

# CARE ACT 2014

---

## EXPLANATORY NOTES

### INTRODUCTION

1. These explanatory notes relate to the Care Act 2014 which received Royal Assent on 14 May 2014. They have been prepared by the Department of Health in order to assist the reader in understanding the Act. They do not form part of the Act and have not been endorsed by Parliament.
2. These notes need to be read in conjunction with the Act. They are not, and are not meant to be, a comprehensive description of the Act. So where a section or part of a section does not seem to require any explanation or comment, none is given.
3. A glossary of terms and abbreviations used in these explanatory notes is provided at the end of these notes.

### BACKGROUND AND SUMMARY

4. The Act contains provisions relating to adult care and support and health.
5. [Part 1](#) of the Act is intended to give effect to the policies requiring primary legislation that were set out in the White Paper *Caring for our future: reforming care and support* (Cm 8378, July 2012)<sup>1</sup>, to implement the changes put forward by the Commission on the Funding of Care and Support, chaired by Andrew Dilnot, and to meet the recommendations of the Law Commission in its report on Adult Social Care (Law Com 326, HC 941, May 2011) to consolidate and modernise existing care and support law.
6. [Part 2](#) of the Act also gives effect to elements of the Government's response to the Mid Staffordshire NHS Foundation Trust Public Inquiry that require primary legislation.
7. [Part 3](#) of the Act makes changes to the Trust Special Administration regime. It also takes forward the necessary legislative measures for the proposals outlined in *Liberating the NHS: Developing the Healthcare workforce - From Design to Delivery*<sup>2</sup>, the establishment of Health Education England as a non-departmental public body; and those in relation to health research that were set out in the Government's *Plan for Growth*<sup>3</sup>, the establishment of the Health Research Authority as a non-departmental public body.
8. [Part 4](#) of the Act establishes a fund for the integration of care and support with health services, to be known as the Better Care Fund and makes provision for additional safeguards around the general dissemination of health and care information.

### OVERVIEW OF THE STRUCTURE

9. The Act contains five Parts and eight Schedules.

---

<sup>1</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf)

<sup>2</sup> [www.gov.uk/government/publications/developing-the-healthcare-workforce-from-design-to-delivery](http://www.gov.uk/government/publications/developing-the-healthcare-workforce-from-design-to-delivery)

<sup>3</sup> [www.hm-treasury.gov.uk/ukecon\\_growth\\_index.htm](http://www.hm-treasury.gov.uk/ukecon_growth_index.htm)

## **Part 1 – Care and Support**

10. **Part 1** sets out the legal framework for the provision of adult social care in England.
11. **Sections 1 to 7** set out the general responsibilities of local authorities. They describe local authorities' broader care and support role towards the local community, including services provided more generally, for instance those with the aim of reducing needs.
12. **Sections 8 to 41** provide for a person's journey through the care and support system. These provisions map out the process of assessments, charging, establishing entitlements, care planning, and the provision of care and support. They include provision to create a cap on the costs of care and for local authorities to enter into deferred payment agreements.
13. **Sections 42 to 47** outline the responsibilities of local authorities and other partners in relation to the safeguarding of adults, including a new requirement to establish Safeguarding Adults Boards in every area.
14. **Sections 48 to 57** set out local authorities' responsibilities for ensuring continuity of care where a provider sustains business failure and ceases to provide a service, and provide for the oversight of registered care and support providers by the Care Quality Commission (CQC).
15. **Sections 58 to 66** will support the transition for young people between children's and adult care by giving local authorities powers to assess children, young carers and parent carers.
16. **Sections 67 to 80** set out provisions in relation to independent advocacy, recovering charges owed to the local authority, reviews of funding provisions, appeals, and other miscellaneous matters, including making explicit when the provision of care and support is a function of a public nature being exercised for the purposes of the Human Rights Act 1998 and restating the law relating to delayed discharges.

## **Part 2 – Care Standards**

17. **Part 2** of the Act deals with a number of the aspects of the Government's response to the findings of the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC.
18. **Section 81** provides that regulations must include a duty of candour on providers of health care and adult social care services registered with the CQC.
19. **Sections 82 to 85** provide for an extended failure regime for NHS (National Health Service) healthcare providers which encompasses quality as well as finance by: enabling the CQC to issue warning notices to NHS trusts and NHS foundation trusts where the services provided by them require significant improvement; extending Monitor's powers to be able to impose additional licence conditions on foundation trusts; and enabling Monitor to make an order authorising the appointment of a trust special administrator for foundation trusts on quality grounds. The sections also ensure that these requirements and powers apply correctly once all NHS trusts have been abolished.
20. **Section 86** prevents registered providers from applying for a change to their conditions of registration where the CQC has commenced proceedings to make the same change and section 87 creates a right of appeal for individuals against whom the CQC requires action to be taken.
21. **Section 88** amends provisions relating to the membership of the CQC.
22. **Section 89** places a duty on the non-executive members of CQC to appoint three Chief Inspectors as executive members of the CQC Board and makes provision for the CQC to determine the functions each Chief Inspector will exercise on its behalf. In

*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

performing CQC's functions, the Chief Inspectors must safeguard and promote CQC's independence from the Secretary of State.

23. [Section 90](#) repeals or amends several of the Secretary of State's powers in the Health and Social Care Act 2008 (the 2008 Act) that could constrain CQC's operational autonomy.
24. [Section 91](#) requires the CQC to conduct periodic reviews, assess performance and publish assessment reports in respect of regulated activities and registered service providers. This is to allow for meaningful comparison of services.
25. [Sections 92 to 94](#) provide for a new offence for care providers who supply, publish or otherwise make available information that is false or misleading, with associated criminal sanctions. The offence will also apply to directors, managers, secretaries or similar officers of care providers in certain circumstances.
26. Finally, section 95 will allow the Government, through regulations, to specify the people or organisations that can set training standards for specific groups of workers, such as healthcare assistants and social care support workers, engaged in an activity regulated by the Care Quality Commission.

### **Part 3 – Health**

27. [Chapter 1](#) establishes Health Education England (HEE) as a non-departmental public body.
28. [Chapter 2](#) establishes the Health Research Authority (HRA) as a non-departmental public body.
29. [Chapter 3](#) deals with transfer orders and interpretation provisions in relation to HEE and HRA.
30. [Chapter 4](#) clarifies functions of the Trust Special Administrator.

### **Part 4 – Health and social care**

31. [Section 121](#) establishes a fund for the integration of care and support with health services (known as the Better Care Fund).
32. [Section 122](#) amends the Health and Social Care Information Centre's (HSCIC) general dissemination powers to clarify the purposes for which the HSCIC may or may not release information and require it to have regard to particular advice in exercising its publishing or other dissemination functions. It also requires the HSCIC, in carrying out any of its functions, to have regard to the need to respect and promote the privacy of those receiving health services and adult social care.

### **Part 5 – General**

33. [Part 5](#) deals with various technical matters such as power to make consequential amendments, orders and regulations, commencement, extent and the short title of the Act.

## **TERRITORIAL EXTENT AND APPLICATION**

34. The Act extends to England and Wales save where specified otherwise.

### ***Territorial extent and application: Wales***

35. [Part 1](#) (Care and Support) in general extends to England and Wales but applies to local authorities in England only. This is because social care is a devolved matter for Wales. However, the provisions in relation to cross-border placements (section 39(8) and Schedule 1), certain provisions on provider failure (sections 49 to 52) and the Human Rights Act 1998 provision (section 73) also apply to Wales. The Law Commission's

report on adult social care makes recommendations in relation to both England and Wales, but the National Assembly for Wales has passed its own legislation, the Social Services and Well-being (Wales) Act 2014.

36. [Part 2](#) (Care Standards) also extends to England and Wales but applies to England only. This Part amends provisions in the 2008 Act relating to the Care Quality Commission (CQC) and provisions in the National Health Service Act 2006 (the 2006 Act) and the Health and Social Care Act 2012 relating to regulation of NHS foundation trusts. The CQC's functions only apply in England by virtue of the fact that the "regulated activities" which it regulates must involve, or be connected with, the provision of health or social care in, or in relation to, England: section 8(2)(a) of the 2008 Act. NHS foundation trusts are established under section 30 of the 2006 Act to provide goods and services for the purposes of the health service in England only.
37. In Part 3 (Health), the majority of provisions relating to Health Education England (HEE) extend to England and Wales and those relating to the Health Research Authority (HRA) extend to the whole of the United Kingdom. The functions of HEE only affect England, by virtue of the fact that they are derived from the Secretary of State's functions to do with the planning and delivery of education and training for persons connected with the provision of health services in England (section 1F of the 2006 Act). However, while neither HEE nor the HRA will take on any devolved functions, there are some implications for the devolved administrations in relation to the establishment of these bodies as non-departmental public bodies.
38. HEE will have a power to exercise any of its education and training functions on behalf of a devolved authority, but only when it is asked to do so: paragraph 17 of Schedule 5.
39. The Act places the HRA and each of the devolved administrations under a duty to co-operate with one another with a view to co-ordinating and standardising the regulation of health and social care research in the UK: section 111(4). The HRA and certain specified bodies which carry out some devolved functions in relation to health and social care research will also be under a duty to co-operate with each other with a view to co-ordinating and promoting regulatory practice: section 111(1) In relation to Wales, this is the Human Tissue Authority.
40. In relation to England and Wales, the HRA will now also undertake the Secretary of State's power to approve the processing of confidential patient information for the purposes of medical research. HRA's committee established under paragraph 8(1) of Schedule 7 will advise HRA and the Secretary of State in respect of their respective functions under the [Health Service \(Control of Patient Information\) Regulations 2002 \(S.I. 2002/1438\)](#) ("Control of Patient Information Regulations") which extend to England and Wales: see section 117.
41. The HRA will also be able to take on related functions from any of the devolved administrations where the parties agree: paragraph 15 of Schedule 7. Steps will also be taken to harmonise the legislation relating to ethics committees across the UK.
42. [Section 120](#) on Trust Special Administration remit extends to England and Wales but applies to England only.
43. [Section 121](#) (Integration Fund) extends to England and Wales but applies to England only. This section amends and inserts a new provision in the National Health Service Act 2006 relating to the National Health Service Commissioning Board and clinical commissioning groups, both of which exercise functions in relation to the health service in England only.
44. Regarding section 122 (Information), subsections concerning the functions of the Health and Social Care Information Centre (HSCIC) under the Health and Social Care Act 2012 apply to England only, as HSCIC currently has functions in relation only to England. However the provisions for the advice to be given to HSCIC by the committee to be appointed by the HRA under paragraph 8(1) of Schedule 7 apply to England and

Wales, as further functions may be conferred on HSCIC in regulations under section 251 of the National Health Service Act 2006. Any implications for Wales in relation to the function described at paragraph 8(1)(c)(i) of Schedule 7 would arise in the context of making of regulations, rather than as a result of this provision, and would therefore be agreed at that point. The implications for Wales would arise as a result of the extent of section 251 of the 2006 Act and the Control of Patient Information Regulations.

***Territorial extent and application: Northern Ireland***

45. Social care is a devolved matter for Northern Ireland so Part 1 in general applies to local authorities in England only. However, the provisions in relation to cross-border placements (section 39(8) and Schedule 1), certain provisions on provider failure (sections 49 to 52) and the Human Rights Act 1998 provision (section 73) extend to Northern Ireland. Certain provider failure duties also apply to Health and Social Care trusts in Northern Ireland.
46. In Part 3, while neither Health Education England nor the Health Research Authority will take on any devolved functions, there are some implications for the devolved administrations in relation to the establishment of these bodies as non-departmental public bodies.
47. Health Education England (HEE) will have a power to exercise any of its education and training functions on behalf of Northern Ireland, but only when it is asked to do so: paragraph 17 of Schedule 5.
48. The provisions on Health Research Authority (HRA) extend to the whole of the United Kingdom. The Act places the HRA and each of the devolved administrations under a duty to co-operate with one another with a view to co-ordinating and standardising the regulation of health and social care research in the UK: section 111(4). The HRA and certain specified bodies which carry out some devolved functions in relation to health and social care research will also be under a duty to co-operate with each other with a view to co-ordinating and promoting regulatory practice: section 111(1) In relation to Northern Ireland, this is the Human Tissue Authority, the licensing authority for the purposes of the Medicines Act 1968 and the Administration of Radioactive Substances Advisory Committee.
49. The HRA will also be able to take on related functions from Northern Ireland where the parties agree: paragraph 15 of Schedule 7. Steps will also be taken to harmonise the legislation relating to ethics committees across the UK.

***Territorial extent and application: Scotland***

50. Social care is a devolved matter for Scotland so Part 1 in general applies to local authorities in England only. However, the provisions in relation to cross-border placements (section 39(8) and Schedule 1), certain provisions on provider failure and the Human Rights Act 1998 provision (section 73) extend to Scotland.
51. In Part 3, while neither Health Education England nor the Health Research Authority will take on any devolved functions, there are some implications for the devolved administrations in relation to the establishment of these bodies as non-departmental public bodies.
52. Health Education England (HEE) will have a power to exercise any of its education and training functions on behalf of Scotland, but only when it is asked to do so: paragraph 17 of Schedule 5.
53. The provisions on Health Research Authority (HRA) extend to the whole of the United Kingdom. The Act places the HRA and each of the devolved administrations under a duty to co-operate with one another with a view to co-ordinating and standardising the regulation of health and social care research in the UK: section 111(4). The HRA and certain specified bodies which carry out some devolved functions in relation to health

and social care research will also be under a duty to co-operate with each other with a view to co-ordinating and promoting regulatory practice: section 111(1) In relation to Scotland, this is the Human Tissue Authority.

54. The HRA will also be able to take on related functions from Scotland where the parties agree: paragraph 15 of Schedule 7. Steps will also be taken to harmonise the legislation relating to ethics committees across the UK.

## **COMMENTARY ON SECTIONS**

### **Part 1 – Care and Support**

#### **General responsibilities of local authorities**

##### ***Section 1 – Promoting individual well-being***

55. This section provides for a set of legal principles, which govern how local authorities are to carry out their care and support functions for adults under this Act.
56. *Subsection (1)* establishes the overarching principle that local authorities must promote the well-being of the adult when carrying out functions under this Part of the Act in relation to that adult. This duty applies both in relation to adults who use services, and to carers. It also applies to children, in relation to the functions set out in sections 58 to 66.
57. The “well-being principle” applies to local authorities (and their officers) when they exercise a function under this Part in the case of an adult. It is not intended to be directly enforceable as an individual right, but to carry indirect legal weight, where a local authority’s failure to follow the principle may be challenged through judicial review.
58. “Well-being” is not defined precisely. However, *subsection (2)* provides guidance on the interpretation of the general duty in subsection (1). It lists outcomes or areas of activity, which develop the concept of well-being. The outcomes are not a series of requirements, but serve as a description to aid understanding.
59. The final element of the statutory principles is provided in *subsection (3)*. This is a list of factors, which local authorities must consider when exercising any function, such as making a decision, about an adult, under Part 1 of the Act.
60. The factors in subsection (3) direct local authorities on a number of issues that they must consider in complying with the general well-being principle. The list of factors is not in order of importance, and the weight afforded to each will differ according to the circumstances of the individual case. Moreover, it is not exhaustive. There may be other factors not listed which are relevant to the well-being of an individual, and which should be considered by decision-makers.

##### ***Section 2 - Preventing needs for care and support***

61. This section requires local authorities to take steps, including providing and arranging for services (“arranging for” may include commissioning from others), which are intended to prevent, reduce or delay needs for care and support for all local people including adults and carers.
62. *Subsection (2)* requires local authorities to have regard to how it could make the best use of community facilities to prevent, delay and reduce needs for care and support; and to have regard to identifying adults and carers in their area who have unmet needs for care and support, when providing or arranging for preventative services under this section.
63. This section is intended to require steps that prevent, reduce and delay needs for care and support. This section relates to other local authority functions in Part 1 of the Act, including duties under sections 4 and 5. Local authorities must give information about



services that can delay, prevent and reduce needs for care and support in their area under section 4, and must shape the market with regards to such services under section 5.

64. *Subsections (3) and (4)* allow for regulations to specify where a local authority may charge for taking steps to prevent, reduce or delay needs for care and support. Any charge made under these regulations can cover only the cost to the local authority of providing or arranging the service. Subsection (3)(b) allows regulations to prohibit charging where subsection (3)(a) would otherwise allow this. This is to allow for local authorities to continue to charge for some preventative services as they do now (for example subsidised leisure services), and to enable local authorities to broaden access to services that can prevent, delay or reduce needs for care and support, that may fall outside of traditional models of care and support, to a wider range of adults and carers in their area. Regulations under section 14 will be used to continue current entitlements to free intermediate care for a specified period and minor aids and adaptations up to a certain cost.
65. *Subsection (6)* acknowledges that a local authority may take steps to prevent, reduce or delay needs for care and support together with one or more other local authorities.

### ***Section 3 – Promoting integration of care and support within health services etc.***

66. This section places a duty on local authorities to carry out their care and support responsibilities (including carer's support and prevention services) with the aim of joining-up services with those provided by the NHS and other health-related services (for example, housing or leisure services). The duty will apply where the local authority considers that integration of services would either promote the wellbeing of adults with care and support needs (including carers), contribute to the prevention or delay of developing care needs, or improve the quality of care in the local authority's area.
67. This section is intended to reflect the similar duties placed on the NHS Commissioning Board (known as NHS England) and clinical commissioning groups by sections 13N and 14Z1 of the National Health Service Act 2006.

### ***Section 4 – Providing information and advice***

68. This section replaces and expands duties in section 1 of the Chronically Sick and Disabled Persons Act 1970, by requiring local authorities to provide an information and advice service in relation to care and support for adults, and support for carers.
69. The service will be available to all people in the local authority's area regardless of whether they have needs for care and support, or whether any needs they do have meet the eligibility criteria. The information and advice service should, where it is reasonable, also cover care and support services that, while physically provided outside the authority's area, are usually available to its local population.
70. *Subsection (2)* sets out the high-level requirements for an information and advice service. This includes an explanation of how care and support operates in the authority's area, how to access it, what services and providers are available, how to access independent financial advice and how to raise concerns about the safety or well-being of a person with care needs. Subject to *subsections (3) and (4)* it will be for local authorities to determine the precise scope and manner of the information and advice they will offer.
71. *Subsection (3)* states that local authorities must have regard to the importance of identifying people who would be likely to benefit from financial advice. They must provide sufficient information and advice to enable adults to consider the financial aspects of meeting their care and support needs and to make plans for how they might meet any future needs for care and support. As part of this, the local authority must seek to ensure that people understand how and where to get financial information and advice on the range of financial options available. For example, the information and advice should cover what people are likely to pay towards their care and support needs,

alert them to potential benefits and financial entitlements, other financial options to help them pay or plan for care and support, including deferred payment arrangements, and where they can access appropriate, independent financial advice on these matters. This supports subsection (2) and the need to include information on how to access independent financial advice.

72. *Subsection (4)* states that information and advice should be accessible to all and provided in a proportionate manner to meet individual circumstances and needs. For example, an information leaflet may be sufficient for some people, for others it may be face-to-face discussion and advice, while some may require more concentrated access to advocacy services.

### ***Section 5 – Promoting diversity and quality in provision of services***

73. This section places a duty on local authorities to facilitate and promote a diverse and high quality market of care and support services (including prevention services) for all people in their local area regardless of who arranges and pays for those services. In particular, local authorities must act with a view to ensuring that there is a range of different services and providers to choose from.
74. *Subsection (2)* lists certain factors a local authority must consider when exercising this duty. These include the importance of ensuring the sustainability of the market and supporting continuous improvement in the quality of services; making available information about the services available to people in its area; facilitating the local market by maintaining awareness of the current and future demand for services in its area, and how this demand can be met by providers; the importance of carers and service users being able to undertake work, education and training; and the importance of fostering an effective workforce capable of delivering high quality services.
75. *Subsection (3)* requires local authorities, when considering current and future local demand and how this might be met by providers, to consider the need for there to be sufficient services to meet the needs of people in their area.
76. *Subsection (4)* requires local authorities to consider, when making decisions about commissioning services, the importance of promoting the well-being of people with care and support needs and carers.
77. *Subsection (5)* requires that the local authority must have regard to the duty when either providing or arranging services to meet the care and support needs of adults with care needs and carers. This is because local authorities' commissioning practices affect the local market of providers.
78. *Subsection (6)* acknowledges that local authorities might work together to exercise this duty. Local authorities might want, for example, to consider the sustainability and diversity of provision across their borders, in order to promote a flexible and responsive market for their local communities.

### ***Section 6 – Co-operating generally***

79. This section requires local authorities and their "relevant partners" (listed in *subsection (7)*) to cooperate with each other in the exercise of their respective care and support functions, including those relating to carers and transition for children with needs to adult care and support. This duty does not confer any new functions but relates to co-operation in the exercise of the respective partners' pre-existing functions relevant to adults with care and support needs and support for carers and children in transition.
80. *Subsection (2)* extends the duty of the local authority to cooperate with its partners to any other person or body who the authority considers appropriate. However *subsection (2)* does not require this person or body to cooperate in return. *Subsection (3)* sets out examples of the types of other persons with whom it may be appropriate for a local authority to cooperate with under *subsection (2)*. This includes but is not limited



to providers of care and support and carer's support services, NHS primary health providers, independent hospitals and private registered providers of social housing.

81. *Subsection (4)* requires the local authority to ensure internal cooperation between its officers: those responsible for adult care and support, housing, public health, and children's services. These officers are employees of the local authority, and are not therefore included in the list of external partners in *subsection (7)*.
82. *Subsection (6)* sets out five aims of cooperation between partners. These are promoting the well-being of adults needing care and support and their carers, improving the quality of care and support for adults and support for carers provided, smoothing the transition from children's to adult services, and protecting adults with safeguarding concerns, whether they are currently experiencing or at risk of abuse or neglect or to investigate past cases of serious abuse or neglect for the purposes of identifying and applying lessons to be learnt. However, the purposes of co-operation are not limited to these matters alone.
83. This section does not require the local authority to take any specific steps to cooperate with relevant external partners, but there are a number of other powers which local authorities may use to promote joint working. For example, local authorities may share information with other partners, or provide staff, services or other resources to partners to improve cooperation. Under section 75 of the NHS Act 2006, a local authority may also contribute to a "pooled budget" with an NHS body – a shared fund out of which payments can be made to meet agreed priorities.

### ***Section 7 – Co-operating in specific cases***

84. This section supplements the general duty to cooperate in section 6 with a specific duty. This duty is intended to be used by local authorities or partners where cooperation is needed in the case of an individual who has needs for care and support. The duty is not limited to specific circumstances, but could be used, for example, when a child is preparing to move from children's to adult services; in adult safeguarding enquiries; when an adult requires an assessment for NHS continuing healthcare; or, when an adult is moving between areas and requires a new needs assessment.
85. *Subsection (1)* states that a local authority may request cooperation from a relevant partner in relation to the case of an individual adult or carer, and the relevant partner must cooperate as requested, unless doing so would be incompatible with the relevant partner's own functions or duties. *Subsection (2)* creates the same duty but in reverse, with the request made by the relevant partner to the local authority.
86. If either the local authority, or the relevant partner, decide not to cooperate after receiving a request, then *subsection (3)* requires them to write to the other person setting out their reasons for not doing so. Local authorities and their relevant partners must respond to requests to cooperate under their general public law duties to act reasonably, and failure to respond within a reasonable time frame could be subject to judicial review.

### **Meeting needs for care etc.**

#### ***Section 8 – How to meet needs***

87. The needs which adults have for care and support will be specific to that individual, and there are many ways in which local authorities can meet such needs. This section is intended to provide some indication of the range of what a local authority can do to meet an adult's needs.
88. *Subsection (1)* lists some general examples of the types of care and support that could be arranged or provided to meet the needs of both adults needing care and carers. This is not intended to be a definition of care and support or an exhaustive list, but to give a partial description for clarity. Local authorities may arrange or provide for any combination or

type of service to meet needs, other than those services which they are prohibited from providing because they fall their outside their care and support functions (see sections 22 and 23). The examples in subsection (1) are applicable both to carers and to adults needing care.

89. In meeting any adult's needs, a local authority may provide a service itself or arrange for a service to be provided by another organisation. The local authority may also make a direct payment in lieu of a service (as detailed in sections 31 and 32), or undertake any combination of these approaches.

## **Assessing needs**

### ***Section 9 – Assessment of an adult's needs for care and support***

90. This section requires a local authority to carry out an assessment, which is referred to as a "needs assessment", where it appears that an adult may have needs for care and support. The objective of the needs assessment is to determine whether the adult has care and support needs and what those needs may be. It is the mechanism by which local authorities assess whether a person requires some form of care and support, and whether the nature of their needs is such that the local authority will be under a duty to meet them (in other words, whether the person has "eligible" needs). Whether or not a person has eligible needs, they will receive tailored information on the services available in their local community to help meet the needs they do have.
91. *Subsection (3)* makes it clear that the local authority must carry out the assessment wherever it appears that an adult may have needs for care and support, whether or not it thinks the adult has eligible needs, and regardless of the adult's financial resources.
92. *Subsection (4)* stipulates that the assessment must consider how the person's needs impact on their well-being and the outcomes that an individual wishes to achieve in day-to-day life: for example, being able to live at home and feed themselves, and whether care and support can help them to meet those outcomes.
93. *Subsection (5)* requires the local authority to involve the adult, any carer they may have, and anyone else the adult may ask to be involved in the needs assessment. Where a person lacks capacity the local authority must also involve any person who appears to be interested in the individual's welfare. The intention is to allow the adult to set the outcomes they wish to achieve and to be fully involved throughout the assessment process. Where the adult would otherwise face difficulty in being involved in the process, for example due to communication problems, and they do not have anyone to support them, the adult will be entitled to the support of an advocate to assist them (as provided for in section 67).
94. *Subsection (6)* requires the local authority to consider whether and to what extent matters other than the provision of care and support could help them reach the outcomes they want to achieve. This might include the adult's own capabilities and what they may be able to do themselves to achieve those outcomes.
95. It also requires local authorities to consider whether the adult would benefit from its prevention or information and advice services (provided under sections 2 or 4) or any other services that might be available in the community. For example the local authority may consider it would benefit the adult to undergo a reablement programme, and this could take place in parallel with the assessment process.
96. The section brings together a number of existing powers and duties to create a single legal basis for assessment, including section 2 of the Chronically Sick and Disabled Persons Act 1970; section 4 of the Disabled Persons (Services, Consultation and Representation) Act 1986 and section 47(1) of the National Health Service and Community Care Act 1990.

### ***Section 10 – Assessment of a carer’s needs for support***

97. This section creates a single duty to assess carers. It requires a local authority to carry out an assessment, known as a “carer’s assessment”, where it appears that a carer may have needs for support at that time, or in the future. The aim of the assessment is to determine whether a carer has support needs either currently or, possibly, in the future and what those needs may be.
98. The duty to assess a carer replaces existing duties in relation to the assessment of adult carers in section 1(1) of the Carers (Recognition and Services) Act 1995 and section 1 of the Carers and Disabled Children Act 2000.
99. A carer is defined as an adult who provides or intends to provide care for another adult. The section makes clear care includes the provision of practical or emotional support. This definition is subject to the proviso that those who care on a contractual or volunteering basis are not considered to be carers for the purposes of this Part. However, if the local authority thinks it is appropriate for such an individual (even if there is a contractual or volunteering element to the relationship) to be treated as a carer, then it may do so.
100. The duty to assess applies regardless of any views the local authority may have about the level of a carer’s needs for support or the financial resources of either the person needing care or the carer. The local authority must involve the carer and any other person nominated by the carer, when carrying out a carer’s assessment.
101. A carer’s assessment must consider certain important factors. These include the carer’s ability and willingness to provide care and support, both now and in the future; the impact of caring on the carer’s wellbeing; and the outcomes that the carer wishes to achieve in day to day life. In carrying out the assessment the local authority must also have regard to whether a carer works or wishes to work, or participates in, or would like to participate in, education, training or recreation.
102. *Subsection (8)* requires the local authority to consider whether and to what extent matters other than the provision of care and support could help the carer reach the outcomes they want to achieve. It also requires local authorities to consider whether the carer would benefit from its prevention or information and advice services or any other services that might be available in the community.

### ***Section 11 – Refusal of assessment***

103. This section sets out what is to happen where an adult or a carer refuses to have a needs or carer’s assessment.
104. Normally if an adult refuses a needs assessment or a carer’s assessment, the local authority need not carry it out.
105. However, the section specifies that there are two situations in which the local authority must carry out a needs assessment even if the adult refuses an assessment:
  - a) if the adult lacks the capacity to agree to an assessment but the local authority is satisfied that an assessment would be in their best interests; and
  - b) if the adult is at risk of harm or financial abuse.
106. Where a person has refused a needs assessment or carer’s assessment and the local authority thinks the circumstances have changed, the duty to carry out an assessment applies, unless the person continues to refuse.

***Section 12 – Assessments under sections 9 and 10: further provision***

107. This section requires the Secretary of State to make regulations about how a needs assessment or a carer's assessment is carried out, to ensure consistent practice in the key elements of the assessment process.
108. The regulations may in particular make provision about matters that a local authority must consider when carrying out an assessment, and about the assessment process, to ensure that it is carried out in an appropriate and proportionate manner. The local authority may be required to have regard to the family needs of the person being assessed, for instance the need to ensure that a child is not undertaking an inappropriate caring role for the adult concerned. Regulations may specify who may or must carry out an assessment, in particular that an expert must carry out the assessment in cases where the adult or carer has a complex condition, including allowing for self-assessment, joint assessments, and for a third party to carry out the assessment on behalf of the local authority. They may also specify when a local authority should refer a person for assessment by the NHS when they believe that the person has NHS continuing healthcare needs.
109. This section also makes clear that a local authority may combine a needs or carer's assessment with some other assessment it is carrying out of the individual or another person, provided that both individuals agree or in the case of a child who lacks capacity or is not competent to agree, provided it is satisfied that combining the assessments would be in the child's best interests. For example, a local authority may combine an assessment of a young carer with the needs assessment of the adult he or she cares for. This section also ensures that a local authority, when carrying out a needs or carer's assessment, may work jointly with or on behalf of another body which is carrying out another assessment of the person or, for example, someone that person is caring for or who cares for that person. For example, if a local authority is carrying out a carer's assessment, and an NHS body is carrying out a continuing healthcare assessment of the person he or she is caring for, the local authority could jointly carry out the continuing healthcare assessment jointly with the NHS body.

***Section 13 – The eligibility criteria***

110. Having carried out a needs assessment or a carer's assessment, this section requires local authorities to determine whether a person's needs are "eligible" needs. In other words, whether they meet the eligibility criteria which are to be set out in regulations. "Eligible" needs are those needs of a level or nature which the local authority may be under a duty to meet. The use of the word "eligible" here refers only to the person's needs, not to their financial resources or other circumstances.
111. As *subsection (1)* sets out, provided that a local authority is satisfied on the basis of an assessment that an individual has any needs, of whatever level, the first requirement following an assessment is for the local authority to establish whether those are needs which the local authority must meet. Everyone will receive a written record of that decision, whether their needs are eligible or not.
112. If the person or carer does have eligible needs, *subsections (3) and (4)* require the local authority to establish the adult's ordinary residence and consider the support (of whatever form) that could be provided to meet those needs.
113. *Subsection (3)(b)* requires the local authority to ascertain whether the adult wants to have their needs met by the local authority. This allows individuals who do not want the local authority to meet their needs to take an independent personal budget (as set out at section 28) and start their care account. This duty is not replicated for carers in *subsection (4)*, as the cap on costs does not apply to carers.
114. Where the individual or carer's needs do not meet the eligibility criteria, *subsection (5)* requires the local authority to provide them with advice on what services are available

in the community to meet the needs they do have and to prevent or delay their need for care and support. This will ensure people are helped to access local services, which may be provided by the local authority or by another organisation.

115. *Subsection (6)* provides for the Secretary of State to set out the eligibility framework in regulations. The regulations will set out how a local authority must go about determining whether an adult's needs meet the eligibility criteria. It provides the power for Secretary of State to set out which needs are "eligible" needs, to enable local authorities to make the determination required in subsection (1).
116. *Subsection (7)* specifies that a person's needs will meet the eligibility criteria if they are of a description specified in the regulations. The regulations will prescribe the minimum level of needs which local authorities must meet, subject to the conditions set out in section 18. Local authorities can decide to arrange services to meet needs at a lower level.

## **Imposing charges and assessing financial resources**

### ***Section 14 – Power of local authority to charge***

117. This section gives local authorities a general power to charge for certain types of care and support, at their discretion.
118. If it does exercise this power, *subsection (4)* stipulates that a local authority may not charge a person more than what it costs it to provide or arrange the care and support. This general power replaces the existing duty on local authorities to charge for care home accommodation set out in section 22(1) of the National Assistance Act 1948, and powers to charge for other types of care and support (including those under section 17 of the Health and Social Services and Social Security Adjudications Act 1983, and section 8 of the Carers and Disabled Children Act 2000).
119. *Subsection (2)* provides that the power to charge is subject to section 15. Section 15(1) stipulates that the local authority cannot charge an adult for meeting needs if the adult has reached the cap on care costs; however section 15(7) makes clear that a local authority can still charge for daily living costs. Therefore, even when someone has reached the cap, they still can be charged if their care includes daily living costs.
120. *Subsection (3)* stipulates that where a local authority makes a charge under *subsection (1)* for meeting a carer's needs by providing care and support to an adult needing care it may not charge the carer.
121. The power to charge extends to all types of care and support, unless regulations state that the specific service must be provided free. Certain services or activities cannot be charged for: for example, needs assessments or carer's assessments. *Subsection (6)* gives examples of how regulations might define the provision of care and support to be provided free of charge. These regulations will replace those made under section 15 of the Community Care (Delayed Discharges etc.) Act 2003.
122. *Subsection (7)* ensures that a person's income does not fall below a certain amount as a result of charging. The amount will be specified in regulations, which could specify different amounts for different circumstances. For example, setting a personal expenses allowance for care home residents or specifying the amount below which the income of a person receiving care and support in their home may not fall.
123. *Subsection (8)* enables regulations to specify cases or circumstances where an adult can be treated as having income that would (or would not) fall below a certain amount as a result of charging. For example, in a case where a local authority would make a notional charge, regulations could ensure that a person who receives a certain welfare benefit is automatically exempt from that charge. This helps protect the person's income while giving greater flexibility to the local authority not to have to carry out a financial assessment where the care package is of low value.



124. When a person has care and support needs but does not qualify for financial support from the local authority, they are still able to request that the local authority arrange the care and support that they require on their behalf. Where the local authority arranges the care and support necessary for that individual, subsection (1)(b) gives the local authority a power to charge a fee to cover the costs of arranging that care and support. However, the local authority may not charge such fees in relation to any types of care and support specified in the regulations under *subsection (6)*.

### ***Section 15 – Cap on care costs***

125. This section establishes a limit on the amount that adults can be required to pay towards eligible care costs over their lifetime. Eligible care costs are the costs of meeting eligible needs that a local authority would meet under section 18. These costs are either specified in a personal budget (under section 26) where the local authority is meeting the person's needs, or in an independent personal budget (under section 28) where the person has decided that they do not want the local authority to meet their needs. *Subsection (1)* restricts local authorities from charging for eligible care costs once the amount of a person's accrued care costs reach the level of the cap.
126. *Subsection (2)* defines what is meant by the costs accrued in meeting eligible needs as being those costs that the local authority would incur if it, or another local authority were to meet the person's needs itself, or, in the case of a person who has an independent personal budget under section 28, what the cost to the local authority of meeting the person's needs would be. *Subsection (3)* defines eligible needs as those that meet the eligibility criteria and are not being met by a carer. Adults must also be ordinary resident, or present in the local authority area to have eligible needs.
127. *Subsection (4)* provides for the level of the cap to be set in regulations, and includes power to set the cap at different amounts for people of different ages. This will allow the cap to be set at different levels for working age adults, and includes the possibility of setting the cap at zero for specified categories of person, for example people who have eligible needs for care and support when they turn 18.
128. When a person receives care and support in a care home, daily living costs such as food and lighting should not count towards an adult's accrued costs; *subsection (6)* ensures that where the costs of meeting a person's needs includes such daily living costs, these will be disregarded when measuring progress towards the cap. *Subsection (7)* allows a local authority to continue to charge for the daily living costs once the adult has reached the cap.
129. *Subsection (8)* provides a regulation making power to set the amount that will be considered as representing an adult's daily living costs.
130. The funding provisions are expected to be commenced in April 2016, and eligible care costs will only start counting towards the cap from the date of commencement of the sections.

### ***Section 16 - Cap on care costs: annual adjustment***

131. This section requires annual adjustments in order to ensure that the level of the cap and an adult's accrued costs keep pace with inflation.
132. *Subsection (2)* ensures that an adult's accrued costs are adjusted by the same measure as the cap, so that if someone was previously 50% of the way towards the cap, then they will remain so after adjustment. *Subsection (3)* specifies the meaning of "average earnings" for the purposes of this section and *subsection (4)* requires adjustment to be considered annually following commencement of the section.
133. *Subsection (5)* makes it clear that the power to set the level of the costs cap in section 15 is not restricted by the annual adjustment.



### ***Section 17 – Assessment of financial resources***

134. This section requires a local authority to carry out a financial assessment if they have chosen to charge for a particular service under the power in section 14. This is in order to determine the individual's contribution towards the cost of the care and support that they require. The rules about how a financial assessment is conducted ensure that such assessments are carried out on a consistent basis.
135. *Subsections (7) to (13)* allow regulations to set rules in relation to financial assessment, including setting the maximum amount of financial resource an adult may have, above which a local authority will not contribute towards an individual's care and support costs, and daily living costs. These provisions replace those in section 22 of the National Assistance Act 1948.
136. The regulations may set rules where the local authority need not carry out a full financial assessment and whether, in these circumstances, the individual needing care and support is entitled to local authority support. This would allow for less detailed financial assessments to be carried out in some situations, and could enable the local authority to meet the needs of people who do not wish to have a full financial assessment, if the authority considers this necessary.

### ***Section 18 – Duty to meet needs for care and support***

137. This section sets out the circumstances when a local authority is obliged to meet an adult's eligible needs for care and support and is the principal individual entitlement to care and support for adults with needs for care and support (the equivalent for carers is provided for in section 20). This replaces a number of duties to provide particular care and support services to adults: sections 21(1), 21(2) and 29(1) of the National Assistance Act 1948, section 2(1) of the Chronically Sick and Disabled Persons Act 1970, and section 45(1) of the Health Services and Public Health Act 1968.
138. *Subsections (1) and (2)* set out the circumstances in which an adult is entitled to care and support to meet their needs where the adult has been assessed by the local authority and has been determined to have "eligible" needs for care and support (this would be decided using the eligibility framework set out in regulations made under section 13).
139. Subsection (1) sets out the preconditions that trigger the local authority's duty to meet an adult's eligible needs for care and support in a case where the adult's accrued costs do not exceed the cap on care costs (see section 15). These are:
- that the adult is ordinarily resident in the local authority area (or has no settled residence in any area, but is living in the local authority area at that time), (provision about ordinary residence is made in section 39); and either:
    - a) that the local authority has either decided not to charge for a particular type of care and support, or is not able to charge. The circumstances in which the local authority does not or may not charge are set out in subsection (6); or
    - b) if it is not such a case, one of the following three conditions is met.
140. *Subsections (2) to (4)* set out the three conditions that trigger the duty to meet eligible needs:
- The first condition is that the adult's financial resources are assessed as being at or below the financial limit set in regulations under section 17. In other words, the adult does not have sufficient financial resources to be able to pay the charge which is assessed as due, although they may be required to make a contribution. The amount of resources required will depend on the type of care and support, and will be calculated following a financial assessment carried out by the local authority (under section 17).

- However, the second condition provides that the adult may request that the local authority meet their needs, even if their resources are assessed as above the financial limit, so that they have to pay for their care in full. That request would trigger the duty on the local authority to meet their needs. Where the adult lacks capacity to make the request, it may be made by someone else acting on their behalf.
  - The third condition is that the adult lacks the mental capacity to arrange care and support, and there is no other person willing or able to arrange that care and support on their behalf. In these circumstances, the duty applies, regardless of other factors such as finances.
141. *Subsection (5)* provides that the local authority is under a duty to meet an adult's needs for care and support which meet the eligibility criteria where the adult's accrued costs exceed the cap on care costs (see section 15) if the adult is ordinarily resident in the local authority area (or has no settled residence in any area, but is living in the local authority area at that time).
142. *Subsection (6)* sets out the circumstances in which there may be no charge for particular types of care and support, for the purposes of subsection (1)(c). These are that:
- regulations prohibit the local authority from charging for the type of care and support being provided by the local authority; or
  - the local authority decides not to charge for the care and support being provided.
143. *Subsection (7)* provides that the local authority is not under a duty to meet any of the adult's eligible needs which are being met at that time by a carer. When conducting the needs assessment and the eligibility determination, the local authority will assess the totality of the adult's needs, regardless of whether a carer is currently meeting any of them. This is sometimes referred to as the assessment being "carer-sighted".
144. However, the local authority is not under a duty to meet any eligible needs which are being met by a carer, because the carer is already doing so. If a carer were to cease providing care and to stop meeting any eligible needs, this would trigger a review of the adult's care and support plan, and may mean that the local authority is required to meet the needs. If the carer has needs for support, they should be entitled to an assessment in their own right, under section 10, and may receive support to meet their eligible needs.

### ***Section 19 – Power to meet needs for care and support***

145. This section provides broad powers to enable local authorities to meet the needs of adults whose needs they are not otherwise required to meet, for instance because the adult is not ordinarily resident, or does not have needs for care and support which meet the eligibility criteria. The local authority must have carried out an assessment in these cases to determine what needs the adult does have, if any.
146. In addition, *subsection (3)* gives a power for local authorities to meet needs in urgent cases, without having first carried out the required assessments. Sometimes, it will be necessary to put in place care and support urgently and there may not be time to undertake a full assessment. In such cases, the local authority must still carry out the assessments, but can do so in due course so as to not delay care and support being put in place.

### ***Section 20 – Duty and power to meet a carer's needs for support***

147. This section sets out the core duty of the local authority to meet a carer's eligible needs for support. This duty replaces the power to provide services to carers in section 2 of the Carers and Disabled Children Act 2000, in respect of those carers who are adults and are providing care for another adult.

*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

148. *Subsections (1) to (5)* set out the different circumstances that may trigger the local authority's duty to meet a carer's needs for support which meet the eligibility criteria. The common requirements are that the adult needing care is ordinarily resident in the local authority's area (or has no settled residence, but is living in the local authority's area at that time); and, that the carer has been assessed by the local authority and has been determined to have eligible needs for support.
149. The application of the remaining "trigger" conditions depend on whether or not the local authority charges for the support or care and support to be provided. The local authority has the power under section 14 to make a charge (unless prohibited by regulations made under that section from making such a charge). However, a local authority may decide (as is usually the case under the current law, in respect of carer's needs) not to exercise that power to make a charge.
150. If a local authority has decided not to charge for support (and, where the care and support is to be provided in the form of care and support to the adult needing care, the adult agrees to its provision), then there are no further conditions, and the duty to meet the carer's eligible needs for support will arise on the basis of the common requirements set out above only.
151. If the local authority does choose to charge for the support to be provided, then one of four additional conditions set out in the section must be met in order for the carer to be entitled to support.
152. These conditions are in turn linked to the question of whether meeting the carer's needs involves the provision of support direct to the carer or whether it involves the provision of care and support direct to the adult needing care. A carer's needs for support may be met by direct provision of support to the carer. Alternatively, as *subsection (7)* acknowledges, a carer's need for support may be met by providing care and support direct to the adult for whom they are caring, for example by providing replacement care to allow the carer to have a break from caring. It does not matter that there may be no duty to meet that adult's needs in their own right. Section 14 makes clear that where the needs are met by providing care and support direct to the adult needing care, the charge may not be imposed on the carer.
153. Where (i) the two common requirements as set out above are met; (ii) there is a charge for meeting the needs; and (iii) one of the relevant conditions, as set out below, is fulfilled, then the duty to meet the carer's eligible needs for support will arise.
154. The first and second conditions both apply where meeting the carer's needs involves the provision of support to the carer. The first condition is that the carer does not have sufficient financial resources to be able to pay any charge which is assessed as due. The second condition is that the carer has sufficient financial resources to pay any charge but nevertheless requests that the local authority meet their needs.
155. The third and fourth conditions both apply where meeting the carer's needs involves the provision of care and support to the adult needing care. The third condition is that the adult needing care does not have sufficient financial resources to be able to pay any charge which is assessed as due, and that the adult concerned agrees to receive such support. The fourth condition is that adult needing care has sufficient financial resources to pay any charge but nevertheless requests the local authority to meet the needs by providing care and support to them.
156. This section also provides a broad power to enable local authorities to meet the needs of carers who are not otherwise eligible, including the provision of care and support to the person needing care, as long as that person agrees. It also acknowledges the situation where a local authority might consider the best way of meeting a carer's needs for support is by providing care and support to the adult needing care but it is not possible to do so (for example, if that adult does not agree to such provision). This section requires

the local authority, as far as it is feasible, to identify some other way of supporting the carer.

***Section 21 – Exception for persons subject to immigration control***

157. This section applies in relation to adults who are subject to immigration control within the meaning of section 115 of the Immigration and Asylum Act 1999. As a result, a local authority may not meet the care and support needs of such an adult which arise solely because the adult is destitute, or because of the physical effects or anticipated physical effects, of being destitute. It replaces existing exclusions set out in: for example, sections 21(1A) and (1B) of the National Assistance Act 1948, section 45(4A) Health Services and Public Health Act 1968.

***Section 22 – Exception for provision of healthcare services***

158. In meeting an adult's needs for care and support, or a carer's needs for support, a local authority may not provide healthcare services which are the responsibility of the NHS. This section sets out the limits on what a local authority may provide by way of healthcare and so, in effect, 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 replaces provisions in sections 21(8) and 29(6) of the National Assistance Act 1948 and section 49 of the Health and Social Care Act 2001.
159. *Subsection (1)* stipulates that a local authority cannot meet care and support needs by providing services of a type which is required to be provided under the NHS Act 2006. Schedule 1, which deals with cross-border placements, provides that this also applies where a local authority is meeting needs by arranging for the provision of accommodation in Wales, Scotland or Northern Ireland. This includes all healthcare services which the NHS is required to provide, for instance primary medical, dental and ophthalmic services, by clinical commissioning groups, the NHS Commissioning Board (known as NHS England), or any other NHS body.
160. However, subsection (1) provides that a local authority may provide some healthcare services in certain circumstances, that is, where the service provided is minor and accompanies some other care and support service which the local authority is permitted to provide and is of a nature that a local authority would be expected to provide. This reflects what has become known as the "quantity and quality test", arising out of the case of *R v North and East Devon Health Authority ex parte Coughlan* [2001] QB 213 ("Coughlan").
161. In the *Coughlan* case, which related particularly to the provision of nursing services, the court considered the effect of the prohibition, in section 21(8) of the National Assistance Act 1948, on a local authority providing health services. As part of its consideration of the question of where the line between local authority services and health services was to be drawn (a line the court concluded was difficult to draw precisely) the court suggested that, as a very general indication, if the nursing services were (i) merely incidental or ancillary to the provision of the service the local authority was under a duty to provide, and (ii) of a nature which a local authority might be expected to provide, then such nursing services could be provided by the local authority. This test, looking at (i) the quantity of the service provided and (ii) the quality of the service provided, has been adopted and developed by the courts as a helpful indicator of the distinction between health and social care provision and it continues to form a fundamental part of the current policy framework underpinning the provision of NHS continuing healthcare.
162. *Subsection (2)* confers power to make provision in regulations about the types of services which may, or may not, be provided by local authorities, and in which circumstances.

163. *Subsection (3)* provides a further restriction, which is that a local authority cannot provide or arrange the provision of nursing care by a registered nurse. This kind of nursing care is something that may only be provided by the NHS.
164. However, *subsections (4) and (5)* provide that the local authority may arrange the provision of accommodation which includes the provision of nursing care by a registered nurse (a term that is defined in *subsection (8)*), provided it has first obtained the agreement of the relevant NHS body (being the body that would be responsible for meeting the cost of that nursing element) or, where it has to arrange the provision of such accommodation as a matter of urgency, provided it obtains the agreement of the relevant NHS body as soon as possible afterwards. The relevant body will usually be a clinical commissioning group. However, as *subsection (9)* acknowledges, it may in certain circumstances be the NHS Commissioning Board (known as NHS England).
165. *Subsection (6)* sets out other matters which may be provided for in regulations. These include detailing the steps which the local authority must take to contribute to an assessment as to whether an adult requires healthcare services and requiring the establishment of a process for dealing with disputes between local authorities and NHS bodies, should there be a disagreement over the responsibility for providing a particular service in an individual case.
166. As this section makes clear, local authorities generally may not provide healthcare services (which are for the NHS to provide under the NHS Act 2006). However, *subsection (7)* clarifies that this section does not prohibit local authorities from doing anything that they, as local authorities, have the power to do under the NHS Act 2006. This includes, in particular, entering into partnership arrangements with NHS bodies under section 75 of the NHS Act 2006.
167. The restrictions imposed by this section also apply where a local authority is doing anything in discharge of its duty under section 2 aimed at preventing, delaying or reducing needs.

### ***Section 23 - Exception for provision of housing etc.***

168. This section sets out the boundary in law between local authorities' care and support functions, and their housing functions. Together with section 22 it replaces provision in section 21(8) of the National Assistance Act 1948.
169. This section prevents local authorities from meeting needs for care and support by doing anything which they or another local authority are required to do under the Housing Act 1996 (to generally provide housing), or under any other enactment added in regulations.
170. This section does not prevent local authorities in their care and support role from providing more specific services (such as housing adaptations), or from working jointly with housing authorities.

### **Next steps after assessments**

#### ***Section 24 – The steps for the local authority to take***

171. This section sets out the steps local authorities must take after carrying out the needs assessment or carer's assessment (and the financial assessment where relevant).
172. *Subsection (1)* requires a local authority which has a duty under section 18 or section 20 or has exercised its discretion under section 19 or section 20 to meet needs for care and support to do the following:
- Prepare a care and support plan for an adult with needs for care and support, or a support plan for a carer (as specified in section 25).



- Inform the adult which of their needs it will meet and where direct payments may be used to meet needs.
  - Help the adult in deciding how to have the needs met.
173. *Subsection (2)* requires the local authority to provide those whose needs it is not required to meet, and has decided not to meet, with the following:
- A written explanation of the reasons why it is not going to meet the needs (e.g.; this could be the adult is ordinarily resident elsewhere, or their needs are being met by a carer).
  - Information and advice in writing on how the adult can meet or reduce their needs independently, including information on how the adult can prevent or delay their needs (unless the adult or carer has received such advice already as required by section 13).
174. *Subsection (3)* applies where the adult has eligible needs for care and support, but the local authority does not have a duty to meet these needs (because, for example, the adult does not want to have their needs met by the local authority). It requires the local authority to prepare an independent personal budget (as required by section 28).

### ***Section 25 – Care and support plan, support plan***

175. This section sets out the information and details which must be specified in the care and support plan (or in the case of a carer, the support plan) provided under section 24.
176. *Subsection (1)* provides that the needs identified in the needs or carers assessment must be specified in the plan and also whether and if so the extent to which the needs meet the eligibility criteria. It requires the plan to specify the needs the local authority will meet and to state how it will meet them, and to specify to which of the various relevant matters covered in the assessment, including the outcomes which the person wishes to achieve in day to day life. It must also include the personal budget for the adult and information and advice about how to prevent, delay or reduce the adult's needs for care and support or the carer's need for support.
177. If the individual's needs are met by a direct payment, *subsection (2)* requires that the plan must specify the needs that will be met by the direct payment, and the amount and frequency of the direct payment.
178. The purpose of *subsections (3) and (4)* is to ensure that all relevant people are involved in the preparation of and agreement to the plan. *Subsection (3)* requires the local authority to involve the adult, any carer they may have, and anyone else the adult may ask to be involved in the development of the care and support plan. Where a person lacks capacity the local authority must also involve any person who appears to be interested in the individual's welfare.
179. *Subsection (4)* requires the local authority to involve the carer, the adult receiving care, and anyone else the adult may ask to be involved in the development of the support plan.
180. *Subsection (5)* requires the local authority to take all reasonable steps to reach agreement with the person for whom the plan is being prepared about how the local authority is going to meet their needs. The local authority may be required to make an advocate available to support the person, see section 67.
181. *Subsection (6)* provides for this by requiring the local authority to have regard to various matters covered by the assessment such as the outcomes of the adult or the carer wishes to achieve.
182. *Subsection (7)* allows the local authority to jointly prepare the plan with another person, including the adult or carer who the plan is being prepared for. *Subsection (8)* requires



the local authority to facilitate the development of the plan by providing such a person with information, resources and access to facilities.

183. *Subsection (11)* allows the local authority to combine a care and support plan or a support plan with any other plan, where those to whom the plans relate agree (or where one of the plans relates to a child who lacks capacity or is not competent to agree, the local authority is satisfied that combining the plans is in the child's best interests). This would allow for a combined care and support plan, for instance to reflect the needs of a family more holistically.
184. *Subsections (13) and (14)* allow regulations to specify circumstances where elements of subsections (1) and (2) do not apply.

### **Section 26 – Personal budget**

185. This section defines a personal budget as a statement and set out the financial information which must be included in the statement.
186. *Subsection (1)* makes clear that the total amount which it costs the local authority to meet the needs which it must or has decided to meet must be set out in a statement and broken down so that the adult can see from the statement the amount if any which the adult must pay towards that cost and the amount if any which the local authority must pay. The amount the adult must pay is calculated on the basis of the financial assessment carried out under section 17.
187. *Subsection (2)* requires the total cost to the local authority of meeting eligible needs which it is required to meet under section 18 to be broken down so that the adult can see from the statement how much of that is attributable to daily living costs. This is because daily living costs do not count for the purposes of working out whether costs accrued in meeting adult's eligible needs have exceeded the cap on care costs, and where they have, this will allow the adult and local authority to distinguish what the adult must pay for their daily living costs and what the local authority must pay to meet the care costs.
188. *Subsection (3)* provides that the personal budget may specify other amounts of public money that are available to the person for spending on matters including those relating to housing, healthcare or welfare.
189. *Subsection (4)* allows regulations to specify costs to be excluded from the personal budget in cases where the local authority decides not to charge, or is restricted from making a charge.

### **Section 27 – Review of care and support plan or of support plan**

190. This section requires the local authority to ensure the care and support plan (or support plan) remains an accurate, up-to-date reflection of the person's needs and the outcomes they wish to achieve and the services arranged to meet these needs and outcomes. This section applies to care and support plans for adults needing care and support, and support plans for carers. The local authority must review the plan on a reasonable request by the adult to whom it relates.
191. *Subsection (2)* states that the local authority may revise the care and support plan, and when doing so must have regard to the outcomes the individual identified in the assessment and other relevant matters identified in the assessment and listed in section 9(4). When revising the plan the local authority must involve the adult, any carer they may have, and anyone else the adult may ask to be involved. Where a person lacks capacity the local authority must also involve any person who appears to be interested in the individual's welfare. *Subsection (3)* places similar requirements on the local authority when reviewing a carer's support plan.
192. *Subsection (4)* states that where the local authority is satisfied that the person's circumstances, for example their needs or finances, have changed in a way that affects

their care and support plan or support plan, the local authority must, where it thinks appropriate, carry out a new needs or carers assessment, and a new financial assessment (or both) and consider whether the person's needs meet the eligibility criteria. The local authority must then revise the care and support plan or support plan as appropriate. This will ensure that the individual's care and support package, and the level to which the local authority contributes to it are up-to-date and in line with the outcomes of the care and support plan review.

193. *Subsection (5)* states that, as with the care and support plan in section 25, the local authority must involve the user of care services and carer and take all reasonable steps to reach agreement with the person for whom the plan is being prepared if there is to be a change in how the person's needs are met.

### **Section 28 – Independent personal budget**

194. This section establishes the concept of independent personal budgets for adults who have eligible needs, and who choose not to have these needs met by their local authority. Such persons will not have personal budgets under section 26 because the local authority is not under a duty to prepare a care and support plan for them, so a separate mechanism is needed to record their care costs for the purposes of measuring progress towards the costs cap.
195. The independent budget is a statement recording how much of the adult's spending on care will count towards the cap. This amount will be equivalent to what it would cost the local authority to purchase care and support that meets their eligible needs.
196. *Subsection (1)* defines the independent personal budget as a statement that shows the amount that it would cost the local authority to meet the adult's eligible needs. The independent personal budget is equivalent to what it would cost the local authority to purchase the care for the individual, if it were doing so under section 18.
197. *Subsection (2)* requires the independent personal budget to specify how much of the total represents daily living costs (see section 15) and the remaining amount of the independent personal budget that is for care costs and therefore contributes towards someone's progress towards the cap. Local authorities are required to keep the independent personal budget under review, and if the person asks for it to be reviewed, must do so if the request is reasonable (*subsection (4)*).
198. If the local authority considers the adult's circumstances to have changed in a way that might affect the independent personal budget, then they must, if appropriate, carry out a new needs assessment and revise the independent personal budget (*subsection (6)*).
199. If an adult refuses a reasonable request to be re-assessed, then their independent personal budget will cease counting towards their accrued costs and the local authority will not have to keep their care account up to date (*subsection (7)*).
200. Following a review, the local authority must notify the adult of the outcome and if the independent personal budget has changed, must explain why (*subsection (8)*).

### **Section 29 – Care account**

201. This section requires local authorities 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 accrued care costs, and progress towards the costs cap.
202. *Subsection (1)* requires the local authority to keep a record of the accrued costs of an adult. It also requires the local authority to inform the adult if the level of accrued costs in their care account reaches the cap.

*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

203. If an adult moves to another local authority's area, the local authority from which the adult is moving must retain the record of their care account up to the point they left for either 99 years, or until they are notified that the person has died (*subsection (2)*).
204. Where the care account includes daily living costs, these must be specified separately (*subsection (3)*).
205. *Subsection (4)* provides a regulation making power that will require the local authority to provide adults with a regular statement of their care account. We anticipate that this will be an annual requirement and will show the adult how they are progressing towards the cap.

### ***Section 30 – Cases where adult expresses preference for particular accommodation***

206. This section provides powers regarding the choice of accommodation, and other matters. It sets out some further factors to be considered when it has been determined that an individual's needs would be best met through the provision of care and support in a care home or other type of accommodation.
207. As *subsection (1)* sets out, regulations may require a local authority to meet an individual's preference for specific accommodation. For example, an individual may want to be in a care home close to a relative in another local authority area. Conditions may be imposed in the regulations, for example, that the local authority is satisfied that the preferred care home is able to provide appropriate care and support to meet the person's needs.
208. In some instances, the local authority may incur additional costs when making arrangements with the preferred care home or other accommodation. An individual, for example, may wish to be placed in a care home that costs more than the amount specified as the cost of meeting the needs in the personal budget. *Subsection (2)* sets out that the regulations may allow the individual, or someone acting on their behalf, to make an additional payment to the local authority to cover the difference between the cost of their preferred accommodation, and the amount specified in the personal budget.

## **Direct payments**

### ***Section 31 – Adults with capacity to request direct payments***

209. As section 8 sets out, a direct payment is one of the ways in which needs may be met. A direct payment is a payment that a local authority can make to an adult to enable that person to arrange care and support to meet assessed eligible needs. This section specifies conditions which must be met to receive a direct payment. It relates to adults who have the capacity to request a direct payment.
210. *Subsection (1)* makes clear that a direct payment may not be made unless the local authority is required to contribute towards the costs of meeting the adult's needs and the adult requests a direct payment to be made to the adult or to someone who is nominated by the adult to receive the direct payment.
211. *Subsection (2)* states that the local authority must agree to the request for and make a direct payment if the four conditions specified in *subsections (4) to (7)* are met (unless provisions in regulations made under section 33 provide otherwise). The four conditions are:
- in *subsection (4)* that the adult must have capacity to make the request for a direct payment, and that any person nominated to receive a direct payment of their behalf must agree to doing so;
  - in *subsection (5)* that the local authority is not prohibited by regulations made under section 33 from meeting the adult's needs by making direct payments to the adult (or person nominated). For example, these regulations may specify that some people

will not be able to receive a direct payment, such as those undergoing some types of drug treatment;

- in *subsection (6)* that the local authority must be satisfied that the adult (or anyone nominated on their behalf) is capable of managing a direct payment, either on their own or with whatever help is available to them (for instance from family members); and,
- in *subsection (7)* that the local authority is satisfied that making direct payments (either to the adult or someone nominated) is an appropriate way of meeting the needs for care and support.

### ***Section 32 – Adults without capacity to request direct payments***

212. This section sets out provisions in relation to adults who lack the capacity to request the local authority to meet some or all of their needs by making a direct payment. The section provides for the local authority to meet the needs of the adult by making direct payments to the authorised person.
213. *Subsection (1)* makes clear that a direct payment may not be made unless the local authority is required to contribute towards the costs of meeting the adult’s needs and an authorised person requests the local authority to meet some or all of the adult’s needs by making a direct payment to the authorised person.
214. By *subsection (2)* the local authority must make payments to an authorised person (defined in *subsection (4)*), subject to any regulations specified under section 33 and provided that the five conditions (set out in *subsections (5) to (9)*) are all met.
215. *Subsection (4)* sets out who is an “authorised person” for these purposes. An authorised person is either: someone who is authorised under the Mental Capacity Act 2005 to make decisions about the adult’s needs for care and support; or a person who the local authority and a person who is so authorised agree is a suitable person to receive the direct payments or; if there is no person authorised under the Mental Capacity Act to make decisions about the adult’s needs for care and support, a person who the local authority considers is a suitable person to whom to make the payment.
216. *Subsections (5) to (8)* set out the conditions which must be met. They include that the local authority: is not prohibited by regulations from making direct payments to the authorised person; is satisfied that the authorised person will use the direct payment in the best interests of the adult to meet their care and support needs; is satisfied that the authorised person is able to manage the direct payment by themselves, or with whatever help they may have available to them; and, is satisfied that making a direct payment to the authorised person is an appropriate way of meeting the adult’s needs for care and support.

### ***Section 33 – Direct payments: further provision***

217. This section makes further provisions about direct payments.
218. *Subsections (1) and (2)* require the Secretary of State to make regulations, which may specify a number of further matters in relation to direct payments.
219. *Subsection (3)* makes clear that that a direct payment must only be used for the purpose of meeting the needs specified in the care and support or support plan.
220. *Subsection (4)* provides that the local authority must stop making direct payments if any of the conditions in sections 31 or 32 are no longer met.
221. *Subsection (5)* allows the local authority to stop making direct payments and to require repayment of direct payments it has already made if there is a breach of any condition imposed by the local authority as permitted by regulations made under *subsections (2)*

(b) and (3) or if the direct payment is not used to pay for the needs specified in the care and support plan.

## **Deferred payment agreements**

### ***Section 34 – Deferred payment agreements and loans***

222. This section provides for deferred payments agreements and loans. A deferred payment is usually made when a local authority is in a position to charge someone for care and support or related services under Part 1 but may also be made to help an adult (for example a person who makes their own care arrangements) to obtain care and support services which are not provided by a local authority under Part 1. In a deferred payment agreement the charges or loan advanced is repaid by the adult or from their estate at a later specified date, or on the happening of a specified event, such as the sale of property. The debt is normally secured against the person's property to ensure repayment. Deferring payment can help people delay the need to sell their home or possessions.
223. *Subsection (1)* provides that regulations may specify when an authority may or must offer someone a deferred payment or loan.
224. *Subsection (2)* makes clear that a deferred payment agreement is an agreement where the sum or part of the sum owed to the local authority does not have to be repaid until a specified time.
225. *Subsection (3)* provides that a deferred payment agreement may include services that are not necessary to meet someone's needs, for example preventive or extra services which may be in addition to the care and support the authority is providing.
226. *Subsection (4) and (5)* allows regulations to be made as to whether a local authority must have, and if so what will constitute security for the deferred payment. Adequate security may include a charge on the individual's property or a guarantee from a third party.
227. *Subsection (6)* makes clear that a "deferred amount" is the amount which the adult does not have to repay until the time specified or determined in accordance with regulations.
228. *Subsection (8)* makes clear that the section also applies to a loan other than a deferred payment agreement which a local authority agrees to make to an adult to assist the adult to obtain care and support. It makes clear that the loan may be for care and support other than that which the authority considers is necessary for the purposes of meeting needs, for example preventive or extra services.

### ***Section 35 – Deferred payment agreements: further provision***

229. The section contains further provisions concerning conditions associated with deferred payments, including interest and administration charges, which may be imposed by regulations made under subsection (1) of section 34.
230. *Subsection (1)* enables regulations to be made to require or allow authorities to charge interest upon a deferred sum, an amount to cover their administrative costs and interest on those costs.
231. *Subsection (2)* enables regulations to be made to specify what costs are administration costs – for example the cost to a local authority of registering a charge at the Land Registry.
232. *Subsection (3)* enables regulations to be made to allow or require a local authority to add any interest or administrative costs to the charges or loan and obtain and specify what will constitute adequate security for the same.



*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

233. *Subsection (4)* makes clear that a local authority may not charge interest at a rate which is higher than any rate specified in regulations.
234. *Subsection (5)* requires regulations to be made so that the adult is permitted to terminate the agreement before the date or occurrence of the event specified in the agreement by giving notice and repaying the sum in full to the authority.
235. *Subsection (6)* allows regulations to make other provision about the duration or termination of the agreement.
236. *Subsection (7)* allows for regulations to be made to address what may happen in a situation where somebody sells or otherwise disposes of property. For example in a case where the agreement provides that it must be repaid when an adult sells their home, regulations might allow the deferred payment agreement to continue rather than to be repaid in cases where a property is sold in order that a new property can be bought as a home for the adult or the adult's partner and that new home can be used as security for the agreement.
237. *Subsection (8)* allows regulations to be made to require authorities to include terms and conditions of a specified type in a deferred payment agreement, to allow local authorities to include such terms and conditions and others which they think are appropriate and to require statements relating to specified matters or in a specified form to be included in the agreement. Regulations under this subsection may provide, for example, that the agreement must contain a term which entitles the adult to receive an annual statement showing the amount they owe under the agreement.
238. *Subsection (9)* allows regulations to be made to enable a local authority to protect or enforce the security it has obtained for the payment of the deferred amount or loan, and for this purpose to make necessary and appropriate amendments to legislation.
239. *Subsection (10)* makes clear that this section also applies to loan agreements.

### ***Section 36 – Alternative financial arrangements***

240. This section provides for local authorities to enter into financial agreements of a similar nature to a deferred payment agreement but without interest charges attached: an 'alternative financial arrangement'.
241. *Subsection (1)* enables regulations to be made to require or allow authorities to enter into an 'alternative financial arrangement' with an adult.
242. *Subsection (2)* defines an alternative financial arrangement as one which is in essence the same as a deferred payment agreement or loan (as set out in section 34) and that achieves a similar effect without charging interest.
243. *Subsection (3)* enables regulations to be made for alternative financial arrangements in relation to any issue on which it is also possible to make regulations for deferred payment agreements (as set out in sections 34 and 35) with the exception of the payment of interest.

### **Continuity of care and support when adult moves**

#### ***Section 37 – Notification, assessment, etc.***

244. This section sets out the duties that local authorities are under when an individual, and potentially their carer, notifies them that they intend to move from one local authority area to another. It seeks to ensure that a person who moves local authority area does so with no interruption to their care.
245. *Subsection (1)* stipulates that the duties on the "first authority" and the "second authority" are triggered when they are notified by an adult who is receiving care and



support that he or she wishes to move local authority area, and the “second authority” is satisfied that their intention to move is genuine.

246. *Subsection (2)* states that these duties also apply to local authorities where the “first authority” is keeping a care account on behalf of an individual who is funding their own care. This will allow for the person’s care account to be transferred to the “second authority”.
247. *Subsection (3)* applies where a person has their care and support arranged by the “first authority” and is residing in a care home in the “second authority’s” area. If that person decides to leave the care home but remain resident in the “second authority’s” area the continuity of care duties apply.
248. *Subsection (5)* sets out the information the “first authority” must provide to the “second authority”. This includes the person’s care and support plan, and where the individual’s carer is moving, their support plan.
249. *Subsection (6)* states that when the “second authority” is satisfied of an individual’s intention to move they are under a duty to carry out an assessment of the needs of that individual, and potentially their carer. This assessment should be carried out before the individual moves. This is the same duty as set out in section 9. *Subsection (7)* requires the “second authority” to take into account the “first authority’s” care and support plan when carrying out their assessment.
250. *Subsection (9)* requires the “first authority” to maintain contact with the “second authority” to ascertain how it is progressing towards putting services in place for the adult, and if necessary their carer, for the day of the move. *Subsection (10)* requires the “first authority” to involve the adult or carer in the contact and keep him or her informed of progress.
251. *Subsection (11)* requires the “second authority” to give the adult a written explanation where it has assessed the adult as having different needs compared with the original care and support plan. *Subsection (13)* places a similar requirement on the “second authority” where the carer’s needs are assessed as different.
252. *Subsection (12)* requires the “second authority” to give an explanation where the cost of providing the care is different.

### ***Section 38 - Case where assessments not complete on day of move***

253. This section applies when the “second authority” has not carried out the assessment required under section 37(6) before the person moves into its area, or has done so, but has not taken the other steps required to meet the adult’s needs. *Subsection (1)* sets out that the “second authority” must meet the needs which the first authority had been meeting, from the day of the adult’s arrival in this area. This will ensure there is continuity of care when an individual, and potentially their carer, move. It is also required to continue to update the person’s care account by the amount set by the “first authority”. Where the “first authority” has not been meeting the adult’s needs under section 18, but has provided an independent personal budget, the “second authority” must only continue the adult’s care account. *Subsection (2)* stipulates that the “second authority” must continue to meet the person’s, and potentially their carer’s, needs until it has carried out its own assessment.
254. *Subsection (7)* provides a power for the “second authority” to recover the costs of care from the “first authority” if it is deemed that the individual moving remains ordinarily resident in the area of the “first authority”.

## **Establishing where a person lives, etc.**

### ***Section 39 – Where a person’s ordinary residence is***

255. The section defines where a person, who is being provided with accommodation to meet their care and support needs, is considered to be “ordinarily resident”. This is to help identify where responsibility lies for funding and/or provision of care.
256. For example, where a person who resides in the area of local authority A (and local authority A funds their care and support) enters a care home in the area of local authority B, their ordinary residence will remain with local authority A. Local authority A therefore retains responsibility for funding their care. They are considered “ordinarily resident” in the area of local authority A during their stay in the care home in local authority B.
257. It is intended that the types of accommodation to which this provision applies will be set out in regulations and for statutory guidance to be available to assist local authorities in deciding where a person is ordinarily resident in complex circumstances.
258. *Subsection (5)* applies the same principle to NHS accommodation. NHS accommodation means accommodation provided as part of the NHS under any relevant NHS legislation. It ensures that a stay in a hospital in England, Scotland, Wales or Northern Ireland will not affect a person’s ordinary residence. This means that their care and support must continue to be provided by the local authority in whose area they were ordinarily resident before their hospital stay.
259. *Subsection (4)* provides that an adult who is being provided with accommodation under section 117 of the Mental Health Act 1983 will be treated as ordinarily resident in the area of the local authority in England or Wales which is under a duty to provide the adult with services by virtue of that section.

### ***Schedule 1 – Cross-border placements***

260. **Paragraph 1** of Schedule 1 makes provision to ensure that where a person in England, who has care and support needs and requires residential accommodation to meet those needs, is provided with that accommodation in another part of the UK by a local authority, generally this does not result in a transfer of that authority’s responsibility for that person. Paragraphs 2 to 4 make similar provision in respect of placements in England of people from Wales, Scotland or Northern Ireland which are arranged under the relevant Welsh, Scottish or Northern Irish legislation. These paragraphs also make similar provision in respect of cross-border placements not involving England i.e. Wales-Scotland, Scotland-Northern Ireland and Northern Ireland-Wales.
261. These provisions support the principle of cross-border placements. The types of accommodation to which these provisions apply may differ for each administration depending on the legislation of each jurisdiction.
262. **Schedule 1** also provides power for regulations to apply these cross-border provisions to specified types of accommodation, for instance supported living placements, and where accommodation is paid for by direct payments. Such regulations would ensure that an individual who arranges cross-border residential accommodation using their direct payment would generally remain the responsibility of their original local authority (or Health and Social Care trust (“trust”) in the case of Northern Ireland) as would individuals who are living in the specified types of accommodation whilst receiving other care and support services from an authority in another administration.
263. If authorities fall into dispute about the application of paragraphs 1 to 4 of Schedule 1 for example if a local authority which has made a cross-border placement falls into dispute with the authority in whose area that person is placed, the authorities involved may request a determination of the dispute to be made. Such determinations would be made by the Secretary of State or the relevant Ministers or Department in Scotland, Wales

or Northern Ireland, depending on the circumstances. Details specifying the dispute resolution process will be set out in regulations and guidance.

264. [Paragraph 6](#) of Schedule 1 enables a local authority or trust to recover the costs of arranging accommodation in England, Wales, Scotland or Northern Ireland from an authority in another of those administrations where the latter was liable to provide the adult in question with that accommodation.
265. [Paragraph 8](#) of Schedule 1 ensures that the general principles of non-transfer of responsibility under paragraphs 1 to 4 of Schedule 1 remain unaffected where the adult in question is provided with NHS accommodation (as defined by section 39(6)).
266. [Paragraph 13](#) of Schedule 1 makes a consequential amendment to the relevant Welsh legislation.
267. [Paragraph 14](#) of Schedule 1 makes transitory modifications to references to the relevant Welsh legislation to deal with the period prior to the commencement of that legislation.

### ***Section 40 – Disputes about ordinary residence or continuity of care***

268. If two or more local authorities fall into dispute about where a person is ordinarily resident, or about a person's continuity of care and support, and cannot resolve the question locally, the local authorities involved may request a determination of ordinary residence to be made by the Secretary of State or a person appointed by the Secretary of State. Details specifying the dispute resolution process will be set out in regulations and statutory guidance. It is intended that the regulations will also set out the procedure local authorities must follow when a dispute occurs when there is a business failure of a provider of care and support who is regulated by the Care Quality Commission.
269. Local authorities may request a review within three months of the original determination being made.

### ***Section 41 – Financial adjustments between local authorities***

270. Following a dispute under section 40, or by some other process, it may become apparent that a local authority has been funding a person's care and support when that person is not in fact ordinarily resident in their area.
271. In such circumstances, section 41 allows for that local authority to reclaim the costs they have paid for that person's care and support from the local authority where they are or were ordinarily resident.
272. This section does not apply where the local authority has chosen to meet the person's needs in the knowledge they are ordinarily resident elsewhere.

## **Safeguarding adults at risk of abuse or neglect**

### ***Section 42 – Enquiry by local authority***

273. This section places a duty on local authorities to make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in its area is at risk of neglect or abuse, including financial abuse. The purpose of the enquiry is to establish with the individual and/or their representatives, what, if any, action is required in relation to the situation; and to establish who should take such action. The duty supplements the existing obligations on other organisations to look after the people in their care effectively, or, in the case of the police, to prevent and respond to criminal activity.
274. *Subsection (1)* provides that the local authorities' enquiry duty applies to adults who have care and support needs (regardless of whether they are currently receiving support, from the local authority or indeed anyone); and who are at risk of or experiencing neglect or abuse, including financial abuse; but are unable to protect themselves. The

eligibility criteria that the local authority sets for services and support are not relevant in relation to safeguarding. Safeguarding enquiries should be made on the understanding of the risk of neglect or abuse, irrespective of whether the individual would meet the criteria for the provision of services.

275. The local authority has a responsibility to make enquiries if the adult is currently in its geographical area of responsibility (whether or not the person is ordinarily resident there).
276. *Subsection (3)* defines “abuse” to include “financial abuse”. The Care Act explicitly refers to financial abuse not because it has a priority status, but for the avoidance of doubt because some definitions of abuse may not ordinarily include this type of abuse.

### ***Section 43 – Safeguarding Adults Boards***

277. This section requires a local authority to establish a Safeguarding Adults Board (SAB), which aims to help and protect individuals who it believes to have care and support needs and who are at risk of neglect and abuse and are unable to protect themselves, and to promote their wellbeing.
278. *Subsection (3)* sets out how the SAB should seek to achieve its objective, through the co-ordination of members’ activities in relation to safeguarding and ensuring the effectiveness of what those members do for safeguarding purposes. An SAB may undertake any lawful activity which may help it achieve its objective. The functions which an SAB can exercise in pursuit of its objective are those of its members.
279. *Subsection (6)* acknowledges that two or more local authorities may establish an SAB for their combined geographical area of responsibility.
280. Further details about SABs are set out in Schedule 2 (see below).

### ***Schedule 2 – Safeguarding Adults Boards***

#### **Membership, etc.**

281. *Paragraph 1* specifies that the core members of the SAB must include the local authority, an appointed representative from each clinical commissioning group (CCG), and the chief officer of police for the SAB’s area. The SAB may include other members that the local authority considers appropriate, after the local authority has consulted the core members of the SAB, as sub-paragraph (2) sets out. The Secretary of State may prescribe other core members of the SAB through regulations.
282. The appointed representative for the CCG or the police may represent more than one CCG or chief officer of police where there is more than one within that SAB’s area. The individual nominated to represent the member on the SAB must be a person whom the member considers to have the required skills and experience. Nominated representatives are required to attend SAB meetings. The local authority must also appoint a chair for the SAB with reasonable skills and experience after consulting the other SAB members.
283. Other than this, there are no particular governance procedures which an SAB must follow, and the SAB can regulate its own procedure.
284. Sub-paragraph (6) sets out that the local authority must act under the guidance issued by the Secretary of State whilst other SAB members must have regard to such guidance.

#### **Funding and other resources**

285. *Paragraph 2* enables the SAB members to contribute financially to the cost of running the SAB. It allows for money from those members to be pooled in a single fund. It also

makes clear that members can provide non-pecuniary resources (such as staff, goods, services or accommodation) in support of the activities of the SAB.

### **Strategic plan**

286. *Paragraph 3* specifies that an SAB must publish for each financial year a strategic plan that sets out how it will meet its main objective and what each SAB member will do to achieve that objective.
287. This plan should, so far as feasible, be developed involving the local community, and the SAB must consult the Local Healthwatch organisation in the development of the plan.

### **Annual report**

288. *Paragraph 4* requires an annual report to be published to account for implementation against the strategic plan described in paragraph 3 and progress on the findings of any Safeguarding Adult Reviews.
289. Sub-paragraph (1) requires the report to describe what the SAB has done during the year to achieve its main objective and its strategy, and how each member of the SAB has helped to implement the strategy. The findings of Safeguarding Adults Reviews concluded that year (whether or not they were started in that year) and actions taken that year in response to Safeguarding Adult Reviews must also be recorded in the annual report. That is either action taken to implement findings or, where a decision has been taken not to implement a finding, then the reason for that decision. The report must also record the total number of ongoing reviews, whether or not they were started in that year.
290. As well as being published, copies of the report must be sent to those people specified in sub-paragraph (2).

### ***Section 44 – Safeguarding adults reviews***

291. This section requires Safeguarding Adults Boards to conduct a Safeguarding Adults Review into certain cases in specific circumstances. The aim of a review is to ensure that lessons are learned from such cases, not to allocate blame but to improve future practice and partnership working, and to minimise the possibility of it happening again.
292. *Subsections (1) to (3)* stipulate that an SAB must arrange for a review where there is reasonable cause for concern about how the SAB, its members or some other person with relevant functions involved in the case worked together and either the adult has died and the SAB knows or suspects that the death resulted from abuse or neglect or the adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect. This does not prevent the SAB carrying out a Safeguarding Adults Review in any other case where they feel it would be appropriate and this is set out in *subsection (4)*. The adult must be in the local authority's area and have needs for care and support (whether or not the local authority has been meeting those needs).
293. *Subsection (5)* specifies that every member of the SAB must co-operate in and contribute to carrying out the review and applying the lessons learnt.

### ***Section 45 – Supply of information***

294. This section provides that, if certain conditions are met, a person or body must supply information to a SAB at its request.
295. Firstly, the information must be requested for the purpose of enabling or assisting the SAB to perform its functions.



296. Secondly, the person or body requested to supply the information must have functions or engage in activities such that the SAB considers it likely to have information relevant to a function of the SAB. This would potentially encompass, for instance, a GP who provided medical advice or treatment to an adult in respect of whom a SAB was carrying out a serious case review, or to a family member or carer of that adult. It would also potentially encompass a person carrying out voluntary work that brought him or her into contact with such an adult or with a family member or carer, or a minister of a church attended by such an adult or by a family member or carer.
297. Finally, either the condition set out in *subsection (4)* or that set out in *subsection (5)* of the section must be met. Subsection (4) relates to the content of the information that may be requested. Subsection (5) effectively enables the onward transmission to a SAB of information that it has previously requested, under the section, to be supplied to a third party, for instance to a NHS body, for collation and onward transmission to the SAB. (But an SAB may request that information be supplied to a third party for collation and onward transmission only if the third party itself is within *subsection (3)*).
298. *Subsection (6)* provides that an SAB may use information provided under this section only for the purposes of its functions.

#### ***Section 46 - Abolition of local authority's power to remove persons in need of care***

299. This section repeals the current power for local authorities to remove people from their homes under section 47 of the National Assistance Act 1948.

#### ***Section 47 – Protecting property of adults being cared for away from home***

300. This section restates the duty originally set out at section 48 of the National Assistance Act 1948, for local authorities to prevent or mitigate loss or damage to the moveable property of adults who have been admitted to a hospital or to a residential care home, and are unable to protect it or deal with it themselves. This duty applies to any tangible, physical moveable property belonging to the adult in question, including pets. The section also re-enacts an offence associated with this duty, found at section 55 of the National Assistance Act 1948, which sets out that any person who obstructs the local authority's exercise of this duty is liable on summary conviction to pay a fine, and provides a defence of reasonable excuse.
301. Local authorities are able to recover from the adult any reasonable expenses incurred in protecting that adult's property.

#### **Provider failure**

302. [Sections 48 to 52](#) set out duties on local authorities in England and Wales and on Health and Social Care trusts in Northern Ireland to meet specified care and support needs of people in their area in the event that a care provider becomes unable to do so because of business failure. In the event of business failure in Scotland, local authorities are required to perform the duties provided for under Part 2 of the Social Work (Scotland) Act 1968 and as specified in regulations under Schedule 1. This would include duties in relation to individuals whose needs are being met under arrangements made by authorities in other countries of the UK.

#### ***Section 48 – Temporary duty on local authority***

303. This section places a duty on local authorities in England to ensure that adults' needs for care and support (or needs for support in the case of an adult who is a carer) continue to be met when there is a business failure of a provider of care and support who is registered with the Care Quality Commission and the provider becomes unable to carry on the regulated care activity in question as a result.



304. *Subsection (2)* requires that the local authority in whose area the failed care provider was meeting needs by carrying on the regulated activity must meet the needs which the provider was meeting immediately before becoming unable to carry on that activity for so long as the authority considers necessary. This subsection also makes clear that the duty to meet needs applies so far as the authority is not already required to do so such as where needs were being met by the provision of services paid for by an individual, or where another local authority was paying for services to meet the needs of an individual (or was making direct payments in respect of those needs). There is no need to apply the duty where the local authority is already required to meet needs because such a requirement does not change simply because there is a business failure of the provider who was meeting the needs.
305. *Subsection (3)* makes clear that the duty in subsection (2) applies regardless of whether the adult is ordinarily resident in the area of the local authority to whom the duty in subsection (2) applies and even if the adult does not have eligible needs and the authority has not carried out a needs, carer's or financial assessment. *Subsection (4)* makes clear that where the local authority is meeting needs under subsection (2), it is not required to carry out any of the assessments referred to in section 9 (needs assessment), 10 (carer's assessment) or 17 (financial assessment) or to determine whether any of the needs meet eligibility criteria. The effect of this is to suspend the provisions of sections 9 to 13 and 17 for the temporary period during which the local authority is meeting needs under section 48. This ensures that the temporary duty to meet needs applies regardless of the results of the relevant assessments so that the provision of a substitute service is not delayed and individuals are not left without the care they need.
306. *Subsection (5)* allows the local authority to charge for needs it meets under subsection (2) except where it meets needs by providing information and advice. It limits charges to the costs incurred in meeting needs.
307. *Subsection (6)* provides that subsection (5) does not apply if section 49 applies (i.e. if the failed service provider was meeting some or all of the adult's needs for care and support or a carer's needs for support under arrangements, or in return for payment made with direct payments, made by a local authority in Wales or Scotland or a Health and Social Care trust in Northern Ireland under the legislative provisions referred to in section 49(1)). This is because in such a case there is provision in section 49(3) for local authorities to recover costs.
308. *Subsection (7)* applies where the individual whose needs the failed provider was meeting is not ordinarily resident in the area of the local authority which has the temporary duty to meet needs and was having their needs met under arrangements made by another local authority in England or was having the care paid for by direct payments provided by such an authority. It requires the local authority which has the temporary duty to meet needs to co-operate with the other local authority in meeting those needs and allows the local authority with the temporary duty to recover from the other authority the cost it incurs in meeting those needs during the temporary period.
309. *Subsection (8)* applies the ordinary residence dispute resolution procedure in section 40 to any disputes between local authorities about the application of section 48 (for example as to the duration of the period for which there is a duty to meet needs).

#### ***Section 49 – Section 48: cross-border cases***

310. This section applies in the cases mentioned in subsections (2) and (3) and imposes certain duties and confers certain powers on local authorities in England in such cases.
311. *Subsection (1)* sets out that section 49 applies where, in cases falling within section 48, the service provider whose business has failed was meeting an individual's needs under arrangements made by a local authority in Wales or Scotland or a Health and Social Care trust in Northern Ireland under the legislative provisions referred to in paragraphs (a) to (c) of subsection (1).

312. *Subsection (2)* sets out that section 49 applies where the failed service provider was meeting the individual's needs in return for payment made with direct payments made by a local authority in Wales or Scotland or a Health and Social Care trust in Northern Ireland under the legislative provisions referred to in subparagraphs (i) to (iii) of paragraph (b) of subsection (2).
313. *Subsection (3)* provides that the local authority in England must, in meeting needs under section 48, cooperate with the authority or trust which made the arrangements or the direct payments and may recover from that authority or trust the cost it incurs in respect of meeting needs which were being met pursuant to those arrangements or purchased with the direct payments. It also allows the authority in England to recover the cost of meeting other needs from the adult – for example needs which the service provider was meeting under separate arrangements made by the adult.
314. *Subsection (4)* provides that any dispute between a local authority in England and an authority in Wales or Scotland or a trust in Northern Ireland must be resolved in accordance with the dispute resolution procedure in paragraph 5 of Schedule 1.

### ***Section 50 – Temporary duty on local authority in Wales***

315. This section places a duty on local authorities in Wales to ensure that adults' needs for care and support (or needs for support in the case of an adult who is a carer) continue to be met when a service provider who is registered under Part 2 of the Care Standards Act 2000 becomes unable to carry on or manage their establishment or agency because of business failure. It only applies in relation to needs which the failed service provider was meeting by providing accommodation or services which were paid for with direct payments, or pursuant to arrangements, made by a local authority in England or Scotland or a Health and Social Care trust in Northern Ireland.
316. *Subsections (1)* and *(2)* make clear that the duty applies where a person who is registered as mentioned becomes unable to carry on or manage their establishment or agency because of business failure and immediately before that was providing the adult with accommodation or other services in Wales, under arrangements made by a local authority in England or Scotland or a Health and Social Care trust in Northern Ireland under the legislative provisions referred to in subparagraphs (i) to (iii) of paragraph (b) of subsection (1), or which were paid for with direct payments made by such an authority or trust under the legislative provisions referred to in subparagraphs (i) to (iii) of paragraph (b) of subsection (2). *Subsection (3)* requires the local authority in Wales in whose area the service was being provided or the accommodation situated to meet the needs which the failed provider was meeting for so long as the authority considers necessary.
317. *Subsection (4)* requires the local authority in Wales, in meeting the adult's needs, to cooperate with the authority or trust which made the arrangements or the direct payments as referred to in subsections (1) or (2) and allows the local authority in Wales to recover the costs it incurs in meeting the needs from that authority or trust.
318. *Subsection (5)* provides that any dispute about the application of this section is to be resolved in accordance with the dispute resolution procedure in paragraph 5 of Schedule 1.

### ***Section 51 – Temporary duty on Health and Social Care trust in Northern Ireland***

319. This section places a duty on a Health and Social Care trust in Northern Ireland which is of equivalent effect to that which applies to a local authority in Wales under section 50. It applies where a person who is registered under Part 3 of the Health and Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 in respect of an agency or establishment becomes unable to carry on or manage their establishment or agency because of business failure and only in relation to accommodation or other

services which were paid for with direct payments, or provided under arrangements, made by a local authority in England, Wales or Scotland.

320. *Subsection (3)* requires the trust in whose area the service was being provided or the accommodation situated to meet the needs which the failed provider was meeting for so long as the trust considers necessary.
321. *Subsection (4)* requires the trust, in meeting the adult's needs, to cooperate with the authority which made the arrangements or the direct payments as referred to in *subsections (1) or (2)* and allows it to recover the costs it incurs in meeting the needs from that authority.
322. *Subsection (5)* provides that any dispute about the application of this section is to be resolved in accordance with the dispute resolution procedure in paragraph 5 of Schedule 1.

### ***Section 52 – Sections 48 and 51: supplementary***

323. This section makes supplementary provision in relation to the duties on local authorities and Health and Social Care trusts set out in sections 48 to 51.
324. *Subsection (1)* sets out that an authority is subject to the duty to meet needs under sections 48(2), 50(3) or 51(3) as soon as it becomes aware of the business failure in question.
325. *Subsection (2)* makes clear that the provisions of section 8 on how to meet needs apply to meeting needs under section 48(2) (thus for example an English local authority can meet needs in any of the ways set out in section 8 and does not have to meet the needs in the way in which they were being met by the failed service provider).
326. *Subsection (3)* makes clear that the provision in the Welsh legislative equivalent of section 8 on how to meet needs applies to meeting needs under section 50(3). There is no such provision for Northern Ireland because there is no provision equivalent to section 8 in Northern Irish legislation.
327. *Subsection (4)* requires that an authority in deciding how it will meet an adult's needs for care and support must involve the adult, their carer, and any person whom the adult asks to be involved, or, if the adult lacks capacity, any person whom the authority considers to be interested in the adult's welfare. *Subsection (5)* makes similar provision for involvement of carers. *Subsection (6)* requires authorities, in involving adults or carers, to take reasonable steps to reach agreement with them about how they should meet needs.
328. *Subsection (7)* makes clear that the restrictions specified in sections 21 to 23 on meeting needs (exception for persons subject to immigration control, exception for provision of health services and exception for provision of housing etc.) apply in relation to the duties on English local authorities to meet needs under section 48(2).
329. *Subsection (8)* applies similar restrictions in Welsh legislation in cases where a local authority in Wales is meeting needs under section 50(3).
330. *Subsection (9)* applies in cases where a failed provider in England is providing the adult with NHS continuing healthcare which is commissioned by a clinical commissioning group which is not in the area of the local authority on which the duty under section 48 falls. It makes clear that the definition of "relevant partner" in sections 6 and 7, which concern cooperation between local authorities and relevant partners, is to be treated as including that clinical commissioning group, even though it is not in the area of the local authority.
331. *Subsection (11)* makes clear that a local authority in England may request from the failed provider, or such other person involved in the provider's business, information

*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

that it considers it necessary to have in order to comply with the temporary duty under section 48(2).

- 332. *Subsection (12)* requires that regulations make provision to interpret references to business failure or to being unable to do something because of business failure.
- 333. *Subsections (13) and (14)* make transitory provision in relation to references to Welsh or Scottish legislation to deal with the period before that legislation comes into force.

## **Market oversight**

### ***Section 53 – Specifying criteria for application of market oversight regime***

- 334. This section deals with the procedures for identifying those providers who are most difficult to replace, and will therefore be subject to financial oversight by the Care Quality Commission (CQC).
- 335. *Subsection (1)* requires that regulations set out the criteria for entry into the CQC's market oversight regime.
- 336. *Subsection (2)* stipulates certain factors which may be regarded for the purposes of setting out the entry criteria. These are the provider's size, its concentration in a particular area or areas, and its level of specialism.
- 337. *Subsection (3)* makes provision for the entry criteria to be kept under review and for the Secretary of State to publish information on how the size, concentration or specialism of a provider and on any other factors considered in setting out the criteria are to be measured.
- 338. *Subsection (4)* sets out that, by regulations, certain providers - who would otherwise, according to the criteria, be subject to financial oversight by CQC - may be exempted from the market oversight regime, or parts of the regime. The circumstances in which such regulations may be made include those in which the Secretary of State is satisfied that certain registered care providers are already subject to a regulatory regime comparable to the market oversight regime (*subsection (6)*).
- 339. Conversely, *subsection (5)* establishes that regulations may specify that the market oversight regime, or parts of the regime, apply, or apply only to the extent specified, to certain providers who would otherwise not fall within the regime.

### ***Section 54 – Determining whether criteria apply to care provider***

- 340. This section sets out that it will be the responsibility of the CQC to identify which providers satisfy the criteria set out for entry into the regulatory regime (*subsection (1)*).
- 341. The market oversight regime will apply to those providers identified by the CQC as meeting the entry criteria (*subsection (1)*) and those providers who are required to comply with the regime, or parts of the regime, by virtue of regulations made under section 53(5). *Subsection (2)* clarifies that the market oversight regime (or parts of the regime) do not apply to such providers identified by regulations made under section 53(4).
- 342. *Subsection (3)* provides that the CQC must inform the providers that satisfy the entry criteria that they are now subject to the market oversight regime. The CQC must also inform those providers who are subject to the market oversight regime by virtue of regulations made under section 53(5) of the same.

### ***Section 55 – Assessment of financial sustainability of care provider***

- 343. This section sets out the duty of the CQC to assess the financial sustainability of those providers which are subject to its regulatory regime with a view to identifying any threats that such providers may face to their financial sustainability. This section also

provides for the CQC's response to situations where it is concerned that a provider's financial sustainability is threatened.

344. *Subsections (2)(a) and (3)* set out that, where the CQC identifies a significant risk to financial sustainability, it can require the provider to develop a sustainability plan. This would set out the provider's plans for mitigating or eliminating the risk. The CQC may require the provider, in developing the plan, to cooperate with it. The final plan may also be subject to the CQC's approval.
345. *Subsections (2)(b) and (4)* allow the CQC, where it identifies a significant risk to financial sustainability, to organise, or require the provider to organise, an independent business review, and charge the costs of the review back to the provider. These costs do not include the administrative costs that the CQC may incur in organising such a review.
346. *Subsection (5)* sets out that regulations may make provision for enabling the CQC to obtain, from certain persons, information which may be helpful to the CQC in assessing the financial sustainability of the provider. The type of information the CQC may need is likely to be information which relates to the finances of the care provider or which relates to the financial position of the particular entity - if the care provider is financially dependent on such entity. The type of person that may be described in such regulations may include companies within the same group as the provider, and companies that hold a significant ownership stake in the provider.
347. *Subsection (6)* provides that regulations may be made about the making of the CQC's assessment of a provider's financial sustainability.
348. *Subsection (7)* sets out that the CQC may consult on how to assess financial sustainability, and publish guidance on the methods it expects to apply in making its assessments.

### ***Section 56 – Informing local authorities where failure of care provider likely***

349. This section sets out that the CQC must inform the relevant local authorities that a registered care provider (within the market oversight regime) is likely to become unable to continue carrying on the regulated activity in respect of which it is registered because of business failure.
350. The CQC will be required to inform all English local authorities which it thinks will be required to carry out the duty under section 48(2) if the provider becomes unable to continue carrying on the regulated activity in question (*subsection (2)*). The CQC is not required to inform local authorities outside of England.
351. *Subsection (3)* sets out that the CQC may require from the service provider, and any other person involved in the provider's business, any information that is necessary in order to assist local authorities in ensuring continuity of care. *Subsection (4)* requires the CQC to share with local authorities any information it has that would assist them in ensuring continuity of care.
352. *Subsection (5)* allows for regulations to make provision as to the circumstances in which the CQC can be satisfied that a registered care provider is likely to become unable to carry on a regulated activity.
353. *Subsection (6)* sets out that the CQC may consult on how it will assess a provider's likelihood of becoming unable to continue carrying on the regulated activity, and publish guidance on how it will make this assessment.

### ***Section 57 - Sections 54 to 56: supplementary***

354. *Subsection (1)* sets out that the CQC's functions of identifying which providers satisfy the entry criteria, and assessing the financial sustainability of care providers, are to be treated as "regulatory functions" of the CQC for the purposes of the 2008 Act. This



establishes that the CQC will be able to rely on its existing powers under the 2008 Act, such as requiring information and explanations from a provider (sections 64 and 65 of the 2008 Act). The CQC will also be able to rely on its enforcement powers, for instance under sections 64(4) and 65(4) of the 2008 Act.

355. *Subsection (2)* sets out that anything which the CQC may do to assist local authorities to ensure continuity of care is to be treated as one of the CQC's "regulatory functions" for the purposes of the 2008 Act. This establishes that the CQC will be able to rely on its existing powers under the 2008 Act.
356. *Subsection (3)* establishes that the CQC may, when imposing requirements on providers as part of exercising the functions set out in sections 54 to 56, rely on sections 17 and 18 of the 2008 Act which provide for the cancellation or suspension of a care provider's registration.
357. *Subsection (4)* provides that the CQC must seek to minimise the burdens it may impose on others in exercising any of its functions under sections 54 to 56.

### **Transition for children to adult care and support, etc.**

#### ***Section 58 – Assessment of a child's needs for care and support***

358. This section provides a duty for local authorities to assess a child's needs for care and support (as provided for by this Part), where it appears to a local authority that the child is likely to have needs for care and support after turning 18 and it considers there is significant benefit to the child in doing so. Children have existing rights to assessment and support under the Children Act 1989, and this provision does not affect those rights.
359. If the child lacks capacity or is not competent to consent to an assessment, the local authority has to be satisfied that carrying it out is in the child's best interests. In any other case, the local authority may not carry out an assessment where the child does not consent to it, but if a child who refuses an assessment is experiencing (or at risk of) abuse or neglect, the local authority must carry out an assessment.
360. A child does not have to be receiving services under children's legislation in order to receive or request this assessment. Similarly, there is no restriction on the age of child assessed, or their proximity to their 18<sup>th</sup> birthday. The local authority must consider, whether the child is likely to have needs for care and support after turning 18 and whether there would be "significant benefit" to the child in undertaking the assessment, so that the authority is able to take all relevant circumstances into account in deciding whether to assess.
361. The purpose of this assessment would be to consider what needs for care and support the child may have after their 18<sup>th</sup> birthday, to support planning for transition to adult care and support. The local authority will therefore assess the child's needs by reference to the adult care and support arrangements, and this power is not intended to be used to assess needs for children's services.
362. Where an assessment is carried out, the information provided to the child or their parent/carer should include an indication of whether they are likely to have eligible needs for care and support after their 18<sup>th</sup> birthday, and advice and information about what can be done to meet eligible needs and what can be done to prevent or delay the development of needs.
363. If the local authority does not comply with a request to carry out an assessment it must explain why in writing and provide information and advice about what can be done to prevent or delay the development of needs.

***Section 59 – Child’s needs assessment: requirements, etc.***

364. This section sets requirements about the assessment of children under section 59 including consideration of the outcomes the child wants to achieve, and whether the provision of care and support will contribute to meeting these outcomes. The section specifies that the assessment must involve the child, the child’s parents and any other person who the child or the child’s parent or carer wants to be involved.
365. The assessment must include an indication of whether the needs identified are likely to be eligible, advice and information about what can be done to meet any of the child’s needs and what can be done to prevent or delay the development of needs for care and support in the future. This information will normally be given to the child; or to their parents where the child lacks capacity to understand their options or express their wishes.
366. Once the young person becomes 18 the local authority must decide whether to treat this assessment as their needs assessment taking into account when the assessment was carried out and whether the young person’s circumstances have changed.
367. As with all assessments, a child’s needs assessment will need to consider whether other matters beyond the provision of services might help the child achieve their desired outcomes or prevent needs arising or increasing (similarly to section 9(6) of the Act).
368. The local authority may combine a needs assessment with any other assessment it is carrying out of the child or another person only if the individuals agree or, if a child to whom an assessment relates lacks capacity or is not competent to consent, the local authority is satisfied it is in the child’s best interests. If carrying out a needs assessment the local authority can also carry out another agency’s assessment of the child or that of another relevant person (provided all parties consent to this) on behalf of the other agency or jointly with the other agency. The provisions relating to this are in section 65.

***Section 60 – Assessments of a child’s carer’s needs for support***

369. This section requires a local authority to assess a child’s carer’s needs for support (as provided for by this Part), when it appears to the local authority that the carer is likely to have needs support after the child turns 18 and it is satisfied that there is significant benefit to the carer in carrying out the assessment.
370. A “child’s carer” is any adult providing care to a child, regardless of whether they are the parent of that child.
371. Child’s carers also have a right to an assessment under section 6 of the Carers and Disabled Children Act 2000, and support would normally be provided under the Children Act 1989, as part of a whole-family approach. However, there may be certain services available only through adult care and support.
372. If a child’s carer refuses an assessment, the local authority is not required to do anything further – although the child’s carer has the right to change their mind later.
373. The purpose of the assessment would be to consider what needs for support the child’s carer may have at the child’s 18th birthday, to support planning for transition to adult care and support. The local authority will therefore assess the child’s carer’s needs by reference to the adult care and support arrangements, and this power is not intended to be used to assess needs for children’s services.

***Section 61 – Child’s carer’s needs assessment; requirements etc.***

374. Assessment of a child’s carer should include assessment of whether the carer is willing and able to provide care to the child and is likely to continue to be willing and able when the child reaches the age of 18.

375. Assessment must include assessment of the outcomes the carer wants to achieve in day-to-day life, whether and to what extent the provision of support will contribute to meeting these outcomes and consideration of whether there are other matters that could help the carer achieve the outcomes. The section specifies that the assessment must involve the carer and any other person who the carer wants to be involved.
376. Once an assessment has been done the carer must be provided with an indication of whether they are likely to have eligible needs for support after the child's 18th birthday, advice and information about what can be done to meet any of the carer's needs and what can be done to prevent or delay the development of needs for support in the future.
377. As with all assessments, such an assessment will need to consider whether other matters beyond the provision of services might help the carer achieve their desired outcomes or prevent needs increasing or arising (similarly to section 9(6) of the Act).
378. The local authority may combine a carer's assessment with any other assessment it is carrying out of the carer or another person only if the individuals agree. If carrying out a carer's assessment the local authority can also carry out another agency's assessment of the carer or that of another relevant person (provided all parties consent to this) on behalf of the other agency or jointly with the other agency. The provisions relating to this paragraph are in section 65.

### ***Section 62 - Power to meet a child's carer's needs for support***

379. This section provides a power for a local authority to meet a child's carer's needs for support. A child's carer's needs will usually be met under section 17 of the Children Act 1989. However, this section allows for additional support to be provided, where appropriate, for instance, because a certain type of support is only available under adult care and support.
380. The section provides that regulations can be made in relation to the exercise of this power.

### ***Section 63 – Assessment of a young carer's needs for support***

381. This section provides a duty for local authorities to assess a young carer's needs for support where it considers the child is likely to have needs for care and support after turning 18 and where there is significant benefit to the young carer in carrying out the assessment. This provision does not affect existing rights to assessment under section 1 of the Carers and Disabled Children Act 2000. A young carer, or a person acting on their behalf, could request an assessment in advance of their 18th birthday, which could indicate to the local authority an appearance of need which would trigger the duty.
382. If a young carer refuses an assessment but is experiencing (or at risk of) abuse or neglect, the local authority must carry out an assessment. It must also carry out an assessment if the young carer does not have capacity or is not competent to consent but it is satisfied that it would be in the young carer's best interests for an assessment to be carried out.
383. There is no prescription about the age at which the local authority must assess. The local authority must consider in all cases whether there would be "significant benefit" to the young carer in undertaking the assessment, so that the authority is able to take all relevant circumstances into account in deciding whether to assess.
384. In judging whether a young carer is likely to have needs for support after they turn 18, this is intended to reflect any need for support, not just those needs that will be eligible after the young carer turns 18. This is similar to the trigger for assessments for carers of adults with care and support needs. When judging whether an assessment would be of 'significant benefit' to the young carer, this is intended to reflect when the assessment should take place.

385. A young carer does not have to be receiving any specific service under children's legislation in order to request this assessment. Similarly, there is no restriction on the age of child for whom the request may be made, or their proximity to their 18<sup>th</sup> birthday. The local authority must consider in all cases whether there would be "significant benefit" in undertaking the assessment, so that the authority is able to take all relevant circumstances into account in deciding whether to assess.
386. The purpose of this assessment would be to consider what needs for support the young carer may have after their 18<sup>th</sup> birthday to support planning for transition to adult care and support. The local authority will therefore assess the child's needs by reference to the adult care and support arrangements, and this power is not intended to be used to assess needs for children's services.
387. Where an assessment is carried out the information provided to the carer should include an indication of whether they are likely to have eligible needs for support on their 18<sup>th</sup> birthday, and advice and information about what can be done to meet eligible needs and what can be done to prevent or delay the development of needs.
388. If the local authority does not comply with a request for an assessment it must explain why in writing and provide information and advice about what can be done to prevent or delay the development of needs.

***Section 64 – Young carer's assessment: requirements etc.***

389. This section sets requirements about the assessment of young carers under section 63, including consideration of whether the young carer is willing and able, both at the time and likely to be so when he or she reaches the age of 18, to provide care to the individual in question. It must also include an assessment of the outcomes the child wants to achieve.
390. Results of an assessment will normally be given to the young carer; or to their parents where the young carer lacks capacity to understand their options or express their wishes.
391. The section specifies who the local authority must involve in the assessment, namely the young carer, the young carer's parents and any other person who the young carer or their parent wants to be involved.
392. When assessing a young carer the local authority must have regard to the extent to which the young person wishes to work or to participate in education, training or recreation.
393. The assessment must include an indication of whether, looking ahead to when the young carer turns 18, the needs identified are likely to be eligible, advice and information about what can be done to meet any of the child's needs and what can be done to prevent or delay the development of needs for care and support in the future.
394. Once the young carer becomes 18 the local authority must decide whether to treat this assessment as their carer's assessment taking into account when the assessment was carried out and whether the young person's circumstances have changed.
395. As with all assessments, a young carer's assessment will need to consider whether other matters beyond the provision of services might help the young carer achieve their desired outcomes or prevent need (similarly to section 9(6) of the Act).
396. The local authority may combine a carer's assessment with any other assessment it is carrying out of the young carer or another person only if the individuals agree. If carrying out a carer's assessment the local authority can also carry out another agency's assessment of the young carer or that of another relevant person (provided all parties consent to this) on behalf of the other agency or jointly with the other agency. The provisions relating to this are in section 65.

***Section 65 – Assessments under sections 58 to 64: further provision***

397. The section includes a power to make regulations about carrying out assessments for children and young carers under these provisions. It also includes provision for the local authority to carry out an assessment of a child jointly with another assessment and specifies that if assessments are to be combined the child must have capacity or be competent to agree to a combined assessment.
398. The local authority may combine a needs assessment with any other assessment it is carrying out of the individual or another person only if the individuals agree or, if a child to whom an assessment relates lacks capacity or is not competent to consent, the local authority is satisfied it is in the child's best interests. So for example an assessment of likely needs after the age of 18 could be included in a young person's education, health and care (EHC) plan, provided for in the Children and Families Act 2014. The EHC offers a joined up assessment for children and young people across education, health and social care. If carrying out a needs assessment the local authority can also carry out another agency's assessment of the child or that of another relevant person (provided all parties consent to this) on behalf of the other agency or jointly with the other agency. For example, if carrying out a child's needs assessment the local authority could carry out a continuing healthcare assessment of his or her carer jointly with the relevant health body.
399. The provisions for assessment in order to plan for transition under sections 58, 59, 60, 61, 63 and 64 apply both to those who are and to those who are not already receiving support.

***Section 66 – Continuity of services under other legislation***

400. A local authority may not provide any care and support under this Part to meet a child's or young carer's needs in advance of their 18th birthday. However, it is possible that on their 18th birthday, adult care and support may not be in place immediately.
401. Where this happens, and the child or young carer has previously been receiving services under section 17 of the 1989 Act or section 2 of the Chronically Sick and Disabled Persons Act 1970, this section provides that the local authority must continue to provide those services until the relevant steps have been undertaken. This is to ensure no gap in provision during the transition to adult care and support.

**Independent advocacy support**

***Section 67 – Involvement in assessments, plans etc.***

402. This section places a duty on local authorities to arrange an independent advocate to be available to facilitate the involvement of an adult or carer who is the subject of an assessment, care or support planning or review process, if that local authority considers that the adult would experience substantial difficulty in understanding the processes or information relevant to those processes or communicating their views, wishes, or feelings.
403. *Subsections (5) and (6)* set out that the duty does not apply if the local authority is satisfied there is an appropriate person to represent the adult, who is not engaged in providing care or treatment to the adult in a professional or paid capacity, and the adult consents to being so represented by that person, or where the adult lacks capacity to consent, the local authority is satisfied that it would be in the adult's best interests to be represented by that person.
404. *Subsection (7)* allows for regulations to specify the arrangements on the provision of independent advocacy including to set out the requirements for an independent advocate, to specify what a local authority has regard to in determining whether an individual would experience substantial difficulties in their involvement in the



assessment, specifying any circumstance in which the exception in subsection (5) does not apply, and making provision as to the manner in which independent advocates are to perform their duties.

### ***Section 68 – Safeguarding enquiries and reviews***

405. **Section 68** places a duty on local authorities to arrange an independent advocate to be available to represent and support an adult who is the subject of an adult safeguarding enquiry or a safeguarding adults review where appropriate, if that local authority considers that the adult would experience substantial difficulty in understanding the processes or information relevant to those processes or communicating their views, wishes, or feelings. The duty does not apply if the local authority is satisfied there is an appropriate person to represent the adult, who is not engaged as that adult's professional or paid care and by whom the adult consents to being so represented, or where the adult lacks capacity to consent, the local authority is satisfied that it would be in the adult's best interests to be represented by that person.
406. The purpose of this section is to ensure that individuals who are the subject of a local authority's safeguarding enquiry or a Safeguarding Adults Review will, where appropriate, have an independent advocate made available to represent and support them so as to enable them to participate meaningfully in those processes.

### **Enforcement of debts**

#### ***Section 69 – Recovery of charges, interest etc.***

407. This section allows authorities to recover as a debt any sums owed, such as unpaid charges and interest. This section replaces sections 22 and 24 of the Health and Social Services and Social Security Adjudications Act 1983 and section 45 of the National Assistance Act 1948.
408. The exception to this is cases where an authority could (in accordance with regulations under section 34) enter into a deferred payment agreement, unless the authority offers someone this option and they refuse (*subsection 2*). This exception is to ensure that a local authority cannot use the debt recovery power as an alternative to entering a deferred payment arrangement.
409. Under *subsection (3)*, sums are recoverable within six years (if they become due following commencement of this section), or within 3 years (if they became due before commencement).
410. When someone misrepresents or fails to disclose any material fact in connection with the provisions in this Part, the authority may recover as a debt, expenditure incurred as a result of the misrepresentation or failure and any sum it would have recovered but for the misrepresentation or failure (*subsection 4*).
411. *Subsection (5)* provides that an authority can recover as a debt the legal and administrative costs it incurs in pursuing that debt.
412. *Subsection (6)* provides a power for regulations to determine the date when a debt becomes due, to specify exceptions to when an authority can recover a debt and to specify when an authority may charge interest on the sum owed, at a rate in accordance with the regulations.

#### ***Section 70 – Transfer of assets to avoid charges***

413. Where a person's needs for care and support have been or are being met by a local authority, the local authority may, under section 14, impose a charge on the person to cover all or part of the cost of meeting the person's needs. If the person has transferred assets to another individual in order to avoid these charges, *subsections (2) and (4)* enable the local authority to recover the lost income from the individual, or individuals.

414. *Subsection (3)* limits the amount the local authority may recover so that it cannot recover more than the individual gained from the transfer.
415. What constitutes an asset and how it should be valued, is set out in *subsections (5) and (6)*.

## **Review of funding provisions**

### ***Section 71 – Five-yearly review by Secretary of State***

416. This section requires the Secretary of State for Health to review how the capped cost system is operating every five years, the results of which can be used to inform decisions on whether to change the level of the cap, or other parameters, such as general living costs, in the system.
417. In reviewing how the cap is operating, the Secretary of State will have to consider how certain factors are having an impact on the capped cost system parameters, such as healthy life expectancy or changes in the way services are delivered (*subsection (2)*). The Secretary of State can commission other people to carry out the review (*subsection (6)*).
418. *Subsection (3)* requires a report of the review to be prepared and published, the report must also be presented to Parliament (*subsection (7)*). *Subsection (4)* requires the first report to be published within five years of the commencement of the section and *subsection (5)* requires subsequent reports to be published within five years of each previous report. This means that there will be a review within any five year rolling period.

## **Appeals**

### ***Section 72 – Part 1 appeals***

419. This section gives the Secretary of State the power to make regulations providing for a process through which appeals may be made against decisions taken by the local authority (in respect of individuals) under Part 1 of the Act.
420. *Subsection (1)* provides that the decisions covered by such an appeal system may include decisions taken under Part 1 prior to the coming into force of the first set of regulations under this section. It is the intention that regulations made under this section will come into force at the same time as the provisions relating to the funding cap, in April 2016. This means there will be a gap between the coming into force of the main provisions of Part 1 in April 2015 and the coming into force of regulations establishing a system under which decisions taken under Part 1 can be challenged. The regulations may therefore provide that such “pre-commencement” decisions may be challenged under the system set up by the regulations, once it is established.
421. The regulations may, in particular, make provision about the various matters set out in *subsection (2)* and expanded on in *subsections (3) to (6)*. These matters include provision about who may bring an appeal; the grounds upon which an appeal may be brought; how an appeal is to be dealt with; who may consider an appeal; the matters that must be taken into account in considering an appeal; the powers of the person or body deciding the appeal and the action the local authority must take as a result of an appeal decision. The regulations may also make provision around publicising the right to bring an appeal and the relevant procedures and about representation and support for someone who wants to bring an appeal. The regulations may also make provision around investigating the way the person or body deciding the appeal carries out that function.
422. *Subsection (7)* enables provision to be made concerning the interaction of the Part 1 appeal system with other appeal or complaint systems. This would enable matters raised

in such other system to be treated as, or considered with, an appeal brought under the Part 1 appeals system or, conversely, a matter raised under the Part 1 appeals system to be taken into account in some other appeal or complaint system.

423. *Subsection (8)* provides that the regulations may confer a function on a person or a statutory body. If it is necessary, in order to do so, the regulations may amend, repeal or revoke an enactment or provide that an enactment applies with modifications. If the regulations amend or repeal an Act of Parliament, or apply an Act with modifications, section 125(4)(k) provides that the regulations would have to be made using the affirmative procedure. The first exercise of the powers in this section will require the use of the affirmative procedure.
424. *Subsection (9)* provides that the regulations may make provision for interim care and support from the local authority for the person bringing the appeal pending their appeal being considered. The regulations may also provide for financial readjustments once the outcome of the appeal is known.

## **Miscellaneous**

### ***Section 73 – Human Rights Act 1998: provision of regulated care or support etc to be public function***

425. *Section 73* makes explicit that registered care providers, when providing adults with either personal care in their home or accommodation with nursing or personal care, which has been arranged or funded by a public authority pursuant to specific duties and powers, are exercising a function of a public nature for the purposes of the Human Rights Act 1998. It extends to the whole of the UK.
426. A registered care provider in England is a person registered under Chapter 2 of Part 1 of the Health and Social Care Act 2008. A registered care provider in Wales is a person registered under Part 2 of the Care Standards Act 2000. In Scotland, the equivalent to a registered care provider is someone who provides a care service which is registered under section 59 of the Public Services Reform (Scotland) Act 2010. A registered care provider in Northern Ireland is a person registered under Part 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

### ***Section 74 – Discharge of hospital patients with care and support needs***

427. This section introduces the provisions about delayed discharges which are set out in Schedule 3 (see below).

### ***Schedule 3 – Discharge of hospital patients with care and support needs***

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

## **Cases where hospital patient is likely to have care and support needs after discharge**

429. *Paragraph 1* places responsibility on the NHS body to inform the relevant local authority of a patient's likely need for care and support. This is known as an 'assessment notice' and is necessary when the patient is unlikely to be safely discharged from hospital without arrangements for care and support being put into place first. The relevant local authority who the NHS body must notify is the one in which the patient

is ordinarily resident or, if it is not possible to determine ordinary residence, the local authority area in which the hospital is situated.

430. The paragraph sets out a number of requirements for the assessment notice:
- The notice must state that it is given under this provision. This is so that the local authority is aware of the consequences that could flow from the assessment notice, such as the liability to pay the NHS body for the costs of delayed discharge arising under [paragraph 4](#) of this schedule.
  - The notice should not be issued more than 7 days before the patient is expected to be admitted into hospital. This is so the notice is not provided too far in advance of admission to avoid the risk of wasting preliminary planning in the event the patient's condition changes.
  - The responsible NHS body must consult with the patient and, where appropriate, the carer before issuing the assessment notification. This is to avoid unnecessary assessments where, for example, the patient wishes to make private arrangements for care and support.
431. These requirements replicate provisions set out in sections 2 and 3 of the 2003 Act and regulation 4(4) and (5) of the [Delayed Discharges \(England\) Regulations 2003 \(S.I. 2003/2277\)](#).

#### **Assessment notice given by responsible NHS body to local authority**

432. [Paragraph 2](#) sets out the process that the responsible NHS body and relevant local authority must follow to ensure a patient with care and support needs can be safely discharged from hospital.
433. There are certain legal obligations that are activated by the discharge of the patient from NHS care. When such a decision has been made and the patient has (or may have) care and support needs, then a safe discharge cannot occur until the NHS and local authority are satisfied that, as sub-paragraph (1) sets out, the patient is ready for discharge and that it is safe for them to be discharged. The NHS body has to give the local authority notice of when it intends to discharge the patient. This is known as a discharge notice.
434. Sub-paragraph (3) provides that the discharge notice must specify whether or not the patient will receive any further health care services upon discharge, and if so, what those services will be.
435. Sub-paragraph (5) sets out the definition of the 'relevant day' until which a discharge notice remains in force. This is relevant to defining any delayed discharge period in the event that the local authority is held to be liable under paragraph 4 to pay the NHS body for the cost of accommodation or personal care caused by the delayed discharge from hospital. The 'relevant day' would either be the day specified in the discharge notice or the end of a period which regulations may set out.
436. This replicates the provisions set out in section 5 of the 2003 Act and regulation 5 of the [Delayed Discharges \(England\) Regulations 2003 \(S.I. 2003/2277\)](#).
437. [Paragraph 3](#) sets out the responsibilities of the local authority who received an assessment notice. The local authority must carry out an assessment of the patient's need and, where applicable, the carer's need, with a view to identifying the care and support that is necessary for them to be safely discharged. The local authority must inform the NHS of the outcome of the assessment.
438. This replicates the provisions in section 4 of the 2003 Act.

### **Cases where the discharge of the patient is delayed**

439. *Paragraph 4* sets out what is to happen if the discharge of the patient is delayed because the local authority has not carried out the relevant care and support assessments or put the required package of care and support in place.
440. Sub-paragraph (2) provides that the local authority is liable to make payments to the responsible NHS body for each day that a patient is unable to be discharged.
441. Regulations will be introduced to set out:
- how the delayed discharge period is to be calculated; and
  - the amount to be paid.
442. This section replicates provisions set out in sections 6 and 7 of the 2003 Act.

### **Delegation to management of independent hospital**

443. *Paragraph 5(1)* provides that an NHS body may make arrangements with others for the person to do anything which is required or authorised to be done by the NHS body under this Schedule. Sub-paragraphs (2) and (3) set out the effect of such an arrangement. This replicates sections 1(3), (4) and (5) of the 2003 Act.

### **Adjustments between local authorities**

444. *Paragraph 6* allows for regulations to be made to modify the provisions relating to delayed hospital discharges where it appears to the NHS body that the patient is ordinarily resident in the area of another local authority. This might require the local authority to accept assessment notices even in cases where it may wish to dispute that it is the relevant local authority. The regulations may also enable the local authority to recover relevant expenditure that it incurs. This re-enacts section 10 of the 2003 Act.

### **Meaning of “hospital patient”, “NHS hospital”, “NHS body”, etc.**

445. *Paragraph 7* sets out the meaning of a number of terms relating to the delayed discharges regime in Schedule 3.

### **Section 75 – After-care under the Mental Health Act 1983**

446. *Section 75* clarifies the meaning of after-care and makes minor amendments to section 117 of the Mental Health Act 1983 (the 1983 Act). The changes remove anomalies in determining the responsible local authority in relation to the provision of after-care services under the 1983 Act to people who have been detained in hospital for treatment of mental disorder and the provision of care and support services to which the Act applies. This section also inserts new section 117A into the 1983 Act. This allows regulations to be made which enable a person to express a preference for particular accommodation to be provided under section 117. Schedule 4 makes a number of modifications to the application of certain provisions of the Act to enable direct payments to continue to be made in respect of section 117 services.
447. *Subsection (1)* of section 75 clarifies that local authorities may commission as well as provide section 117 services. Consequent upon the amendments made by subsection (1), *subsection (2)* preserves the effect of section 117(2D) that a clinical commissioning group is under a duty to commission rather than provide section 117 services.
448. *Subsections (3) and (4)* apply the ordinary residence rules to section 117 in order to avoid anomalies which can currently arise where one local authority is responsible for commissioning section 117 services whilst another commissions any other services a person may need. They apply consistent after-care ordinary residence rules in England and Wales, in particular, in relation to which health body and local authority are



*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

responsible for commissioning after-care services. One benefit of this will be to empower the Secretary of State to resolve disputes as to which authority is liable to commission section 117 services, which can currently only be resolved through the courts. The Secretary of State and the Welsh Ministers will publish arrangements for determining cross-border disputes.

449. *Subsection (5)* inserts a definition of “after-care services” for the purposes of section 117. It makes clear that section 117 services must meet a need arising from or related to the person’s mental disorder. Additionally, the purpose of these services must be to reduce the risk of deterioration in the person’s mental condition and, accordingly, to reduce the risk of the person’s re-admission to hospital for treatment for mental disorder.
450. The definition of after-care services is nevertheless broad. For example, after-care can encompass health, social care and employment services, supported accommodation and services to meet the person’s wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular patient’s mental disorder, and help to reduce the risk of a deterioration in the patient’s mental condition.
451. *Subsection (6)* inserts a new section 117A into the 1983 Act. This empowers the Secretary of State to make regulations to place a duty on a local authority to enable a person who qualifies for accommodation under section 117 to live in accommodation of their choice, provided that conditions specified in the regulations are met. This may involve the person themselves or another person paying some or all of the additional cost.
452. *Subsection (7)* provides that a local authority may exercise its duty under section 117 by making direct payments, and for that purpose Part 1 of Schedule 4 has effect.
453. As a consequence of the amendments to section 117 as it applies to Wales, *subsections (8), (9) and (10)* amend the Social Services and Well-being (Wales) Act 2014 (“the Wales Act”). *Subsection (8)* inserts a new section 53(11) in the Wales Act to provide that a local authority in Wales may discharge its duty under section 117 by making direct payments, and *subsection (9)* inserts a new Schedule A1 to the Wales Act for that purpose. *Subsection (10)* inserts a new section 194(4A) in the Wales Act to provide that an adult will be treated as ordinarily resident in the area of the local authority in England or Wales in which that person is being provided with accommodation under section 117 of the Mental Health Act 1983. *Subsection (11)* updates the references to legislation in section 117(2C) under which direct payments for mental health after-care services may be made.
454. *Subsection (12)* provides that the changes to the commissioning responsibility made by subsections (3) and (4) will not apply where a person is already in receipt of section 117 services when these changes come into force. The current authority will remain responsible for commissioning those services for as long as the person concerned continues to need them.

#### ***Schedule 4 – After-care under the Mental Health Act 1983: direct payments***

455. **Part 1** of Schedule 4 modifies the application of certain direct payments provisions of the Act (sections 31, 32 and 33) to make sure they also apply to services provided or commissioned under section 117 by local authorities in England. **Part 2** inserts Schedule A1 (direct payments: after-care under the Mental Health Act 1983) into the Social Services and Well-being (Wales) Act 2014, which modifies the application of certain direct payments provisions of that Act (sections 50, 51 and 53) to apply to services provided or commissioned under section 117 by local authorities in Wales.

***Section 76 - Prisoners and persons in approved premises etc.***

456. This section sets out the responsibilities for provision of care and support for adult prisoners and people residing in approved premises (which includes bail accommodation). Where it appears to a local authority that adults in prison or approved premises may have needs for care and support, the local authority will be under a duty to assess their needs under section 9 and where they have needs which meet the eligibility criteria, may be under a duty to meet those needs. This will provide consistency of approach between institutions and ensure prisoners and residents in approved premises receive services equivalent to people with similar needs in the community.
457. *Subsections (1) and (2)* of section 75 make clear that the local authority in whose area a prison, or approved premises, is located will be responsible for providing assessments and meeting care and support needs for the residents of those custodial settings. A detainee's previous ordinary residence will not be a consideration while they are in these settings, and responsibility will fall to the local authority in whose area the prison or approved premises are located without reference to the general ordinary residence criteria.
458. *Subsection (3)* applies the same principle where an adult is required to reside in any other premises as a condition of bail, so that responsibility will fall to the local authority in whose area the premises are located.
459. *Subsection (4)* makes clear that prisoners and those in approved premises will not be able to express a preference for particular accommodation except where the individual is being released into the community. The duty for local authorities to protect property will not apply to the property of adult prisoners and residents in approved premises with care and support needs whilst in custody.
460. *Subsection (5)* makes clear that sections 31 to 33 on the provision of direct payments do not apply to prisoners or residents in approved premises, except those who have not been convicted of an offence, for example some people in bail accommodation. Prisoners and residents in approved premises who have been convicted of an offence will not be eligible to receive direct payments for the costs of their care and support.
461. *Subsection (6)* covers continuity of care for prisoners and those in approved premises whose needs for care and support are being met by a local authority. The continuity provisions in sections 37 and 38 will apply to prisoners and residents in approved premises being moved between different custodial settings and on release to the community.
462. *Subsection (7)* also makes clear that the duties for local authorities to carry out adult safeguarding enquiries and to protect property do not apply to people in prison or approved premises.
463. *Subsection (10)* makes clear that governors and officers of a prison will not be required by regulations to become members of Safeguarding Adult Boards. However, it does not prevent a Safeguarding Adult Board from inviting governors and officers of a prison to become members by virtue of Schedule 2 paragraph 1(2)). By virtue of *subsection (11)*, this also extends to young offender's institutions, secure training centres and secure children's homes.
464. The eligibility framework will apply to prisoners and residents in approved premises.
465. Youth offenders with care and support needs should receive the same transition procedures to adult care and support as young people in the community. A request for an assessment can be made on the youth offender's behalf by the professional responsible for their care in the Young Offenders' Institution, Secure Children's Home or Secure Training Centre.

466. Charging arrangements for care and support services received by prisoners will be the same as for people in the community.
467. *Subsection (14)* makes clear that someone who is temporarily away from their prison or approved premises, such as for visits to hospital, is deemed to be still detained in that prison or residing in those approved premises whilst away. This means, for example, that if someone is receiving care or support from the local authority in which their prison is based and they are temporarily in hospital in the area of a different local authority, the responsibility for providing the support does not change local authorities.

### ***Section 77 – Registers of sight impaired adults, disabled adults, etc.***

468. *Subsection (1)* sets out the requirement on local authorities to establish and maintain a register of people who are ordinarily resident in their area and are sight impaired. This replaces the requirement on local authorities to maintain registers of disabled people under section 29(4)(g) of the National Assistance Act 1948.
469. There is no legal definition of “sight impairment”, but clinical guidelines make it clear that someone can be certified as sight impaired if they are “substantially and permanently handicapped by defective vision caused by congenital defect or illness or injury”.
470. *Subsection (2)* allows for regulations to describe what “sight impairment” and “severe sight impairment” mean for the purposes of compiling a local authority register.
- Subsection (3)* gives local authorities the option to establish and maintain registers of people living in their area who require care and support or who might in the future. This section will allow those people whose needs may change over time to be accurately recorded – for instance, to take account of an individual with a progressive neurological condition who may need care and support at some point in the future.
471. *Subsection (4)* defines the categories of people who might be included in these voluntary general registers.

### ***Section 78 – Guidance, etc.***

472. This section provides a power for the Secretary of State to issue guidance to local authorities about how they exercise their functions under this Part of the Act. It has been drafted with the intention that this guidance will have the same legal effect as guidance issued under section 7 of the Local Authority Social Services Act 1970. Like section 7, the provision requires local authorities to “act under the general guidance of the Secretary of State”. The Courts have interpreted this to mean that local authorities must “follow the path charted by the Secretary of State’s guidance, with liberty to deviate from it where the local authority judges on admissible grounds that there is good reason to do so, but without freedom to take a substantially different course” (*R v Islington LBC ex parte Rixon* [1997] 1 CCLR 119 at 123).
473. **Section 7** continues to apply in relation to guidance about the exercise of all other social services functions.
474. *Subsection (2)* requires the Secretary of State to consult relevant persons including stakeholders before issuing guidance under this section. *Subsection (3)* requires the Secretary of State when issuing guidance or making regulations under this Part to have regard to the general duty of local authorities to promote individual well-being.

### ***Section 79 – Delegation of local authority functions***

475. This section provides a power for local authorities to authorise a third party to carry out certain care and support functions.

476. However, certain functions are excluded from this power. *Subsection (2)* sets out the functions which are excluded, and which therefore may not be delegated to a third party.
477. *Subsection (4)* provides that that the local authority may determine the extent to which it delegates the function in any particular case. For example, a local authority may delegate the carrying out of all needs assessments to a third party organisation, or it may choose to delegate assessments only for certain groups of people, but carry out other assessments itself. When delegating any function, the local authority may impose conditions on the way the third party may exercise the function.
478. *Subsection (5)* provides that any authorisation is only for the period specified in the authorisation and the local authority may revoke the authorisation at any time during that period. Delegating the function does not prevent the local authority from being able to carry out the function itself.
479. *Subsection (6)* makes clear that anything done (or failed to be done) by the third party in carrying out any function delegated to them is treated as done (or not done) by the local authority itself (though as *subsection (7)* makes clear this does not mean that the third party can avoid liability for any criminal actions nor for any disputes between it and the local authority arising out of any contractual relationship between them). This means that the delegation of any function does not absolve the local authority from ultimate responsibility for ensuring the function is carried out properly and in accordance with all relevant statutory obligations.
480. *Subsection (8)* makes provision permitting the disclosure of information between the local authority and anyone to whom it has delegated a function under this provision (even where such disclosure would otherwise be unlawful) where such disclosure is necessary for the exercise of that function. It does this by applying the provisions of Schedule 15 of the Deregulation and Contracting Out Act 1994 to any delegation made under this provision. Schedule 15 of the 1994 Act contains detailed provisions governing the disclosure of information in cases such as this (where a function is delegated to a third party). The effect is that the third party may be given information by the local authority where it is necessary for the exercise of the delegated function but the third party is then subject to the same kind of confidentiality requirements in respect of that information as was the local authority.
481. This section includes an order-making power to enable the Secretary of State to change the list of functions to which this power applies, and also to impose conditions and limitations on the exercising of the power.

## **General**

### ***Section 80 - Part 1: interpretation***

482. This section provides an index of defined expression in respect of terms used in Part 1 of the Act.

## **Part 2 – Care standards**

### **Quality of Services**

#### ***Section 81 – Duty of candour***

483. **Section 81** amends section 20 of the 2008 Act (regulation of regulated activities), by inserting a new subsection (5A). This new subsection provides that regulations made by the Secretary of State under section 20 must include a duty of candour on providers of health care and adult social care services registered with the CQC.
484. This duty will mean that such providers will be required to ensure that patients and service users are told when something unexpected or unintended occurs in the course

of their care or treatment, helping to ensure that honesty and transparency are the norm in every organisation overseen by the CQC. The details of the duty, including when it will apply and what information is to be given to patients or service users, will be included in the regulations.

### ***Section 82 – Warning notice***

485. This section makes amendments to the powers of the Care Quality Commission (CQC) to issue warning notices to NHS trusts and NHS foundation trusts.
486. Warning notices under section 29 of the 2008 Act will no longer be able to be issued to NHS Trusts and NHS foundation trusts (*subsection (1)*). Instead, where it appears to the CQC that the quality of health care services provided by a trust requires significant improvement, the CQC will be able to highlight these areas in a new form of warning notice. This notice will be given under a new section 29A of the 2008 Act (*subsection (3)*).
487. The new warning notice will state the reasons for the CQC's view that significant improvement is needed and require that improvements in the quality of services are delivered within a specified time. If the notice deals with multiple failings, the CQC will be able to specify a different time period for improvement in relation to each failing. The CQC will not prescribe the action that is to be taken to address significant failures in the quality of health care services.
488. At the end of the time period specified in the notice (or, where the notice specifies more than one time period, the latest of the specified periods) the CQC must review whether the requirements specified in the notice have been met. Where the CQC is not satisfied that the requirements have been complied with it must review what, if any, further action to take in respect of the trust. In the case of an NHS foundation trust, the CQC's review must include use of its power to require Monitor to put the trust into special administration under section 65D(2) of the National Health Service Act 2006.

### ***Section 83 – Imposition of licence conditions on NHS foundation trusts***

489. This section amends section 111 of the Health and Social Care Act 2012 (imposition of licence conditions on NHS foundation trusts) (the 2012 Act) to extend Monitor's powers to be able to impose additional licence conditions on foundation trusts. Monitor will be able to impose additional licence conditions on a foundation trust when the CQC has issued a warning notice to that trust requiring it to make a significant improvement to the quality of the health care provided by it (*subsection (2)*). At present Monitor can only make use of these powers if there is a failure in governance of a foundation trust.
490. Where there was a breach of any such additional licence conditions by the NHS foundation trust concerned, Monitor's powers to suspend or remove directors or governors under section 111(5) of the 2012 Act would also apply (*subsection (3)*). In the event of health care services provided by the trust requiring significant improvement, Monitor will, as a result, be able to take timely action to make changes to leadership or governance with the intention of securing improvements to those services.

### ***Section 84 – Trust special administration: appointment of administrator***

491. This section amends section 65D of the National Health Service Act 2006 (NHS foundation trusts: appointment of trust special administrator). The amendment will enable Monitor to make an order to authorise the appointment of a trust special administrator where it, or the CQC, is satisfied that there is a serious failure by an NHS foundation trust to provide health care services of sufficient quality and it is appropriate to make the order (*subsections (2) and (3)*). At present Monitor is only able to authorise the appointment of a trust special administrator in cases of insolvency.



492. Monitor may make an order when it is so satisfied, but must make the order when required to do so by the CQC.
493. Before requiring Monitor to make an order for the appointment of an administrator, the CQC will need to consult first the Secretary of State and Monitor, and then the foundation trust, the NHS Commissioning Board (known as NHS England) and any other person, for example a clinical commissioning group, to which the foundation trust provides services (*subsection (4)*).

### ***Section 85 – Trust special administration: objective, consultation and reports***

494. This section amends provisions in Chapter 5A of Part 2 of the National Health Service Act 2006 (in relation to trust special administrators for NHS foundation trusts) to bring within coverage the quality and safety of health care services. To achieve this, the objective of trust special administration, as laid down in section 65DA, has been broadened to include an additional requirement for the services, whose continuous provision is to be secured through special administration, to be of sufficient safety and quality (*subsection (1)*). The objective will apply to any foundation trust in special administration regardless of whether the order was made to resolve a financial failure or a serious failure to provide services of sufficient quality.
495. In particular, *subsection (2)* provides for the CQC to be added to the list in section 65F of persons that must be consulted before the trust special administrator provides a draft report to Monitor recommending the action to be taken by Monitor in relation to the trust. Also, the administrator may not provide a draft report to Monitor, under section 65F or 65G, unless the administrator has first obtained a statement from the CQC that the part of the objective relating to the quality of services has been met (*subsections (3) and (5)*). The intention is to ensure that the CQC is satisfied that the services which are to be continued to be provided by the foundation trust are of sufficient safety and quality.
496. Additionally, when considering the final report from the trust special administrator under section 65KB (or the re-submitted report under section 65KD), the Secretary of State must also be satisfied that the CQC has discharged its functions for the purposes of Chapter 5A (*subsection (8)*). If, on considering a re-submitted final report, the Secretary of State is not satisfied that the CQC has discharged its functions, the Secretary of State is able to use his powers under section 82 of the 2008 Act (failure by the CQC in discharge of functions) to intervene, which includes power to direct the CQC as to the carrying out of its functions (*subsection (14)*). *Subsection (15)* ensures that these provisions apply correctly once all NHS trusts have been abolished.

## **Care Quality Commission**

### ***Section 86 – Restriction on applications for variation or removal of conditions***

497. This section makes an amendment to section 19 of the 2008 Act. The amendment will have the effect of prohibiting providers registered with the CQC from making an application to vary or remove a condition on their registration if the CQC has already served a notice of proposal or a notice of decision to change the conditions of registration in the same way.
498. This addresses an inconsistency in the way that the CQC is able to use its enforcement powers in respect of facilities that do not meet the essential levels of safety and quality set out in the regulations under section 20 of the 2008 Act.
499. Where the CQC has commenced enforcement action to close down a single location of a provider that operates from several sites, the provider may be able to avoid this enforcement action by making an application under section 19 to vary the conditions of its registration to remove the location.

*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

500. This is not possible in cases where the registered provider only carries on a regulated activity from a single location. In these instances, the CQC would cancel the provider's registration. Under section 19(2) and (3) of the 2008 Act the provider is prohibited from making an application to cancel its registration where the CQC has commenced proceedings to cancel the registration.

### ***Section 87 – Rights of appeal***

501. This section creates a right of appeal for individuals against whom the CQC requires action to be taken. This is in anticipation of a new registration requirement for providers of health or adult social care services, to be set in secondary legislation, that their directors (or persons of equivalent position) must be fit and proper persons. Where CQC decides to impose a condition on a registered provider requiring removal of an individual director who was not considered to be a fit and proper person to fulfil their role, this section gives the individual a right of appeal against CQC's decision.

### ***Section 88 – Unitary board***

502. **Section 88** amends provisions relating to the membership of the CQC. Under paragraph 3 of Schedule 1 to the 2008 Act all members of the CQC must be appointed by the Secretary of State. *Subsection (1)* amends paragraph 3 of Schedule 1 so that the Secretary of State only appoints the Chair and other non-executive members whilst the CQC appoints its own executive members (including the Chief Executive) without the involvement of the Secretary of State. *Subsection (2)* defines “non-executive members” and “executive members” and provides that the number of non-executive members must exceed the number of executive members.
503. *Subsections (3) to (8)* make further amendments to Schedule 1 to the 2008 Act to clarify where necessary which provisions apply to non-executive members only, executive members only, or both. For example, *subsections (4) and (5)* make amendments to the Secretary of State's regulation-making powers in paragraph 3 of Schedule 1 to the 2008 Act so that any regulations relating to the appointment, suspension and termination relate only to non-executive members, whilst the power to make regulations to limit the number of members may apply to both executive and non-executive members. This is intended to ensure that the CQC's Board remains at an appropriate size as set in regulations and to ensure that the non-executive members appointed have the requisite skills and knowledge.
504. *Subsections (7) and (8)* make amendments to paragraph 5 of Schedule 1 to the 2008 Act to clarify that since executive members are employees and the CQC appoints its employees on such terms and conditions as it considers appropriate, it will accordingly also determine the terms and conditions of its appointment of executive members.

## **Increasing the independence of the Care Quality Commission**

### ***Section 89 – Chief Inspectors***

505. This section inserts a new paragraph 3A of Schedule 1 to the 2008 Act which places a duty on the non-executive members of CQC to appoint a Chief Inspector of Hospitals, a Chief Inspector of Adult Social Care and a Chief Inspector of General Practice as executive members of the CQC Board.
506. *Subsection (2)* makes provision for CQC to determine the functions each Chief Inspector will exercise on its behalf.
507. *Subsection (3)* places a requirement on the Chief Inspectors to perform their roles in a way that safeguards and promotes CQC's independence.

### ***Section 90 – Independence of the Care Quality Commission***

508. This section repeals or amends several of the Secretary of State's powers in the 2008 Act that could constrain CQC's operational autonomy.
509. This section, and section 91 in part, repeal:
- powers to prescribe, by regulations, CQC's inspection programme and methodology;
  - powers (inserted by the Health and Social Care Act 2012) to approve reviews, investigations and studies CQC wish to undertake into the provision of care;
  - powers to prescribe, by regulations, CQC publication procedures for compliance and investigation reports, reviews and studies; and
  - a power to direct CQC regarding the content of its annual report on the state of health and adult social care services.
510. Powers to set the legal framework for CQC, to appoint the non-executive members of the CQC Board, to approve CQC's remuneration policy and to intervene if CQC fails to properly discharge any of its function will remain.

### **Performance ratings**

#### ***Section 91– Reviews and performance assessments***

511. **Section 91** substitutes section 46 (periodic reviews) and amends section 48 (special reviews and investigations) of the 2008 Act. The CQC's duty to conduct periodic reviews, assess performance and publish reports of such assessments (henceforth known as ratings) is to apply in respect of any regulated activities and any registered service providers as may be prescribed in regulations.
512. The substituted section 46 replaces and consolidates the CQC's existing periodic review duty in respect of the provision of healthcare by English NHS providers, the provision of adult social services by English local authorities and the Secretary of State's power to extend the scope of periodic reviews by way of regulations in section 49 of the 2008 Act, which is to be repealed by section 91(3). The new powers in section 46 will allow the Secretary of State to prescribe the particular types of services or providers in relation to whom the CQC should publish performance information so as to enable the public to make informed choices about the quality of services being provided.
513. The CQC is given the responsibility for determining the quality indicators against which services and providers will be assessed (section 46(5)). This may include measures of financial performance and governance in its assessments if the CQC deem this appropriate. The CQC will also prepare a statement setting out the method it will use to assess and evaluate performance and the frequency and period of any reviews (section 46(6)). Different quality indicators, methods and frequency and periods may be used for different types of cases. The CQC may also review the indicators of quality and method statement from time to time as it sees fit (section 46(7) and (8)).
514. The CQC will be required to consult the Secretary of State and any other persons as may be prescribed or CQC considers appropriate before publishing the indicators of quality and the statement on method and frequency and before publishing any subsequent revisions to them which are significant (section 46(9)). Consultation undertaken by CQC on the development of its new performance methodologies before section 91 comes into force is to be as effective as consultation carried out after it comes into force (section 46(11)).
515. The changes to section 48 (special reviews and investigations) make clear that CQC can, subject to the approval of the Secretary of State, undertake special reviews and investigations of the commissioning of adult social services by local authorities as well

as the commissioning of NHS services by clinical commissioning groups or the NHS Commissioning Board (known as NHS England). The effect is to retain the requirement to gain relevant Secretary of State approval before CQC undertakes a special review or investigation into the commissioning of services.

516. In parallel, the requirement for CQC to obtain Secretary of State's approval before conducting special reviews or investigations relating to the direct provision of NHS care and adult social services is being repealed (in line with section 90). The regulation of provision is part of CQC's core business and therefore does not need to be subject to ministerial approval.

## **False or misleading information**

### ***Section 92 – Offence***

517. This section creates a new offence so that providers of health services and adult social care in England, which supply, publish or otherwise make available information that is false or misleading, could be subject to criminal sanctions. The offence applies to a care provider as a corporate body. Section 94 sets out the circumstances in which a director, manager, secretary or similar officer of a care provider is also liable to be prosecuted for the offence.
518. [Section 92](#) outlines the scope of the offence, including which care providers are potentially subject to it and the type of information to which it relates (further detail will be specified in regulations as appropriate). It provides that the information must be required under a statutory provision or other legal obligation.
519. *Subsection (1)* enables the offence to apply to information that is supplied, published or otherwise made available by a care provider, and which is materially false or misleading. The offence will only be applicable, in practice, to those care providers set out in regulations, and in relation to such information as is described in regulations. Section 125(4)(m) states that such regulations will be subject to the scrutiny of both Houses of Parliament under the affirmative procedure.
520. *Subsection (1)(b)* states that this offence will relate only to information that care providers are legally obliged to supply, either by a statutory provision or by another legal requirement such as a contractual requirement. An example of information required by a contract, rather than by a statutory provision, might be information required to be supplied by the provider of health services in accordance with a term in its "commissioning contract"<sup>4</sup> with a clinical commissioning group. *Subsections (1) and (6)* provide that, in practice, the offence will only be applicable to information of a type that is described in regulations. It is envisaged that the offence will typically apply in cases involving the supply of information to the Secretary of State, the Health and Social Care Information Centre, regulators and commissioners, in accordance with those persons' and bodies' statutory powers to require information.
521. *Subsection (2)* provides a defence for care providers that can demonstrate that they "took all reasonable steps and exercised all due diligence". This defence will be available to those care providers that have made a genuine mistake or administrative error, provided that they can demonstrate that they had adequate procedures in place to ensure that false and misleading information was not provided.
522. The care providers that fall within the scope of the offence are described generically at *subsection (3)*. The offence thus applies to public bodies that provide health services or adult social care in England, such as NHS Trusts, NHS Foundation Trusts and local authorities; and to all types of GP practice, whether sole practitioners or partnerships (and whether they have entered into personal medical service or general medical service

---

<sup>4</sup> "Commissioning contract" is defined in section 6E of the National Health Service Act 2006 (as inserted by section 20 of the Health and Social Care Act 2012).

contracts with NHS England). It also applies to providers who are not public bodies, but who provide health services or adult social care on behalf of a public body, such as independent providers of hospital services and independent care homes, in relation to the publicly-funded care that they provide. Further, it applies to those who provide health services or adult social care for which they are paid, in full or in part, by a direct payment made to a patient or service user to procure services directly. “Adult social care” is further defined at *subsection (5)* and covers all necessary forms of personal care and other practical assistance. Subsection (5)(b) introduces a caveat in that any social care provided by an establishment or agency registered with Her Majesty’s Chief Inspector of Education, Children’s Services and Skills will not be subject to this offence. Subsections (1) and (6) provide that, in practice, the offence will only apply to care providers that are specified in regulations.

523. *Subsections (7) to (9)* ensure that there is no overlap or duplication between this false or misleading information offence and certain offences under the Competition Act 1998, the Enterprise Act 2002 and the Health and Social Care Act 2008.

### **Section 93 – Penalties**

524. This section provides for the penalties applicable when a court decides that a care provider, or subject to section 94, a director, manager, secretary or similar officer of a care provider, has committed the offence of providing false or misleading information. When the care provider is a local authority, the penalties are applicable to a member of the authority (see section 94).
525. *Subsection (1)* states that a person convicted of providing false and misleading information could be subject to an unlimited fine or up to two years imprisonment, or both.
526. *Subsection (2)* states that as well as, or instead of, a fine the court may also impose a remedial or publicity order by way of penalty on the care provider. Section 94(2) and (8) respectively provide that remedial or publicity orders are not applicable penalties in relation to a director, manager, secretary or similar officer of a body corporate and in relation to an officer of an incorporated association or a member of its governing body.
527. *Subsection (3)* states that a remedial order will permit the court to require the convicted care provider to take certain steps to remedy the breach that led to the conviction; this includes correcting any deficiencies in conduct, management of information, policies, systems or practices. *Subsection (5)* outlines the procedures to be followed in obtaining a remedial order. The prosecution must apply to the court and suggest the terms of the proposed order, and the court must consider the representations made on behalf of both the prosecution and the convicted care provider and any evidence presented by either party.
528. *Subsection (4)* concerns publicity orders, which require a convicted care provider to publicise information about the offence, including the particulars of that offence, and details of any fines or remedial orders made.
529. For both remedial orders and publicity orders, a time period must be stated within which the required actions must have been completed (*subsections (6) and (7)*).
530. Breach of either a remedial order or a publicity order would result in a further offence and further punishment on conviction by an unlimited fine.

### **Section 94 – Offences by bodies**

531. This section provides for the offence of providing false or misleading information to apply to directors, managers, secretaries or similar officers of care providers in certain circumstances.



532. *Subsections (1), (2) and (3)* state that where the offence is committed by a corporate body and it is committed by, or with the consent and connivance of, or is attributable to neglect on the part of a director, manager, secretary or similar officer (or a member, in the case of a local authority), they too are guilty of the offence and liable to be prosecuted and punished. The court could impose an unlimited fine or custodial sentence of up to two years imprisonment, or both, on such an individual (section 93(1)). A remedial order or publicity order (section 93(2)) could not be made in respect of an individual.
533. *Subsections (4) to (8)* make provision where the offence is committed by a care provider that is an unincorporated association. Subsection (4) provides that where proceedings are brought against an unincorporated association they are to be brought in the name of the association not in the name of the members of the association.
534. *Subsections (7) and (8)* provide that an officer of an unincorporated association, or a member of its governing body, is also guilty of the offence, where an offence committed by the unincorporated association has been committed by, or with the consent or connivance of, or is attributable to neglect on the part of, an officer or a member of the governing body of the association. Subsection (8) provides that a remedial order or publicity order cannot be made in respect of an officer or member who is convicted of the offence. The maximum penalty available to the court is an unlimited fine or up to two years imprisonment, or both (section 93(1)).

## **Regulated activities**

### ***Section 95 – Training for persons working in regulated activity***

535. This section amends section 20 of the 2008 Act to enable the Secretary of State, through regulations, to specify the people or organisations that can set training standards for specific groups of workers. In this context, this section will allow the Government to specify in regulations: the person who sets the training standards and to whom those standards apply. Groups to whom these standards could apply include healthcare assistants and social care support workers.

## **Part 3 - Health**

### ***Chapter 1 - Health Education England***

#### **Establishment**

### ***Section 96 – Health Education England***

536. This section establishes Health Education England (HEE) as a non-departmental public body. HEE will be the national body responsible for the planning and delivery of education and training for the NHS and public health workforce. It will also be responsible for establishing Local Education and Training Boards (LETBs) which will be responsible for planning and commissioning education and training at a local level.
537. *Subsection (2)* gives effect to Schedule 5 which, amongst other things, makes provision for the constitution of HEE, the exercise of its functions and its financial and accounting obligations.
538. *Subsection (3)* abolishes the Special Health Authority called HEE, and *subsection (4)* makes provision for the Secretary of State to transfer from that Special Health Authority any property, rights and liabilities to HEE. Section 118 makes further provision on transfer orders.

## **Schedule 5 – Health Education England**

### **Part 1 – Constitution**

#### **Membership**

539. *Paragraph 1* set outs the requirements for the membership of the Board of HEE. It provides that the Board must consist of a chair and six other non-executive members appointed by the Secretary of State, and a chief executive and no more than four executive members appointed by the chair and other non-executive members. Non-executive members are not employees of HEE. The chief executive and executive appointments will be employees of HEE.
540. *Paragraph 2* specifies that the Board of HEE must include persons with clinical expertise of a type set out in regulations. Regulations may specify the number of executive and non-executive members which must have that clinical expertise. The regulations will set out the types of expertise that must be represented, for example a doctor, a nurse or a member of one of the other healthcare professions.
541. *Paragraph 2* also makes provision that the non-executive members of HEE must include a person who will represent the interests of patients.

#### **Non-executive members: terms of office**

542. *Paragraph 3* makes provision about the terms of appointment and tenure of office of non-executive members of the Board of HEE. Sub-paragraph (2) provides that non-executive appointments will be for a maximum period of four years. Sub-paragraph (3) confirms that non-executive members can be reappointed after they have ceased to be a member or at the end of the four year term of office. Sub-paragraph (4) provides that persons appointed to non-executive roles may resign from office by giving notice to the Secretary of State. Sub-paragraph (5) gives the Secretary of State a power to remove any person from a non-executive appointment on the grounds of incapacity, misbehaviour, or failure to carry out their duties properly. Sub-paragraph (6) permits the Secretary of State to suspend a person from a non-executive role for any of the reasons set out in sub-paragraph (5).

#### **Non-executive members: suspension from office**

543. *Paragraphs 4 and 5* set out the procedural requirements to be complied with when the Secretary of State suspends a non-executive member of the Board of HEE, make provision for the Secretary of State to review the suspension and gives the Secretary of State power to appoint an interim chair. HEE will have no power to appoint an interim chair, but could choose to appoint a deputy chair (regardless of any suspension of the chair).

#### **Non-executive members: pay**

544. *Paragraph 6* requires HEE to pay to the non-executive members such remuneration as the Secretary of State may decide. Sub-paragraph (2) provides that the Secretary of State may also determine the allowances and gratuities that HEE must pay a person who is or has been a non-executive member.

#### **Employees: terms of office**

545. *Paragraph 7* gives HEE the power to appoint the chief executive, executive members and other employees on such terms as it decides. The appointment of the chief executive requires the consent of the Secretary of State.

### **Employees: pay**

546. *Paragraph 8* provides that HEE must pay its employees such remuneration as it decides. HEE must also pay such pensions, allowances or gratuities as it may determine. In common with other arms-length bodies, HEE is required to obtain the approval of the Secretary of State to its policy on pay before making a decision on these matters.

### **Committees and sub-committees**

547. *Paragraph 9* provides that HEE may appoint committees and sub-committees and pay remuneration and allowances to those members of a committee or sub-committee who are not employees of HEE. Any committees or sub-committees of the Special Health Authority called HEE will become part of HEE when it is established as a non-departmental public body and will be treated as appointed for the purposes of this paragraph.

### **Procedure**

548. *Paragraph 10(1)* provides that HEE regulates its own procedure. *Paragraph 10(2)* confirms that the validity of any act of HEE, will not be affected by vacancies or any defects in appointments.

### **Seal and evidence**

549. *Paragraph 11* makes provision in relation to HEE's seal.

### **Status of HEE**

550. *Paragraph 12* states that HEE is not to be regarded as a servant or agent of the Crown and will not enjoy any status, privilege or immunity of the Crown. HEE's property will not be regarded as property of, or property held on behalf of, the Crown.

## **Part 2 – Functions**

### **Exercise of functions**

551. Sub-paragraph (1) of *paragraph 13* imposes a duty on HEE to exercise its functions effectively, efficiently and economically. Under sub-paragraph (2) HEE may arrange for any of its committees, sub-committees, or members or any other person to exercise any of its functions on its behalf, subject to sub-paragraph (5).
552. Under sub-paragraph (3) HEE may arrange for any person to assist it in the exercise of its functions.
553. Under sub-paragraph (4) HEE may provide payment for remuneration and allowances when it arranges for any other person to exercise or assist in the exercise of its functions.
554. Sub-paragraph (5) provides that HEE is not permitted to arrange for a committee which is not an LETB, sub-committee, members or any other person to exercise the functions which are exercisable by a LETB.
555. Under sub-paragraph (6) HEE has a power to involve health care workers, patients and their carers in decisions about the exercise of its functions. In this context, "carer" means an adult who provides or intends to provide care for another person.
556. Under sub-paragraph (7) HEE has a general power to do anything necessary or desirable for the purposes of or in connection with the exercise of its functions.
557. Sub-paragraph (8) amends section 247C of the National Health Service Act 2006 (the 2006 Act) to include HEE in the list of bodies that the Secretary of State has a duty to keep under review in the exercise of their health service functions. In line with other arms-length bodies, the purpose of this is to ensure that the Secretary of State

is ultimately accountable for ensuring that HEE performs its health care functions effectively.

### **Help or advice for public authorities**

558. *Paragraph 14* states that HEE may provide help or advice to another public authority on such terms as it decides. Public authority is defined in sub-paragraphs (3) and (4) as any person whose functions are functions of a public nature and excludes the Houses of Parliament or a person exercising functions in connection with proceedings in Parliament. Public authorities in the Channel Islands or the Isle of Man are included within this definition, but others outside the UK are not.

### **Co-operation**

559. *Paragraph 15* requires HEE to co-operate with the Secretary of State in the exercise of his public health functions. Public health functions are defined in section 1H of the 2006 Act.
560. Sub-paragraph (2) amends section 72 of the 2006 Act so that HEE is treated as a NHS body for the purposes of that section. Section 72 requires NHS bodies to co-operate with each other in the exercise of their functions. This means that all NHS bodies, along with those bodies included within the definition of NHS bodies for the purpose of this section such as the National Institute for Health and Care Excellence and the Health and Social Care Information Centre, will be required to co-operate with HEE in the exercise of their functions, and in turn HEE will be required to co-operate with them.
561. Sub-paragraph (3) requires HEE and the Care Quality Commission to co-operate with each other, and HEE and Monitor to co-operate with each other.
562. Sub-paragraph (4) gives the Secretary of State a power to specify in regulations other bodies with which HEE must co-operate, and bodies which must co-operate with HEE.

### **NHS contracts**

563. *Paragraph 16* adds HEE to the list of bodies eligible to enter into NHS contracts under the 2006 Act.

### **Arrangements with devolved authorities**

564. *Paragraph 17* gives HEE a power to exercise on behalf of a devolved authority any functions which are similar to HEE's functions. There are occasions where UK wide co-operation and activity is required to support education and training, for example in planning for the medical workforce. This will allow HEE to lead work of this nature on behalf of the devolved authorities in circumstances where all parties have agreed to this. Sub-paragraph (2) makes provision for HEE to receive payment from the devolved authorities for any costs incurred under such arrangements.

### **Failure to exercise functions**

565. *Paragraph 18* empowers the Secretary of State to intervene to direct HEE in the delivery of its functions, where he considers HEE is failing, or has failed to exercise any of its functions properly, and that the failure is significant. A significant failure could include circumstances where there is evidence that public money is not being used effectively; there are concerns about the quality of education and training and these are not being adequately addressed; plans look likely to lead to a shortfall in an important part of the professional workforce; or there are concerns that education and training is impacting on patient safety.
566. Sub-paragraph (2) states that if HEE fails to act as directed by the Secretary of State, the Secretary of State, or another person on his behalf, may carry out HEE's functions.

567. Sub-paragraph (3) requires the Secretary of State to publish reasons for intervention where HEE is failing, or where HEE has failed to take the remedial action stipulated by Secretary of State.

### **Part 3 – Finance and Reports**

568. *Paragraphs 19 to 23* set out how the Secretary of State will fund HEE. It also sets out the general financial duties of HEE, including restrictions on the use of resources.

#### **Funding**

569. *Paragraph 19* provides that the Secretary of State must pay HEE the amount allotted for meeting HEE's expenditure. Sub-paragraph (2) provides that an amount will be regarded as allotted once HEE is notified of the amount. The payment is subject to such conditions relating to records, certificates or otherwise as the Secretary of State requires.
570. Sub-paragraph (3) states that the Secretary of State is able to increase or decrease the allotted amount if HEE agrees to the change, there is a parliamentary general election, or the Secretary of State considers that there are exceptional circumstances which make an increase or a decrease necessary. Such exceptional circumstances might include a severe disease outbreak or unpredictable and substantial damage to infrastructure.
571. Sub-paragraph (4) provides that the Secretary of State may direct HEE in respect of HEE's payments to it in respect of charges or other amounts relating to the valuation and disposal of assets.

#### **Financial duties: expenditure**

572. Under *paragraph 20*, HEE will have an obligation to ensure that its total expenditure does not exceed the aggregate of the amount allotted to HEE by the Secretary of State for that year and any income derived from other sources. This is in effect an annual "cash limit" on the total amount of cash expenditure which may be incurred.
573. The income which counts for the purposes of this limit would include, for instance, funds received as a result of the power in paragraph 21 for HEE to generate its own income.
574. The Secretary of State has the power to determine by directions what will and what will not count as total expenditure for the purposes of sub-paragraph (1). Sub-paragraph (3) gives the Secretary of State a power to determine in directions the extent to which, and the circumstances in which, sums received by HEE under *paragraph 19* but not yet spent must be treated for the purposes of this section as part of total expenditure, and to which financial year's expenditure they must be attributed.
575. The Secretary of State also has a power to direct HEE to use banking facilities that he specifies in the Directions.

#### **Financial duties: use of generated income**

576. *Paragraph 21* provides that any income that HEE generates must be re-invested for education and training purposes.

#### **Financial duties: controls on total resource use**

577. *Paragraph 22* is concerned with HEE's annual resource allocation. Under this paragraph, the total use of capital resources and the total use of revenue resources by HEE in a financial year must not exceed amounts specified by the Secretary of State. HEE is placed under a duty to ensure that these total limits are not exceeded.
578. The resource allocations include not only HEE's expenditure in the form of cash spending (that is, the cash spending that should be accounted for in that financial year,



in line with resource accounting standards), but also consumption of other resources and the reduction in value of assets belonging to HEE (paragraph 22(4)). For example, the reduction in value of a photocopier across the year, or the distribution of leaflets previously kept in storage would be counted as part of the resource allocation. This system of setting not only a cash limit on HEE's expenditure but also a limit on use of resources reflects the system for controlling government resources under the Government Resources and Accounts Act 2000.

579. Sub-paragraph (2) gives the Secretary of State a power to give directions that specify what descriptions of resources must be treated as capital or revenue resources, and the uses of resources that must, or must not, be taken into account, when determining whether HEE has remained within the resource allocations for a financial year.
580. As with the allotment, the Secretary of State may only vary the resource allocations within a financial year if certain conditions are met. These conditions are set out in sub paragraph (3) and are that if HEE agrees that the change is necessary, if there is a parliamentary general election, or if the Secretary of State considers that exceptional circumstances require a variation of the allocation.

### **Financial duties: additional controls on resource use**

581. *Paragraph 23* enables the Secretary of State to specify additional limits within the total revenue resource limit on the maximum use of resources attributable to administrative matters by HEE (sub-paragraph (1)(c)). Sub-paragraph (2) provides that the matters relating to administration which count for the purposes of these limits may be set out in directions.
582. Under sub-paragraphs (1)(a) and (1)(b), the Secretary of State will also be able to set additional limits on total revenue or total capital resource use attributable to particular matters specified in directions. Sub-paragraph (3) requires that the Secretary of State may only impose such limits for the purpose of complying with limits imposed by HM Treasury. These limits relate to specific budgetary limits applied across all Government Departments on certain elements of spending. For example within the revenue Departmental Expenditure Limit, HM Treasury applies a ring-fence to spending on depreciation. HM Treasury applies controls on Annually Managed Expenditure under which there are limits on the creation of new provisions (charges for spending that is likely to happen in future years e.g. the economic cost of providing student loans over the full repayment period. The Department of Health would also apply a limit on the balance of spending not covered by the specific limits, again to provide consistency with the controls applied by HM Treasury. These types of spending will fall within the total resource limits but need to be separately controlled within them.

### **Losses and liabilities etc**

583. *Paragraph 24* provides that HEE is included in the list of authorities covered by section 265 of the Public Health Act 1875. The effect of this is to protect members and officers of HEE from personal liability in certain circumstances.
584. Sub-paragraph (3) includes HEE in the list of bodies eligible to enter into schemes for meeting losses and liabilities as set out in section 71 of the National Health Service Act 2006.

### **Accounts**

585. *Paragraph 25* requires HEE to keep proper accounts and proper records in relation to the accounts (with such content and in such form, and using such methods and principles to prepare the accounts, as the Secretary of State may direct with the approval of HM Treasury). The chief executive of HEE is to be the chief accounting officer.

## **Annual accounts**

586. *Paragraph 26* requires HEE to prepare consolidated accounts annually in respect of each financial year. HEE's consolidated accounts must include the accounts of each LETB, any other committees of HEE, and HEE's activities.
587. Sub-paragraph (3) provides that HEE must submit the accounts to the Secretary of State and to the Comptroller and Auditor General within such period as is directed by the Secretary of State. The Comptroller and Auditor General must examine, certify and report on the accounts of HEE and lay copies of the accounts, along with a report of them, before Parliament.

## **Interim accounts**

588. Additional provision is made in *paragraph 27* for the Secretary of State, with the approval of HM Treasury, to direct HEE to prepare interim accounts. The interim accounts must include the accounts of any committees, including the LETBs.
589. HEE must submit the interim accounts to the Secretary of State and, if the Secretary of State directs, to the Comptroller and Auditor General within such period as is directed by the Secretary of State. The Comptroller and Auditor General must examine the interim accounts of HEE and if the Secretary of State directs, send a copy of the report to the Secretary of State, and lay copies of the accounts, along with a report of them, before Parliament.

## **Annual report**

590. *Paragraph 28* requires HEE to prepare an annual report for each financial year about how it has exercised its functions. This assessment must include an assessment of HEE's achievement of the objectives and reflection of the priorities set by the Secretary of State under subsection (1) of section 100 and an assessment of its achievement of the outcomes set by the Secretary of State for the purposes of subsection (2) of section 100. HEE must provide this report as soon as possible after the end of the financial year.
591. HEE must send a copy of the report to the Secretary of State and lay a copy of the report before Parliament. HEE must also provide such other reports and information relating to the exercise of its functions as the Secretary of State requests.

## **Part 4 – Consequential amendments**

592. This Part makes consequential amendments to the following acts to include references to HEE where relevant – the Public Records Act 1958, the Public Bodies (Admission to Meetings) Act 1960, the Parliamentary Commissioner Act 1967, the House of Commons Disqualification Act 1975, the Copyright, Designs and Patents Act 1988, the Freedom of Information Act 2000, and the Equality Act 2010.

## **National Functions**

### ***Section 97 – Planning education and training for healthcare workers etc.***

593. The Secretary of State has a duty in section 1F of the National Health Service Act 2006 (the 2006 Act) to carry out his functions under prescribed enactments, including section 63 of the Health Services and Public Health Act 1968 and the 2006 Act, to secure an effective system for the planning and delivery of education and training to persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England. The duty applies in relation to people working in the NHS and public health system, and to trainee professionals at the start of their career, before they enter employment in the NHS and public health system. The Secretary of State's duty was introduced in the Health and Social Care Act 2012.

594. Section 63 of the Health Services and Public Health Act 1968 gives the Secretary of State a power to provide, either directly or by entering into arrangements with others, education and training to persons specified in that section, which include all NHS and public health workers. Section 258 of the 2006 Act imposes a duty on the Secretary of State to make available facilities required by universities for clinical teaching and research connected with clinical medicine or clinical dentistry.
595. *Subsection (1)* delegates to HEE the Secretary of State's duty under section 1F, so far as it applies to its functions under section 63(1) and (5) of the Health Services and Public Health Act 1968, section 258(1) of the 2006 Act and any other of the enactments listed in section 1F(3) of that Act as regulations may specify. The delegation of the Secretary of State's duty gives HEE powers to take on responsibility for a wide range of matters relating to education and training, for example relating to workforce planning, the commissioning of education and training and the quality assurance and management of education and training provision. This power will also enable HEE to take on responsibility at a national level for continuing professional and personal development (CPD) provision, for example coordinating and leading CPD activities and investing funds in CPD.
596. *Subsection (2)* gives the Secretary of State a power by regulations to specify other functions of the Secretary of State to which section 1F(1) of the 2006 Act will apply, and to require HEE to carry out the resulting duty.
597. *Subsection (3)* gives the Secretary of State a power to specify that the duty in section 1F of the 2006 Act may be applied to persons of a specified description.
598. The 2006 Act places a duty on providers of NHS services, the National Health Service Commissioning Board (known as NHS England) and clinical commissioning groups to promote education and training to assist the Secretary of State in the discharge of his duty in section 1F. These duties are amended by *subsection (4)* to require co-operation with HEE to assist HEE, in addition to the Secretary of State, in the discharge of the section 1F duty.
599. *Subsection (5)* gives the Secretary of State power to make regulations to specify further functions for HEE relating to education and training.
600. *Subsection (6)* gives HEE a power to carry out other activities related to education and training, with the consent of the Secretary of State.
601. Section 63(6)(b) of the Health Services and Public Health Act 1968 gives the Secretary of State a power to pay travelling and other allowances to persons who are undertaking education and training under that section. *Subsection (7)* amends section 63(6) of that Act to give the Secretary of State a power to make such other payments as the Secretary of State considers appropriate and for payments to be made subject to such terms and conditions as the Secretary of State decides. The Secretary of State's power to make such payment means that provisions can be made about suspension or termination of payments, and overpayments could be required to be repaid.
602. *Subsection (8)* provides that the power of the Secretary of State under section 63(6) of the 1968 Act is exercisable concurrently with HEE, but in exercising the power HEE must have regard to any guidance or other information issued by the Secretary of State.

### ***Section 98 – Ensuring sufficient skilled health care workers for the health service***

603. This section places a duty on HEE to ensure that there is a sufficient number of healthcare workers with the skills and training to provide health services in England. For example, HEE will need to ensure that sufficient nurses are trained nationally to meet anticipated demand for future NHS service provision.
604. HEE has direct control over the investment in education and training for health professionals funded through the education and training budget. This budget totalled

approximately £4.9 billion in 2013/14 and is invested in a wide range of undergraduate programmes, post registration and postgraduate training programmes and in NHS student support arrangements. Where necessary, HEE will work closely with other bodies to influence investment. For example, HEE will work with the Higher Education Funding Council for England, and universities across England who deliver healthcare related training programmes, to ensure that their funding is invested in the right areas and suitable training opportunities are available in the right places and in the right numbers.

605. *Subsection (2)* gives the Secretary of State the power to specify in regulations in relation to which healthcare workers the duty to ensure sufficient skilled workers should apply.

### ***Section 99 – Quality improvement in education and training, etc.***

606. *Subsection (1)* provides that HEE must exercise its functions with a view to securing continuous improvement in the quality of education and training provided to healthcare workers and in the quality of NHS services. The professional regulators such as the General Medical Council set the standards for health professionals to be registered to practise in the UK. In commissioning education and training, HEE and the LETBs must build on these standards and will work with education providers to ensure that the provision of education and training continually improves in quality and delivers health professionals who are fit for purpose and meet the needs of employers in the NHS and their patients and service users.
607. *Subsection (2)* provides that HEE must, in exercising its functions, promote research into the activities listed in section 63(2) of the Health Services and Public Health Act 1968, such as primary dental or medical services, in so far as they are relevant to HEE's functions. HEE may do this by, for example, working closely with organisations such as the Academic Health Science Centres and Academic Health Science Networks. HEE must also promote the use of evidence obtained from this research.
608. *Subsections (3) and (4)* require HEE to have regard to the NHS Constitution and promote the NHS Constitution in carrying out its functions.

### ***Section 100 – Objectives, priorities and outcomes***

609. *Subsection (1)* stipulates that the Secretary of State must publish a document which specifies the objectives and priorities for HEE in relation to the education and training to be provided to health care workers. This document will be commonly referred to as HEE's mandate. It will be reviewed annually, before the beginning of each financial year, and republished if changes are made.
610. *Subsection (2)* stipulates that the Secretary of State will publish a document that sets the outcomes for HEE to achieve having regard to its objectives and priorities. The document will be known as the Education Outcomes Framework and will include outcomes applicable to other organisations in the health and public health system. It will be supported by a range of measures so that the system can demonstrate at all levels education quality outcomes as they impact on patient experience, care and safety.
611. *Subsection (3)* permits the Secretary of State to revise HEE's mandate and the Education Outcomes Framework and also provides that it must be republished if it is revised.
612. *Subsection (4)* requires HEE to publish a document which specifies the priorities, objectives and outcomes it expects to achieve; these priorities, objectives and outcomes must be consistent with those set by the Secretary of State at subsections (1) and (2) above. The document must also include guidance to LETBs about how they should carry out their commissioning functions. HEE is required to review the document annually and republish it if it is amended. This document will be developed in consultation with the NHS Commissioning Board (known as NHS England) and Public Health England. It will underpin the relationship and resource allocation arrangements between HEE

and the LETBs. It will set out the medium to long term context for the development of the NHS and public health workforce, and will provide the framework within which the LETBs will develop their education and training plans. *Subsection (5)* provides that in producing the document, HEE must have regard to longer term objectives relating to workforce planning and education and training provision. HEE's duty under subsection (4) can be met by publishing two or more documents which taken together comply with its obligations.

613. *Subsection (8)* requires HEE to review the document annually and if it revises it then it must republish the revised document.

### ***Section 101 – Sections 98 and 100: matters to which HEE must have regard***

614. This section specifies matters that HEE must have regard to when exercising its duties under sections 98(1) (ensuring sufficient skilled workers) and 100(4) (setting objectives, priorities and outcomes for education and training).

### ***Section 102 – Advice***

615. This section stipulates that HEE must make arrangements for obtaining advice from persons who are involved in, or have an interest in, the provision of education and training. The education and training landscape is multi-faceted, and many organisations have an interest in the development of health professionals, ranging from local employers in the NHS through to national organisations such as the professional regulators like the General Medical Council and professional bodies such as the medical Royal Colleges.
616. *Subsections (2) and (3)* stipulate that HEE must ensure it receives representations from specified groups. These groups include providers of NHS services, patients and their carers, the NHS and public health workforce or the trades unions who represent them and, professional regulators such as the Health and Care Professions Council. It also includes the range of bodies involved in the development and provision of education and training such as the medical Royal Colleges who support the development of curricula and the bodies involved in the delivery of further and higher education such as colleges and universities.
617. *Subsection (4)* requires HEE to advise the Secretary of State on any matters relating to its functions as the Secretary of State requests. The Secretary of State may specify in his request how and when the advice is to be provided.

## **Local functions**

### ***Section 103 – Local Education and Training Boards***

618. This section provides for HEE's appointment of committees, known as Local Education and Training Boards (LETBs), to exercise HEE's functions on its behalf in so far as they are exercisable in respect of the local area. LETBs will plan and commission education and training and quality assure the education and training that has been commissioned for their areas. The LETB, as a committee of HEE, will work within the national framework set by HEE, but within that will address local priorities for education and training and be a forum for local workforce development in the NHS and public health system.
619. *Subsection (3)* confirms that the LETB should represent the interests of all providers of NHS and public health services in the area of the LETB. It is important that the LETB acts on behalf of all providers, for example, across primary care, secondary care and the public health system.
620. *Subsection (4)* ensures that the duties imposed on HEE by section 99 (1), (2) and (4) (quality improvement in education and training etc.) also apply to LETBs.



621. *Subsection (5)* provides that LETBs may co-operate with each other and two or more LETBs may exercise their functions jointly. LETBs may also be required to work closely together on specific elements of workforce planning or education provision, for example, where a healthcare provider has a presence in two or more LETBs.
622. *Subsection (6)* permits HEE to attend any LETB meetings about a matter of concern to HEE. This may be required where HEE has serious concerns about delivery of national workforce priorities, objectives and outcomes.

#### **Section 104 – LETBs: appointment etc.**

623. This section deals with the process by which HEE appoints LETBs. LETBs will be supported by operational staff who will be employed by HEE. These will include staff from the former Strategic Health Authorities and postgraduate medical and dental deaneries.
624. HEE will appoint LETBs, where a group of persons, which must include local healthcare providers for the area, persons who have clinical experience of a type specified in regulations and a person who will represent the interests of patients, come together and fulfil the requirements of the appointment criteria. HEE will set appointment criteria will be contained in a document that will primarily assess potential LETB's potential to carry out HEE's functions at a local level. They will assess the LETBs capacity and capability to carry out those functions, their ability to secure financial control and the proposed local governance arrangements. Schedule 6 makes further detailed provision about the area of LETBs, the appointment criteria and the exercise of HEE's functions.
625. HEE will assess potential LETB applicants and there will be three possible outcomes from the application process. Firstly, as set out in *subsection (1)* the applicants may meet all the criteria set by HEE and HEE is therefore satisfied that the LETB is capable of taking on all functions delegated to it. In this case the LETB will be appointed without any further conditions. Secondly, as set out in *subsection (2)* the applicants may meet some of the criteria set by HEE and HEE is satisfied that they are capable of taking on some, but not all of the functions delegated to them. In this case, the LETB will be appointed with conditions attached to their appointment. The third outcome is that the applicants meet some of the criteria but not all, and HEE is not satisfied that they can take on functions delegated to them, or that they do not meet any of the criteria. In this case, the LETB will not be appointed. In such circumstances HEE may, under *subsection (8)*, appoint its own employees as members of the LETB to take on responsibility for the education and training functions in that area until an application meets sufficient criteria.
626. *Subsections (3) to (8)* provide more detail on eligibility for LETB membership and the required composition of its membership. *Subsection (3)* sets out types of person who must be represented on a LETB. *Subsection (4)* specifies that regulations may set out the required numbers of persons with clinical expertise. *Subsection (5)* confirms that persons involved in the provision of education and training may also be members of a LETB and *subsection (5)(b)* allows HEE to specify other persons who are eligible to be appointed. *Subsection (6)* confirms that non-executive and executive members of HEE are not eligible for membership. *Subsection (7)* confirms that the majority of the members of the LETB must be drawn from providers of NHS and public health services in the LETB geographical area. This is important. Whilst LETBs will rightly include other partners as members, for example, from the education sector or commissioning organisations, their primary purpose is to plan and commission on behalf of local healthcare providers.
627. *Subsection (9)* requires HEE to appoint the chair of the LETB. The chair may not be a provider of NHS or public health services in the LETB's geographical area or a representative from a further or higher education institution in the LETB's geographical area.

628. *Subsection (10)* requires HEE to notify applicants in writing of the outcome of its decision, and any reasons for rejection. HEE will then publish the decision as set out in *subsection (11)*.
629. *Subsection (12)* provides that the members of the LETB must not use information obtained in that capacity for any other purposes.
630. *Subsection (13)* gives the Secretary of State a regulation making power to make further provision on the appointment of members of the LETB, the removal by HEE of members of a LETB and the suspension by HEE of members of a LETB.

## **Schedule 6 – Local Education and Training Boards**

### **The area for which a LETB is appointed**

631. *Paragraph 1* makes provision for the geographical area covered by the LETB. Sub-paragraph (1) requires HEE to ensure that the areas covered by all LETBs together cover the whole of England and do not overlap or coincide geographically.
632. Sub-paragraph (2) gives HEE a power to vary the area of a LETB. This may be required if there are changes in the area of neighbouring LETBs which lead to part of England being unrepresented by a LETB. HEE must also keep an up to date record of the geographical areas and publish that record.

### **Assessment of whether the members of LETBs meet the appointment criteria**

633. *Paragraph 2* requires HEE to continue to assess LETBs to ensure they are compliant with the appointment criteria set by HEE. If a LETB in question is not meeting the criteria HEE must assess whether it is still able to exercise its functions. HEE will undertake such an assessment whenever it considers this appropriate. Sub-paragraph (2) requires HEE to notify the LETB of the outcome of the assessment and where HEE is not satisfied that it meets the appointment criteria HEE is required to give the reasons for this and publish these.
634. Sub-paragraph (3) provides that where a LETB is continuing to meet some but not all appointment criteria and HEE determines that it can still exercise its functions, HEE may impose conditions on the LETB relating to its operation.
635. Sub-paragraph (4) stipulates that where a LETB fails to meet sufficient appointment criteria to enable it to exercise its functions, HEE may do one or more of the following: appoint new members of the LETB; exercise the functions on behalf of the LETB; arrange for another LETB to take responsibility for the area.
636. Sub-paragraph (5) requires HEE to notify the LETB of the conditions it proposes to impose or action it proposes to take, and the reasons for doing so, before it may impose the conditions at sub-paragraph (3) or take actions described under sub-paragraph (4).
637. Sub-paragraph (6) requires HEE to publish the details of these conditions and the reasons for imposing them or taking that action.
638. Sub-paragraph (7) requires HEE to obtain the approval of a LETB before asking it to take on another LETB's functions as described in sub-paragraph (4)(c).
639. Sub-paragraph (8) provides that regulations must require specified commissioners of health services to include in the arrangements under the National Health Service Act 2006 for the provision of such services terms to ensure that the provider complies with requirements mentioned in sub-paragraphs (8)(a) and (b). Sub-paragraph (8)(a) states that providers must co-operate with any LETB which represents that provider because it has been appointed by HEE to represent it by virtue of sub-paragraph (4)(c). This obliges providers to co-operate with any LETB that represents both its interests and the interests of providers from a different geographical area that the LETB originally

represented before it was appointed to additionally represent the interests of another LETB. Sub-paragraph (8)(b) states that providers must provide LETBs with such information as they may request.

640. Sub-paragraph (9) allows the Secretary of State to make regulations specifying other circumstances where HEE may intervene in the operation of the LETB.

### **Publication and review of the appointment criteria**

641. Sub-paragraph (1) requires HEE to publish the appointment criteria that persons applying to be appointed as a LETB must meet. HEE is required to obtain the approval of the Secretary of State before publishing this criteria. Sub-paragraph (2) requires HEE to keep the appointment criteria under review and make any necessary revisions. HEE is required to obtain the approval of the Secretary of State for any revisions that HEE considers significant.

### **Exercise of functions**

642. *Paragraph 4* enables the Secretary of State, through regulations, to give the LETBs additional functions relating to education and training and impose requirements about how those functions should be exercised.
643. Sub-paragraph (2) allows a LETB to do anything which it considers necessary or desirable to enable it to carry out its functions.
644. Sub-paragraph (3) provides that where HEE considers that a LETB is failing to exercise one or more of its functions, or there is a significant risk that it may do so, HEE must direct the LETB on the exercise of such functions.
645. Sub-paragraph (4) stipulates that where a LETB fails to comply with the direction under sub-paragraph (3), HEE may intervene as described under paragraph 2(4) of this Schedule, which means that HEE may appoint new members of the LETB, exercise functions on behalf of the LETB, or arrange for another LETB to represent providers of services in the area.

### ***Section 105 – LETBs: co-operation by providers of health services***

646. *Subsection (1)* provides that regulations must require specified commissioners of health services to include in the arrangements under the National Health Service Act 2006 (the 2006 Act) for the provision of such services terms to ensure that the provider complies with requirements imposed under paragraphs (a), (b) and (c). Paragraph (a) states that providers must co-operate with any LETB in which it provides services. Paragraph (b) requires providers to provide LETBs with such information as they may request and paragraph (c) requires providers to comply with other obligations that may be specified. The regulations will seek to ensure that providers of NHS and public health services co-operate with the LETB in their area to support the planning, commissioning and provision of education and training. This may include the provision of workforce information to support such activities. Such regulations will support the duty imposed on commissioners by section 1F(2) of the 2006 Act.
647. *Subsection (3)* provides that the regulations may specify matters that the LETB must have regard to when considering the reasonableness of requesting a provider to cooperate with it, or to provide it with information.

### ***Section 106 – Education and training plans***

648. *Subsection (1)* requires LETBs to publish an education and training plan for each financial year. The education and training plan will set out, amongst other matters, the LETB's proposed investment in their current and future workforce. *Subsection (2)* makes provision for the content of the education and training plan. In developing their plans, the LETB must have regard to national objectives, priorities and outcomes set

by the Secretary of State and HEE (under section 100), alongside the local priorities of the NHS and public health providers represented by the LETB.

649. *Subsection (3)* lists matters that a LETB must have regard to in the preparation of the plan.
650. *Subsection (4)* places a duty on the LETB to involve the providers it represents in the preparation of its education and training plans, along with commissioners of health services, Health and Wellbeing Boards and such other organisations that either it or HEE considers appropriate. It is important that education and training plans are informed by the local needs of the health and public health system.
651. *Subsection (5)* requires the LETB to submit its education and training plan to HEE for approval prior to publication. *Subsection (6)* enables HEE to direct LETBs to amend their education and training plans prior to approval. By operation of *subsection (7)*, in the case of LETBs which meet all appointment criteria, HEE's power is restricted to amendments that HEE considers necessary to ensure that the LETB will achieve the outcomes set by HEE under section 100(4)(b). This is intended to respect the autonomy of the LETB and therefore restricts any amendments to issues linked to nationally agreed priorities, objectives and outcomes. HEE must publish the amendments and the reasons for making them as described in *subsection (8)*.

### ***Section 107 – Commissioning education and training***

652. This section requires each LETB to commission education and training activity that will support their plans for that year. HEE has a duty to allocate appropriate funding to each LETB in order to commission the necessary education and training activity.
653. There may be some circumstances where it is advantageous to have nationally coordinated provision of education and training, rather than leaving it to the discretion of LETBs. For example, some professions and medical specialties may require only very small numbers to be commissioned across England, so national level commissioning may be more appropriate. In such cases, *subsection (2)* gives HEE a power to make arrangements itself for the provision of education and training, or to direct a lead LETB to do so on behalf of itself (but the latter is subject to consultation with the LETB in question (*subsection (3)*)).
654. *Subsection (4)* requires HEE to allocate to the LETB the resources that are required to deliver its education and training plan for that year.
655. *Subsection (5)* requires HEE to take account of any requirements placed on the LETB by section 108 – which requires an LETB to make payments by reference to an approved tariff price or price varied under a specified procedure – when making such an allocation.
656. *Subsection (6)* allows the LETB to arrange for another person to assist in the exercise of its commissioning functions.
657. *Subsection (7)* places a duty on LETBs to keep under review the quality of the education and training provision that it commissions, and imposes a duty on them to report its findings to such bodies that the LETB considers may be interested. This could include, for example, the relevant professional regulatory body.
658. *Subsection (8)* requires the LETB to produce such reports on the commissioning of education and training as HEE may require.

## **Tariffs**

### ***Section 108 – Tariffs***

659. This section establishes a tariff-based system for funding clinical education and training – whereby providers receive the same payment for the same activity. This will enable a national approach to the funding of clinical placements, and provides for equality of treatment between different providers. The Secretary of State will set the tariff price.
660. One of the functions of HEE is to determine the way in which education and training activities are grouped together for the purposes of payment. *Subsection (2)* recognises that different tariffs will need to be set by the Secretary of State, depending on the groups developed by HEE.
661. *Subsection (4)* allows the Secretary of State to specify a procedure for making variations to a published tariff. This could either be a variation to the price of the tariff itself, or a variation to the price being paid to a particular provider (or group of providers) on a case-by-case basis.
662. *Subsection (6)* allows the Secretary of State to revise or revoke any such variations. It also allows the Secretary of State to make any revisions or revocations to the tariff itself.
663. *Subsection (9)(a)* stipulates that where a tariff has been published by the Secretary of State, HEE – through their LETBs – will be required to make payments to providers at the published tariff price. *Subsection (9)(b)* confirms that – where there has been a variation to an approved price – that this new price should be used by HEE.

### ***Chapter 2 – Health Research Authority***

#### **Establishment**

#### ***Section 109 – The Health Research Authority***

664. This section establishes a new body to be known as the Health Research Authority (HRA). The HRA is to have functions relating to health and social care research which are conferred in other sections in this chapter.
665. The HRA is to replace the Special Health Authority (SpHA) also known as the Health Research Authority and take on its functions, which include those relating to reviewing the ethics of research proposals in England. Like the SpHA, the HRA will have the objective of protecting and promoting the interests of actual and potential participants in health and social care research and the general public by facilitating and promoting high quality research that is safe and ethical. *Subsection (3)* abolishes the SpHA and the relevant instruments establishing it and conferring functions on it. *Subsection (4)* makes provision for the Secretary of State to make an order to transfer the property, rights and liabilities from the SpHA to the HRA.

#### ***Schedule 7 – The Health Research Authority***

666. This Schedule makes provision for the constitution and establishment of the HRA.

#### **Part 1 – Constitution**

667. *Paragraph 1* makes provision about the membership of the HRA. The Board will be made up of a chair, three or four non-executive members, a chief executive and two or three executive members.
668. *Paragraph 2* makes provision about the terms of appointment and tenure of office of non-executive members. Sub-paragraph (2) specifies that the maximum term for a non-executive is 4 years. Sub-paragraph (3) specifies that a person who ceases to be a non-executive member is eligible for re-appointment. Provision is made in sub-



*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

paragraph (4) to enable a non-executive member to resign at any time by giving notice to the Secretary of State, and sub-paragraphs (5) and (6) enable the Secretary of State to remove or suspend non-executive members from office on the grounds of incapacity, misbehaviour or failure to carry out his or her duties as a non-executive member.

669. *Paragraph 3* sets out the procedural requirements to be complied with where the Secretary of State suspends a non-executive member of the HRA under the power in paragraph 2(6).
670. *Paragraph 4* enables the Secretary of State to appoint a non-executive member as interim chair where the chair is suspended under paragraph 2(6), and sets out the conditions that apply to that appointment.
671. *Paragraph 5* requires the HRA to make payments to the non-executive members and the chair. The level of these payments would be determined by the Secretary of State.
672. *Paragraph 6* gives the HRA powers to appoint employees on such terms as it may determine. The appointment of the chief executive must be agreed by the Secretary of State.
673. *Paragraph 7* allows the HRA to decide the levels of pay, pensions or allowances it will make to its staff. In line with other arms-length bodies (for example, Monitor, Care Quality Commission, NHS Commissioning Board (known as NHS England) and, as covered by this Act, HEE), the HRA would be required to seek the approval of the Secretary of State to its policy on pay, pensions and allowances.
674. *Paragraph 8* makes provision about the appointment of committees and sub-committees by the HRA. Sub-paragraph (1)(a) and (b) requires the HRA to appoint a committee to advise the HRA and the Secretary of State in relation to their respective functions under the Health Service (Control of Patient Information) Regulations 2002. The advice to be given under sub-paragraphs (1)(a) and (1)(b) includes advice on applications to process confidential patient information for medical purposes to the HRA in the case of medical research and to the Secretary of State in other cases.
675. Sub-paragraph (1)(c) requires the committee to advise the Health and Social Care Information Centre. The committee would supply advice in connection with HSCIC's exercise of functions pursuant to further regulations under section 251 of the 2006 Act, and also in connection with any publication or other dissemination by HSCIC of information which identifies an individual or could potentially be used to identify an individual.
676. Sub-paragraph (3) requires the committee under sub-paragraph (1) to consist of persons independent of the HRA. Sub-paragraph (2) enables the HRA to appoint other committees and sub-committees. Committees appointed under paragraph 8 can include participants in research, potential participants and the public as well as any persons with particular expertise relevant to the committee's work, for example, nurses or social workers or any other person HRA considers appropriate. The HRA may pay members of its committees where they are not employees of the HRA.
677. *Paragraph 9* provides a power to set out in regulations the specific factors or matters to which the committee appointed by the HRA under paragraph 8(1) of Schedule 7 must have regard when advising on the exercise by:
- the HRA or the Secretary of State of functions under the Health Service (Control of Patient of Patient Information) Regulations 2002, or
  - the HSCIC of functions pursuant to further regulations under section 251 of the 2006 Act or any publication or other dissemination by the HSCIC of information which identifies or could be used to identify an individual.

Such factors or matters might include the need to ensure processing must respect and promote patient privacy and that an applicant for access to such information has not breached confidentiality in the past.

678. *Paragraph 10* allows the HRA to regulate its own procedure. So for example, this power may enable the HRA to remove the risk of a conflict of interest by preventing executive members from being involved in determining their own pay. Sub-paragraph (2) provides that a vacancy amongst the members of the HRA or a defect in appointment of a member does not prevent the HRA from continuing to operate.
679. *Paragraph 11* makes provision in relation to the HRA's seal which would be used to show approval of official HRA documents.
680. *Paragraph 12* provides that the status of the HRA would be a non-departmental public body that is not part of the Crown, nor regarded as a servant or agent of the Crown.

## **Part 2 - Functions**

681. *Paragraph 13* places a requirement on the HRA to exercise its functions effectively, efficiently and economically. Provision is made to enable the HRA to arrange for any person to exercise on its behalf, or assist with the exercise of its functions and to make payments to them. Sub-paragraph (5) gives the HRA a general power to do anything which appears to it to be necessary or desirable for the purpose of, or in connection with the exercise of its functions.
682. *Paragraph 14(1)* makes provision for the HRA to provide help or advice to another public authority (as defined in sub-paragraphs (3) and (4)) for the purpose of the exercise of functions by that public authority to meet its objectives. By way of example, it is envisaged that this power could be used to enable HRA to advise and assist the Human Fertilisation and Embryology Authority in relation to applications to process information under the [Human Fertilisation and Embryology \(Disclosure of Information for Research Purposes\) Regulations 2010 \(S.I. 2010/995\)](#). Sub-paragraph (2) makes provision for the HRA to determine the terms under which it provides the help or advice in sub-paragraph (1), including rates of pay and allowances.
683. *Paragraph 15* enables Scottish Ministers, Welsh Ministers, or the Department of Health, Social Services and Public Safety in Northern Ireland to arrange for the HRA to exercise certain functions. These are those functions which relate to health or social care research and correspond to a function of the HRA, or to provide services or facilities to them in connection with the exercise of such functions. Sub-paragraph (2) makes express provision to enable the parties to agree for the HRA to receive payments to recoup its costs.
684. If the Secretary of State considers that the HRA is failing or has failed to exercise its functions, and the failure is significant, *paragraph 16(1)* would give the Secretary of State the power to direct the HRA to perform its functions. If the HRA fails to comply with the direction made under sub-paragraph (1), sub-paragraph (2) would enable the Secretary of State to exercise the functions specified in the direction, or make arrangements for another person to exercise those functions on his behalf. Where the Secretary of State exercises the power under sub-paragraph (1) or (2), he must publish the reasons for doing so

## **Part 3 – Finance and reports**

685. *Paragraph 17* makes provision for the Secretary of State, with the consent of the Treasury, to make payments to the HRA. The payments could be made at any time and have any conditions attached to them which the Secretary of State considers appropriate.
686. *Paragraph 18* gives the Secretary of State the power to make regulations requiring a fee to be paid to the HRA for specified functions. Any regulations made under this section

would be subject to the affirmative parliamentary procedure. Any fees prescribed under this section, as determined by the HRA, would need to take account of the cost of the functions involved and must be approved by the Secretary of State.

687. *Paragraph 18(7)* applies existing legislation so that the members and staff of HRA are protected from personal liability whilst carrying out work on behalf of HRA. *Paragraph 17(9)* amends section 71 of the National Health Service Act 2006 to add the HRA to the list of bodies that may join a scheme established by the Secretary of State for the purpose of meeting expenses arising from any loss, damage or injury incurred by members, to their property and liabilities, and to third parties for loss damage or injury arising out of carrying out the functions of the bodies.
688. *Paragraph 19(1)* requires the HRA to keep accounts and prepare annual accounts for each financial year in a form to be determined by the Secretary of State, and which must be audited by the Comptroller and Auditor General.
689. *Paragraph 20* requires the HRA to prepare an annual report on the activities it has undertaken during the previous financial year and the activities it proposes to undertake during the current financial year. The report must include information about health and social care research which has taken place during the year as well as setting out the steps the HRA has taken to fulfil its objectives under section 110(2). The HRA must lay a copy of the report before Parliament and send a copy to the Secretary of State. *Paragraph 19(4)* provides that the HRA must provide the Secretary of State with other reports and information relating to the exercise of its functions on request.

#### **Part 4 – Consequential amendments**

690. *Paragraphs 21 to 27* make amendments to other primary legislation so that the relevant provisions apply to the HRA. For example, paragraph 23 amends Part 2 of Schedule 1 to the House of Commons Disqualification Act 1975 to insert the HRA into the list of bodies whose members are disqualified from membership of the House of Commons.

#### **General functions**

##### ***Section 110 – The HRA’s functions***

691. *Subsection (1)* sets out the HRA’s main functions. These functions relate to the co-ordination and standardisation of practice relating to the regulation of health and social care research, research ethics committees, membership of the United Kingdom Ethics Committee Authority under the Medicines for Human Use Clinical Trials) Regulations 2004 (Clinical Trials Regulations), and the process for approving the processing of confidential patient information for medical research. The functions are set out in detail in sections 109 to 115.
692. *Subsection (2)* sets out the main objective of the HRA when performing its functions to:
- protect participants and potential participants in health and social care research and the general public by encouraging safe and ethical research which conforms to generally accepted ethical standards as described in *subsection (6)*; and
  - promote their interests by facilitating the conduct of research which is safe and ethical. This includes by promoting transparency in research. *Subsection (7)* lists some of the ways in which transparency in research can be promoted, for example, by promoting the publication and dissemination of research findings and conclusions.
693. Therefore, for example, in carrying out its duty to cooperate with other bodies that hold research related functions the HRA would need to act in a way that will ensure that people are protected through safe and ethical standards whilst also facilitating research. This might involve, for example, removing duplication and ensuring proportionate regulation.

694. *Subsection (3)* defines health research as research into matters relating to people's physical or mental health. The definition does not include health research involving animals that is regulated by the Animals (Scientific Procedures) Act 1986. *Subsection (4)* defines social care research as research into matters relating to personal care or other practical assistance for individuals aged 18 or over who are in need of care or assistance for any of the reasons listed. The definitions of health research and social care research are not restricted to any particular professional group so, for example, they would include nurse-led research. The references to health or social care research in this chapter do not, except where otherwise stated, include research into matters which are within the legislative competence of the devolved legislature (the Scottish Parliament, the National Assembly for Wales or the Northern Ireland Assembly) (*subsection (5)*).
695. *Subsection (8)* provides a power to amend by order the list of functions in subsection (1) in consequence of functions being given to or taken away from the HRA or amended by other statutory enactments.

## **Regulatory practice**

### ***Section 111 – Co-ordinating and promoting regulatory practice etc.***

696. *Subsection (1)* imposes an obligation on the HRA and the people and bodies listed to co-operate with each other. The aim of this subsection is to encourage co-ordination and standardisation of practice of such bodies and persons when carrying out functions relating to the regulation of health and social care research. *Subsection (2)* provides that when exercising the duty to co-operate the HRA and specified people and bodies must have regard to the need to protect participants in health and social care research and the general public by encouraging safe and ethical research as well as promoting the interests of those people by facilitating the conduct of such research.
697. For example, the Secretary of State has both a duty to promote research in relation to the health service under section 1D of the National Health Service Act 2006 (the 2006 Act) and a power under paragraph 13 of Schedule 1 to the 2006 Act to conduct, commission or assist the conduct of research into any matters relating to the causation, prevention, diagnosis or treatment of illness, and research into any other matters connected with a service provided under the 2006 Act. The Secretary of State currently relies on these provisions to establish the National Institute for Health Research (NIHR) which funds research and the infrastructure to support research. As part of this role, the NIHR seeks to promote and coordinate proportionate research management systems within the NHS. Subsection (1)(a) requires the Secretary of State to work cooperatively with the HRA in relation to functions such as that of the NIHR.
698. The references to the Secretary of State and the licensing authority in subsection (1) (a) and (b) ensure that functions carried out by the Medicines and Healthcare Products Regulatory Executive Agency fall within the duty to co-operate. The reference to the Chief Medical Officer in subsection (1)(d) ensures that the Chief Medical Officer's function of receiving abortion notifications under regulation 4(1) of the Abortion Regulations 1991 (made under section 2 of the Abortion Act 1967) is covered by the duty.
699. There is a power to add to the list of the HRA's co-operation partners by way of regulations under subsection (1)(i). This may be used to include bodies that have relevant health and social care research functions conferred upon them in the future.
700. *Subsection (3)* imposes a freestanding duty on the HRA only to promote the co-ordination and standardisation of practice in relation to the regulation of health and social care research giving it the lead role in removing duplication and streamlining the regulation of health and social care research across the regulatory system. This is in addition to the reciprocal duty on HRA and the other bodies listed in subsection (1) to co-operate with each other in this particular area insofar as their respective functions relate to the regulation of health and social care research. One way in which the HRA

might meet this duty could be by continuing to run an integrated research application system (IRAS) currently administered by the HRA SpHA and by building on it to create a unified approvals process for research. The IRAS enables a researcher to enter information about their project into one application form which includes the information required for a number of different research approvals by different bodies.

701. *Subsection (4)* imposes an obligation on the HRA and the devolved authorities to co-operate with each other in the exercise of their functions where they relate to the regulation of assessments of the ethics of health and social care research, with a view to coordinating and standardising practice in the United Kingdom relating to the regulation of such research. Health and social care research in this context includes research that relates to the functions exercisable by a devolved authority or which is within the legislative competence of the devolved legislature (*subsection (10)*).
702. *Subsection (5)* requires the HRA to undertake a horizon scanning function to keep under review matters relating to the ethics of health and social care research and to advise the Secretary of State about such matters if requested.
703. The Department of Health currently publishes the Research Governance Framework for Health and Social Care which sets out the broad principles for good research governance. *Subsection (6)* requires the HRA to publish guidance on principles of good practice in the conduct and management of health and social care research, and any requirements imposed upon researchers in legislation or by other sources.
704. Under *subsection (7)*, a local authority, an NHS trust in England and an NHS foundation trust must have regard to guidance published under subsection (6).
705. *Subsection (8)* makes express provision that co-operation under subsection (1) or (4) can include sharing information.

## **Research ethics committees**

### ***Section 112 – The HRA’s policy on research ethics committees***

706. This section states the general policy of the HRA in relation to research ethics committees (RECs) it recognises or establishes under sections 114 and 115. The HRA needs to ensure that RECs provide an efficient and effective means of assessing the ethics of health and social care research. *Subsection (4)* sets out ways in which the HRA may fulfil this function, such as co-ordinating and allocating work to RECs, and providing help and advice. The HRA may also develop and maintain a training programme to ensure that RECs’ members and staff can carry out their work effectively. *Subsection (9)* requires the HRA to indemnify members of the RECs against certain risks that may be involved in the exercise of the committees’ functions in assessing the ethics of health and social care research.
707. RECs are defined by *subsection (2)* as a group which assesses the ethics of research involving individuals and gives examples of how research may involve individuals, including obtaining information, tissue or fluid from them.
708. *Subsection (3)* requires the HRA to publish a REC policy document to set out the requirements that RECs recognised or established by the HRA would be expected to comply with and must monitor their compliance. These requirements are currently set out in the Governance arrangements for RECs (GAfREC) document published by the Department of Health. *Subsection (5)* lists the requirements that may be included in the REC policy document. *Subsection (6)* requires the HRA to ensure that the requirements in the REC policy document do not conflict with the requirements imposed on ethics committees under the Clinical Trials Regulations. The Clinical Trials Regulations establish a body called the United Kingdom Ethics Committee Authority (UKECA) which has the power to establish and recognise ethics committees for the purpose of approving clinical trials on investigational medicinal products for human use in the UK



under the Clinical Trials Regulations. This subsection would enable a committee which is recognised or established by the HRA also to be able to meet the requirements for recognition by UKECA to ethically approve clinical trials of investigational medicines under the clinical trials regulations so as to avoid duplication. *Subsection (8)* allows the HRA to revise the document.

709. *Subsection (7)* requires the HRA to consult the devolved authorities and anyone else it considers appropriate on the content of the document before it is published. This also applies to any significant revision of the document made under subsection (8).

### ***Section 113 – Approval of research***

710. At present the Department of Health issues policy guidance on RECs (the GAFREC document) which sets out when the Department considers it is good practice or legislation requires them to seek approval of research by a REC, or where legislation requires the researcher to do so. *Subsection (1)* of this section requires the HRA to publish guidance setting out when it considers it good practice to seek approval of research by a REC.
711. *Subsection (2)* requires the HRA to consult the devolved authorities and other people it considers appropriate, and obtain approval of the Secretary of State before publishing guidance. Where the HRA revises its guidance, and it considers the revisions significant, it must consult and seek approval from the Secretary of State before publishing the revised guidance (*subsection (3)*).
712. *Subsection (4)* introduces Schedule 8, which contains amendments relating to references to RECs in secondary legislation.

### ***Schedule 8 – Research ethics committees (RECs): amendments***

713. **Schedule 8** makes consequential amendments to secondary legislation where references are made to RECs. The amendments replace references to ethics committees recognised by the Secretary of State with reference to those established or recognised by the HRA. The amendments also standardise the definitions of RECs to bring them into line with the definition of a REC under section 112.

### ***Section 114 – Recognition by the HRA***

714. This section makes provision for the HRA, following an application by or on behalf of a group of people, to recognise that group as a REC for the purpose of approving research of a type specified by the HRA in the guidance issued under section 113(1) or for the purpose of approving research where this is required under other legislation.
715. Under *subsection (2)* the HRA would only be able to recognise a REC if it is satisfied that the REC meets the requirements of the REC policy document published by the HRA under section 112(3), and that there is, or will be, a demand for such a group. *Subsection (3)* would require the HRA to take into consideration whether the group is already recognised as a REC by, or on behalf of, a devolved authority. *Subsection (4)* enables the HRA to do anything (including provide financial assistance) to help a group of people who want to be recognised to make an application which is likely to be successful. Therefore, for example the HRA may consider it appropriate to make a meeting room available to a REC in which they can conduct their business.
716. *Subsection (5)* gives the HRA the power to revoke recognition of a REC where it is satisfied that the recognised REC is not complying with the requirements of the REC policy document published by the HRA under section 112(3). Recognition may also be revoked if the HRA is satisfied that the group is not carrying out its function of assessing the ethical aspects of research, or is not doing so properly, or that the revocation is necessary or desirable for another reason.

717. Any group which was established or recognised by the SpHA Health Research Authority or by the Secretary of State as a REC, and which exists when the new provisions come into force would, under *subsection (6)*, receive automatic recognition by the HRA.

### ***Section 115 – Establishment by the HRA***

718. This section gives the HRA the power to establish RECs for the purpose of approving research of the type specified by the HRA in the guidance document issued under section 113(1), or giving such other approvals as are required. The HRA would be required, under *subsection (2)*, to ensure that any REC it establishes complies with the requirements in the REC policy document. Therefore, for example, if the guidance sets out requirements for lay membership, the REC must comply. *Subsection (3)* provides that the HRA has the power to abolish a REC it has established under this section.

### ***Section 116 – Membership of the United Kingdom Ethics Committee Authority***

719. This section amends regulation 5 of the Clinical Trials Regulations which provides for the membership of the United Kingdom Ethics Committee Authority (UKECA) to replace the Secretary of State's membership with that of the HRA and makes other amendment consequential on this change.

## **Patient Information**

### ***Section 117 – Approval for processing confidential patient information***

720. This section makes a number of amendments to the [Health Service \(Control of Patient Information\) Regulations 2002 \(S.I. 2002/1438\)](#) (the 2002 Regulations). These amendments transfer the Secretary of State's power to approve the processing of confidential patient information for research purposes to the HRA and change the way that the requirement for REC approval is expressed legally. These changes will retain the safeguards currently in place.
721. *Subsection (2)* amends regulation 5 of the 2002 Regulations to replace the requirement for approval from the Secretary of State and a REC for the processing of confidential patient information for the purpose of medical research, with a requirement for approval only from the Health Research Authority (new regulation 5(1)(a)). *Subsection (3)* inserts new sub-paragraph (2) into regulation 5 of the 2002 Regulations which provides that the HRA may not give approval under new paragraph 5(1)(a) unless a REC has approved the medical research concerned. This means that approval for processing confidential patient information for the purpose of medical research would require approval by the HRA as well as REC approval of the ethical aspects of the research concerned.
722. *Subsection (4)* inserts new sub-paragraph (3) into regulation 5 of the 2002 Regulations to require the HRA to put in place a system for reviewing decisions it makes in relation to the processing of patient information under sub-paragraph (1)(a).
723. *Subsections (5) to (8)* amend regulation 6 of the 2002 Regulations to require the HRA to record in a register details about any transfer of information which is approved under the regulations. Provision is also made to require the HRA to retain such information and to enable it to publish any entries in the register, as it considers appropriate.

### ***Chapter 3 – Chapters 1 and 2: Supplementary***

#### **Miscellaneous**

##### ***Section 118 – Transfer orders***

724. **Section 118** makes provision on transfer orders under section 96 (establishment of Health Education England) or section 109 (establishment of the Health Research Authority). Such an order may make provision for rights and liabilities relating to an individual's contract of employment.
725. In particular, it provides that, a transfer order may, amongst other matters, require that employees of the Special Health Authority are transferred to HEE or HRA as the case may be, under terms which are the same as or similar to those made by the Transfer of Undertakings (Protection of Employment) Regulations 2006 which provides certain protections of employment rights for transferred staff.

#### **General**

##### ***Section 119 – Part 3: interpretation and supplementary provision***

726. This section contains interpretation provisions for Part 3.

### ***Chapter 4 – Trust Special Administration***

##### ***Section 120 – Powers of administrator etc.***

727. This section further amends provisions relating to the functions of Trust Special Administrators (TSAs). Appointment of a TSA is one way in which action can be taken in exceptional circumstances to deal with NHS trusts and NHS foundation trusts which are operating unsustainably in their current form. On a TSA's appointment, an NHS trust's board of directors, and for an NHS foundation trust its council of governors also, is suspended. The TSA must produce a report stating the action the TSA recommends should be taken by the Secretary of State (in relation to NHS trusts) or Monitor (in relation to NHS foundation trusts).
728. The provisions for the Trust Special Administration regime were first introduced in the Health Act 2009, and provisions in the Health and Social Care Act 2012 amended them in relation to NHS foundation trusts. Although the arrangements for NHS trusts and NHS foundation trusts are similar, there are differences that reflect the greater autonomy of NHS foundation trusts. The Secretary of State appoints a TSA to an NHS trust, whilst Monitor appoints a TSA to an NHS foundation trust. The statutory objective of the trust special administration when a TSA is appointed to an NHS foundation trust is to ensure the continued provision of essential NHS services provided by that failing trust, whereas the Secretary of State sets the objective of the trust special administration at an NHS trust at the time of appointment of the TSA. The TSA of an NHS foundation trust is required by statute to seek the support of commissioners for their recommendations, whereas current expectations of a TSA of an NHS trust are set out in statutory Guidance. The final report on an NHS trust is submitted to the Secretary of State who decides what action to take, whilst the final report on an NHS foundation trust is submitted to Monitor which decides whether to accept the recommendations, with the Secretary of State having power to veto the recommendations if he is not satisfied, in accordance with various specified criteria.
729. This section amends the parts of the NHS Act 2006 and the Health and Social Care Act 2012, relating to the TSA's functions and special administration arrangements, to make six changes.
730. *Subsection (1)* provides that a TSA appointed to a failing NHS trust or NHS foundation trust has power to make recommendations, and Monitor/the Secretary of State has the

power to take decisions, that go wider than the trust under administration. This includes where the action affects other NHS trusts and NHS foundation trusts, and action which is “necessary for and consequential on” action taken in relation to the failing trust. These powers are not to be applied retrospectively.

731. *Subsections (2) and (5)* will give the TSA more time to complete two stages in their work. Subsection (2) increases the time period for the TSA to produce the draft report from 45 to 65 working days. Subsection (5) increases the period for the TSA to carry out the statutory consultation from 30 to 40 working days. The Secretary of State and Monitor’s powers to extend the statutory deadlines of the regime remain in place.
732. *Subsections (3), (4), (6) and (7)* amend the provisions relating to commissioner agreement to the recommendations of a TSA appointed to an NHS foundation trust, by requiring agreement to be sought from commissioners of other NHS trusts or NHS foundation trusts affected by the recommendations, in addition to commissioners of the trust under administration. This applies in relation to the TSA’s draft report, under subsections (3) and (4), and before any variation can be made to the draft report when producing the final report after the TSA’s consultation, under subsections (6) and (7).
733. Each commissioner must agree that the objective of the TSA has been achieved by the recommendations. In addition, each commissioner who commissions services from other trusts which the TSA’s recommendations affect, must also agree that the recommendations do not harm essential services at those other trusts which they commission. Essential services are defined at subsections (4) and (7) by reference to the same criteria as are applied originally when setting the objective of the TSA for the trust under administration. If any commissioner does not give a statement of their agreement, then the NHS Commissioning Board has to decide whether to give a statement of its agreement to the TSA’s recommendations or lay a copy of its reasons why not before Parliament. The Board will consider whether the objective of the TSA has been achieved, whether affected services at other trusts are essential and if so whether they are harmed, taking into account the views of all the local commissioners.
734. *Subsections (8), (9) and (11)* add to a TSA’s obligations to consult (including by holding meetings) by requiring a TSA to consult: (i) other NHS trusts and NHS foundation trusts affected by wider recommendations, their staff and their commissioners; (ii) any local authority in whose area the trust in administration and other affected trusts provide goods and services; and (iii) any Local Healthwatch organisation in the area of any such local authority. “Affected trust” is defined, and what is meant by the reference to a local authority is described, in *subsection (12)*. *Subsections (10) and (13)* make consequential and technical amendments.
735. *Subsection (14)* requires the Secretary of State to include in the statutory guidance for a TSA appointed to an NHS trust, guidance on seeking commissioner support and involving the NHS Commissioning Board in relation to finalising the draft and final report.
736. *Subsections (15), (16) and (17)* clarify that specific statutory consultation requirements on commissioners, NHS Commissioning Board and NHS trusts and foundation trusts that apply elsewhere in the NHS Act 2006 where those bodies plan and make service change, do not apply in respect of the special administration procedure and requirements arising from it. In the context of a trust special administration, section 65H of the 2006 Act requires the TSA to consult the public and certain other specified parties before finalising the draft report setting out his or her recommendations. These amendments avoid the need for duplicatory parallel consultation by these bodies.
737. *Subsection (18)* makes consequential amendments to Schedule 14 to the Health and Social Care Act 2012 in relation to these six changes.

## **Part 4 – Health and social care**

### **Integration**

#### ***Section 121 – Integration of care and support with health services etc: integration fund***

738. This section makes provision for a fund for the integration of care and support with health services, to be known as the Better Care Fund.
739. *Subsection (1)* amends section 223B of the National Health Service Act 2006 (funding of the National Health Service Commissioning Board) to allow the Secretary of State to specify in the mandate a sum which the Board must use for objectives relating to service integration. The mandate is given to the Board by the Secretary of State under section 13A of the National Health Service Act. ‘Service integration’ means the integration of health services with health-related or social care services.
740. *Subsection (2)* inserts a new section 223GA into the National Health Service Act 2006. Section 223GA allows the Board to direct clinical commissioning groups (CCGs) to use a designated amount of their financial allocation for purposes relating to service integration. It also makes provision for how the designated amount is to be determined. Payment of the designated amount must be subject to a condition that the CCG pays the money into a pooled fund established under arrangements made with a local authority under section 75 of the National Health Service Act. The Board may also set other conditions as to use of the designated amount, including conditions as to the agreement of a spending plan for how to use the amount, and the meeting of performance objectives. Where conditions are not met, the Board has various powers, including the withholding or recovery of payments. The mandate can include a requirement for the Board to consult with the Secretary of State or other persons before it exercises those powers. There is also provision for payments to be made out of a pooled fund to a local authority which is not a party to that fund, in respect of disabled facilities grants. In exercising its powers in relation to the Better Care Fund, the Board must have regard to the need for provision of health services, health-related and social care services.

### **Information**

#### ***Section 122 – The Health and Social Care Information Centre: restrictions on dissemination of information***

741. This section amends the Health and Social Care Act 2012 to provide that the Health and Social Care Information Centre (HSCIC) may only disseminate information under its general dissemination power in section 261(1) for the purposes of the provision of health care or adult social care or for the promotion of health. This would enable data to be made available for a wide range of health and care related purposes – including for the commissioning of those services, and the epidemiological research that is needed at the earlier stages of developing new treatments – but not for solely commercial purposes such as for commercial insurance. Section 122 also amends section 253 of the 2012 Act to make clear that, in carrying out any of its functions, the HSCIC must have regard to the need to respect and promote the privacy of those receiving health services and adult social care in England. *Subsection (4)* amends the 2012 Act to provide that the HSCIC must in exercising its functions under the 2012 Act of publishing or otherwise disseminating information have regard to any advice given to it by the committee that must be appointed by the HRA under paragraph 8(1) of Schedule 7 to the Act.



## **Part 5 – General**

### ***Section 123 – Power to make consequential provision***

742. This section provides power for the Secretary of State by order to make provision in consequence of the Act; in particular, an order may amend, repeal, revoke or modify the application of an enactment.
743. This power, in particular, will be used to make provision in respect of the repeal of the statutory provisions currently underpinning adult social care in England, and any necessary consequential amendments arising from such repeal.
744. This approach, making provision by order rather than on the face of the Act, is required to ensure consistency with similar repeal and consequential provision to be made, by order, under the Social Services and Well-being (Wales) Act (“the Welsh Act”). The Welsh Act received Royal Assent on 1 May 2014. The Welsh Act deals with the reform of adult social care in Wales, and therefore envisages repeal, in respect of Wales, of the same statutory provisions as will need to be repealed in respect of England. Such repeals, in respect of both territories, will be effected by a sequence of orders providing for, first, disapplication and then repeal (and in both cases for any necessary consequential amendments). The sequence would depend on which Act comes into force first. The repeals would be subject to savings in respect of the existing rights of those under the age of 18 and also in respect of any provisions that also extend to Scotland.

### ***Section 124 – Power to make transitional etc. provision***

745. This section provides power for the Secretary of State by order to make transitional provision in connection with commencement of the Act.

### ***Section 125 – Regulations and orders***

746. This section makes general provision about the powers to make regulations, and orders under the Act and for the Parliamentary procedures that apply in relation to such instruments. *Subsection (4)* lists the secondary legislation which is subject to the affirmative resolution procedure.

### ***Section 126 – General interpretation***

747. This section provides definitions for the purposes of the Act.

### ***Section 127 – Commencement***

748. *Subsection (1)* of this section provides that the provisions of Part 1 to 4 of the Act come into force on the day or days specified by the Secretary of State in an order, and different days may be specified for different purposes, including different geographical areas (*subsection (5)*). The provisions of Part 5 of the Act come into force on Royal Assent.

### ***Section 128 – Extent and application***

749. This section sets out the Act’s extent, a full description of which is in the “Territorial extent and application” section of this document.

### ***Section 129 – Short title***

750. This section provides the Act’s short title.

## **COMMENCEMENT**

751. [Section 127](#) provides for commencement. The provisions of the Act will come into force on a day specified in an order made by the Secretary of State.

## HANSARD REFERENCES

752. The table below contains a list of the Hansard references for the Care Bill's passage through Parliament. Copies of the various prints of the Care Bill that were produced during its passage can be found at <http://services.parliament.uk/bills/2013-14/care/documents.html>.

<i>Stage</i>	<i>Date</i>	<i>Hansard reference</i>
<b>House of Lords</b>		
<b>Introduction</b>	9 May 2013	Vol. 745 Col. 21
<b>Second Reading</b>	21 May 2013	Vol. 755 Cols. 746-834
<b>Committee</b>	4 June 2013	Vol. 745 Cols. 1113-1127; 1141-1168
	10 June 2013	Vol. 745 Cols. 1406-1429; 1453-1475; 1485-1506
	12 June 2013	Vol. 745 Cols. 1615-1663; 1678-1696
	3 July 2013	Vol. 746 Cols. 1227-1274; 1290-1312
	9 July 2013	Vol 747 Cols. 173-218; 239-266
	16 July 2013	Vol 747 Cols. 665-712; 726-150
	22 July 2013	Vol. 747 Cols. 1062-1125; 1135-1160
	29 July 2013	Vol. 747 Cols. 1546-1613;
<b>Report</b>	09 October 2013	Vol. 748 Cols. 82-137; 148-170
	14 October 2013	Vol. 748 Cols. 269-346
	16 October 2013	Vol. 748 Cols. 543-606; 621-640
	21 October 2013	Vol. 748 Cols. 786-858
<b>Third reading</b>	29 October 2013	Vol. 748 Cols. 1453-1481
<b>House of Commons</b>		
<b>Introduction</b>	30 October 2013	(no debate)
<b>Second Reading</b>	16 December 2013	Vol. 572 Cols. 487-586
<b>Committee</b>	9 January 2014	First Sitting - Cols. 1-26 Second Sitting - Cols. 27-80
	14 January 2014	Third Sitting - Cols. 83-116 Fourth Sitting - Cols. 117-166
	16 January 2014	Fifth Sitting - Cols. 169-192

*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

<i>Stage</i>	<i>Date</i>	<i>Hansard reference</i>
		Sixth Sitting - Cols. 193-240
	21 January 2014	Seventh Sitting - Cols. 243-282 Eighth Sitting - Cols. 283-326
	23 January 2014	Ninth Sitting - Cols. 329-356 Tenth Sitting - Cols. 357-404
	28 January 2014	Eleventh Sitting - Cols. 405-444 Twelfth Sitting - Cols. 445-500
	30 January 2014	Thirteenth Sitting - Cols. 503-528 Fourteenth Sitting - Cols. 529-564
	4 February 2014	Fifteenth Sitting - Cols. 567-612
<b>Report</b>	10 March 2014	Vol. 577 Cols. 46-145
	11 March 2014	Vol. 577 Cols. 181-279
<b>Third Reading</b>	11 March 2014	Vol. 577 Cols. 279-290
<b>House of Lords</b>		
<b>Lords Consideration of Commons Amendments</b>	7 May 2014	Vol. 753 Cols. 1477-1540
<b>House of Commons</b>		
<b>Commons Consideration of Lords Amendments</b>	12 May 2014	Vol. 580 Cols. 436-455
<b>Royal Assent</b>	14 May 2014	House of Lords Hansard: Vol. 753 Col. 1920 House of Commons Hansard: Vol. 580 Col. 859

## **GLOSSARY OF ABBREVIATIONS**

### ***ABBREVIATIONS USED IN NOTES***

<b>Abbreviation</b>	<b>Meaning</b>
1983 Act	Mental Health Act (1983)
2003 Act	Community Care (Delayed Discharges etc.) Act 2003
2006 Act	National Health Service Act 2006
2008 Act	Health and Social Care Act 2008
2012 Act	Health and Social Care Act 2012

*These notes refer to the Care Act 2014 (c.23)  
which received Royal Assent on 14 May 2014*

<b>Abbreviation</b>	<b>Meaning</b>
CCG	Clinical commissioning group
CQC	Care Quality Commission
ECHR	European Convention on Human Rights
EHC	Education, health and care
GAfREC	Governance arrangements for research ethics committees
HEE	Health Education England
HRA	Health Research Authority
HSCIC	Health and Social Care Information Centre
IRAS	Integrated research application system
LETBs	Local Education and Training Boards
NHS England	The name used by the NHS Commissioning Board established under the Health and Social Care Act 2012.
NIHR	National Institute for Health Research
RECs	Research ethics committees
SAB	Safeguarding Adults Board
SpHA	Special Health Authority
TSA	Trust Special Administrator
UKECA	United Kingdom Ethics Committee Authority
Wales Act	Social Services and Well-being (Wales) Act 2014