



The Care Bill explained
***Including a response to consultation and pre-legislative
scrutiny on the Draft Care and Support Bill***

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

May 2013



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ISBN: 9780101862721

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID 2556092 05/13 29320 19585

Printed on paper containing 75% recycled fibre content minimum.

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Foreword

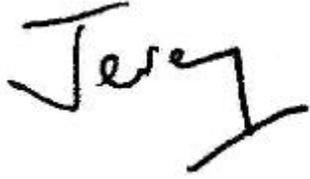
It is over six decades since the foundations of social care law were put in place, based on principles that are no longer relevant in today's society. We need new laws that reflect modern standards, modern expectations and modern practices. The first part of the Care Bill is a critical step in reforming care and support and achieving the aspirations of the white paper, *Caring for our Future*. It also introduces a cap on the costs that people will have to pay for care in their lifetime, as recommended by the Commission on the Funding of Care and Support. The Bill pulls together threads from over a dozen different Acts into a single, modern framework for care and support. But it is far from being a mere compilation – it fundamentally reforms how the law works, prioritising people's wellbeing, needs and goals so that individuals will no longer feel like they are battling against the system to get the care and support they need. It highlights the importance of preventing and reducing needs, and putting people in control of their care and support. For the first time, it puts carers on a par with those for whom they care. We would like to thank the Law Commission on whose excellent three-year review Part 1 is based.

The second part of the Bill takes forward elements of our response to the unacceptable failings in care at Stafford Hospital. The quality of care and people's experience should be the basis on which providers of health and care are judged and this Bill takes a step towards that. It will allow for Ofsted-style ratings for hospitals and care homes that will allow patients and the public to compare organisations or services in a fair and balanced way, so they can see which they prefer and where they want to go. The Bill will give the new Chief Inspector of Hospitals the power to instigate a process to tackle unresolved problems with the quality of care more effectively than before. And it will make it a criminal offence for providers to supply or publish false or misleading information.

Part 3 of the Bill establishes Health Education England as a statutory body which will assist local healthcare providers and professionals to take responsibility for educating and training their staff. It also establishes the Health Research Authority in the same way, strengthening its ability to protect patients' interests in health and social care research whilst promoting research and streamlining the approvals process. Both of these bodies will be independent of the Department of Health, giving them the impartiality and stability they need to carry out their vital roles. Improving the quality of education and training and encouraging research that is both safe and ethical will support improved care for patients.

The Bill also reflects the recommendations of the Joint Committee that scrutinised the Draft Care and Support Bill and the comments we received during the

consultation. The Coalition Government is grateful to everyone who took the time to consider and comment on the Draft Bill and to the Joint Committee for its careful scrutiny. The feedback we received has considerably improved the final provisions in this historic piece of legislation.

Handwritten signature of Jeremy Hunt in black ink.

JEREMY HUNT MP

Secretary of State for Health

Handwritten signature of Norman Lamb in black ink.

NORMAN LAMB MP

Minister for Care and Support

Introduction

1. The Care Bill takes forward the Government's commitments to reform social care legislation, to drive up the quality of care following the findings of the Francis Inquiry, and to establish Health Education England (HEE) and the Health Research Authority (HRA) as non-departmental public bodies (NDPBs).
2. This document explains the provisions in the Care Bill. Parts 1 and 3 of the Care Bill build on the provisions set out in the draft Care and Support Bill, which was published in July 2012. This document therefore also provides our response to the public consultation on the Draft Care and Support Bill¹, and to the report from the Joint Committee that scrutinised it², and makes clear the changes we have made as a result. It also describes the new measures in Part 2 of the Care Bill that take forward the Government's response to the Francis report.³

Summary of the main provisions

Care and support

3. The Bill delivers the commitments in the Government's white paper *Caring for our future: reforming care and support* (July 2012)⁴, which set out our vision for a modern system that promotes people's well-being by enabling them to prevent and postpone the need for care and support and to pursue education, employment and other opportunities to realise their potential. The Bill takes forward the recommendations of the Law Commission⁵ to consolidate existing care and support law into a single, unified, modern statute. It refocuses the law around the person not the service, strengthens rights for carers to access support, and introduces a new adult safeguarding framework.
4. This Bill also puts in legislation the changes recommended by the Commission on the Funding of Care and Support⁶ to introduce a cap on the costs that people will have to pay for care in their lifetime.

¹ www.gov.uk/government/publications/draft-care-and-support-bill-published

² www.parliament.uk/business/committees/committees-a-z/joint-select/draft-care-and-support-bill/publications/

³ www.midstaffspublicinquiry.com/report

⁴ www.gov.uk/government/publications/caring-for-our-future-reforming-care-and-support

⁵ lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf

⁶ www.dilnotcommission.dh.gov.uk/our-report/

Care standards

5. This Bill delivers a number of elements in the Government's response⁷ to the findings of the Francis Inquiry, which identified failures across the health and care system that must never happen again. Our response will help ensure that patients are 'the first and foremost consideration of the system and everyone who works in it' and restore the NHS to its core values.

Health Education England (HEE) and the Health Research Authority (HRA)

6. The Bill establishes HEE and the HRA as NDPBs to ensure they have the impartiality and stability they need to carry out their vital roles

Public consultation and pre-legislative scrutiny

7. Almost all of the provisions in Parts 1 and 3 of the Bill have been subject to a detailed process of public consultation, engagement and pre-legislative scrutiny between July 2012 and March 2013.
8. The Government held a public consultation from July to October 2012. It attracted around 1,000 written responses through a variety of channels, including an online comments platform created for clause-by-clause comments. We also held a number of engagement events with stakeholders, those who use social care services and their carers. A summary of the responses was published in December 2012.⁸
9. Following consultation, a Joint Committee of Parliament was established to conduct pre-legislative scrutiny on the Draft Care and Support Bill. Over three months, the Joint Committee received further written evidence and held 10 oral sessions with a range of stakeholders. The Joint Committee's work concluded on 7 March, and their final report was published on 19 March setting out 107 recommendations.⁹ A table setting out our response to each recommendation is included at Annex A.
10. We have carefully considered the comments received during the consultation and the recommendations of the Joint Committee. Parts 1 and 3 of the Care Bill reflect changes made in response to what we have heard.

⁷ www.gov.uk/government/news/putting-patients-first-government-publishes-response-to-francis-report

⁸ caringforourfuture.dh.gov.uk/2012/12/10/responses-to-the-draft-care-bill/

⁹ www.publications.parliament.uk/pa/jt201213/jtselect/jtcare/143/14302.htm

Care and support (Part 1)

The case for change

11. Care and support is something that everyone will experience at some point in their lives, whether they need it themselves, know a family member or friend who does, or provide care themselves.
12. Today's care and support system often fails to live up to the expectations of those who rely on it. Whilst many do have good experiences, the system can often be confusing, disempowering and not flexible enough to fit around individuals' lives. Moreover, the care and support system faces some major additional challenges. Demographic changes mean that we can expect 1.4 million more people to need care and support in the next 20 years.
13. In this context, the Government's White Paper *Caring for our future: reforming care and support* (July 2012)¹⁰, set out a long-term programme to reform care and support. At the centre of the White Paper is a vision for a modern system that promotes people's well-being by enabling them to prevent and postpone the need for care and support, and puts them in control of their lives so that they can pursue opportunities, including education and employment, to realise their potential.
14. The Care Bill is a crucial step in delivering that vision.
15. The existing law that underpins care and support is outdated and confusing, and must be overhauled. The Law Commission concluded after a three-year review¹¹ that the current legal framework makes it difficult for people who need care and support, and carers, to know what they are entitled to, and for local authorities to understand their responsibilities. Compared to our White Paper vision, it is narrow and paternalistic – built around providing State-defined services, rather than meeting and responding to the needs and goals of individuals with personalised care and support. Part 1 of the Care Bill takes forward the recommendations of the Law Commission's report on adult social care.
16. More than simply modernising the legislation, the Bill takes forward many significant policy reforms for care and support. In doing so, the Bill also responds to the recommendations of the Commission on the Funding of Care and Support¹².

¹⁰ www.gov.uk/government/publications/caring-for-our-future-reforming-care-and-support

¹¹ lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf

¹² www.dilnotcommission.dh.gov.uk/our-report/

17. The current care and support system offers little financial protection for the cost of care. The report by the Commission on the Funding of Care and Support, as well as *Caring for our Future: progress report on funding reform*¹³, set out in detail the difficulties the current system creates for people.
18. The Commission found that because care needs are unpredictable, individuals and families do not know what care costs they might face in the future. A quarter of people may need to spend very little, but one in ten people will have more serious care needs, and will face care costs in excess of £100,000. Those who pay the most and face unlimited costs are likely to be those with long-term chronic disabilities such as dementia, which means that they need care and support for a long period. This situation is unfair, and must be changed.
19. This Bill will put into legislation the changes proposed by the Commission to reform the funding system for care and support. It introduces a cap on the care costs which people will incur in their lifetime.

What the Bill does

20. In summary, the Bill:

- modernises over 60 years of care and support law into a single, clear statute, which is built around people's needs and what they want to achieve in their lives;
- clarifies entitlements to care and support to give people a better understanding of what is on offer, help them plan for the future and ensure they know where to go for help when they need it;
- provides for the development of national eligibility criteria, bringing people greater transparency and consistency across the country;
- treats carers as equal to the person they care for – putting them at the centre of the law and on the same legal footing;
- reforms how care and support is funded, to create a cap on care costs which people will pay, and give everyone peace of mind in protecting them from catastrophic costs;
- supports our aim to rebalance the focus of care and support on promoting wellbeing and preventing or delaying needs in order to reduce dependency, rather than only intervening at crisis point;

¹³ www.gov.uk/government/publications/government-publishes-progress-report-on-social-care-funding-reform

- provides new guarantees and reassurance to people needing care, to support them to move between areas or to manage if their provider fails, without the fear that they will go without the care they need; and
 - simplifies the care and support system and processes to provide the freedom and flexibility needed by local authorities and care professionals to integrate with other local services, innovate and achieve better results for people.
21. The rest of this chapter describes the provisions of Part 1 of the Care Bill – those related to care and support. It explains how they have changed from the provisions in the Draft Care and Support Bill in response to public consultation and pre-legislative scrutiny by the Joint Committee.
22. Of the 107 recommendations the Joint Committee made, 93 related to care and support. Most of the recommendations reflected issues raised during the consultation and engagement with stakeholders.

Promoting well-being

23. Clause 1 of the Bill creates a new statutory principle designed to embed individual well-being as the driving force behind care and support. The first clause of the Bill sets the context for all the provisions which follow: that the well-being of the individual is paramount and that local authorities must promote the individual’s well-being in all decisions made with and about them. ‘Well-being’ is described in terms of the most important outcomes for people who use care and support for carers. This principle is intended to establish what the Law Commission called a *‘single unifying purpose around which adult social care is organised.’*

What we heard, and changes to the Bill

24. The well-being principle was welcomed both by people who responded to the consultation and the Joint Committee on the Draft Care and Support Bill. The Joint Committee recommended a number of changes, such as including a specific reference to both the dignity of the adult, and the availability of safe and settled accommodation. It also suggested clarifying that the well-being principle applies to carers as well as adults who use care and support. The Government agrees with these recommendations, and has changed the clause in response.
25. Although the duty to promote wellbeing applies to local authorities when they perform any function under the Bill, the Joint Committee proposed that the duty should also apply to the Secretary of State when making regulations or guidance. We have considered this recommendation carefully, but on balance we do not believe that it would be appropriate to apply this duty to the Secretary of State.

Care and support is a locally managed and delivered service, for which local authorities are responsible. New legal duties on the Secretary of State may confuse these important local accountabilities.

Preventing and reducing needs for care and support

26. It is critical that care and support works to actively promote people's well-being and independence, rather than waiting for people to reach a crisis point. Set out in statute for the first time, clause 2 outlines the local authority's role in preventing, reducing or delaying the need for care and support.
27. This is a general duty that applies in relation to all local people – applying equally to carers and those with care needs. Following our White Paper vision, this duty is part of a series of provisions in the Bill that are intended to rebalance the focus of care and support towards well-being and independence. This is not just about what the local authority does itself, but also how it works with other local organisations to build community capacity and make the most of the skills and resources already available in the area.

What we heard, and changes to the Bill

28. Whilst there was widespread support for the inclusion of a new duty linked to prevention, we heard consistently through consultation that prevention is not a one-off or standalone activity, and neither is it solely about the provision of services. Rather, it includes helping people to make use of existing resources available in their community, and should be considered throughout the care and support system. We agree, and we have made a number of changes throughout the Bill to better reflect this view.
29. In relation to local authorities' other general responsibilities, the Joint Committee recommended that the Bill be revised to make clear that both the provision of universal information and advice and the market-shaping role are linked to the duty of prevention. We agree, and have made further references in both clauses to demonstrate this link. We have also revised the prevention provision itself to address comments made during consultation about the need to be very clear about the scope and parameters of the clause. This includes clarification that the prevention clause does apply in relation to carers, that it can be carried out jointly with other local authorities, and that regulations about charging will specify what local authorities both can and cannot charge for.
30. To ensure that the focus on prevention is replicated and reinforced throughout the care and support system, we have made further changes to the Bill. Accordingly, the Bill now requires that as part of assessments of needs and care and support plans, local authorities must consider whether other support is

available that could contribute to the outcomes the adult wishes to achieve, and provide information on how to prevent or delay future needs. We have strengthened the offer to people who do not have eligible needs, to ensure they receive advice and information about reducing, preventing or delaying needs for care and support.

Promoting integration

31. Clause 3 places a duty on local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services, such as housing. It is the counterpart to the duty on the NHS in the Health and Social Care Act 2012, to ensure that organisations work together to improve outcomes for people.

What we heard, and changes to the Bill

32. We have heard from stakeholders and from the Joint Committee about the importance of local authorities working together across health social care and housing to meet people's care and support needs. Some respondents to the consultation wanted to see specific reference to areas in which integration is particularly important, and the Joint Committee recommended the inclusion of 'a particular emphasis on the adequacy of housing provision on discharge.'
33. This clause is intended to apply broadly across the local authority's functions, and to reflect the partner duty on the NHS to promote integration in the Health and Social Care Act 2012. Whilst we agree with those who said that housing should be included as one example of a 'health-related service', we have not sought further to be prescriptive about how and when local authorities (including housing authorities) should integrate. Instead, we want to encourage local authorities to innovate and make decisions according to the needs the people in their area.
34. We do not agree with the Joint Committee that this clause should include a power to prescribe groups of people or services that should be subject to joint commissioning and joint budgets. We want commissioners to have autonomy and flexibility as to how they work together to secure services to deliver improved outcomes for patients and their families.

Providing information and advice

35. We know that the care and support system can be complex and difficult to understand. Clause 4 of the Bill aims to clarify and modernise existing duties on local authorities by setting out the broad, high-level requirements for what local authority information and advice services should include, so that people are able

to understand how the care and support system works, what services are available locally, and how to access those services. The Bill provides for a universal information and advice service, which is available to all people who request it, and is not just limited to those people with assessed care and support needs.

What we heard, and changes to the Bill

36. We have heard through both the public consultation and from the Joint Committee that people should be able to access independent financial information and advice, particularly in view of recently announced reforms on care and support funding, the availability of deferred payments and an increasing use of direct payments. We accept this argument, and we have revised this clause to clarify that the local authority must, as part of its general advice service, provide advice about how to access independent financial advice.
37. The Joint Committee also recommended that the information and advice local authorities are required to provide should include matters such as housing options and charging arrangements. We do not consider it necessary to be so specific on the face of the Bill, as this clause is intended to set a broad framework on which guidance will provide further detail.
38. Many people told us that information and advice has to be accessible to all people - for example, online information might not be appropriate for everyone. We agree, and have redrafted this clause to state that information and advice must be accessible to everyone who needs it.
39. A number of respondents to the public consultation felt that access to independent advocacy should be a universal service, that is offered as part of local authority information and advice services. We agree that advocacy might be necessary in some circumstances, and consider that this is already covered by the clause. However, given what we have heard, we have revised the clause to make clear that information and advice must be 'proportionate' to a person's needs. We believe this is best judged on a case-by-case basis, which we will explain in guidance. For example, this could mean a simple leaflet in some circumstances, a face-to-face conversation in others, or at the other end of the spectrum, it could mean more intensive, long-term access to advocacy.

Market shaping

40. In order to ensure that people are able to access care and support services to meet their needs, there must be a range of high quality services in every area. Local authorities have a critical role to play in building and managing the local market of services for the benefit of all local people. Clause 5 creates a new duty

to reflect this role, requiring local authorities to promote the diversity and quality of local services, so that there is a range of high quality providers in all areas allowing people to make the best choice to satisfy their own needs and preferences.

What we heard, and changes to the Bill

41. There was considerable support through the public consultation for the duty on local authorities to promote diversity and quality in the provision of services. Almost all respondents were supportive of a diverse market, including microenterprises, small and medium enterprises (SMEs) and voluntary organisations, where better information, advice and guidance is available for local people, particularly people with direct payments.
42. Respondents wanted the clause to be more specific about how the duty to ensure a 'sufficiency of services' would enable people to stay in employment, and about people's access to services outside a local authority's area. We have therefore changed the clause to clarify that the duty is to ensure diversity in the types of support being provided; and is about shaping services that people in the area use, as opposed to only shaping services that are located in the area. We have also made clear that, in fulfilling the duty, local authorities should consider the importance of enabling carers and people who use care and support to undertake work, education or training.
43. The Joint Committee recommended that this duty should require local authorities to monitor the match between supply and demand and report on the sufficiency of care and support in their area. The clause now requires local authorities to consider how to ensure the sufficiency of local services to meet local need. However, we have decided not to require local authorities to publish an assessment of the sufficiency of services, as this would create a disproportionate burden on local authorities.
44. The Joint Committee recommended that regulations or statutory guidance should address how unacceptable local authority commissioning practices affect the market and individuals' experience of services. We will do this through guidance.
45. We agree with the Joint Committee that the Department of Health should support local authorities to promote choice and diversity, improve commissioning and join up services with housing and health, by understanding local demand and involving service users and carers in decisions that matter to them. The national support programme 'Developing Care Markets for Quality

and Choice'¹⁴ addresses many of these issues. Local authorities and clinical commissioning groups are required to assess and address the current and future health and social care needs of the whole population through joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (HWBSs). The need for local authorities and clinical commissioning groups to engage with providers, those who use care and carers will be made clear in guidance.

46. We do not accept the Joint Committee's recommendation to establish an independent adjudicator to consider disputes between local authorities and providers over the cost of care, or to prescribe a mechanism to measure the quality of provision, as this would create additional disproportionate burdens.

Co-operation

47. Clauses 6 and 7 contain new duties on the local authority and other authorities which have functions relevant to care and support to cooperate. A general duty to cooperate as a matter of course is backed up by a more specific duty to cooperate in relation to individual cases, where the local authority can request cooperation from one of the partners (or vice versa) to help with a specific issue to do with a carer or an adult who uses care and support. These provisions include a duty on the local authority to ensure cooperation between its officers responsible for adult care and support, housing, children's services and public health.

What we heard, and changes to the Bill

48. Most comments in relation to these clauses suggested additional 'relevant partners' to be included within the scope of the duties to cooperate. We have considered the case for each of those put forward.
49. Some people suggested that care and support providers should be included. Whilst we agree with the principle that local authorities must cooperate with local providers, we do not believe that widening the duty to cover independent and private organisations, who are not subject to the same legal obligations as public authorities, would achieve this aim.
50. The Joint Committee further recommended that the list of relevant partners should be extended to cover registered housing providers, including housing associations and registered social landlords. We agree with the Joint Committee's view of the importance of housing provision in meeting needs for care and support, and cooperation with statutory housing functions is ensured through clause 6(3). Clause 6(6) includes those public bodies with functions

¹⁴ ipc.brookes.ac.uk/dcmqc.html

relevant to the care and support of adults and their carers within the local area, with an ability to extend this list to other bodies through regulations. As above, we consider that co-operation with independent, private and voluntary sector housing providers is better achieved through commissioning and contractual means, as well as through the market-shaping duty in clause 5, rather than inclusion in the 'relevant partner' list in this clause.

51. We also heard views that further public bodies should be included within the scope of these duties. In particular, many said that local authorities' new responsibilities for public health needed to be reflected. We agree, and the list at clause 6(3), which names departments between which a local authority must ensure cooperation, now includes the director of public health.

Assessing needs for care and support

52. One of the core objectives of Bill is to provide clarity for people on what they can expect from care and support. A local authority can meet an adult's needs for care and support in many ways, and it is important that the law does not get in the way of choosing the best approach. Clause 8 sets out just some examples of what a local authority might do to meet care and support needs, in order to give an illustration of the range of options available.

53. Clauses 9-13 relate to the start of the person's journey through the care and support system, setting out the process of assessments for both those who need care and carers, ensuring that the focus is on an individual's needs and outcomes. These clauses:

- state a single right to an assessment for adults, and one for carers, based on having an appearance of needs for care and support (clauses 9-12);
- provide for an eligibility framework in legislation for the first time, by requiring regulations to set a national minimum threshold for eligibility and thereby provide clarity on what constitutes 'eligible' needs (clause 13); and,
- describe what happens after the process of assessments, whether the person has eligible needs or not, including considering other forms of support available in the community, and how the person can prevent or delay future needs.

What we heard, and changes to the Bill

54. Respondents were pleased with an increased focus upon outcomes in the assessment process. Some wanted the clauses to be more specific. We agree with those who felt local authorities should be required to actively involve people, not just 'consult' them, in the assessment process. We have made

changes in clauses 9 and 10 to reflect this, as well as removing the qualification that engagement should be undertaken ‘as far as feasible’ in relation to developing the care and support plans (clause 25), and conducting reviews (clause 27).

55. There was considerable support through the consultation and from the Joint Committee for extended rights for carers and in particular the removal of the ‘regular and substantial test’, which limits entitlement to carer’s assessments in the current law. Some respondents argued that a carer’s assessment should focus more clearly on the impact of caring and on the outcomes that a carer wants to achieve. We agree, and have changed clause 10 accordingly.
56. The Joint Committee called on the Government to revise the Draft Bill provisions to support people planning to achieve wellbeing within their own resources, in order to frame assessment as a discussion about the additional support people may need to maintain or achieve wellbeing. We agree, and have made a number of changes to reflect this more ‘asset-based’ approach to prevention in both assessment and planning, including providing for local authorities to be required to carry out assessments in a proportionate way that reflects the needs of the individual in clause 12(1)(c).
57. The Joint Committee also recommended that if it appears to a local authority when undertaking an assessment that a person has a health or housing need or other relevant need, it should be obliged to bring this need to the attention of the relevant authority. We agree, and have therefore introduced provision at clause 12(1)(g) for local authorities to be required to refer adults who they believe have a primary health need to the NHS for assessment for NHS continuing healthcare.
58. To meet a further Joint Committee recommendation, we have now clarified in clause 12 that local authorities must provide a person with a written record of their assessment, and the decision on eligibility, in all cases.
59. We sympathise with the Joint Committee’s proposal to include provision for fast-tracking needs assessments for terminally ill people. We believe that clause 19(3), which enables local authorities to meet urgent needs for care and support without carrying out a full assessment where necessary, provides sufficient powers for this. We will reinforce this through guidance.
60. The majority of respondents were very supportive of the intention to introduce a national minimum threshold for eligibility for care and support. This was widely seen as an equitable and progressive move. Many people made a case for the level at which the threshold for eligibility should be set – some arguing it should

be set at the equivalent of the current 'moderate' level, others that it should not be below 'substantial'. Local authorities emphasised the need to take resources into account when setting the threshold.

61. We will say more about the minimum eligibility threshold when we publish a draft of the regulations to be made under this clause during the Bill's passage, following the settlement for social care that will be announced as part of the Spending Round in June 2013. However, we have made substantial changes to clause 13, particularly in line with the 'asset-based' approach, to:

- describe more clearly the alternatives available to people following an assessment, including the offer for those without eligible needs, and the ability for people to choose not to undergo a financial assessment, if they only want to record their eligible care costs for the purposes of progressing towards the new cap;
- require local authorities to consider which needs could be met by information and advice or through preventative services; and
- make clear that everyone with needs for care and support who is assessed, whether they meet the eligibility threshold or not, will be informed of support available in the community to prevent, or reduce their needs for care and support.

Charging, financial assessment and the cap on care costs

62. Adult care and support is not a free, universal service, and charging has always been part of the system. Clause 14 gives local authorities a power to charge for care and support services. The clause is clear about the powers and rules for charging, so that people know what to expect and so that the rules about charging are transparent.

63. Clauses 15 and 16 provide for two key aspects of the new funding system for care and support. This new system, based on the cap on care costs and extended means-test, will define a clear and fair partnership between individuals and the Government, with shared responsibility for care costs. People will still have responsibility for their initial care costs, but in the eventuality that they need a lot of care, they will not face catastrophic costs.

64. Clause 15 provides regulation-making powers to set the level of the cap and prevents local authorities from being able to charge for the costs of meeting eligible needs once people have reached the cap. The power to make regulations specifying the level of the cap will enable the Secretary of State to amend the cap, and to set different levels of the cap for different age groups. This will

enable Government to ensure that people who have eligible care needs when they reach 18 years of age will receive free care and support.

65. People will remain responsible for a contribution towards general living costs. In their own home, people remain responsible for non-care expenses such as utilities and rent. In residential care, they will pay a contribution of around £10,000 in 2010/11 prices (equivalent to around £12,000 in 2016/17) to help meet expenses associated with room and board. Clause 15 ensures that progress towards the cap will not include people's contribution towards their general living costs.
66. The cap will be adjusted in line with inflation, and the adjustment will occur once a year. Clause 16 outlines the basis on which this will happen. The clause also requires the record of accrued costs in the person's care account (see clause 30) to be adjusted by the same inflation measure so that everyone's rate of progress towards the cap remains the same. This means that if someone is 50% of the way to the cap before the annual adjustment, they will remain 50% of the way to the cap after the adjustment. This ensures that the real value of the cap remains constant.

What we heard, and changes to the Bill

67. Most of the changes to these clauses are a result of new provisions to reform the funding system and create the cap on care costs. Consistent with the recommendation of the Joint Committee, the regulations that set the level of the cap for the first time will be subject to the affirmative procedure.
68. During consultation, some felt that using the word 'impose' in relation to charging was inappropriately strong. We agree with this, and have changed the language used in clause 14.
69. The Joint Committee argued that it should be made clear in clause 14 that where charges are made they should be limited to what it is 'reasonably practicable' for the person to pay, and that local authorities cannot simply charge the carer for services provided to the person cared for. On the first of these, our view is that the Bill already provides for regulations to set an amount below which a person's income cannot fall after paying any charges. This creates a stronger protection for people's income than limiting charging to what is 'reasonably practicable' and we do not believe that further changes are necessary. We have also made it clear that local authorities cannot charge carers for services provided to the people that they care for.
70. Clause 17 requires that if the local authority is considering providing a service for which they require a charge, then they must carry out a financial assessment to

determine how much the person can afford to pay towards the cost of care and support. How they calculate this will be set out in regulations. Following consultation, this clause has been revised to require local authorities to provide people with a written record of their financial assessment. The clause now also specifies that where a person has an eligible need, the local authority cannot assess under this section unless it has advised the adult that they have the right to choose not to have their needs met by the local authority. This is to allow people to opt out of financial assessment, if they do not want the local authority to meet their needs (for instance, if they only want to record their care costs for the purposes of progressing towards the cap).

Duties and powers to meet needs

71. The question of who is entitled to care and support is critical and, in the past, different duties and legal tests for different services have caused confusion. One of the key aims of the new statute is to remove anomalies and differences resulting from the type of care or setting, and provide a single route through which consistent entitlements to care and support can be established.
72. Clauses 18-19 provide this single route, replacing the precedents with a clear duty to meet an adult's needs for care and support. This includes the ability for people with eligible needs to request that the local authority help them by brokering care and support on their behalf, regardless of their personal finances, subject to a small administrative charge.
73. Clause 20 provides the equivalent right for carers, and is their first ever legal entitlement to public support, putting them on the same footing as the people for whom they care.
74. Clauses 21-23 clarify those circumstances in which adult care and support may not meet needs, because the responsibility rests with another organisation. This is intended to set out the boundary between care and support and other services, for instance, to determine whether the provision of a certain service falls to the NHS, or to a local housing authority, rather than local authorities.

What we heard, and changes to the Bill

75. These clauses were welcomed, particularly the provision to allow individuals to ask the local authority to meet their eligible needs, regardless of the level of their personal finances, and stronger rights for carers.
76. Some changes have been made to clause 18, for the most part in order to provide for the effect of the cap on care costs. This now requires that where an adult's total accrued care costs have reached the level of the cap, the local

authority must meet their needs. This will be the mechanism by which people receive financial support once they have reached the cap.

77. Clause 22 sets out the limits on what a local authority, in meeting needs for care and support, may provide by way of healthcare. In effect, therefore it sets the boundary between the responsibilities of local authorities for the provision of care and support, and those of the NHS for the provision of health care. This clause seeks to reproduce the effect of the current limitations on what a local authority may provide by way of health care and it is not the intention to change that boundary. It attracted a large amount of interest and comment, both through the public consultation and from the Joint Committee. Most respondents to the consultation welcomed the principle of setting a clear boundary between the care and support system and the NHS. However, many respondents expressed the view that there was need for greater clarity still on the split of responsibilities. Several respondents also wanted to see greater clarity around the relationship between care and support and NHS continuing healthcare, including practical considerations as to assessments and joint working between local authorities and the NHS.
78. The Joint Committee called on the Government to redraft clause 22 to clarify that the boundary between health and care was not changing. It also called into question the desirability of subsections (3) and (4). These are the provisions which seek to re-state the current restrictions on a local authority providing, or arranging the provision of, nursing care by a registered nurse.
79. We considered these points carefully. The intention of this clause is not to change the boundary between local authorities and the NHS but to enable the current boundary to be replicated and to continue to work as before albeit with the new NHS landscape brought about as a result of the Health and Social Care Act 2012. We have made some clarifications to address this feedback, and we are satisfied that the clause enables the existing boundary between the care and support system and the NHS to be maintained.

Care and support planning, personal budgets and direct payments

80. Clauses 24-35 of the Bill sets out what must happen after the conclusion of the assessments, whether or not the local authority is going to meet the person's needs. This includes new clauses to capture in law for the first time the process of care and support planning, including entitlements to personal budgets and ongoing reviews.
81. Where the local authority is going to meet a person's needs, the purpose of these clauses is to determine how those needs will be met, via a person-centred

planning process. Unless regulations specify otherwise, all people will have a personal budget included in their care and support or support plan to help them understand the options available to them and exercise control over how their care and support is provided.

82. Other new clauses have been introduced to the Bill to provide for the new funding system – clauses 28 and 29.
83. Clause 28 requires the local authority to give everyone who has eligible care needs, but where the local authority is not meeting their needs, an independent personal budget. The independent personal budget will set out what it would have cost the local authority to meet those needs. This ‘notional’ cost is used to ensure consistency between the independent personal budget and the personal budget in the care and support plan, so that people who choose to spend more on their care do not reach the cap more quickly. It will clearly separate out the general living costs from the care costs so that people can clearly see the care costs that are contributing to their progress towards the cap. This clause also requires the local authority to review the independent personal budget on a regular basis, to ensure that it is up to date.
84. A care account (clause 29) will be an up-to-date record of a person’s total care costs accrued to that point in time. Local authorities will be required to keep a care account for adults whose care costs are counted towards the costs cap. The purpose of the account is to maintain a record of the adult’s total lifetime accrued care costs, and progress towards the costs cap. The care account will be adjusted annually by the same measure as the cap, so that everyone’s rate of progress towards the cap remains the same. In general, individuals with a care account will receive a regular statement of their accrued costs. Once the person reaches the ‘cap’, the local authority must inform them of this.

What we heard, and changes to the Bill

85. With regard to care and support plans (clause 25), respondents to the consultation wanted to ensure that the balance of decision-making lies with individuals rather than the local authority. Respondents felt that the original drafting placed too much emphasis on the local authority, which conflicts with the wider personalisation agenda. We have now changed clause 25(5) to make clear that in involving an adult or carer to prepare the care and support plan, the local authority must take all reasonable steps to reach agreement.
86. Respondents were supportive of the inclusion of personal budgets in law for the first time (clause 26) and the provisions relating to direct payments. Some felt that people should be offered appropriate support to use direct payments, and

that the legislation must be clear about people having the right to request direct payments, rather than being forced to use them. We have considered these points, and believes that the clauses as originally drafted are fit for purpose.

87. The Joint Committee recommended that the only requirement around the use of direct payments should be that they are used to meet the needs and outcomes in the care and support plan, in order to ensure greater flexibility. We agree, and have changed clauses 25 and 33 accordingly.

88. We have decided not to adopt the recommendation that the ban on direct payments being used to pay for local authority direct services should be lifted. In our view, it should be more efficient for the local authority to provide this to the person as part of a managed service, rather than as a direct payment. Current guidance allows people to receive services as a mixed package (i.e. a council-provided service along with a direct payment) and our intention is to continue this in updated guidance that will be produced to complement the Bill.

89. The Joint Committee also recommended that the Bill should require that the amount of a personal budget should be equivalent to the reasonable cost of securing the provision of the service concerned in the local area. We accept this point, and clause 26 now makes clear that the personal budget *is* the cost to the local authority of meeting the needs it is required or has decided to meet.

Deferred payments

90. Clause 34 provides for authorities to enter into agreements with individuals to defer payments payable to the local authority for chargeable services. Regulations may set out when authorities may or must allow someone to defer payment, what charges may be deferred, and any interest or administration fee that may be charged by the authority. We intend, through these regulations, to place duties on authorities to offer a deferred payment agreement to people going into residential care so that adults who would otherwise need to sell their home to pay for residential care may defer payment of reasonable care home fees. The introduction of this 'universal deferred payment scheme' will mean that people will not have to sell their home in their lifetime to pay for care. We plan to consult on the details of the scheme during the passage of the Bill.

What we heard, and changes to the Bill

91. The Joint Committee, and some consultation respondents, recommended that local authorities should not be allowed to charge interest on an outstanding administration fee in relation to deferred payments. We want deferred payments to be cost-neutral to local authorities and financially sustainable over the long-term. Clause 35 allows authorities to charge interest and an upfront

administration fee when they offer a deferred payment – this is to help authorities recover their costs. The provisions allow authorities to let people pay the administration fee upfront, or to defer it so it is repaid later along with the rest of the deferred payment. In the second case, we think it is reasonable to charge interest on the deferred amount so the authority does not make a loss over time. It will make a very small difference to what someone pays while ensuring overall fairness.

Continuity of care when moving between areas

92. People have told us about how difficult it can be to move between areas in England, because of the fear that they will lose their care and support in the new area. Clauses 36-37 ensure that when a person moves local authority area they do not face a gap in their care and support, by assigning to the new local authority responsibility for meeting needs from the day of arrival. They provide clarity on the responsibility of each of the local authorities during the person's move and places duties on local authorities to share information to make the move as easy as possible.

What we heard, and changes to the Bill

93. Those who commented on these clauses largely welcomed the new provisions for continuity of care. The Joint Committee and respondents to the public consultation recommended that the terms 'sending' and 'receiving' authorities be replaced with more neutral language which emphasises that people control their own decisions. We accept this, and these clauses have been revised to refer to 'first' and 'second' authorities.
94. Some respondents to the consultation wanted these provisions to go further, and guarantee that the same care and support would be provided in the new area as in the previous one, perhaps for a limited period of time only.
95. Where the second authority has not assessed the individual before he or she has moved, clause 37 requires that authority to meet the needs for care and support which the first authority was meeting until it carries out its own assessment. When people move local authority area, their circumstances are likely to change. They may be moving to be nearer family support, or to take up employment. The needs that they have for care and support may also change. It will not always be appropriate for them to have the same or equivalent services after the move to those that they had before. Moreover, equivalent services may not be available in the new area.
96. We therefore do not believe that any requirement should be made to guarantee the same support. However, we have revised this clause to require the second

local authority to take into account the plan(s) supplied by the first authority when it is developing its own care and support plans. We have also included a requirement that the second authority provide a written explanation to someone if there is a difference between their assessment of the adults identified needs, or the cost of meeting the needs differs from the assessment made by the first authority.

97. Revisions have also been made to these clauses to accommodate the new circumstances in which someone in the capped costs system with an independent personal budget may wish to move between areas. When someone moves local authority areas, they will take their care account and independent personal budget with them. They will be re-assessed by their new local authority, so their independent personal budget may change. However, their accrued costs in their care account will remain the same. To ensure that people can be sure there is a record of their care costs when they move, the local authority that the person is moving from will be required to retain a record of their care account.

Establishing where a person lives

98. Clause 38 sets clear rules that when a local authority arranges accommodation outside its own area, the placing authority remains responsible for meeting the person's needs under circumstances described in the clause. This ensures that people have confidence that local authorities will be able to determine who is responsible for meeting their care and support needs. It closes the gap in current law which meant that, in some cases, it was not clear which local authority was responsible for some types of accommodation arranged in other areas.
99. Clause 39 gives power to the Secretary of State to resolve disputes between local authorities where local processes have not been successful. These clauses re-enact existing powers and extend them through regulations to a wider range of accommodation settings.

What we heard, and changes to the Bill

100. Since publishing the Draft Bill, we have worked with the devolved administrations to clarify care and support responsibilities when a person requiring residential care moves between countries in the United Kingdom. These provisions are set out in schedule 1. They include provision to allow cross border placements between England and other parts of the UK, as well as provision to enable cross border placements in residential care between Wales, Northern Ireland and Scotland. This addition to the Bill will support people to exercise choice and control, wherever they are in the UK.

101. We have also added a new clause 40, which allows a local authority to recover the costs it has incurred in meeting a person's needs, but for which another local authority was liable.

Safeguarding adults at risk of abuse or neglect

102. Clauses 41-46 and schedule 2 of the Bill set out the first ever statutory framework for adult safeguarding. They require local authorities to ensure enquiries are made into allegations of abuse or neglect, and to establish a safeguarding adults board (SAB) in their area. SABs will be required to produce a safeguarding plan, on which it must report progress annually. Where SABs know or suspect that serious abuse or neglect has contributed to the death or serious harm of an individual, and there is reasonable cause for concern about how SAB members or other persons with relevant care and support functions acted, then SABs will be required to carry out a safeguarding adult review. The aim of the safeguarding adult review will be to learn lessons on how to prevent such occurrences in the future. SABs do have the power to undertake reviews in other circumstances if they so choose.

103. Clause 45 also repeals the local authority's power to remove a person from his or her home in certain circumstances.

What we heard, and changes to the Bill

104. There was considerable support for placing adult safeguarding on a statutory footing for the first time. Consultation respondents and the Joint Committee thought that additional organisations, such as the health and wellbeing board and housing organisations, should be included in the list of required members of SABs. Schedule 2 specifies that the members of an SAB must include at least the local authority that established it, the NHS and the police. However, we do not feel it appropriate to prescribe any further than this, as we believe that local areas should have the freedom to decide the composition of their SABs in line with local circumstances.

105. Respondents to the consultation told us that referencing financial abuse specifically when defining 'abuse' was confusing and might give the impression that it is the only type of abuse. The reason for highlighting it is that the term 'abuse' in other legislation does not usually include financial abuse. We have redrafted clause 41(3) to make clear that financial abuse is only one type of abuse that people might experience. We note that the Joint Committee agreed with our approach on this.

106. The Joint Committee recommended that the safeguarding provisions should put beyond doubt that the duty of local authorities to make enquiries extends to

cases where abuse or neglect has occurred in the past. This was always our intention, so we have made this clear.

107. A number of stakeholders and the Joint Committee told us that when an SAB requests information from other organisations to exercise its functions, it might encounter resistance (for example, due to misconceptions around data protection laws). In order to remove any doubt, and to allow SABs to exercise their functions properly, we have introduced a new duty on relevant organisations to supply information to SABs on request (clause 44). This mirrors a duty in children’s legislation relating to local safeguarding children boards.
108. The Joint Committee and some respondents to the consultation wanted local authorities to have a new power of entry or access to a person in certain circumstances. Since publishing the Draft Bill, we also held a separate public consultation specifically on this issue. The consultation did not provide a compelling case to create such a power, and on this basis, we have decided not to add a new safeguarding power of entry to the Bill¹⁵.

Managing provider failure and oversight of the care market

109. Clauses 47 to 49 provide for a new approach to managing the oversight of registered care and support providers, and set out local authorities’ responsibilities for ensuring continuity of care where a provider sustains business failure and ceases to provide a service.
110. These clauses were not included in the Draft Care and Support Bill, but were subject to a separate consultation process from December 2012 to March 2013. The consultation invited views on two potential changes to the current system, and asked:
- first, what further measures are needed to strengthen and clarify the responsibility of local authorities in relation to care users in the event of the failure of a care provider; and,
 - second, whether a targeted model of central oversight would be appropriate and if so, what the elements of this model would be.
111. The aim of any change is to protect people receiving care services by taking steps to ensure continuity of care in the event of the financial failure of a provider.

¹⁵ www.gov.uk/government/consultations/consultation-on-a-new-adult-safeguarding-power

What we heard and clauses inserted into the Bill

112. The separate consultation on managing provider failure and oversight of the care market received around 60 written responses. During the consultation period, the Department of Health held and attended events with 111 organisations, which included local authorities, providers, user and carer representative groups, banks and commercial advisors. The events included four ‘deep-dive’ roundtables with relevant experts to consider and scrutinise the proposals in detail. Respondents were generally supportive of our proposals to clarify local authority responsibilities and to introduce a central oversight model, but provided detailed comments on how the system should work. Our response to that consultation is published alongside this document¹⁶.
113. Local authorities are already responsible for managing the impact of provider failures and ensuring continuity of care for people whose needs they are already required to meet. Clauses 47 and 48 set out the duties of a local authority for people whose needs they are not already required to meet when a provider fails. These clauses apply to people who pay for care themselves whether they receive care in a care home or in their own home. They allow flexibility for local authorities in considering how they will respond to provider failure – whilst they may have to arrange temporary replacement care to ensure people’s need do not go unmet, in other cases, it may be sufficient to offer advice and information on alternative providers if a person wishes to arrange care themselves.
114. In some cases, the failure of a social care provider will be more difficult to manage, for example because it is located across many areas, it has complex business arrangements, or it is providing specialist services. Clauses 50 to 54 provide for a new regime of central oversight, which will be operated by the Care Quality Commission (CQC), to monitor the financial position of the most ‘difficult to replace’ providers in England. This central system will support local authorities to prepare and to manage continuity of care in a way, which minimises stress and anxiety amongst local people.
115. In overseeing this system, the CQC will monitor the financial sustainability of providers who are ‘difficult to replace’ for any reason, including their size, concentration or specialism. The CQC will assess the financial sustainability of these providers. The clause enables the CQC to take a number of steps in order to maintain quality care services, mitigate risks to business sustainability and ensure continuity of care for any person who receives care services. These steps include:
- requiring regular financial and relevant performance information;

¹⁶ www.gov.uk/government/consultations/new-protection-if-care-providers-fail

- working with the provider to develop a ‘sustainability plan’ to manage any risk to the organisation’s ongoing sustainability;
- using powers to commission an independent business review to help the provider to return to financial stability; and
- requiring information from the provider to enable the CQC to (amongst other reasons) support local authorities to manage provider failure.

Transition for children to adult care and support

116. We recognise that transition to the adult system of care and support can be difficult for young people and that having the information about adult care and support is essential to planning and preparation for the future. Clauses 55 to 63 of the Bill aim to smooth the transition to adult care and support for young people, young carers and carers of children. These clauses allow a local authority to assess a young person’s needs under the adult care and support statute when they are nearing adulthood and it would be of significant benefit for an assessment under the adult provisions to take place. Such an assessment could help the young person to understand whether they, and their carer where relevant, are likely to be eligible for care and support when they turn 18 years of age, and what might be available to them.

117. These provisions include powers to assess children and young carers on request (clauses 55 and 56) and a duty to assess the carers of children on request (clause 57). These clauses also provide that if a child has been receiving a children’s service just prior to their 18th birthday and they are due to transition to adult care and support but the local authority is not ready to put in place such support, then it must continue to provide the children’s services in the interim. They also give a general power to provide support to meet the needs of the carers of children.

What we heard, and changes to the Bill

118. We heard from respondents to the consultation and from the Joint Committee that these provisions should not be limited only to young people who are receiving services under the Children Act 1989. We agree, and have made changes to these clauses to address this in two respects. Firstly, to incorporate the other legislation (in addition to the Children Act 1989) under which young people may be receiving services, and secondly, to enable assessment of young people who are not already in receipt of services. Consistent with the recommendations of the Joint Committee, explanatory notes make the links between this Bill and the Children and Families Bill, and guidance will support this, providing clarity about the interactions between children’s and adults

legislation. In particular, guidance will address the proposed Education, Health and Care (EHC) plan, clarification about joint assessments (including the EHC plans and the other types of assessment this could include) and the support available to carers and young carers, regardless of the legislation under which the provision is made.

119. We also heard concerns from many respondents and the Joint Committee that an unintended consequence of strengthening rights for adult carers was that young carers would be left with lesser entitlements. Many were concerned that young carers should not fall between the cracks or face a higher threshold for receiving support. They argued that the most straightforward solution would be to bring updated legislation for young carers into the Care Bill, in line with the Law Commission's stated preference¹⁷.
120. The Joint Committee further recommended that local authorities should have the power to make provision for children aged 16 and 17, including young carers, where an assessment under the Bill identifies need.
121. We have considered both these points but do not believe it would be appropriate for children to receive adult care and support before the age of 18. The adult care and support system is designed with adults in mind, and includes factors such as charging that do not apply to children's services. It is right to maintain a clear distinction between what can reasonably be expected for adults and what we would expect for children, and we wish to ensure children are supported as children. As such, we do not think it would be in a child's best interests for adult support to be provided before the point of transition. However, it is of course crucial that adult and children's services work well together so that young people do not carry out inappropriate caring roles, are not disadvantaged in their education, and do not lose their childhood because of caring.
122. We want to encourage professionals to take a 'whole family' approach in practice, meaning that an individual is not looked at in isolation. In line with the Joint Committee's recommendation, clause 12 provides a power to make regulations that require the local authority to have regard to the needs of the family of the person to whom an assessment relates. This would include identifying the presence of a carer, including a young carer. The Bill also allows for the assessment of the adult to be linked to any other assessment. This will allow practitioners to consider the effect of an individual's support needs on the

¹⁷ www.parliament.uk/documents/joint-committees/Draft%20Care%20and%20Support%20Bill/Oral%20evidence%20volume.pdf

rest of the family, and provide appropriate services that address the needs of the whole family.

Other provisions

123. The final clauses in Part 1 set out a number of other important provisions:
- powers for local authorities to recover debts, for instance where someone has stopped paying any charges that are due and where assets have been transferred to avoid payment (clauses 64-65);
 - a new duty on the Secretary of State to review the level of the cap on care costs every five years (clause 66);
 - restating and rationalising the provisions which focus local authorities and the NHS on reducing delayed discharges from hospitals (clause 67 and schedule 3);
 - making a number of amendments to section 117 of the Mental Health Act 1983 to remove anomalies between aftercare services provided under that Act to people who have been detained in hospital for a mental disorder, and care and support provided under the Bill (clause 68 and schedule 4);
 - clarifying the responsibilities of local authorities towards people in prison who have care and support needs (clause 69).
 - requiring local authorities to hold registers of blind and partially sighted people in their local area (clause 70);
 - allowing the Secretary of State to issue guidance to local authorities in relation to their functions in this Bill. This new statutory guidance will be an important element of the new framework, which will determine the way in which local authorities carry out their responsibilities (clause 71); and
 - a new power for local authorities to delegate some of their care and support functions to other organisations, for instance, the assessment process or care planning. When delegating its functions to a third party, the local authority retains responsibility for ensuring its legal obligations are met, and the local authority is accountable for any breach of those obligations (clause 72).

What we heard, and changes to the Bill

124. Clause 66 is a new clause, related to the inclusion of the reformed funding system in the Bill. This is intended to require the Secretary of State to review the level of the cap, financial thresholds and other provisions every five years. The

clause sets out some principles to be followed in carrying out this review, which must be laid before Parliament.

125. In relation to clause 68 (mental health aftercare), some consultation respondents raised concerns that the wording in the Draft Bill could lead to 'aftercare' being interpreted only as services directly arising from a mental disorder. Our policy intention is that it should also include services that are related to someone's mental disorder. We have also clarified the purpose of section 117 services - to reduce the risk of a deterioration in the mental health of the people who receive them (and, accordingly, reduce the risk that they will require admission to a hospital again for treatment for the disorder). To remove any doubt about these points we have redrafted the clause accordingly.
126. Clause 69 makes a number of small changes to the Bill to clarify the responsibilities of local authorities towards people in prison who have care and support needs. In our response to the Law Commission's report, we agreed that responsibilities in this area needed to be made clear, as there is evidence that a lack of clarity in this area has led to care needs not being assessed or identified, which has increased the risk of re-offending upon release. Clarity in this area would ensure that people in prisons are able to access care and support on a similar basis to those in the community. The Bill confirms local authorities' responsibilities towards this group, by applying core duties to assess and meet needs on the same basis as for other groups.
127. In considering how to apply care and support legislation most effectively for people in prison, we have concluded that some provisions should not be applied, in order to reflect the different context. The clause provides that certain duties on local authorities do not apply when the individual is in prison, including entitlements to direct payments, protection of property and the right to a choice of accommodation, as these will not be relevant. We will continue to work with local authorities and the National Offender Management Service, amongst others, to develop statutory guidance to support the way in which care and support is provided in prisons to implement the new legal framework.
128. Given the increase in assessments and independent personal budgets resulting from the introduction of a capped cost scheme, the Joint Committee called on the Government to establish a care and support tribunal to provide redress and complaints resolution. We agree that it is vital that people have an effective way to complain and seek redress that provides real challenge, particularly to the decision-making process. We will be looking at the existing arrangements in light of findings of the 'Review of NHS Complaints' led by Ann Clwyd MP and Professor Tricia Hart, which is due to report at the end of June, and also our own consultation on the capped cost scheme. We do not believe

that a formal independent tribunal process is likely to be the appropriate response to introduce additional challenge, as it would slow down the process of resolving complaints, is likely to be expensive and would add a further burden to the existing system.

129. The Joint Committee considered that the Bill should state that all providers of publicly arranged care and support should consider themselves to be bound by the obligations of the Human Rights Act 1998. The Government's position has been that all providers of publicly arranged health and social care services, including those in the private and voluntary sectors, should consider themselves to be bound by the duty imposed by section 6 of the Human Rights Act 1998 not to act in a way that is incompatible with a Convention right. The CQC as the regulator is bound by the Human Rights Act 1998 and has a positive obligation to ensure that individuals are protected, which is reinforced by its enforcement powers in the Health and Social Care Act 2008. This obligation covers all individuals who receive care and support and not just those whose care is publicly arranged.

130. Regarding clause 71 (which provides for statutory guidance), the Joint Committee recommended that the status of this guidance should be revised to provide for a 'code of practice'. Our view remains that a code of practice would be too inflexible for adult care and support guidance that may quickly become out of date. Our new bank of statutory guidance would have the same legal status and be subject to consultation in the same way as a code of practice. However, because it would not need to be laid before Parliament each time it is amended for any future changes, it could be kept up to date to reflect emerging policy and practice, which would be particularly important in relation to implementing new funding reforms. Our approach is consistent with children's social services legislation, which also uses statutory guidance rather than a code of practice. Where codes of practice are used in other cases, this is usually where the function impacts on fundamental individual rights (for example, in relation to mental health and mental capacity legislation) and the case for Parliamentary oversight is stronger.

Care standards (Part 2)

Summary

131. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC and published on 6 February 2013¹⁸, makes for horrifying reading.
132. It is also a watershed moment for the health and care system and a call to action for every individual member of staff and every organisation across the system. Many thousands of staff are committed, caring and hardworking and deliver good or excellent care. Yet in Mid Staffordshire NHS Foundation Trust from 2005 to 2009, many patients received appalling care, and the wider system failed to identify the problem and then failed to share information and act on warning signs. What occurred in the hospital was unique in its severity and duration, however pockets of poor care do exist elsewhere and some of the features that contributed to the tragedy – unsafe and poor quality care, problems not picked up early and dealt with promptly and the interests of patients put last – all point to wider problems.
133. The report called for a system-wide response, across health and care, to ensure that the failures of Mid Staffordshire NHS Foundation Trust are not repeated. The report made 290 recommendations with the aim of ensuring that the commissioning, delivery, monitoring and regulation of healthcare brings about a transformational change that focuses on achieving reliably safe and high quality care, that puts patients at its heart and where compassionate care and patient experience is as important as clinical outcomes.
134. The Government intends to produce a further response to Robert Francis' recommendations, including a system-wide update on progress and next steps, later this year. Our initial response to the Inquiry¹⁹ highlights the urgent priorities for ensuring safe, compassionate care in hospitals and sets out a five-point plan:
- Preventing problems;
 - Detecting problems quickly;
 - Taking action promptly;

¹⁸ www.midstaffspublicinquiry.com/report

¹⁹ www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

- Ensuring robust accountability;
 - Ensuring staff are trained and motivated.
135. Most of the measures within this plan focus on greater cohesion and cultural change across the system and can be implemented within the existing framework or can be achieved through secondary legislation - work on these changes is ongoing. We will also publish a separate document that articulates more fully our vision for the regulation and oversight of NHS providers and how this will be realised.
136. There are a further set of limited but significant measures that require adjustments to the system, primarily to the way health and social care information is used for assessment and to tackling poor performance. These changes are our key early priorities in responding to the Inquiry, and are needed at the earliest opportunity, through primary legislation. They will complement ongoing work being taken forward through secondary legislation and formulate a package that supports our five-point plan. Together, these changes will help bring about a revolution in the care that patients experience, rooting out unacceptable care, tackling failure promptly and effectively, and ensuring that the inspectorate and ratings framework inspires all hospitals to drive for continuous improvement.
137. Part 2 of this Bill takes forward a package of measures, the most significant of which focus on:
- requirements for the CQC to develop a system of performance reviews and assessments – a single version of performance that will allow organisations and the services they provide to be compared like for like in a fair and balanced way, that is meaningful to patients and the wider public.
 - powers to allow the new Chief Inspector of Hospitals, appointed by the CQC, to instigate a new failure regime. This will mean that in cases where urgent changes are needed to address poor care or quality failings in NHS hospitals, this will be detected quickly, and there will be a clear and time limited process for intervening and tackling unresolved problems urgently.
 - greater transparency and stronger accountability about the information providers produce on their own performance and outcomes, making it an offence for care providers to supply or publish certain types of false or misleading information and introducing additional legal sanctions.

The measures within Part 2 of the Care Bill were not included in the Draft Care and Support Bill, and therefore were not subject to the same public consultation and pre-legislative scrutiny as the other areas of the Bill.

Ratings

The case for change

138. While there is a significant amount of information available on organisations providing health and social care in England, there is currently no aggregate ‘rating’ to summarise and compare the performance of organisations or the services provided by them. Better quality information is critical to modernising the NHS and care services. For all who need health care or social care, the quality and safety of care available, including the experience of people using services, is crucial. An aggregate rating summarising and comparing the performance of organisations and the services provided by them will help people choose the right services, and encourage organisations purchasing or providing services to improve them.
139. We commissioned the Nuffield Trust to consider whether aggregate ratings of provider performance should be used in health and social care, and if so how best this might be done. The Nuffield Trust considered current arrangements and accountabilities in the NHS and social care to improve quality and safety, and the possible place of provider performance ratings alongside these. The Nuffield Trust’s report, *Rating providers for quality: a policy worth pursuing?*,²⁰ suggests an overall approach to ratings that allows complex organisations, particularly hospitals, to be assessed not just at an organisational level, which could be misleading on its own, but at different levels, with service-specific ratings where possible. It suggested any rating should include measures on safety, effectiveness and user experience and alongside these, particularly for larger health organisations, ratings for quality should also include measures related to financial health and management. Ratings should be based on routinely collected data and data from inspections, be transparent and updated and made available to the public, for example in the form of an annual judgement.

What the Bill will do:

140. Clause 80 will:
- allow the CQC to undertake periodic review (ratings) of providers of health services (which will be specified in regulations);
 - remove the requirement for the Secretary of State to approve the way in which periodic reviews are carried out, and instead require the CQC to devise its own approach, after consulting with the Secretary of State and other relevant stakeholders.

²⁰ www.nuffieldtrust.org.uk/ratings-review

Single Failure Regime

The case for change

141. In the past, when poor care was detected, it has too often been put in a ‘too difficult’ pile. Patients have been left with no one acting with urgency on their behalf to ensure a decent standard of care. A critical finding from Robert Francis’s report was the significant failures of accountability and transparency in the roles of system managers and regulators. Francis found that focus was directed at financial and organisational issues rather than the protection of patients and ensuring quality of care. A new failure regime, encompassing quality as well as finance, will build on the changes already made through the Health and Social Care Act 2012 and ensure that, where quality of care is below an acceptable standard, firm action is taken to resolve it properly and promptly.
142. The single failure regime will deliver a clear and coordinated regulatory approach to identifying and tackling failures of quality. There will be three elements to the proposed failure regime.
143. It is essential that there is a common understanding of provider performance amongst regulatory bodies – a ‘single version of the truth’. There will be a single rating of providers led by the Chief Inspector of Hospitals at the CQC which draws on information from Monitor and the NHS Trust Development Authority (TDA) on finance. There will be one agreed national definition of quality, consistent with the Mandate and the NHS Outcomes Framework. The application of the national method will take account of the need to reflect and not crowd out local commissioner priorities.
144. When the quality of care at an NHS Trust or FT requires significant improvement, the Chief Inspector will issue a warning notice requiring the hospital board to improve within a fixed time period. Monitor (for foundation trusts) or the NHS Trust Development Authority (for NHS trusts) will be able to step in to take appropriate action, including removing or suspending hospital boards if necessary. Where breaches remain after a warning notice has expired, CQC must review its powers, including whether to trigger special administration, to ensure problems don’t become long-standing. In the cases of clinically unsustainable providers, we will ensure that the local population can access a comprehensive range of safe, sustainable health services.

What the Bill will do:

145. Clauses 74 to 77 will:

- allow the CQC to highlight failures in the quality of the health care provided by a NHS trust or NHS foundation trust that require significant improvement;
- ensure Monitor has sufficient powers to intervene in Foundation Trusts that are failing on quality; and
- provide a suitable mechanism to ensure that the local population can access a comprehensive range of safe, sustainable health services where providers are deemed clinically unsustainable.

Closing a loophole in the CQC's regulatory powers

The case for change

146. There is an inconsistency in the way that the CQC takes action to close down locations that are failing to provide acceptable standards of care. In the case of a small provider that operates from a single location, the CQC will close the location by cancelling the provider's registration. The provider is prohibited from itself applying to have its registration cancelled once the CQC has commenced enforcement proceedings. However, in the case of a larger provider which provides services from numerous locations, each location is listed as a condition on the provider's registration. In order to close a single location, the CQC will vary the conditions of the provider's registration. However, the provider is able to make an application to vary the condition in the same way, and thereby give the impression that the closure of the location is voluntary rather than as a result of enforcement action taken by the CQC.

147. The fact that providers operating from more than one location are able voluntarily to have a condition removed and thereby evade enforcement action by the CQC gives a false impression of compliance with registration requirements to both service users and commissioners, and a misleading impression of the extent of enforcement action taken by the CQC.

148. In order to ensure transparency of the regulatory system, both large and small providers should be subject to the same prohibition on voluntarily changing its registration status in the way that the regulator has already proposed. The additional clause in the Bill will mean that it will no longer be possible for providers to make an application for a change to its conditions of registration once the CQC has commenced enforcement proceedings relating to the same matter.

What the Bill will do

149. Clause 78 amends section 19 of the Health and Social Care Act 2008 in order to prohibit service providers from making an application for the removal or

variation of a condition of registration in cases where the CQC has issued a notice of proposal and/or a notice of decision to vary or remove the condition in the same way.

Sanctions for care providers that report false or misleading information

The case for change

150. Robert Francis made a range of recommendations in relation to criminal sanctions to ensure openness, transparency and candour. We agree there is a need for providers of NHS care to demonstrate the right balance between accountability and openness, and to strengthen sanctions for organisations that have been shown to have provided misleading information about their performance for patients. The Bill will make the supply or publication of certain types of false or misleading management and performance information by a provider subject to criminal sanctions. Regulations will limit the application of the criminal offence to providers of NHS secondary care.

151. The introduction of a new criminal sanction for care providers who supply or publish false or misleading management information will ensure providers are vigilant in the information they produce about their business and performance including clinical outcomes, and thereby:

- provide greater transparency and openness so that regulators, commissioners and the public have a more accurate picture about the organisation's performance; and,
- enable the CQC to detect quickly any signs of poor quality or safety and alert the relevant regulatory bodies to intervene appropriately.

What the Bill will do

152. Clauses 81 to 82 will create a new offence relating to the supply or publication of false or misleading information by providers. Regulations will limit the application of the criminal offence to certain information supplied or published by providers of NHS secondary care. These provisions will aid transparency and accountability in the provision of care.

The CQC Unitary Board

The case for change

153. The Department of Health's performance and capability review into the CQC²¹ found that there is a strong case for introducing a unitary board comprised of executive and non-executive members. The creation of an independent unitary board will bring the CQC's accountability and governance arrangements in line with best practice and ensure that the board is accountable and informed, and best able to oversee the regulatory work of the Commission.

What the Bill will do

154. Clause 79 will allow the CQC chair and non-executive directors to appoint executive members to the Board without the Secretary of State's intervention.

²¹ www.gov.uk/government/news/performance-and-capability-review-of-the-care-quality-commission

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

155. Part 3 of the Bill establishes Health Education England (HEE) as a non-departmental public body (NDPB) to provide the necessary independence and stability to empower local healthcare providers and professionals to take responsibility for planning and commissioning education and training. It also establishes the Health Research Authority (HRA) as an NDPB to strengthen its ability to protect and promote the interests of patients and the public in health and social care research, as well as providing assurance that the HRA will continue streamlining the research approvals process and encouraging investment in research.

HEALTH EDUCATION ENGLAND (HEE)

156. Education and training for healthcare workers plays a critical role in the continued improvement of health services. There are approximately 1.4 million people employed in the NHS, and in 2012/13, the Government invested around £5 billion in educating and training health and public health professionals.

157. As the healthcare system adapts to meet the challenge of sustaining high quality services and continuing to improve health outcomes in the face of demographic and technological change, the workforce must be responsive to these changing needs, supported by an education and training system that reflects the future shape of the NHS.

158. The Government wants to secure a responsive education and training system, where local healthcare providers and healthcare professionals take a lead role in workforce planning and development. This is so workforce plans can better meet the needs of local patients and communities.

159. Plans for the education and training system were set out in *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery (2012)*²² which responded to the second NHS Future Forum report on education and training²³.

160. HEE was established as a special health authority on 28 June 2012 to provide national leadership for education and training. It has established Local Education

²² www.gov.uk/government/publications/developing-the-healthcare-workforce-from-design-to-delivery

²³ www.gov.uk/government/uploads/system/uploads/attachment_data/file/135152/dh_127543.pdf.pdf

and Training Boards (LETBs) and they have taken on responsibility for the workforce planning and education and training functions of the Strategic Health Authorities (SHAs) following their abolition at the end of March 2013.

161. The Government wishes to establish HEE as an NDPB, placing it on a more stable and independent footing that will support the planning, commissioning and delivery of education and training. In providing for this change, the Bill takes forward a commitment made during the passage of the Health and Social Care Act 2012.

Establishing HEE as a non-departmental public body (NDPB)

162. Clause 83 establishes HEE as a statutory NDPB, in order to provide the certainty needed to plan on a long term and strategic basis. While the Secretary of State will retain overall accountability for securing an effective education and training system, HEE will have day-to-day responsibility for meeting this obligation. The Secretary of State's ability to require HEE to act in a specified way will be limited to specific areas subject to Parliamentary control. This will ensure operational independence and transparency that is consistent with other arm's length bodies performing key NHS functions, such as the NHS Commissioning Board.

What we heard, and changes to the Bill

163. Throughout consultation and pre-legislative scrutiny, we heard widespread support for establishing HEE as an NDPB. Those consulted believe this will provide a secure foundation for the education and training system and ensure greater objectivity in decision making. We heard that the creation of HEE provides the opportunity to build a new system that is more closely aligned with the needs of patients and able to be more responsive to changes taking place across the wider NHS and public health system.
164. The Joint Committee on the Draft Care and Support Bill recommended that the persons for whom HEE has education and training responsibilities should not be described in this Part of the Draft Bill as 'care workers', but that some other generic description should be found, such as 'health and care sector staff'. This issue was also raised by other stakeholders during consultation. We agree with the Joint Committee that the term 'care workers' is misleading. The Bill now uses the term 'healthcare workers'.
165. Respondents to the consultation confirmed the importance of HEE being professionally informed and taking a multi-professional approach to education and training. We agree that it is critically important that HEE and the LETBs have strong professional leadership. We have strengthened the Bill by placing an

explicit requirement on the HEE Board and the LETB to have members with clinical expertise (see paragraph 2 of schedule 5).

166. The provision for the Annual Report in paragraph 28 of schedule 5 has been revised to require HEE to report annually on how effectively it has discharged its functions, and to set out its assessment of its achievement against the objectives, priorities and outcomes set by the Secretary of State.

167. The Joint Committee called on the Government to consider giving both HEE and LETBs a duty to ensure that the principles and practice of safeguarding are integral to education and training. The HEE mandate includes a requirement for HEE to ensure that the principles of safeguarding are integral to education and training. The mandate is the preferred route for setting specific objectives for HEE and the LETBs with regard to the delivery of education and training.

National leadership for education and training

168. The Bill gives HEE a clearly defined set of duties and powers centring around providing national leadership for education and training. HEE will ensure that the workforce has the right skills, behaviours and training, and that staff are available in the right numbers, to support the delivery of high quality healthcare and drive health improvement.

169. The Bill also sets out the matters to which HEE must have regard in setting objectives, priorities and outcomes for education and training and ensuring sufficient skilled workers for the health service in clause 88.

What we heard, and changes to the Bill

170. Respondents to the consultation stressed the importance of HEE and the LETBs taking a strategic approach to workforce planning. Although commissioning of education and training takes place on an annual cycle, it is crucial that this is informed by a long term workforce strategy that identifies the workforce skills needed for the next three to five years and longer in the case of some professions such as medicine where there is a lengthy pathway for education and training.

171. The Joint Committee called for clause 88 to be revised to make clear that the duty on HEE is not merely to ensure a sufficiency of skilled workers, but to ensure that supply and demand are as far as possible matched, not just overall, but within each group of 'persons of a specified description'. In exercising its duty to secure sufficient skilled workers to work in the NHS and public health system, HEE is already required to have regard to factors influencing supply and demand. HEE does not operate on unlimited resources and has a duty to exercise its

functions effectively, efficiently and economically. Wherever possible, it will strive to match supply to demand to ensure that it secures the delivery of services and achieves value for money from its investment in education and training. There is therefore no substantive change to this clause.

172. The regulation-making power which required HEE to exercise specified functions in a specified manner has been removed from what is now clause 86. This power was no longer deemed necessary given the detailed provisions on HEE functions and the other regulatory-making powers available.
173. The Joint Committee recommended that clause 87 be revised to make clear that, in setting out its forward plans, HEE should include one plan looking at least five years ahead, and preferably longer, and that it should be updated annually. They argued that LETBs should have a similar requirement. We agree with the Joint Committee. It is absolutely the intention that, where appropriate, HEE and the LETBs should carry out their functions taking a strategic, long term perspective. We have revised clause 87 and clause 93 so that the Bill is clear that HEE and the LETBs should take account of short term and long term objectives in the development of education and training plans.
174. Clause 87 has been reworked since the Draft Bill so that it is clearer that the Secretary of State will set out HEE's objectives and priorities on an annual basis (through a document that will be known as the HEE mandate). Longer term outcomes will be set out in the Education Outcomes Framework, which will be reviewed at least every three years.
175. With regard to the list of matters to which HEE will have to regard in setting objectives, priorities and outcomes at clause 88, the Joint Committee recommended adding to that list (a) the promotion of integration (including between health and care and support) to align HEE with the duties placed on the NHS Commissioning Board and clinical commissioning groups, and (b) the desirability of enabling people to switch between and work across a range of different health and care and support settings. We welcome and accept the Joint Committee's recommendation, and have strengthened the provisions to promote integration and recognise the multidisciplinary workforce working across both the health and social care sectors.

Information and advice

176. HEE will have a duty to obtain advice (clause 89) from those who are involved or have an interest in the provision of education and training, such as professional bodies.

What we heard, and changes to the Bill

177. The Joint Committee argued it should be a statutory requirement for HEE to work in partnership with the NHS Leadership Academy to ensure that, in their training, managers learn alongside their clinical colleagues, with a specific objective of ensuring that a greater proportion of future managers have clinical experience. We fully support the need for partnership working between HEE and the NHS Leadership Academy in developing clinical leaders for the future. However, the NHS Leadership Academy is not a statutory body so it is not possible to put in place a statutory duty on HEE to work in partnership with the NHS Leadership Academy, and therefore we cannot accept the Joint Committee's recommendation. HEE is represented on the NHS Leadership Academy Programme Board, which provides strategic leadership and assurance on its business. HEE's mandate reinforces the importance of partnership working with the NHS Leadership Academy to deliver the leadership strategy.
178. The regulation making power in clause 89 has been removed. This power enabled the Secretary of State to specify through regulations other matters that HEE must seek advice on and the persons they should seek advice from. On reflection, this power was not considered necessary. This clause already includes a broad duty on HEE to seek advice on its functions from a wide range of stakeholders listed at clause 89(1) and(2), and there is a separate provision at clause 89(4) requiring HEE to advise the Secretary of State on any matter relating to its functions
179. Clause 89(2) has been revised so that it is clearer that HEE must 'seek to' ensure that it receives representations. This reflects the fact that in securing advice on its functions, HEE cannot compel the listed groups to participate or respond.

HEE and research

180. The Bill, at clause 86, gives HEE a duty to promote research into matters relating to the exercise of its functions. HEE can make an important contribution to research and innovation, through investment in the clinical academic workforce and by developing a research and learning culture there.

What we heard, and changes to the Bill

181. There was a widespread view during consultation that the education and training system can play an important role in supporting the development of a research-centred NHS. Education and training must equip the workforce to use the latest knowledge and research.

182. The Joint Committee recommended that clause 86 be revised so that HEE has – like the Secretary of State, the NHS Commissioning Board, and clinical commissioning groups – a duty to promote research on matters relevant to the health service. They argued that for HEE this duty should extend to other matters listed in paragraph (a), which includes social services. We agree with the Joint Committee’s recommendation to give HEE a duty to promote research on matters relevant to the health service and have reflected that in the Bill.

183. The Joint Committee also recommended that the provisions in clause 89 be broadened to allow HEE’s obligation to obtain advice to include the commissioning of research on the exercise of its functions. Whilst we agree with the sentiment of this recommendation, HEE will already be able to commission research on the exercise of its functions so such a change is not required.

Local Education and Training Boards

184. Clauses 90 to 94 cover Local Education and Training Boards (LETBs). At a local level, HEE will appoint and support the development of LETBs, which will enable local healthcare providers and professionals to take responsibility for planning and commissioning education and training. LETBs will bring together all those who provide NHS and public health funded services to work in partnership with education providers and other partners to develop and shape their workforce.

What we heard, and changes to the Bill

185. Stakeholders were supportive of the LETBs being appointed as committees of HEE. They felt this would help ensure better co-ordination and strengthen accountability through HEE, which will provide the necessary leadership and oversight. Respondents felt that the appointment of an independent chair was a positive step. However, during consultation we heard concerns from some stakeholders that the concept of all providers becoming a member of a LETB was misleading and potentially confusing. It is the policy intention that all providers of NHS and public health funded services should be represented by a LETB, and where appropriate cooperate with the LETB to support education and training activities. These objectives do not require that LETBs should be membership organisations. We have therefore reworked these clauses so that the basis for appointment as committees of HEE is clearer, with a specific clause addressing co-operation by providers of health services (clause 92).

186. Clause 93, which covers education and training plans, has been revised so that it is clearer that all LETB plans must be submitted to HEE for review and approval. This takes account of views received through consultation.

Equitable funding of education and training

187. HEE introduced a tariff system for education and training from April 2013 to ensure all providers are reimbursed fairly for the education and training they deliver. Clause 95 will put the tariff system on a statutory footing to ensure it continues when HEE becomes an NDPB.

HEALTH RESEARCH AUTHORITY (HRA)

188. The complexity of health research regulation and governance has increased over the last 20 years. The system can be confusing, time-consuming and therefore costly, for anyone who is seeking approval to carry out research in this area.

189. The Government's arm's length bodies' review announced the intention to create a research regulator. Following an independent review of the regulation and governance of health research by the Academy of Medical Sciences, the proposal to create the HRA was announced in the Plan for Growth (2011)²⁴ in recognition of the contribution health research makes to the UK economy.

190. As an interim measure, the HRA was established as a special health authority in December 2011. Its purpose is to protect and promote the interests of patients and the public in health research, and to streamline the regulation of research.

191. As a special health authority, the HRA has already taken on a number of key functions: the National Research Ethics Service; providing independent advice on the approval of processing of confidential patient information; and approving processing of confidential information for research purposes. It is already working jointly with others, such as the Medicines and Healthcare products Regulatory Agency (MHRA), to create a unified approval process for research and to promote consistent and proportionate standards for compliance and inspection.

192. As an NDPB, the HRA will retain these functions, but be able to act independently of government, which is appropriate given its role as a research regulator. It will provide the research sector with a greater amount of stability, assuring researchers and funders that the HRA will continue working with others to streamline regulatory processes, which is key to attracting investment in research.

²⁴ www.hm-treasury.gov.uk/ukecon_growth_index.htm

193. Establishing the HRA through primary legislation will provide a stronger basis for promoting a consistent system of research regulation across the UK, through formal duties of cooperation, and across the health and social care system, as HRA's remit will be extended to cover research in social care.
194. Legislating in this area also fulfils a commitment made during the passage of the Health and Social Care Act 2012.

The HRA's functions

195. In establishing the HRA as an NDPB, clause 97 sets out clear functions for the HRA. In carrying out its functions, the HRA's overarching objectives are to protect participants and potential participants in health and social care research and the general public by encouraging safe and ethical research, as well as to promote the interests of these groups by facilitating the conduct of such research.

What we heard, and changes to the Bill

196. The Joint Committee recommended that clause 97(2) be revised to make the facilitation and promotion of health and social care research the first of the main objectives of the HRA.
197. The HRA's overarching objective is to protect and promote the interests of participants and potential participants in research. In meeting this objective, the HRA will have a key role in facilitating and promoting research as encouraging high quality research is in the interests of patients and the public. Respondents to the consultation were concerned that the HRA should not allow its role in promoting research to outweigh its duty to protect research participants.
198. We therefore agree with the Joint Committee that the HRA will have a crucial role in facilitating and promoting high quality, ethical research but have deliberately framed the HRA's main objective in a way that ensures the interests of participants and the public are put first.
199. The Joint Committee recommended that clause 97(2) be revised so that promoting transparency in research and ensuring full publication of the results of research, consistent with preservation of patient confidentiality, becomes a statutory objective of the HRA.
200. We fully support the principle of transparency in research. It will be essential for the HRA to promote transparency in research in order to facilitate the conduct of safe, ethical research, which is a key part of the objective of the HRA NDPB.

201. The HRA special health authority is considering these issues at the moment. The Government would want to take account of the HRA's findings and of the relevant inquiry of the House of Commons Science and Technology Committee in determining the HRA's future role in relation to transparency of research. In doing so, we would want to ensure that any further legislation did not make the environment for research in this country less favourable than elsewhere.
202. While taking oral evidence, the Joint Committee asked for clarification on whether research conducted with animals is included in definition of health research in clause 97(3). We confirmed that it was not our intention that health research involving animals is within the HRA's remit. In light of this, we have tightened the definition to clarify that for the purposes of the Bill, health research does not include anything authorised by the Home Office under the Animals (Scientific Procedures) Act 1986.

Co-ordinating and promoting regulatory practice

203. The HRA will have a duty to cooperate with a number of other bodies that regulate research, and with the governments of Scotland, Wales and Northern Ireland. It will have the lead role in promoting a coordinated and standardised approach to the regulation of health and social care research across the UK. As part of this role, the HRA must seek to ensure that the regulation of research is proportionate (clause 98). The provisions also require the HRA to publish guidance on the principles of good practice in the conduct and management of health and social care research, and any requirements imposed upon researchers, for example, in legislation. Local authorities and NHS bodies are required to have regard to this good practice guidance.

What we heard, and changes to the Bill

204. Respondents to the consultation said they would like to see further clarification of the relationship between the HRA and those responsible for research governance in the NHS in the Bill.
205. We have revised clause 98 to require NHS bodies and local authorities to have regard to guidance that the HRA is required to publish under subsection (6) of this clause. The clause now makes clear that this guidance should not only set out principles of good practice in the conduct of research but also in the management of research. The proper management and conduct of research is essential to ensure that the public can have confidence in, and benefit from, high quality, ethical research in health and social care. This guidance would replace the Research Governance Framework for Health and Social Care currently published by the Department of Health.

206. The Joint Committee called on the Government to consider giving the HRA primary responsibility for coordinating and standardising the regulatory practice of all health and social care research carried out by the persons and bodies listed in clause 98(1) and by any others with similar responsibilities.
207. This is precisely what is envisaged for the HRA and is why the clauses give the HRA a unique, free standing duty to promote the coordination and standardisation of practice in the UK relating to the regulation of health and social care research, in addition to the duty to cooperate with other regulatory bodies. The duty in clause 98(3) will require the HRA to take the lead in actively identifying ways to remove duplication, streamline regulation of health and social care research and seek to ensure that regulation is proportionate.
208. As a special health authority, the HRA has been developing its programme of work to speed up research approvals in the UK. This programme will facilitate the creation of a unified approval process for research and support the HRA to promote consistent and proportionate standards for compliance and inspection. In doing so, the HRA is working closely with other regulatory bodies in order to identify and implement shared solutions that make it faster to initiate research.
209. In addition, we have restricted the power in clause 98 to revise the list of bodies that must cooperate with one another. The power has been limited to adding bodies to the list. Any other changes to the list as a result of future legislation, for example removal of a body from the list due to its abolition, can be made through consequential amendments. For consistency with similar provisions in the Bill, we have made this power exercisable by Regulations.

Public and patient involvement in the HRA's work

210. The main objective of the HRA is to protect and promote the interests of participants, potential participants and the public, which should be at the heart of everything the HRA does. To meet its main objective, we would expect the HRA to involve these people in its work. In order to do so, schedule 7, paragraph 8 enables the HRA to appoint committees, which can include people who are not members or employees of the HRA.

What we heard, and changes to the Bill

211. In our discussions with stakeholders and in the responses to the consultation, we heard calls for greater detail about how the HRA will engage with patients and the public in carrying out its functions as set out in the clauses. As set out above, schedule 7 will give the HRA the power to involve participants, potential participants and the public in its work.

212. Respondents to the consultation asked for clarification about the bodies with which the HRA should consult when preparing guidance required under the Bill. In preparing guidance, we would expect the HRA to consult all those with an interest in the regulation and management of health research and social care research.

Research ethics committees

213. Clauses 99-103 set out the requirements for research ethics committees, their recognition and establishment. The HRA will have a role in running a system of research ethics committees to assess the ethics of health and social care research (where the research does not relate to a devolved matter - unless a government of Wales, Scotland or Northern Ireland has arranged for the HRA to undertake this role in respect of a devolved matter). The HRA will be required to publish a document for research ethics committees setting out the requirements they are expected to comply with. In addition, clause 103 gives the HRA the Secretary of State's functions as a member of the UK Ethics Committee Authority, the body responsible for establishing, recognising and monitoring ethics committees in the UK in respect of clinical trials.

What we heard, and changes to the Bill

214. The Joint Committee recommended that the list of persons and bodies in clause 98(1) specifically include the Social Care Research Ethics Committee. Respondents to the consultation also suggested a number of other bodies that might be added.

215. Only statutory bodies can be included on the face of legislation, as non-statutory bodies can be abolished or functions can change without Parliament being notified. The bodies listed are therefore persons or bodies with statutory functions relating to the regulation of health or social care research.

216. It would not be appropriate to include the Social Care Research Ethics Committee in clause 98(1) as it is not a statutory body. However, the HRA special health authority is working closely with the Social Care Institute for Excellence (SCIE), which is the appointing authority for the national Social Care Research Ethics Committee, to promote processes and standards that are consistent across NHS and social care. As an NDPB, the HRA will be in a position to appoint research ethics committees that review social care research. We anticipate that the Social Care Research Ethics committee will be recognised by the HRA and become part of the National Research Ethics Service when the HRA is established as an NDPB.

217. The Joint Committee recommended that in its guidance to research ethics committees, the HRA must place on them an obligation to include provisions on the publication of research when granting approval for the conduct of research, and an obligation to ensure that such provisions are complied with.
218. We agree with the spirit of this recommendation. Research ethics committees already consider their applicants' proposals for registering and publishing research; for disseminating the findings, including those who took part; and for making available any data or tissue collected for the research. This helps promote transparency in research, which is essential to facilitating the conduct of safe, ethical research – a key part of the HRA main objective in clause 97(2). From April 2013, the HRA special health authority began undertaking checks of research ethics committee applicants' end-of-study reports to see if they have registered and published as they declared they would to the research ethics committee.
219. We are committed to HRA's independence, without which it cannot command public confidence in the research that is subject to its processes and decisions. In view of this, we do not intend to prescribe the content of HRA's guidance to research ethics committees. It is also not our intention to establish research ethics committees as regulatory bodies with enforcement powers in their own right, which this recommendation, as drafted, would seem to require. This would go significantly beyond their activities as assessors of the ethics of health and social care research proposals and fundamentally alter their established role, as well as their relationship to the HRA as an NDPB.

Functions relating to approving processing confidential information

220. Clause 104 sets out functions for the HRA relating to approving the processing of confidential patient information for the purposes of medical research, whilst ensuring that current safeguards remain in place.
221. The Bill gives HRA general powers to help and advise another public authority, for example to advise and assist the Secretary of State in relation to the approvals for processing confidential patient information for research purposes.

What we heard, and changes to the Bill

222. Respondents to the consultation were supportive of the function of approving processing of confidential patient information for medical research being given to the HRA, but asked for more information about how the process will work.

223. The HRA special health authority took on approving the processing of confidential information for research purposes from 1 April 2013 from the Secretary of State.
224. In addition, the HRA has appointed an independent committee (the Confidentiality Advisory Group) to provide advice to itself and to the Secretary of State on approvals for the processing of confidential information for research purposes and for other medical purposes respectively. Schedule 7 paragraph 8 would give the HRA the power to appoint such a committee in the future and paragraph 13 gives the HRA the power to provide help or advice to other public authorities.
225. The HRA held two stakeholder events in January ahead of taking over this function. Now that the HRA has taken on this function, it is looking at how it can best be delivered in the future and where improvements can be made. The HRA will be integrating the function into HRA systems to ensure efficiency of the function.

HUMAN EMBRYOLOGY AND FERTILISATION AUTHORITY (HFEA) AND HUMAN TISSUE AUTHORITY (HTA)

226. The Draft Bill contained a clause amending the Public Bodies Act 2011 to allow for the abolition of the HFEA and HTA and to transfer their functions to other bodies as appropriate.
227. Following consultation about the proposed transfer of HFEA and HTA functions, we announced on 25th January 2013²⁵ our decision not to press ahead with the transfer of functions to the CQC and the HRA at this time. We announced that we would continue a programme of further efficiencies for both bodies, include the HFEA and HTA in the scope of the DH shared services programme, and commission an immediate independent review of the way in which the HFEA and HTA undertake their regulatory functions.
228. The relevant clause has therefore not been included in the final Bill, which is consistent with the Joint Committee's recommendation that ministers should not have the power to abolish the HFEA or the HTA. Should the review recommend a merger that requires some legislative basis, we will consider options for how this might best be enacted. We are not pre-judging the outcome of the independent review, and we would not want to include a clause in the Bill on a 'just in case' basis.

²⁵ www.gov.uk/government/news/fertility-and-tissue-regulators-to-be-reviewed-following-consultation

229. The Joint Committee also recommended we retain the current entry of both bodies in schedule 5 of the Public Bodies Act 2011, allowing ministers to modify or transfer their functions, if not now, at some future date. We plan to retain these powers.

ANNEX: Table of recommendations from the Joint Committee and the Government response

The numbers in the first column refer to paragraph numbers in Chapter 11 of the report of the Joint Committee on the Draft Care and Support Bill.

No.	Recommendation	Government response
2	The overall level of funding available for the care and support system will impact on how far the reforms envisaged in the draft Bill and the Government's White Paper can be realised, particularly the stated goal of shifting the emphasis from crisis intervention to prevention and early intervention.	<p>We agree that the level of funding available will have an impact on how far the reforms are realised.</p> <p>That is why we made a strong commitment to adult social care in this Spending Review period, prioritising an additional £7.2 billion over four years. £1.12 billion of this is funding specifically for re-ablement, demonstrating our commitment to early intervention. Independent research by the King's Fund supported our view that this was enough for councils to maintain services, provided they focused on efficiency. Since then, a further £0.5 billion has been provided.</p> <p>In the context of a challenging local government settlement, this provides the resources for local authorities to protect access to care. But ultimately, spending on social care is a matter for local decision making.</p> <p>We cannot improve care and support simply by putting ever more money into the system. We have already seen examples of local authorities redesigning services to find more efficient ways of working. Many local authorities are innovating and achieving much greater integration between health and care services, thereby improving care for people and optimising use of the resources available.</p>
3	Regulations determining the level of the cap for working age adults should be subject to affirmative resolution.	<p>We completely agree that it is critical that the cap and the process for setting the cap is transparent and subject to proper and appropriate Parliamentary scrutiny.</p> <p>When we establish the level of the cap in regulations for the first time, this will be subject to the affirmative resolution. This includes the differing levels of cap for working age adults.</p> <p>Any future substantial changes that are not part of the annual indexation will also be subject to the affirmative resolution. The Bill provides for this.</p> <p>We have accepted the Dilnot Commission's recommendations that the cap should be automatically adjusted annually to reflect increases in care costs. The basis for this will be in primary legislation and so we believe that provides the highest form of Parliamentary scrutiny of the Government's approach.</p> <p>The means test thresholds and tariff income are currently set using the negative procedure and this has been the case for many years. We are committed to annually uprating the means test threshold, but do not agree that we need to change the basis on which the regulations are made in order for our intentions on the threshold or tariff income to be clear.</p>
4	We endorse the recommendation made by the Dilnot Commission that the Government should act quickly to devise a new assessment scale in conjunction with service users, carers and other interested parties. This work needs to proceed at pace.	<p>In response to the Dilnot Commission recommendation we gave a commitment in <i>Caring for our future: reforming care and support</i> that we would develop and test potential new models for an assessment and eligibility framework. We will do this with stakeholders. We will consider the evaluation of the potential frameworks and decide their implications for the care and support system in England.</p> <p>The Dilnot Commission recommended that in advance of developing a new model that the Government should set a national minimum eligibility threshold for adult social care, and we have taken a power in the Bill to do this through regulations. The level at which the eligibility threshold will be set must match the overall resource allocated to adult</p>

	Draft regulations should be published before Second Reading to support Parliamentary scrutiny of the Bill during its passage through both Houses.	social care through the Spending Review. We will publish a draft of the eligibility regulations during the Bill's passage, following the settlement for social care that will be announced as part of the Spending Round in June 2013.
5	The introduction of a capped cost scheme, which will result in many more people being assessed and entitled to a personal budget, is likely to lead to an increase in disputes and legal challenges. We are not confident that Ministers have yet fully thought through the implications for local authorities of these changes.	See recommendation number 86.
6	Clarity and openness are essential to successful implementation of these reforms. The Government should place resource allocation systems for determining the notional costs recorded in a care account on a statutory footing, making it clear that they are subject to the well-being provisions in clause 1 of the draft Bill, and requiring local authorities to publicise their schemes and to include full details of how the amount included in the personal budget is calculated.	<p>We welcome the Joint Committee's recommendation regarding increasing clarity and transparency of resource allocation systems (RAS).</p> <p>We do not agree that the operational processes for calculating personal budgets should be placed on a statutory footing. As with other processes, local authorities should be free to develop their own operational systems that meet the needs of their local populations, and is flexible enough to cater for individual needs.</p> <p>The Bill sets out the matters that must be considered when working through the care and support plan, which will reflect the needs and desired outcomes of the person and how the local authority will meet them. The Bill also places a duty on local authorities to consult with the adult, the carer and any other person the adult wishes. Therefore, all parties will be made aware of how the assessment of needs the local authority will meet and the personal budget have been reached.</p> <p>Statutory guidance will expand on the processes which local authorities should use, and set expectations in relation to the transparency of any systems determined locally.</p>
7	We also urge the Government to put beyond doubt that a resource allocation system cannot include a blanket policy of reducing a person's personal budget or notional cost on the basis of the presence of a carer, without the carer's knowledge or consent.	<p>We welcome the Joint Committee's views, and we believe the Bill already has provisions in place to this effect.</p> <p>The Bill states that the local authority must take all reasonable steps to agree with the person as to how their needs are to be met and places a duty on local authorities to consult with the adult, the carer and any other person the adult wishes. Therefore, all parties will be made aware of how the assessment of needs the local authority will meet and the personal budget have been derived.</p> <p>In addition, written records of assessments and eligibility determinations are to be provided, so there will be the ability to challenge any incorrect assumptions about carers' input. Finally, it should not be possible for local authorities to use the resource allocation system to have a blanket policy of reducing the personal budget (for any reason) because the Bill provides that the personal budget must be based on the costs to the local authority of meeting the individual's needs.</p> <p>In terms of carer support, the Bill establishes for the first time that carers will be recognised in the law in the same way as those they care for, creating parity between the two groups.</p>

8	<p>The Bill must provide that regulations governing</p> <ul style="list-style-type: none"> • the level and indexation of the cap, • any subsequent changes to the cap that fall outside the defined measure, and • arrangements for indexing the care account are subject to affirmative resolution. 	See recommendation number 3.
9	<p>The Bill must provide for automatic uprating of the lower and upper means test thresholds using a defined measure specified in regulations. The Bill must also provide that regulations that make:</p> <ul style="list-style-type: none"> • amendments to the defined measure, • changes to the lower and upper thresholds outside the defined measure, and • changes to the assumed tariff income are subject to affirmative resolution. 	See recommendation number 3.
10	<p>In the case of people for whom there is no duty to meet needs (i.e. those who opt out before the financial assessment, or who do not meet the financial requirements and do not request the local authority to meet their needs) the Government should ensure that the ordinary residence rules and portability (continuity of care) provisions protect their care accounts and personal budgets.</p>	<p>We agree that when someone moves to a different local authority, they should take their care account with them. This will ensure that all their financial contributions to their own care will count towards their lifetime costs and should be considered when determining at what point they would reach the cap and receive their care for free. This should be the case, even if their care is received in more than one place.</p> <p>The continuity of care requirements will apply to all people with a personal budget, whether they are having their needs met by the local authority or not. A person will receive a personal budget following an assessment of eligible needs. If a person relocates, their circumstances will be reassessed by the second local authority. The person's personal budget will remain the same until the person is reassessed by their new local authority. This may mean that once they are reassessed, their personal budget could change in line with their new care and support plan.</p>
11	<p>Enactment of the Care and Support Bill will constitute the biggest change in the law governing the operation of care and support in England since the National Assistance Act 1948. The Bill, when enacted, will not just consolidate and streamline into a single statute 60 years of piecemeal law making; it will also place on a statutory footing for the first time both the principles and the</p>	<p>We recognise the scale of the challenge of implementing social care reform as set out in Part 1 of the Care Bill and agree with the Joint Committee's recommendation. The final impact assessment builds on the initial analysis undertaken on the key parts of the care and support workforce as part of the 2011 white paper <i>Caring for our Future</i>. This brings together an assessment of the impact on social workers and other local authority staff and associated workers. We will update the impact assessment as new evidence becomes available.</p>

	practice of self-directed personalised care. When taken together with the introduction of a capped cost system and a national eligibility threshold the Bill presents a significant implementation challenge for everyone with a stake in the care and support system.	
12	The volume and complexity of assessments, of carers, of people with care needs, the application of mean-testing, and the determination of notional costs all raise questions about the level of initial and ongoing training and support needed for local authority staff and social workers. These are matters we would expect to be fully analysed in the revised impact assessment that accompanies the final Bill.	See recommendation number 11.
13	Arrangements should be set in place either in statute, in regulations or in guidance to ensure that, where either the NHS or local authorities assess a person and determine that they are not eligible to have their needs met by them, they ensure that assessments are coordinated and information shared to minimise any delay in putting in place suitable arrangements to meet their needs, for example by provision of information and advice or by exercising the prevention duty in clause 7 of the draft Bill.	<p>We agree in principle with the Joint Committee’s recommendation that there should be efficient coordination of assessments and provision of information.</p> <p>We have included a new requirement in the Bill to ensure that everyone who approaches their local authority and has a care need will be informed of what support and services are available in the community to help maintain their wellbeing.</p> <p>We will provide further detail on the assessment process in statutory guidance.</p> <p>Due to the close relationship between social care and NHS continuing healthcare we have introduced a power that will require local authorities to refer to the NHS any person who they believe may be eligible for NHS continuing healthcare.</p> <p>Part 1 of the Bill does not make provision in relation to the responsibilities of the NHS. The responsibilities of clinical commissioning groups and the NHS Commissioning Board when an individual is found ineligible for NHS continuing healthcare are set out in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.</p>
14	The Government must devise a campaign that raises awareness of what the national care and support offer is. This should make clear how people can plan and prepare, what their rights are and how to access the information, advice and assistance they need both to prevent and postpone the development of care needs	<p>Access to information and advice from local and national bodies will be crucial in supporting people to plan and prepare for their care needs. We agree with the Joint Committee that a strategic approach to maximise the public's understanding of care and support is required. We accept that this will need to cover:</p> <ul style="list-style-type: none"> • the new funding arrangements; • how individually people may act to prevent or postpone the development of care needs and maintain their independence; • how they may plan or prepare to meet the cost of any future care needs they may have; and • how they arrange a care and support needs assessment from their local authority.

	and to support people to maintain their independence when they do have care needs.	Initially, this will be taken forward as part of the implementation of the Department's wider information strategy, published in May 2012. This strategy set out a plan for bringing care and support, NHS and public health information together in an easily accessible way for the public. This will build on current national information channels such as the NHS Choices website, and will provide easy-to-navigate information, including a place for people to provide their comments on services. New information explaining some of the main aspects of care and support, such as entitlements and rights, as well as a tool to compare the different services of registered care providers, were published on NHS Choices on 25 April 2013. We will work with stakeholders to add to this with a wider range of information covering areas such as the new funding arrangements,
15	We are glad to know that the Department intends to look again at the drafting of clause 21. Whatever reassurance they may seek to give us, a court is likely to take the view that any change in wording which goes beyond bringing the drafting into the 21st century implies a change in the intended meaning of the provision. We therefore expect the Department to redraft the clause to put the question beyond doubt.	We welcome the Joint Committee's observations, and have looked again at the clause in the light of our clear intention to retain the existing legal boundary between local authority care and support and the NHS. We are satisfied that the revised clause (now clause 22) enables us to maintain the existing boundary between care and support and NHS continuing healthcare, and that it is as clear as it can be without returning to the unhelpful and confusing language used in the past.
16	Clause 14(3) must be amended to make clear that, where a local authority provides services on behalf of a Clinical Commissioning Group, the authority may not recover the cost from the individual whose needs are being met.	There is no intention to change the existing charging policy through which NHS services are provided free at the point of use. Clause 23 in the Care Bill provides that a local authority may not meet needs by arranging anything which is required to be provided by the NHS Acts unless the provision is incidental or ancillary to meeting care and support needs, which broadly reflects the current situation and the remainder of the clause provides further details. Regulations will make clear the boundaries.
17	We question whether subsections (3) and (4) of clause 21 are desirable. If they are retained, we are of the view that regulations made under clause 21(2)(a) should not be able to override the provisions of subsections (3) and (4), and consider that this should be made clear in the drafting.	We welcome the Joint Committee's perspective on what were subsections 21(3), 21(4) and 21(2)(a) of the draft Bill. The policy intention has been to reflect the current position with regards to the limits of local authority provision of registered nursing care. We are satisfied that this has been achieved through the provisions set out in what are now subsections 22(3) and 22(4), particularly in the light of the revisions made to the clause on the definition of nursing care. It is not the intention that the regulation making power in 22(2)(a) be used to override these provisions and indeed it is not considered that it could do so.
18	We recommend that the status of the third tier of the hierarchy of rules should be clarified. Clause 50 should be replaced by provisions modelled on sections 42 and 43 of the Mental Capacity Act 2005, allowing the	We agree with the Law Commission on the need to produce new statutory guidance to underpin the implementation of the legal framework, and that it is important that this is produced with partners and subject to consultation. Our approach is consistent with these principles, even though we have proposed to develop a consolidated bank of statutory guidance, rather than a 'code of practice'. Our view is that a 'code of practice' would not be flexible or responsive enough to support adult social care into the future, because it would require parliamentary

	Secretary of State to issue guidance contained in a statutory Code of Practice.	oversight for publication and all future changes. Our proposed statutory guidance would look and feel like a code of practice, and critically would have the same legal status. However, it could be amended more regularly to ensure it remains of best value to care workers and those receiving care.
19	The clause must make clear that the Code of Practice is subject not just to the Act and other primary legislation, but also to the regulations made under the Act and any other applicable law.	See recommendation number 18.
20	We recommend that the list in clause 1(2) of matters to which well-being relates should be enlarged to include the dignity of the adult, and the availability of safe and settled accommodation.	We believe that the Joint Committee's recommendation to include dignity of the adult and the availability of safe and sound accommodation in the list at clause 1(2) to be sound. These additions have been incorporated into the clause.
21	Clause 1(5) should be amended to make clear that the well-being principle applies as much to an adult carer as to the adult needing care.	We have revised clause 1 in line with the Joint Committee's recommendation, so as to make clear that the wellbeing principle applies to carers.
22	We welcome the importance that Ministers attach to the well-being principle. We recommend that the draft Bill should include a provision requiring the Secretary of State, when making regulations or issuing guidance, to have regard to the general duty of local authorities under clause 1.	We do not agree that the Bill should require the Secretary of State, when making regulations or issuing guidance, to have regard to the general duty of local authorities under clause 1. Local authorities are responsible and accountable for social care. We believe that creating new duties for the Secretary of State would distort these clear lines of accountability.
23	The Bill should make clear that 'information' and 'advice' include financial information and advice, and that local authority services should recommend financial advisers only if they are regulated by the Financial Services Authority.	<p>We agree that access to financial information and advice is of particular importance and should be provided as an essential component of the local authority's information and advice service. We want to remove any doubt that this is an essential component of the information and advice service provided by the local authority. We have revised clause 4 to make this clear.</p> <p>We also agree that the quality of financial advice is important. However, while sympathetic to the Joint Committee's argument, the clause covers a service for broad range of needs. Some people may require financial advice on the welfare benefits available, while others may require detailed advice on financial products such as equity release. This level of detail is most appropriately covered within guidance. For example guidance will emphasise the importance of access to an independent, regulated financial advice for anybody considering the deferred payment arrangements.</p>
24	The following matters should be added to the list in clause 2(2) of matters on which the local authority's service must provide information and advice:	We agree with the Joint Committee that all of these subjects are important elements in the information and advice service to be provided for in clause 4. However, we do not consider it necessary or appropriate to cover all these on the face of the Bill. Our intention is that clause 4 sets a broad framework for which detailed guidance will provide greater depth, and that guidance will cover all these issues.

	<ul style="list-style-type: none"> • ways in which people can contribute to the design of services, where none are available to meet their needs; • local housing options, including specialist housing, accessible housing and adaptations; • any relevant charging arrangements for care and support in the local authority's area; • obtaining independent financial advice on the options for paying for care and support; and • where such advice can be found. 	<p>We have accepted the Joint Committee's recommendation on access to financial information and advice (covered in recommendation 23) to reflect its particular importance and its wider relevance to other clauses in the Bill.</p>
25	<p>Clause 2 should be amended to make clear that independent advocacy is to be available before the assessment process has begun, not only as one of the ways of meeting needs under clauses 17-19.</p>	<p>We agree with the Joint Committee, and with certain respondents to the consultation, that some people will need independent advocacy. However, we do not consider it necessary to specifically reference advocacy within the information and advice service. Rather, we have revised clause 4 to be clear that in meeting this duty, local authorities must provide information and advice that is accessible and proportionate to all. An individual's requirements for information and advice might be best met in a number of ways. For example, this could be a simple leaflet, a face-to-face conversation, and in some instances, it could mean long-term independent advocacy.</p>
26	<p>The Government should ensure that the Department of Health's national support programme and guidance to local authorities address these concerns; in particular they should make certain that Joint Strategic Needs Assessments provide a sufficiently detailed picture of the scale and character of current and future individual needs to support market shaping.</p>	<p>We agree with the Joint Committee's recommendation.</p> <p>The guidance on this duty (now clause 5 of the Bill) and the work of the national support programme 'Developing Care Markets for Quality and Choice' to produce a market position statement (MPS), will cover the points raised in this section on choice and diversity, commissioning, joined-up services with housing and health and understanding demand. Whilst assessing demand will primarily be based on joint strategic needs assessments (JSNAs) at first, the MPS will form the basis for future engagement with providers, service users and carers, allowing the quality of local information to develop over time.</p> <p>There is however, an existing duty²⁶ on local authorities and clinical commissioning groups, through health and wellbeing boards, to assess the current and future health and social care needs of the whole local population through JSNAs. Boards will then develop joint health and wellbeing strategies (JHWSs) to address the identified needs. Taken together, JSNAs and JHWSs will inform commissioning of local health and care services by local authorities, clinical commissioning groups and the NHS Commissioning Board. JSNAs and JHWSs are an objective, comprehensive and – most importantly – a locally-owned process of developing evidence based priorities for commissioning, and as such it would not be appropriate to dictate local content or priorities.</p>
27	<p>We believe clause 3 should be amended to put beyond doubt that local authorities</p>	<p>We refer the Joint Committee to clause 5(2)(b), which requires local authorities to have regard to 'the need to ensure it is aware of current and likely future demand for such services and to consider how providers might meet such demand'. It would not be</p>

²⁶ Section 116 Local Government and Public Involvement in Health Act 2007 as amended by the Health and Social Care Act 2012.

	must involve service providers, service users and carers in market shaping activity.	possible to achieve this outcome without proper engagement with service users, carers and providers. We therefore agree fully with the intention of this recommendation, but we do not believe further revision is required to stipulate the process in legislation. The need for engagement with providers, service users and carers will be made clear in the guidance that accompanies the Bill.
28	Clause 3(2) should be amended by the addition of a paragraph to provide for a duty analogous to that set out in section 6 of the Childcare Act 2006, which would require local authorities not only to develop a local market but also to monitor the match between supply and demand in their areas and to report publicly on the sufficiency of care and support services.	We accept this recommendation in part. Clause 5 (which was clause 3 in the Draft Bill) has been revised to reflect the need for local authorities to have regard to the sufficiency of local services to meet local need. Local authorities must also have regard to the importance of enabling adults and carers to undertake employment and training. This is based on the provisions referred to in section 6 of the Childcare Act 2006 'Duty to secure sufficient childcare for working parents'. However, we do not accept the recommendation to require local authorities to publish an assessment of the sufficiency of services as this would create a burden on local authorities.
29	The draft Bill should include a requirement that local authorities properly take into account the actual cost of care when setting the rates they are prepared to pay providers.	We welcome and accept the Joint Committee's recommendation. To address it, the Bill now provides that the personal budget is the amount it will cost to meet the needs identified in the care and support plan.
30	The Government should examine the scope for introducing an independent adjudicator to settle disputes between local authorities and providers over the cost of care.	We have noted the Joint Committee's recommendation. This is a proposal that has wider implications which we will investigate as part of the summer consultation on funding reform.
31	The Government should amend the market shaping duty in clause 3 by making an explicit link to both the essential standards of quality and safety and to NICE quality standards. This could be achieved by adding to clause 3(2) a requirement to have regard to regulations made under section 20 of the Health and Social Care Act 2008, and to the quality standards prepared by NICE under section 234 of the Health and Social Care Act 2012.	We intend that local authorities should promote a market which offers quality services. There will be a range of ways in which they can determine quality which could include compliance with NICE standards, as well as user feedback mechanisms and local engagement. We do not intend to stipulate the process in legislation, but we will consider whether it is appropriate to provide further information in guidance, to support local authorities in exercising this function.
32	The Government should ensure that they have the necessary statutory authority to make regulations or issue guidance concerning what	We accept this recommendation in so far as it relates to the publication of guidance. We will issue guidance to support continuous improvement in commissioning practice.

	they call ‘unacceptable’ commissioning practices, and amend the draft Bill if necessary.	
33	The list of relevant partners in Clause 4(5) should be extended to cover registered housing providers, including housing associations and registered social landlords.	We recognise and support the Joint Committee’s view of the importance of housing provision in meeting needs for care and support. The list of local authority departments between which a local authority must ensure cooperation in clause 6(3) includes housing. Clause 6(6) (which replaces clause 4(5) in the Draft Bill) lists the public bodies with functions relevant to the care and support of adults and their carers within the local area. We consider that co-operation with independent, private and voluntary sector housing providers is better achieved through commissioning and contractual means rather than inclusion in the ‘relevant partner’ list in clause 6(6).
34	In clause 6(1) a reference to ‘housing provision’ should be added to the reference to ‘health provision and health-related provision’.	We agree with the importance of ensuring integration between housing, care and support, and health. Housing already falls within the definition ‘health-related’, and therefore there is already a duty on local authorities to ensure integration between care and support, health, and housing provision, that we will clarify in guidance. As housing provision is already covered under clause 3(1) (which was clause 6(1) in the Draft Bill) we see no reason to revise the Bill in this way.
35	We recommend that the words ‘it considers that’ should be deleted from clause 6(1).	We agree that local authorities should not be able to avoid their duty to promote integration, but we are content that the wording of the Bill is strong enough to ensure this. The words ‘it considers that’ are permissive rather than restrictive of the circumstances in which the local authority will be under a duty to promote integration. They reflect the intention that decisions about integrating the provision of services should be made locally by the local authority. Local authorities are not able to unreasonably decide that integrating the provision of services would not promote well-being, contribute to the delay and prevention of needs, or improve quality of care and support.
36	Clause 6 should be amended to reflect the approach taken in the Children and Families Bill by giving the Secretary of State a power to prescribe groups of people or services that should be subject to joint commissioning and joint budgets.	We want commissioners to have autonomy and flexibility as to how they work together to secure services to deliver improved outcomes for patients and their families. Placing a requirement on commissioners to enter into joint commissioning arrangements or to pool budgets would run counter to the principle established by the Health and Social Care Act 2012 that it is for clinically-led commissioners should to determine what services should be secured locally, and how they might collaborate to do this,. There are already duties on the NHS Commissioning Board and clinical commissioning groups to promote integration where it would benefit patients; the Bill will place similar duties on local authorities, and there are a range of ways in which commissioners might come together to do this, for example using a section 75 agreement to pool health and care budgets, without impinging on their expertise and independence.
37	The Government should take the opportunity to review section 75 of the National Health Service Act 2006 to make the requirements less onerous.	<p>Section 75 of the NHS Act 2006 is a statutory provision that supports joint working between local authorities and health bodies. The provisions enable NHS bodies and local authorities to voluntarily enter into partnership arrangements for specified NHS or health related functions where it is likely to lead to an improvement in the way the functions are exercised. It is at the discretion of local NHS and Social Care partners as to how section 75 arrangements are agreed, in line with the regulations that sit under the 2006 Act. These arrangements are not complex or cumbersome, and any further clarity can be provided through revised guidance.</p> <p>At national level, we are working to create the climate for local partners to work together for their local populations. We are demonstrating our commitment to integration through clear duties in legislation. National and local bodies have been given statutory duties on integration through the Health and Social Care Act 2012, and we are reinforcing these through the Bill.</p> <p>We recognise that barriers still exist at national level – and we are taking action to tackle them. A national collaborative between all the key partners is demonstrating our</p>

		commitment to making integrated care the norm. The collaborative will tackle the national barriers that still exist and draw together the tools and support local areas need to build success.
38	The Government should review before the introduction of the Bill whether they have the necessary powers to support the implementation of information sharing using a common identifier such as the NHS number across different services.	<p>The adoption and use of the NHS Number as a common identifier across organisations is recognised as an important underpinning aspect that supports information sharing and improved integration across health and care services. The NHS Commissioning Board's <i>Everyone Counts: Planning for Patients 2013/14</i> commits to universal adoption of the NHS number as the primary identifier by all providers in 2013/14.</p> <p>The Health and Social Care Act 2012 provides new powers for information standards, such as the NHS number, to be prepared and published. The powers provide a legal framework so that anyone providing publicly funded health services or adult social care in England must 'have regard' to any standard published under the legislation. We believe these provisions in the 2012 Act already provide the necessary powers to support the implementation of information sharing using a common identifier across different health and care services.</p> <p>Dame Fiona Caldicott's independent review of the balance between protecting patient information and its sharing, to improve patient care was published on 26 April 2013. A number of the review's conclusions relate to the NHS Number and we will be considering these as part of the detailed government response to the review in the summer.</p>
39	Clause 6(1) should be amended to require local authorities to ensure the integration of care and support provision with health provision on discharge from hospital, with particular emphasis on the adequacy of housing provision on discharge.	<p>We agree that smooth, timely and safe discharges are of key importance in maintaining individuals' wellbeing, and that the adequacy of housing provision is a vital component of this. Clause 3(1) (which was clause 6(1) in the Draft Bill) already requires local authorities to ensure the integration of care and support provision with health provision, and health-related provision (including housing), and this applies to hospital discharges. Other provisions in the Bill apply to hospital discharges including the requirements on local authorities and their relevant partners to cooperate generally and in specific cases, the requirement for local authorities to assess adults and carers who it appears to them may have needs for care and support, and schedule 3 of the Bill deals with discharges from the acute secondary sector.</p> <p>Subject to and following the passage of the Bill we intend to issue fresh guidance on safe and timely discharges, and discharge planning. This will make clear the requirements in the Bill that relate to ensuring timely and safe discharges, and will emphasise the importance of housing to this. This will include working with NICE on a quality standard for transition between health and social care.</p>
40	The Government should consider redrafting schedule 2 to reflect its ambitions for integration and parity of esteem between physical and mental health. Any redrafting should seek to codify best practice in the coordination of the care of a person before, during and after their discharge.	Achieving integrated and joined-up care, and parity of esteem between physical and mental health are important aspirations of the Government, and ensuring safe and timely discharges of all patients is an integral part of these aspirations. As the report concedes, extending the provisions of schedule 3 of the Bill, including reimbursement, to other groups could be likely to have unintended consequences. Subject to and following the passage of the Bill, we intend to carry out further analysis and subject to the outcome we are willing to look at removing this exemption to ensure parity of esteem between physical and mental health.
41	The Government have sought to translate the Law Commission's recommendation on section 117 of the Mental Health Act 1983 into the draft Bill. Insofar as this simply reflects	We will address concerns about the changes eventually made to section 117 in the guidance the Secretary of State issues in the <i>Code of Practice Mental Health Act 1983</i> . The purpose principle set out in the Code includes the important elements of maximising the safety and maximising both the mental and physical wellbeing of patients. We will continue to uphold this important principle.

	<p>the court’s interpretation of the current legal framework for after care, we do not recommend any change. However, ministers should ensure that in the guidance to local authorities the risks are recognised and the well-being principle upheld.</p>	
42	<p>Ministers should ensure that the explanatory notes to the Bill and the guidance both provide clarity about the prevention duty and how it should be seen as an integral part of the care and support system at every stage.</p>	<p>The term ‘prevention’ is not well understood. We agree that it is important that the explanatory notes to the Bill and the guidance both provide clarity about the prevention duty and how it should be seen as an integral part of the care and support system at every stage. We are satisfied that the explanatory notes are sufficiently clear in this regard.</p>
43	<p>Clause 7(2) should be amended to state that, additionally, local authorities must have regard to the importance of identifying adults at risk of developing care and support needs, or increasing such needs, who may benefit from support to prevent deterioration in their well-being.</p>	<p>We agree with the Joint Committee’s principle of local authorities engaging at an early stage with adults who may have future care or support needs or may have needs, which are at risk of deteriorating. We consider that local authorities’ duties with regards to wellbeing (clause 1), prevention (clause 3) and provision of information and advice (clause 4) taken together ensure that all adults can benefit from preventative interventions. It is not clear how the Joint Committee’s recommended approach would be carried out in practice and there may be unintended consequences and cost burdens to local authorities.</p>
44	<p>The draft Bill should be amended to make clear that both clause 2 and clause 3 are linked to the duty of prevention.</p>	<p>Our intention is for both clause 4 (which was clause 2 in the Draft Bill and covers information and advice) and clause 5 (which was clause 3 and covers market shaping) to be linked to the duty of prevention. Both the Bill and Explanatory Notes reflect this.</p>
45	<p>Realising the ‘public health’ benefit from introducing a capped cost system could result in significant quality of life gains by helping to engage more people in maintaining their health and well-being, with a positive impact on demand for long term care.</p>	<p>We note this conclusion.</p>
46	<p>The Safeguarding provisions of the draft Bill should be moved to the General Responsibilities section.</p>	<p>Unlike the general responsibilities, the safeguarding clauses in the Bill have a threshold that must be met before they are triggered. Having separate clauses for safeguarding adults also underlines the importance of these responsibilities for local authorities and others.</p>
47	<p>Local authorities should be placed under a statutory duty to take steps to empower individuals to understand what abuse is, and how to protect themselves from it, whether</p>	<p>The Bill stresses the provision of information, advice and support in all situations. In particular, clause 4 provides that local authorities must provide information and advice on how the system provided for in Part I of the Bill (including the safeguarding provisions) operates in the local area. Specifically at clause 4(2)(d), local authorities are under a duty to provide information and advice on how to raise concerns about the safety and wellbeing of an adult who has needs for care and support. The Secretary of State can issue guidance under clause 71 to ensure a local authority exercises its</p>

	by seeking help or otherwise.	information and advice duty in this way. Also, the focus of the Bill on assessment on empowerment, choice, control and management of risk supports this approach. One of the key responsibilities of safeguarding adults boards (SABs) in particular, and partners in general, is ongoing awareness-raising of the issues of abuse and neglect of adults. Safeguarding is everybody's business and that requires understanding on all our parts.
48	Clause 34(1) should be amended to put beyond doubt that the duty of local authorities to make enquiries extends to cases where abuse or neglect has occurred in the past but still needs to be investigated. A similar amendment should be made to clause 4(4)(c).	It has always been our intention that local authorities (as part of the SAB) can hold reviews into past cases of abuse or neglect under clause 43. We are happy to state this power expressly in clause 43 in order to remove any doubt that the duties of co-operation apply to the performance of relevant safeguarding functions whether they relate to past or present safeguarding concerns. Clause 41 (which was clause 34 in the Draft Bill) relates to immediate action on present risk so changing it would not address the concern raised.
49	The Government should ensure that both the explanatory notes to the Bill and the guidance make clear what obligations the words 'cause to be made' place on local authorities and other agencies.	We will make the safeguarding responsibilities of local authorities clear, while ensuring we do not lose local flexibility or impose unjustified burdens on other organisations.
50	The safeguarding provisions should include a power of entry for local authority representatives where a third party is refusing access to a person who may be at risk of abuse or neglect.	<p>The consultation on a power of entry showed that, as we expected, this was a very sensitive and complex issue that divided opinion.</p> <p>We particularly noted the strength of feeling from members of the public who were against such a power, and the risk of unintended consequences highlighted by some respondents. There is also no conclusive proof that this power would not cause more harm than good overall, even though in a very few individual cases it may be beneficial.</p> <p>Based on the views expressed, and the qualitative evidence provided by respondents, we have concluded that the responses to the consultation did not provide a compelling case to legislate for a new power of entry. Therefore, we have not added a safeguarding power of entry to the Bill.</p>
51	The local Health and Well-being Board should be added to the list of members in paragraph 1(1) of schedule 1 to the draft Bill. The Care Quality Commission should be added to the list of recipients of reports in paragraph 3(2).	<p>We recognise that there need to be strong links between SABs and a range of partners, including health and wellbeing boards, local healthwatch and the CQC. There is flexibility in the legislation for SABs to invite any members to join as they consider appropriate. However, the size and circumstances of local authorities varies hugely across the country and that will have an impact on how SABs are established and how they link with relevant partners.</p> <p>The Bill requires annual reports of all SABs to be made publicly available, and that they must be sent to the local health and wellbeing board and healthwatch.</p>
52	The Government should consider amending paragraph 1(1) of schedule 1 to include appropriate housing representation in the membership of Safeguarding Adults Boards.	<p>We have intentionally restricted core statutory membership to a few core public bodies, leaving local areas with maximum flexibility whilst securing the statutory position of adult safeguarding.</p> <p>We anticipate and expect membership to be far wider. We would be most concerned if SABs did not address the role, contribution and responsibilities of housing providers in adult safeguarding. We would also expect SABs to draw on the housing sector for in-put, collaboration and advice. Government will not dictate how this happens, as this will depend on local circumstances, which vary widely across the country. For example, in some areas the SAB may operate sub-groups, including one devoted to housing-related issues that reports back to the main Board.</p>

53	Paragraph 1 of schedule 1 should be amended to specify the circumstances in which a local authority should not take part in the proceedings of the Safeguarding Adults Board.	As statutory lead for adult safeguarding, it is essential that the local authority is present at an SAB. We would expect Boards to develop protocols to deal with both the routine operation of their business as well as any exceptional circumstances, for example, a perceived conflict of interest.
54	The draft Bill should include an explicit power to obtain information relevant to the conduct of safeguarding adults reviews.	The Data Protection Act 1998 should provide sufficient powers for information relevant to safeguarding adults reviews to be obtained. However, in the interests of clarity and transparency, we have decided to accept this recommendation and include such a clause to remove any doubt.
55	The Department of Health should take the opportunity to review and revise the explanatory note for clause 8 and subsequent guidance to make clear that the list is not intended to limit the ways in which a local authority might meet any eligible needs or agreed outcomes, removing any possible ambiguity on that point.	We have revised the explanatory note for clause 8. It now makes clear that this list is not exhaustive, and is not intended to limit the ways in which a local authority might meet any eligible needs or agreed outcomes. In addition, guidance will set out how local authorities can meet needs, which will further clarify that there are a number of ways in which needs might be met, to reduce any ambiguity.
56	The Department should amend the draft Bill to support people planning to achieve well-being within their own resources. The aim should be to frame assessment as a discussion about the additional support people may need to maintain or achieve wellbeing.	We agree with the Joint Committee's recommendation that local authorities should support all adults who approach them in order to maintain their well-being, including those who are and those who are not assessed as having eligible needs, and those who are self-funders. The Bill includes a duty that will require local authorities to carry out assessments in a proportionate way that reflect the needs of the individual. We have made a number of changes to reflect a more asset based approach to prevention in both assessment and planning. The Bill now includes a requirement that everyone who approaches their local authority and has a care need, regardless of their eligibility, should be informed of what support and services are available in the community to help maintain their wellbeing.
57	The draft Bill should be amended to provide that if it appears to a local authority, when undertaking a needs assessment under clause 9 or a carer's assessment under clause 10, that the person being assessed has a health or housing need or other relevant need, it should be obliged to bring this need to the attention of the relevant authority.	<p>We agree with the sentiment of the Joint Committee's recommendation, but we believe that the Bill already achieves it. The Bill will require local authorities to cooperate with their partners, such as the NHS and housing authorities. Indeed, the Bill promotes integration between care and support and health services. This will ensure that local authorities work with relevant stakeholders depending on the needs of the individual or carer. We will underpin this requirement with guidance in which we will remind local authorities that they should refer people to other organisations based on their needs.</p> <p>Due to the close relationship between social care and NHS continuing healthcare we have introduced a power that will require local authorities to refer to the NHS any person who they believe may therefore be eligible for NHS continuing healthcare</p>
58	We welcome the fact that for the first time local authorities will be required to assess whether a carer has, or is likely to have in the future, needs for support.	We are grateful for the Joint Committee's views on this important reform.
59	Clause 9(5) lists those who	The Mental Capacity Act 2005 already requires local authorities to consult those persons

	must if possible be consulted by a local authority carrying out a needs assessment. In the case of a person lacking capacity, this should include those concerned for the person's care and well-being in accordance with section 4(7)(b) of the Mental Capacity Act 2005.	listed in section 4 of that Act (best interests) and there is no need to reproduce this requirement in the Bill.
60	Clause 12(1), which lists the matters relating to needs or carer's assessments for which regulations must make further provision, should include provision for fast-tracking needs assessments for terminally ill people.	<p>We have every sympathy with the Joint Committee's proposal, but instead of placing a statutory duty on local authorities we will set out in statutory guidance that they should fast-track assessments for terminally ill people.</p> <p>Local authorities also have powers under clause 19(3) to meet urgent needs for care and support, including an ability to meet needs without carrying out a full assessment, where the urgency of the situation requires. This provision will also support local authorities to fast-track processes for terminally ill people, so that they can get the care they need more quickly.</p>
61	Clause 12(1) should be amended to make clear that local authorities, when carrying out a needs or carer's assessment, must have regard to the need to prevent any children from undertaking inappropriate caring responsibilities.	We agree with the Joint Committee that when carrying out an adult's assessment, a local authority should have regard to the caring role that children and young people in the family are undertaking so that steps can be undertaken to prevent them from undertaking inappropriate caring responsibilities or levels of caring. It has always been our intention to set this out in regulations and guidance within the wider context of a whole family approach to assessment – which importantly would not just be limited to young carers.
62	We support the possibility of combining a needs and carer's assessment under clause 12(3), particularly to underpin whole-family assessment, and we believe that the requirement for agreement of the adult needing care and of the carer provide sufficient protection for the adult.	We welcome the Joint Committee's support for our approach to joint assessments between the person using the service and their carer.
63	We have already recommended that, in making regulations, the Secretary of State should have regard to the duty of local authorities to promote individual well-being. We recommend that clause 13(2) should be amended to make it a specific requirement for the Secretary of State, when making regulations concerning eligibility, to have regard to this duty.	<p>We reject the recommendation that clause 13(2) should be revised to make it a specific requirement for the Secretary of State, when making regulations concerning eligibility, to have regard to the general duty of local authorities to promote individual wellbeing under clause 1.</p> <p>Local authorities are responsible and accountable for social care. We believe that creating new duties for the Secretary of State would distort these clear lines of accountability.</p>
64	We are glad that the Secretary of State confirmed	We agree with the first part of the Joint Committee's recommendation and have revised the clause to make clear our intention to introduce a national minimum eligibility

	<p>the Government’s intention to set a national minimum eligibility threshold. The Government should put this beyond doubt by redrafting clause 13 to make this policy explicit. We also suggest that the Government should consider whether the regulation-making power in clause 13 provides an opportunity to establish criteria that would clarify the boundary between eligibility for local authority funded care and support and NHS funded continuing care.</p>	<p>threshold.</p> <p>In relation to the second part of the recommendation, the regulation-making power will set the national minimum eligibility threshold for care and support. It will not set the maximum level of care to be provided nor the boundary between care and support and NHS continuing healthcare. The <i>National Framework for NHS continuing healthcare and NHS-funded nursing care</i> already looks at the process for establishing eligibility for NHS continuing healthcare and sets out when it should be provided. These principles are reflected in the <i>National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012</i>.</p> <p>It is important that people receive the right level of care and we have introduced a power that will require local authorities to refer to the NHS any person who they believe has a primary need which may be a health need and may therefore be eligible for NHS continuing healthcare.</p>
65	<p>It should be made clear in clause 14 that where charges are imposed they should be limited to what it is ‘reasonably practicable’ for the person to pay. Clause 14 should also be amended to make clear that local authorities cannot simply charge the carer for services provided to the person cared for.</p>	<p>We intend that what a person is liable to pay, in relation to all care and support services, should be set out in regulations and guidance. Regulations will define a minimum below which an adult's level of income should not be reduced by local authority charges, which should ensure charges are not more than it is reasonably practicable for a person to pay.</p> <p>We are satisfied that the powers in the Bill will not allow a local authority to charge a carer for a service being provided to the person they care for.</p>
66	<p>Our recommendation that clause 2(2) should be amended to ensure that the adult is informed of the importance of independent financial advice from an adviser regulated by the Financial Services Authority, and is advised how to obtain it, is of particular importance in the case of deferred payment agreements.</p>	<p>See recommendation number 23.</p>
67	<p>We recommend that clause 16(4)(c) should be deleted. 16(4)(c) allows authorities to charge interest on an outstanding administration fee (subject to regulations making this possible).</p>	<p>We want to provide a legislative framework that allows deferred payments to be cost-neutral to local authorities and financially sustainable over the long-term.</p> <p>Clause 34(4) (which was 16(4)) allows local authorities to charge interest and an upfront administration fee when they offer a deferred payment – this is to help local authorities recover their costs.</p> <p>The Bill allows local authorities to let people pay the administration fee upfront, or to defer it so it is repaid later along with the rest of the deferred payment. In the second case, we think it is reasonable to charge interest on the deferred amount so the local authority does not make a loss over time. It will make a very small difference to what someone pays while ensuring overall fairness.</p> <p>We will shortly be publishing a consultation that will contain further details of what interest and administration fees councils might charge, and this will allow further</p>

		scrutiny of this issue.
68	The Government should review the efficacy of RAS and ensure that the code of practice or guidance makes clear that the development and application of any methodology for calculating the cost of meeting eligible needs is transparent, has regard for the well-being principle, and is subject to the duty to meet eligible needs.	<p>We support this recommendation in principle. However, it is for local authorities to develop their own resource allocation scheme, taking into account the needs of the local population, but ensuring the process is flexible enough to cater for individual needs.</p> <p>The 2010 guidance <i>Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care</i> makes clear that the development of a resource allocation scheme should be ‘to provide a transparent system for the allocation of resources, linking money to outcomes while taking account of the different levels of support people need to achieve their goals.’ The Department remains committed to this approach.</p> <p>In producing updated guidance to accompany the new legislation, the Department will work with the adult social care sector to ensure that any resource allocation system is transparent and reflects the requirements of the new legislation, including the well-being principle and the duty to meet eligible needs. This will ensure that people are clear on the approaches taken to calculate their personal budget.</p>
69	Independent financial advice from an adviser regulated by the Financial Services Authority is as important in the case of additional cost under clause 27 as it is in the case of deferred payments.	See recommendation number 23.
70	Clause 25(1)(a) should be amended to make clear that the amount of a personal budget should be equivalent to the reasonable cost of securing the provision of the service concerned in that local area.	<p>We welcome and accept the Joint Committee’s recommendation.</p> <p>Personal budgets are new and this is the first time they have been provided for in legislation. The Bill provides that the personal budget must specify the amount which is the cost to the local authority of meeting the adult’s needs, and which the local authority is required and/or decides to meet. This will ensure that the personal budget is focussed on the needs and outcomes of the person, rather than limited to the provision of services.</p>
71	The purposes for which direct payments can be used should be clarified, and the presumption should be that individuals can spend their direct payments as they like to achieve the agreed outcomes. We would prefer to see this in the draft Bill itself. If it has to be included in regulations under clause 30, they should be subject to affirmative resolution.	<p>We agree with the Joint Committee’s recommendation that the general presumption should be that that individuals can spend their direct payments as they like to achieve the agreed outcomes.</p> <p>The Joint Committee’s recommendation reflects responses to the consultation on the Bill. Therefore, we have removed a provision from the Bill that required the care and support plan to state ‘how needs could be met by the direct payment’. Respondents felt that this provision could inhibit flexibility, was overly prescriptive, and could imply that the person would need local authority permission for minor variations in how the direct payment is used.</p> <p>The Bill requires that the care plan specifies the needs that the local authority is to meet, and how it is going to meet them. Where there is a direct payment, associated regulations and guidance will require that the plan specifies how the person intends to arrange services using the direct payment.</p>
72	The Department of Health should lift the ban on direct payments being used to pay for local authority direct services if the individual so chooses.	We welcome the Joint Committee’s approach to ensuring that an individual with a direct payment should be free to spend that as they choose. The policy intention reflects this. However, we do not agree with the Joint Committee’s recommendation to allow direct payment users to spend their payment with their local authority. If an individual wishes to choose a ‘local authority direct service’ it should be more efficient and less bureaucratic for the local authority to provide this direct to the person as part of a managed service rather than as a direct payment. Current guidance allows an individual

		<p>to choose to take a mixture of services (i.e. a mixture of local authority or third party arranged, and direct payment) to allow for flexibility if they wish to receive a local authority service but also have a direct payment. New guidance will continue this policy.</p> <p>This will ensure that a person with care needs has flexibility in choosing local authority arranged services or a direct payment, or a combination of the two.</p>
73	<p>Direct payments are another area where independent financial advice will be essential both when the payments are first arranged, and subsequently.</p>	<p>See recommendation number 23.</p>
74	<p>We agree with those of our witnesses who object to the language of ‘sending’ and ‘receiving’ individuals. We prefer neutral language which emphasises that people control their own decisions, and recommend that clause 31 should refer to the ‘first’ and ‘second’ authority, or to the ‘original’ and ‘new’ authority – the wording we use in this report.</p>	<p>The Joint Committee makes a very good point about the use of language in the continuity of care clause. We accept their recommendation and the Bill has been revised according to their preferred terminology.</p>
75	<p>We do not accept the suggestion that individuals should have the option of deciding their own ordinary residence status and therefore which authority continues to fund their care package. Funding must be for the local authority where the person is ordinarily resident or is treated as being ordinarily resident.</p>	<p>We agree that a person’s ordinary residence should remain a question of fact and degree, based on their individual circumstances.</p>
76	<p>We are glad that after a move to a new local authority area there will be continuity of care until a re-assessment. We think it inevitable that the level of care may change after a move; indeed, that may have been the purpose of the move.</p>	<p>We welcome the Joint Committee’s support for our proposal for continuity of care.</p> <p>Where the second authority has not assessed the individual before he or she has moved, the Bill requires that authority to meet the needs for care and support which the first authority was meeting until it carries out its own assessment. This does not mean that the original assessment is protected but that the second authority will meet the needs as described in the first authority’s care and support plan. We agree with the Joint Committee that the second authority should not rely on the assessment carried out by the first authority indefinitely, and we will set out in statutory guidance more detail about the process. The guidance will cover the timings when both local authorities have to comply with the requirements on continuity of care, including the timeframe in which the second authority has to undertake its assessment.</p>
77	<p>We do not accept the suggestion that the original authority should continue to fund the care so long as the person is eligible for it.</p>	<p>See recommendation number 76.</p>

	Funding must be for the local authority where the person is ordinarily resident. However the Government may wish to consider whether there should be guidance on the minimum period during which an original assessment should be protected.	
78	Clause 31(8) should be amended so that the original authority is absolved from meeting the adult's or carer's needs only once the new authority has itself begun to meet their needs, as it is required to do by clause 31(6).	It is important that both local authorities are fully aware of their responsibilities to ensure that the person does not have any disruption to their care. There is a danger that requiring the first authority to continue to meet the person's needs could see the second authority delaying putting its own arrangements in place. The second authority will know its own market and any delay in it taking over responsibility for meeting the person's needs could see the person not receiving the most appropriate care and support for their new surroundings. To ensure there is no confusion over which authority is responsible to meet the individual's needs we reject this recommendation.
79	We recommend that the transition clauses (39–44) be amended, in line with the threshold set in clauses 9(1) and 10(1), to apply where it appears to a local authority that a child or young carer may have needs for care and support at the time of the request for the assessment or on reaching 18 years. This should apply regardless of whether or not support is currently being provided, but there should be a presumption that any child in receipt of an Education, Health and Care Plan under the Children and Families Bill, and any child receiving care and support, or who has family members receiving care and support, under other legislation, comes within this definition.	The Bill includes provision for young people who are not in receipt of services as children but who are likely to need care and support as adults. This will allow local authorities the power to assess young people in advance of their 18th birthday even if they are not in receipt of services provided under the Carers and Disabled Children Act 2000, and the Chronically Sick and Disabled Persons Act 1970 because they are likely to need services as an adult. This will include children who are receiving support under children's legislation and who have an education, health and care (EHC) plan. This is clarified in the explanatory notes accompanying the Bill.
80	We recommend that clause 43 be extended to include services provided under the Carers and Disabled Children Act 2000, the Chronically Sick and Disabled Persons Act 1970 and in Education, Health and Care Plans under the Children and Families Bill.	We agree that provisions about continuity of care during transition from childhood to adulthood should include reference to all provisions under which a child might be receiving services. We have revised these provisions accordingly. Guidance will provide clarity about the interactions between children's and adult legislation, particularly in relation to the EHC plan.
81	Clauses 12(4), 42(4) and 42(5) should be amended to	The Bill allows assessments to be carried out together and with another organisation, if appropriate. This includes EHC plans and this point is clarified in the explanatory notes.

	make clear that ‘another assessment’ includes assessments carried out under other legislation, and specifically Education, Health and Care Plans.	Guidance will also provide further illustration of the types of assessments this could include including examples and best practice.
82	We share the concern of a number of our witnesses that an unintended consequence of the draft Bill applying only to adults will be to leave young carers with lesser rights than adults.	<p>We do not believe that the adult statute is the right place to make provision for children. The boundary between children’s and adult legislation ensures an appropriate distinction between what is expected of adults and what is expected of children. It is important that both adult and children services work together well so that young people are not carrying out inappropriate caring roles, or disadvantaged in their education and in effect lose their childhood because of caring.</p> <p>We want to encourage professionals to take a ‘whole family’ approach in practice, meaning that an individual is not looked at in isolation. The Bill contains a power to make regulations that require the local authority to have regard to the need of the family of the person to whom an assessment relates. These regulations are the appropriate place to set the expectation that local authorities take a whole family approach and consider the impact on the family/household as a whole. For example, when assessing an individual, the impact of the care need on the family should also be considered. This would include identifying the presence of a carer, including a young carer. The Bill also allows for the assessment of the adult to be linked to any other assessment, which will allow practitioners to consider the effect of their support needs on the rest of the family and provide appropriate services that address the needs of the whole family.</p> <p>The Department of Health works closely with the Department for Education, carers organisations and young carers themselves to consider how young carers can best be supported through legislation and other means.</p>
83	We welcome the Minister’s commitment to discussions on young carers, and expect the Departments of Health and Education to work together to ensure that young carers do not fall between the cracks or face a higher threshold for receiving any support. The most straightforward solution would be for the draft Bill to be amended in line with the Law Commission preference to bring updated legislation for young carers into the draft Care and Support Bill.	See recommendation number 82.
84	Guidance on the application of the assessment and transition clauses should provide local authorities with clear information on the support available to carers and young carers. This guidance should aim to ensure that there is easy	We will use guidance to ensure that there is clarity about the support available to carers and young carers, regardless of which legislation the provision is made under.

	access to provision for carers, regardless of which legislation the provision is made under.	
85	We agree with the Law Commission's view that local authorities should have the power to make provision for children aged 16 and 17, including young carers, where an assessment under clauses 39 to 44 identifies need. We further recommend that this should be done in a way that recognises that the aims of support to young carers will often be different from those for adult carers.	We do not believe it would be appropriate for children to receive adult care and support before the age of 18. Adult care and support is a separate system, with factors such as charging that do not apply to children's services. We do not think it would be in a child's best interests for adult support to be provided early, before the point of transition. Instead, our focus is on making the experience of transition as smooth and easy as possible.
86	We believe that the significant extension of local authority responsibility for assessment, and the introduction of the well-being principle into decision making, warrant an urgent review of arrangements for providing redress and complaints resolution. The Government should reconsider establishing a care and support tribunal to provide independent merit reviews of decisions made by local authorities.	<p>We agree that the role of local authorities is changing significantly and that it is important to ensure that the arrangements for providing redress and resolving complaints are effective in this context.</p> <p>We will look at the existing complaints arrangements, including considering how best to provide effective challenge of local authorities' decisions, in the light of the findings of the Review of NHS Complaints led by Ann Clwyd and Professor Tricia Hart and our consultation on the capped cost scheme.</p>
87	The Government should consider giving a care and support tribunal the responsibility for resolving disputes over NHS Continuing Health Care.	<p>We welcome the Joint Committee's views on the resolution of disputes over NHS continuing healthcare.</p> <p>The National Framework for NHS continuing healthcare and NHS-funded nursing care and the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ('the Standing Rules') already set out clear processes for disputes where these involve individual cases. These Standing Rules are addressed to NHS bodies.</p> <p>As regards disputes between local authorities and the NHS, the Standing Rules also set out that the relevant bodies should agree a dispute resolution procedure with local authorities to deal with disputes with local authorities concerning NHS continuing healthcare. The regulation making provision at clause 22(6) (as the Joint Committee noted) provides that similar requirements may be imposed on local authorities.</p>
88	We recommend that where abuse or neglect of an adult has resulted in the commission of an offence by an employee of a body corporate acting as such, and	We agree that it should be possible to prosecute corporate bodies that provide health and care services that result in harm to patients and service users. It is offence under section 3 of the Health and Safety at Work Act 1974 to place the health and safety of patients and service users at risk, including through neglect and abuse. In future, where the CQC identifies criminally negligent practice in hospitals, it will refer the matter to the Health and Safety Executive to consider whether criminal prosecution of individuals or

	<p>this is proved to have been committed with the consent of, or to have been attributable to any neglect on the part of, a director, manager or similar officer of the body corporate acting as such, he as well as the body corporate should be guilty of an offence.</p>	<p>Boards is necessary. We will ensure sufficient resources are available to the HSE for this task.</p>
89	<p>We share the Secretary of State's view that the application of a statutory duty of candour should not be limited to health but should extend to all regulated care settings. The Care and Support Bill would provide an early opportunity for the Government to legislate on these matters.</p>	<p>We intend to introduce a statutory duty of candour on health and care providers to inform people if they believe treatment or care has caused death or serious injury, and to provide an explanation. We will need to carefully consider the scope of this duty on all providers. We will also work closely with professional regulators to examine what more can be done to encourage professionals to be candid with their patients at all times. We intend to introduce this duty through secondary legislation, and not through the Care Bill.</p>
90	<p>We agree with the Government and witnesses that free social care at end of life has 'merit', and strongly endorse the case for its introduction at the earliest opportunity. We welcome the clarification by the Government that the draft Care and Support Bill does not need to be amended to enable this.</p>	<p>We note the Joint Committee's endorsement of our position that free social care at end of life has 'merit' and note that they strongly endorse the case for its introduction at the earliest opportunity.</p>
91	<p>Clause 51 should be amended to state that the person with delegated authority to carry out a function on behalf of a local authority is subject to the same legal obligations as the local authority itself.</p>	<p>We appreciate that this recommendation reflects concern that where a local authority delegates a function to a third party, the discharge of that function should continue to be subject to the legal obligations to which the local authority is subject. We agree that clarity on the chain of accountability is important. However, we are satisfied that the clause currently provides for such continued accountability. Anything done (or failed to be done) by a third party is treated as done (or not done) by the local authority. The local authority therefore, although delegating the discharge of the function to a third party, will remain liable for the proper discharge of that function.</p>
92	<p>While we agree that all providers of publicly arranged care and support should consider themselves to be bound by the obligations of the Human Rights Act, we are of the view that, as a result of the decision in the YL case, statutory provision is required to ensure this.</p>	<p>The Government's position has been that all providers of publicly arranged health and social care services, including those in the private and voluntary sectors, should consider themselves to be bound by the duty imposed by section 6 of the Human Rights Act 1998, not to act in a way that is incompatible with a Convention right. The CQC as the regulator is bound by the Human Rights Act 1998 and has a positive obligation to ensure that individuals are protected. This obligation covers all individuals who receive care and support and not just those whose care is publicly arranged.</p> <p>The Health & Social Care Act 2008 strengthened regulatory powers to ensure that the CQC can enforce regulatory requirements that are in line with the spirit of the relevant provisions of the European Convention. This applies to all providers of regulated care and all service-users, whether publicly or privately funded. These requirements should ensure that everyone receives care that conforms to the spirit of the Convention rights.</p>

93	The draft Bill should be amended to ensure that private and third sector providers of care services regulated by public authorities are deemed to be performing public functions within the meaning of section 6(3)(b) of the Human Rights Act 1998.	See recommendation number 92.
94	We recommend that the persons for whom HEE has education and training responsibilities should not be described in this Part of the draft Bill as 'care workers', but that some other generic description should be found, such as 'health and care sector staff'.	We agree with the Joint Committee that the term 'care workers' is misleading. The Bill now uses the term 'healthcare workers'.
95	It should be a statutory requirement for HEE to work in partnership with the NHS Leadership Academy to ensure that managers in their training learn alongside their clinical colleagues, with a specific objective of ensuring that a greater proportion of the managers of the future have clinical experience.	We fully support the need for partnership working between HEE and the NHS Leadership Academy in developing clinical leaders for the future. However, we cannot accept the Joint Committee's recommendation. The NHS Leadership Academy is not a statutory body so it is not possible to put in place a statutory duty on HEE to work in partnership with the NHS Leadership Academy. HEE is represented on the NHS Leadership Academy Programme Board, which provides strategic leadership and assurance on its business. HEE's mandate reinforces the importance of partnership working with the NHS Leadership Academy to deliver the leadership strategy.
96	Clause 59 lists seven matters to which HEE must have regard in setting priorities and outcomes for education and training. We recommend adding to that list (a) the promotion of integration (including between health and care and support) to align HEE with the duties placed on the NHS Commissioning Board and Clinical Commissioning Groups, and (b) the desirability of enabling people to switch between and work across a range of different health and care and support settings.	We welcome and accept the Joint Committee's recommendation. We have revised clause 88 (which was clause 59 in the Draft Bill) to require HEE to consider how it can promote integration and recognise the multidisciplinary workforce working across both the health and social care sectors.
97	Clause 58(3) should be amended to make clear that, in setting out its forward plans, HEE should include	We agree with the Joint Committee. It is absolutely the intention that, where appropriate, HEE and the LETBs should carry out their functions taking a strategic, long term perspective. We have revised these provisions so that is clear that HEE and the LETBs should take account of short term and long term objectives in the development of

	one plan looking at least five years ahead, and preferably longer, and that it should be updated annually. LETBs should have a similar requirement.	education and training plans.
98	Clause 56 must be amended to make clear that the duty on HEE is not merely to ensure a sufficiency of skilled workers, but to ensure that supply and demand are as far as possible matched, not just overall, but within each group of 'persons of a specified description'.	In exercising its duty to secure sufficient skilled workers to work in the NHS and public health system, HEE is already required to have regard to factors influencing supply and demand. HEE does not operate on unlimited resources and has a duty to exercise its functions effectively, efficiently and economically. Wherever possible, it will strive to match supply to demand to ensure that it secures the effective delivery of services and achieves value for money from its investment in education and training.
99	Clause 57(2) should be amended so that HEE has, like the Secretary of State, the NHS Commissioning Board, and Clinical Commissioning Groups, a duty to promote research on matters relevant to the health service. In the case of HEE this duty should extend to other matters listing in paragraph (a), which includes social services.	We agree with the Joint Committee's recommendation to give HEE a duty to promote research on matters relevant to the health service and have reflected that in the Bill. It is not necessary to extend the duty to cover social services, as the Health Services and Public Health Act 1968 which gives the Secretary of State his education and training powers extends to cover social services.
100	We recommend that clause 60 should be broadened to allow HEE's obligation to obtain advice to include the commissioning of research on the exercise of its functions.	Whilst we agree with the sentiment of this recommendation, HEE will already be able to commission research on the exercise of its functions so such a change is not required.
101	The Government should consider amending the draft Bill to give both HEE and LETBs a duty to ensure that the principles and practice of safeguarding are integral to education and training.	The HEE mandate includes a requirement for HEE to ensure that the principles of safeguarding are integral to education and training. The mandate is the preferred route for setting specific objectives for HEE and the LETBs with regard to the delivery of education and training.
102	Clause 67(2) should be amended to make the facilitation and promotion of health and social care research the first of the main objectives of the HRA.	The Health Research Authority's (HRA's) overarching objective is to protect and promote the interests of participants and potential participants in research. However, the HRA will have a key role in facilitating and promoting research as encouraging high quality research is in the interests of patients and the public. So while we agree with the Joint Committee that the HRA will have a crucial role to play here, we have deliberately chosen to draft its objectives in this way to ensure participants' interests are put first.
103	The Government should consider giving the HRA primary responsibility for coordinating and standardising the regulatory	This is precisely what is envisaged for the HRA and this is why the clauses give the HRA a unique, free standing duty to promote the coordination and standardisation of practice in the UK relating to the regulation of health and social care research in addition to the duty to cooperate with other regulatory bodies. The duty in clause 98(3) will require the HRA to take the lead in actively identifying ways to remove duplication, streamline

	<p>practice of all health and social care research carried out by the persons and bodies listed in clause 68(1) and by any others with similar responsibilities.</p>	<p>regulation of health and social care research and seek to ensure that regulation is proportionate.</p> <p>As a special health authority, the HRA has been developing its programme of work to speed up the research journey in the UK. This programme will enable the creation a unified approval process for research and will support the HRA to promote consistent and proportionate standards for compliance and inspection. In doing so, the HRA is working closely with other regulatory bodies in order to identify and implement shared solutions to making it faster to initiate research.</p> <p>The programme of work includes a feasibility study with a number of pilots, to test the effect of rationalising and combining elements of NHS study-wide review with elements of the research ethics committee (REC) review into a single HRA assessment. This could potentially improve both study set-up times and the quality and consistency of ethical review.</p> <p>Through the duty in clause 98(3) and the duties to cooperate with other regulatory bodies and the devolved authorities, the HRA will create an environment where there are increased opportunities for patients and the public to participate in and benefit from health and social care research. Initiating high quality, ethical research will be quicker and simpler making the UK a more attractive place to undertake research.</p>
104	<p>The list of persons and bodies in clause 68(1) should specifically include the Social Care Research Ethics Committee.</p>	<p>It would not be appropriate to include the Social Care REC in this list as it is not a statutory body. However, the HRA is working closely with the Social Care Institute for Excellence (SCIE), which is the appointing authority for the national Social Care REC, to promote processes and standards that are consistent with regard to both the NHS and social care elements.</p> <p>As an NDPB the HRA will be in a position to appoint RECs that review social care research. We anticipate that the HRA will become the appointing authority for the Social Care REC and it will achieve the status of a National Research Ethics Service (NRES) REC.</p>
105	<p>Clause 67(2) of the draft Bill must be amended so that promoting transparency in research and ensuring full publication of the results of research, consistently with preservation of patient confidentiality, becomes a statutory objective of the HRA.</p>	<p>We fully support the principle of transparency in research. It will be essential for the HRA to promote transparency in research in order to facilitate the conduct of safe, ethical research, which is a key part of the objective of the HRA NDPB.</p> <p>The HRA special health authority is considering these issues at the moment. The Government would want to take account of the HRA's findings and of the relevant inquiry of the House of Commons Science and Technology Committee in determining the HRA's future role in relation to transparency of research. In doing so, we would want to ensure that any further legislation did not make the environment for research in this country less favourable than elsewhere.</p>
106	<p>In its guidance to Research Ethics Committees, the HRA must place on them an obligation to include provisions on the publication of research when granting approval for the conduct of research, and an obligation to ensure that such provisions are complied with.</p>	<p>We agree with the spirit of this recommendation. RECs already consider their applicants' proposals for registering and publishing the research; for disseminating the findings, including to those who took part; and for making available any data or tissue collected for the research. This helps promote transparency in research, which is essential to facilitating the conduct of safe, ethical research -- a key part of the HRA NDPB's objective. From April 2013, the HRA special health authority will begin undertaking checks of research ethics committee applicants' end-of-study reports to see if they have registered and published as they declared they would to the research ethics committee.</p> <p>We are committed to HRA's independence, without which it cannot command public confidence in the research that is subject to its processes and decisions. In view of this, we do not intend to prescribe the content of HRA's guidance to research ethics committees. It is also not our intention to establish research ethics committees as regulatory bodies with enforcement powers in their own right, which this recommendation, as drafted, would seem to require. This would go significantly beyond their activities as assessors of the ethics of health and social care research and fundamentally alter their established role, as well as their relationship to the HRA NDPB.</p>

107	We believe that ministers should not have the power to abolish the HFEA or the HTA, and we recommend that clause 75 should be deleted.	The clause that allowed for the abolition of the Human Fertilisation and Embryology Authority (HFEA) and the Human Tissue Authority (HTA) has been deleted from the Bill.
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ISBN 978-0-10-186272-1



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