

# HEALTH AND SOCIAL CARE ACT 2008

---

## EXPLANATORY NOTES

### BACKGROUND AND SUMMARY

#### Part 5 – Miscellaneous

##### Duty of Primary Care Trusts

36. All NHS bodies are currently under a duty under section 45 of the Health and Social Care (Community Health and Standards) Act 2003 to ensure they have arrangements in place for the purpose of monitoring and improving the quality of care.
37. [Section 139](#) amends the National Health Service Act 2006 ('NHS Act 2006') by inserting a duty on PCTs to make arrangements to secure continuous improvement in the quality of healthcare provided by or for them. This duty replaces the current duty to improve quality in section 45 of the Health and Social Care (Community Health and Standards) Act 2003, requiring on-going improvement activity, and is aligned more closely with the duty imposed on English local authorities by section 3 of the Local Government Act 1999. The duty in section 45 of the 2003 Act will cease to apply in relation to English NHS bodies.

##### Pharmaceutical services

38. There are two different sources of finance which pharmacies receive for providing community-based NHS pharmaceutical services in England. One of these is the funding held centrally by the Department, known as the 'Global Sum'. The other source of finance, which also funds the cost of drugs and medicines, is currently included in the sums allocated to PCTs annually to meet the general expenditure incurred in discharging their functions ('the baseline allocations'). The proposed amendment refers to the Global Sum funding only.
39. The Global Sum funding pays fees and allowances for services such as dispensing prescriptions. It also pays for other essential pharmaceutical services such as advice on medicines, and pays the fees and allowances for appliance contractors who provide medical appliances.
40. The Department proposes that this central funding should be devolved to PCTs and be included in their baseline allocations, and published the consultation document "*Modernising financial allocation arrangements for NHS pharmaceutical services 2007*" on this proposal in July 2007. The current funding arrangements are provided for by sections 228 to 231 of, and Schedule 14 to, the NHS Act 2006. Amendments to these parts of the NHS Act 2006 are required in order to move the Global Sum to the baseline allocations of the PCTs in England.
41. The way that funding for the provision of pharmaceutical services in Wales operates mirrors the current system in England. The Welsh Ministers hold centrally the funding that pays fees and allowances for services such as dispensing prescriptions and the provision of advice to patients, which is also referred to as the 'Global Sum'. The Welsh Assembly Government proposes that this centrally held funding should be devolved to

Local Health Boards and be included in their baseline allocations. The current funding arrangements are provided for by sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 ('NHS (Wales) Act 2006'). Amendments to these parts of the NHS (Wales) Act 2006 are required in order to move the Global Sum to the baseline allocations of the Local Health Boards in Wales.

42. [Section 140](#) introduces Schedule 12, which contains the changes to the NHS Act 2006 that are needed to move funding for pharmaceutical services to PCTs and to allocate funding by reference to the PCT of the prescriber. These changes bring the management of funding for pharmaceutical services in line with funding for other community-based health services. Section 140, by introducing Schedule 12, also makes the changes necessary to the NHS (Wales) Act 2006 to move the funding for pharmaceutical services to Local Health Boards, and also to introduce the allocation of funding by reference to the Local Health Board of the prescriber.
43. The Secretary of State has committed to continue to set the levels of fees and allowances for nationally agreed services provided by community pharmacies in negotiation with the Pharmaceutical Services Negotiating Committee and in discussion with the NHS, and similarly for nationally agreed services provided by appliance contractors. An equivalent commitment has been given in respect of the setting of fees and allowances for pharmaceutical services in Wales. However, if in the future the Secretary of State decides to appoint PCTs or other persons to determine the funding for essential services, section 141 requires the instrument of appointment to be made in regulations, and likewise for Wales.

### **Indemnity schemes in connection with provision of health services**

44. Schemes can be set up through regulations made under section 71 of the NHS Act 2006 for meeting losses and liabilities of NHS bodies. These schemes can meet:
  - expenses arising from any loss or damage to their property; or
  - liabilities to third parties for loss, damage or injury arising out of the carrying out of the functions of the bodies concerned.
45. The NHS Act 2006 limits the membership of the schemes to specified individual NHS bodies or groups of NHS bodies. Current schemes cover clinical negligence, liabilities to third parties, and property expenses.
46. When these liability schemes were first established, the vast majority of NHS care was provided directly by NHS bodies. However, in recent years, non-NHS bodies have started to deliver NHS care, and the Secretary of State for Health also procures some health services directly. Section 142 will enable the regulations that establish the Clinical Negligence Scheme for Trusts to be amended to take account of these recent developments in the delivery of NHS care, so that the Secretary of State and non-NHS bodies treating NHS patients can benefit from the same cover that is available to NHS bodies in the unfortunate event that a liability arises.

### **Weighing and measuring of children**

47. The Foresight Report "*Tackling Obesities: Future Choices*"<sup>1</sup>, commissioned by the Government in 2005, was published by the Government's Chief Scientific Adviser and the Foresight Team from the Government Office for Science on 17 October 2007. The report sets out that in 2004 approximately 10% of boys and girls aged 6-10 were obese, and forecasts that these figures are likely to increase to 21% (boys) and 14% (girls) by 2025, and 35% (boys) and 20% (girls) by 2050. (These figures are based on the international standard and therefore give a lower prevalence of obesity than that

---

<sup>1</sup> *"Tackling Obesities: Future Choices" Government Office for Science, Department of Innovation, Universities and Skills, published October 2007. URN 07/1184*

currently recorded by the UK standard, which estimates that just under 17% of children aged 2-10 were obese in 2005).

48. The National Child Measurement Programme ('NCMP') records the height and weight of children (currently children in Reception and Year 6) in maintained primary and middle schools in England during the academic year. Some non-maintained schools also choose to participate in the programme. The Act allows for the extension of the NCMP to early years settings and to other primary school year groups.
49. The purpose of the NCMP is to gather population-level data to monitor trends in obesity and to inform local planning and delivery of services for children. It is one element of the Government's work programme to tackle childhood obesity.
50. Under current arrangements, parents may withdraw their children from participating in the programme. Children are also able to opt-out of the programme if they indicate they do not wish to participate. These features of the NCMP will continue. At present, parents are able to request their child's height and weight results from their PCT. The Act enables regulations to be made such that all parents whose children participate in the programme receive the results routinely.
51. Personal identifiers are stripped from the data before it is sent for analysis: the name of the child is removed; the date of birth is replaced with month of birth; and the home postcode is converted into lower super output area, which represents a larger geographic area.
52. The powers in the Act will enable regulations to be made to enable the aggregated data gathered during weighing and measuring to be used for performance management purposes, for example, as part of the new Local Government National Indicator Set, which will inform negotiation of Local Area Agreements.
53. In Wales, there is not currently a national programme of child height and weight measurement. Many NHS Trusts record height and weight at school entry, and some record it in Year 6, but this is not undertaken on a consistent organised basis, and data is not recorded or analysed centrally.
54. The National Public Health Service has been asked to undertake a feasibility study in 2007-08 for the creation of a national surveillance programme of children's height and weight. The Act will allow the Welsh Ministers to define the scope of any future national weighing and measuring programme. They will also be able to make provision by regulations regarding the manner in which children are to be weighed and measured and how any information gathered is to be made available to parents.

### **Human Rights Act 1998: provision of certain social care to be public function**

55. The Human Rights Act 1998 places a duty on all public authorities, which includes independent sector organisations when carrying out a public function, **not** to act incompatibly with the European Convention on Human Rights ('the Convention'). The Government's intention at the time of the passage of the Human Rights Bill through Parliament was that this would mean the protections provided by the Convention should apply to independent sector care homes when providing accommodation and care to an individual under a local authority contract. In the case of *YL v Birmingham City Council* [2007] UKHL 27, the House of Lords decided that when providing accommodation and care under a local authority contract independent sector care providers were not carrying out a public function and were therefore not public authorities for the purposes of the Human Rights Act. Accordingly, these providers are not required by the Human Rights Act to act compatibly with the Convention rights. Section 145 ensures that the protections provided by the Human Rights Act apply to people receiving publicly arranged care in an independent sector care home.

### **Direct payments in lieu of provision of care services**

56. Direct payments are cash in lieu of social services. They offer individuals who are assessed as needing community care services the opportunity to arrange their own personalised care, rather than receiving services directly provided by a local authority.
57. Direct payments have been available for adults of working age since 1997 (created by the Community Care (Direct Payments) Act 1996 and now made under the Health and Social Care Act 2001). The scheme was extended in 2000 to include older people and was further extended in 2001 (through the Health and Social Care Act 2001) to include carers, parents of disabled children and 16 and 17 year olds.
58. Direct payments are not currently available to people who lack capacity (within the meaning of the Mental Capacity Act 2005). A person lacks capacity in relation to a matter if they are unable to make a decision for themselves in relation to a particular matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
59. The current legislation (section 57(1) of the Health and Social Care Act 2001) states that an individual must be able to give their consent in order to receive a direct payment. People who lack capacity are unable to give this consent. In addition, regulations made under section 57 provide that individuals must also be able to manage their direct payments (with help if necessary) in order to be eligible to receive them.
60. This Act extends the existing direct payments scheme to include people who lack capacity (within the meaning of the Mental Capacity Act 2005). It allows a direct payment to be made to a person who can receive and manage the payment on behalf of a person who lacks capacity. This fulfils a commitment made in the 2006 White Paper "*Our health, our care, our say*". Extending direct payments will enable individuals currently unable to receive a direct payment, because they cannot consent to or manage the payment, to benefit from the flexibilities that direct payments offer. The section only covers direct payments made to adults under section 57 of the Health and Social Care Act 2001. It does not cover the direct payments made to the groups specified by section 17A of the Children Act 1989 (as substituted by section 58 of the Health and Social Care Act 2001): people with parental responsibility for a disabled child, disabled people with parental responsibility for a child, or disabled children aged 16 or 17.

### **Abolition of maintenance liability of relatives**

61. The liable relatives rule is set out in sections 42 and 43 of the National Assistance Act 1948 and in various other provisions mentioned in section 147. The liable relatives rule provides that spouses are liable to maintain each other and parents are liable to maintain their children. Local authorities have discretionary powers to ask such "liable relatives" to contribute to the cost of care should a relative for whom they are liable require assistance from the council. This power is inconsistently applied by local authorities across the country. The origins of the liable relatives rule date back to the time before the welfare state, when divorce was rare and there was only one breadwinner in the family, and it was commonly accepted that one spouse should support the other. These principles are now out of date, and do not apply to other aspects of the benefits system such as Pensions Credits. The Act will remove the powers of local authorities to seek liable relatives payments. This will bring the operating principles for the charging policy for social care in line with those that are used in the rest of the health and social care system.

### **Ordinary residence for certain purposes of National Assistance Act 1948 etc.**

62. The National Assistance Act 1948 gives local authorities statutory responsibilities in respect of persons over 18 for the provision of accommodation to those who are in need of care and attention which is not otherwise available. It also gives them responsibility for making welfare arrangements for specified people. The provision of accommodation

and care packages is generally funded by the authority in which an individual is “ordinarily resident”, which is usually where a person lives.

63. Under section 24(6) of the National Assistance Act 1948, if an individual is admitted to an NHS hospital they will be deemed to be ordinarily resident in the area in which they were living immediately before being admitted as a patient to the NHS hospital. This is regardless of whether or not they in fact continue to be ordinarily resident in that area. This is referred to as the “deeming provision”. In recent years the NHS has increasingly accommodated patients in places other than NHS hospitals. The statutory rules governing how local authorities establish the person’s ordinary residence, when providing social care services, after the patient leaves these non-NHS settings are therefore out of step with the way NHS services are provided.
64. Disputes about where an individual is ordinarily resident arise between local authorities when, for example, an individual has lived in different areas whilst receiving care or moves to a different area to receive the care needed. Section 32(3) of the National Assistance Act 1948 originally provided that all disputes between local authorities as to the ordinary residence of a person were to be determined by the Secretary of State. As a result of the transfer of functions following Welsh devolution, the Secretary of State remains responsible for determinations in relation to disputes between English local authorities while the Welsh Ministers make determinations in relation to disputes between Welsh local authorities. This Act puts a mechanism in place to allow for the determination of disputes between English and Welsh local authorities.
65. The Chronically Sick and Disabled Persons Act 1970 does not state explicitly whom local authorities should approach to resolve ordinary residence disputes under section 2 of that Act. This Act makes provision to fill this gap.
66. In summary, section 147 makes provision about a number of discrete matters, which include:
  - the extension of the deeming provision in section 24(6) National Assistance Act 1948;
  - a mechanism for resolving ordinary residence disputes between English and Welsh local authorities; and
  - provision for ordinary residence disputes under section 2 of the Chronically Sick and Disabled Persons Act 1970 to be determined by the Secretary of State for Health or by the Welsh Ministers (in accordance with arrangements made and published under the National Assistance Act 1948).

### **Financial assistance related to provision of health or social care services**

67. The Department of Health’s White Paper, “*Our health, Our care, Our say*” (published in 2006) included a commitment to support and encourage social enterprises in health and social care.
68. There is no single definition of a social enterprise and there are many legal forms. However, a general description would be ‘businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community’.
69. In the White Paper, the Department also identified lack of access to finance as a barrier to the development of social enterprises. To address this, the Department made a commitment to establish a fund within its budget to support social enterprises delivering health and social care. This fund is now the Social Enterprise Investment Fund (‘SEIF’), which was established in August 2007 as a means of facilitating access to finance for social enterprises and to provide support for business start-ups. While it has been possible to open the SEIF and make grants to 26 social enterprise pathfinders, existing powers are not sufficient to allow further development of the SEIF; for example, to

provide a range of different investments (for example, grants, loans and guarantees) to qualifying organisations.

70. [Sections 149 to 156](#) ensure that the Secretary of State has the powers to finance social enterprises delivering health and social care, and social enterprises providing services that are related to health and social care, provided the social enterprises meet certain qualifying conditions. This means that the Secretary of State may, for example, finance a social enterprise delivering integrated health and social care for homeless people and/or a social enterprise providing support services to NHS or social care providers.
71. In addition, the Secretary of State will be able to finance any person (this includes bodies) who wishes to set up a social enterprise to deliver such services. However, like the existing social enterprises, the social enterprise that is being set up must comply with the qualifying conditions.
72. The qualifying conditions set out in the sections are intended to ensure that the funding is only for those businesses with primarily social objectives, which reinvest their surpluses or profits into the community, or into a service with social benefits.
73. The sections allow the Secretary of State to delegate these powers to NHS trusts, PCTs, Strategic Health Authorities, Special Health Authorities, and other organisations such as companies. The latter will enable a company to manage the SEIF within the parameters set by the Secretary of State. Provision is also made for the Secretary of State to impose terms and conditions on the financial support given to social enterprises.

### **National Information Governance Board for Health and Social Care**

74. Information governance refers to the structures, policies and practices which are used to ensure the confidentiality and security of records relating to the delivery of services. It aims to ensure the ethical and appropriate use of them for the benefit of individuals and the public good.
75. A review of information governance carried out in 2005 by Harry Cayton, then National Director for Patients and the Public at the Department of Health, identified nine different bodies or groups developing, contributing to or interpreting information governance with no single coordinating body. The bodies identified included the Patient Information Advisory Group ('PIAG'), which is a statutory body reporting to the Secretary of State. Whilst it has some responsibility for advising the Secretary of State on general information governance matters, its major role is to advise on and administer the statutory arrangements which allow the Secretary of State to lift the common law duty of confidentiality in specific circumstances. These arrangements enable identifiable patient information to be disclosed and used for essential NHS activity and medical research without patient consent where the activity is sufficiently in the public interest.
76. The majority of the bodies identified have now been closed, merged or do not have a national role in information governance, and an interim National Information Governance Board has been put in place. However, PIAG remains as the statutory body.
77. To complete the transition to a clear, authoritative and accountable structure with a single board dealing with all information governance matters for both health and social care a statutory National Information Governance Board will replace PIAG as the statutory body. Its remit and statutory powers will be broader than those of PIAG and its membership will reflect this. The functions of PIAG will be transferred to the statutory National Information Governance Board.
78. [Section 157](#) establishes the National Information Governance Board for Health and Social Care ('the National Information Governance Board').
79. Currently there is a lack of clarity for individual organisations seeking advice on information governance matters and this could lead to different interpretations of

legislation and policy. A single body is needed that is structured to meet current and future needs, and which also has the necessary statutory powers to oversee information governance arrangements, in order to support the NHS and social care staff by providing a national source of guidance and advice. The National Information Governance Board will aim to provide service users and the public with confidence that appropriate measures are in place to protect information. It will work to facilitate the appropriate sharing of information in order to support the delivery of seamless care.

80. The increasing use of information technology to support the delivery of care, and the existence of some public concerns about this, also serves to emphasise the need for national clarity about information governance and openness in its application. The Act defines the role and constitution of the Board to support the pursuit of these objectives.
81. Establishing the National Information Governance Board will not remove local responsibility for information governance. This will continue to be exercised by the heads of local NHS and/or social care organisations.
82. The Secretary of State will make provision by regulations on several matters relating to the Board, including the appointment of the Chair and other members of the Board. However, the intention is that the Chair will be appointed by the Secretary of State and that the membership will be either lay members, appointed by an independent appointments body (for example the Appointments Commission), or representative members nominated by stakeholder organisations to represent them on the Board. It is also intended that the number of lay members will exceed the number of representative members.
83. The National Information Governance Board will have responsibility for the NHS Care Record Guarantee for England. This sets out the rules that will govern information held in the NHS Care Records Service, which is being implemented as part of the National Programme for IT in the NHS. An equivalent guarantee is being developed for social care.
84. Once established as a statutory body the National Information Governance Board will take over the responsibilities of the current statutory body, PIAG, which will then be abolished.

### **Functions of the Health Protection Agency in relation to biological substances**

85. The National Biological Standards Board ('the NBSB') was established as a body corporate under the Biological Standards Act 1975 and it performs functions relating to the establishment of standards for, the provision of standard preparations of, and the testing of, biological substances. The transfer of its functions to the Health Protection Agency delivers one of the outcomes of the Department of Health's Arm's Length Body Review by reducing the number of Arm's Length Bodies.
86. [Section 159](#) abolishes the NBSB and gives functions to the Health Protection Agency corresponding to the NBSB's functions. It also enables the Health Protection Agency to be given any other functions that could have been given to the NBSB.