related issues, such as voluntary termination of the agreement by the adult with care needs, and what may happen in a situation where somebody sells or otherwise disposes of property.

Clause 36 would provide for alternative financial arrangements to be made that carry out the function of deferred payments but do not include the payment of interest. This clause was added to the Bill by a Government amendment agreed during Committee Stage in the House of Lords. It is intended principally to allow authorities to make such alternative arrangements for people who would not otherwise wish to have a deferred payment because of a religious objection to paying interest.[182]

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177 Department of Health, *The Care Bill Explained*, p24
178 Section 55, *Health and Social Care Act 2001*
179 *Charging for Residential Accommodation Guidance*, April 2012, paras 7.024-7.025
180 Department of Health, *The Care Bill Explained*, p24
181 Explanatory Notes paras 145 and 148
182 PBC 22 Jul 2013 c1070 and c1077

In its pre-legislative scrutiny report, the Joint Committee stated that it considered the draft Bill's provisions to charge interest on administrative costs to be excessive and that the relevant provision should be deleted.[183] The Government acknowledged that some consultation respondents, as well as the Committee, had voiced this view, but rejected the recommendation. It stated:

> We want deferred payments to be cost-neutral to local authorities and financially sustainable over the long-term. Clause 35 allows authorities to charge interest and an upfront administration fee when they offer a deferred payment – this is to help authorities recover their costs. The provisions allow authorities to let people pay the administration fee upfront, or to defer it so it is repaid later along with the rest of the deferred payment. In the second case, we think it is reasonable to charge interest on the deferred amount so the authority does not make a loss over time. It will make a very small difference to what someone pays while ensuring overall fairness.[184]

Discussion of deferred payments schemes in the House of Lords

In debate during Committee Stage in the House of Lords, concerns were raised both about the timing of the introduction of deferred payments across England, which the Government intends to be implemented in April 2015, and the deferred payment schemes themselves, which the Government intends would be developed by local authorities rather than rolled out nationally.[185]

During Report Stage in the Lords, Lord Hunt moved an amendment to provide that the Government make available to local authorities a model deferred payment scheme which all local authorities must follow unless they can show due cause not to. The House divided upon this amendment, and it was disagreed by 224 votes to 202.[186]

Also during Report Stage, Lord Lipsey raised concerns about the operation of the proposed deferred payment scheme. Lord Lipsey tabled an amendment to instruct local authorities to direct people seeking a deferred payment to a financial adviser, and that any loan under the scheme should be sufficient to cover the costs of this advice. The amendment was withdrawn.[187]

Lord Lipsey also referred to the Government's consultation on care funding reform, which included a proposal for the deferred payment scheme to be available to those who, alongside other eligibility criteria, have less than £23,250 in assets excluding the value of their home (i.e. in savings and other non-housing assets).[188] Lord Lipsey stated that this was a:

> ...huge restriction that will mean that very few people will take advantage of the deferred payment scheme. It would not in any case have been 40,000, but now I think that it will be nearly nil...most people who have reasonably valuable houses, who are the people most likely to want to adopt this measure, will have far more than £23,250 worth of other assets. Most of them will not feel the least bit happy if they have to spend down until they have only £23,250 left in the bank before they can get any help from the deferred payment scheme. That hardly pays for a daily delivery of the *Racing Post* for the rest of their lives, their nightly gin and tonic or more important things such

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183 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 199
184 Department of Health, *The Care Bill Explained*, p24-25
185 PBC 22 Jul 2013 c1062-1077
186 HL Deb 14 Oct 2013 c309
187 *Ibid*., c299
188 Department of Health, *Caring for our Future: Consultation on reforming what and how people pay for their care and support*, p44

> as the literature they want to read or all the things that make their life fuller. For those people, a deferred payment scheme is simply not available.[189]

On behalf of the Government, Earl Howe responded:

> The second issue raised by the noble Lord was about the deferred payment scheme and his perception that the Government have effectively emasculated it. I do not share that perception. There will be some circumstances in which local authorities must offer a deferred payment, and that is when the Bill specifies that the local authority would be under a duty to offer a deferred payment. We are consulting on the eligibility criteria for when people must be offered a deferred payment, which is where the figure of 23,250 is used. The Bill has an additional power for local authorities to offer deferred payments more widely, and we are seeking views on this through the consultation.[190]

Lord Lipsey emphasised that this provision would mean that the Bill does not provide for a universal deferred payments scheme.[191]

During the Third Reading debate, Lord Lipsey moved an amendment to provide that regulations on deferred payments may not specify any threshold of other assets above which a person is not eligible to receive a deferred payment loan,[192] prompting further discussion of a cap on eligibility for deferred payments. The amendment was subsequently withdrawn.[193]

4.6 The Establishment of Ordinary Residence and Portability

Local authorities are responsible for the care needs of those 'ordinarily resident' in their area. Clauses 37-41 and Schedule 1 of the Bill set out what ordinary residence means, and how continuity of care and support should be ensured when a person moves from one local authority to another; this is commonly referred to as 'portability'.

Clause 37 would provide duties for local authorities when a person receiving care and support, and possibly their carer, tell them that they are moving to another area, aimed at ensuring care is continuous despite the move. **Clause 38** would provide duties for local authorities when arrangements for the transition of care and support have not been completed by the day the recipient moves home.

Clause 39 would provide a definition of ordinary residence for people who are provided with accommodation as part of their care and support needs being met. **Schedule 1** would facilitate cross-border care placements within the UK. **Clause 40** would provide a mechanism for disputes between local authorities about ordinary residence to be resolved. **Clause 41** would require that, after such disputes are resolved, financial adjustments may be made between local authorities when an authority has been funding care and support that was not their responsibility.

Portability

The Bill aims to ensure that people who move from one local authority to another do so with no interruption in their care.[194] **Clause 37** would provide a framework intended to achieve this, and sets out responsibilities on the 'first' local authority where the adult is currently residing, and the 'second' where he or she is moving to, to share relevant information to ensure this happens. The clause would provide that the 'second' authority must carry out a

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189 HL Deb 14 Oct 2013 c300-301
190 *Ibid*., c305
191 *Ibid*., c307
192 HL Deb 29 Oct 2013 c1470
193 Ibid., c1476
194 Explanatory Notes paras 226

needs assessment of the care recipient, and potentially their carer, before the move takes place. **Clause 38** would provide that in cases where this process has not been completed by the time the person moves, the 'second' authority must maintain the level of care and support that the adult has previously been receiving, and potentially their carer's, from the day of their arrival to the completion of that authority's own assessments.

The Joint Committee was generally positive about the draft Bill's portability provisions in its pre-legislative scrutiny report. It stated:

> We are glad that after a move to a new local authority area there will be continuity of care until a re-assessment. We think it inevitable that the level of care may change after a move; indeed, that may have been the purpose of the move.
>
> [...] the Government may wish to consider whether there should be guidance on the minimum period during which an original assessment should be protected.[195]

The Government responded:

> Where the second authority has not assessed the individual before he or she has moved, the Bill requires that authority to meet the needs for care and support which the first authority was meeting until it carries out its own assessment. This does not mean that the original assessment is protected but that the second authority will meet the needs as described in the first authority's care and support plan. We agree with the Joint Committee that the second authority should not rely on the assessment carried out by the first authority indefinitely, and we will set out in statutory guidance more detail about the process. The guidance will cover the timings when both local authorities have to comply with the requirements on continuity of care, including the timeframe in which the second authority has to undertake its assessment.[196]

The Joint Committee raised concerns about the situation that might arise if the 'second' authority did not fulfil its duties to meet the adult's needs, and recommended that the Bill be amended to absolve the 'first' authority of its responsibilities only when the second has begun to meet the adult's needs.[197] The Government rejected this recommendation, stating that it could lead to confusion about which authority had responsibility in a given case, and also potentially to the second authority delaying putting the necessary provision in place.[198]

Cross-border placements

Schedule 1 would provide that cross-border care and support placements can be made between all four countries within the UK, so that, for example, an adult ordinarily resident in England could be placed in residential care in Wales, or an adult ordinarily resident in Northern Ireland could be place in residential care in Scotland. The Schedule would also provide for regulations to apply these cross-border provisions to specified types of accommodation, and for disputes between cross-border authorities to be resolved by the relevant authorities, depending on the circumstances of a particular case.

Ordinary residence: Definition

A definition of ordinary residence would be provided by **clause 39**. It would define which authority is responsible for an adult who moves into residential care as part of their care and support needs being met. The clause would provide that:

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[195] Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 224-225
[196] Department of Health, *The Care Bill Explained*, p72
[197] Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 228
[198] Department of Health, *The Care Bill Explained*, p73

> For example, where a person who resides in the area of local authority A (and local authority A funds their care and support) enters a care home in the area of local authority B, their ordinary residence will remain with local authority A. Local authority A therefore retains responsibility for funding their care. They are considered "ordinarily resident" in the area of local authority A during their stay in the care home in local authority B.[199]

In its pre-legislative scrutiny report, the Joint Committee stated that it was content with this provision and did not accept the suggestion made to it in evidence that people might be able to choose where they were considered ordinarily resident (in a similar way that choice can be exercised over where the person is accommodated).[200]

Ordinary residence: Disputes

Clause 40 would provide that, where local authorities dispute where an adult with care needs is ordinarily resident, and cannot resolve the issue locally, they may request a resolution of the dispute by the Secretary of State or someone appointed by the Secretary of State, using a mechanism to be set out in guidance. It would also provide that the determination made to resolve that dispute could be reviewed within three months of its being made. **Clause 41** would provide for a local authority to reclaim costs from another local authority where, as a result of a determination made under clause 40 or otherwise, it becomes apparent that the former authority has been funding care and support that should have been provided by the latter because ordinary residence was wrongly assigned.

4.7 Adult Safeguarding

The *Care Bill* would introduce a statutory footing for adult safeguarding. Clauses 42-47 and Schedule 2 establish this framework. **Clause 42** would require local authorities to make enquiries where abuse or neglect of an adult is suspected. **Clause 43** would require local authorities to establish a Safeguarding Adults Board (SAB), whose membership, funding, and other requirements are set out in **Schedule 2**. **Clause 44** would require SABs to carry out safeguarding adults reviews in certain circumstances. **Clause 45** would require persons or bodies to provide information to SABs under certain conditions. **Clause 46** would repeal the current power for local authorities to remove people in need of care from their homes. **Clause 47** would restate an existing duty for local authorities to protect the property of adults who have been admitted to a hospital or to a residential care home, and are unable to protect it or deal with it themselves.

In its pre-legislative scrutiny report, the Joint Committee recommended that the Bill's safeguarding provisions be moved to Part 1 of the Bill, which provides for local authorities' general duties, in particular to link adult safeguarding duties to the Bill's prevention requirements.[201] The Government rejected this recommendation, stating that unlike the general duties in Part 1, the Bill's safeguarding duties require a trigger, and that separate clauses such as those included in the Bill served to emphasise safeguarding's distinct importance.[202]

Conducting enquiries

Clause 42 would establish that when a local authority has reason to suspect that an adult in its area (whether they are ordinarily resident there or not), who has care and support needs, is experiencing or at risk of neglect or abuse, including financial abuse, the authority must make enquiries, or ask others to, as to what action, if any, may be required and who should

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199 Explanatory Notes para 238
200 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 218
201 *Ibid*., para 148-149
202 Department of Health, *The Care Bill Explained*, p66

take that action. This duty would apply regardless of whether the adult's needs are 'eligible needs' for local authority assistance.

In its pre-legislative scrutiny report, the Joint Committee recommended that this clause be amended to make clear that the duty would include cases where past neglect or abuse has not yet been investigated.[203] The Government accepted this recommendation.[204]

Safeguarding Adults Boards

Establishment, constitution and aims

Clause 43 would require local authorities to establish Safeguarding Adults Boards (SAB), whose aim would be "to help and protect individuals who it believes to have care and support needs and who are at risk of neglect and abuse and unable to protect themselves, and to promote their wellbeing."[205] The clause states that an SAB must achieve this objective "by co-ordinating and ensuring the effectiveness of what each of its members does," and "[a]n SAB may do anything which appears to it to be necessary or desirable for the purpose of achieving its objective."[206] The clause would also permit two or more local authorities to establish an SAB covering their geographical areas of responsibility.

Schedule 2 would specify that the core members of an SAB include:

- The local authority;
- An appointed representative from each clinical commissioning group (CCG) in the area;
- The chief officer of police for the SAB's area.

The Schedule would provide that further core members may be specified by the Secretary of State in regulations.

The Schedule would also provide that:

- Members of the SAB may contribute to the funding of the SAB, either directly or through a pooled fund;
- The SAB must publish a strategic plan each financial year, setting out how it will meet its aims and how each member will contribute to it. This plan should, as far as is feasible, be developed involving the local community and must include consultation with the Local Healthwatch organisation;
- The SAB must publish an annual report measuring success against the strategic plan, and the findings of any Safeguarding Adults Reviews undertaken that year, including actions taken or not taken in response to those findings, and send that report to:
    - The chief executive and the leader of the local authority which established the SAB,
    - The local policing body the whole or part of whose area is in the local authority's area,
    - The Local Healthwatch organisation for the local authority's area; and

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[203] Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 153
[204] Department of Health, *The Care Bill Explained*, p27-28
[205] Explanatory Notes para 256
[206] Clause 43(3) and 43(4)

- The chair of the Health and Wellbeing Board for that area.

The Joint Committee recommended in its pre-legislative scrutiny report that the local Health and Well-Being Board and appropriate housing representation should be added to the core membership list of the SAB, and that the Care Quality Commission should be added to the list of recipients of SAB annual reports.[207] The Government responded that it had:

> intentionally restricted core statutory membership to a few core public bodies, leaving local areas with maximum flexibility...
>
> We anticipate and expect membership to be far wider. We would be most concerned if SABs did not address the role, contribution and responsibilities of housing providers in adult safeguarding. We would also expect SABs to draw on the housing sector for input, collaboration and advice. Government will not dictate how this happens, as this will depend on local circumstances, which vary widely across the country.[208]

The Government also indicated that SAB annual reports would be publicly available.[209]

The Joint Committee also recommended that Schedule 2 be amended to include circumstances in which a local authority should not take part in SAB proceedings, because an SAB may often be asked to investigate the shortcomings of a local authority.[210] The Government rejected this recommendation, stating that local authorities, as the statutory lead for adult safeguarding, would need to be present at SAB proceedings, but that it expected boards to develop protocols to deal with any perceived conflict of interest.[211]

Safeguarding Adults Reviews

Clause 44 of the Bill would provide that a SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

- There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and one of the two following conditions is met:
  - The adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect, whether or not it has been aware of those concerns previously; or
  - The adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect.

The clause would provide further provision for reviews to be carried out in other cases where the above conditions were not met but the SAB considered a review was appropriate.

In all cases, the clause would provide that reviews must be carried out with the co-operation and contribution of each member of the SAB, with the aim of learning the lessons of the case involved and applying those lessons in future.

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207 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 162-163
208 Department of Health, *The Care Bill Explained*, p67
209 *Ibid*.
210 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 164
211 Department of Health, *The Care Bill Explained*, p68

Provision of Information to Safeguarding Adults Reviews

In its pre-legislative scrutiny report, the Joint Committee raised concerns that safeguarding adults reviews would not have the same statutory authority to obtain information as serious case reviews involving children, and recommended that the Bill be amended to include an "explicit power to obtain information relevant to the conduct of safeguarding adults reviews."[212] In response, the Government stated its belief that powers under the *Data Protection Act 1998* should provide sufficient powers for such information to be obtained, but that it would amend the Bill to remove any doubt.[213]

As a result, the Government added **clause 45** to the Bill, which would provide that, if certain conditions (relating to the appropriateness of the information requested, and who it is requested from, to the SAB's investigations) are met, a person or body must supply information to a SAB at its request.

Repeal of power to remove people from their homes

Section 47 of the *National Assistance Act 1948* gives local authorities the power to remove adults from their homes, after a court application, if because of infirmity or old age, they are living in unsanitary conditions or are unable to devote proper care and attention to themselves, and are not receiving that care and attention from others. **Clause 46** of the Bill would repeal this power.

Protecting the property of adults being cared for outside their home

Clause 47 of the Bill would provide a restatement of a duty originally set out in section 48 of the *National Assistance Act 1948*, for local authorities to prevent or mitigate loss or damage to the property of adults who have been admitted to a hospital or to a residential care home, and are unable to protect it or deal with it themselves as a result.

4.8 Care and support as a function under the *Human Rights Act 1998*

In its pre-legislative scrutiny report, the Joint Committee stated that:

> A number of witnesses have emphasised the importance of human rights to the provision of care and support. The Human Rights Act 1998 applies to public bodies and "any person certain of whose functions are functions of a public nature" and, therefore, to local authorities implementing the draft Care and Support Bill. This means that local authorities must observe the rights under the Human Rights Act 1998 and the provisions of the draft Bill must be interpreted, as far as possible, so as to be compatible with those rights.[214]

The Joint Committee noted that concerns raised in evidence to it that the Bill should explicitly state bodies that carry out care and support functions delegated to them by the local authority (a power that would be provided by clause 78 of the Bill; see section 4.12) are subject to the same obligations under the *Equality Act 2010*, *Human Rights Act 1998* and *Freedom of Information Act 2000* that local authorities are; the Committee recommended that the Bill be amended to state this.[215]

The Joint Committee also cited evidence from the Equality and Human Rights Commission which stated:

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[212] Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 165
[213] Department of Health, *The Care Bill Explained*, p68
[214] Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 280
[215] *Ibid*., para 283

> The Commission has received advice from Senior Counsel that, because of the case of *YL v City of Birmingham Council*,[216] human rights protection does not extend to ... home care services. As a result approximately 500,000 older people may lack the protection of the Human Rights Act. Similarly, disabled adults receiving home care under these arrangements are unlikely to be covered by the Human Rights Act. This means many people may be denied direct legal redress against the care provider for human rights abuses.[217]

The Committee stated that, in evidence, the Government expressed its belief that all providers of publicly funded or arranged health and social care services should consider themselves bound by section 6 of the *Human Rights Act*, which states that it is unlawful for a public authority to act in a way which is incompatible with a right guaranteed under the *European Convention on Human Rights*.[218] However, the Committee believed that *YL v City of Birmingham Council* meant that statutory provision was required to ensure this and recommended that it be added to the Bill.[219] It also recommended that the draft Bill should be amended to ensure that private and third sector providers of care services regulated by public authorities would be deemed to be performing public functions under the *Human Rights Act*.[220]

The Government rejected these recommendations, stating:

> The Government's position has been that all providers of publicly arranged health and social care services, including those in the private and voluntary sectors, should consider themselves to be bound by the duty imposed by section 6 of the Human Rights Act 1998, not to act in a way that is incompatible with a Convention right. The CQC as the regulator is bound by the Human Rights Act 1998 and has a positive obligation to ensure that individuals are protected. This obligation covers all individuals who receive care and support and not just those whose care is publicly arranged.
>
> The *Health & Social Care Act 2008* strengthened regulatory powers to ensure that the CQC can enforce regulatory requirements that are in line with the spirit of the relevant provisions of the European Convention. This applies to all providers of regulated care and all service-users, whether publicly or privately funded. These requirements should ensure that everyone receives care that conforms to the spirit of the Convention rights.[221]

As a result, no amendment was made to the Bill at this point.

House of Lords debate and amendment

During Report Stage in the House of Lords, Lord Low tabled a new clause to make the provision of care and support a public function under the *Human Rights Act 1998*. Lord Low stated:

> The Human Rights Act 1998 applies to all public authorities and to other bodies when they are performing functions of a public nature. That means that it should apply to all

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216 (2007) UKHL 27. Held that care home services provided by private and third sector organisations under a contract with the local authority did not come under the definition of "public function" for the purposes of the Human Rights Act.

217 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 285; Full evidence from the Equality and Human Rights Commission is available in Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill: Written Evidence*, 7 February 2013, p294-296

218 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 288; s6(1) *Human Rights Act 1998*

219 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 289

220 *Ibid*., para 292

221 Department of Health, *The Care Bill Explained*, p76

> providers of care, given that the provision of care is a public function. However, the matter was thrown into doubt in 2007 by the case of YL v Birmingham City Council, which held that care home services provided by private and third sector organisations under a contract with the local authority did not come under the definition of "public function" for the purposes of the Human Rights Act. This meant that thousands of service users had no direct remedy against their care provider for abuse, neglect or undignified treatment. Though the public body commissioning the care remained bound by the Human Rights Act, that was of little practical value to the individual on the receiving end of poor or abusive treatment, or the person given four weeks' notice to leave because they had antagonised their provider, about whom the noble Lord, Lord Warner, told us in Committee.
>
> Accordingly, Section 145 was introduced into the Health and Social Care Act 2008 to clarify that residential care services provided or arranged by local authorities are covered by the Human Rights Act. There has been concern that this Bill would undo Section 145 by repealing Sections 21A and 26 of the National Assistance Act 1948, under which persons were placed in residential care and through which Section 145 has operated. However, the noble Baroness, Lady Northover, responding to the debate in Committee, set minds at rest on that when she provided the assurance that,
>
> > "there will be a consequential amendment to Section 145 of the Health and Social Care Act 2008 so that there will be no regression in human rights legislation".—[*Official Report*, 22/7/13; col. 1118.]
>
> However, there remains concern that Section 145 does not cover all care service users, or even all residential care service users. It only protects those placed in residential care under the National Assistance Act. That being so, it is anomalous not to treat residential care provided under other legislation and domiciliary care in the same way.[222]

The subject was debated at length, with wide support for the amendment.[223] Responding for the Government, Earl Howe expressed his belief that the amendment would represent an unprecedented expansion of the *Human Rights Act* and did not support it:

> For the first time, [the HRA] would capture purely private arrangements, such as a privately arranged social care contract between a private care home and a private individual—an arrangement in which there is no state involvement.
>
> The European Convention on Human Rights and the Human Rights Act, which gives further effect to the convention rights in our domestic law, impose public law obligations that apply separately from, and in addition to, the duties and obligations on the private sector.
>
> However desirable it might appear to be, it is obviously difficult to draw a crisp dividing line as to whether a function is of a public or a private nature. Ultimately, the legislation has to bear the test of time. The courts have acknowledged that there is no single test to determine whether a function is of a public nature and have pointed out that there are "serious dangers" in trying to formulate such a test.
>
> In determining whether a function is a public function for the purposes of Section 6, our courts undertake a factor-based approach which is fact-specific in each case. Consequently, it is neither appropriate nor desirable to introduce amendments bringing

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[222] HL Deb 16 Oct 2013 c544-545
[223] *Ibid*., c544-562

> specific categories of person within the Human Rights Act which do not reflect the factors that have been applied by our courts.
>
> Difficult as it may be to do so, it is important to take a wider view of how the Human Rights Act applies outside the immediate context of social care and to see whether the amendment would have any unfortunate unintended consequences, such as calling into question whether other groups are covered.
>
> It is clear that the amendment seeks to expand Section 6 of our own domestic Human Rights Act. However, as I have already noted, the Human Rights Act is not free-standing legislation. Its purpose is to give effect in our domestic law to the rights in the European Convention on Human Rights. Arguably, the proposed amendment would mean that, for the first time, we would be legislating for an expansion in scope of the Human Rights Act that included claims that cannot be brought before the European Court of Human Rights.[224]

Lord Low pressed the amendment to a vote, stating that the legal position in this area should be put beyond doubt. The House divided on the amendment, and it was agreed by 247 votes to 218.

Clause 48 of the Bill would provide that providers of care and support are to be taken to be exercising a function of a public nature for the purposes of section 6 of the *Human Rights Act 1998*. As a result, all care and support providers who are regulated by the Care Quality Commission would be required to act in a way which is compatible with the *European Convention on Human Rights*.[225]

4.9 Provider failure and oversight of the care market

Background and Government consultation

In December 2012, the Government launched a consultation on oversight of the care market and local authority responsibilities in the event of a care provider failing, which had been announced in the *Care and Support* white paper in July 2012.[226] The white paper had noted that measures are already in place to gain early warning of, and manage, provider failure:

> Local authorities have a duty to provide accommodation to anyone – publicly or self-funded – who has an urgent need for care which is not otherwise available. As commissioners of care services, local authorities should be overseeing local care provision, encouraging a diverse range of providers and managing cases of provider failure.
>
> The Care Quality Commission already has an important role to play, as it is responsible for ensuring the safety and wellbeing of people who use social care services. In addition, the Government, working with the Association of Directors of Adult Social Services and the Care Quality Commission, is gathering greater intelligence on the care and support market and its major providers that will be used to give early warning of impending problems.[227]

However, the white paper, and subsequently the consultation document published in December 2012, set out the Government's belief that events in previous years, in particular the failure of Southern Cross, required regulation in this area to be revisited and the measures already in place potentially strengthened. The consultation document stated:

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[224] *Ibid.*, c558-559
[225] Explanatory Notes, para 280
[226] HM Government, *Caring for our Future: Reforming Care and Support*, p47-48
[227] *Ibid.*, p48

> Recent events have highlighted the need for the Government to review whether or not current mechanisms to oversee the social care market are sufficient, and whether additional measures are necessary to protect service continuity for care users;
>
> - The difficulties faced by Southern Cross Healthcare in 2011 demonstrated that there are specific challenges associated with monitoring and managing transition and continuity of service if a provider that is operating across England with highly complex financial structures fails;
>
> - The National Audit Office (NAO)[228] recommended that the Department of Health should determine where current oversight was insufficient and where more central oversight is necessary. The NAO stated that the case of Southern Cross demonstrated that the Government needs further arrangements at a national and local level to protect users from provider failure;
>
> - The Government committed to developing continuity regimes for key services in the *Open Public Services* White Paper.[229] [230]

As a result, the consultation sought views on:

- What further measures were needed to strengthen and clarify the responsibility of local authorities in relation to care users in the event of the failure of a care provider; and

- Whether a targeted model of central oversight would be appropriate and if so, what the elements of this model would be.[231]

The consultation ran until March 2013.

The Government's response to the consultation was published in May 2013.[232] The response set out the Government's intention to legislate in light of the responses received:

> First, the Government believes that all people receiving care, regardless of whether it is paid for by their LA, the NHS or out of their own or their families' pocket, should have the peace of mind that their LA will support them in cases of provider failure. **The Government will therefore create a new legislative provision to apply specifically in the case of provider failure.**
>
> Second, the Government believes that financial factors can put at risk the quality and continuity of people's care. **The Government intends therefore to bring in a system of financial oversight** which requires providers to disclose financial information, creates an early warning system, and allows necessary interventions to protect people's care.[233]

Both of these commitments are carried forward in the *Care Bill*.

Provider failure

Clause 49 of the Bill would place a duty on local authorities to ensure that adults' needs for care and support (or needs for support in the case of an adult who is a carer) continue to be met when a business provider regulated by the Care Quality Commission fails. The duty

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228 National Audit Office, *Oversight of User Choice and Provider Competition*, September 2011
229 HM Government, *Open Public Services*, Cm 8145, July 2011
230 Department of Health, *Market Oversight in Adult Social Care: Consultation*, December 2012, p8
231 *Ibid.*, p7
232 Department of Health, *Oversight in Adult Social Care: The Consultation Response*, May 2013
233 *Ibid*, p12

would apply to needs which the authority was not already meeting at the point of the provider failure. The duty would not apply to needs which the local authority in the area of the provider was already meeting at the when the provider failed, because the local authority's duty to meet those needs is unaffected by the business failure of the provider who had been meeting those needs on their behalf.

The clause would further provide that the authority in whose area the service was being carried out must meet the needs which the provider is no longer able to meet for as long as it considers necessary, regardless of where that adult is ordinarily resident and even if the adult does not have eligible needs and the authority has not carried out a needs, carers or financial assessment. The clause would provide for the authority to charge, with certain restrictions, for services carried out in this way.

The clause would also provide that, if the adult whose needs are being met is ordinarily resident outside of the local authority with the temporary duty to meet their needs, then that authority must co-operate the local authority where they are ordinarily resident in respect of those needs; the clause would also allow the local authority with the temporary duty to recover from the other authority the cost it incurs in meeting those needs for a temporary period.

Clause 50 would ensure that the duties in clause 49 apply in cross-border cases where a failed provider in England had been providing a service under arrangements made by relevant authorities in Wales, Scotland or Northern Ireland. **Clause 51** would place a temporary duty on local authorities in Wales to ensure that adults' needs continue to be met where a failed provider had been providing a service under arrangements made by relevant authorities in England, Scotland or Northern Ireland. **Clause 52** would place a provider failure duty on Health and Social Care trust in Northern Ireland, equivalent to that applied to a local authority in Wales under clause 51, to ensure that adults' needs continue to be met where a failed provider had been providing a service under arrangements made by relevant authorities in England, Scotland or Wales.

Clause 53 would provide further clarifications in relation to the previous four clauses, including that authorities would not necessarily have to meet the needs under this duty in the same way as they had been previously provided, and that authorities must discuss with the adult with care needs, and any other relevant persons including their carer, how their needs will be met.

Market oversight

The Bill would provide for a new regime of central oversight of the care market operated by the Care Quality Commission (CQC). The CQC would monitor the financial position of the most 'difficult to replace' providers in England. Providers may be considered difficult to replace for any reason set out in regulations, although the Government has identified a provider's size, concentration in a certain area, or specialism as initial criteria for inclusion.[234] The system is intended to support local authorities to prepare and manage continuity of care, with the aim of minimising anxiety for local people.[235]

Clause 54 would provide for regulations to set out the criteria for entry into the central oversight regime, and stipulate that the eligibility criteria must be made with particular regard to the provider's size, its concentration in a particular area or areas, and its level of specialism. The clause would also provide discretion for eligible providers to be excluded from the regime where the Secretary of State is satisfied that sufficient regulation is already

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[234] Department of Health, *The Care Bill Explained*, p29
[235] *Ibid*., p76

in place from another source, and for providers who do not fit the eligibility criteria to be included in the regime.

Clause 55 would confer responsibility on the CQC to identify those providers who fit the eligibility criteria, and to inform them that they are subject to the oversight regime. The CQC would also be made responsible for informing providers who do not fit the eligibility criteria, but are brought under the regime, that this has been done.

Clause 56 would provide a duty for the CQC to assess the financial sustainability of providers subject the regulatory regime, with a view to identifying threats to their financial sustainability, and to take steps if threats are identified, which may include:

- Requiring further information from the provider, likely to be particularly relevant to the finances of the provider or another entity on which it depends;
- Requiring the provider to develop a 'sustainability plan' to manage any risk to the provider's sustainability;
- Organising, or requiring the provider to organise, an independent business review to help the provider return to stability.

Clause 57 would require the CQC to inform the relevant local authorities in England when a provider is likely to fail. The clause would provide further powers for the CQC to require information from the provider that will help for care services to be maintained, and require that the CQC share information that will help to maintain continuity of care with local authorities.

Clause 58 is a supplementary provision, and would link the new responsibilities of the CQC for market oversight to its existing regulatory functions.

4.10 Transition for children to adult care and support

Children have rights to assessment and support under the *Children Act 1989*. The Bill leaves these rights in place, but includes provision in clauses 59-67 aimed at easing the transition to adult care and support for young people, young carers and carers of children.

Clause 59 would provide for local authorities to assess a child's care and support needs where it appears to a local authority that the child is likely to have needs for care and support after turning 18 and it considers there is significant benefit to the child in doing so, or on request of the child, their parent or carer. **Clause 60** would set out the aims of such an assessment and how it would proceed.

Clause 61 would provide a similar duty for authorities to assess the needs of a child's carer (whether or not they are the child's parent) when it appears to the local authority that the carer is likely to require support after the child turns 18 and that there would be significant benefit to the carer in carrying out the assessment. **Clause 62** would provide the requirements for what must be considered in such an assessment. **Clause 63** would provide powers for the local authority to meet a child's carer's needs. A child's carer's needs would normally be met under section 17 of the *Children Act 1989*; this clause would provide for additional assistance not available under the 1989 Act, to be defined in regulations.[236]

Clause 64 would provide a further duty for local authorities to assess young carers, when it appears to the local authority that the young carer is likely to have needs support after they

[236] Explanatory Notes, para 354

turn 18 and that there would be significant benefit to the carer in carrying out the assessment, or on request of the young carer or someone acting on their behalf. **Clause 65** would provide the requirements for what must be considered in such an assessment.

Clause 66 makes further provision in relation to clauses 59-65, including that assessments may be combined with other assessments (for instance between a child and the child's carer) if the relevant consent and agreement is available. **Clause 67** would provide that, where care and support is needed immediately after a child or young carer's 18th birthday but is not in place, local authorities have a duty to continue services previously provided under other legislation until the relevant steps have been undertaken, to ensure continuity of services.

In its pre-legislative scrutiny report, the Joint Committee recommended that the Bill should be amended to ensure that children under 18 who are not receiving care but who are likely to require it after age 18 should be eligible under this section, and that the Bill should include a "presumption that any child in receipt of an Education, Health and Care Plan under the *Children and Families Bill*, and any child receiving care and support, or who has family members receiving care and support, under other legislation, comes within this definition."[237] In response the Government said that the Bill included provision for children not receiving care and support already, including those Education, Health and Care Plan, and that it would clarify this in the Bill's Explanatory Notes.[238]

The Joint Committee also recommended that it be made clear that transition assessments could be carried out alongside assessments made under other legislation, and specifically Education, Health and Care Plans.[239] The Government responded that the Bill would allow for this, and that it would clarify this point in the Explanatory Notes and in more detail in subsequent guidance.[240]

The Joint Committee recommended that local authorities should have power to make to make provision for children aged 16 and 17, including young carers, if assessments made under this section identified need.[241] The Government rejected this recommendation, stating that adult care and support is a distinct system from that in place for children, and that it would focus instead on easing the transition from one to the other.[242]

4.11 Independent Advocacy Services

Clause 68 would provide that, where the local authority believes that an adult or carer who is the subject of an assessment, care or support planning or review process would have 'substantial difficulty' understanding the process, or in communication their thoughts and feelings about it, the authority would be under a duty to arrange for an independent advocate to be available to facilitate their involvement. This duty would not apply if the authority was satisfied that an appropriate person to represent the adult was otherwise available. The clause would also provide for regulations to be made to specify the requirements for an advocate, as well as what would constitute 'substantial difficulty' and who would count as an appropriate person to remove the duty.

Clause 69 would place a similar duty on local authorities to arrange for an advocate to be made available for an adult who is the subject of an adult safeguarding enquiry or a safeguarding adults review and would have 'substantial difficulty' understanding the process,

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237 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 238
238 Department of Health, *The Care Bill Explained*, p73
239 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 244
240 Department of Health, *The Care Bill Explained*, p73-74
241 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 256
242 Department of Health, *The Care Bill Explained*, p75

or in communication their thoughts and feelings. This duty would not apply if the authority was satisfied that an appropriate person to represent the adult was otherwise available.

4.12 Other provisions

Enforcement of debts

Clause 70 would provide a power for local authorities to recover as a debt any sums owed to them under Part 1 of the Bill, such as unpaid charges and interest, where a deferred payment is not available or has been refused by the adult concerned. The clause would provide for such sums to be recoverable within six years (if they become due following commencement of the clause), or within three years (if they became due before commencement), and that any expenditure incurred by the local authority due to misrepresentation on the part of the adult concerned may also be recovered as a debt. It would also provide for further regulations to be made to determine when a debt is due, when exemptions to recovery may apply, and when an authority may charge interest on a debt owed.

Clause 71 would empower local authorities to recover amounts lost if, where a person is or has been having their care and support needs met by an authority, that person transfers assets to another person in order to avoid charges.

Capped Cost System: Five Year Review

Clause 72 would require the Secretary of State to review the operation of the capped cost system every five years, with a report to be published and laid before Parliament. The review must include consideration of:

- The level of the care cap;
- The level that 'daily living costs' are being set at;
- The level of financial means an adult may have before financial support is provided by the state.

In reviewing these matters, the Secretary of State must consider:

- The financial burden on the state of each of those matters being at their then-current level;
- The financial burden on local authorities of each of those matters being at their then-current level in question;
- The financial burden on adults who have needs for care and support of each of those matters being at their then-current level;
- The length of time for which people can reasonably be expected to live in good health;
- Changes in the ways or circumstances in which adults' needs for care and support are being or are likely to be met;
- Changes in the prevalence of conditions for which the provision of care and support is or is likely to be required, and
- Such other factors as the Secretary of State considers relevant.

Discharge of hospital patients with care and support needs

Clause 73 introduces provisions about delayed discharges set out in Schedule 3. This re-enacts the effect of the delayed discharges provisions of the *Community Care (Delayed Discharges etc) Act 2003* and relevant regulations, subject to simplification and amendments to fit the new NHS architecture. **Schedule 3** deals with the planning of safe discharge of patients in England from NHS hospital care, or hospital care arranged for by the NHS, to local authority care and support to ensure that patients are not delayed in hospital despite being fit, safe and ready to be discharged.[243]

After-care under the Mental Health Act 1983

Clause 74 is intended to clarify the meaning of, and makes minor amendments to, section 117 of the *Mental Health Act 1983.* The Explanatory Notes to the Bill state the changes remove anomalies in determining the responsible local authority in relation to the provision of after-care services under the 1983 Act to people who have been detained in hospital for treatment of mental disorder under certain sections of the 1983 Act. The clause also inserts new section 117A into the 1983 Act, enabling a person to express a preference for particular accommodation to be provided under section 117. **Schedule 4** makes a number of modifications to the application of certain provisions of the Bill to enable direct payments to continue to be made in respect of section 117 services.[244]

The definition of after-care was debated during the Committee and Report stages in the Lords, and the Government introduced amendments to reflect the Government's policy on the appropriate scope of the duty to provide free aftercare services. Labour Peer Lord Patel of Bradford raised concerns that the clause, which he said provided the "first ever statutory definition of after-care services", was too narrowly defined around medical needs and would be detrimental to patients' welfare. He introduced his own amendment (128A), which was disagreed on division (Contents 178; Not-Contents 198).[245] The Minister, Earl Howe, stated that Lord Patel's amendment would have imposed a duty on local authorities to commission free after-care services based on needs unrelated to patients' mental disorders. The Minister explained that this "would create an inequity between this group of people and others with equivalent needs for care and support who are not eligible for free aftercare, either because they have been detained under other provisions of the [1983] Act or not detained at all."[246]

Prisoners and those in bail accommodation

The Bill sets out the safeguarding responsibilities of local authorities relating to prisoners and those in approved premises (such as bail accommodation). **Clause 75** would set out the responsibilities for provision of care and support for adult prisoners and people residing in approved premises such as bail accommodation. It states that the local authority in whose area a prison, or approved premises, is located will be responsible for providing assessments and meeting care and support needs for the residents of those custodial settings. A detainee's previous ordinary residence will not be a consideration while they are in these settings. The clause would make further provision to ensure that continuity of care is maintained for prisoners moved between locations, and for young offenders who move into adult care and support. It would also provide that certain care and support provisions in the Bill, such as direct payments or preference of accommodation, do not apply for prisoners.

During Committee Stage in the House of Lords, Government amendments were agreed which clarified the interface between local adult safeguarding boards and prisons, and how

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243 *Care Bill* Explanatory Notes
244 *Ibid.*
245 HL Deb 16 October 2013 c593-601
246 *Ibid.*

they should work together; and to provide that safeguarding adult boards will not carry out serious case reviews in prisons or bail premises, but be available for advice.[247]

During Report Stage, Lord Patel tabled an amendment to ensure that that people in prison and those residing in approved premises have equivalence of care when it comes to safeguarding inquiries by local authorities. The amendment was subsequently withdrawn.[248]

During the Third Reading debate, Lord Patel tabled an amendment to state that the Secretary of State should report to Parliament on the discharge by probation trusts of their responsibilities for safeguarding adults residing in approved premises, within one year of the relevant provisions coming into force.[249] In response, Earl Howe said that guidance for prisons, probation officers, and local authorities was being developed to ensure that duties were discharged correctly.[250]

Registers of sight-impaired adults

Clause 76 would require local authorities to establish and maintain a register of people who are ordinarily resident in their area and are sight-impaired. This replaces the duty on local authorities to maintain registers of disabled people under section 29(4)(g) of the *National Assistance Act 1948*,[251] which is in practice rarely used. The clause would provide for local authorities to maintain a register of people in their area with care and support needs, or potential future care and support needs, if they wish to do so.

Guidance

Clause 77 would provide for the Secretary of State to issue statutory guidance to local authorities about how they must carry out their duties under Part 1 of the Bill.

In its pre-legislative scrutiny report, the Joint Committee recommended that guidance be issued as a statutory Code of Practice, following the model of the *Mental Capacity Act 2005*. The Committee acknowledged the Government's belief, expressed in evidence to the Committee, that guidance in this area should be flexible and that a Code of Practice would be too rigid, but stated:

> It is not the title of the document which matters—section 42 of the Mental Capacity Act 2005 makes clear that the codes of practice issued by the Lord Chancellor are "for the guidance" of those involved—but their statutory status, their Parliamentary control, and the fact that courts may specifically take them into account.[252]

The Government rejected the Committee's recommendation. It stated:

> Our view remains that a code of practice would be too inflexible for adult care and support guidance that may quickly become out of date. Our new bank of statutory guidance would have the same legal status and be subject to consultation in the same way as a code of practice. However, because it would not need to be laid before Parliament each time it is amended for any future changes, it could be kept up to date to reflect emerging policy and practice, which would be particularly important in relation to implementing new funding reforms. Our approach is consistent with children's social services legislation, which also uses statutory guidance rather than a code of practice. Where codes of practice are used in other cases, this is usually where the function

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247 PBC 29 Jul 2013 c1578-1588
248 HL Deb 16 Oct 2013 c621-625
249 HL Deb 29 Oct 2013 c1476
250 *Ibid*., c1479-80
251 Explanatory Notes, para 433
252 Joint Committee on the Draft Care and Support Bill, *Draft Care and Support Bill*, para 65

> impacts on fundamental individual rights (for example, in relation to mental health and mental capacity legislation) and the case for Parliamentary oversight is stronger.[253]

Delegation of local authority functions

Clause 78 would provide a power for local authorities to delegate certain care and support functions to a third party, to varying extents and for time periods as appropriate.

The clause would stipulate that certain functions could not be delegated in this way:

- The promotion of the integration of care and support with health services;
- The duty to co-operate, both generally and in specific cases;
- The local authority's power to charge;
- The making of direct payments;
- The authority's adult safeguarding duties.

The clause would provide that anything done (or that was failed to be done) by the third party two whom a function was delegated would be treated as done (or not done) by the local authority itself, so that ultimate responsibility would remain with the authority. (This would not make the third party immune from liability for any criminal actions.)

The clause would also provide an order-making power to enable the Secretary of State to change the list of functions to which the power to delegate functions would apply, and also to impose conditions and limitations on the exercising of the power.

4.13 Comment on Part 1 of the Bill

The *Care Bill* has prompted a large amount of comment and responses from many organisations, both to the Bill as a whole and to particular reforms. This section provides an overview of some of these responses, and links to articles and briefings that have been produced. It should be noted that many of the briefings listed were produced when the Bill was first published in May 2013, and so do not take account of changes that have been made subsequently, and may also refer to clauses which have been relocated in later versions of the Bill.

Labour Party

Responding to publication of the Bill, Liz Kendall, the Shadow Minister for Care and Older People, stated:

> We need a far bigger and bolder response to meet the challenges of our ageing population: a genuinely integrated NHS and social care system which helps older people stay healthy and living independently in their own homes for as long as possible.[254]

In November 2013, it was reported that a Labour Party analysis of the proposed cap on care costs stated that elderly people might pay £150,000 for residential care before reaching the cap.[255]

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253 Department of Health, *The Care Bill Explained*, p34
254 Labour Party, *Care Bill - bigger and bolder response needed to meet the challenges of our ageing population - Liz Kendall*, 10 May 2013
255 BBC News Online, *Elderly 'face £150,000 care bill before hitting cap'*, 14 November 2013

Action on Elder Abuse

Action on Elder Abuse have published a briefing on potential changes to the Bill's safeguarding provisions, advocating a new criminal charge of elder/adult abuse.[256] The group also published a briefing alongside Age UK and Mencap in September 2013 (see following section).

Age UK

Age UK published a briefing in May 2013, which discussed various issues in the Bill, including:

- Meeting currently unmet care needs;
- Information and advice;
- Care quality and individual dignity;
- Adult safeguarding;
- Integration of services;
- The cap on care costs;
- Care fee top-ups and charges.[257]

The briefing stated that "[t]he Care Bill is a vital part of the changes [to the adult social care system] that are necessary. Age UK urges Parliamentarians to support this important Bill that clarifies and brings up to date the legal framework of the care system."[258] It also raised concerns about whether the Bill's intentions could be realised within the funding likely to be available:

> The current and future funding of adult social care is likely to be 'the elephant in the room' throughout the progress of this Bill [...]
>
> The Care Bill offers an ambitious and positive vision for the future of social care. It guarantees an individual's wellbeing and protects them from unreasonable costs. But in the current funding climate the sad truth is that this vision cannot possibly be realised.[259]

In September 2013, Age UK, alongside Action on Elder Abuse and Mencap, published a briefing advocating that the Bill's safeguarding provisions be strengthened. It proposed the following additions to the Bill:

- A duty on care providers and other relevant partners to inform the local authority when they suspect an adult is at risk.
- A power of access to allow local authorities to carry out a confidential interview with a vulnerable adult believed to be at risk of abuse or neglect, when a third party is denying access to that person. This would only be able to be used as a last resort and would need to be applied for through the magistrates' court. A similar power already exists in Scotland.

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256 Action on Elder Abuse, *The protection of 'vulnerable' adults* [accessed 6 December 2013]
257 Age UK, *Care Bill Briefing*, May 2013
258 *Ibid.*, p1
259 *Ibid.*

- A new offence of Corporate Neglect should be introduced to sanction care home or care agency managers who allow a culture of abuse and neglect to continue in their organisations.

- A new offence of ill treatment or neglect should be introduced to extend protection to vulnerable adults who have mental capacity.[260]

Age UK also published a separate briefing in October 2013 that advocated amendments to the Bill to:

- **Ensure that people with moderate care needs are eligible to receive support.** Many people do not realise that access to the provisions of the Care Bill, including starting the counter on the care payments which accumulate up to the £72,000 care cap, will only apply to people whose care needs are deemed to be 'eligible' for local authority support. It is vital that the national eligibility criteria should be set low enough to make a difference to people's lives before they reach a 'critical' level of need.

- **Improve safeguarding** for people at risk of abuse and neglect, and improve access to redress mechanisms if someone's human rights are infringed.

- **Ensure that the cap on individual spending on social care is implemented fairly**, based on a proper consideration of individual care needs and on eligibility criteria that are not unreasonably restrictive. In addition, the proposed national deferred payments scheme, intended to ensure that people do not have to sell their homes within their lifetime, must cover the full costs of living in residential care.

- **Ensure the assessment process is fair for everyone** by ensuring local authorities do not unreasonably cut corners through the use of unqualified assessors or an over reliance on digital, remote, assessment tools.

- **Strengthen access to advocacy**. The Bill has already been amended to give an individual the right to an advocate if they are 'unbefriended' but we believe that where there is family disagreement on the best type of care or a low level of understanding of the assessment process, someone should also have the right to request an advocate.[261]

Care and Support Alliance

The Care and Support Alliance published a briefing in May 2013 which stated:

> The CSA welcome the Care Bill. The current legislative framework is outdated and failing the very people it should be supporting, the Care Bill has the potential to bring about major improvements; taking us closer to ending the care crisis.
>
> However, the care system is vastly underfunded and the Bill will need to be accompanied by a sustainable funding commitments in the June 2013 Comprehensive Spending Review in order to succeed.[262]

The briefing also recommended the eligibility threshold for social care be set at the 'moderate' band:

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[260] Age UK, Action on Elder Abuse, Mencap, *Leading charities highlight inadequacies in Care Bill*, 11 September 2013

[261] Age UK, *Care Bill Briefing*, October 2013, p1

[262] Care and Support Alliance, *Care Bill – Lords Second Reading Briefing*, May 2013, p1

> We urge the Government to ensure that the threshold is no higher than the equivalent of the current 'moderate' band. To set the threshold higher will undermine the Government's own ambition to promote well-being.[263]

Carers UK

Carers UK published a briefing on the key changes in the Bill in May 2013,[264] and subsequently a more detailed analysis of the parts of the Bill most relevant to carers.[265]

The latter briefing raised several particular concerns. In relation to clause 6, on local authority co-operation with relevant partners, it stated:

> Carers UK welcomes [the clause] which states that a local authority should work with a relevant partner organisation. This is, however, where the letter of the law falls down over the NHS in relation to carers, since none of its functions in primary legislation relate to carers apart from as patients – which is only partially relevant in this instance.
>
> Therefore, Carers UK recommends that there should be a NEW CLAUSE placing a duty on NHS bodies to promote the wellbeing and welfare of carers. The arguments and opportunities for this have been set out in the Private Members Bill promoted by a cross party group of MPs – the Local Sufficiency of Supply and Identification of Carers Bill.[266]

In relation to clause 9, on the assessment of an adult's needs for care and support, it stated:

> In considering how outcomes can be met, the Bill now requires the assessment to look at factors beyond formal services such as the contribution of friends and family and the person's 'own capabilities'. Whilst this broader approach to meeting needs may bring benefits to some, Carers UK is extremely concerned that by incorporating this approach into the statute, the duty on local authorities to meet needs with services will be weakened. We believe that this could fundamentally threaten the rights of disabled people and carers.[267]

The briefing raised similar concerns about the wording of clause 10, and the assessment of a carer's need for support.

On the eligibility criteria for care and support, the briefing stated that:

> Carers UK has urged the Government to fund eligibility to be set at a level that meets what are classed as moderate needs in the current system.[268]

The briefing also raised concerns about the position of young carers and parent carers:

> Carers UK has been working with Carers Trust and Contact a Family to redress the fact that both groups have weaker rights than adults caring for adults.
>
> Ministers have pledged to amend both aspects of the Care Bill and are considering how the Children and Families Bill could be amended to better support young carers. We are disappointed that no such progress has been made yet for parents of disabled children when the opportunity exists to establish similar rights across all groups.

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263 *Ibid.*, p2
264 Carers UK, *Briefing on Key Changes in the Care Bill*, May 2013
265 Carers UK, *Care Bill: Carers UK analysis of the main provisions for carers*
266 *Ibid.*, p3
267 *Ibid.*, p3-4
268 *Ibid.*, p6

> Carers UK is also working with the Care & Support Alliance on a new clause for advocacy for disabled people and carers who are particularly vulnerable. We hope that the Government will accept this very important amendment to the Bill.[269]

Equality and Human Rights Commission

The EHRC published two briefings in advance of the Committee Stage debate in the House of Lords, the first in support of an amendment to clarify that the *Human Rights Act 1998* extends to regulated care services, and the second to support the introduction a power of access in specified circumstances where someone is at risk of abuse or neglect.[270]

Human Rights Act and the Care Bill

A joint policy briefing was published in May 2013 by Mind, Liberty, the Equality and Disability Forum, Scope, Disability Rights UK, the British Institute of Human Rights, Real Life Options, and Age UK, supporting an amendment to the Bill "to ensure that the vital safeguards enshrined in the HRA 1998 extend to all those whom, we have learnt through bitter experience, face a significant risk of abuse."[271]

Law Society

The Law Society published a briefing on 21 May 2013 welcoming the Bill, and noting that it had supported the Law Commission report. The briefing made several recommendations to improve the Bill, including that:

> The Society does not agree that this legislation would not benefit from a statutory Code of Practice and would request this is re-considered.[272]

London Councils

London Councils has produced two briefings; one for the Second Reading in the House of Lords, and another for Report Stage. The latter states that:

> London Councils supports the government's reform of adult social care in the Care Bill. However, we have serious concerns about the level of funding being made available to local government who will have a range of new duties and responsibilities arising from the legislation.[273]

The briefing provides information on what London Councils expects these costs to be.

Macmillan

Macmillan cancer support published a briefing in October 2013, which focused on Macmillan's two 'key priorities' for the Bill:

> 1. Care Bill legislation must specify that health bodies and local authorities work together to identify carers and signpost them to the enhanced support outlined in the Bill as early on in their journey as possible.
>
> 2. The Government should reconfirm its commitment to make a decision on implementing free social care at the end of life by the end of this Parliament and

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269 *Ibid*., p15
270 Equality and Human Rights Commission, *Care Bill Committee Stage House of Lords* [accessed 6 December 2013]
271 Mind, Liberty, et al, *Care Bill 2nd Reading: Human Rights and Social Care*, May 2013
272 Law Society, *Care Bill: House of Lords Second Reading*, 21 May 2013
273 London Councils, *Care Bill – Report Stage*, October 2013, p1

provide cancer patients with the support they need to die in their preferred place of care.[274]

Nuffield Trust

The Nuffield Trust published a briefing in May 2013 that raised concerns on:

- The new cap and a higher upper means test threshold for social care are a major step forwards. But the funding which will support the new cap and means test threshold will not fully bridge the growing gap between funding and demand for social care.

- The funding pressures facing the current system of social care are causing eligibility thresholds to rise, leaving out people whose needs may be serious but are not classed as 'substantial'. Although we welcome the standardisation of eligibility, we are concerned that many of these people will continue to be excluded.[275]

Parkinson's UK

Parkinson's UK published a briefing in May 2013, which raised concerns about funding for local councils, and advocated eligibility for care should be set at the 'moderate' threshold.[276]

Royal College of Nursing

The Royal College of Nursing published a wide-ranging briefing on the Bill in June 2013. The briefing was particularly approving of the integration of care and support services and also measures relating to the provision of information, although the RCN stated it would like to see specific reference to the types and formats of information and advice that local authorities should provide.[277]

Royal College of Physicians

The Royal College of Physicians published a briefing in May 2013 that focused on the latter parts of Bill but stated the College's belief that the passage of the *Care Bill* must lead to greater integration between health and social care sectors.[278]

United Kingdom Homecare Association (UKHCA)

Bridget Warr, the chief executive of UKHCA, a professional association for homecare providers, published an article in the *Guardian* in November 2013, in support of the preventative measures in the Bill, and also its integration health and social care.[279]

Other

The following articles and reports may also be of interest:

- London School of Economics, Personal Social Services Research Unit, *Long-term care funding in England: an analysis of the costs and distributional effects of potential reforms*, April 2013

- King's Fund, *Paying for Social Care: Beyond Dilnot*, May 2013

- Shared Lives plus, *Strengths-based approaches in the Care Bill*, June 2013

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274 Macmillan, *Macmillan Briefing on the Care Bill*, 29 October 2013
275 Nuffield Trust, *Care Bill: Second Reading, House of Lords*, May 2013
276 Parkinson's UK, *What does the Care Bill mean for people affected by Parkinson's in England*, May 2013
277 Royal College of Nursing, *Royal College of Nursing briefing in advance of the Second Reading of the Care Bill in the House of Lords*, June 2013
278 Royal College of Physicians, *RCP parliamentary briefing, Care Bill – Second Reading*, May 2013
279 Let's turn the aspirations in the Care Bill into a reality, *Guardian*, 21 November 2013

- Community Care, *Nationwide care threshold 'will exclude hundreds of thousands in need'*, 28 June 2013

- Community Care, *Government risks funding gap for national care threshold, warns Adass chief*, 1 July 2013

- Community Care, *Social work leaders warn ministers against outsourcing care assessments*, 22 July 2013

5 Part 2: Care Standards

5.1 The Francis Report and reform of care standards and regulation

On 6 February 2013 the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC, was published.[280] This public inquiry was specifically established to examine why serious failures in care at Mid-Staffordshire NHS Foundation Trust before 2009 were not acted on sooner by the various responsible organisations (and followed a number of earlier inquiries).[281] The Francis Report made 290 recommendations designed to create "a common patient centred culture across the NHS".[282] Key themes included the need for clear fundamental standards and measures of compliance, and greater openness, transparency and candour throughout the system, underpinned by statute where necessary.

Following an earlier initial response to the report[283], on 19 November 2013 the Department of Health published *Hard Truths, the Journey to Putting Patients First,* setting out its detailed response to each of the 290 recommendations, and the action it had already taken.[284] The report said the Government had fully or partially accepted all but nine of the recommendations.

The measures in Part 2 of the Bill largely address specific recommendations from the Francis Report about transparency and care standards, and also respond to wider concerns about how regulatory systems are co-ordinated to ensure patient safety, raised by the Francis review and the subsequent Keogh and Berwick reviews.[285]

5.2 Single failure regime for NHS hospitals

The Care Quality Commission (CQC) monitors, inspects and regulates health and social care services to make sure they meet fundamental standards of quality and safety. Under the *Health and Social Care Act 2012* Monitor has become the "sector regulator" for health services in England. It has a duty to promote the provision of economic, efficient and effective health care services. Under transitional arrangements Monitor also continues its

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280 *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Francis Report), 6 February 2013

281 Further background can be found in Library standard note *The Francis Report (Report of the Mid-Staffordshire NHS Foundation Trust public inquiry) and the Government's response*, SN/SP/6690.

282 The Mid Staffordshire NHS Foundation Trust Public Inquiry, *Publication of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, press release, 6 February 2013, p1

283 Department of Health, *Patients First and Foremost: the Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (26 March 2013). See also: DH, *Joint Policy Statement to Accompany Care Bill Quality of Services Clauses, signed by Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority* (May 2013). This joint policy statement provides further detail on the changes to the regulation and oversight of NHS trusts and NHS foundations trusts proposed in the Government's initial response to the Mid Staffordshire NHS Foundation Trust Public Inquiry and related clauses in Part 2 of the Care Bill.

284 DH response to the Francis Report, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-I (19 November 2013)

285 http://www.nhs.uk/NHSEngland/bruce-keogh-review
https://www.gov.uk/government/publications/berwick-review-into-patient-safety

original function in ensuring compliance with corporate and financial governance for NHS foundation trusts.

The Francis Report recommended that there should be a single regulator dealing both with financial and care quality standards for all trusts.[286] While the Government has said it does not accept this recommendation it instead proposes to establish a unified regime for detecting and intervening in failures in care quality and financial performance.

Under the reformed failure regime for NHS hospitals there will be a three stage process: identification, intervention and, as a last resort, special administration. The CQC will focus on exposing problems and rather than intervening itself, it would require Monitor, in relation to NHS foundation trusts, or the NHS Trust Development Authority (TDA), in relation to NHS trusts, to take action.[287] If a poor-performing provider is unable to resolve the situation working with commissioners and regulators the TDA, under existing powers and acting on behalf of the Secretary of State[288], or Monitor, under powers in the Bill, would be able to replace a trust's board or to appoint a special administrator. Proposals in the Bill are designed to ensure that this action can be taken in relation to foundation trusts as well as trusts and in cases of clinical as well as financial unsustainability.[289]

In May 2013 the Department of Health issued a joint policy statement to accompany the quality of service clauses in the Bill, which provided a summary of the roles and responsibilities of the CQC, Monitor and the TDA, as well as NHS England, clinical commissioning groups and the Department of Health. This made it clear that Monitor's powers to intervene in Foundation Trusts under the single failure regime would apply until at least April 2016:

> To ensure that Monitor can take prompt action where the CQC, through the Chief Inspector, has identified a need for significant improvements in quality of health services provided by a foundation trust, the Care Bill will clarify that Monitor can apply additional licence conditions to be imposed where the CQC has issued a warning notice to a foundation trust. Failure to comply with these extra conditions provides grounds for Monitor to remove, suspend or replace the foundation trust's governors or directors. These powers will apply to all foundation trusts until at least 1 April 2016. After that date, the Secretary of State may exercise his discretion under the Health and Social Care Act 2012 to order that they should no longer apply to foundation trusts that have been authorised for at least two years, if they meet certain criteria. Those criteria would be developed by Monitor and would be subject to consultation and approval by the Secretary of State before they could take effect.[290]

Clauses 81 to 84 provide for a single failure regime by enabling CQC to issue warning notices to NHS trusts and NHS foundation trusts where the services provided by them require significant improvement; extending Monitor's powers to be able to impose additional licence conditions on foundation trusts; and enabling Monitor to make an order authorising the appointment of a trust special administrator for foundation trusts on quality grounds. **Clause 85** prevents registered providers from applying for a change to their conditions of registration where the CQC has commenced proceedings to make the same change.

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[286] *Francis Report*, recommendation 19, chapter 10

[287] CQC will retain its enforcement powers for social care, general practice and independent sector providers.

[288] The TDA is a Special Health Authority established under the *NHS Act 2006* and, as such, it is not featured in primary legislation, including the Care Bill. It operates in accordance with the directions issued to it by the Secretary of State and will continue to fulfil its role until all NHS trusts are authorised as foundation trusts.

[289] DH, *Factsheet 12 The Care Bill- Single Failure Regime*, May 2013

[290] DH, *Joint Policy Statement to Accompany Care Bill Quality of Services Clauses, signed by Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority* (May 2013).

5.3 Trust Special Administrators

In October 2013 the Government introduced an amendment to the Bill about the powers of Trust Special Administrators (TSAs), who are appointed to take charge of failing trusts and make recommendations about the future of their services, to make recommendations about service changes that involve neighbouring trusts. This amendment (168A) was tabled on 16 October and agreed during the Report Stage in the Lords on 21 October. It is currently **clause 118** in part 3 of the Bill. Earl Howe the Minister introducing the amendment stated that the amendment would: "...put beyond doubt the Government's existing position that the remit of a trust special administrator is to make recommendations that may apply to services beyond the confines of the trust in administration...".[291] He added that this "clarification of the scope of the administrator does not constitute a change of policy, is not retrospective, and is intended only to remove any uncertainty for the future."[292]

The new clause also extends the time that the administrator has to produce and consult on their draft report, strengthens requirements for a TSA to seek the support of commissioners affected by their recommendations, would require the Secretary of State to produce guidance for TSAs about seeking commissioner support for their proposals, and would clarify that the statutory obligations of commissioners - to involve and consult patients and the public in planning and making service changes - do not apply in respect of the TSA regime.

Opposition spokesperson Lord Hunt of King's Heath said that he viewed the Government amendment "not as a clarification of the law but as a major policy change that is at odds with the approach taken by the Secretary of State in the 2012 [Health and Social Care] Act, when he repeatedly put his faith in local commissioning by local doctors." Although the Minister, Earl Howe, said that he was open to further inter-party discussions about the matter, an amendment to delay the introduction of an extension of the scope of the administration process was disagreed on division (176 for and 242 against).[293]

The extent of TSA powers were considered in a recent judicial review of the South London Healthcare Trust TSA's recommendation to downgrade A&E services at neighbouring Lewisham NHS Trust. Both the High Court and, following a Government appeal, the Court of Appeal overturned the Secretary of State's decision to accept the TSA's recommendation in this case.[294]

The debates in both Houses on 30 October 2013 on changes to health services in London included responses from Ministers about the Court of Appeal's judgment of 29 October in relation to the TSA regime.[295] While confirming that he would not be pursuing any further appeal the Secretary of State for Health explained why he considered the amendment to the *Care Bill* was important:

> It is important to make that amendment to the Care Bill because hospitals are not islands on their own. We have a very interconnected health economy, and what happens in Lewisham has a direct impact on what happens in Woolwich and vice versa. If we are to turn around failing hospitals quickly—something that the last

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[291] HL Deb 21 Oct 2013 c788-9

[292] *Ibid.*

[293] *Ibid.*

[294] The High Court decided to quash the TSAs recommendations relating to Lewisham NHS Trust and the Secretary of State's decision to accept these; see R (Lewisham Council and another) v SS for Health and the TSA, [2013] EWHC 2329 (Admin), 31 July 2013. For coverage of the Court of Appeal judgement on 29 October 2013 see: http://www.bmj.com/content/347/bmj.f6771

[295] See HC Deb: 30 October 2013 c921 to 938 and HL Deb: 30 October 2013, c1585 to 1595.

> Government sadly did not do—we need to have the ability to look at the whole health economy, not at problems in isolation.[296]

5.4 Care Quality Commission (CQC) and health and social care ratings

The Government introduced new clauses at Report Stage to give the CQC greater statutory independence **(clause 88)** and to establish the newly created positions of Chief Inspector of Hospitals, General Practice and Adult Social Care in law **(clause 87)**.[297] There was broad cross-party agreement on the new clause promoting CQC independence although there were divisions on opposition amendments about the CQC's role in reviewing the commissioning of health and social care services (194 for and 220 against),[298] and to provide that CQC must have regard to any official guidance on staffing numbers and skills mix (194 for and 204 against).[299]

The Francis Report[300] called for evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. The Minister, Earl Howe, attempted to provide reassurance around the issue of staffing levels, highlighting the work that was already underway on issuing staffing guidance and ensuring that providers published information on staffing levels. However, the Minister noted "...the fundamental point, that it is the responsibility of individual providers to be accountable for staffing levels in their organisations."[301]

In November 2012 the Secretary of State for Health commissioned the Nuffield Trust to review whether aggregate ratings of provider performance should be used in health and social care, and if so how best this might be done. The report of the review, *Rating providers for quality: a policy worth pursuing?*, was published in March 2013. It concluded that while, on their own, aggregate ratings would not help identify poor-quality care they might be of value to the public in helping to choose services, and to those organisations purchasing or providing services, if focused on quality and introduced incrementally.[302] **Clause 89** provides for CQC to devise a new ratings system for providers, and would require CQC to conduct periodic reviews, as set out in regulations, and to consult with the Secretary of State and other key stakeholders on the new system.[303]

5.5 New duty of candour

The Francis Report recommended that a statutory obligation should be imposed on providers and healthcare professionals to observe a duty of candour.[304] The Government had previously said it would use regulations to make the provision of certain information a condition of registration with the Care Quality Commission (CQC) but during the Lords Report stage Ministers introduced a new "duty of candour" clause **(clause 80)**, to specify that the Secretary of State must introduce these regulations.[305] The new clause states that these regulations must be made "as to the provision of information in a case where an incident of a specified description affecting a person's safety occurs in the course of the person being provided with a service." The Department of Health will consult on the regulations setting this

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296 HC Deb 30 Oct 2013 c929-30
297 Amendments 142 and 143 (new clauses 87 and 88), HL Deb 21 October 2013 cc803-819. For further background see DH press notice, *Government strengthens health regulator's independence*, 1 October 2013
298 HL Deb 21 October 2013 c819-833
299 *Ibid.*
300 Francis Report, 6 February 2013, Recommendation 23
301 HL Deb 21 October 2013 c829
302 Nuffield Trust, *Rating providers for quality: a policy worth pursuing?, 22* March 2013
303 For further information see DH, *Factsheet 13 The Care Bill – Health and social care ratings*, May 2013
304 Francis Report, 6 February 2013, Recommendation 181
305 HL Deb 16 October 2013, cc635-40

duty which would require providers to inform people of the incident, provide an explanation, and where appropriate an apology.

The duty would apply to health and adult social care providers of regulated activities and would be enforced using CQC powers. The Government has decided against adopting Francis's recommendations in full in relation to a statutory duty of candour on individual healthcare professionals and making it a criminal offence to obstruct individuals from exercising a duty of candour; the Department has said it plans to address these issues by strengthening professional codes of conduct:

> We are working with the General Medical Council, Nursing and Midwifery Council and other professional regulators to strengthen the references to candour in their work – including clear guidance that professionals who seek to obstruct others in raising concerns or being candid would be in breach of their professional responsibilities.[306]

The Government has also said it will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident.[307]

Commenting on the Government's response to the Francis Report, and the decision not to apply the duty of candour to individuals, the Labour spokesperson Lord Hunt of King's Heath said "It is not entirely clear how an organisational duty alone will help individuals challenge an organisation where there is a dysfunctional culture. Is it not the case that an individual duty, as proposed by Francis, is needed?"[308]

He also called for further clarity about whether the duty of candour would extend to all healthcare organisations, including private providers:

> The duty of openness and transparency should apply equally to all organisations providing NHS services, including, as Francis rightly recommended, contractors providing outsourced services. The Government are clearly bringing in more outside providers. Surely patients need reassurance that we do not have an uneven playing field where private providers face less scrutiny. Will the Government extend the duty of candour to all healthcare organisations as Francis proposes? The amendments to the Care Bill do not seem to make that clear.[309]

The Shadow Health Secretary Andy Burnham has called on the Government to implement "in full the recommendation from the Francis Inquiry on a new duty of candour on individual NHS staff" and said "Labour will force this issue to the vote when the Care Bill reaches the Commons...".[310]

5.6 New criminal offense for care providers to give false or misleading information

Clauses 90 to 92 of the Bill provide for a new criminal offence for care providers who supply, publish or otherwise make available information that is false or misleading, with associated criminal sanctions. The criminal offence will apply to the organisation as a whole (as a legal corporate entity) rather than individuals. However, the offence will allow for the prosecution of directors and senior individuals, where the offence has been committed with their consent or

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306 DH, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-II (19 November 2013) pages 156-9
307 *Ibid.* page 49
308 HL Deb 19 November 2013 c862
309 *Ibid.*
310 http://press.labour.org.uk/post/65335866765/we-welcome-ann-clwyds-report-on-patient-complaints-in

connivance or through their neglect, and a successful prosecution has been brought against the provider.[311]

The Government has said that initially, regulations will limit the criminal offence to providers of NHS hospital care (whether provided by NHS trusts, foundation trusts, or independent providers such as private companies and charities). Regulations will also set out the type of information covered by the offence, which the Government has said could include data used to establish mortality rates.[312]

The Health Select Committee has said it "remains to be persuaded" of the case for the introduction of a statutory offence - in effect criminalising a breach of the proposed statutory duty of candour - in addition to existing contractual duties and professional obligations.[313]

Lords stages

During Report Stage in the Lords, the Government made two substantive amendments to these clauses. Firstly, to extend the offence to directors and other senior individuals who "consent to or connive in an offence committed by the care provider", as well as to cases where the negligence of senior individuals has led to the offence by the care provider. This amendment brings the offence into line with a number of other offences where senior individuals are also liable for the offence. Secondly, to introduce a maximum penalty on indictment of two years' imprisonment in the most serious cases. The Minister emphasised that the Government was not of the view that the custodial penalty would be used with any frequency: "The aim of the offence is not to punish directors and other senior individuals but, rather, to drive improvement and performance."[314]

6 Part 3: Health Education England (HEE) and Health Research Authority (HRA)

Part 3 of the Bill would establish Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental bodies (NDPBs). These measures are intended to strengthen the independence of the two recently created bodies, which lead national systems for the education and training of health care professionals and that regulate health and social care research respectively. The Bill would also introduce a duty for HEE to ensure education and training for healthcare workers is provided in such a way that promotes the NHS Constitution.

6.1 Health Education England

Proposals for a new system for the education and training of NHS staff were set out in *Liberating the NHS: developing the healthcare workforce*, published in December 2010.[315] Under these proposals Health Education England (HEE) was established as a Special Health Authority to provide national leadership for the planning and commissioning of education and training for the health workforce. HEE has taken on the education and training functions of Strategic Health Authorities (SHAs), which were abolished in April 2013, including responsibility for postgraduate deaneries. HEE has a budget of £4.886 billion in 2013-14 and directly employs 1,872 full-time equivalent staff. The salaries budget for the staff directly employed by HEE is £107.7 million.

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311 DH, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-II (19 November 2013), pages 79-80

312 For further information see DH, *Factsheet 14 The Care Bill – false or misleading information*, May 2013

313 Health Select Committee, *After Francis: making a difference* (HC657, 2012-13, 18 September 2013), para 59

314 HL Deb 21 October 2013 c834-5

315 See also NHS Future Forum, *Education and Training – next stage* and DH, *Liberating the NHS: developing the healthcare workforce: from design to delivery,* January 2012. In May 2012 the Health Select Committee published a report on the Government's proposals, *Education, training and workforce planning* (HC 6-I, 2012-13, 26 May 2012)

HEE has established 13 committees, known as local education and training boards (LETBs), which together cover the whole of England and are responsible for the training and education of healthcare staff within their area. LETBs provide local delivery and leadership. LETBs are the forum for providers and professionals to work collectively to improve the quality of education and training in their local area and to meet the needs of service providers, patients and the public. LETBs include representatives from NHS providers, education providers, the professions, local government and the research sector.

The *Health and Social Care Act 2012* gave the Secretary of State for Health an explicit duty to secure an effective system of education and training. While HEE will have day-to-day responsibility for meeting this duty, overarching objectives will be set out by the Department in a mandate for HEE, which in turn will be shaped by the Government's Education Outcomes Framework.[316]

Lords stages

During the Bill's Committee Stage in the Lords, Peers discussed the role of HEE in ensuring the staff they train are able to work across the health and social care boundary in an integrated way. They also considered quality improvement in education and training and whether HEE should introduce registration or mandatory training standards for healthcare assistants and social care support workers.[317]

The Francis Report recommended the creation of a registration system for healthcare support workers.[318] The Government did not accept this recommendation but on 21 October 2013, Earl Howe introduced a new clause **(clause 93)**, updating the provisions in the *Health Social Care Act 2008*, that would enable regulations to be made to specify a body that would set training standards in respect of healthcare assistants and social care support workers.[319]

The Francis Report included a recommendation that HEE should include a lay patient representative on its board. The Government supported that recommendation and tabled amendments to **Schedule 5** to require the HEE board to include a non-executive member who will represent the interests of patients. A Government amendment would also require local education and training boards to include a person who will represent the interests of patients.[320]

6.2 Health Research Authority

Part 3 of the Bill would establish the Health Research Authority (HRA) as an NDPB. The HRA is intended to create a unified approval process for research, to promote the interests of patients and the public in health and social care research, streamline the research approvals process and encourage investment in research. The plan for the HRA was announced in the Government's 2011 *Plan for Growth*[321] and it was established as a Special Health Authority in December 2011. The HRA has already taken on the core functions of the National Research Ethics Service and is working jointly with others, such as the Medicines and Healthcare products Regulatory Agency (MHRA), to create a unified approval process for research and to promote consistent and proportionate standards for compliance and inspection. However, as a Special Health Authority, the HRA is generally limited to exercising the Secretary of

316 DH, *The Education Outcomes Framework*, March 2013
317 HL Deb 10 June 2013 c1407.
318 (Francis Report), 6 February 2013, Recommendation 209
319 HL Deb 21 October 2013 c837. The Government has asked HEE to lead work to develop a new Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users. See the DH response to the Francis Report, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-I (November 2013) para 68
320 *Ibid.*
321 HM Treasury and BIS, *The Plan for Growth*, March 2011

State's functions in relation to the health service. The changes in the present legislation would give the Government greater power to transfer UK-wide functions to the HRA, subject to consultation and secondary legislation. The HRA will also serve as a member of the UK Ethics Committee Authority, take on authority for research ethics committees (governing their requirements, approval and establishment), and take on functions relating to processing confidential patient information from the Secretary of State.

7 Further health related provisions

The *Health Service Journal* has reported a number of other areas where further Government amendments are expected. These include additional powers for the Care Quality Commission (CQC) to apply a "fit and proper persons test" to all NHS hospital executive and non-executive directors, in response to a recommendation in the Francis Report.[322] It is also expected that there will be Government amendments to the Bill to facilitate the sharing of part of clinical commissioning group budgets with local authorities, to promote the integration of services (a £3.8 billion integration transformation fund was announced as part of the 2015-16 spending round in June 2013).[323]

The Department of Health's full response to the Francis Report, *Hard Truths, the Journey to Putting Patients First,*[324] made a commitment to legislate at the earliest available opportunity to introduce a new criminal offence related to wilful neglect:

> The Government agrees with Professor Don Berwick's recommendation that there should be a new criminal offence 'in the very rare cases where individuals or organisations are unequivocally guilty of wilful or reckless neglect or mistreatment of patients'. This will help to ensure that there is ultimate accountability for those guilty of the most extreme types of poor care. The Government will seek to legislate on this, will work with stakeholders beforehand to determine the details of this measure, and will consult on proposals for legislation as soon as possible.[325]

8 Comment on the health provisions in the Bill

Organisations representing NHS patients and staff have broadly welcomed the Government's response to the Francis Report and the Government's efforts to legislate on its recommendations.[326] However, there was disappointment from the Royal College of Nursing and the Patient's Association that the Government had decided not to legislate for the creation of a mandatory register for health care support workers.[327] The Royal College of Surgeons and the Nuffield Trust have sought reassurance about how Monitor, the CQC and the TDA will work together under the new single failure regime for NHS hospitals.[328]

In response to the introduction of the Bill in May 2013 the Nuffield Trust commented that the framework for the introduction of ratings for health and social care providers broadly reflects

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322 "CQC to oversee barring scheme for directors", *HSJ*, 19 November 2013; recommendation 80 of the Francis Report was that people found to be incompetent or guilty of serious misconduct should be disqualified from taking other senior roles. In July 2013 the Government issued a consultation on *Strengthening Corporate Accountability in Health and Social Care.* This proposed a new requirement that all Board Directors (or equivalents) of providers registered with Care Quality Commission must meet a new fitness test. This will apply to providers from the public, private and the voluntary sectors.

323 "Ministers to legislate on £3.8bn pooled budget", *HSJ*, 5 November 2013

324 DH response to the Francis Report, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-I (19 November 2013)

325 *Ibid*. para. 55

326 See for example, Royal College of Nursing briefing on Care Bill, June 2013

327 *Ibid.,* and Patients Association, Reaction to Government announcement on Francis Inquiry, November 2013

328 Royal College of Surgeons, Care Bill Report Stage Briefing, October 2013; Nuffield Trust, Care Bill - parliamentary briefing, May 2013

its own recommendations and welcomed the general principles of the Government's proposals.[329] The NHS Confederation chief executive Mike Farrar welcomed the emphasis on ensuring patients get clear information about their local health services but said it would be wrong to introduce a new ratings system in a rush.[330] The British Medical Association (BMA), the Royal College of Physicians and the King's Fund have raised concerns that "Ofsted-style ratings" for health services are too simplistic and could mask pockets of poor performance in organisations performing well overall.[331]

A number of organisations commented on the Governments response to the Francis Report, published 19 November 2013.[332] The NHS Confederation said it welcomed measures to make the NHS more open and accountable and absolutely supports a duty of candour at an organisational rather than an individual level.[333] The King's Fund welcomed the Government's focus on making honesty and transparency the guiding principles for patient safety but called for realism about what could be achieved by Whitehall and regulators, noting that leaders within NHS organisations are best placed to foster cultural change.[334]

The RCN welcomed the establishment of Health Education England (HEE) as a non-departmental public body and its responsibility for national oversight of education and training. While welcoming the establishment of HEE on a statutory basis the BMA and the RCP also raised a number of concerns around education and training, and long term workforce planning.[335]

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329 *Ibid.*
330 NHS Confederation, Care Bill – briefing for members, May 2013
331 BMA Parliamentary Brief - Care Bill, October 2013; The Royal College of Physicians briefing, May 2013 King's Fund Care Bill briefing, May 2013
332 DH response to the Francis Report, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-I (19 November 2013)
333 NHS Confederation, Government's full response to the Francis Report, November 2013
334 King's Fund, Statement on the government's full response to the Francis Inquiry report, November 2013
335 BMA Parliamentary Brief - Care Bill, October 2013; The Royal College of Physicians briefing, May 2013