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Statutory guidance

Adult social care provider information provisions:

guidance for providers on data collection

Updated 6 October 2022

Applies to England

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This publication is available at <https://www.gov.uk/government/publications/health-and-care-act-2022-adult-social-care-provider-information-provisions/adult-social-care-provider-information-provisions-guidance-for-providers-on-data-collection>

Background

The coronavirus (COVID-19) pandemic exposed challenges in bringing together data needed to effectively manage outbreaks and ensure that emerging risks and issues could be identified at all levels and appropriate action taken. This has highlighted the importance of having robust data flows in the adult social care (ASC) sector to provide assurance that local and national government have the data and local intelligence to provide oversight and national support where it is needed in the longer term.

We need quality and timely ASC data that is collected to high standards and is transparent and accessible to all who need it to support high-quality commissioning, systems assurance and the management of risks at local, regional and national levels. This will help to ensure that nationally, regionally, locally and at provider-level, ASC data is used to benefit the system and support people who draw on care and support to make informed choices about their care. In collaboration with the Capacity Tracker Data Advisory Group (CT DAG), we will consider mechanisms to make clear how the data is being used centrally.

Many bodies currently collect information but there is little standardisation in how it is collated, shared and used. The current aggregated data collected by local authorities shows a significant gap that needs to be addressed to include people drawing on privately funded care and support. Doing so will help ensure a fuller picture and enable improved outcomes for all people receiving care and support.

In the government's health and social care data strategy, [Data saves lives: reshaping health and social care with data](https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data) (<https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data/data-saves-lives-reshaping-health-and-social-care-with-data>), we set out our vision to transform adult social care data so that people who draw on support have access to information and can make more informed choices about their care, and for their carers to have timely data so that they can provide the best possible care.

As outlined in the [People at the Heart of Care](https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper/people-at-the-heart-of-care-adult-social-care-reform) (<https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper/people-at-the-heart-of-care-adult-social-care-reform>) white paper, access to reliable data is key to underpinning the government's ambition for social care reform. The COVID-19 pandemic has brought into sharp focus the need for high-quality data and information to be shared and used well. Prior to the pandemic, the Department of Health and Social Care (DHSC) had no comprehensive national source of data from providers on capacity, workforce status or numbers of people in receipt of care. Emergency data measures taken in response to COVID-19 have given us near real-time data to manage the pandemic and shown us the benefits of using data to respond to emerging risks and issues. Data from social care providers has been critical to the government's COVID-19

response and will continue to be crucial to help us to understand capacity and risk in the care system, to judge when and how to target support to providers and ultimately to help facilitate the care of individuals across the care system.

Through technology and data strategies, and the Data Alliance Partnership, we are working to ensure the most efficient methods of data collection and improvement in the interoperability of systems. We have committed to ensuring that the data architecture underpinning the health and care system can easily work together to make more effective and efficient use of data.

The [Health and Care Act 2022](#)

(<https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted>) received Royal Assent in April 2022. It includes:

1. A power for the Secretary of State for Health and Social Care to require adult social care providers to provide information relating to themselves, to their activities in connection with the provision of ASC in England or to persons to whom they have provided such care (section 99).

This power commenced on 31 July 2022 and applies to all ASC providers regulated by the Care Quality Commission (CQC). These are providers required to be registered under the Health and Social Care Act 2008 in respect of the carrying on of a regulated activity involving, or connected with, the provision of ASC in, or in relation to, England.

2. A power to make regulations enabling the Secretary of State for Health and Social Care to impose a financial penalty on private providers that do not comply with an information request or provide false or misleading information without reasonable excuse (section 100).

[Draft regulations](#) (<https://www.legislation.gov.uk/ukdsi/2022/9780348238716>) were laid on 5 September 2022. It is intended that this power and the regulations will come into force from November 2022. Enforcement regulations will apply to all ASC providers regulated by the CQC.

Data collection

Information required from 31 July 2022

From 31 July 2022 we mandated a core subset of the data which providers have already been submitting through the Capacity Tracker (CT). This is gathered on a monthly basis. Providers are required to update the CT with the required data within a designated 7-day reporting window. This window will open at the start of

the 8th day of each month and run until the end of the 14th day of each month, or the next working day where the 14th day falls on a weekend or public holiday. This is shown in the graphics below.

Figure 1: data collection reporting windows

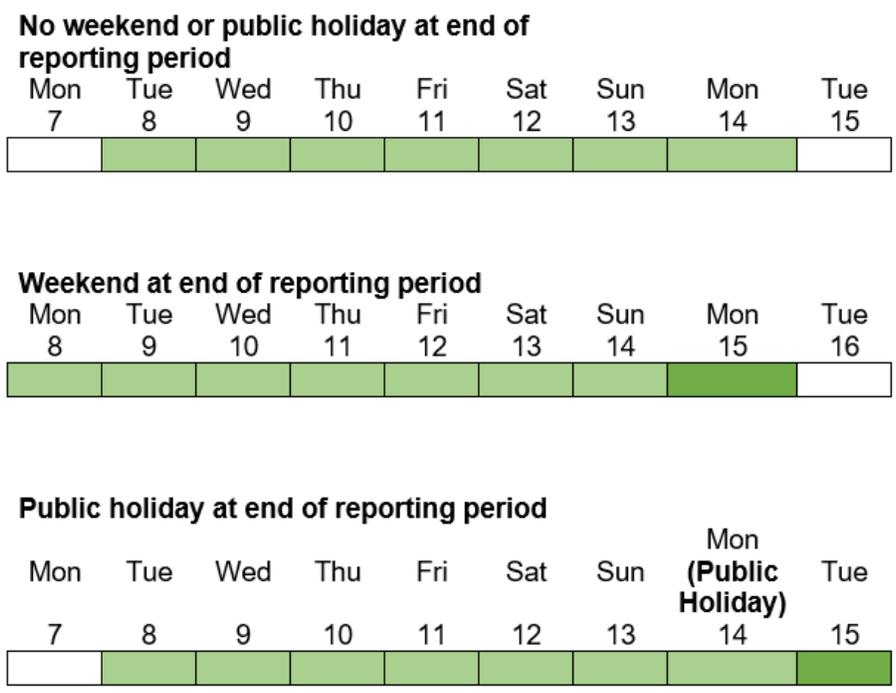


Figure 1 shows 3 graphics of the reporting windows:

- graphic 1 shows the reporting window if the 14th day falls on a weekday. The window is highlighted as being between the 8th and the 14th inclusive (both dates included)
- graphic 2 shows the reporting window if the 14th day falls on a Sunday. The window is highlighted as being between the 8th and the 15th inclusive (both dates included), which is the next working day from the Sunday
- graphic 3 shows the reporting window if the 14th day falls on a Monday and it is a public holiday. The window is highlighted as being between the 8th and the 15th inclusive (both dates included), which is the next working day from the Monday

Full dates to March 2023 are in Annex B (below).

Updates for this data will need to be made via the CT using the same method as at the time of this guidance's publication – by providers either updating each mandated field individually or by the bulk update functionality. The data must be reviewed within the reporting window of each month, and, even if there are no changes to be made, the page is saved so that it is marked in the system as having been updated.

As always, the department is regularly engaging with and consulting the CT DAG on improvements to the wording and content of specific data items and questions based on feedback received from ASC providers and data users. This is intended to ensure that any changes improve data quality and relevance, while also managing data burdens on providers.

Other data items in CT are often key for local operational support and providers will be asked to provide more regular updates to these items – for example, confirmed and suspected COVID-19 cases in staff and residents, vaccination updates, PPE availability, daily bed vacancy updates and workforce data. Such data requests are separate to the mandated list but are essential to continue to support you as providers, and health and social care partners, such as discharge teams, to keep people and staff as safe and healthy as possible. The daily vacancy data is useful when more frequent because it supports people to be in the right place for their specific needs.

Data items that form part of the mandatory collection are clearly marked in the CT system during the reporting window period.

For care home provider locations, the mandatory information is:

- care home bed vacancies:
 - maximum capacity
 - occupied or used
 - (vacant) reserved
 - (vacant) accepting admissions
 - (vacant) not available for admission – reasons bed not available
- workforce resourcing including absences:
 - total headcount of directly employed registered nurses
 - total headcount of directly employed care providing staff
 - total headcount of directly employed non-care providing staff
 - total headcount of agency or bank registered nurses

- total headcount of agency or bank care providing staff
- total headcount of agency or bank non-care providing staff
- number of directly employed registered nurses absent, COVID-19 related
- number of directly employed care providing staff absent, COVID-19 related
- number of directly employed non-care providing staff absent, COVID-19 related
- number of directly employed registered nurses absent, not COVID-19 related
- number of directly employed care providing staff absent, not COVID-19 related
- number of directly employed non-care providing staff absent, not COVID-19 related
- COVID-19 vaccination:
 - number of directly employed staff known to have received a full primary course of the COVID-19 vaccination
 - number of agency or bank staff known to have received a full primary course of the COVID-19 vaccination
 - number of residents known to have received a full primary course of the COVID-19 vaccination
 - number of directly employed staff known to have received an autumn booster [\[footnote 1\]](#)
 - number of agency or bank staff known to have received an autumn booster [\[footnote 1\]](#)
 - number of residents or staff known to have received an autumn booster [\[footnote 1\]](#)
- flu vaccination (seasonal: 1 September to 31 March):
 - number of directly employed staff known to have received this season's flu vaccination
 - number of agency or bank staff known to have received this season's flu vaccination
 - number of residents known to have received this season's flu vaccination
- visiting:
 - if residents have been able to take part in visits in and/or out of the care home

- the visiting options currently being supported

For domiciliary care settings, the mandatory information is:

- how many service users are currently registered and receiving care from your agency?
- number of staff in the organisation that have face-to-face contact with the people being supported
- number of staff delivering care that are not working because of coronavirus
- COVID-19 vaccination:
 - number of staff known to have received a full primary course of the COVID-19 vaccination
 - number of staff known to have received an autumn booster [\[footnote 1\]](#)
- flu vaccination (seasonal: 1 September to 31 March):
 - number of staff known to have received this season's flu vaccination

Full definitions for the COVID-19 vaccination data collection are at Annex A (below).

Changes to workforce data collection and domiciliary care packages of care collection

From the end of September 2022, in response to feedback and to highlight pressures over the winter period, new workforce related questions were added for both care home and domiciliary care providers. Appropriate help text for these new questions is available within CT.

For care home providers, new workforce related questions are:

- how many hours have you paid direct employees to work in the last month or 4 weeks, including any overtime?
- how many hours of overtime have you paid for in the last month or 4 weeks? [\[footnote 2\]](#)
- how many hours of agency staff time have you paid for in the last month or 4 weeks? [\[footnote 2\]](#)
- how many days or hours of absence have you recorded in the last month or 4 weeks? [\[footnote 2\]](#)

For domiciliary care providers, new workforce related questions are:

- how many hours have you paid direct employees to work in the last month or 4 weeks, including any overtime? [\[footnote 2\]](#)
- how many hours of overtime have you paid for in the last month or 4 weeks? [\[footnote 2\]](#)
- how many hours of agency staff time have you paid for in the last month or 4 weeks? [\[footnote 2\]](#)
- how many days or hours of absence have you recorded in the last month or 4 weeks? [\[footnote 2\]](#)

In addition, for domiciliary care providers new packages of care related questions are:

- in the last 28 days, how many current NHS and local authority funded service users' care packages have you had to return?
- in the last 28 days, how many current self-funded service users' care packages have you had to end?

These questions refer to previously agreed packages that have been returned or ended after service provision started.

The new workforce and packages of care questions will become mandatory in December 2022.

We are currently reviewing the necessity of the collected workforce absence questions for both care home and domiciliary care providers in light of these additions.

Purpose of collecting this information

Availability of good quality and timely data from ASC providers is essential to:

- supporting efficient commissioning and systems assurance
- managing national, regional and local risks
- assisting with evolving situations, like COVID-19
- ultimately, helping to facilitate the care of individuals

Data mandation will build on the stronger data sharing practices we have built during the pandemic where providers have shared data and information via the CT tool. This has highlighted the importance of having robust data flows in the ASC

sector to ensure that the right level of capacity and support is available for service continuity. It will support a consistent and transparent approach to the processing of data across privately and publicly funded care to support improved safety and quality of provision.

Data is needed to:

- continue to support COVID-19 recovery
- monitor vaccination levels
- understand capacity and risk in the care system more generally
- understand the impact of winter pressures
- determine when and how to target support to providers
- ultimately, help facilitate the care of individuals across the care system long term

For example, during the pandemic, provider data sharing facilitated:

- flagging a need for a visit from a COVID-19 vaccination team – vaccination teams also used data to arrange visits directly
- highlighting issues with accessing flu vaccinations
- flagging PPE shortages
- receipt of targeted support from regional teams, using data from the workforce RAG status
- visualising and benchmarking your own provider data against local authority, regional and national data to understand how it compares

Emergency data measures taken in response to COVID-19 gave us near real-time data to manage the pandemic and showed the benefits of using data to respond to emerging risks and issues – for example, in outbreak management and prioritising PPE supplies for providers in highest need.

Currently, providers are able to view their data in the CT and use this for benchmarking purposes, comparing against the local authority, regional and national aggregate. This provider view will be reviewed and improved to better meet provider needs and support them to realise the full value of their data, noting such needs will differ depending on provider characteristics. We will be seeking feedback from providers on how to improve this view using the CT DAG member organisations. Furthermore, we are keen to explore what wider data sources we can add to this view, to offer a richer source of data to providers that they would not be able to access without it.

Data also helps us to identify issues at an early stage and provide an evidence base for central government funding discussions. For example, CT data on staff absence in January 2021 showed the need for support with recruitment and that additional staff hours were needed, one of the drivers of the £120 million Workforce Capacity Fund being established. CT data also continues to be the best source of vaccination data, enabling our NHS partners to prioritise areas through current and upcoming booster campaigns.

With more and better data, we can plan the future care of our population and will have the potential to generate significant health and care benefits such as increased independence, improved quality of care, higher satisfaction for people drawing on health and care support, and more efficient use of funding. Improved data on the ASC workforce can also benefit recruitment, retention and equality policies.

We have carried out an [impact assessment](https://www.gov.uk/government/publications/health-and-care-act-2022-adult-social-care-provider-information-provisions) (<https://www.gov.uk/government/publications/health-and-care-act-2022-adult-social-care-provider-information-provisions>) in relation to the financial implications of mandatory completion of the CT.

Engaging on future changes

The burden on ASC providers in providing data is a key consideration in all changes and our aim is to reduce the burden overall where possible, while also improving the information data gives. It is our intention that the data listed above will be the only data mandated during 2022 to 2023 and we will endeavour to keep to this. If the data needs of DHSC or other ASC partners evolve or issues with data arise, wherever possible, we will give at least 3 months' notice of any change to the mandated data listed above or to the frequency of collection before making it a legal requirement. If DHSC receive feedback on the usefulness or burden of the above listed data items, we will work with the sector to review and iteratively improve these as needed.

We intend to engage on changes with providers and representatives through the CT DAG. The CT DAG has met fortnightly since the start of the pandemic and includes provider and local authority representatives and is expected to continue to advise on data changes. The CQC chairs CT DAG meetings and the full member list is as follows:

- Care Providers Alliance (CPA)
- Home Care Association (HCA)
- National Care Forum (NCF)
- Care Association Alliance (CAA)
- Care England

- Local Government Association (LGA)
- Association of Directors of Adult Social Services (ADASS)
- CQC
- Department for Levelling Up, Housing and Communities (DLUHC)
- DHSC
- NHS England
- NHS North of England Commissioning Support Unit (NECSU)

If a change to a data item or a new data item is required by DHSC, DHSC will first consider key criteria such as whether it can be obtained elsewhere, what any output will be used for and the benefit of collecting it for providers, settings and other sector partners. If the need is clear, an example of how the data item will appear in the CT will be shared with CT DAG for feedback and further iteration as part of co-building.

Depending on the scale of the change, any engagement might be solely via email feedback, representations at a CT DAG meeting itself, or could involve workshop sessions. This iterative process seeks to refine the new or changed data item to a point where it is ready for development and adding to the collection. Once the process is complete, we will notify providers of the upcoming change, giving at least 3 months' notice, where possible.

Support and guidance

Filling in the Capacity Tracker

The CT is managed by the North of England Care System Support (NECS) unit. NECS provides a dedicated support centre – Monday to Friday, 8am to 5pm – to support care providers and wider stakeholder users of the CT. If providers need support completing or updating the system, accessing or using the reports and analytics, they can reach out either by phone 0191 691 3729 or via necsu.capacitytracker@nhs.net.

In addition, the CT has an integrated resource centre – all communications, user or help guides and video tutorials along with contact details for local System Champions can be found there.

NECS also utilises regional leads that are split across the 7 NHS England regions. They run regular provider engagement sessions and have set up regional forums to help support continuous improvement of the system and support our user centred design approach.

For guidance relating to how to answer specific questions, you can email capacitytracker-guidance@dhsc.gov.uk.

Providers will be contacted when they have not updated their CT data and will be offered support or advice on completing the return. This will be done via NECS as at present, or via other routes depending on the issue. Contact will normally be established via a combination of emails, telephone calls and NECS regional leads and local system champions.

For administrative amendments, account support and more, you can contact NECS directly already at: necsu.capacitytracker@nhs.net.

Data use and privacy

These provisions will not enable data to be sold to private organisations. Our intention is that data collected will be shared appropriately with organisations who need the data across the ASC sector (for example, local authorities, the CQC, integrated care systems) to guide delivery, policy development and research in the area for purposes connected with the health or ASC system in England. We will continue to encourage all such partners to look to data in CT in the first instance rather than instigating separate data collections covering similar data.

The information will be subject to the UK General Data Protection Regulation (GDPR) and statutory restrictions on disclosure. This includes not sharing commercially sensitive data without taking into account both the interests of the provider (or the person to whom that data relates) and the public.

Section 277A states that the provision of information under that section:

- does not breach any obligation of confidence owed by the person providing it, but
- is subject to any express restriction on disclosure imposed by any enactment (other than a restriction which allows disclosure if authorised by an enactment)

DHSC will seek to ensure that data requests comply with these principles including UK GDPR but providers should take their own legal advice as necessary.

Enforcement powers

Specific guidance on enforcement will be published once the enforcement regulations are made and will be linked here once published.

Although we will be mandating data from 31 July 2022, we will not be rolling out the enforcement mechanism before November 2022.

Financial penalties will normally be a last step, which we anticipate using where both the following apply:

- a provider continues to be, or is persistently, in breach of their data obligations
- our delivery partner (the NHS Business Services Authority (NHSBSA)) has reached out to offer guidance and support, but the provider is still not sharing their data, and has not made appropriate attempts to do so

The level of the fines will be the same as a provider's CQC registration fee which is scaled to the provider type and size.

We expect that from the first concern, the enforcement process will happen over a period of months, rather than weeks. A provider will always be given the opportunity to make representations as to why they have not supplied the required data and why a financial penalty should not be imposed. Even after a final penalty notice is issued, we expect that providers may be able to avoid a fine by providing the data required.

A provider who has been issued with a final penalty notice will be able to appeal to the First-tier Tribunal.

There may be rare instances where some of the required information cannot be updated by a provider because the information is not relevant to their setting (for example, Shared Lives providers who offer no other services), because the provider is no longer operating, or because the provider is unable to get that information, despite making reasonable attempts to do so. In those cases, we ask that the provider submits the information that they do know, or submits a nil return, and saves the page so that it is marked in the system as having been updated, so that enforcement action is not pursued. What is most important is that the provider has made a reasonable attempt to provide the data they have.

Annex A: COVID-19 vaccination question definitions

A full primary course does not include COVID-19 boosters. For most people, a full primary course is defined as 2 doses of COVID-19 vaccination. For a small number of people, however, including people who were vaccinated abroad, people who have received a single-dose vaccination such as Janssen, or people who are severely immunosuppressed, a full primary course may mean a different number of doses.

As CT no longer includes a separate question asking for the number of care home staff who have been fully vaccinated abroad, individuals falling in this category should be recorded as having received a full primary course of COVID-19

vaccination, together with those who received it in the UK.

An autumn booster is defined as any booster delivered under the autumn booster campaign, which began in September 2022, [as announced in May 2022](https://www.gov.uk/government/news/jcvi-provides-interim-advice-on-an-autumn-covid-19-booster-programme) (<https://www.gov.uk/government/news/jcvi-provides-interim-advice-on-an-autumn-covid-19-booster-programme>).

While COVID-19 vaccination data forms part of the mandatory provider dataset, we recognise that staff may choose not to disclose their vaccination status to their employer. Providers should complete CT with the numbers of staff who are known to have received a vaccination and are not asked to disclose the numbers not vaccinated and the numbers with unknown vaccination status.

Annex B: reporting window periods until April 2023

The reporting window periods are:

- 8 October 2022 to 14 October 2022 (inclusive – both dates included)
- 8 November 2022 to 14 November 2022 (inclusive – both dates included)
- 8 December 2022 to 14 December 2022 (inclusive – both dates included)
- 8 January 2023 to 16 January 2023 (inclusive – both dates included)
- 8 February 2023 to 14 February 2023 (inclusive – both dates included)
- 8 March 2023 to 14 March 2023 (inclusive – both dates included)

-
1. Autumn booster questions will become mandatory in October 2022.
 2. Time period optional to suit working practice, such as, could cover last complete pay period using payroll data in recognition that pay periods will differ between or even within providers (some staff will be paid weekly and others fortnightly or monthly) and no one pay period option will be meaningful to all.

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