



***Care Bill [HL]* Committee Stage Report**

Bill No 168 of 2013-14

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This is a report on the House of Commons Committee Stage of the *Care Bill*. It complements Research Paper 13/71 prepared for the Commons Second Reading and has been written to inform the Report Stage debate.

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. 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 final section of the Bill would enable the establishment of the Better Care Fund to promote joint working between the NHS and care and support services.

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Research Paper 14/13

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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)
- The establishment of the Better Care Fund to promote joint working between the NHS and care and support services (Part 4)

The Bill had its Second Reading in the Commons on 16 December 2013.

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 issues of eligibility criteria to receive social care eligible for the Bill's cap on social care costs, and that cap itself, provoked particular debate, as did deferred payments for social care and the Bill's provisions on the safeguarding of adults at risk of neglect or abuse. The Government introduced a new clause providing for appeals of decisions under this part of the Bill, which was agreed.

The Bill as brought from the Lords included provision 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*. The Government opposed this provision, which had been added to the Bill during Report Stage in the Lords. The Care Minister proposed that the Bill be deleted from the Bill, and following a division it was removed.

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.

There were debates on clauses introducing a duty of candour for health and social care providers and on the new offence of giving false or misleading information. Ministers introduced a new clause to the Bill setting out a right of appeal for individuals who are removed from their post as a result of action taken following a new "fit and proper person" test for senior managers. There were also debates on the single failure regime for hospitals and the powers of Trust Special Administrators (TSAs), appointed where there are failures in care quality or financial performance at NHS hospitals. A new clause was introduced in the House of Lords to ensure the TSA powers can be used to fast-track changes to services at a hospital other than the one to which the TSA is appointed. In Committee, the Government introduced amendments to this clause to clarify and strengthen the consultation requirements for TSAs in these cases.

Part 3 of the Bill would establish Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental bodies. A number of amendments were tabled although none were successful.

A new clause, enabling the creation of pooled budgets to improve the integration of health and social care services was introduced in Committee and this clause forms a new **Part 4** of the Bill.

No divisions took place on any of the health related provisions in the Bill.

1 Introduction

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 announced in the Queen's Speech in May 2013, and subsequently introduced in the House of Lords as HL 1. The Bill's First Reading in the Lords was held on 9 May 2013. Following its Lords Stages, 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); and
- The creation of the Better Care Fund, to improve the integration of health and social care services, introduced during the Committee Stage in the Commons (this clause forms a new Part 4 of the Bill as amended in Committee).

1.1 Library briefings on earlier stages of the Bill

Three previous documents have been produced by the Commons Library on the earlier stages of the Bill. Two standard notes set out developments during Lords Stages, and a full research paper was produced ahead of the Second Reading debate:

- [Lords Stages of the Care Bill: Social care provisions](#) (SN/SP/6753)
- [Lords Stages of the Care Bill: Health provisions](#) (SN/SP/6769)
- [Care Bill \[HL\]](#) research paper for Second Reading (RP 13/71)

1.2 Second Reading in the Commons

The Bill's Second Reading debate in the House of Commons was held on 16 December 2013. The Bill was introduced by the Secretary of State for Health, Jeremy Hunt.¹

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

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.

¹ HC Deb 16 Dec 2013 c487

2.1 General duties of local authorities

Individual well-being

Paul Burstow and the shadow Health Minister Jamie Reed introduced a number of amendments to **clause 1**, to impose duties on the NHS to co-operate with local authorities and to identify carers and promote well-being. The amendments received support from a number of Members of the Committee, from government and opposition parties, and while the Care Minister, Norman Lamb, agreed with the aims of the amendments, he replied that there were already sufficient duties in these areas. He said that the NHS constitution already provided duties for the NHS to promote well-being and that measures in clause 6 of the Bill would already require NHS bodies and local authorities to co-operate with each other when exercising their respective functions relevant to care and support, including those relating to carers. Furthermore Mr Lamb explained that there are existing duties under the *Health Act 2009* on promoting and safeguarding the health and well-being of patients, which would cover patients who are carers. He said that these, together with the Bill's co-operation provisions, already fulfilled the intention of the amendments being discussed.² The Minister said he would also be willing to consider whether the statutory guidance that would accompany the Bill "might usefully refer to the identification and support of carers as an example of co-operation..."³

Jamie Reed spoke to a number of Opposition amendments to clause 1, including Amendment 70, which would introduce a duty for the NHS to promote integration between health and care services as he said the Government measures in the Bill would "only give local authorities a duty to promote integration between these services". He also spoke to Amendment 69, which would give similar duties to all housing providers. Norman Lamb responded to Amendment 70 by setting out the range of measures the Government had put in place to promote integration between health and social care services, under the *Health and Social Care Act 2012* and under the Care Bill:

"Reflecting the importance that the Government place on integrated, joined-up services, the Health and Social Care Act 2012 created a major focus on integration between local services, and that is supplemented by the provisions in the Bill. That will support the establishment of the £3.8 billion better care fund to promote joint working between the health service and local authorities in 2015-16, which will we discuss further in our coming sittings.

Clause 3 requires local authorities to promote integration between care and support, health and health-related provision. That reflects sections 13N and 14Z1 of the National Health Service Act 2006, which already—this is the important point—place clear duties to promote integration on NHS England and clinical commissioning groups respectively, particularly when that would promote the well-being of adults and carers in their area. That creates a clear duty on NHS bodies to promote integration when it would promote health and well-being.

Furthermore, section 195 of the 2012 Act places a duty on health and wellbeing boards to promote integrated working when that would promote health and well-being. Given that health and wellbeing boards must have a representative on the relevant clinical commissioning group, that places a clear duty on clinical commissioning groups to work as a constituent part of the health and wellbeing board towards integration of services, when that would promote health and well-being.

Clause 6 sets out a duty of co-operation between local authorities and relevant partners, including NHS bodies. Given that the integration duty in clause 3 and the co-

² [PBC 9 Jan 2014 c23](#)

³ *Ibid.* c24

operation duties apply to all care and support functions, there is already a requirement on local authorities and NHS bodies to work together to further integration and co-operation.

In conclusion, while we all share the aim of better integration between different organisations, I hope that right hon. and hon. Members will agree that the amendments and new clause are not the way to go about achieving it and that the existing framework of the Bill, together with existing duties on the NHS, achieve the objectives of those provisions.⁴

Paul Burstow said the purpose of the debate on his amendments to clause 1 had been to probe the Government: “We wanted to understand their intentions regarding the relationship of the NHS to well-being and, in particular, to the identification of carers.” He said:

I take the Minister’s point about the way in which different duties already operate to place an obligation on the NHS to pursue well-being. I welcome what he said about statutory guidance, which is incredibly helpful when it comes to the identification of carers. I also welcome what he said about the vulnerable older people’s plan. It is essential that GPs see this as part and parcel of their job, not as a bolt-on extra that they may or may not do. The vulnerable older people’s plan and clear statutory guidance, for both the NHS and social care, are critical in that regard.

We have seen some progress. I hope that those organisations with which the Department is engaging on drawing up statutory guidance feel emboldened to press to make sure that they get exactly the right language in the guidance that will follow.⁵

He withdrew his amendments and the Opposition Members did not press the other amendments in the group to a vote.⁶

Liz Kendall, the shadow Care Minister, tabled a series of amendments designed to improve the independence and involvement in community life of those receiving care.⁷ Ms Kendall stated that “many organisations, such as Inclusion London, Scope and Mencap, have argued that a duty to promote independent living is...essential. [...] Independent living is crucial to ensuring that disabled people have the same rights, choices and chances as any other citizen in this country.”⁸ Responding for the Government, the Care Minister, Norman Lamb, stated that the amendments “would add independent living to the well-being principle, but they are unnecessary because the concept of independent living is already a core part of that principle,”⁹ and that the associated amendments would either confuse or not add to the Bill’s well-being principle.¹⁰ Liz Kendall pressed amendment 57, which would have added ‘independent living’ to the definition of ‘well-being’ in clause 1, to a vote. The Committee divided and the amendment was defeated by 12 votes to 10.¹¹

Liz Kendall moved further amendments for local authorities to have regard to parents who care for children who are sick and disabled when carrying out their duties under clause 1 and a similar amendment to clause 10 (on the assessment of a carer’s needs for support); the

⁴ PBC 9 Jan 2014 c25

⁵ *Ibid.* c26

⁶ *Ibid.*

⁷ PBC 9 Jan 2014 c29

⁸ *Ibid.*, c30

⁹ *Ibid.*, c36

¹⁰ *Ibid.*, c37-38

¹¹ *Ibid.*, c38

shadow Minister described parents of disabled children as a “serious omission” from the Bill as drafted.¹² The Care Minister responded:

I fear that it is a recipe for confusion to include a provision for those caring for children within a Bill that focuses on provision relating to adults. The term “an individual” in clause 1 already includes both an adult and a child. Replacing that with “an adult or a disabled child” as proposed in amendment 65 would in fact narrow the definition in this case, by excluding children without disabilities from that definition.¹³

Liz Kendall pressed amendment 65 to a vote. It was defeated by 11 votes to 9.¹⁴

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. Paul Burstow tabled an amendment that would require local authorities to have regard to suitable living accommodation when exercising that duty. The amendment was withdrawn following reassurances from the Care Minister that the relevant guidance would refer back to the well-being principle.¹⁵

An amendment was tabled by Jamie Reed, the shadow Health Minister, to require that local authorities must have regard to “the importance of working with health bodies” in carrying out their prevention duties. The amendment was divided upon and defeated 11 votes to 8.¹⁶

Promoting the 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. Amendments were tabled by the shadow Health Minister, Jamie Reed, which would require local authorities to promote the integration of care and support into the area of housing. The amendments were withdrawn; Mr Reed said the amendments sought “to ensure that the role of housing and housing support services for older people, and all people with care needs, is not overlooked,” he did not want to divide the committee on the issue.¹⁷

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. Liz Kendall, the shadow Care Minister, tabled amendments to the clause that would require for that provision to include discussion of housing options, for financial advice to be provided by appropriately qualified persons, and also for specific advice to be available for those with particular conditions. Paul Burstow also spoke to an amendment he had tabled on provision of information about housing.

Liz Kendall also tabled **New Clause 7**, which would provide that the Secretary of State and local authorities conduct a public awareness campaign to ensure that the public are aware of and understand the terms and implications of the cap on care costs.

The Care Minister, Norman Lamb, stated that “there is little that we disagree with in the amendments, and we are wholeheartedly in tune with the intentions behind them, but we believe that they are unnecessary... [the Government] do not consider it appropriate to

¹² PBC 9 Jan 2014 c39

¹³ *Ibid.*, c43-44

¹⁴ *Ibid.*, c46

¹⁵ *Ibid.*, c50

¹⁶ *Ibid.*, c50

¹⁷ *Ibid.*, c55 and 57

provide a comprehensive list of what the information and advice duty is intended to cover, not only because the list would change over time, but because anything left off the list may look less important.”¹⁸

Liz Kendall pressed one amendment, Amendment 73, which would provide that financial advice under clause 4 must be provided by appropriately trained individuals and to an appropriate standard, to a vote. The amendment was defeated 10 votes to 8.¹⁹

Appeals

Paul Burstow moved an amendment for information to be provided on how people would be able to make complaints under Part 1 of the Bill, and spoke to **New Clause 8**, tabled by the Opposition, to provide for an appeals procedure, which would include a review element independent of the local authority, by which adults or carers could appeal a decision made by the local authority. The Care Minister stated that an appeals procedure was being considered, and that powers already existed for many of the options under consideration.²⁰ The amendments were withdrawn.²¹

Later in Committee Stage, the Care Minister moved **New Clause 28** to provide for a regulation-making power to provide for appeals of decisions under Part 1 of the Bill. The provision was broad, to allow flexibility to provide for a range of options that might be put in place by regulations.²² Liz Kendall spoke for the Opposition in favour of the new clause, noting that it was similar to New Clause 8, which she and Jamie Reed had previously tabled.²³ Paul Burstow also spoke in favour of the New Clause.²⁴ It was agreed without a vote.

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. Paul Burstow tabled amendments aimed at “ensuring that services meet the well-being principle [in clause 1] and the outcomes that people want to achieve for themselves, and that services are right for them.”²⁵ Liz Kendall, the shadow Care Minister, spoke to an Opposition amendment that would require local authorities to ensure a diversity of providers from the public, private and third sectors and from mutual and co-operative organisations.²⁶ All amendments were withdrawn or not moved following assurances from the Minister that the Bill as drafted requires local authorities to work with people and providers in their areas to develop sustainable and high quality markets in care and support services.²⁷

Liz Kendall moved a further amendment, subsequently withdrawn, to clause 5, which would provide for local authorities to have regard to the importance of independent and effective advocacy services, following assurances from the Care Minister that the Bill as drafted already achieved this, and that the matter would be clarified in guidance.²⁸

¹⁸ PBC 9 Jan 2014 c64

¹⁹ *Ibid.*, c71

²⁰ *Ibid.*

²¹ *Ibid.*

²² [PBC 4 Feb 2014 c584](#)

²³ *Ibid.*, c585

²⁴ *Ibid.*

²⁵ PBC 9 Jan 2014 c72

²⁶ *Ibid.*, c74

²⁷ *Ibid.*, c78

²⁸ [PBC 14 Jan 2014 c85-87](#)

Paul Burstow moved an amendment for regulations under clause 5 to provide arrangements for independent arbitration of disputes between local authorities and providers concerning fees paid by local authorities. The Care Minister stated that he could not support the amendment:

Appointing or establishing a new independent arbitrator would add cost and bureaucracy to the commissioning process. It would be most likely to increase the risk of disputes, and might lead to participants in a dispute feeling absolved of a responsibility to negotiate and compromise. It could also mean issues becoming protracted by requiring more time for resolution, inevitably risking the continuity of care and support.²⁹

Mr Burstow withdrew the amendment, although he stated that he was not persuaded that the issue had been resolved, and believed there was support for an amendment of this kind among care providers.³⁰

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. Liz Kendall, the shadow Care Minister, tabled an amendment to clause 6 to provide that, when co-operating, relevant bodies should share information and data to ensure high quality care and support. The Care Minister, Norman Lamb, stated that information and data sharing will fall within the scope of the Bill's co-operation duties. The amendment was withdrawn.³¹

A Government technical amendment to clause 7 was agreed without debate.³²

2.2 Assessing and Meeting Care Needs

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. Liz Kendall moved an amendment to extend this duty to young carers, "to ensure consistency with the changes that the Government propose to the *Children and Families Bill*."³³ The Minister stated his belief that the amendment would duplicate provision in the *Children and Families Bill* and so was unnecessary.³⁴ Liz Kendall withdrew the amendment, but stressed that it was necessary "to ensure that it is clear to people in practice who does what, and that we do not have two separate systems developing."³⁵

Liz Kendall also moved amendments to clause 10 that would require a carer's assessment to be carried out for family members providing care for people in receipt of NHS continuing care. The Care Minister, Norman Lamb, said he understood the concerns behind the amendment but noted that the national framework for NHS continuing care already provided that carers should be informed of their entitlements to an assessment:

It is important that no assumptions are made about a family member's ability to care, or about an existing carer's ability to continue to care, either by the NHS or by local

²⁹ PBC 14 Jan 2014 c90

³⁰ *Ibid.*, c91

³¹ *Ibid.*, c95

³² *Ibid.*

³³ *Ibid.*, c96

³⁴ *Ibid.*, c102

³⁵ *Ibid.*, c103

authorities. If a carer is identified in the course of an NHS continuing health care assessment, the national framework for NHS continuing health care and NHS-funded nursing care makes it clear that the clinical commissioning group should: inform such carers about their entitlement to have their needs as carer assessed; and, where appropriate, advise the carers either to contact the local authority or, with their permission, refer them to the local authority for an assessment. That directly addresses the concern expressed in the amendment.³⁶

The amendment was withdrawn.

Assessments

Clause 12 would require the Secretary of State to make regulations about how a needs assessment or a carer's assessment is carried out. Liz Kendall, the shadow Care Minister, moved an amendment to this clause to ensure that the assessment regulations would specify the kinds of cases where assessments must be conducted face to face. The Care Minister, Norman Lamb, stated that the issue of face-to-face assessment would be provided for in regulations.³⁷ The amendment was withdrawn.

Liz Kendall also moved an amendment to clause 12 to require joint working between local authorities and organisations with appropriate expertise when conducting assessments. The Minister responded that he believed the Bill already provided for this. Liz Kendall withdrew the amendment, stating that this capacity should be noted properly in guidance.³⁸

Eligibility criteria

Paul Burstow moved an amendment to **clause 13**, which 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. The amendment sought to provide a definition of the needs that would make someone eligible. Liz Kendall, the shadow Care Minister, spoke to an amendment which would require that the regulations that set out the eligibility criteria under the new system should be subject to the affirmative procedure.

Discussion of the eligibility criteria, and the implications and costs of setting eligibility at different levels, was lengthy.³⁹ Mr Burstow described clause 13 as a "pivotal part of the Bill's architecture. It is the mechanism by which this and future Governments will determine the line that will be drawn on eligibility and access to state support for care needs."⁴⁰ He further stated that his amendments were designed "to probe the Government's intentions and seek further clarity about how they intend to use the regulation-making power and what guidance they intend to have sitting around it to ensure that the spirit of the Bill is translated into practice on the ground."⁴¹

Liz Kendall spoke to the amendment requiring eligibility criteria regulations to be subject to the affirmative procedure, stating:

We have tabled the amendment because how we set the eligibility criteria will be absolutely central to the new care and support system and to the so-called cap on care

³⁶ PBC 14 Jan 2014 c105

³⁷ *Ibid.*, c116

³⁸ *Ibid.*, c120

³⁹ *Ibid.*, c121-150

⁴⁰ *Ibid.*, c121

⁴¹ *Ibid.*, c125

costs—that is, the future funding of social care. It is essential that Parliament properly considers this before the regulations are introduced.⁴²

The Care Minister, Norman Lamb stated:

The significance of the national minimum threshold is undisputed. Consultation has demonstrated almost universal support for a national approach. There can be little consistency in the current system between local authorities on what needs are eligible. Local authorities can set their own thresholds for eligibility and change them over time. That results in uncertainty and can even lead to reductions in services if, for instance, the local authority decides to change its eligibility criteria. We have heard in lots of contributions about the extent to which authorities under both Governments—that is the truth of it—have changed from “moderate” to “substantial” over the last few years.

It has therefore been the Government’s goal from the outset to overcome those problems by introducing a national minimum threshold. The best way to achieve that is by setting the threshold—which, incidentally, the Dilnot commission recommended setting as substantial—in secondary legislation, as recommended by the Law Commission. If we were to set out the eligibility criteria in the Bill, as suggested, future changes to the threshold would be possible only through primary legislation, which would be cumbersome and time consuming.⁴³

Mr Lamb further stated:

Amendment 94 would require regulations made under clause 13(6)—in relation to making eligibility determinations—to be subject to affirmative resolution. However, we do not think that is necessary, and I shall try to explain why.

The regulations that set the eligibility criteria under clause 13(7) are already subject to affirmative resolution. My right hon. Friend the Member for Sutton and Cheam made this point earlier. Since these regulations describe the national eligibility threshold, we believe it is right that this is the case. In practice, we do not anticipate that the powers in clause 13(6) and (7) would be disaggregated. Regulations would cover both matters together, the criteria and any matters about how the determination should be made. There would be a single set laid together and that would be subject to the affirmative procedure.

I can confirm that we have no intention of making regulations using the power in clause 13(6) alone. However, if Government were ever to use clause 13(6) alone, this would be solely for procedural matters around making the eligibility determination, which would not affect the threshold itself. Such regulations would not normally be required to be made under the affirmative procedure.

We are all agreed that the national minimum threshold is of the utmost importance. I hope, therefore, that we agree on the value of making regulations under the affirmative procedure so that Parliament will have the opportunity to scrutinise them before they are introduced, as well as any future changes to them.⁴⁴

Mr Burstow withdrew his amendment. Liz Kendall pressed amendment 94 to a vote, where it was defeated by 12 votes to 9.⁴⁵

⁴² PBC 14 Jan 2014 c125

⁴³ *Ibid.*, c145

⁴⁴ *Ibid.*, c148

⁴⁵ *Ibid.*, c150

Local authorities' power to charge

Clause 14 would provide a general power for local authorities to charge, at their discretion, for care services. Paul Burstow moved amendments to the clause which would provide that local authorities could not charge for social work assessments and which would impose a legal limit on charges. The Minister argued that the Bill's provisions meant that such charges could not be imposed.⁴⁶ The amendment was withdrawn.

Liz Kendall spoke to an amendment that would require local authorities to publish on their websites and in other places the costs that the local authority incurs for the services that it charges for. The Minister stated that guidance would make it clear that local authorities should give people the information that they need to make an informed decision about the best way to meet their needs.⁴⁷ The amendment was withdrawn.

Cap on care costs

Liz Kendall, the shadow Care Minister, moved a series of amendments to **clause 15**, which would provide for a limit to be imposed on the amount a person may spend on care in their lifetime. The amendments would remove the phrase 'cap on care costs' from the Bill and replace it with a 'set level above which an adult starts receiving financial assistance with the costs of their care'. Ms Kendall welcomed the principle of a cap on care costs, but raised concerns about what the level of expenditure might actually be for individuals, because of the eligibility criteria and also because the cap would be based on the standard rate that a local authority pays for care, rather than a person's own contribution. Ms Kendall also highlighted that 'hotel costs' paid for a person in residential care would not count towards the cap, and would be set at £230 per week when the cap was introduced.⁴⁸

The Minister responded that:

we all live with the fear of catastrophic costs destroying everything and, as the shadow Minister said, taking away everything we have ever worked for. The great value of the Dilnot proposals is that they reassure everyone that they are protected against catastrophe, because any of us could be in that position. My hon. Friend the Member for Truro and Falmouth made the point that that greater certainty will allow people to plan for old age.

The amendments renaming the cap on care costs would be detrimental to our aims. They would cause not only inconsistency with the rest of the Bill, but confusion for those we are trying to help to prepare for the risk of future care needs.⁴⁹

Liz Kendall withdrew those amendments. Ms Kendall then pressed to a vote a separate amendment which would provide that the Secretary of State report on the likely impact of the care cap before it is implemented and annually thereafter. The amendment was defeated by 13 votes to 10.⁵⁰

Assessment of financial resources

Liz Kendall tabled an amendment to **clause 17**, which 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 amendment would provide that regulations under this section would be subject to the affirmative procedure. Ms Kendall stated that the means test was "critical" to the fairness of the Bill and that Members should be allowed to scrutinise the

⁴⁶ PBC 14 Jan 2014 c154

⁴⁷ *Ibid.*, c156

⁴⁸ *Ibid.*, c158-160

⁴⁹ *Ibid.*, c164

⁵⁰ *Ibid.*, c166

regulations fully.⁵¹ The Minister stated that existing regulations on financial assessments of those in residential care are subject to the negative resolution.⁵² Ms Kendall withdrew the amendment.

Duties to meet needs for care and support

Clause 18 would provide for cases where local authorities have duties to provide care and support services. Paul Burstow moved an amendment to this clause, to rectify a perceived disadvantage for self-funders who lack the capacity to make decisions for themselves. Mr Burstow stated that:

...the clause effectively allows for circumstances in which a person has the means to pay for their care and asks the local authority to arrange that care. If they have the capacity, they can ask the authority, but it is not clear that the situation is as straightforward when a person, under the mental capacity legislation, does not have that capacity.⁵³

The Care Minister responded that the Bill as drafted allowed that where an adult lacks capacity, a friend or relation might act on their behalf. This could be done using the existing law on mental capacity; the Minister noted that the ability of a friend or relation to act on a person's behalf in this way had been made explicit in the Bill's explanatory notes.⁵⁴ Mr Burstow withdrew the amendment.

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. Paul Burstow moved an amendment to the clause to strengthen the clause's provisions that relate to terminally ill patients, so that local authorities would be obliged to treat terminally ill patients' care as urgent, rather than discretionary.⁵⁵ The Minister stated that he did not think a duty in this area would be appropriate.⁵⁶ The amendment was withdrawn.

Dr Sarah Wollaston spoke to **New Clause 12**, which would provide for terminally ill patients to have their preference for place of death recorded by local health and social care services and for that preference to be implemented wherever practicable, and for associated charges to be waived.⁵⁷ The Care Minister stated that "the Government are committed to moving towards choice for all on how to have a decent and dignified death and where that should be," and that a review in 2014 would determine when such an offer of choice in end-of-life care could feasibly be introduced. He added that [pilots were underway](#)⁵⁸ to develop a system for free end-of-life care, and what while the Government was committed to the aim it would be necessary to have the results of those pilots before acting further.⁵⁹

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. Paul Burstow moved an amendment to the clause, which aimed to bring the wording of the clause into line with other legislation and raised concerns

⁵¹ [PBC 16 Jan 2014., c174](#)

⁵² *Ibid.*, c176

⁵³ *Ibid.*, c179

⁵⁴ *Ibid.*, c180

⁵⁵ *Ibid.*, c186

⁵⁶ *Ibid.*, c199

⁵⁷ *Ibid.*, c188-190

⁵⁸ For information see Department of Health, [Palliative care pilot sites announced](#), 20 March 2012

⁵⁹ [PBC 16 Jan 2014 c200](#)

that the boundary between NHS and community care was set in regulations rather than primary legislation, and therefore might be more easily changed. The Minister stated in response that:

The provisions in clause 22 are not intended to change the current boundary—let me place that clearly on the record—and we do not believe that they will have that result. The limits on the responsibility by reference, as now, to what should be provided by the NHS remain the same. However, the prohibition, combined with the regulation-making power, is framed in a way that allows greater flexibility and greater clarity.⁶⁰

Mr Burstow withdrew the amendment, stating that he might divide the House on this issue at a later stage.⁶¹

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*. Grahame Morris tabled an amendment which aimed to ensure that local authorities would be provided with the flexibility they required to deliver housing solutions for vulnerable people with complex needs. The Care Minister, Norman Lamb, responded that the clause was in place to define boundaries, and that local authorities would not be prevented by it from providing accommodation where necessary to meet care and support needs, and that he would be happy to further discuss concerns in this area outside Committee.⁶² Mr Morris withdrew the amendment.

2.3 Next steps after assessments

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

Clause 24 would provide the immediate next steps for a local authority to take after a needs or carer's assessment is completed. Emma Lewell-Buck tabled an amendment to provide that service users should be clearly informed of when they will receive an assessment after it had been agreed that one will take place. Mrs Lewell-Buck stated that “the reality on the ground is that [existing] performance indicators are not having their desired effect. Stronger incentives are needed.”⁶³ The Care Minister responded that the varying needs of individuals, and the need to involve experts or independent advocates in particular cases, would make such a provision over-prescriptive.⁶⁴ The amendment was withdrawn.

The Minister tabled a minor and technical amendment to **clause 25**, on the contents of care and support plans and support plans, which was agreed without debate.⁶⁵

Personal budgets

Personal budgets are an allocation of funding given to users after a social services assessment of their needs. **Clause 26** of the Bill would define these budgets in law. Paul Burstow moved an amendment to the clause which would clarify that definition and that the amount specified in the budget must cover an adult's eligible needs. Liz Kendall spoke to an Opposition amendment that would provide for similar clarification.

⁶⁰ PBC 16 Jan 2014 c207

⁶¹ *Ibid.*, c209

⁶² *Ibid.*, c212

⁶³ *Ibid.*, c213

⁶⁴ *Ibid.*, c214

⁶⁵ *Ibid.*, c216

The Care Minister stated that “the amendment is not required because clause 26 already ensures that the personal budget specifies the cost to the local authority of meeting the person’s eligible needs.”⁶⁶ Mr Burstow withdrew his amendment.

Review of care and support plan or of support plan

Clause 27 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. Emma Lewell-Buck moved amendments to the clause to provide for regular reviews of plans. The Care Minister responded that the clause provided for reviews to be made when reasonably requested, and that guidance would set out best practice.⁶⁷ Mrs Lewell-Buck withdrew her amendment.

Direct payments

The Care Minister, Norman Lamb, introduced minor, technical amendments to **clause 33** on direct payments for care and support, which were agreed without debate.⁶⁸

Deferred payments

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.

Liz Kendall, the shadow Care Minister, moved amendments to the clause to provide:

- For a model deferred payment scheme to be made;
- For interest on deferred payment to count towards the care cap;
- That no upper threshold for eligibility for deferred payments could be made;
- That a local authority would direct people to financial advisers when considering deferred payments;
- That this financial advice would be paid for by the deferred payment loan⁶⁹

The issue of deferred payments was discussed at some length by the Committee, and in particular the upper limit on deferred payments proposed by the Opposition amendment. The Care Minister argued that the amendment would “not target those people who most need support but instead ensure that anyone, even those with assets of great monetary value in addition to their main home, can have a deferred payment agreement. [...]. I do not think that the public purse should be helping people who do not need financial support to pay their care fees.”⁷⁰

Liz Kendall questioned why the “fundamental principle of a universal, all-in system” had not been maintained in the Bill.⁷¹ Although Liz Kendall withdrew her amendments, she said that the Opposition would consider whether to table further amendments at Report Stage.⁷²

Grahame Morris moved **New Clause 29**, which would create a national body, underwritten by central Government, for a system of deferred payment agreements. Mr Morris envisaged that the company would work in a way similar to the Student Loans Company and would

⁶⁶ PBC 16 Jan 2014 c222

⁶⁷ *Ibid.*, c226

⁶⁸ *Ibid.*, c228

⁶⁹ *Ibid.*

⁷⁰ *Ibid.*, c236

⁷¹ *Ibid.*, c237

⁷² *Ibid.*, c240

provide councils with the flexibility to opt into a national framework for deferred payments, should they wish to do so. He stated:

The rationale to support the clause is essentially twofold. First, a national body would provide an important single point of contact and an important degree of consistency for people entering into a deferred payment agreement, irrespective of where they live. I am sure the Minister will agree that it is in the interest of the public purse and the individual that deferred payment agreements are run in the most efficient and consistent way possible. Secondly, it makes good financial sense for a bespoke body to concentrate the financial risk involved, rather than expose 152 councils to such risk.⁷³

The Care Minister, Norman Lamb, stated that he did not believe that this reform was desirable or necessary:

Is it desirable to move delicate decisions, which can be heavily affected by local factors, such as local housing markets and the cost of care locally, away from a local organisation and put them in the hands of a national body? I cannot see that it is. Further, I do not think that it is desirable to force individuals and their families, at a point of crisis, to approach an additional national organisation and potentially battle their way through an additional layer of bureaucracy. [...]

If we can therefore conclude that this amendment is not desirable, we must consider whether it is necessary. It might be considered necessary because local authorities do not have the skills to administer the universal scheme. I find that hard to believe, given that—as I have already said—many local authorities already offer their own scheme. In addition, we have also committed to providing a model agreement and statutory guidance, which I think the Opposition also suggested, and other implementation support, to help local authorities to expand their offers in line with the national scheme.

Therefore, the proposed new clause does not strike me as being necessary. Perhaps it is considered necessary for reasons of funding, but the Department has committed to funding the expansion of the scheme, including providing £110 million in 2015-16. As local authorities already operate deferred payments, any additional administrative costs would be minimal and they would certainly be significantly less than those required to set up a new body.⁷⁴

The Minister also mentioned that he would be happy to meet Mr Morris to discuss the matter. Mr Morris withdrew the amendment.⁷⁵

2.4 Ordinary residence and portability

Ordinary Residence

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. Liz Kendall spoke to **New Clause 20** alongside the clause stand part. The new clause would require the Secretary of State to report to Parliament on what legislation would be required to ensure portability of care within the UK, within six months of the Bill receiving Royal Assent. She stated that:

although the Bill makes provision for people to take residential care packages with them when they move, say, between England and Scotland, there is no such provision

⁷³ PBC 4 Feb 2014 c605

⁷⁴ *Ibid.*, c605-606

⁷⁵ *Ibid.*, c606-607

for community or home-based care...the Bill rightly gives people the ability to take a residential care package with them when they move, which is a good step forward, but we need to make sure that that applies equally to people who have community-based packages of care and support and are moving between England and the devolved Administrations.⁷⁶

In response, the Minister stated that the Government was speaking to the devolved Administrations and looking to have principles to achieve this in place by November 2014.⁷⁷ Liz Kendall did not press the new clause to a vote.

2.5 Adult Safeguarding

Safeguarding Enquiries

Clause 42 would require local authorities to make enquiries where abuse or neglect of an adult is suspected. A large number of amendments and related new clauses were tabled and discussed in connection with this clause.

Paul Burstow spoke to amendments to provide for a new adult safeguarding access order (a power of entry) for authorised officers to speak with and assess those who are suspected of being abused or neglected. The amendments would also provide that where a local authority had reason to believe safeguarding enquiries were being impeded to the extent that it could not determine whether any action was necessary, the authority shall record whether or not an application for an adult safeguarding access order was considered or made. Mr Burstow stated:

What happens when a person is too frightened to speak up, is under duress, or is effectively a prisoner in their own home? Ultimately, we are told, the High Court has jurisdiction to act. It can hear any matter that comes before it; that is where the buck stops. This is a very rarely used power of inherent jurisdiction. I know that the Minister takes some comfort from this principle of inherent jurisdiction, but I and the Joint Committee [that conducted pre-legislative scrutiny on the Bill] do not believe that this is sufficient.⁷⁸

Mr Burstow further stated that **New Clause 3**, which would provide for adult safeguarding access orders, would provide “a proportionate power to support the duty to make inquiries in clause 42.”⁷⁹

Speaking to **New Clause 24**, which would amend the *Corporate Manslaughter and Corporate Homicide Act 2007* to widen its scope to include abuse and neglect, Mr Burstow stated that there was a “gap in the law,” and that the new clause:

...is not about acts of commission, but acts of omission by boards of directors of care organisations that do not take their duty of care seriously and do not get out on the shop floor of their organisations. Using the corporate manslaughter legislation would remove the defence, “I did not know what was going on in my organisation.” In other words, there would not have to be a guiding mind actively soliciting the abusive behaviour for the directors to be subject to criminal prosecution.⁸⁰

⁷⁶ PBC 21 Jan 2014 c245-246

⁷⁷ PBC 21 Jan 2014 c248

⁷⁸ *Ibid.*, c252

⁷⁹ *Ibid.*, c254

⁸⁰ *Ibid.*, c255

Mr Burstow also spoke to a new clause to create an offence of wilful neglect or ill-treatment, and asked whether the Government was considering or intended to legislate on this issue.⁸¹

Liz Kendall, the shadow Care Minister, spoke to an Opposition amendment to provide an expanded definition of abuse. She stated:

The Bill, rightly, defines financial abuse, in order to protect vulnerable adults from the examples we have seen, whether in care homes or in their own homes, where their money was stolen or where they were wrongly or persistently charged for services and support. However, the Bill does not define other types of abuse, leaving them instead to be spelled out in guidance.

Some organisations are concerned that having a more explicit definition of financial abuse but not of other types of abuse means that financial abuse will be given priority over other types of abuse.⁸²

Liz Kendall also spoke to amendments to extend duties on organisations to report suspected abuse or neglect to the police, and also for suspected financial abuse to be investigated after a complaint by someone with power of attorney for a person with care needs.⁸³

Nick Smith spoke to **New Clause 19**, which would create a new offence of corporate neglect, to “make it crystal clear that it is not just the foot soldiers—the care assistants or the nurses—who will be held responsible in cases of neglect or abuse.”⁸⁴

The Care Minister, Norman Lamb, responded on these issues. On the power of entry, he noted that the Government had consulted on this issue in 2012 and:

...received no compelling evidence for further legislation. Even those respondents in favour pointed to how rarely a new power might be applied and identified potential unfortunate, and potentially devastating, outcomes of that.⁸⁵

On the issue of an expanded definition of abuse, the Minister said:

[The Government] made the decision not to provide a statutory definition of abuse and neglect on the face of the Bill, but to rely on the ordinary meaning of those words. We do not want to restrict the scope of local authorities' inquiry duty to a prescribed list. It is inevitable that creating a list risks excluding something into which a local authority or its partners may wish to inquire... We have the opportunity to issue guidance on the meaning of abuse if necessary.⁸⁶

The Minister stated that he supported the sentiment behind New Clause 19 on corporate neglect, tabled by Nick Smith, and stated that the Bill's provisions as they stood would amend the law so as to make prosecution possible in a way that has not been the case under previous legislation and guidance, as the Care Quality Commission would no longer be required to issue a warning notice prior to any prosecution.⁸⁷ Nick Smith asked that the Minister give further thought to this issue.⁸⁸

⁸¹ *Ibid.*

⁸² PBC 21 Jan 2014 c257

⁸³ *Ibid.*, c257-8

⁸⁴ *Ibid.*, c264

⁸⁵ *Ibid.*, c266

⁸⁶ *Ibid.*, c276-277

⁸⁷ *Ibid.*, c277-280

⁸⁸ *Ibid.*, c294-295

The Minister further stated that the Government had accepted the recommendations of the [Berwick report](#)⁸⁹ to create a new offence of wilful neglect or ill-treatment and was working to develop proposals, which would include a consultation on the issue.⁹⁰

Later in the Committee's proceedings, Paul Burstow moved **New Clause 30**, which would create a statutory power for the courts to authorise local authorities to exercise a power of entry with a police constable in a set of prescribed circumstances. Mr Burstow said he wanted to revisit the matter after reflecting on the previous debate. He stated:

My new clause seeks to take on board a number of the comments the Minister has made; it would require an application to a circuit judge authorised by the Court of Protection and add a notification requirement so that in such a case both parties had the ability to challenge what was being done. It explicitly states that the circuit judge would have to be satisfied that all reasonable steps had been taken to gain access without the benefit of an order. It would make it a requirement that a police constable was present, something about which Mind was very concerned, and would expand the requirements about the notification of complaints procedures.⁹¹

The Care Minister, Norman Lamb, responded that while he agreed with Mr Burstow that legislation in this area had lagged behind similar powers for children, “[a]dults with capacity have rights and the state must intervene on those rights with great care or else we will have serious unintended consequences.”⁹² He cited in particular the absence of a right to remove the adult concerned from their premises from New Clause 30, leaving them vulnerable to abuse when the police who have used this power of entry have gone.⁹³ Mr Burstow withdrew the amendment.

Safeguarding Adults Boards

Liz Kendall moved amendments to **Schedule 2**, which would provide for the membership and duties of Safeguarding Adults Boards. The amendments would provide that safeguarding adults reports would be given to the Secretary of State and the Chief Inspector for Social Care. Liz Kendall said these amendments aimed “to ensure that across the country we draw out any key themes that emerge about types of abuse that are occurring or increasing, or about any problems, in policy and practice, in preventing, tackling or stamping out abuse.”⁹⁴ In response, the Minister stated that “because there will be that complete transparency [of the reports, which would be published], we do not think it necessary to add a requirement for [them] to be sent up.”⁹⁵ The amendments were withdrawn.

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

Clause 48 of the Bill would require 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*. This clause was added to the Bill during Report Stage in the House of Lords, and was opposed there by the Government.

The Care Minister, Norman Lamb, moved an amendment to delete this clause from the Bill. The Minister stated:

⁸⁹ Department of Health, [Berwick review into patient safety](#), 6 August 2013

⁹⁰ PBC 21 Jan 2014, c281-282

⁹¹ PBC 4 Feb 2014 c609

⁹² *Ibid.*, c609

⁹³ *Ibid.*, c610

⁹⁴ PBC 21 Jan 2014 c295

⁹⁵ *Ibid.*, c297

The Human Rights Act 1998 is about the relationship between the state and the individual, and that is why the convention was established. It is a powerful document that sought to protect the individual citizen from the oppressive power of the state, whether that was the national state or the local state, and I strongly sign up to that principle. The Act, however, was not intended to apply to entirely private arrangements, and it requires quite a contortion of the legislation to make it do that. [...]

If clause 48 became law it would be the first time the Act extended into the purely private sphere, in this case the relationship between an individual and a private care provider. If that principle were established, other interest groups self-evidently could argue that they should also be able to challenge private providers on human rights grounds in other areas, taking us further and further from the purpose of the Act into duplication and overlap with other legislation.⁹⁶

Paul Burstow raised the concern that the law as it stands is not “clear about whether publicly arranged care is covered by the *Human Rights Act*,”⁹⁷ an issue that had been raised both during pre-legislative scrutiny of the Bill and in the House of Lords. The Minister responded that while that discussion could continue, the clause did not address it and would not provide protection that was not already provided elsewhere.⁹⁸

Liz Kendall, the shadow Care Minister, spoke on the clause for the Opposition. She supported the clause, stating that there were “clear gaps in the system, with some people receiving publicly funded care being able to seek redress directly through the provisions of the Human Rights Act, but others, in private or third sector-provided home care, not being able to do so.”⁹⁹

Dr Daniel Poulter, the Health Minister, stated that “while an individual with private funding has the choice of state and private providers, the relationship is different for those who are funded publicly because they have less choice.”¹⁰⁰ Paul Burstow disagreed with this point, stating that once the Bill was in force, it would “have included a personal budget mechanism and clarified the rights in respect of direct payments. A citizen may, therefore, have a relationship with a local authority, but that local authority gives the money to them to make their own decisions about purchasing care.”¹⁰¹

Grahame M. Morris spoke in favour of the clause being retained in the Bill. He stated that:

the clause would do more than provide a legal entitlement that could be enforced in the courts. In the analysis by the Equality and Human Rights Commission, which was commissioned by the Government, clarifying human rights in this way would also encourage providers to build a human rights approach into service delivery, helping to drive up standards in the care sector.¹⁰²

The Care Minister expressed his sympathy for the aims of the organisations that supported the clause, but stated his belief that that:

...this is ultimately tokenistic because I do not think that it makes a substantive difference to the rights that individuals have... The establishment in statute of adult safeguarding boards, something that has been widely welcomed and supported by the

⁹⁶ PBC 21 Jan 2014 c298

⁹⁷ *Ibid.*, c300

⁹⁸ *Ibid.*, c300-301

⁹⁹ *Ibid.*, c303

¹⁰⁰ *Ibid.*, c310

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*, c316

shadow Minister, the new, much tougher CQC inspections with a chief inspector of social care and a chief inspector of hospitals, and the corporate accountability that we are bringing in with the fundamental standards of care, all provide real protection for individuals in a way that I do not think the Human Rights Act would achieve, with the best will in the world.

[...]

The shadow Minister expressed the concern that people will want a route to a remedy without having to wait for the Care Quality Commission. People who have private arrangements, who enter a contract with a care provider, have rights under that contract to pursue a remedy without having to rely on the Care Quality Commission to do so. Interestingly, and why there is a sort of balance of rights with the publicly arranged service for an individual, where the local authority funds the care of an individual in a care home, the contract is likely to be between the local authority and the care provider, so that the individual citizen does not, in that circumstance, have rights under a contract. The Human Rights Act could potentially provide some support and protection for that individual, but that is not the case in an entirely private arrangement, because they have rights under the contract which the publicly funded citizen does not have.¹⁰³

The clause was divided upon, and the motion that it stand part of the Bill was defeated by 12 votes to 10.¹⁰⁴ The clause was accordingly deleted from the Bill.

2.7 Provider failure and oversight of the care market

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 (CQC) fails.

Liz Kendall, the shadow Care Minister, spoke on this clause for the Opposition, stating that the Bill's new regime for provider failure was "welcome and necessary," but stressed that the regime must be put in place to operate as effectively as possible.¹⁰⁵ She asked how a stable market in care might be ensured, how local authorities might proactively prevent provider failure, and how local authorities might be provided with the right tools to prevent the failure not just of major but also smaller providers.¹⁰⁶

The Care Minister, Norman Lamb, responded on these points, stating that the clause would provide the ability to prevent provider failure in a way that has not previously been possible, and that, once the legislation was in place, the Government would ensure that the CQC would have the funding and the time to recruit the expertise to enable it to carry out its functions. He stated that a consultation would be carried out on the relevant regulations in May.¹⁰⁷

The clause was agreed to stand part of the Bill.

¹⁰³ PBC 21 Jan 2014 c318

¹⁰⁴ *Ibid.*, c321

¹⁰⁵ *Ibid.*, c321-322

¹⁰⁶ *Ibid.*, c324

¹⁰⁷ *Ibid.*, c326

Market oversight

Clause 56 would provide a duty for the CQC to assess the financial sustainability of providers subject the Bill's regulatory regime, with a view to identifying threats to their financial sustainability, and to take steps if threats are identified.

Liz Kendall spoke to amendments to the clause, which would strengthen the CQC's ability to access all the financial data that it needed to carry out its duties, including from parent or holding companies.¹⁰⁸

The Care Minister responded that regulations would make provision for the CQC to have sufficient powers to carry out its oversight duties effectively.¹⁰⁹ The amendment was withdrawn.

2.8 Transition for children and young carers to adult care and support

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.

Liz Kendall, the shadow Care Minister, spoke on this clause, stating that the education, health and care plans being legislated for under the *Children and Families Bill* should be linked up with assessments under this clause. The Care Minister, Norman Lamb, agreed that this should be a joined-up process and that he would write to the shadow Minister on the process, particularly as there was a disparity in the ages concerned (education, health and care plans may be assessed until age 25).¹¹⁰

Clause 60 would set out the aims of such an assessment and how it would proceed. A minor and technical Government amendment to the clause was agreed without debate.¹¹¹

Clause 61 would provide a similar duty for authorities to assess the needs of a child's carer (whether or not they were 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.

Paul Burstow moved an amendment to this clause, and spoke to two new clauses. The amendments and new clauses would provide for parents who are carers for their children to be supported by local authorities under the Bill.¹¹²

The Care Minister responded that duplicating provisions relevant to adults caring for adults would be inappropriate, and that legislation for children and families should be used in this area. However, he stated the Government recognised the concerns that had been raised over this issue and were in discussions with carers' organisations, parent carers and other stakeholders, and that results of that review would be available before the Bill's passage through Parliament was concluded.¹¹³ The amendments were withdrawn.

¹⁰⁸ [PBC 23 Jan 2014 c331-333](#)

¹⁰⁹ [PBC 23 Jan 2014 c336-337](#)

¹¹⁰ *Ibid.*, c340-341

¹¹¹ *Ibid.*, c341

¹¹² *Ibid.*, c342-344

¹¹³ *Ibid.*, c344-345

Minor and technical Government amendments were agreed without debate to **clauses 61, 62, 63, 64, 65, and 67**, all dealing with aspects of the transition to adult care and support for children and young carers.¹¹⁴

2.9 Other provisions

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.

During the stand part debate, Meg Munn spoke to **New Clause 13**, which would provide that sufficient funding must be made available for extra costs incurred by the Bill's social care reforms. Meg Munn cited increased demand for assessments as an example of reforms that could bring cost pressures.¹¹⁵

Liz Kendall, the shadow Care Minister, spoke to several New Clauses which would provide that:

- the Department of Health's joint care and support reform programme board must inform the Secretary of State whether there is sufficient funding to implement the Bill satisfactorily;
- an independent committee advise Ministers on the workings of the cap on care costs;
- the Secretary of State be required to ask the Office for Budget Responsibility to conduct an assessment of social care funding including the Bill's reforms;
- the Secretary of State must publish an impact assessment of the Bill's provisions on eligibility criteria, the means test and deferred payments before they come into force.¹¹⁶

Liz Kendall raised particular concerns about funding, stating:

When the Government spelled out further details of the local government funding settlement in July 2013, we and the LGA discovered that that money was not new, but was top-sliced from existing council budgets. Following that, the Department of Health announced that it had figured out that it needed another £130 million to pay for implementing the adult safeguarding boards, putting carers on a par with users in terms of assessment, and for setting the national eligibility criteria. Again, that money is not new. It has been taken from the better care fund. The £3.8 billion integrated budget for the NHS and social care, as we have heard, is not new money, but a pooled budget. They are taking money out of that to set up care accounts, assessment and other things. Almost £500,000 of implementation costs will come from existing budgets. That will mean taking money away from existing services and existing users to pay for setting up care accounts, adult safeguarding boards and so on.¹¹⁷

Ms Kendall also questioned whether the Bill's provisions would be sufficient to enable insurers to create products to help people protect themselves against the cost of care.¹¹⁸

Bill Esterson spoke to **New Clause 14**, which he had tabled, which would require the Secretary of State to prepare a report on the costs and benefits of requiring, and providing

¹¹⁴ *Ibid.*, c346-347

¹¹⁵ PBC 23 Jan 2014 c350

¹¹⁶ *Ibid.*, c353

¹¹⁷ *Ibid.*, c353-354

¹¹⁸ *Ibid.*, c355-356

funding for, local authorities to offer all social care free at the point of use.¹¹⁹ The Care Minister, Norman Lamb, commented that this was “the most regressive option” for care funding;¹²⁰ Mr Esterson stated that the new clause was “a probing amendment asking for the issue to be studied properly.”¹²¹ The Minister stated that this system had been considered by the Dilnot Commission and found by the Commission to be “not...a resilient proposal,” due to rising costs that foreign governments who had implemented such a system could not meet.¹²²

The Care Minister responded to New Clause 13, tabled by Meg Munn, stating:

New clause 13 seeks to ensure that local authorities have the resources to implement the Care Bill and deliver lasting change for the millions of people in this country who give and receive care and support. I completely agree with this aim, but there are already sufficient safeguards in place and this new clause would duplicate those provisions.¹²³

The Minister further stated that the New Clause to “establish an independent ministerial advisory committee to keep the level of the cap under review...would place ministerial oversight, an activity that is in the normal course of Government business, on the face of the Bill.”¹²⁴

The Minister said that the new clause to require the Office for Budget Responsibility to complete a review of the funding of social care, and the cost and impact of the reforms, by the end of 2014 would duplicate work already carried out by the Government’s impact assessments for the reforms, and be an inappropriate task for an independent body like the OBR to carry out.¹²⁵

The Minister also stated, in response to the new clause that the Secretary of State must publish an impact assessment of the Bill’s regulations on eligibility criteria, the means test and deferred payments, that the Government intended “to publish impact assessments for those regulations, and for all regulations associated with part 1.”¹²⁶

Clause 72 was ordered to stand part of the Bill without a vote.

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 to people who have been detained in hospital for treatment of mental disorder under certain sections of the 1983 Act. Clause 74(5) seeks to introduce a definition for aftercare services. Grahame Morris introduced an amendment to remove these sections as he said there were concerns among a number of mental health charities that the proposed definition could restrict access to aftercare services. The amendment received the support of Dr Sarah Wollaston. The Care Minister, Norman Lamb, replied that the current definition was the result of extensive consultation and that the advantage of introducing a clear definition of aftercare was to prevent varying court judgements creating uncertainty over its scope. Mr Morris withdrew his amendment.

¹¹⁹ *Ibid.*, c360

¹²⁰ *Ibid.*, c361

¹²¹ *Ibid.*

¹²² *Ibid.*, c365

¹²³ *Ibid.*, c364

¹²⁴ *Ibid.*, c368

¹²⁵ *Ibid.*, c369

¹²⁶ *Ibid.*

Detention of persons with mental health needs in police cells

Paul Burstow moved **New Clause 26**, primarily in name of Dr Wollaston, to place duties on the police and the Secretary of State to gather and report information on police use of powers, under sections 135 and 136 of the *Mental Health Act 1983* to take people with mental illness to a "place of safety" (which often involves temporary detention in police custody). The new clause would require recording of when people with mental health problems were kept in police cells; it would also require the Secretary of State to report on this issue annually, and to prepare a report on charging local health and care services for the inappropriate use of cells.¹²⁷

The Minister, Norman Lamb, explained that although there was no statutory requirement to collect data on the use of these police powers the Health and Social Care Information Centre had recently included, for the first time, data collected by police forces. The report included information on the number of detainees under 18, although it did not include further detail of their ages. He explained why the Government did not want to introduce statutory data collection requirements:

Having said that, in general neither the Home Office nor I think it appropriate to impose centralised data collection burdens on the police or mental health professionals, when it is important that local commissioners and service providers understand and use their local data to improve mental health services.¹²⁸

The Minister referred to a number of changes to the guidance and regulation concerning the use of police cells as a place of safety for people with mental illness, including the announcement from the Home Secretary that there would be a review of sections 135 and 136 of the *Mental Health Act 1983*.

Registers of sight-impaired adults

Clause 76 would require local authorities to establish and maintain a register of adults who are ordinarily resident in their area and are sight-impaired. Emma Lewell-Buck spoke on the clause, stating that the omission of children from the register was a missed opportunity and that existing duties for councils to maintain lists under the *Children Act 1989* were often ignored.¹²⁹ The Care Minister, Norman Lamb, responded that provision did exist, even if it was not being complied with, and that reforms in the *Children and Families Bill*, would reinforce the existing duty through that Bill's statutory code of practice for special educational needs.¹³⁰

Statutory guidance: Part 1 of the Bill

Paul Burstow moved an amendment to **clause 77**, which 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. The amendment would require that all guidance issued under regulations made under Part 1 would be made easily available in a range of formats and kept up to date. Mr Burstow stated that the amendment aimed to make guidance "easy for practitioners to understand, easily accessible for practitioners and also easy for us in this place to find and interpret when we come to cross-check how things are being implemented in practice."¹³¹

¹²⁷ PBC 4 Feb 2014 c596

¹²⁸ *Ibid.* c602

¹²⁹ PBC 23 Jan 2014 c379-380

¹³⁰ *Ibid.*, c381

¹³¹ *Ibid.*, c382

The Care Minister, Norman Lamb, responded that the Department of Health would take steps to ensure that the guidance is accessible in formats that enable people to make use of it, and to keep guidance under regular review and updated.¹³²

Grahame Morris spoke to an amendment he had tabled at the request of the National Autism Society, which aimed to ensure that the statutory guidance arising from duties placed on NHS bodies by the *Autism Act 2009* would continue to apply once the new suite of statutory guidance and regulations under the *Care Bill* was issued. Mr Morris said that the “National Autistic Society is concerned that, as other guidance affected applies only to local authorities, there is a need to maintain those duties, and that that need may be overlooked.”¹³³

Norman Lamb responded that the Government:

...intend to develop a single, consolidated bank of guidance covering all functions within part 1 of the Bill, to support implementation of the new statute. As part of that, we will replace all existing guidance that covers that territory, to remove the potential for any misunderstanding. We are mindful of the need to ensure that there is no gap in provision during transition. I assure hon. Members that the existing guidance will remain in place until it is superseded by new guidance.

Unlike other statutory guidance related to care and support, the autism statutory guidance, about which there has been concern, is issued under a specific requirement in the Autism Act 2009. That guidance is addressed to local authorities and NHS bodies. The 2009 Act and the duty to issue guidance under it are not affected by clause 77 and remain in place.¹³⁴

The amendments were withdrawn.

Interpretation

Minor and technical Government amendments made to **clause 79**, which would provide guidance on interpretation, were agreed without debate.¹³⁵

Young Carers and Student Carers: Further duties

Liz Kendall, the shadow Care Minister, moved **New Clauses 10 and 11**. The first provided for young carers to be identified in schools and through children’s services, and the second for similar duties to apply in higher education and further education settings for student carers. Liz Kendall stated that:

I am sure that when the Minister responds he will say that these new clauses are not needed because there are wider duties in the Bill on local councils and NHS authorities to identify carers, but we believe that the duty needs to be on individual organisations. So the head teacher of a school, the principal of a university or college or the person running a hospital or a community care service would know that their organisation had to have the proper processes in place to identify a carer and had to know what to do—who to refer that person to and what support to provide within the school, college, GP practice or hospital.¹³⁶

The Care Minister, Norman Lamb, responded that:

¹³² PBC 23 Jan 2014., c384

¹³³ *Ibid.*, c383

¹³⁴ *Ibid.*, c384-385

¹³⁵ *Ibid.*, c386

¹³⁶ PBC 4 Feb 2014 c587

...a legislative approach that compels schools to identify young carers, as set out in new clause 10, is not in keeping with the Government's drive to reduce burdens on schools and free them from central prescription. That is the point that the shadow Minister made in another context about the risks of central prescription.¹³⁷

He further added:

Legislating to require further education establishments and universities to identify student carers would override the existing arrangements in place in higher education and develop a care policy that goes against the Government's commitments to reduce regulation on the sector. Although I appreciate the wish to improve recognition and support for young carers and student carers, the Government do not agree that a legislative approach compelling schools, colleges and universities to identify them is the right way forward. It could lead to exactly the sort of tick-box culture that the shadow Minister described in her GP's surgery and ultimately achieve nothing for young carers.¹³⁸ (c591)

Grahame Morris also spoke in favour of a duty on universities, noting the particular pressures on student carers.¹³⁹

Liz Kendall withdrew the new clauses, although she noted that she disagreed with the Minister and expected to return to the issue.¹⁴⁰

Clarity of statutory guidance

Liz Kendall, the shadow Care Minister, moved **New Clause 21**, which would provide for guidance from the Secretary of State on how people are presented with information such as the amount that they are charged for care services. Liz Kendall stressed the importance of clear information in this area, particularly as many recipients will be vulnerable.¹⁴¹ The Care Minister, Norman Lamb, responded that existing duties in the Bill, in clauses 4 and 5, would provide the transparency that the new clause sought, and so it would not be necessary.¹⁴² The clause was withdrawn.

Amendment to long title

The Care Minister, Norman Lamb, moved an amendment to the Bill's long title to include the integration of care and support with health services, which was agreed without a vote.¹⁴³

3 Part 2: Care standards

The measures in Part 2 of the Bill largely address specific recommendations from the Francis Report¹⁴⁴ 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.¹⁴⁵

¹³⁷ *Ibid.*, c590

¹³⁸ PBC 4 Feb 2014 c591

¹³⁹ *Ibid.*, c592-593

¹⁴⁰ *Ibid.*, c593

¹⁴¹ *Ibid.*, c593-594

¹⁴² *Ibid.*, c596

¹⁴³ *Ibid.*, c610

¹⁴⁴ Robert Francis QC, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (Francis Report), 6 February 2013

¹⁴⁵ Professor Sir Bruce Keogh KBE, *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*, 16 July 2013; Professor Don Berwick, *A promise to learn – a commitment to act: improving the safety of patients in England*, August 2013

3.1 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.¹⁴⁶ 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.¹⁴⁷ The new clause states that 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 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.¹⁴⁸

The shadow Health Secretary Andy Burnham has previously 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...”.¹⁴⁹

During the Commons Committee Stage, the shadow Health Minister Jamie Reed introduced amendment 139 to **clause 80** to set out the requirements for a statutory duty of candour for healthcare in the Bill, rather than in regulations, and to place a requirement on individual staff to inform their employers if they suspect that care or treatment has resulted in death or serious injury. The Minister, Norman Lamb, referred to the working group that had been set up to consider where the threshold for the duty of candour should be set. The expert group, headed by Professor Norman Williams, president of the Royal College of Surgeons, and David Dalton, chief executive of Salford Royal hospital. One of the questions that the group will consider is whether the threshold for the duty of candour to apply should be death and serious injury, or death, serious injury and moderate harm.

Ministers, and Dr Sarah Wollaston, also referred to the risk that placing the duty of candour on individual staff, as the Opposition amendment and the Francis report proposed, could have the unintended consequence of restricting staff openness about their mistakes. Norman Lamb stated that professional regulators are working to agree consistent approaches to the reporting of errors and to strengthen the references to candour in professional regulation, making clear a requirement to be open, whether the incident is serious or not.

Health professionals will have to be candid with patients. Guidance will make it clear that obstructing colleagues in being candid will be a breach of their professional codes. The professional regulators will also review their guidance to panels, taking decisions on professional misconduct, to ensure that they take proper account of whether professionals have raised concerns properly.¹⁵⁰

¹⁴⁶ Francis Report, 6 February 2013, Recommendation 181

¹⁴⁷ [HL Deb 16 October 2013, cc635-40](#)

¹⁴⁸ DH, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-II (19 November 2013) pages 156-9

¹⁴⁹ Labour Party, *We welcome Ann Clywd’s report on patient complaints in the NHS – Burnham*, 28 October 2013

¹⁵⁰ PBC 28 Jan 2014 c402

The Opposition spokesperson Jamie Reed withdrew the amendment, saying he accepted the Government was acting in good faith. The Minister promised to provide an update on progress with the professional guidance at Report stage and confirmed that the Dalton-Williams report would be published in March.

3.2 Criminal offence 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 connivance or through their neglect, and a successful prosecution has been brought against the provider.¹⁵¹

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.¹⁵²

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.”¹⁵³

Shadow Health Minister Jamie Reed introduced Amendment 160 to **clause 90**, which sought to add an additional offence to the list in clause 90(1) by making it an offence to wilfully withhold relevant information with the intention to mislead or misdirect. Mr Reed said that this would mean that in the process of exercising their legal requirements care providers would be under an obligation to provide access to relevant information:

It is proper that when under investigation by the regulator or others a provider has a legal duty to supply the relevant information, and that it does not seek to mislead anyone by withholding that information. It would not be right for a provider to be able to withhold information that could assist the regulator in its investigation. That act should be on a par with providing misleading information, because it achieves the same end, although by different means. There should be parity of esteem in the clause for actions that mislead, whether through the circulation or publication of misleading information, or by withholding information that would better allow the regulator to carry out its duties.

The duty to not withhold relevant information is the second pillar that is needed to ensure that the clause encourages openness. The Government argued that an individual duty of candour would create a culture of fear; we heard that argument again from the Minister. They said that people would close ranks and pull down the shutters

¹⁵¹ DH, *Hard Truths, the Journey to Putting Patients First*, Cm 8754-II (19 November 2013), pages 79-80

¹⁵² For further information see DH, *Factsheet 14 The Care Bill – false or misleading information*, May 2013

¹⁵³ HL Deb 21 Oct 2013 c834-5

in the NHS before disclosing information. By creating an offence for publishing misleading information without making it an equal offence to hide information, providers could be perversely incentivised to remain quiet about an issue, rather than be accused of publishing misleading information. Clearly, nobody wants that unintended consequence. We cannot allow that to happen, which is why we should create a system that puts hiding information on the same level as knowingly providing misleading information.¹⁵⁴

The Health Minister, Daniel Poulter, set out the some of the differences between the false or misleading information offence and the duty of candour, which were both added to the Bill in response to the recommendations of the Francis report. He explained that, while both measures are designed to improve openness among providers of care, they focus on different things:

The duty of candour is about the day-to-day interaction of provider organisations with patients. It will require that health-care providers registered with the CQC do not withhold information from patients, and will require providers to inform patients where there are failings in the care that they have received. This duty will be overseen, as we discussed last week, by the CQC.

By contrast, the false and misleading information clauses are about performance and management information that providers are required to supply or publish. They create a new criminal offence, prosecuted by the Crown Prosecution Service, where care providers supply or publish specific false or misleading performance and management information provided under a statutory or other legal obligation. Taken together, the two measures aim to increase openness to patients and service users under the duty of candour and reporting performance of health care providers under false or misleading information.¹⁵⁵

Dr Poulter said that an offence of wilfully withholding information with intent to mislead, which would be created by opposition Amendment 160, would be more difficult to prosecute than the Government's proposed offence of providing false or misleading information:

Establishing wilfulness or intent on the part of an organisation is far from straightforward. For that reason, the false or misleading information offence does not rely on establishing intent on the part of the care provider. It is a strict liability clause in the Bill. The offence as regards care providers is indeed strict liability, which means that the prosecution would have to prove that the information was, as a matter of fact, false or misleading. There is no need to prove intent, wilful or otherwise, to provide false or misleading information on the part of a corporate body or partnership.¹⁵⁶

Jamie Reed also spoke to Amendment 145 to clause 90, which sought to extend the false or misleading information offence to the health-related services provided by local authorities (to take account on the greater integration between services). The Minister said that this amendment would greatly increase the scope of the offence and, as a result, the Government could not support this change:

As I have set out, the offence of providing false or misleading information could, as the clause is currently drafted and subject to regulations, apply to a provider of health services, defined—by reference to section 1 of the National Health Service Act 2006—as services provided as part of the comprehensive health service, which includes public health services provided by local authorities. However, the amendment would

¹⁵⁴ [PBC 28 Jan 2014 c460-1](#)

¹⁵⁵ [PBC 28 Jan 2014 c462-3](#)

¹⁵⁶ *Ibid.* c463

extend that to cover health-related services provided by local authorities. The meaning of that is not defined in the amendment. I suspect the interest may be in local authority public health services, which, as I have said, are already covered by the clause.

What would be the effect of extending the offence to health-related services? Section 13N(4) of the National Health Service Act 2006 defines those services, for the purposes of that Act, as

“services that may have an effect on the health of individuals but are not health services or social care services”.

As drafted, the amendment could refer to almost any service provided by local authorities, for example, housing services, leisure services or even refuse services. I am sure the hon. Member for Copeland [Jamie Reed] did not intend the amendment to be so far reaching. That would certainly not be in the spirit of the Francis inquiry.

The scope of the offence is deliberately restricted to care providers and is intentionally narrow. The amendment would make the possible scope of the offence too broad. I hope that helps to clarify the Government’s position on that aspect.”¹⁵⁷

Mr Reed withdrew the amendments to clause 90.

3.3 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 original function in ensuring compliance with corporate and financial governance for NHS foundation trusts; the NHS Trust Development Authority (TDA) performs a similar role in relation to NHS trusts.

The Government proposes to establish a unified regime for detecting and intervening in failures in care quality and financial performance at NHS hospitals.¹⁵⁸ Under the reformed failure regime 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.¹⁵⁹ 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 State¹⁶⁰, would be able to replace a trust’s board or appoint a special administrator. The Bill would confer new powers on Monitor, to replace a trust’s board or to appoint a special administrator to a Foundation Trust where there is a serious failure in care.

Clauses 81 to 84 would 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; extend Monitor’s powers to be able to impose additional licence conditions on foundation trusts; and enable Monitor to make an order authorising the

¹⁵⁷ *Ibid.* c462

¹⁵⁸ DH, *Factsheet 12 The Care Bill- Single Failure Regime*, May 2013

¹⁵⁹ The CQC will retain its enforcement powers for social care, general practice and independent sector providers.

¹⁶⁰ 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.

appointment of a trust special administrator for foundation trusts on quality grounds. **Clause 85** would prevent registered providers from applying for a change to their conditions of registration where the CQC has commenced proceedings to make the same change.

Definition of significant improvement

Paul Burstow moved Amendment 48 to **clause 81** that would require regulations to set out the detail of what “significant improvement” entails and how the CQC will assess progress in making that improvement. The Health Minister, Daniel Poulter, attempted to reassure him that the existing framework provided by clauses 81 to 84 would require the CQC to publish guidance to detail their approach to issuing the new warning notices:

The CQC’s existing guidance on warning notices will be revised in the light of the Bill to include the CQC’s interpretation of when significant improvement would be required. In addition, the CQC, Monitor and the NHS Trust Development Authority will publish further joint guidance on how they will work together to address risks to quality and bring together financial performance and quality in the same judgment, where appropriate. This will set out how the CQC will assess progress and work with Monitor and the TDA to ensure action is taken.¹⁶¹

Opposition amendments to clause 81 (Amendments 140, 141 and 157) requiring the CQC to provide greater clarity to providers about what they are required to do to improve were also discussed during the debate on Amendment 48. The amendments were withdrawn after the Minister promised to write to the Committee with further information.

3.4 Trust Special Administration

The Trust Special Administration (TSA) regime was introduced under the *Health Act 2009* in order to take action in response to NHS trusts and foundation trusts that are failing or in financial difficulties. Trust Special Administrators (TSAs) are appointed to take charge of failing trusts and make recommendations about the future of their services. When a trust is placed into administration, the Secretary of State, or Monitor where a foundation trust is involved, can appoint a TSA in order to ensure that services continue to be provided sustainably and to a high standard.

Appointment of administrator

Clause 83 on the appointment of TSAs to NHS foundation trusts, requires the CQC to consult the Secretary of State, Monitor and NHS England before making an appointment. It is also required to consult any bodies that commission services from the provider in question. Opposition spokesperson Jamie Reed spoke to Amendment 146, which would require that the CQC must consult the relevant local authority, but this was later withdrawn.

Powers of administrator

As a consequence of a judicial review decision concerning Lewisham Hospital in summer 2013, the Bill was amended by the Government in the House of Lords to ensure that the powers of the TSA can be used in relation to NHS hospital trusts and foundation trusts other than those to which the TSA is appointed (the new clause is currently clause 119 of the Bill, as amended in Committee, but was initially clause 118 and is referred to by this number in the debates on the clause).¹⁶² During the [Second Reading debate](#) in the Commons on 16 December 2013 the Labour shadow Health Secretary Andy Burnham set out his opposition to the new clause on TSAs:

¹⁶¹ PBC 28 Jan 2014, c415

¹⁶² Page 60 of the [Library Research Paper for the Second Reading of the Care Bill](#) (11 December 2013) deals with the background to this amendment, which was agreed during Report Stage on 21 October 2013.

Clause 118 makes it clear that the Secretary of State wants more control: he wants sweeping powers to close hospitals without proper consultation and clinical support.¹⁶³

Mr Burnham continued that:

Hospital reconfiguration should always be driven by a clinical case first and foremost, but clause 118 paves the way for a new round of financially driven closures. It rips up established rules of consultation and the clinical case for change. It allows the Secretary of State to reconfigure services across an entire region for financial reasons alone, which means that no hospital, however successful, is safe. The House needs to stand up to this audacious power grab by the Executive.¹⁶⁴

The Opposition tabled an amendment at the Bill's Second Reading, which referred to clause 118. The amendment, which said the new clause on TSAs put "NHS hospitals at risk of having services reconfigured without adequate consultation and without clinical support", was negated by 289 votes to 231.

The Government introduced a number of amendments to clause 118, agreed without a vote (Amendments 135 to 138), intended to clarify and strengthen the consultation requirements for TSAs. The Parliamentary Under-Secretary of State for Health, Daniel Poulter, explained that:

Clause 118, as amended by the Government, would mean the Secretary of State must decide whether he is satisfied that all affected trusts, their staff and commissioners have been properly consulted and their views considered. If not, the TSA must amend the report to address his concerns. Furthermore, following ordinary principles in public law, the Secretary of State would expect to have assurance that the consultation has been conducted reasonably, and that responses had been adequately considered.

All administrators must attach to their final report a summary of all responses to their draft report which were received during their formal consultation. It will show how responses were given consideration. The final report is also published and laid before Parliament prior to the Secretary of State's consideration in the case of a foundation trust or an NHS trust in administration. In the case of a foundation trust, the Secretary of State must decide whether he is satisfied the administration duties have been met.¹⁶⁵

There was a lengthy clause stand part debate, with Opposition Members referring to the judicial review judgements that had overturned the Government decision to accept a TSA recommendation in relation to a neighbouring hospital trust. Jamie Reed said "Clause 118 is a disfiguring clause in an otherwise modest Bill." Liz Kendall asked the Minister why a trust that has not failed on quality or finances, but has been brought into a special administration process being used to deal with another trust that has failed on quality or finances, should be subject to less consultation than the standard public consultation process for hospital reconfigurations.¹⁶⁶ The Minister, Daniel Poulter, responded that the appointment of a TSA was a last resort and that other neighbouring trusts, and the broader "health economy", would have been involved in trying to resolve problems at an earlier stage and that where

¹⁶³ HC Deb 16 Dec c504

¹⁶⁴ *Ibid.* c505

¹⁶⁵ [PBC 30 Jan 2014 c532](#)

¹⁶⁶ Statutory guidance under s242 of the NHS Act 2006 recommends that the full reconfiguration process should take at least 48 weeks, the TSA regime should be concluded within 20 weeks.

there are serious issues of patient care at stake, it is important that they are dealt with quickly.¹⁶⁷

Ministers urged the Opposition team to set out their position on trust special administration and alleged that the Labour position amounted to treating problems at individual hospitals in isolation. The Opposition spokesperson Jamie Reed offered his party's cooperation if the clause were withdrawn. Clause 118 was subsequently ordered to stand part of the Bill as amended.

3.5 The Care Quality Commission

Clause 87 would establish the newly created positions of Chief Inspector of Hospitals, Chief Inspector of General Practice and Chief Inspector of Adult Social Care. **Clause 88** would give the CQC greater statutory independence.¹⁶⁸ **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.¹⁶⁹

There was broad cross-party agreement on the clauses promoting CQC independence, although during the debate on clause 88 concerns were raised by Paul Burstow and Opposition Members about possible limitations on the CQC's role in reviewing the commissioning of health and social care services. Mr Burstow spoke to a number of amendments to ensure that CQC would have powers to investigate local authority commissioning without first securing Ministerial approval, but these were ultimately withdrawn.¹⁷⁰

Paul Burstow tabled a number of amendments to clause 89 to introduced specific requirements for CQC to consider mental health services and adult safeguarding, amongst other things. He withdrew his amendments to this clause having received reassurance from the Minister.¹⁷¹

Clause 86 amends provisions relating to the membership of the CQC. Under paragraph 3 of Schedule 1 to the *Health and Social Care Act 2008* all members of the CQC must be appointed by the Secretary of State. In particular, Clause 86(1), amends paragraph 3 of Schedule 1 so that the Secretary of State only appoints the Chair and other non-executive members whilst the CQC appoints its own executive members (including the Chief Executive) without the involvement of the Secretary of State. The Minister promised to write to the Committee about the process for the appointment of CQC board members.

Fitness to practice: right of appeal

In response to the recommendations of the Francis Report, the Government is consulting on the introduction of a "fit and proper person" test for directors of providers registered with CQC. While it is expected that this new requirement for registration with CQC will be brought in by regulations in October 2014, the Care Minister, Norman Lamb, moved a new clause to the Bill (now clause 86 of the Bill as amended in Committee) setting out a right of appeal to the first tier tribunal for individuals who are removed from their post as a result of action taken by CQC. The Minister said that while it was important that CQC should be able to prevent people who are not fit and proper from continuing in their role, it was right that where

¹⁶⁷ PBC 30 Jan 2014 c527-8

¹⁶⁸ These two clauses were new Government amendments introduced at Report Stage in the House of Lords ([Amendments 142 and 143, HL Deb 21 October 2013 cc803-819](#)). For further background see DH press notice, [Government strengthens health regulator's independence](#), 1 October 2013

¹⁶⁹ For further information see DH, [Factsheet 13 The Care Bill – Health and social care ratings](#), May 2013

¹⁷⁰ PBC 28 Jan 2014 c428

¹⁷¹ *Ibid.* c459

action was taken against an individual director, given that the CQC would in effect be removing their livelihood, that there should be a right of appeal against the CQC's actions. The Opposition spokesperson, Jamie Reed, asked for some clarification but accepted the principle behind the new clause.¹⁷²

Training for persons working in a regulated activity

The Francis Report recommended the creation of a registration system for healthcare support workers.¹⁷³ The Government did not accept this particular recommendation but on 21 October 2013, Health Minister 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.¹⁷⁴

Clause 93 would amend section 20 of the 2008 Act to enable the Secretary of State, through regulations, to specify the bodies or persons who can set training standards in respect of a specific group of workers. It would allow the Government to specify in regulations the person who sets the training standards and to whom those standards apply. Groups to whom the standards could apply include health care assistants and social care support workers.

During the Commons Committee Stage the Opposition tabled a new clause that would require the Secretary of State to provide for a system of registration of healthcare support workers. The Health Minister, Dr Daniel Poulter replied that such a system of registration would not be appropriate or proportionate for health care assistants. He referred to the Government's plans to develop a "care certificate" for health and social care assistants, as recommended by the Cavendish Inquiry into care assistants¹⁷⁵:

Clause 93 allows the Secretary of State a power to make regulations to specify a person or persons to set training standards for a specific group of workers. Once the regulations have gone through the parliamentary process and come into force, the person or persons specified will provide a set of common training standards for health care assistants and social care support workers who work for a registered provider of any regulated activity. In the first instance, we envisage that the person specified will be Health Education England, which will work with key partners to deliver the care certificate. An update on that will be delivered in the refreshed second mandate to Health Education England, which will be published in the next few weeks.¹⁷⁶

Shadow Health Minister Jamie Reed withdrew the new clause but said it would be a matter he would return to on Report.

4 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 these two recently created bodies, which lead national systems for the education and training of health care professionals and that regulate

¹⁷² PBC 4 Feb 2014 c570

¹⁷³ Francis Report, 6 February 2013, Recommendation 209

¹⁷⁴ [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

¹⁷⁵ Camilla Cavendish, *An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings*, July 2013

¹⁷⁶ PBC 28 Jan 2014, c472

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.

4.1 Health Education England

Paul Burstow and Opposition Members tabled a number of amendments to Schedule 5 of the Bill on the functions of HEE, focusing on the importance of Health Education England promoting quality and diversity in exercising its functions. Two of Mr Burstow's amendments would require HEE to set out in its annual report details of how effectively it has discharged its duties under the *Equality Act 2010* or regulations under the Act and to publish the objectives and priorities it has set to promote equality and diversity. Similarly, the Opposition tabled amendments that would require the education outcomes framework to include development and implementation of anti-discriminatory practices within the health-related provisions. The Minister, Daniel Poulter, responded that HEE and the Department of Health, which publishes the education outcomes framework, are already subject to the public sector equality duty and must demonstrate compliance with the Equality Act. Paul Burstow and the Opposition spokesperson, Jamie Reed, withdrew their amendments.¹⁷⁷

4.2 Health Research Authority

Paul Burstow introduced amendments to **clause 109** requiring greater involvement of senior nurses in the work of the HRA; opposition amendments also referred to nurses input and involvement by the Medicines and Healthcare products Regulatory Agency. These amendments were subsequently withdrawn. During the clause stand part debate on **clause 111** Paul Burstow asked about the approval of health research for children and the Minister promised to meet him to discuss this.¹⁷⁸

During the stand part debate on **clause 115**, relating to approval for processing confidential patient information, the Minister, Daniel Poulter, was keen to avoid the conflation of wider concerns about the confidentiality of patient data under the care.data scheme with the narrow purpose of the clause in relation to the HRA:

Clause 115 makes a number of consequential amendments to... regulations to transfer the Secretary of State's power to approve the processing of confidential patient information for medical research purposes to the HRA, which is best placed to protect and promote the interests of patients and the public. No substantive changes are being made at all to the safeguards around the processing of confidential patient information, and the amendments ensure that the HRA cannot give approval for processing of confidential patient information unless a research ethics committee has approved the medical research concerned.¹⁷⁹

The question that the clause stand part of the Bill was agreed.

The Health and Social Care Information Centre: restrictions on dissemination of information

On 3 March 2014 the Government tabled a new clause that would place additional restrictions on dissemination of information by the Health and Social Care Information Centre. **New clause 14** would amend sections 253, 261 and 262 of the *Health and Social Care Act 2012* to insert a general duty for the HSCIC "to respect and promote the privacy of recipients of health services and of adult social care in England". Apart from in limited circumstances where there is a statutory requirement to disclose data, the new clause would

¹⁷⁷ *Ibid.* c487

¹⁷⁸ PBC 30 Jan 2014, c512

¹⁷⁹ *Ibid.* c519. For further information on care.data see the [Library Standard Note SN6781](#)

ensure that HSCIC could only disseminate information to requesting organisations if “disseminating the information would be for the purposes of the provision of health care or adult social care.”¹⁸⁰ It would also require HSCIC to “have regard to any advice given to it by a committee appointed by the Health Research Authority”.¹⁸¹

5 Part 4: Measures to establish the Better Care Fund

The Care Minister, Norman Lamb, moved a new clause (now clause 120 in a new Part 4 of the Bill as amended in Committee), to establish the Better Care Fund, to promote joint working between the NHS and care and support services. In the 2013 Spending Round¹⁸² the Chancellor announced the creation of a pooled budget for health and social care of £3.8 billion for 2015/16, designed to promote joint working and reduce hospital admissions (initially known as the Integration Transformation Fund, it is now known as the Better Care Fund).¹⁸³

The Minister explained that the new clause creates the legal framework for NHS involvement in the Better Care Fund by enabling the Secretary of State’s mandate to NHS England to specify the size of pooled budgets between clinical commissioning groups and local government for use on integrated care:

It is primarily enabling legislation because the mandate will include objectives and requirements for how the fund operates. The new clause enables the mandate to specify what funding the NHS should contribute and the need to work with local government. NHS England will ensure that the pooling happens between CCGs and local authorities. It would have powers to tell CCGs what amount to include in the pooled budget, and would release the funding only once satisfied that there was a robust, locally agreed integration plan. It could also attach conditions to the funding, including performance objectives, such as improved patient experience and reduced emergency admissions so that we achieve something tangible for patients as a result of the pooling arrangement. A new duty would require NHS England to use those powers in the combined interests of health and social care.¹⁸⁴

There was some debate about the transfer of NHS funding to the Better Care Fund and the appropriate use of the fund.

¹⁸⁰ The *Health and Social Care Act 2012* sets out powers for the Health and Social Care Information Centre (IC) to collect, analyse, publish or disseminate information.

¹⁸¹ [Notices of Amendments, 3 March 2014](#)

¹⁸² HM Treasury, *Spending Round*, 26 June 2013

¹⁸³ More information on this funding can be found in this [Statement on the health and social care Integration Transformation Fund](#), published on 8 August 2013. From 2014 additional funding is coming across from the health service budget to provide adult social care and support the integration of health and social care services (£1.1 billion in 2014/15 and £3.8 billion in 2015/16)

¹⁸⁴ PBC 4 Feb 2014, c575