



Department
of Health

New offences of ill-treatment or wilful neglect

Government response to consultation

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Prepared by the Department of Health

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Introduction

1. In November 2013, the Government accepted the recommendation of the National Advisory Group on the Safety of Patients in England that a new statutory criminal offence of ill-treatment or wilful neglect of patients should be created. The Government committed to consulting on detailed proposals as soon as possible, with the aim of legislating as soon as Parliamentary time allowed.
2. Since then the Department of Health has been working to develop a set of proposals, on which we began a public consultation on 27th February 2014. The consultation document¹ set out the background to the proposals and asked for views on a number of different issues. The consultation period ran until 31st March. This document summarises the responses received to each of the questions we asked, and sets out how we will be proceeding on each issue following the consultation.
3. This document talks about “the offences”, as, in light of the comments received from respondents to the consultation, the legislation will set out two offences, one relating to individuals, and a separate one relating to organisations.

Overarching issues

i) The new offences

4. We received more than 130 responses to the consultation, from a wide range of organisations and individuals. Not every respondent answered every question, and some provided a narrative response and did not specifically answer any of the questions. In general, the vast majority of respondents were supportive of the principles behind the proposals and agreed with the approaches set out in the consultation document. For example, the Royal College of Physicians told us that it:

agrees that patients should be protected from wilful neglect and ill-treatment. In the rare instances where a practitioner is aware of the risk to their patient, but shows wilful disregard of the risk, they should face a criminal sanction. Such conduct goes against the fundamental tenets of medical professionalism and the ethical duty of care that all healthcare professionals have towards their patients.

5. However, a small minority were not supportive, largely because they did not accept the underpinning premise of there being a gap in existing legislation which needs to be filled.

¹ *New offence of ill-treatment or wilful neglect; consultation document*. Published 27 February 2014: <https://www.gov.uk/government/consultations/ill-treatment-or-wilful-neglect-in-health-and-social-care>

Rather, these respondents tended towards the view that existing legislation already provides adequate safeguards against the behaviours that we are seeking to capture through the new offences. The Medical Defence Union (MDU), argued particularly in favour of the strength of the powers of the professional regulators, such as the General Medical or Nursing and Midwifery Councils, saying:

The threshold for a finding of impaired fitness to practise is that of the civil standard, lower than the criminal standard, and thus provides greater protection to patients. A finding of impaired fitness to practise that results in erasure from the register will effectively end that healthcare professional's career. There is no need of an additional criminal sanction, especially one with a higher threshold of proof.

6. There are two issues to consider in this respect. Firstly, not all health and social care workers are subject to professional regulation, so there are significant staff groups to whom the MDU's argument cannot apply. The Nursing and Midwifery Council made clear in their response that they support the new offences applying across all sectors and roles, in order to create consistency and equity.
7. Furthermore, a key element of the new offence with regards to the individual, is that of acting deliberately or with a "couldn't care less" attitude, which represents a step up in severity from many of the existing offences, and indeed from the very many reasons why a professional regulator may reach a finding of impaired fitness to practise. It is this additional element which in our view merits a response beyond the solely regulatory.
8. Whilst we accept – as we did in the consultation document – that there are existing offences that may apply in some cases where the ill-treatment or wilful neglect has been of a particular type (for example physical violence), we remain of the view that existing legislation is not sufficient to cover each and every situation that an offence of ill-treatment or wilful neglect would.
9. Some respondents also pointed out that the objective of creating consistency of response wherever ill-treatment or wilful neglect has occurred cannot be achieved by relying on existing legislation which has a multiplicity of differences in application and available penalties.

ii) Potential unintended consequences

10. A common theme across many responses, both positive and negative, has been the importance of being aware of and guarding against "unintended" negative consequences. In particular, the risk of adverse effects on the new culture of openness and candour that the Government is seeking to embed within the NHS and social care was highlighted by a number of respondents, for example by the Academy of Medical Royal Colleges. Concerns focussed on the possibility of staff being less open and honest when things go wrong out of fear that doing so may expose them to criminal charges of ill-treatment or wilful neglect. It was also suggested that the new offences could cause some healthcare professionals to

“practise inappropriately defensive medicine” to protect themselves from possible accusations.

11. Linked to this, some respondents also expressed concerns about the possibility of individual employees becoming “scapegoats”, when in fact their actions had been constrained by the management or organisational practices of their employer, for example by providing inadequate training or induction.
12. These are important and understandable concerns, which we recognise we must ensure we address in the development of the offences. For example, we agree that It will be essential to be able to hold organisations to account as well as individuals, and it is for exactly that reason that we are establishing an offence for organisations as well as for individuals.
13. However, we also share the view on these issues expressed by the Association of Independent Local Safeguarding Children Boards that it “does not consider this to be a reason to avoid introducing the proposed new offence”. We remain of the view that there will be adequate safeguards in place to address the concerns, including guidance on how the Crown Prosecution Service would be likely to go about assessing available evidence when deciding whether to pursue a prosecution.
14. Overall, it is clear that the bulk of respondents have been convinced by the arguments set out in the consultation document that it is right and appropriate to create the new offences of ill-treatment or wilful neglect of users of health and adult social care services. **We can therefore confirm that we are moving forward to establish these statutory offences.**

Summary of consultation outcomes

15. The responses to the specific consultation questions are detailed in the next section, together with how we now propose to proceed in the light of those responses. Those headlines are drawn together here to present an overview of how the new offences will be structured. The offences will apply:
 - to all formal healthcare provision for adults and children in both the NHS and private sector, other than in specific excluded children’s settings and services which are already subject to comprehensive legislative and regulatory safeguards;
 - to all formal adult social care provision, in both the public and private sectors, including where care is self-funded; and,
 - to individuals and organisations paid to provide or arrange for the provision of these health and adult social care services, but with the offence for organisations formulated differently from that for individuals.
16. Penalties for individuals will mirror those attached to the offence of ill-treatment or wilful neglect of persons without capacity set out in section 44 of the Mental Capacity Act 2005.

For organisations, penalties will include fines, and/or the issuing of publicity orders and remedial orders, similar to those available in respect of convictions of corporate manslaughter in the Corporate Manslaughter and Corporate Homicide Act 2007. There is now also a precedent for this approach in the context of health and social care, as the Care Act 2014 makes provision for the use of remedial orders and publicity orders following conviction of the offence of providing false or misleading information.

17. The offences will not apply:

- to the provision of any non-health children’s services (e.g. children’s social care);
- to informal caring arrangements where the care is not provided as part of paid work;
- in situations that are the result of a genuine accident or error;
- to any sectors other than health care or adult social care; and,
- to the provision of health care for children or adults in some specified settings or services, such as schools or children’s homes.

18. As indicated in the consultation document, the offences will apply in both England and Wales.

19. The rest of this document sets out a summary of the responses to each of the specific consultation questions

Scope of the offences

i) NHS or wider

20. The consultation document outlined our proposal that the offences should apply more widely than “all NHS patients”, as recommended by the National Advisory Group, whose remit extended only to the NHS. We said:

We propose that the new offence should apply in all formal adult health and social care settings, in both the public and private sectors. Do you agree with this approach?

21. Respondents were overwhelmingly in favour of this approach (of those who answered the question, 98% support our proposal) with only those who considered the offences as a whole unnecessary arguing against. Typical comments made on this question included:

The new offence...should not be restricted to only NHS services, but should apply across all formal health and social care settings. Patients and clients have an increasingly wide choice of health and social care provision and should be afforded the same safeguards in whatever setting they are provided with treatment. (Nuffield Health)

Yes we fully agree and strongly advocate this approach. (Patients Association)

22. In the light of this hugely supportive response, **we can confirm that the new offences will apply to the provision of adult health and social care in all formal health or adult social care settings.**
23. We have also considered the extent to which the offences should also apply in respect of the provision of health care and social care to adults in other settings which are not primarily for the provision of health or adult social care services, for example in a patient or service user's home, or in prisons etc. There seems to be a clear argument in favour of including these non-health settings in most cases. It is entirely appropriate, for example, that someone receiving adult social care services in their own home should have the protection afforded to them by having the offence apply in that setting.
24. However, we also asked questions in the consultation document about how the offences should apply in relation to non-health children's settings and services. This is discussed in more detail below, but it became clear that many key stakeholders took the view that it was not appropriate for the offences to apply in these situations. After careful consideration, we agree with the arguments put forward, and can therefore **confirm that the offence will apply to the provision of all formal adult social care services, and to all formal healthcare provision for adults, other than in specific excluded children's settings and services.**

ii) Children

25. The consultation document discussed the current situation in relation to the existing legislative framework for protecting children and keeping them safe from harm, in particular the duties of local authorities under sections 17 and 47 of the Children Act 1989. The document also explained that existing legislation, in particular section 1 of the Children and Young Persons Act 1933 (the cruelty to children offence), may not encompass individuals and organisations providing health care to children. We therefore asked the question:

Should the new offence apply in all formal health settings in both the public and private sector used by children (including services used by both children and adults)? Please explain your view.

26. Again, the vast majority of respondents supported this proposal, arguing that the principles of consistency and equity should apply equally in children's health care settings as in adult settings. In particular, this approach was endorsed by the Association of Directors of Children's Services (ADCS) who said:

We agree that the offence should apply equally to children, young people and adults who are NHS patients. Moreover, we believe that the principles could be applied more widely to include all formal health care settings used by children and young people (including services used by children and adults) in the public and private sectors.

27. The joint response of the Association of Directors of Adult Social Services (ADASS) and Local Government Association (LGA) was:

We feel that this is relevant within formal health care settings used by children and young people, where we understand that a certain ambiguity is felt to exist in current legislation. We agree the offence should apply equally to children and young people who are NHS patients.

28. There were, however, a number of respondents who felt that an amendment to Section 1 of the Children and Young Persons Act 1933 might be a more appropriate way to deliver this for children, rather than creating a new offence. For example, the joint response of the NSPCC, Action for Children, Barnardo's and the Children's Society said:

We believe that the outcomes for children sought by government in response to the issues raised by the Mid-Staffs Review would be better achieved by amending the existing law in relation to cruelty and wilful neglect contained in Section 1 Children and Young Persons Act 1933.

29. Nonetheless, there was a clear indication that respondents are, for the most part, in agreement with the proposal to include children's healthcare within the scope of the offence. **We can therefore confirm that the new offences will apply in respect of all formal healthcare settings where healthcare is provided to children.**

30. The consultation document sought further views in relation to children, on whether non-health settings for children should be included within the proposed offence. Such settings could include those such as children's social care (fostering, children's residential care, and social work), services for children with disabilities (which may or may not be described as health services), early years provision and education. We asked:

Should the new offence apply in any other settings used by children (including services used by both children and adults)? Please explain your view and what sorts of services you believe should or should not be included.

31. Responses to this question covered both whether the offences should apply to children's services more widely, but also whether the offences should apply to the provision of healthcare for children in non-healthcare settings, such as schools. Responses to both were varied, however many key stakeholders in the children's sector were very clearly opposed both to any extension into health provision to children beyond formal healthcare settings and to the extension into children's services more widely. They believed that there were sufficient existing criminal offences which addressed ill-treatment or wilful neglect already in place. For example the Association of Directors of Children's Services (ADCS) believe:

there are sufficient existing offences which address ill-treatment, neglect (wilful or otherwise) and child cruelty and that other safeguards exist in respect of the protection and safety of children and young people.

32. In addition, the Fostering Network was not in favour of any extension of criminal offences to children's services more broadly, being mindful of the evidence that a risk adverse culture can impact negatively on the ability of carers to provide children and young people with a full experience of family life. They responded that:

We are not of the view that there is any evidence to suggest that an additional offence covering children's social care is required. The 1933 Children and Young Persons Act provides a satisfactory legal framework for holding foster carers to account and see no benefit from the introduction of a new offence.

33. A number of respondents however, agreed that this legislation was not appropriate, but as highlighted earlier, the Children and Young Persons Act 1933 should be amended instead. For example, the joint response from NSPCC, Action for Children, Barnado's and the Children Society:

we agree that ill-treatment and wilful neglect of children in formal or informal health and social care settings should be illegal. We believe that the existing cruelty and neglect law, if amended would provide a sound basis to establish a consistent standard of care for children, whatever the setting.

34. It is clear that key stakeholders in this area do not think that the offences are either required or appropriate in relation to wider children's services within the context of the existing legislative and regulatory framework, and we agree with that view. **For that reason, we can therefore confirm that the offences of ill-treatment or wilful neglect will not apply to non-healthcare services for children.**

35. It is also clear that there is a broad range of views on whether the offences should extend to the provision of healthcare to children in non-healthcare settings. Similar to considering the offences with regards to the provision of adult health and social care outside of health settings, we have carefully considered these responses, as well as the legislative and regulatory framework which already exists in the context of all non-healthcare settings where children may receive healthcare services.

36. On balance, we do not think the offences are necessary for non-healthcare settings, for example schools, which are already covered by this extensive existing legislative and regulatory framework. As indicated above, this would be in respect of adults working in those settings as well as children – we believe there would be a high risk of confusion and incorrect application if the offence applied in respect of adults but not to children. Given that the incidence of adults working in the children's services and settings that we are proposing to exclude from the offences would be small, and the likelihood of them suffering ill-treatment or wilful neglect during receipt of such treatment smaller still, our view is that excluding all health care provision in these settings is appropriate.

37. However, there are other settings where children may receive health care which are not covered by the legislative and regulatory framework described above, for example Young Offenders Institutions. To ensure a consistent approach, therefore, the offences will apply in relation to health care provided to children and adults in any setting that is not specifically excluded in the legislation.
38. Taking all this into account, **we can confirm that the offence will not extend to the provision of children’s or adult health care in specified non-health care children’s settings and services.**
39. This will include:
- all schools, Academies and free schools, both state and independent, including boarding schools;
 - all children’s homes and residential family centres; and,
 - all childcare provision.

Formal service provision

40. The consultation document raised the issue of whether the offences should only apply in relation to “formal” health and adult social care services, or should apply more widely to include informal provision. We described “formal arrangements” as covering those situations where a person (whether an individual or an organisation) is employed or contracted to provide particular services. These arrangements give rise to a contractual or other formal obligation to provide those services to a reasonable standard, including to any standard agreed with the commissioner/employer. This seems to represent a significant and important difference from informal arrangements, where the care provided is usually based on a family relationship or friendship and there is no element of prescribed obligation.
41. We explained our view that the offences should apply only to formal health and social care settings, where there is a contractual or employment duty to provide services, and asked:
- we propose that only formal health and social care arrangements... should be within scope of this offence. Do you agree with this approach? Please explain your view.
42. Opinions on this proposal were mixed, with some taking the view that the offences should apply across any and every case where healthcare or adult social care services are being provided, irrespective of the employment/contractual status of the person providing it. Indeed one or two respondents, such as the Association of Independent Local Safeguarding Children Boards, argued in favour not only of extending the offences to informal health and care settings, but also to other services such as police, probation or housing. However, we are clear that this would not be appropriate in the context of this offence as it is beyond the overall objectives that we are trying to achieve.

43. Nevertheless, around two thirds of respondents who answered this question agreed with our proposal to restrict the offence to formal health and social care provision. The British Medical Association summed up the views we received very well, when it said:

...we would support the proposal not to extend the offence to informal health and social care settings. Many individuals receive exceptional care provided by family and friends and it is often a crucial element of the health and well-being of patients. If the offence were extended to informal arrangements, we believe it could jeopardise the existing willingness and compassion society offers to so many who are in need.

30. Overall, responses demonstrated clear support for our proposals, and **we can therefore confirm that the new offences will apply only in respect of formal health and adult social care provision, where there is an employment or contractual element to the provision.**

Elements of the offences

i) Conduct or outcomes

44. The National Advisory Group on the Safety of Patients in England proposed that the ill-treatment or wilful neglect must cause serious harm or death to the victim in order for the proposed offence to bite. The consultation document discussed a range of issues arising from this approach, in particular the fact that the gap in legislation would not in fact be fully closed by the offence if a threshold was maintained. In addition, in our view, there would be a risk of being perceived as effectively condoning or disregarding lesser harm. We also discussed the concerns held by some about the risk of creating a “climate of fear”. Taking all the issues into consideration, we reached a view that the disadvantages of including a harm element outweigh the merits, and asked the question:

We propose that the new criminal offence should focus entirely on the conduct of the provider/practitioner, rather than any consideration of the harm caused to the victim of the offence. Do you agree with this approach? Please explain your view.

45. The responses to this question reiterated the messages we set out in the consultation document about the importance of ensuring that the offences do not undermine the vital reforms to promote openness and honesty in health and adult social care. As already indicated above, we accept that entirely. Nevertheless some respondents felt the risks to be too significant. For example, the Medical Protection Society said:

We think that the likely consequence of new sanctions will be healthcare professionals becoming more fearful of the way their conduct may be later criticised, less open and willing to admit genuine errors to either patients or management and therefore make healthcare less responsive and accountable to patients.

46. Linked to this, a few respondents also expressed concerns about how the offences would operate in practice without a harm threshold. For example, the Academy of Medical Royal Colleges told us they thought that:

[basing] the offence on the conduct and intention of the individual will make the issue more complex and make cases harder to prosecute, especially if no harm occurs and there is only the intention of the individual to consider.

47. However, it is also the case that, having made the overarching points about the importance of supporting a culture of honesty and openness, the majority of respondents (81%) supported focussing the offence with regards to the individual on the conduct of perpetrator, rather than the outcomes for victim. As the Royal College of Physicians put it:

The focus should be on the conduct and the intent, rather than the outcome for the patient...to avoid incidents being overlooked where a severe outcome was avoided, but where there was a clear indication of wilful neglect or ill treatment. Also by excluding the harm element, one avoids the difficult decisions that have to be made as to what constitutes 'severe' and what falls below that threshold.

48. On balance, the majority of respondents supported our proposals on this issue. **We therefore confirm that the offence will focus on conduct rather than outcomes, with no threshold of harm.**

Describing the offence for organisations

49. The National Advisory Group was clear in its report that the offence should apply to both individuals and organisations which provide care. We agreed and explained how we envisage the offence would operate alongside the work to introduce fundamental standards as part of the Care Quality Commission's (CQC) registration requirements.

50. The consultation document also discussed the challenges associated with trying to establish an offence that will make an effective impact on organisations. We therefore proposed an approach to the offence for organisations similar to that taken in the Corporate Manslaughter and Corporate Homicide Act 2007, focussing on the way the organisation's activities are managed and organised. We asked:

Do you agree that an approach based on the way in which an organisation managed or organised its activities is the best, most effective way to establish the offence in respect of organisations? Please explain your view.

51. All but a small proportion of respondents (4%) were supportive of this proposal. Those few who were not were mainly respondents who did not support the creation of the new offence, rather than objecting to this specific proposal. But many of those who supported the proposal also emphasised the importance of providing guidance and examples of the sort of activities and organisational conduct that might lead to prosecution.

52. We agree that it will be important to provide clarity as to how the offence will operate, but it is nevertheless clear that our proposal was very strongly supported, and **we therefore confirm that the offence for care provider organisations will be based on the formulation of the corporate manslaughter offence.**

Other issues

i) Penalties

53. The National Advisory Group made recommendations on penalties in respect of both individuals and organisations. For individuals it suggested that penalties should mirror those specified in section 44 of the Mental Capacity Act 2005. These are, on summary conviction, up to 12 months' imprisonment, or a fine of not more than the statutory maximum, or both, or on conviction by indictment, imprisonment for up to 5 years, or a fine, or both. We accepted that recommendation and asked:

We propose that penalties for individuals convicted of this offence should mirror those set out in section 44 of the Mental Capacity Act 2005. Do you agree? Please explain your view.

54. This proposal met with almost universal support from respondents, with 96% of those who answered the question supporting the proposal. An alternative approach was suggested in the joint NSPCC/Action for Children/Barnardo's/Children's Society response, which advocated that the individual penalties should mirror those in section 1 of the Children and Young Person's Act 1933. However, this would create a significant inconsistency between the new offence and the other equivalent specific ill-treatment or wilful neglect offences in existing legislation. The 1933 Act offence relates to child cruelty, which includes neglect or ill-treatment, but also a range of other acts and omissions that are not covered by the offences in either the Mental Capacity Act 2005 or the Mental Health Act 1983. So it seems more logical to have a similar approach towards penalties as in those offences which are most closely equivalent to the offences we are proposing. **We are therefore able to confirm that the penalties for individuals convicted of the new offence will mirror those in section 44 of the Mental Capacity Act 2005.**

55. As regards organisations, the National Advisory Group suggested that sanctions might include:
- removal of the organisation's leaders and their disqualification from future leadership roles;
 - public reprimand of the organisation; and
 - *in extremis*, financial sanctions, but only where that will not compromise patient care.

56. We agreed with the first two of these, and set out proposals for how they could be implemented in the offence for organisations. However, in relation to the use of fines,

these are the conventional punishment for organisations, both in the health and social care sectors and elsewhere. In our view, there seemed to be little to justify making an exception to this approach for the ill-treatment and wilful neglect offence, and we proposed that fines should be one of the options available to the Court. With that in mind, we asked:

Do you agree with our proposals in relation to penalties in respect of organisations? Do you think there are other penalties which would be appropriate?

57. Again, the vast majority of respondents who answered this question supported this proposal, although there were some who indicated that they shared the concerns raised by the National Advisory Group in relation to the use of fines that care needed to be taken to ensure that these did not adversely affect patient care. As we said in the consultation document, we take the view that these decisions properly lie with the Courts, which have sufficient experience and expertise to be able to make judgements on this issue. This view has not changed.
58. Although a few respondents offered alternative suggestions, these were largely congruent with existing proposals. For example several respondents proposed variations around “naming and shaming” of the organisation. However, our proposals do allow the Courts to make publicity orders and would effectively do that. Organisations would be required to publicise the fact that they had been convicted of the offence, and, if a remedial order was made, to publicise what action they were taking to put matters right.
59. Nevertheless, the overall level of support for this proposal was very high, and **we can therefore confirm that the offence for organisations will attract penalties that include fines, publicity orders and remedial orders.**

ii) Matters for prosecutorial discretion

60. The consultation document set out the proposed scope of the new offences. Many respondents, although generally supportive, reiterated the importance of the issues we identified in the section on matters for prosecutorial discretion: being absolutely clear that genuine accidents and errors would not result in prosecution; ensuring that health and social care professionals remain free to exercise clinical judgement; and ensuring that organisations remain able to make considered decisions on selection criteria for particular treatments. We remain very clear that these are all situations which should not attract the potential for prosecution,
61. We also discussed specific concerns around the risk of malicious or vexatious allegations. Whilst we accept that this is a risk we also discussed the safeguards that are already in place to minimise that risk not just in relation to this new offence but also more generally, including as regards the section 44 offence in the Mental Capacity Act 2005. We asked:

We propose adopting the same approach to referral of private prosecutions to the DPP as is available in respect of the section 44 offence in the Mental Capacity Act 2005. Do you agree? Are there other ways to address this issue?

62. Again most respondents (95%) were very supportive of this approach, and very few made any specific comments. **We can therefore confirm that the option of referring private prosecutions for this offence to the Director of Public Prosecutions will be adopted,** in the same way as it is in respect of section 44 of the Mental Capacity Act 2005. This will mean that where the Crown Prosecution Service thinks that the evidential and public interest tests in the Code of Public Prosecutors are not met, it can intervene to take over the prosecution and stop it from prosecuting.

Equality issues

63. The consultation document discussed the application of the Public Sector Equality Duty (PSED) to the development of this policy. We explained that we would be completing an initial screening exercise, but also sought views on whether any of the proposals in the consultation document could have implications in relation to the matters needing to be considered through the PSED. We asked:

Do you think that any of the proposals set out in this consultation document could have equality impacts for affected persons who share a protected characteristic, as described above? If so, please tell us about them.

64. Although some respondents to the consultation indicated that they felt there could be possible equality impacts, very few offered specific examples and analysis of the responses raised no issues or concerns with respect to the nine protected characteristics across the three elements to be considered within the PSED.
65. In addition, several responses to the consultation made the point that the implementation of the new offences would be an advance to equality, as by closing the gap in the legislation, there will be consistency in the options available in the event of someone being subjected to ill-treatment or wilful neglect.
66. In parallel with the consultation, we also conducted an initial screening exercise which sought to identify the scope of those who may be affected and whether the proposed policy may have equality impacts for affected persons who share a protected characteristic.
67. We took all of these into account alongside the development of the screening work, and are of the view that the offences do not have any implications in relation to the matters needing to be considered through the PSED and other duties on the Secretary of State. As a result, a full Equality Impact Assessment will not be required.

Next steps

68. We have always been clear that the establishment of these new offences is a vital element of the Government's overall strategy and response to the events at Mid Staffordshire NHS Foundation trust. We have therefore also been determined to move ahead with the development of the offences as quickly as possible. That is one of the reasons why our consultation on the proposed formulation was short and tightly focussed.
69. In addition, we committed to legislating at the earliest possible opportunity. We have been able to identify such an opportunity which avoids the time and complexity of working up a bespoke stand-alone Bill. Rather, we will be adding clauses which establish the two offences to the Criminal Justice and Courts Bill, which is currently proceeding through Parliament. Subject to Parliamentary approval, we envisage that this will allow the new offences to come into effect in 2015.

Annex A – list of organisations that responded to the consultation

The following organisations have responded to the consultation. A number of responses were also received from members of the public, service users and individual members of other groups and organisations, whose comments did not necessarily represent those organisations.

Academy of Medical Royal Colleges
Action against Medical Accidents
Action for Children
Association of Directors of Adult Social Services
Association of Directors of Children's Services
Association of Directors of Social Services Wales
Association of Independent Local Safeguarding Children's Board Chairs
Association of School and College Leaders
Barchester Healthcare
Barnado's
Betsi Cadwaladr University Health Board
Bracknell Forest Council
British Association of Fostering and Adoption
British Dental Association
British Medical Association
Bury Council – Adults Services Senior Management Team
Bury Council – Children's Services Senior Management Team
Cardiff Council
Care England
Chartered Society of Physiotherapy
Cheshire West and Chester Council
Children's Society
Classic Care Homes Devon
College of Emergency Medicine
College of Social Work
Council for Disabled Children
County Durham and Darlington NHS Foundation Trust
Darlington Local Authority
Devon County Council

East Lancashire Clinical Commissioning Group
Elcena Jeffers Foundation
Equality and Human Rights Commission
Foundation Trust Network
Gateshead Council
General Medical Council
General Pharmaceutical Council
Hampshire Safeguarding Children's Board
Handling, Movement and Ergonomics LMT
Health and Safety Executive
Health Foundation
Her Majesty's Chief Inspector of Education and Training in Wales
Hertfordshire Safeguarding Adults Board
Hywel Dda University Health Board
Institute of Chartered Secretaries and Administrators
Lancashire County Council
Lancashire Local Safeguarding Children's Board
Leeds Safeguarding Adults Board
Local Government Association
London Borough of Newham Safeguarding Adults Board
Manchester Safeguarding Adults Board
Margaret Sheather LMT
Medical Defence Union
Medical and Dental Defence Union of Scotland
Medical Protection Society
Mencap
National Care Association
National Society for the Prevention of Cruelty to Children
NHS Nene and NHS Corby Clinical Commissioning Group
North Durham, Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups Nuffield Health
Northamptonshire Safeguarding Adults Board
Northumberland Safeguarding Children Board Members
Nursing and Midwifery Council
Older People's Commissioner for Wales
Parkinson's UK
Patients Association

Practitioner Alliance for Safeguarding Adults
Professional Standards Authority
Real Life Options
Relatives and Residents Association
Rochdale Borough Safeguarding Adults Board
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians
Royal College of Physicians and Surgeons of Glasgow
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons
Royal College of Surgeons of Edinburgh
Royal Pharmaceutical Society
The Priory Group
St. Helen's Council
St. John's Ambulance
Salford Children's Services
Slough Safeguarding Adults Partnership Board
Social Care Institute for Excellence
Solihull Metropolitan Borough Council
Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board
Stockton-on-Tees Borough Council
Surrey Downs Clinical Commissioning Group
Voluntary Organisations Disability Group
Warrington Clinical Commissioning Group
West Sussex County Council
Worcester Safeguarding Adults Board