These notes refer to the Health and Social Care Act 2008 (c.14) which received Royal Assent on 21 July 2008

HEALTH AND SOCIAL CARE ACT 2008

EXPLANATORY NOTES

BACKGROUND AND SUMMARY

Part 1 – The Care Quality Commission

3. The regulation of health care in England is currently carried out by the Commission for Healthcare Audit and Inspection ('CHAI'), known as the Healthcare Commission. Social care is regulated by the Commission for Social Care Inspection ('CSCI'). CHAI and CSCI were created by the Health and Social Care (Community Health and Standards) Act 2003.

4. The Mental Health Act Commission ('MHAC') is the body currently responsible for monitoring key aspects of the operation of the Mental Health Act 1983 (the 'Mental Health Act') in England and Wales. It has other specific functions as well, notably to appoint registered medical practitioners to give second opinions where this is required by the Mental Health Act, to review decisions to withhold postal packages of patients detained in high security psychiatric hospitals, to visit and interview, in private, patients subject to the Mental Health Act, and to investigate complaints.

5. In the 2005 budget statement, the Chancellor announced plans to reduce the number of public service inspectorates. This included the creation of a single inspectorate for social care and health by merging CHAI and CSCI. The Department of Health had already announced plans to bring together CHAI and MHAC in 2004 following a review of Arm's Length Bodies[1].

6. The *NHS Improvement Plan*[2], (published by the Department of Health in 2004) and "*Health Reform in England: update and next steps"* (published by the Department in 2005) set out the main strands of health reform, which include diversity in provision of services, increased patient choice, and a stronger patient voice and stronger commissioning. These reforms require changes to be made to the regulatory framework.

7. The Department of Health commissioned a research study in July 2006[3] to support the development of the policy on regulation of health and adult social care. It followed wide engagement with interested stakeholders as part of the Wider Regulatory Review. It drew on lessons from other sectors, and from other health and social care systems abroad to describe the regulatory functions needed to ensure the effective operation of these systems. It then proposed options for the future regulatory architecture for health and social care, and assessed the advantages and disadvantages of each option.

8. The Department of Health consultation "*The future regulation of health and adult social care in England"*, published in November 2006, built on this initial study and announced the Government's intention to create a new single regulator responsible for regulating health care and adult social care, and monitoring the operation of the Mental Health Act. The consultation ran for three months and the Department consulted widely with a range of stakeholders. In addition to receiving over 100 responses to

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1 [1] *Reconfiguring the Department of Health's Arms Length Bodies, published July 2004.*
2 [2] *The NHS Improvement Plan: Putting People at the Heart of Public Services, The Stationery Office, published June 2004.*
3 *Independent Research Study: the Future of Health and Adult Social Care Regulation,* published November 2006.

the consultation, workshops were held for NHS Confederation members, including independent sector affiliates. Two social care workshops, one for social care service users and provider organisations, and one for commissioners of adult social care and Local Government representatives were also held. The Department also worked with the existing regulators throughout the process.

9. Chapter 1 of Part 1 of the Act establishes a new body called the Care Quality Commission ('the Commission'). The Commission will be responsible for the registration, review and inspection of certain health and social care services in England (but not any care services that are regulated by the Chief Inspector of Education, Children's Services and Skills ('CIECSS')). It will replace CHAI and CSCI. The functions currently performed by MHAC will be transferred to the Commission and the Welsh Ministers.

10. Chapter 2 of Part 1 creates a system of registration for providers and, in some cases, managers of health and adult social care. Regulations will set out the health and social care activities (referred to as 'regulated activities'), which a person will not be able to carry on unless that person is registered to do so. The intention is that all providers, including, for the first time, NHS providers, will be brought within the ambit of registration. The new registration system replaces (in England) the current requirement for certain establishments and agencies providing independent health care or adult social care to be registered under the Care Standards Act 2000. The Commission will need to be satisfied that applicants for registration comply with registration requirements, which will be set out in regulations. Once a provider or manager has been registered, the Commission will be responsible for checking continued compliance with these requirements, and will have a range of sanctions so that it can take appropriate action where providers or managers fail to meet the requirements. The Commission will have a wider range of powers than its predecessor organisations, including the power to issue penalty notices for non-compliance with regulatory requirements and the power to suspend registration.

11. Chapter 3 of Part 1 requires the Commission to carry out periodic reviews of care provided by or commissioned by Primary Care Trusts ('PCTs') or English local authorities to see how well the bodies reviewed are doing. It also requires the Commission to review health care provided by PCTs, English NHS Trusts and NHS Foundation Trusts. It provides for the Secretary of State to extend the review power to cover care provided by other registered providers by regulations. These reviews will assess performance by reference to indicators of quality that will be set or approved by the Secretary of State. The Commission may also carry out other special reviews and investigations, and must carry out such reviews and investigations if the Secretary of State requests it to do so. Chapter 3 of Part 1 replaces and expands CHAI's and CSCI's review and investigation functions under the Health and Social Care (Community Health and Standards) Act 2003.

12. Chapter 4 of Part 1 transfers to the Commission and the Welsh Ministers various functions under the Mental Health Act. It also makes some changes to those functions.

13. Chapter 5 of Part 1 confers further functions on the Commission, including a requirement for the Commission to provide information and advice to the Secretary of State on the provision of NHS care and adult social services and the carrying on of regulated activities. It also enables the Commission to report on the efficiency and economy of local authority and NHS provision and commissioning. The functions in Chapter 5 replace and expand equivalent functions of CHAI and CSCI under the Health and Social Care (Community Health and Standards) Act 2003.

14. Chapter 6 of Part 1 sets out the powers of entry and inspection which the Commission has for the purposes of carrying out its functions. It also deals with the Commission's interaction with other authorities and makes a number of other provisions relevant to Chapters 1 to 5 of Part 1.

Part 2 – Regulation of Health Professions and Health and Social Care Workforce

15. There is a statutory framework for the regulation of each of the healthcare professions and for the social care workforce. The Act's provisions affect the following 12 independent statutory bodies:

- General Chiropractic Council
- General Dental Council
- General Medical Council ('GMC')
- General Optical Council ('GOC')
- General Osteopathic Council
- Health Professions Council
- Nursing and Midwifery Council ('NMC')
- Pharmaceutical Society of Northern Ireland ('PSNI')
- Royal Pharmaceutical Society of Great Britain ('RPSGB')
- General Social Care Council ('GSCC')
- Care Council for Wales ('CCW')
- Hearing Aid Council

16. The main purpose of these regulatory bodies is to provide protection for both patients and the public through the execution of their statutory duties. Each regulator's constitution, functions, and duties are laid out in individual Acts and statutory instruments.

17. In addition, the Council for the Regulation of Health Care Professionals ('CRHP') was established by the National Health Service Reform and Health Care Professions Act 2002 ('the Health Care Professions Act 2002'). Its general functions (as set out in section 25 of that Act) are:

- to promote the interests of patients and other members of the public in relation to the performance of the healthcare regulatory bodies, their committees and officers;
- to promote best practice in the performance of those functions;
- to formulate principles relating to good professional self-regulation, and to encourage regulatory bodies to conform to them; and
- to promote co-operation between regulatory bodies, and between them and any other body performing corresponding functions.

18. Prior to the Health Act 1999 it was only possible to make changes to the Acts relating to the healthcare professions by presenting a Bill to Parliament. Section 60 of the Health Act 1999 allows Her Majesty, by Order in Council, to modify the regulation of the existing regulated healthcare professions, and to bring other healthcare professions into statutory regulation. An Order may repeal or revoke an enactment or instrument, amend it, or replace it (subject to the restrictions in paragraphs 7 and 8 of Schedule 3 to the Health Act 1999). The Government must consult on draft Orders prior to laying them before Parliament. The Orders are subject to the affirmative procedure.

19. The regulation of the social care workforce in England and Wales is governed by Part 4 of the Care Standards Act 2000 which established the GSCC and the CCW. The GSCC and the CCW (referred to collectively as 'the Councils') regulate the training of social workers, maintain registers of social care workers, and produce codes of good practice for social care workers and for employers of such staff. The purpose of regulation is to

establish an independent standard of training, conduct and competence for the social care workforce for the protection of the public and for the guidance of employers, with the goal of improving standards in social care work. New powers in this Act will enable modification of the regulation of the social care workforce. These powers broadly mirror the existing powers in section 60 of the Health Act 1999 which enable modification of the regulation of the healthcare professions.

20. Paragraphs 4.32 to 4.37 of the White Paper *"Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century"* (*'Trust, Assurance and Safety'*, published in February 2007) set out the Government's intention regarding the separation of adjudication of fitness to practise cases from their investigation and prosecution. Part 2 of the Act provides the legislative underpinning for this through the creation of the Office of the Health Professions Adjudicator ('the OHPA').

21. Paragraphs 1.8 to 1.14 of *Trust, Assurance and Safety* set out the Government's position regarding the independence and composition of the health profession regulatory bodies, particularly the current proportion of lay membership of the councils of these bodies. Recommendations were made that future lay involvement in the work of the regulators should be expanded generally, but specifically that there should, as a minimum, be parity of lay members with professional members and that a lay majority should also be possible if desired. Part 2 of the Act provides the legislative underpinning for this through amendments to the Health Act 1999.

22. Paragraphs 4.3 to 4.13 of *Trust, Assurance and Safety* set out the inconsistency in respect of the standard of proof used in fitness to practise proceedings by the health profession regulatory bodies. Only two regulators (the GOC and the NMC) still use the criminal standard while all other regulators use the civil standard. The Government recommended that all the regulators should use the civil standard in fitness to practise proceedings and Part 2 of the Act provides for this to be incorporated into legislation through amendments to the Health Act 1999. A similar provision is made to use the civil standard in any proceedings which relate to a social care worker's suitability to be or remain registered. This ensures consistency between the regulation of health professionals and the social care workforce in this area.

23. The regulation of pharmacy is shared by two bodies, the RPSGB and the PSNI. The RPSGB's responsibilities cover professional regulation as well as leadership and representation of the profession. It also has an important role regulating and inspecting pharmacy premises and the Government has recently put in place legislation (in England and Wales) to enable it to take on the role of regulating pharmacy technicians. The RPSGB's responsibilities towards pharmacists for professional leadership are potentially in conflict with its role as an independent regulator for the profession itself. The professions are taking on an increased clinical role in the treatment of patients, whereby pharmacists have the autonomy to prescribe potent drugs. Therefore, this dual responsibility does not provide sufficient reassurance to the public that there is effective independent regulation of this role. Separation of the regulatory system from that of professional and clinical leadership will allow each distinct function to focus solely on its core role.

24. Amendments are required to the Health Act 1999 to allow an Order made under section 60 of that Act to remove the statutory function of pharmacy regulation from the RPSGB and the PSNI and transfer these functions to the proposed General Pharmaceutical Council. This new General Pharmaceutical Council will be responsible for the regulation of pharmacists, pharmacy technicians and pharmacy premises. This approach was set out in paragraphs 1.29 to 1.36 of *Trust, Assurance and Safety* and supported by the Working Party chaired by Lord Carter of Coles. The statutory powers of the RPSGB and the PSNI (subject to a decision by Northern Ireland Ministers to proceed in this way) would be transferred to the new regulatory body.

25. The Hearing Aid Council was established by the Hearing Aid Council Act 1968. Since 2003 it has been operating as an Executive Non-Departmental Public Body. Its general functions are:

- to set requirements for registration and practice as a "dispenser of hearing aids" (as defined in section 14 of the 1968 Act, and referred to elsewhere in these notes as a "private hearing aid dispenser");
- to maintain a register of hearing aid dispensers and of employers of registered hearing aid dispensers;
- to maintain standards of practice for dispensers;
- to investigate whether standards have been breached by registered dispensers;
- to take disciplinary action against dispensers who have breached its regulations/ standards.

26. Amendments are required to section 60 of, and Schedule 3 to, the Health Act 1999 to allow for the transfer of the regulation of private hearing aid dispensers, currently regulated by the Hearing Aid Council, to the Health Professions Council. The Government committed, following the Hampton Report[4], to abolishing the Hearing Aid Council by April 2009. The decision was taken to transfer responsibility for the regulation of private hearing aid dispensers to the Health Professions Council. This will reduce the number of regulators but more importantly provide improved protection for the hearing impaired. Part 2 of the Act therefore also contains provision for the dissolution of the Hearing Aid Council following this transfer.

27. Paragraphs 3.35 to 3.39 of *Trust, Assurance and Safety* set out the Government's intention for oversight of local elements of revalidation and sharing information on concerns about doctors. Part 2 of the Act provides the legislative underpinning for this through the establishment of the role of the "responsible officer".

28. By way of overview, Part 2 of the Act contains changes to the regulation of health professions and the health and social care workforce. This is in line with the Government's response[5] to various inquiries into the actions of specific health professionals[6]. Provision is made for:

- the creation of a new body, the OHPA, which will have adjudication functions in relation to the professions regulated by the Medical Act 1983 and the Opticians Act 1989;
- amendments to Part 3 of the Health Act 1999: extending the powers under section 60 of that Act (including, in relation to pharmacy, measures to facilitate

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4 *Reducing administrative burdens: effective inspection and enforcement*, published March 2005.

5 A White Paper: *Trust, Assurance and Safety - the Regulation of Health Professionals in the 21st Century*, published February 2007;
Safeguarding Patients – the Government's response to the Shipman Inquiry's fifth report and the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries; and
Learning from tragedy, keeping patients safe: Overview of the Government's action programme in response to the recommendations of the Shipman Inquiry

6 *An inquiry into quality and practice within the National Health Service arising from the actions of Rodney Ledward:* published 2002;
The Report of The Royal Liverpool Children's Inquiry: published January 2001*;*
Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995: published July 2001;
The Shipman Inquiry Third Report: Death Certification and the Investigation of Deaths by Coroners: published July 2003;
The Shipman Inquiry Fourth Report: The Regulation of Controlled Drugs in the Community: published July 2004;
The Shipman Inquiry Fifth Report: Safeguarding Patients: Lessons from the Past - Proposals for the Future: published December 2004;
Committee of inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neal: published August 2004;
Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling – published September 2004; and
The Kerr/Haslam Inquiry: published July 2005

the establishment of a General Pharmaceutical Council; measures to allow the transfer of the regulation of private hearing aid dispensers from the Hearing Aid Council to the Health Professions Council; and the removal of the restriction that currently prevents there being a lay majority on the councils of the regulatory bodies); imposing the use of the civil standard of proof by healthcare professions regulators in proceedings relating to fitness to practise;

- the renaming of the CRHP as the Council for Healthcare Regulatory Excellence, and amendments to its constitution and functions and the way members are appointed;
- regulations to require designated bodies in the United Kingdom to nominate or appoint "responsible officers" who will have responsibilities relating to the regulation of doctors. Designated bodies will be bodies that provide, or arrange for the provision of, health care or employ, or contract with, doctors;
- the extension of the role of responsible officers in England and Wales and Northern Ireland to clinical governance issues, in particular the monitoring of conduct and performance of doctors, through regulations;
- the creation of a general responsibility on healthcare organisations, and other specified bodies in England and Wales, to share information regarding concerns about the conduct and performance of healthcare workers, and to agree the actions needed to protect patients and the public;
- the abolition of the Hearing Aid Council on the basis of the transfer of responsibility for the regulation of private hearing aid dispensers to the Health Professions Council;
- a regulation-making power to enable modification of the legislation governing regulation of social care workers in England and Wales; and requiring the application of the civil standard of proof in proceedings concerning the suitability of a social care worker to be or remain registered in England or Wales;
- a regulation making power to enable modification of the functions of the GSCC and the CCW in relation to the education and training of approved mental health professionals ('AMHPs').

Part 3 – Public Health Protection

29. The Public Health (Control of Disease) Act 1984 ('the Public Health Act 1984') consolidates earlier legislation, much of it dating from the 19th century. Many of its assumptions, both about risks and about how society operates, are now out of date. Most concerns about health threats have, since the 19th century, related to infectious disease (plague, cholera and the like). This is reflected in the way that Part 2 of the Public Health Act 1984 focuses on infectious disease. It makes highly detailed provision on some matters (for example, it is a criminal offence to expose a public library book to plague, or to hold a wake over the body of a person who has died of cholera) but does not address other matters that are now of concern, such as contamination by chemicals or radiation. Part 3 of this Act updates the Public Health Act 1984 to take account of these points.

30. Internationally the case for taking an "all hazards" approach to dealing with such health threats was taken up by the World Health Organization ('WHO') and reflected in the International Health Regulations 2005 ('IHR'). The IHR are the means by which WHO aims to prevent and control the international spread of disease, by action that is commensurate with and restricted to public health risks, and which avoids unnecessary interference with international traffic and trade. The previous International Health Regulations (1969) were concerned with action at international borders in relation to three specific infectious diseases (cholera, plague and yellow fever), but increasingly were recognised as unable to deal with new threats, such as SARS. The new IHR are

concerned with infectious diseases generally, and also with contamination. They also pay more attention than their predecessors to the arrangements needed in-country to deliver an effective response to health risks. The IHR came into effect in June 2007. This Act amends the Public Health Act 1984 to enable IHR to be implemented, including WHO recommendations issued under them.

Part 4 – Health in Pregnancy Grant

31. The health and general well-being of pregnant women in the last months of pregnancy is widely acknowledged to have a correlation with the health and development of a child later in life. Providing pregnant women with additional financial support towards meeting the extra costs at this time, linked to the requirement to seek maternal health advice from a health professional, is intended to help provide them with the knowledge and means to invest in their pregnancy to meet their individual needs.

32. Under the Government's current strategy of financial support, families on low incomes may claim support during pregnancy in the form of the Sure Start Maternity Grant to help with additional costs at the time of the child's birth, and Healthy Start Vouchers to help with the costs of a healthy diet during pregnancy.

33. In the Pre-Budget Report 2006, the Chancellor of the Exchequer announced that additional financial support would be made available to all women in the last months of pregnancy in line with the principle of progressive universalism, delivering support for all pregnant women and more help for those who need it the most.

34. Part 4 creates the Health in Pregnancy Grant. The Health in Pregnancy Grant will sit within the existing financial support system and will make support available to all expectant mothers in the UK in recognition of the importance of a healthy lifestyle, including diet, during the final weeks of pregnancy, and to help women to afford the other additional costs faced at this time. It is a new non-contributory, non-income related benefit payable where a woman has reached a specified stage of her pregnancy and has received the necessary health advice. It will be administered by HM Revenue and Customs. It is not taxable.

35. Part 4 also contains measures regarding the conditions of entitlement, the rate and the administration of the Health in Pregnancy Grant to be provided for in:

- Part 8A of the Social Security Contributions and Benefits Act 1992 ('the Contributions and Benefits Act');
- Part 8A of the Social Security Contributions and Benefits (Northern Ireland) Act 1992 ('the Northern Ireland Contributions and Benefits Act');
- The Social Security Administration Act 1992;
- The Social Security Administration (Northern Ireland) Act 1992;
- The Northern Ireland Act 1998;
- The Immigration and Asylum Act 1999.

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*"[7], 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 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

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7 [7] *"Tackling Obesities: Future Choices" Government Office for Science, Department of Innovation, Universities and Skills, published October 2007. URN 07/1184*

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 themself 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.

Part 6 – General

87. Part 6 provides for the territorial extent of the provisions of the Act and lays down the Parliamentary procedure which applies to orders and regulations made under powers contained in the Act. It also provides for the provisions of the Act to come into force in accordance with orders made by the Secretary of State (or by the Welsh Ministers in relation to a number of provisions in so far as they apply to Wales, or by the Department of Health, Social Services and Public Safety in Northern Ireland ('DHSSPSNI') in relation to a number of other provisions in so far as they relate to Northern Ireland, or by the Treasury in relation to Part 4). It confers power on the Secretary of State to make transitional, transitory, supplementary, incidental or consequential provision or savings by order. Power is also conferred on the Welsh Ministers to make transitional or transitory provision or savings in relation to those provisions of the Act which they have the power to commence.