PARLIAMENTARY DEBATES

HOUSE OF COMMONS
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GENERAL COMMITTEES

Public Bill Committee

CARE BILL [*LORDS*]

Tenth Sitting

Thursday 23 January 2014

(Afternoon)

CONTENTS

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Monday 27 January 2014

STRICT ADHERENCE TO THIS ARRANGEMENT WILL GREATLY FACILITATE THE PROMPT PUBLICATION OF THE BOUND VOLUMES OF PROCEEDINGS IN GENERAL COMMITTEES

The Committee consisted of the following Members:

Chairs: †Hugh Bayley, Andrew Rosindell

† Abrahams, Debbie *(Oldham East and Saddleworth)* (Lab)
† Burstow, Paul *(Sutton and Cheam)* (LD)
† Doyle-Price, Jackie *(Thurrock)* (Con)
† Esterson, Bill *(Sefton Central)* (Lab)
† Griffiths, Andrew *(Burton)* (Con)
† Jones, Andrew *(Harrogate and Knaresborough)* (Con)
† Kendall, Liz *(Leicester West)* (Lab)
† Lamb, Norman *(Minister of State, Department of Health)*
† Lewell-Buck, Mrs Emma *(South Shields)* (Lab)
† Malhotra, Seema *(Feltham and Heston)* (Lab/Co-op)
† Morris, Anne Marie *(Newton Abbot)* (Con)
† Morris, David *(Morecambe and Lunesdale)* (Con)
† Morris, Grahame M. *(Easington)* (Lab)
† Munn, Meg *(Sheffield, Heeley)* (Lab/Co-op)
† Newton, Sarah *(Truro and Falmouth)* (Con)
† Penrose, John *(Weston-super-Mare)* (Con)
† Poulter, Dr Daniel *(Parliamentary Under-Secretary of State for Health)*
† Reed, Mr Jamie *(Copeland)* (Lab)
† Shannon, Jim *(Strangford)* (DUP)
† Smith, Nick *(Blaenau Gwent)* (Lab)
Stephenson, Andrew *(Pendle)* (Con)
† Wheeler, Heather *(South Derbyshire)* (Con)
† Wollaston, Dr Sarah *(Totnes)* (Con)

John-Paul Flaherty, *Committee Clerk*

† attended the Committee

Public Bill Committee

Thursday 23 January 2014

(Afternoon)

[Hugh Bayley *in the Chair*]

Care Bill [*Lords*]

Clause 72

Five-yearly review by Secretary of State

Question (this day) again proposed, That the clause stand part of the Bill.

2 pm

The Chair: I remind the Committee that with this we are also discussing the following:

New clause 13—*Funding for new costs arising from Part 1*—

'(1) The Secretary of State must provide local authorities with sufficient funding to enable them to meet new costs arising directly or indirectly to them by virtue of this Part.

(2) The costs mentioned in subsection (1) include (but are not limited to)—

(a) costs of introducing the new measures set out in this Part;

(b) on-going costs of implementing those measures (to be allocated through the annual spending review);

(c) costs identified by the Department of Health to be funded through the Better Care Fund.'.

New clause 14—*Social care free at the point of use*—

'The Secretary of State must prepare a report on the costs and benefits of requiring, and providing funding for, local authorities to offer all social care free at the point of use. This report must be laid before each House of Parliament within 12 months of section 3 coming into force.'.

New clause 15—*Joint Care and Support Reform Programme Board: assessment of funding*—

'(1) Before any provision of Part 1 is brought into force, the Joint Care and Support Reform Programme Board must have informed the Secretary of State whether sufficient funding is in place or will be put in place to ensure that the provision in question can be implemented satisfactorily.

(2) In subsection (1), the "Joint Care and Support Reform Programme Board" means the board of that name consisting of representatives including the Local Government Association, the Association of Directors of Adult Social Services and the Department of Health.'.

New clause 16—*Ministerial advisory committee*—

'An independent ministerial advisory committee shall be set up to keep under review the workings of the set level as set out in section 15, and the means-testing arrangements set out in section 17.'.

New clause 17—*Initial funding assessment*—

'The Secretary of State must ask the Office for Budget Responsibility to complete by the end of 2014 a review of the funding of adult social care that assesses—

(a) the adequacy of current public funding of these services;

(b) the proposals for funding the provisions in this Act;

(c) the implications of the Act and its funding for the NHS over the next five years; and

(d) in particular the short and long term costs of setting the eligibility criteria at the level set out in regulations.'.

New clause 18—*Impact assessments of regulations*—

'(1) Before bringing into force sections 13, 17 and 35, the Secretary of State must lay before Parliament an impact assessment of the regulations set out in those sections.

(2) In relation to the regulations set out in subsection 13(6), the assessment must show how the provisions will affect the likely impact of the set level above which an adult starts receiving financial assistance with the costs of their care.'.

Bill Esterson (Sefton Central) (Lab): I tabled new clause 14 after Second Reading when I spoke about social care that was free at the point of use. It seemed logical, if we have an NHS that is free at the point of use and we are trying to integrate health and social care, that at some point in the not too distant future we must consider the concept of social care that is free at the point of use. Our discussions in Committee and before about the difficulties with the cap highlight just why this is an important discussion.

Paul Burstow (Sutton and Cheam) (LD): I agree entirely with the hon. Gentleman that it is an important discussion. But when he explains why the new clause is merited, can he address himself to the question why on earth, for 13 years when there was resource, the previous Labour Government chose not to do anything about this?

Meg Munn (Sheffield, Heeley) (Lab/Co-op): Because my hon. Friend was not a Member then.

Bill Esterson: My hon. Friend helpfully points out that I was not here. Perhaps if I had been we might have resolved it. As ever with these things, it is about where we are now and how we go forward. The growing demands of social care and the needs of an ageing population and the pressures on services increasingly bring this forward. It is unfortunate that the right hon. Gentleman asked the question in the way he did. An enormous amount of progress was made by the previous Government to address the issues and the challenges around social care.

Liz Kendall (Leicester West) (Lab): Like my hon. Friend, I was not a Member under the previous Government but I seem to remember that in 1997 people were waiting 18 months for hospital operations and dying on the hospital waiting list. At the time we thought that was an absolutely key priority for a Government caring about reforming the care system.

Bill Esterson: My hon. Friend might have added that by the time we left office we had the best NHS in the world according to international comparisons. The Labour Government's record on the NHS bears great scrutiny and we are extremely proud of it.

The new clause tries to look at the long-term implications of funding. We have debated the cap and, as we said, it is a cap that may not really be a cap. People are worried about losing their homes. The Under-Secretary claimed that they do not really lose their homes because they are dead before the homes are sold; they do not have to sell their houses. That was the point he was making. Whether people sell their houses before they die or they are sold after they die to pay for their care, they and their families still bear the cost. It is still the individual who bears the cost, either directly or indirectly, of their care.

The Minister of State, Department of Health (Norman Lamb): Is the hon. Gentleman aware that of all the different options, entirely free social care is the most regressive of all? It gives bucketloads of money to rich people. Is that what the hon. Gentleman is arguing for?

Bill Esterson: We could say that about the NHS. We could say that about any service.

We have an increasing demand. We have an increasing ageing population. The way that we pay for an integrated health and social care system is proving to be extremely problematic, as we have debated on a number of occasions. My amendment is a probing amendment asking for the issue to be studied properly. I am not aware of an in-depth study on how free social care might be achieved. That is what my amendment is asking for.

Is there a way of raising funding without the individual's having to take responsibility at the time? I am assuming a moderate eligibility threshold. I am waiting for an intervention.

Paul Burstow: My hon. Friend the Member for Truro and Falmouth and I were questioning what the hon. Gentleman was saying about there being no attempt to scrutinise and study these issues over the past 13 years. There was a royal commission; there was Derek Wanless doing work. Tonnes of files of paperwork have been generated. Shelves have been gathering dust with the reports that have been written on this subject. The difference between the Labour side of the Committee and this side is that this side has actually done something about it—published a White Paper, and now we are debating a Bill that will become an Act to make the changes. That was never delivered under the last Government.

Bill Esterson: We have established already in this short debate the proud record of the last Government in addressing issues of health and social care.

Norman Lamb: Thirteen years of inaction.

Bill Esterson: There was plenty of action on social care. The point is that we need Government to carry out that analysis and I do not think that has been achieved so far. I am not going to revisit the entire debate on the cap and where it is set and the concerns about costs that do not count towards the cap and the impact of the cap on different parts of the country. Those concerns are on the record and have been expressed many times.

The Parliamentary Under-Secretary of State for Health (Dr Daniel Poulter): The hon. Gentleman expresses concern about the contributions that people may or may not have to pay towards their care. Generally speaking, that would be people who are better off. Would he accept—I think this point was made in the Dilnot report—that if the previous Government had done something about the cost of social care and providing better social care, these costs might be considerably less than they are now?

Bill Esterson: This is becoming a politicised debate, by choice of Members on the Government side of the Committee. It was not for want of trying on the part of the last Labour Government that we failed to achieve a consensus across all parties. It was not the Labour party that had difficulty with the concept of all-party talks and trying to achieve agreement. Agreement across the parties is essential on this, because the issue is not just for one Parliament or one Government or one party. We were trying to achieve cross-party agreement and it is unfortunate that it did not happen.

The Chair: Order. May I interrupt the hon. Member's speech for a moment? I have been very tolerant. Members on the Government side have put on record their strongly held view that the previous Government did not do what they wish they had done, but we are here to debate a proposal from the current Government for new legislation and it is the new legislation, and not history, that we ought to be debating in this Committee.

Bill Esterson: I appreciate your comments. The Minister in his earlier remarks made the point, which I accept, that one of his aims is to avoid an individual's facing excessive costs. That is one of the things that the cap achieves at any level. It is debatable how high those costs might be in some parts of the country. Nevertheless, I accept the principle of what he says. I think we all accept the Dilnot principle on that. But they are still expensive costs. I am trying to remove the requirement to pay up front—for individuals themselves to pay for social care.

The issue of funding is identified in this group. My hon. Friend the Member for Sheffield, Heeley, in proposed new clause 13, addresses the need for adequate funding for local government. We need to grapple with how social care is funded in whatever system, both under the current arrangements ensuring local government has enough money, and longer term as pressures continue to grow. That is what my probing proposed new clause seeks.

We discussed free social care at the end of life and talked about the need to define end of life. If we agree that social care should be free at the end of life, at what point do we bring that forward? I made that point on Second Reading. The London School of Economics estimates £2.8 billion to set the threshold at moderate. If we accept a figure of £2.8 billion or thereabouts, the question is how to fund it. I am asking whether there are other ways of doing it through general taxation, presumably, rather than an individual's making a contribution for their own care.

Given the many difficulties we have discussed, the nature of the debate, and the long-term challenges that have yet to be resolved, whether social care should be free at the point of use in order to fit in with the NHS merits further discussion. I think the Government should analyse that proposition. I hope they will address the point made in my proposed new clause and look at the costs and benefits, to see whether it is the answer to the challenges we have debated in Committee.

Norman Lamb: It is really good to be back, Mr Bayley. I will start by saying how disappointed I was by the tone of the hon. Member for Sheffield, Heeley. I felt we were having a constructive debate. In previous sittings she had made some powerful points about the need to do things differently, to facilitate families, provide support

[Norman Lamb]

for loved ones and recognise the need to maintain sustainability in the system. Then we had an outpouring of the sort of political rhetoric that we have not had up until now in this Committee. I find that sort of sanctimony hard to take. When I asked to intervene to challenge what she was saying she refused, on the basis that, "We all want to go to lunch." That is the new concept of strictly limited moral outrage.

Meg Munn: Will the Minister give way?

Norman Lamb: No, I will not. Let me make the point. She talked about "this dreadful Government". The dreadful Government are now overseeing the fastest growth in the western world.

Liz Kendall: That is, back to where we were in 2010.

Norman Lamb: If the shadow Minister would listen, I suspect she probably agrees with me. This Government are now overseeing the biggest cut in unemployment for very many years, something we are all incredibly proud of on the Government Benches. There seems to be a sense of complete denial in the Opposition about the need to get public finances back under control. When we took office the Government were spending every year £160 billion more than they were bringing in in taxes.

Liz Kendall: How much more are they borrowing?

Norman Lamb: Every single cut that we have tried to introduce has been opposed by the Opposition.

Andrew Griffiths (Burton) (Con): Does the Minister also agree with me that it is this terrible Government who have brought forward this legislation that will help the people who desperately need support when they get ill in old age? Despite 13 years of a Labour Government, they never brought forward this Bill to help these vulnerable people in the way that this Government have.

2.15 pm

Norman Lamb: I am grateful to my hon. Friend for making that point. This Committee has heard a lot from the other side about how much they welcome what is in the Bill. Then they try to send out a message to their supporters in the country that it is a dreadful Government. Well, it is a dreadful Government—

Meg Munn: Will the Minister give way?

Norman Lamb: No, I will not. I am making a point. It is a dreadful Government who are introducing really important reforming legislation which will make a massive difference to people's lives. What frustrates me above all is the fact that this is empty rhetoric, because when we challenged Opposition Members about what they would do about it, the answer from the shadow Minister was: "No, we are not talking about new money; we are talking about using the money that is available in a better way". That is exactly what this Government seek to do by integrating care in a more effective way.

Meg Munn: I am grateful to the Minister for giving way. I do not apologise for anything I said, but I want to put straight the point he made. I did not say that we all wanted to go to lunch. I said that lunchtime was coming up. As the Minister well knows, he gets to respond to every point in the debate, as he is doing now. That is the point I was making. That is why I wanted to finish what I had to say. I am perfectly happy to debate the issues with the Minister—that is what we are here for—but would he have the courtesy not to portray what I said in an incorrect way?

Norman Lamb: I do not want to detain the Committee on this. I wrote down the hon. Lady's precise words. That is all I am saying. The point of substance is, if you make a complaint about how tight public finances are, which we all accept on this side, and if you claim that it is all a disaster, then you have to come up with an alternative. We have heard no alternative from the other side. All we had was a Government leaving office in 2010, spending £160 billion more a year than it was raising in taxes—a completely unsustainable position. We all know, incidentally, that if you do not get public finances under control, it is always the most vulnerable in society who get hit the most. We should always remember that.

So let us get back to a more rational debate, discussing some incredibly important reforms, and discuss them in a way that we have previously done with the hon. Lady, looking at some really difficult challenges for society and how we try to make lives better for people. Let us not indulge in empty political rhetoric.

New clause 13 seeks to ensure that local authorities have the resources to implement the Care Bill and deliver lasting change for the millions of people in this country who give and receive care and support. I completely agree with this aim, but there are already sufficient safeguards in place and this new clause would duplicate those provisions. The new burdens doctrine states that the net additional cost of all new burdens placed on local authorities by central Government,

"must be properly assessed and fully funded".

All Government Departments must honour this commitment and the Care Bill is no different. The Department of Health has fully assessed the cost of implementing the Bill and published a suite of impact assessments. In last year's spending round we ensured that the costs will be met in full in 2015-16.

Liz Kendall: Will the Minister now confirm on the record that all the costs for implementing this Bill that we listed come from existing budgets?

Norman Lamb: I come back to another point.

Liz Kendall: I am just asking the Minister to confirm it.

Norman Lamb: I will absolutely confirm it. The Labour party seems to believe that there is some new money somewhere, as if money grew on trees. Where is this new money coming from? If the Labour party has a proposal to bring in new taxes to pay for something additional, will hon. Members please tell us? Yes, of course this is money, as we have made clear throughout, that comes

from the way in which the Government have already spent money. We want to spend it more effectively. The shadow Minister made an absolutely fair point in an earlier debate in this Committee that it is all about how we can spend the money more effectively by integrating the health and care system. That is precisely what the better care fund seeks to achieve.

Liz Kendall: I will tell the Minister where the money could have come from: not wasting £3 billion on a top-down reorganisation that nobody wanted and nobody voted for, and not spending £225 million on delayed discharges from hospital. Instead of having one budget, where they could have put the money in the right place—

Andrew Griffiths: Put it in the manifesto.

Liz Kendall: We are full of suggestions. I am simply asking the Minister to confirm on the record, so that councils will know, that the cost of setting up the new care accounts and the means test will be coming from existing budgets. Yes or no?

Norman Lamb: I simply make the point that the reforms that the shadow Minister criticises are achieving substantial administrative savings every year. My hon. Friend the Member for Central Suffolk and North Ipswich tells me that it is £1.5 billion per year, and the number of managers and administrators employed by the NHS is significantly down and the number of clinicians significantly up. That is the right direction. In addition, we are working closely with the sector through the care and support reform programme board to keep costs under review. New clause 14 would require the Government to publish a report on the costs and benefits of providing social care free at the point of use.

The amendment is years too late. I apologise to the hon. Member for Sefton Central for that, but the issue has been debated for 15 or 20 years. When this Government came to power, we moved quickly to set up an independent commission led by Andrew Dilnot to explore the options for how people pay for their social care. The Dilnot commission looked at the costs and benefits of different approaches, including providing free social care funded from taxation, which was the hon. Gentleman's suggestion. The commission recommended that the best way to provide a fair and sustainable system was to put a cap on care costs.

My point was that—counter-intuitively—introducing a new spending commitment for free social care is regressive in its impact, as the people who benefit most are the wealthiest. If Opposition Members want to do that with public money, fine, but they need to be clear on that. Dilnot stated:

"Experience in other countries, such as Germany and Japan, which have recently reformed their social care funding models, demonstrates the vulnerability of a free care system to a changing economic and political environment. In both of these countries, social care costs rose more quickly than had been predicted or governments were willing to sustain, and both governments adjusted their systems—by making them less generous—to control these costs. This then went some way to undermining the promise of free care as people were still exposed to significant costs."

The conclusion was:

"Free care is not in our judgement a resilient proposal."

I supported the extra investment in the health service undertaken by the previous Government, but in a period of 13 years the Labour Government did nothing to reform a broken system of social care. There was a royal commission in 1999, but nothing happened to implement its conclusions, or any alternative conclusions. We had manifesto commitments and wonderful statements from the former Prime Minister—who has so much support from Opposition Members—Tony Blair. He said he did not want to live in a country where people have to sell their home to pay for care. And yet 13 years later, tens of thousands of people had sold their homes during their lifetime to pay for care, and the Labour party did nothing.

Paul Burstow: It is worse than that. Not only did it do nothing—

The Chair: Order. This is not a partisan debate. We are here to debate the proposals in the Bill. The new clauses currently under debate relate to the financing of care. We can debate the financing of care, but we will not have party political speeches about somebody who was Prime Minister three terms ago.

Paul Burstow: I will take that guidance. May I simply draw the Minister's attention to the work done by Derek Wanless? He looked at how we had financed the health care system and recommended that the then Government conduct a similar review of social care, but no such review was undertaken. What conclusions does the Minister draw from that?

Norman Lamb: I draw the conclusion that the reform is long overdue and that it is brilliant. I am so proud of the fact that the Government are reforming a broken system. On the cost of what the hon. Member for Sefton Central proposes, the Dilnot commission estimated that at £4.75 billion in 2016-17, with that escalating over time owing to demographic change. If that is his proposal, that is fine, as that is a legitimate alternative, but he needs to say where the money will come from and I have not heard that so far.

Bill Esterson: The point of the new clause is to ask the Government to come up with a study to look at the costs and benefits. For precisely that reason, it is a probing new clause.

Norman Lamb: That is precisely what we did with Dilnot. We asked Andrew Dilnot and his commission, which included Lord Warner who is a Labour party member, to look at exactly these issues and the options available. I have read to the hon. Gentleman the conclusions that the commission reached on that proposal and we are acting on its recommended proposition to implement a cap from April 2016. That is a significant step forward that will end decades of uncertainty by providing a clear system that shares the cost fairly between the individual and the state. Now is not the time for another report to go over old ground; now is the time for action, and that is what the Government are producing.

New clause 15 would require the care and support reform programme board to inform the Secretary of State that sufficient funding is available before the Bill

[Norman Lamb]

can be implemented. The establishment of the board is a vital step in the process and reflects our continued commitment to collaboration.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): Will the Minister say how that can be married with the cuts that my hon. Friend the Member for Sheffield, Heeley mentioned this morning of 45% by 2016-17? Oldham council has had cuts of more than £10 million from social care in the last three years, which is 15% of its budget, and that will only get worse.

Norman Lamb: The hon. Lady expresses a legitimate concern. I have never sought to deny that councils are under financial pressure—I completely understand that. We sought, because of the settlement that local government experienced to try to get public finances back under control, to compensate local authorities by way of—I think—£7.2 billion in the Government's first spending plan and, indeed, that has since been enhanced. It is also true that some local authorities have not committed all of those resources to social care, but used them to prop up other services.

Councils of all political persuasions are under an enormous burden of responsibility to re-engineer how they work, but there is great scope for that, such as cutting bureaucracy out of the system. The tri-borough experiment in London, where three councils merged their bureaucracies into one, released funds to be spent on the front line. That seems to be exactly the way in which councils ought to be behaving.

Paul Burstow: I agree with the Minister's balanced approach in acknowledging that local authorities have pressures on them and that different authorities are making different hard choices about how to balance their books. Would he be interested to know that a report just yesterday from *Community Care* that looked at a King's Fund survey found that 64% of the local authorities who responded expected either to underspend or break even on their social care budgets this year? Of course, that leaves a third that reported difficulties, but the picture that has been presented in the debate suggests that it is far worse. The report suggests something different.

2.30 pm

Norman Lamb: I am grateful to my right hon. Friend for that intervention. One of the think-tanks—I believe it was Civitas—did the analysis. When one analyses the impact of spending on services, one finds that there is not a close correlation between the money spent and the quality of the service provision. The councils that provide great services are often those that radically change the way they do things by introducing personal budgets and direct payments, empowering communities to do things differently and giving voluntary organisations a greater role in the provision of local services. Those are the sorts of changes that need to be made.

If the Labour party returns to power at any stage, it will be confronted by exactly the same challenges and will have to think about how to do things differently. What worries me is that I do not see Labour Members thinking about how that can be done and how public services can be improved in a time of austerity.

Meg Munn: That is not correct. Even without austerity and the cuts, we would be looking at how better to meet people's needs. The services that I have talked about in previous sittings, which are relatively cheap and easy to deliver, can deal with the greater need. My point was that the Bill would be more likely to be successful if we had up-front funding to put those services in place before the cuts. I speak with the experience of having done precisely that 20 years ago. It is not correct to say that we do not have ideas. That is what I am asking for.

Norman Lamb: That is a very reasonable proposition, but we have provided for that. We have gone through a rigorous process to identify the cost of implementing the Bill. We have worked closely with representatives from local government. There may have been disagreements, but it has been a highly collaborative process, and we will keep it under review. Local authorities must, of course, be able to maintain the reforms we are talking about. That is why we are saying that it should be reviewed periodically when it is in place.

The hon. Lady's earlier contributions were thoughtful and fully cognisant of the challenges we all face, but I was disappointed that she became aggressively party political. We will simply not take sanctimony when we are having to make incredibly difficult decisions to clear up the mess that the Labour party left.

Liz Kendall: The mess was created by the worldwide crash.

Norman Lamb: We had the largest deficit in the G20.

I assure Opposition Members that, given our approach, it would not be possible to get to the point of implementation without being informed of the opinion of our partners on all aspects of the reforms. It is neither necessary nor appropriate to elevate a particular board to legal status simply to give prominence to a view that we could not possibly ignore even if we wanted to. I therefore hope that, on reflection, Opposition Members do not press their new clauses to a Division.

New clause 16 would establish an independent ministerial advisory committee to keep the level of the cap under review. There needs to be ministerial oversight of the implementation of that critical set of reforms to ensure that they deliver both protection against catastrophic costs and peace of mind, with the most help going to those with the greatest need. The new clause would place ministerial oversight, an activity that is in the normal course of Government business, on the face of the Bill. One of the key drivers of the reforms is the need for greater certainty and clarity on the potential long-term costs of care. Creating an additional ministerial oversight committee would introduce uncertainty and give the impression that the system was subject to change at any moment. It would undermine the certainty and peace of mind that the cap will deliver, and make it more difficult for the financial services industry to develop products.

Again, I make this offer to the shadow Minister: it would be far better if we could agree that the framework of the funding reforms makes sense, and that the reforms provide greater certainty and protection against catastrophic loss. There can be a debate in the years ahead about the level of the cap, but let us, as a group of politicians

coming together, support the case for the reforms and then go out and raise awareness, and ensure that we give them the best chance of succeeding. The issue would be important for a Labour Government, too. Crucially, it is important for the people who rely on the social care system.

Sarah Newton (Truro and Falmouth) (Con): The Minister is making an essential point, as we are so close to the general election. Dilnot and all the thousands of people who have been involved in the debate over many years have said that, unless there is cross-party support, the reforms will not stand a chance of working. The financial products and all the other things that need to come into place simply will not do so. It is therefore essential that we hear an answer from the Opposition this close to an election. Otherwise, people who need the reforms simply will not benefit from them.

Norman Lamb: I agree. That was a helpful intervention. I just do not know where the Opposition stand—that is the problem—and I do not know when we will find out.

New clause 17 would require the Office for Budget Responsibility to complete by the end of 2014 a review of the funding of social care, and the cost and impact of the reforms. The Government have robust processes in place to ensure that policies are costed accurately. We have published full impact assessments for all the reforms and have worked closely with the sector and leading experts to ensure that the reforms are based on the best possible evidence.

In addition, when allocating funding for specific policies, the Government need to take a broad overview of activity across all public services and not look at individual policies in isolation, so they can make the best possible decisions. That is the purpose of the spending review, and why a spending review is the best place to take funding decisions.

It would not be productive to ask the OBR to repeat the analysis in 2014, as that would duplicate what has already been done, and it will have no further evidence on which to base its work. Nor would that be an appropriate role for the OBR, which is independent and has complete discretion to determine the content of its publications and its programme of research and analysis. Instead, we will conduct post-legislative scrutiny, which the Government have committed to do across the board for all new Acts.

New clause 18 would require the Government to lay before Parliament impact assessments for regulations on eligibility criteria, financial assessment and deferred payment agreements. They are three elements of the reformed care and support system, so I recognise the desire to ensure that proper consideration is given to their impact and that that is published. I hope I can reassure the Committee that it has always been and remains our intention to publish impact assessments for those regulations, and for all regulations associated with part 1.

We have already heard support in the Committee for the open and collaborative approach that has been taken to developing part 1. I have not been the only one to demonstrate support—other hon. Members have done so. That collaborative approach does not end here. It will continue through the publication of draft regulations for part 1.

We will definitely publish impact assessments for regulations made under part 1, but it is unnecessary to place such a provision in the Bill. I trust that that provides sufficient reassurance for hon. Members not to press the new clauses to a Division.

Liz Kendall: First, there was a worldwide financial crash affecting all western industrialised countries. Our former Prime Minister helped to pull the country back from a depression—*[Interruption.]* I am answering the points raised by the Minister, and it is only fair. We did not bring that up—he did—and I am going to respond. Unemployment was coming down. We were borrowing less than we had expected post the crash in 2010. For the record, it has taken this Government three years to get back to where we were before.

Secondly, I am proud of what we did on social care. We started the whole process of introducing rights for carers. We put in investment, carers' breaks and training for carers. I have seen all of it. Before the general election, we had a big and bold proposal on funding social care—the Minister would have signed up to it if it would not have turned into a dreadful row with his Conservative partners. We have made positive proposals to improve the Bill and try to work together where can. Outside the Committee, we proposed big, bold plans for a fully joined-up health and social care system, which would have made better use of taxpayers' money, but our job in Committee is to scrutinise the Bill. That is what we are doing and it is right that we are doing it. I hear what the Minister says about our new clauses. I am happy not to press them to a Division, but I am proud that we put the issues on the record.

Meg Munn: I am disappointed that the Minister was disappointed. I am also disappointed that he described the political rhetoric as "empty". It might have been rhetoric, but it certainly was not empty. I will not talk about the coalition's fantasy of how the economic crisis came about and Government Members' failure to mention how well the Labour Government were doing, or the fact that the economy was growing and the coalition Government choked it off. I will not mention those things because they are not the subject of the debate. I entirely accept that the debate is complex and difficult, so coming to a position is not easy. We can say, "Your Government didn't do this and your Government didn't do that," but it is a complex and difficult subject, so it would have been preferable to have proper agreement on everything.

The Opposition support the overall approach to well-being. I have already been critical of a number of aspects of it, but I see where I made my mistake: I was critical in an aggressive way. The Minister said I was aggressive, but I would have said I was assertive—women are used to being called aggressive when they are being assertive.

I genuinely feel angry. I spent a lot of my career in social work and as a local councillor having to make cuts, and it is tough—extraordinarily tough. When I raise the issue of funding, as I do with my new clause, I do it with genuine concern. It is heartbreaking to sit

[Meg Munn]

with people in the NHS and the local authority who say, "We don't know where we're going to find the money." I get angry because we all know and understand the differences of deprivation, and the greater reliance on the public sector, in certain parts of the country.

The Government's choice to give a greater proportion—it is not a fair share, as the Minister has claimed—of the cuts to local government and services has devastated some of our councils. The choices councils have to make are on whether they close every library, sports centre and everything they do not absolutely have to provide so that they can provide care services and completely protect their child protection services. That is what my local authority has done. It had a 5% cut to its adult services, but has defended its child protection services.

It is easy for us. When I sit with councillors, I feel dreadfully sorry for them, because they have the weight of tremendously difficult decisions on them. The Minister and his hon. Friends are asking an awful lot if they think that we will sit here and not at times get angry and raise our voices. We are elected and sent here by our constituents. We have to do right by them. I do not think I would be doing right by them if I did not raise these issues, even if he does not like the way I raise them.

2.45 pm

Norman Lamb: I made the point at the start that most of the hon. Lady's contributions in Committee have been brilliant. They have been constructive and thoughtful and she obviously speaks with a lot of experience. I agree that things are tough. There are really difficult challenges out there and they will probably get worse because of the demographic change that we face. But does she not agree that it is incumbent on all of us, at whatever level of government we are, to find ways to make the money go further, to stretch that public resource to ensure that we safeguard and secure the services that are really important for some very vulnerable people? It requires innovation and change and a willingness to do things differently. Does she agree?

Meg Munn: I do agree with that but top-slicing budgets that are already under pressure to produce the new innovative ways of providing the care will make it extraordinarily difficult. I worry. I went to see my director of adult services only a few weeks ago and I spoke to her in great depth. We agreed that some of the cuts they have had to make that withdraw services from people who are deemed not to be at a high level of need are likely to be the wrong thing in the long term. There are some innovative approaches going on. There is a great new scheme happening in the Lowedges, Batemoor and Jordanthorpe part of my constituency where funding is being found from some budgets to employ community support officers.

Norman Lamb: Barnsley as well.

Meg Munn: Great place. They are coming up with innovative solutions to problems that elderly people and lonely people face. They are not just bringing in the public sector but the baker and the Co-op—a great thing too—to help support people. They are using local services and local businesses to do that. That work is ongoing, but inevitably, all public sector organisations, whether it is the NHS, GPs or social workers, have things they absolutely have to do. If the money for the things they absolutely have to do keeps getting cut, finding that money to go into the services that will save money becomes nigh on impossible. They get so exhausted because they continue to give of their time and energy to undertake these tasks and they find there is no energy to provide these new innovative solutions.

Mr Jamie Reed (Copeland) (Lab): Is my hon. Friend concerned that there might be a particularly disproportionate regional aspect to this? I am not talking just about the north of England but about peripheral economies, areas of market failure whether they are Conservative, Liberal Democrat or Labour areas, where precisely the kind of situation she describes will be most keenly felt.

Meg Munn: I am. One thing I wanted to mention in responding to the Minister is that the figures I quoted were from the County Councils Network, which is not massively Labour, and the Local Government Association, which is cross party. It was not party political rhetoric as such. It came from those people who will have to implement the measures. I know the Minister was disturbed that I would not take his intervention. I was genuinely concerned about the time and wanted to move that forward. He has been in the House longer than me but it has been my experience in Committee, and certainly when I was a Minister, that generally speaking, Ministers respond at the end rather than by intervening in colleagues' speeches. That was why I did not take his intervention rather than being hungry or something. I hope that has reassured him on that matter.

The Minister rightly referred to the new burdens doctrine. That was the basis on which I tabled my proposed new clause. His officials have undertaken an impact study and come up with certain figures. I am afraid those are disputed by me, based on figures prepared by the Local Government Association's County Council Network. There is a fear that this measure will not achieve what we want, due to a lack of proper funding.

I explained that this was a probing new clause and that I did not intend to press it to a vote. The Minister might be pleased to know—though I am not sure about my Front-Bench colleagues—that I do not support free care for everybody. I think there are a lot of pitfalls. I set out my position earlier: a system that levers in as much community, family and other carer's support as possible by meeting whatever they need so that they can continue to perform the wide range of tasks that they do.

Norman Lamb: May I express my delight that the hon. Lady is back on track and speaking sensibly again? That is so welcome.

Meg Munn: I am not sure what they call that, Mr Bayley. However, as far as I was concerned, I was never off track. Some day the Minister may come to understand that the Member of Parliament who gets up and has a go because they are angry and concerned about their constituents is precisely the same person who has lots of experience of this area, has some good ideas about how

it should go forward as well as legitimate concerns about how the legislation is drafted and how it will be implemented. I hope he will come to see that in his calmer moments.

Bill Esterson: The continual accusations about partisan politicking coming from Government Members are interesting given the way that they intervene. I will not repeat the responses to the partisan comments from Government Members. I am far more likely to listen to the advice of my hon. Friend Member for Leicester West than the Minister's on my new clause on free social care. I am grateful to the Minister for going through the detail of the analysis of the Dilnot commission and the international comparisons, and I take the point. However, I do not think this issue is going to go away. I do not think it has been resolved by the process of the cap, which is the point I made earlier. I predict we will return again and again to how we pay for social care and whether it should be free at the point of use.

Norman Lamb: I have received information, Mr Bayley, that the hon. Gentleman has tweeted that I have said that local authorities will have to pay for new responsibilities from existing budgets. That is simply not the case and I wanted to put the record straight.

Bill Esterson: The Minister has not denied the point put to him by the shadow Minister. The logic of that point is that that is exactly what will happen. That is exactly what he said. I will give him the chance now to say on the record that new money will be provided to local authorities to pay for the new requirements under this legislation.

Norman Lamb: The better care fund sensibly encompasses all the different elements of sums both for the implementation of the Bill and adaptations to people's homes and money coming from the NHS. Of course, the whole point is that it is grouped together into one fund, because all this is related. However, these are clearly identified resources that will be used to implement this Bill and are additional to what councils would otherwise have had.

Bill Esterson: There is a lot of double counting going on. I shall take interventions shortly from my own Front Bench, but I will just tell the Minister what my local authority said on this issue. It is very clear that it is not new money and that it is insufficient to cover the known additional demands—and that is before the Bill comes in. It also says that the money is to be found from hospitals, which will create pressures of its own and is a point that we made earlier in the discussion.

Liz Kendall: Perhaps my hon. Friend would agree with me. I do not know why the Minister will not say that £335 million for setting up the early assessments, deferred payments and information campaign comes from council budgets, and that £130 million directly for adult safeguarding boards and assessments for carers comes from the better care fund. That is what councils say. In the spirit of honesty, for which the Lib Dems are well known, I would have thought the Minister would confirm that point.

Bill Esterson: Once again: what I put on the tweet is very clear. I will give the Minister the opportunity now to say on the record that every penny of the new duties and responsibilities being given to local authorities as a result of this legislation will be provided.

Norman Lamb: The reason that I objected is that it is untrue. Councils would not have had this resource had we not been introducing these reforms. There is a clearly identified sum of money, which has gone through a rigorous and robust process, being allocated to local government as part of the better care fund, which they would not have had but for these reforms. I would be most grateful if the hon. Member could withdraw what he has said in his tweet, because it is not true.

Bill Esterson: I am listening very carefully. I have given the Minister a number of opportunities to put on the record that local authorities will be given the funds to pay every penny of the new responsibilities and duties. He has just not said that, so I stand by what I have said. The expectations among service users and carers is another point made to me by my local authority. It says that central Government should provide funding for the initial peak in work that passing the Bill would generate. It makes the same point as the LGA: there is real concern that local authorities will have neither the money nor the facilities—by which they mean software and staff—to get up and running immediately when the Bill is passed. They request that the Government provide both funding and access to relevant data to each local authority to support the transition. That is the view of local authorities. I have heard nothing from the Minister to indicate that what the local authorities say is not true, so I stand by my comment.

As for my amendment, this issue will not go away. Mine is a probing amendment. I understand the analysis, but we have not anywhere near resolved this issue for the long term with the proposal the Government are bringing forward. Although I will not press the new clause, I fear that we will come back to this in the very near future.

The Chair: We have had a good debate on the new clauses that were grouped with a stand part debate on clause 72, which we have hardly mentioned. We have been told that each of the new clauses will not be pressed to a vote, but we have to dispose of the question that clause 72 stand part of the Bill.

Clause 72 ordered to stand part of the Bill.

Clause 73 ordered to stand part of the Bill.

Schedule 3 agreed to.

3 pm

Clause 74

AFTER-CARE UNDER THE MENTAL HEALTH ACT 1983

Grahame M. Morris (Easington) (Lab): I beg to move amendment 131, in clause 74, page 65, leave out lines 35 and 36.

I will be extremely disciplined and focused on the subject of the clause. I refer the Committee to a declaration that I made previously and the specific issues that I wish to raise have been suggested to me by the charity Mind. Clause 74 seeks to amend section 117 of the Mental Health Act 1983, clarifying anomalies in determining

[Grahame M. Morris]

the responsibilities of local authorities in relation to the provision of aftercare treatment of mental disorders and the provision of care and support services to which the Bill applies.

Clause 74(5) seeks to introduce a definition for aftercare services. It is a concern of mine, as well as the consensus among a number of charities such as Mind, the Mental Health Lawyers Association, the Law Society, the Care and Support Alliance and some eminent lawyers, that the proposed definition is problematic and ought to be amended. There is a danger that the existing definition in clause 74 will not protect those suffering from mental disorders, probably the most vulnerable group in the mental health system.

The Chair: Order.

3.2 pm

Sitting suspended for a Division in the House.

3.16 pm

On resuming—

Grahame M. Morris: Before that important vote, we were discussing clause 74 and the concerns expressed about the Bill containing a new, restrictive definition of aftercare. I remind the Committee that those to whom the clause will apply will have been sectioned under the Mental Health Act 1983 and detained in hospital against their will because they are so unwell. The clause is important because those are some of society's most vulnerable people. They are in need of great consideration when deciding on their eligibility for care. My amendment proposes to remove proposed new subsection (6)(a) of the Act altogether.

I was initially minded to press the amendment to a vote, but I hope that the Minister will think carefully about the issues I am raising. I think that they address a point he has raised several times about the law of unintended consequences. The amendment would remove a provision from the Bill, for reasons that I hope will become apparent.

Jim Shannon (Strangford) (DUP): The hon. Gentleman has outlined a clear course of action that he feels is appropriate. Is he aware that both the Law Commission and the Law Society have indicated that there is a need to change the law to ensure that people with mental difficulties, at the times when those are most difficult for them, are looked after correctly?

Grahame M. Morris: With due respect, I do not think that I have made the case yet, but I hope to do so. The hon. Gentleman is right. They are among a number of organisations who made that point forcefully and I will refer to those. Unless we address that, the risk is that these vulnerable people will receive only the bare minimum of medical and social services in the future.

Section 117 of the Mental Health Act ensures that people who have been detained in hospital receive aftercare after having been discharged. That mix of health and social care is designed to help people cope once they have left hospital. Because these people are so vulnerable, their lives tend to be chaotic and, because being sectioned is such a traumatic experience, it is vital that clinical commissioning groups and local authorities work together so that they can rebuild their lives, look after themselves and avoid being sectioned again.

The code of practice, which provides guidance on how the Mental Health Act should be applied, states that, when creating an aftercare package, professionals must consider not only the patient's psychological and mental health needs, but whether they need physical health care, daytime activities, appropriate accommodation, assistance with welfare rights and managing finances, social and cultural assistance and specific assistance arising from drug and alcohol problems.

At the moment, when a patient is discharged from hospital, the aftercare package is provided free of charge. The services do not last for ever: people who require them have a review at some point to see if they still need them. Section 117 of the Mental Health Act is unique in that it requires health authorities to work together with local authorities to provide care; one cannot make a decision without reference to the other. In other words, health cannot make a decision without reference to a local authority.

Secondly, the package has to be free of charge. This is in recognition of the fact that the state—this may come back to the Minister's stout defence of the Human Rights Act and the need to protect the individual from the overbearing state—has detained an individual against their will, for their own protection, and has a duty of care to do everything possible to give them back their freedom and support them outside hospital. It is important that people with such serious problems get all the care they need and do not risk falling through the gaps and ending up back in hospital.

Lines 35 and 36 are problematic because of the narrow criteria of meeting a need arising from or relating to a person's mental disorder. They may well result in complicated disputes about whether a service meets a need arising from a person's mental disorder or not and therefore whether it should be provided.

The whole package of care keeps a person well and out of hospital. Removing or trying to remove elements of the package because it does not serve a need arising from or relating to a mental disorder will put a person's health at risk. It will also mean patients will spend unnecessary amounts of time in hospital beds—an issue that we are all concerned about—which may not be the best place for them. This will be at considerable public expense and the patients will be unable to regain their freedom in society

Where there are disputes about what services should or should not be provided, people will find that they cannot be discharged from hospital when they should be, exacerbating the shortage of in-patient psychiatric beds. Members of the Health Committee are well aware of this issue.

The nature of mental health disorders also means that if people are asked to pay, there is a high risk of non-compliance. The existing limiting wording employed in lines 35 and 36 will prevent some of the most vulnerable people in our society receiving the care that they need. Parliament will have failed its responsibility to give

freedom back to those who have suffered from the most severe mental disorders. Until now, there has been no statutory definition of aftercare, just a lot of guidance in the Mental Health Act 1983 code of practice. The reason for this is not by chance.

This side of the House has often argued for things to be included on the face of the Bill, rather than in guidance, but there is a particular reason for this in relation to patients who have been sectioned. The reason is that law-makers, when they were writing the Mental Health Act, realised that exactly what people need in an aftercare package varies because mental health conditions and the way they affect people are varied. The drafters of the Act wanted professionals to be free to put together the most appropriate care package and not to be restricted by legislation. I think this concept is well understood.

It might be useful to illustrate this point. For example, it might be argued that a person who has been sectioned because they are suffering from schizophrenia will require some talking therapies to address their depression, although they were not originally sectioned for depression. It might be argued that benefits or employment advice services are generic services that everybody needs, not services to meet a need arising from a mental health disorder or that a mental disorder is for the NHS to deal with, not the local authority.

Without the amendment, perverse incentives will be encouraged and those with mental health disorders will be damaged. I do not want to detain the Committee much longer, but I want to say that, rather than creating inequality, this amendment will preserve the status quo where professionals have the flexibility to design an aftercare package that is suitable for individual needs and looks at the whole person. That is a strong argument, and as my hon. Friend the Member for Strangford pointed out, it is supported by a whole series of informed opinions from charities and others. I hope the Minister will look carefully at those issues to ensure that we are not failing in our responsibility to care for the most vulnerable people in society.

Dr Sarah Wollaston (Totnes) (Con): I rise to support the amendment in the name of the hon. Member for Easington, a fellow member of the Health Committee. The Minister will know that the greatest health inequalities in our society relate to people with severe mental illness. Men with severe mental illness are likely to die 20 years earlier, and for women the figure is 15 years. That is almost entirely due to physical health problems, not mental health problems. The hon. Gentleman eloquently outlined a series of issues relating to people who have been detained against their will under the Mental Health Act 1983. We need to prevent readmissions under the 1983 Act, but there are other issues that we must consider. People's circumstances are critical, and we need to ensure that they do not drift into becoming rough sleepers.

The issue of interpretation is not irrelevant, as we saw in the case of R (Mwanza) *v.* Greenwich. We should remove the line in the Bill to which the hon. Gentleman's amendment refers, and the word "both" in the line above it is also problematic, because it would mean that both those circumstances would have to be present. Somebody who assesses an individual with mental health problems may see them when they are relatively well. However, mental health conditions can be variable, and just because somebody at the point of assessment is not acutely unwell and their condition is controlled, that does not mean they are not acutely at risk.

I ask the Minister to look again at the clause because there are already issues of interpretation. If we are to achieve what we want from section 117 of the 1983 Act, I urge the Minister to look at it again, because it is already causing problems and we have the opportunity to use the Bill to clarify it. I hope the Minister will address those matters in his response.

Norman Lamb: I thank the hon. Member for Easington for raising this issue. As he rightly said, we are dealing with some of the most vulnerable people in our communities, so we must ensure that the clause is right. I welcome the chance to debate it.

My hon. Friend the Member for Totnes is absolutely right that people with severe and enduring mental health problems are among the most let down by society. As she rightly said, their physical health causes them to die many years earlier than others, which is a cause of massive concern and is completely unacceptable. My hon. Friend may have noticed that the Government launched a mental health action plan on Monday called "Closing the gap", which seeks to address the lack of parity between the way that mental and physical illnesses are treated. We set out 25 priorities for essential change, and the report's contents were widely welcomed. I thank the hon. Gentleman and my hon. Friend for their contributions.

The amendment would alter the Government's definition of mental health aftercare services in the 1983 Act. The key point is whether it would give us a clearer, more useful definition than the one in the Bill. One advantage of introducing a clear definition will be that the scope of aftercare will no longer be entirely open to interpretation by the courts, whose views have varied and led to uncertainty over time. The hon. Member for Easington made the point about how legislation can sometimes provide clarity, as long as the words used are clear. Because our definition is more targeted, I feel it will be more helpful than the hon. Gentleman's in assisting clinical commissioning groups, Welsh local health boards and both English and Welsh local authorities to commission aftercare services more promptly.

3.30 pm

Importantly, our definition provides that section 117 services may "relate to" as well as "arise from" the person's mental disorder. That is an important broadening of the definition so that a wide breadth of services is covered. They simply need to "relate to" and not only "arise from". The current definition results from extensive consultation, which has led us to add a positive objective to reduce the risk of both deterioration in a person's mental condition and readmission to hospital.

We have further changed the clause to replace a reference to "the disorder"—I suspect the hon. Member for Easington will be aware of this from the debate in the House of Lords—with "mental disorder", which is something that the Mental Health Alliance had been lobbying for, and for which Lord Patel of Bradford made the case in another place. This change was to remove any doubt that aftercare may relate to more

than one form of mental disorder, and not necessarily the specific mental disorder for which the person was admitted to hospital.

We will also clarify the scope of the definition in the Bill's revised explanatory notes. Lawyers from the Mental Health Alliance have told us that this would be of considerable value in resolving disputes at a local level. The definition will be further explained when we revise the code of practice on the Mental Health Act 1983 later this year. We have given a commitment to work with all interested stakeholders when revising the code of practice.

Finally, I can reassure the hon. Gentleman and my hon. Friend that our definition contains a carefully framed duty that reflects the Government's policy on the appropriate scope of the duty to provide free aftercare services for a very small group of patients who have been detained for treatment under the Mental Health Act. It has carefully drawn limits, because the Government do not consider it would be appropriate for the Mental Health Act to impose a duty on the responsible bodies to provide or commission services that are based on needs that neither arise from nor are related to a mental disorder. That is what the purpose of the provision is all about.

In reaching their decision, the Government have taken a holistic approach to the provision of mental health services across the population and the funding implications of that. In the light of that, I hope the hon. Gentleman will feel able to withdraw his amendment.

Grahame M. Morris: I am grateful for the Minister's consideration, but I am not persuaded by what he says. A weight of evidence from experts and charities is at odds with the Government's position. I recognise the maths of the voting system, so I am willing to withdraw the amendment, but I am not satisfied with the assurances I have received from the Minister. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 74 ordered to stand part of the Bill.

Schedule 4 agreed to.

Clause 75 ordered to stand part of the Bill.

Clause 76

REGISTERS OF SIGHT-IMPAIRED ADULTS, DISABLED ADULTS, ETC.

Question proposed, That the clause stand part of the Bill.

Mrs Emma Lewell-Buck (South Shields) (Lab): I am grateful for the opportunity to debate the clause, as I believe it limits the requirement for local authorities to keep a register of sight-impaired or disabled children by referring to adults only. The Bill denies support to children and families and misses an opportunity to create a unified register that can support local authorities in managing service users' transition into adulthood. Such issues are, of course, already recognised in legislation. The Children Act 1989 requires local authorities in England to maintain registers of disabled children, including blind and partially sighted children.

However, as the Minister may be aware, that is often ignored. The Royal National Institute of Blind People has found that 20% of local authorities have no register for disabled children. Even where registers exist, they are often poorly maintained. Six in 10 registers contain 10% or fewer of the disabled children known to the authority through other channels, such as special educational needs statements.

Clearly, the duty needs to be reinforced, and the Bill is an ideal opportunity to do so. The change will not create any new burdens on local authorities but would underline the importance of registers to support disabled individuals, including those who are blind or partially sighted.

The benefits are clear: registers would help children and their families by providing access to additional help and support from the council, including social services and the local education authority. A register can also act as a passport to help for families. Failing to maintain a register means that the passport function is completely lost to families that struggle to cope with the needs of a disabled child. The registers would also benefit local authorities, because they can be used to assess demand in an authority's area for support and help it commission services now and in the future.

I acknowledge that the Bill already includes clauses covering the transition from child to adult social care, but the transition would be greatly aided by the existence of well-kept registers that are comparable across child and adult services. At the moment, a lack of information about young people entering the adult system leads to disruption for service users and confusion for councils. The clause represents an opportunity to redress that balance.

The Bill, rightly, acknowledges the important role that registers play to ensure that disabled people have access and are guided to appropriate support. However, I believe that there currently is a loophole that makes it more difficult for disabled children and their families to access support, which undermines the Bill's efforts to join up child and adult social care in a better way. I hope that the Minister will consider my arguments and look to include a requirement for a disabled children's register in the Bill.

Norman Lamb: I fully support the hon. Lady's intention of ensuring that registers are kept for children as well as adults. However, the Bill's remit is for adult social care. Although it deals with children's transition to adult care and support, it does not otherwise cover children's health or social care.

I am happy to inform the hon. Lady that there is an existing statutory provision in the appropriate legislation that meets her objective. I understand her point that some local authorities may be in breach of that requirement, but such a requirement, which is what she seeks, already exists.

Under schedule 2 to the 1989 Act, every local authority in England is under a duty to maintain a register of disabled children in their area, which will include children who are blind or have a visual impairment. Any changes to this Bill are therefore unnecessary, as they would duplicate an existing statutory duty.

Heather Wheeler (South Derbyshire) (Con): It is interesting to hear that there is a statutory requirement on our councils to do that. To put the mind of the hon.

Member for South Shields at rest, I wonder whether it would be beholden on us to ensure that all our councils—we could write to them as individual MPs—are doing that now.

Norman Lamb: That is a good suggestion. We all have the potential in our roles to hold our local authorities to account. Perhaps the Local Government Association could help as well. The statutory duty exists, and we need to be getting the message out to local authorities that they need to comply with it.

During the passage of the Children and Families Bill through Parliament, the Government committed to reinforcing the duty—this is an important point too—through that Bill's statutory code of practice for special educational needs. This will ensure that the local authorities are fully apprised of their duty to maintain this register and to have a clear picture of the numbers of disabled children in their area, including data on low incidence needs such as visual impairment or hearing impairment.

The Children and Families Bill will introduce an enhanced approach to meeting the needs of children and young people with special educational needs and disability. It will require clinical commissioning groups and local authorities to agree joint arrangements for working together for such children with a view to integrating education, health and care plans for children with special educational needs. Identifying these children and maintaining a register will be essential to ensure that the nature of local needs is understood.

I hope hon. Members will join me in welcoming these important steps to ensure that children with special educational needs will have the necessary holistic support to help them fulfil their potential. I hope that I have responded sufficiently to the hon. Lady who raises an important point. The duty is already there and further steps are being taken to reinforce that duty. We can all assist in that regard to apply pressure on local authorities to meet that duty.

Mrs Lewell-Buck: I thank the Minister for his response. I am comforted by the changes that are being made through the Children and Families Bill, and I hope that those changes have an effect on the ground. We are talking about the forgotten 80% of children with special needs who go missing from the system when they become adults. I hope the Children and Families Bill achieves what it says it will in that regard, but I am a bit sceptical.

Question put and agreed to.

Clause 76 ordered to stand part of the Bill.

Clause 77

GUIDANCE, ETC.

Paul Burstow: I beg to move amendment 121, in clause 77, page 69, line 29, at end add—

'(4) The Secretary of State must take reasonable steps to ensure that all guidance issued under regulations made under this Part is made easily available in a range of formats and kept up to date.'.

The Chair: With this it will be convenient to discuss amendment 125, in clause 77, page 69, line 29, at end add—

'(4) A local authority, and NHS bodies, must continue to act under general guidance previously issued by the Secretary of State until a declaration of intent has been made by the Secretary of State in relation to new general guidance.

(5) Any general guidance issued by the Secretary of State relating to the exercise of functions as defined in subsection (1) will, unless otherwise specified, use the definition of an NHS body set out in this Act.'.

Paul Burstow: This is a small amendment that goes to an issue that was covered in the Law Commission's report and was picked up in the Joint Scrutiny Committee's report. It is simply how best to marshal or regiment guidance that is issued in a way that makes it easy for practitioners to understand, easily accessible for practitioners and also easy for us in this place to find and interpret when we come to cross-check how things are being implemented in practice. The explanatory notes state that the courts' interpretation of the duty under the Local Authority Social Services Act 1970 is that local authorities must

"follow the path charted by the Secretary of State's guidance, with liberty to deviate from it where the local authority judges on admissible grounds that there is good reason to do so, but without freedom to take a substantially different course".

This is very important. This is one of the more important clauses, if not the most important clause. It sets up so much of what the rest of the Bill provides for, which is to issue guidance. Ministers make very clear promises and undertakings in this Committee, in the House and in the other place about something being put in guidance. That is why the clause matters. It will be something that binds and has to be followed. Whether through this amendment or by the Minister giving us some further clarity, the key point I want to make is that if we are not to go as far as a code we must be clear that we are producing a consolidated bank of guidance in a series of formats that are accessible so that we can use it well.

The other point I wanted to make was to thank the Government for listening and changing the legislation to reflect a recommendation made by the Joint Scrutiny Committee, albeit in the Lords on amendment. That was to make the Secretary of State subject to, or at least to have to have regard to, the general duty under clause 1—the well-being duty—when he or she is issuing guidance or regulations under this part of the Bill. It is very important that the whole system is unified through clause 1. That means that the Secretary of State when issuing guidance or regulations also has to take the duty in clause 1 into account. That is very welcome; it means we will have a coherent system that will deliver the well-being principle effectively. I am grateful to the Government for taking that on board, and I hope the Minister will be able to respond to my question about access to the guidance.

3.45 pm

Grahame M. Morris: I wanted to make a few points in support of the arguments advanced by the right hon. Member for Sutton and Cheam on an issue considered in the Joint Committee on the draft Bill. Without repeating those arguments, we come back to the question of whether regulation or guidance applies only to local authorities.

I refer to my earlier declaration of interest. I was asked to table amendment 125 by the National Autism Society. It wants to ensure that the statutory guidance arising from duties placed on NHS bodies by the Autism Act 2009 will continue to apply once the new suite of

[Grahame M. Morris]

statutory guidance and regulations is issued. It is like my earlier amendment in respect of the Mental Health Act 2007. I appreciate that the guidance will be voluminous once the Care Bill is enacted.

The National Autistic Society is concerned that, as other guidance affected applies only to local authorities, there is a need to maintain those duties, and that that need may be overlooked. Let us reflect for a moment on the fact that the Autism Act is England's only disability-specific legislation, in that it applies only to people with autism. There is no Diabetes Act or Parkinson's Act. As the right hon. Gentleman pointed out, it began life as a private Member's Bill. The Bill was passed into law with cross-party support, because it was recognised that there was a dearth of services for adults with autism. It led to the publication of the adult autism strategy and accompanying statutory guidance, which commits the Government, local authorities and NHS bodies and other stakeholders to take action to improve the lives of adults with autism across England. Indeed, the Department of Health is currently undertaking a statutory review of the strategy.

Last year, research by the National Autism Society showed that although the Act had succeeded in putting autism on the agenda, change had not been fast enough. Many local authorities and NHS bodies are yet to meet the number of outstanding commitments and it therefore remains important that those duties that apply to clinical commissioning groups and NHS foundation trusts are maintained and not deleted as a consequence of the passing of the Care Bill.

The amendment seeks to ensure that the statutory guidance resulting from the Autism Act is embedded in the new legislation in the Care Bill, and that nothing that currently gives protection to people with an autistic spectrum disorder slips through the net. The Autism Act statutory guidance commits NHS bodies and NHS foundation trusts to a number of particular responsibilities that are crucial to improving the lives of adults with autism, and ensuring that the adult autism strategy is successful.

I have some examples of clinical commissioning groups being responsible for developing a diagnostic and care pathway for adults with autism. Diagnosis is crucial. The Minister referred to the NAS research "Push for Action" campaign. As my hon. Friend the Member for South Shields mentioned in relation to registers of children, the research discovered that a diagnostic and care pathway is in place in only 63 of 152 local authorities. The statutory guidance states that NHS bodies and NHS foundation trusts should ensure that autism awareness training is available to all staff working in health care. I hope the Minister will reassure me on that point. Amendment 125 is a probing amendment, so I will not press it to a vote, but I want to raise some points with the Minister and seek assurances.

The NAS believes that autism awareness training should be included in general equality and diversity training programmes as a minimum. In a survey, general practitioners identified that they need more understanding and awareness of autism and where to refer people with autism for appropriate help and support. May I give an example of why that is important? It is not a trivial issue.

I am grateful to the NAS for providing me with an anonymised example. Chris, a 47-year-old man, was diagnosed with Asperger's syndrome in 2007, but for more than 20 years before that he had been presenting to his GP and had been given medication for mental ill health and told to pull himself together. At the age of 15, he had been diagnosed with depression, obsessive compulsive disorder and mild Tourette's syndrome, but getting a diagnosis of Asperger's syndrome was extremely difficult because the understanding of autism at that time was poor. Chris had learned adaptive strategies to conceal his difficulties and appear "normal". He finally got a diagnosis only after paying for a private service with someone who had the necessary skills and understanding. He told the NAS that if he had not been able to get that diagnosis, he probably would have taken his own life.

The issue is serious and the example I give brings home to us all how important it is to ensure that adults with autism, and children, get the right diagnosis. It clearly illustrates the importance of ensuring that the good work in the Autism Act 2009 and elsewhere continues. I hope the Minister can assure me, the Committee and people with autism and their carers that the statutory guidance published as a result of the 2009 Act applies to and puts duties on local authorities and the NHS, and that that situation will be maintained.

Norman Lamb: I thank my right hon. Friend the Member for Sutton and Cheam and the hon. Member for Easington for their amendments. The purpose of the statutory guidance is to guide local authorities on how they should exercise their functions under the Bill. However, the guidance should also be useful and informative to others in the care and support sector, including people using care and support, their families and anyone else who needs it.

Amendment 121 requires the guidance to be made easily available in a range of formats. I can confirm that the Department will take steps to ensure that the guidance is accessible in formats that enable people to make use of it—I hope that gives some reassurance to my right hon. Friend. That will include continuing to engage closely with stakeholders about what we can do to ensure that guidance is accessible to not only local authorities, but the people using care and support services and their families. The amendment also seeks to ensure that the statutory guidance is kept up to date. As part of the ongoing implementation and delivery of the reforms, we are certainly committed to keeping the guidance under regular review, and it will be updated as necessary. The power in clause 77 gives us the flexibility to reissue and update the guidance.

I turn now to Amendment 125. The proliferation of guidance over many years has caused much confusion, and the lack of a clear understanding of the legal status of different documents has not helped. The Bill represents an opportunity to resolve that and create a new clarity and consistency in our approach to guidance. However, the transition to the new legal framework must also be managed carefully, to ensure that nothing is lost in the process. That is a concern of the hon. Member for Easington. We intend to develop a single, consolidated bank of guidance covering all functions within part 1 of the Bill, to support implementation of the new statute. As part of that, we will replace all existing guidance

that covers that territory, to remove the potential for any misunderstanding. We are mindful of the need to ensure that there is no gap in provision during transition. I assure hon. Members that the existing guidance will remain in place until it is superseded by new guidance.

Unlike other statutory guidance related to care and support, the autism statutory guidance, about which there has been concern, is issued under a specific requirement in the Autism Act 2009. That guidance is addressed to local authorities and NHS bodies. The 2009 Act and the duty to issue guidance under it are not affected by clause 77 and remain in place.

The hon. Gentleman mentioned the National Autistic Society, and I pay tribute to its work. It has worked collaboratively with Government over the review of the autism strategy. As a quick reflection, it seems that we have made considerable headway on the legislation, the strategy and the guidance, but making change happen on the ground remains a massive challenge. That will be reflected in the review when it emerges, which is not that far away. It is incumbent on central and local government to work collaboratively to ensure that these good intentions are implemented to make a difference to people's lives.

Grahame M. Morris: Does the Minister acknowledge that we have the classic dilemma here of whether we address these issues through the Bill containing a statutory obligation or through guidance? If we have guidance that is unclear, meaning that the measure is not implemented on the ground, we are not doing our job properly in Committee.

Norman Lamb: I take the point, but history is littered with Acts of Parliament, regulations and guidance that have not been implemented adequately. To give another example, the Mental Capacity Act 2005 is very good legislation, passed by the Opposition when they were in government, but it has not yet been fully implemented. There is nothing magic about an Act of Parliament that guarantees that its measures will be implemented from day one. Work has to be done on the ground to make the change happen. Our job in this place is to facilitate that change. The challenge is the implementation, and that is where we are at with autism. The guidance under the Autism Act 2009 will remain in force until new guidance supersedes it.

Amendment 125 would create a consistent application of the definition of an NHS body. We agree that definitions must be clear and consistent in the Bill, regulations and guidance and that there should not be differences between the Bill and other documents. We are keeping that issue in mind in drafting regulations and guidance to ensure that key terminology and definitions are consistent. I hope that what I have said persuades my right hon. Friend and the hon. Member for Easington that their amendments are not necessary.

Paul Burstow: I am grateful to the Minister for his reassurance about the guidance being published in a consolidated form and appropriate formats. He rightly indicates that the Bill will trigger the production of a whole new set of guidance. At some point, presumably once the Bill has become an Act, it will be useful for the intended timetable for the production of that guidance to be placed in the Library so that hon. Members can see it, be aware of it and be informed.

Norman Lamb: I can confirm that that can happen.

Paul Burstow: That will be helpful. The reassurance on the guidance under the Autism Act 2009, which I had responsibility for taking through, is helpful. I am sure that the hon. Member for Easington will be grateful for that. Unless he is hoping to speak as well, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 77 ordered to stand part of the Bill.

Clause 78 ordered to stand part of the Bill.

Clause 79

PART 1: INTERPRETATION

Amendments made: 22, in clause 79, page 71, line 18, at end insert—

'Child's carer's assessment	Section 61(2)
Child's needs assessment	Section 59(2)'.

Amendment 23, in clause 79, page 71, line 29, at end insert—

'Parent	Section 59(6)'.

Amendment 24, in clause 79, page 72, line 3, at end insert—

"Young carer	Section 64(6)
Young carer's assessment	Section 64(2)"

—(Norman Lamb.)

Clause 79, as amended, ordered to stand part of the Bill.

4 pm

Clause 80

DUTY OF CANDOUR

Mr Reed: I beg to move amendment 139, in clause 80, page 72, line 20, at end insert—

'( ) The duty of candour specified in regulations made under this section shall require—

(a) healthcare service providers who believe or suspect that treatment or care provided by their service has caused or contributed to death or serious injury to that patient to inform that patient, their representative or other authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient or other person mentioned may reasonably request, and

(b) registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.'.

Norman Lamb: It has been so long.

Mr Reed: It has been so long indeed. It was a rather high-octane session before the Division in the Chamber, so let me say from the outset, where there is discord,

[Mr Jamie Reed]

may I bring harmony. I was not in the Chamber for the maiden speech of my hon. Friend the Member for South Shields, but I think I was in this Committee for her maiden amendment to a Bill. I may have that wrong, but I noticed that the public gallery emptied as soon as she finished speaking, so it was sheer magnetism. It would be remiss not to congratulate my hon. Friend the Member for Easington, who I see is sporting a Sunderland football club tie, on its success in reaching Wembley.

Bill Esterson: I hope I am not out of order by associating myself with those remarks. Representing a Merseyside constituency, I could not resist.

Mr Reed: I completely understand where my hon. Friend is coming from. I shall speak to amendment 139, in my name and that of my hon. Friend the Member for Leicester West. We are discussing what I suspect will be the last piece of health legislation from this Government in this Parliament—I may be mistaken, I cannot read the Government's mind—and part 2 of this Bill is exceptionally important. Amendment 139 is an important amendment to an important clause, Mr Bayley, and with your permission I will seek to explore the reasoning for it in due depth.

It is important that we all understand the genesis for this part of the Bill, the important issues that it seeks to address and the likely effect of the remedies proposed by the Government in clause 80. Part 2 is simply entitled "Care Standards", yet each of us knows that this simple definition does not accurately reflect the need for this part of the Bill or, in fact, its genesis. In the course of my contribution, I hope to identify common thinking, so this can lead to the development of common approaches and enduring solutions for the benefit of patients, medical professionals and the NHS as a whole.

Clause 80 seeks to place a duty of candour on providers of health care and adult social care services registered with the Care Quality Commission. The duty means that such providers would be required to ensure that patients and service users are told when something unexpected or unintended occurs in the course of their care or treatment, helping to ensure that honesty and transparency are the norm in every organisation overseen by the CQC. The details of the duty, including when it will apply and what information is to be given to patients or service users, is to be included in regulations.

Given the importance of this issue, I regret that this information is not included in the Bill, as we heard earlier. Such a move would have provided an opportunity for a full, frank and transparent debate between patient groups, care providers, the Department, trade unions, the royal colleges and others. It would undoubtedly have been a difficult debate, but it would in my view have reached a consensus during the passage of this Bill that would have been arrived at transparently. It is a missed opportunity and I hope that the Minister will explain why this has been done in this way. Such a debate on detail could have obviated the need to table this amendment and subsequent amendments. However, we are where we are and the amendment is before us.

The Opposition welcome clause 80, but we are concerned that it does not go far enough. The amendment, which squarely follows Francis recommendation 181, seeks to strengthen the Bill by ensuring that patients and medical professionals are better protected than the clause currently makes provision for. Most importantly, for reasons that I will explain, it would help to lead towards better standards of care.

Robert Francis made openness, transparency and candour one theme in his report and he made 11 recommendations on that: recommendations 173 to 184. Those holistic recommendations would be much more effective if taken together, rather than treated as a menu of options. Recommendation 181 of the report,

> "Enforcement of the duty: Statutory duties of candour in relation to harm to patients"

stated:

> "A statutory obligation should be imposed to observe a duty of candour".

That recommendation was in two parts and sought to impose a statutory obligation to observe a duty of candour first:

> "On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request".

Secondly, it recommended:

> "On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable."

Our amendment follows that recommendation to the letter. However, what it does not contain, but is directly relevant to the concerns expressed by medical professionals about the individual duty of candour, is that Francis made it clear that:

> "The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy."

I find that hard to resist.

Clearly, we are all passionate about the quality of our health care services and, in recent years, this House, much of the public and the commentariat have focused on that, the most immediate reason being the appalling revelations contained in not one but two reports that relate to separate independent inquiries undertaken by Robert Francis, QC, into the suffering experienced by many patients at the hands of the Mid Staffordshire NHS Foundation Trust. Those reports followed the investigation and subsequent report published by the Healthcare Commission in 2009 that also highlighted appalling failures at Stafford hospital.

This is the first time that the Committee has ventured into any real detail on those issues. Discussion of what took place is, therefore, not only inevitable, but necessary. I repeat the apology made by my right hon. Friend the Member for Kingston upon Hull West and Hessle (Alan Johnson) who, when Secretary of State for Health 2009, apologised on the Floor of the House on behalf of the Government and the NHS for the pain and anguish caused to so many patients and their families. I also repeat the apology made by my right hon. Friend the Member for Leigh (Andy Burnham) when he announced

the first Francis inquiry in February 2010. He was right to state that the quality of care provided at Stafford was

"totally unacceptable and a fundamental breach of the values of the NHS."—[*Official Report*, 24 February 2010; Vol. 506, c. 309.]

It is right to pay tribute to all the campaigners who worked so hard to shine a light on the deficiencies they saw, and from which their loved ones suffered, at Mid Staffs. It is also right that we recognise the remarkable work done by Robert Francis and his team, which was laborious, forensic and, sadly, necessary. We owe it to those who have suffered, to every patient using the NHS and to every medical professional who works in it to consider carefully the Francis recommendations. The Labour party has accepted the recommendations entirely and believes that they should be implemented in full.

When considering our amendment, which relates in large part to people working in the NHS, it is important to be clear about what Robert Francis wrote with regard to the NHS and the 1.3 million people who work in it. He wrote:

"The NHS is a service of which the country can be justly proud, offering as it does universal access to free medical care, often of the highest order. It is a service staffed by thousands of dedicated and committed staff and managers who have been shocked by what they heard of the events surrounding the Trust. It is inconceivable to many of them that conditions of the type described by so many patients can have been allowed to exist let alone persist."

Every member of the Committee will recognise that to be true. On a personal note, I again thank the medical professionals in my community and all those at West Cumberland hospital. I have far too much to thank them for over far too many years. Suffice it to say that they have saved my life twice in recent years, for which I am certain the entire Committee rejoices.

In his statement responding to the publication of the latest Francis report in February 2013, the Prime Minister announced further streams of work stemming from that report. Professor Don Berwick, my right hon. Friend the Member for Cynon Valley (Ann Clwyd) and Professor Tricia Hart were tasked with producing separate reports so that the Department and Parliament could better understand and assimilate the likely consequences of the Francis report for the health service in its entirety in order to determine appropriate policy responses through which to deliver the improvement that Francis recommended. In addition, Professor Sir Bruce Keogh was commissioned to look into 14 trusts across the country.

Those reports are directly relevant to amendment 139 on the principles of candour, accountability and the drive to improve patient care. Building on the work of the Francis report, Professor Don Berwick wrote in "A promise to learn—a commitment to act" that:

"In its core and concept, the NHS has been and remains a world-leading example of commitment to health and health care as a human right—the endeavour of a whole society to ensure that all people in their time of need are supported, cared for, and healed. The vast majority of those who serve in the NHS—clinicians, staff, managers, executives, and boards, contractors and partners—try every day to help to the very best of their abilities, and with deep and appropriate pride in their mission."

I am sure we all echo those sentiments, to which the amendment is directly relevant.

We all want to stop the feckless demonisation of our medical professions. That is not, and must never be confused with, writing a blank cheque or turning the other cheek when inadequacies are identified, but we must recognise the damage that constant criticism, frequent hyperbole and frankly false and wilfully misleading media coverage of such issues can cause. The amendment is directly related to that emerging and, for some, seemingly addictive practice. Professor Berwick strongly makes the point in his recommendations:

"Society, in general, and leaders and opinion formers, in particular, (including national and local media, national and local politicians of all parties, and commentators) have a crucial role to play in shaping a positive culture that, building on these strengths, can realise the full potential of the NHS."

It is essential that we recognise that fact and act accordingly. There is little point in commissioning eminent experts to assist us all in delivering improvements in the national health service if we then turn our back on their work. Professor Berwick makes clear the value to patients and medical professionals if we as politicians consent to work in that way:

"When people find themselves working in a culture that avoids a predisposition to blame, eschews naïve or mechanistic targets, and appreciates the pressures that can accumulate under resource constraints, they can avoid the fear, opacity, and denial that will almost inevitably lead to harm."

That is entirely what the amendment would achieve: the full implementation of what Francis intended with his recommendations.

When we read the latest Francis report and the other reports that were based on it, there are obviously many similarities. Each report shares the same essential analysis and the same desired end point. Part of that shared analysis is on the differences between systemic failure in the national health service and individual failures. That point was scrutinised in depth by Francis and acknowledged by the Prime Minister in his response to the Francis report when he said:

"Too many doctors 'kept their heads down' instead of speaking out when things were wrong."—

[*Official Report*, 6 February 2013; Vol. 558, c. 280.]

That was part of what Francis called

"an insidious negative culture involving a tolerance of poor standards".

I firmly believe that an individual duty of candour would help to change and inform the behaviour of medical professionals in the event of a repeat of anything like the failures that we saw at Mid Staffs. In short, the amendment would prohibit medical professionals from keeping their heads down.

4.15 pm

We are trying to improve standards of health care. Francis defines health care thus:

"Health care is not an activity short of systems intended to maintain and improve standards, regulate the conduct of staff, and report and scrutinise performance".

But time and again, Francis reminds us of the dangers of relying upon systems in the flawed belief that systems are infallible or

"assumptions that monitoring performance management or intervention was the responsibility of someone else".

He goes further in his letter to the Secretary of State for Health introducing his report, when he describes an individual duty of candour as "an essential aim" of his recommendations. Francis states that it is an essential aim to:

"Make all those who provide care for patients, individuals and organisations, properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service".

In the same letter, he goes further by saying:

"it is not the system itself which will ensure that the patient is put first day in and day out. Any system should be capable of caring and delivering an acceptable level of care to each patient treated, but this report shows that this cannot be assumed to be happening".

Repeated illustrations of care failings occurring since Francis published his report, sadly continue to make the case for an individual duty of candour. It is clear that, in order to improve a system, we have to change the cultures and practices within that system. Francis makes the point repeatedly and I am sure we all share this view. Amendment 139 seeks to achieve a culture change. We seek this culture change with a view to being able to improve the system in which the culture exists and as a means to safeguard against system failure.

Professor Berwick also makes this point extremely well with perhaps one of the most telling illustrations of the need for the individual duty of candour that I have found. I am well aware of what Professor Berwick says with regard to the specific Francis recommendation, but he makes the case here exceptionally well:

"In the end, culture will trump rules, standards and control strategies every single time and achieving a vastly safer NHS will depend far more on major culture change than on a new regulatory regime".

In my view, the introduction of an individual duty of candour is the best way in which we can achieve that major culture change.

With regard to the events at Mid-Staffs, Professor Berwick stated:

"The only conceivably worthy honour due to those harmed is to make changes that will save other people and other places from similar harm".

I see this major culture change as being facilitated in part by the introduction of an individual duty of candour.

An individual duty of candour would also assist in the development of better communication in a hospital environment—better communication between medical professionals and patients and better communication between medical professionals themselves. Time and again, the quality of communication is cited as a significant factor in determining medical outcomes and the quality of the patient's experience. It is also the case—many hon. Members will know this—that the ability to effectively communicate is one of the core principles and values of medical professionalism, as described by the Royal College of Physicians. An individual duty of candour can surely only help in this regard.

I completely understand the anxiety that some medical professional groups have with regard to the introduction of an individual duty of candour. The point is repeatedly made that there is no need for such an individual duty, because existing professional guidelines, professional standards and more already ensure that this duty is observed.

Norman Lamb: I am grateful to the shadow Minister for giving way. I note the second part of his amendment which seeks to introduce the individual duty. Is it his intention that breach of that duty would be a criminal offence on the individual clinician?

Mr Reed: I will address that in the full course of the introduction of the amendment. It is an incredibly important point. If you look at Francis's recommendations 182 and 183, they are clearly dependent upon each other, to a degree, at least in terms of their efficacy.

I was pointing out my understanding of the anxiety that some medical professional groups have shown with regard to the introduction of individual duty of candour. I get that entirely. The point is repeatedly made that there is no such need for an individual duty because existing professional guidelines, professional standards and more already ensure that this duty is observed. As I have indicated, I accept this argument to a degree. However, the logic of the case for the introduction of an individual duty is not changed by this. On the contrary, it is strengthened. If professional standards and guidelines already exist to ensure such candour, there should be no problem or objection to placing such obligations on a clear statutory footing. I would go further and say that such a move is more about the patient than the professional and that although medical professionals will always be aware of their duties and obligations, patients almost certainly will not be.

Dr Wollaston: There would be a difference in that clinicians would be criminalised. Any clinician will tell you that a clinical decision made in the heat of the moment may well have been right at the point at which it was made. We are asking clinicians to make difficult judgments and if we shifted to a far more defensive culture of practice, there is the danger of unintended consequences. Criminalising clinicians would be a serious step. While I completely agree with the need for culture change, it is better to set such things in regulations, simply because as the culture shifts we may shift other factors, such as moving towards asking doctors and other health professionals not to make disclosures under anonymity. Once we fully protect whistleblowers and the culture changes, there is a shift. The unintended consequences are therefore a strong argument for setting this in regulations and not actually criminalising clinicians.

Mr Reed: I understand the hon. Lady's point and respect her professional judgment, but Robert Francis addresses the point in the language used in recommendation 181. He makes it clear that such an individual duty of candour should not be considered to be an admission of liability or a criminal offence. My point about recommendations 181 and 182 being consistent with each other is that I believe it is the Government's intention to introduce criminal offence charges with regard to the duty of candour. It is the Government's prerogative to accept recommendation 182 without accepting recommendation 181, but the two actually strengthen each other if taken together.

Norman Lamb: I am grateful to the shadow Minister for giving way. The Government are introducing a statutory duty of candour on providers, making it clear that a failure to comply with that duty is a criminal offence. We have stopped short of placing that duty on individuals for the reasons that my hon. Friend the Member for Totnes explained. I am not yet clear whether a breach of the individual duty of candour that the shadow Minister describes would amount to a criminal offence, so will he clarify that specific point?

Mr Reed: It is not our intention that a breach of the individual duty of candour would amount to a criminal offence.

Norman Lamb: That is very interesting, but if it does not amount to a criminal offence, what is the point? What does the wording actually achieve beyond a statement of good will and intent?

Mr Reed: There is a real point to it, which I will come on to during the rest of my speech on the amendment.

Everyone in the Committee will be aware of the need to protect whistleblowers in public and private institutions, in particular one as important as the NHS. Placing an individual duty of candour on medical professionals strengthens both the whistleblowing principle and whistleblowing practice. Time and again, reports relating to episodes of inadequate care mention the culture of fear that prohibits medical professionals from speaking out for fear of the consequences. Amendment 139 seeks to address that. If the duty of candour is made an individual responsibility, the culture of fear is legislated against. It would not be easy or comfortable, but bearing in mind Robert Francis's clear recommendation that the

"provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability",

the case for an individual duty and an explicit commitment to protection within the law make the case for an individual duty. With regard to the NHS complaints process, Professor Hart's report urges a "freedom from fear". Amendment 139 seeks to establish that freedom for not only patients, but medical professionals. The amendment is entirely consistent with Francis recommendation 183 about criminal liability, which is accepted by both Government and Opposition. Recommendation 183 states:

"It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation: knowingly to obstruct another in the performance of these statutory duties; to provide information to a patient or nearest relative intending to mislead them about such an incident; dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties."

Surely, an individual duty of candour would make the need for a prosecution in any of the likely situations suggested by Francis less likely. Not only that, but in the event of a prosecution being brought, whether or not it is successful, individual identities, actions and the consequences of those actions would be highlighted and placed in the public domain.

Clearly, to improve the effectiveness of recommendation 183, recommendation 182, as laid out in amendment 139, would be of significant benefit. The shadow Secretary of State of Health put it best when he said:

"It is only when an individual is both required to speak out, and protected in doing so, that this House can say it has done enough to safeguard patients."—[*Official Report*, 19 November 2013; Vol. 570, c. 1099.]

That is the fundamental purpose of amendment 139.

I will turn to the support provided by the Patients Association regarding the introduction of an individual duty of candour on medical professionals. Irrespective of its support for our amendment, I thank it for the vital work that it has undertaken for decades now. Like us, the association is not convinced that the duty of candour as expressed by the Government will adequately address the issue of poor care in hospitals. It has said:

"Patients who have experienced poor care in hospital are generally not subject to the whim of an individual but have been let down by a team who have either failed to notice the actions of one of their colleagues or who have turned a blind eye to unacceptable practice. There are already professional guidelines in place that require individuals to come forward if they feel a patient is suffering harm or distress. However, we know from our Helpline"—

accessed by thousands of people each year, as I understand it—

"that there are too many cases where healthcare professionals are not raising the alarm regarding substandard patients care."

The association poses a critical question, which I hope the Minister will answer.

Dr Poulter: Just to tease that point out further, how would the hon. Gentleman judge whether a medical or health care professional has met the standards he has set and been candid when something goes wrong? How would he put a test in place to do that? All they would need to do is fulfil that.

Mr Reed: As with the Government's existing proposals, we would need to establish a clear threshold, either in statute or with reference to published guidelines. The threshold, which would have to be produced with the involvement and consent of medical professionals, would take time; it would not be simple.

Dr Poulter: To give a real-life example, if a junior doctor raises a concern with their consultant orally, but then there is a disagreement about the facts, could the junior doctor be prosecuted because they had not raised the concern in writing? This is a difficult area, and it highlights the potential adverse consequences of an individual duty. The hon. Gentleman's proposal could lead to innocent doctors who have tried to do the right thing, but not through the right process, finding themselves in difficulty or even being prosecuted.

Mr Reed: I appreciate that real-life example, but if the hon. Gentleman looks carefully at both the detail of the Francis recommendations and the report published by Professor Berwick with regard to data capture and the duty placed on medical professionals to provide or produce real-time data of how they are looking after certain patients, and the information that they are providing that patient, he will see that that poses precisely the same issue that he said would arise with regard to what we are collectively seeking to do.

Dr Poulter: I think the point here is not about the judgment of whether a health care professional has met that duty, which the professional regulators should already be enforcing. Regulators can take action against a medical professional, and they should be doing so if that professional has not fulfilled their duty to act in patients' best interest.

Mr Reed: I have a great deal of sympathy with that point, but surely, the point of the latest Francis report, the Berwick recommendations, Professor Hart's study

[Mr Jamie Reed]

and the Keogh review is that such systems fail. Individuals need to be more empowered and more accountable for the decisions they make on a case-by-case daily basis.

4.30 pm

I will come to the key objective of the Patients Association in a second, but it posed a critical question that relates to the interventions just made. I hope the Minister will be able to answer this in due course. The Patients Association stated:

"We question that if individuals are not already motivated by their own professional code, how will a duty on their employer encourage them to come forward?"

That is a critical question that in many ways goes to the heart of the matter. The key objective for the Patients Association is to ensure that whistleblowers come forward without fear of retribution. If they feel that a patient is receiving substandard care, they ought to be encouraged and safeguarded in coming forward. The Patients Association claims:

"Without this fundamental change within the NHS, the Duty will just be providing lip service to the issue of patient safety and patients will struggle to see any real improvements."

Taking such concerns in tandem with the observations of Robert Francis and Professor Berwick with regard to the limitations of systemic change in achieving the necessary culture change in the national health service, can the Minister convince the Patients Association why an individual duty of candour is not necessary? Systems are characterised by individual actions, and the introduction of individual enforceable duties is key to improving how a system works.

Amendment 139 also seeks to address the hierarchy culture that I am sure many Members will have experienced with regard to the NHS. I am not talking about a procedural hierarchy culture, but a cultural hierarchy. In some NHS institutions—in many workplaces, public and private—it can be suffocating, operating almost like a caste system. Such attitudes are probably embedded within the NHS, rather than caused or produced by the NHS, but it does little for holistic working practices.

In his superb report of 16 July last year, Professor Sir Bruce Keogh noted how the

"limited understanding of how important and how simple it can be to genuinely listen to the views of patients and staff and engage them in how to improve services"

was a common theme among the 14 trusts he investigated. He then made an incredibly important point directly relevant to the intentions of amendment 139:

"For example, we know from academic research that there is a strong correlation between the extent to which staff feel engaged and mortality rates."

The new duties placed upon individuals in amendment 139 seek to better ensure such engagement.

On clause 80 as it stands—there is strong support for the intention behind the clause—amendment 139 would improve it and would better assist that culture change on the shop floor of the NHS that we all want to see. Clause 80 was introduced by the Government in the Lords only in the middle of October last year. The record shows that there was significant agreement among all parties with regard to the intention under the clause, but there was little analysis or debate.

Can the Minister tell us whether the regulations that will be published under this section will be subject to affirmative procedure? Secondly, will he publish the Government's rationale for setting the threshold? Lord Hunt of Kings Heath raised the issue in the other place. He said:

"Clearly, there is a distinction between severe harm and seriousness, but most patients and their relatives, or anyone involved in anything that could be described as a serious case, would wish the organisation in the health service to be as open as possible about what had happened."—[*Official Report, House of Lords,* 16 October 2013; Vol. 748, c. 637.]

Such issues are important and it is essential, whether or not the Government accept our amendments, that any ambiguity is removed from the duties that clause 80 would introduce. We owe that to medical practitioners and patients, although I make the point again that amendment 139 is an attempt in part to help resolve the ambiguity.

The issues are difficult and complex. Will the Minister tell us what consultation with patient groups has been undertaken by the Government with regard to the clause as it stands? Does the Minister intend to change the NHS constitution after developing the duty of candour threshold, as it currently does not place any limit on the level of harm that would be disclosed? It is essential, as Professor Berwick pointed out, that advice and guidance for patients and medical practitioners points in the same direction. We can all accept that.

I am grateful for all the advice and guidance given by the Clerks. This is one of the few Committees I have been involved in, as a Front or Back Bencher, where we have had two Ministers, two Chairs and two Committee Clerks. We have remained on track and made good progress, discussing difficult issues in a genuinely constructive spirit. Anyone observing this Committee over recent weeks will have seen politicians from different parties coming together to address issues of profound national importance, usually pursuing the same aim and often agreeing upon certain principles. I pay tribute to my hon. Friend the shadow Minister for leading on these issues for the Opposition and to the Minister for his constructive engagement and skilful advocacy.

I pay tribute to Members from both sides for their conduct and approach, particularly the right hon. Member for Sutton and Cheam for the work he has undertaken on these issues over many years and again throughout this Committee. The Minister knows my views and those generally of the Opposition about the Bill. We see it as a modest Bill. We do not believe it contains the necessary ambition to truly meet the scale of the care challenge or some of the quality challenges facing our hospitals, but it contains improvements which build upon the work of the previous Labour Government. We welcome that.

Issues like those facing us, thankfully, have the ability to cut through the detritus of what is coming to pass for political debate and political campaigning in our country. If we consider the scale of the challenge facing our country as the care crisis unfolds—by no means a new crisis, which is a point that has been made repeatedly—we know that the solutions to these problems require a lasting political consensus. In an era of increasing disengagement and detachment from politics and the political process, this is more important than ever before.

In a febrile political environment with public attitudes towards political parties oscillating sometimes wildly, we owe it to the public and the people who rely upon our efforts to solve the problems that they face in their lives, to reach political consensus wherever we can, particularly with issues as important as this. In what can be a daunting, terrifying prospect for people accessing the care system, we owe it to those people and their families to provide stability and predictability, to provide as best we can some form of calm in what will be a time of personal anguish and chaos. This stability, this clarity, this predictability is essential in providing individuals with the knowledge they need to make informed decisions. That means retaining control of their lives, as well as achieving better care outcomes. The same principles should apply across part 2 of the Bill.

My hon. Friend the Member for Leicester West in the early stages of this Committee said that it was her view—mine, too, I should add—that the progressive purpose of securing power was to give it away to those people who do not have it. Empowerment is a critical issue and one which should run throughout all aspects of health policy. It is an issue that should concern us all at every stage with regard to every policy consideration. Whether with regard to improving care services, or in developing effective, workable proposals for other aspects of our health system, empowerment is essential, so we welcome in general terms the modest improvements that part 1 seeks to provide and I sincerely hope that we can conduct the debate on part 2 in a similar vein.

It is clear from the Francis report, which I am sure all members have read and if they have not they should, and the reports from Professor Sir Bruce Keogh, Professor Don Berwick and from Professor Hart and my right hon. Friend the Member for Cynon Valley, that an individual duty of candour would improve communication between clinicians and patients. It would help change the culture of the NHS; strengthen new and emerging regulatory systems designed to achieve change; significantly improve the way in which patients' complaints were assessed and understood; and most importantly, make a genuine and lasting improvement to care standards and quality across our system of healthcare.

To repeat the considered view of Robert Francis, it is not the system itself which will ensure that the patient is put first, day in and day out. I agree with Professor Berwick that the NHS is unique in the world and can do what no other system can. It has the potential to be the safest health care system in the world. Francis recommendation 182, our amendment 139, is an important step towards making the NHS the safest system in the world and surely that is what we all desire.

Debbie Abrahams: I shall be brief. I rise to support the amendment. The duty of candour that we propose should be placed on individual health care workers is paramount. As my hon. Friend so eloquently explained, it was one of the key recommendations of the Francis report and we all know the horrors that lay behind that report. Across the House, we have all spoken passionately about ensuring that what happened at Mid Staffs never happens again. We believe very strongly that this is an important way of implementing the recommendations and reassuring patients and the public that this should not happen again.

I cannot remember which Minister mentioned that there were safeguards in other places that fulfil the same purpose, but the point about culture is vital. The amendment is not about criminalising doctors and nurses, but about reinforcing the culture. Legislation can do that, and we have talked before in Committee about this. It sets the tone and culture for organisations and the country as a whole as to what is important. The amendment would help to achieve that.

If Committee members have read the Keogh report, they may note that section 6.1 refers to trusts briefing staff on how they should report during inspections. This would provide concerned clinicians with the opportunity to challenge and say, "I have concerns and want to be able report that." The amendment would reinforce the right of clinicians to do that.

Dr Poulter: The hon. Lady is right that the spirit of the debate has been consensual. We all aim to deliver a more open culture in the NHS, and that is welcome. Sometimes, however, something that seems to deliver a more open culture has perverse outcomes. That is the point that we are making. An individual duty or rigid definition of things in statute and guidance takes away from real life situations in health care. Something particular that happens one day might well need to be judged through a prism later. In real life situations, bad things happen, although sometimes people do the right thing. We would not want to see the unintended consequence of well meaning medical and health care professionals prosecuted and blamed for not following due process when they have done everything possible not only to deal with an incident, but to put things right later. That is a concern, which is why things are often left to the professional regulators to take a more informed view.

Debbie Abrahams: I recognise what the Minister is saying. Labour Members have no intention of doing that. What I am trying to put across—I hope that I am succeeding in some measure—is that setting the tone in the culture is important. We want safety assurance in the culture of an NHS organisation. The amendment is in no way intended to criminalise individuals. Furthermore, there are ways and means to avert the unintended consequences suggested by the Minister. I think it is important to include the amendment in the Bill, which is why the Opposition hope it is accepted.

Dr Wollaston: I want to return to the earlier point about unintended consequences and the extraordinary difficulties faced by clinicians. Of course, everyone in the room and beyond wants to see a culture change so that doctors feel that openness to a discussion of issues is a marker of success and good professional practice. Such problems, however, are deeply rooted in health care.

We only need to go back to the 1990s, for example, and look at the words of Professor Bolsin, the whistleblower in the Bristol heart scandal. He said that the real scandal in Bristol was not that no one knew, but that everyone knew and did nothing about it. The point is that Professor Bolsin raised the matter individually and repeatedly, but the system refused to listen. There was a systematic cover-up. That is why having the statutory

[Dr Wollaston]

duty of candour applying to organisations is where this issue has to lie. Culture comes from the top in such organisations.

The real difficulty with an individual statutory duty of candour is that we will be asking courts to make complex decisions on professional judgments made in the heat of the moment, and those are often better handled by the General Medical Council. The General Medical Council needs to improve its act. Be under no illusion, there is nothing that spooks doctors more than an envelope from the General Medical Council. It is a major sanction to face losing the ability to practise professionally.

4.45 pm

We need the GMC to muscle up and be more aggressive in the action it takes against doctors. It needs not only to act against doctors who are behaving in an unprofessional manner, but to make it clear that doctors are behaving unprofessionally if they knowingly look away when a colleague is behaving unprofessionally.

Mr Reed: The hon. Lady is making a genuinely telling point. However, did not Robert Francis go out of his way to point out in great detail that the system she describes did not spot the failures that happened at Mid Staffs and that, it could be argued, we still see?

Dr Wollaston: Indeed. We are all aiming for how to get where we want to be with the fewest unintended consequences. I understand that patients expect and deserve all doctors and health professionals to be open and honest with them. However, I honestly believe that we are going to get there with fewer unintended consequences through reform of the way in which the GMC handles it.

Doctors could retreat back into a defensive position if they know that, by raising professional concerns about a colleague, criminal sanctions could be involved if they have not been candid. The difficulty is where to draw the line. Clinical judgments are quite difficult. What genuinely felt like the right decision in the heat of the moment may turn out to be wrong in retrospect. At what point on that scale does the doctor discuss that with the patient? I would like to see all those issues discussed with patients, but at what point would someone be criminally liable for not doing that? Those are very difficult issues and I think they are best dealt with through the GMC and professional guidance rather than through the clunky tool of a statutory individual responsibility. Having worked in clinical practice, I think there would be unintended consequences.

Liz Kendall: I am seriously listening to the hon. Lady's points. Why does she think Francis recommended this measure?

Dr Wollaston: Of course, I have huge respect for the work of Robert Francis. I think we should take forward almost all his points; in fact, the Government are taking forward almost the entire report. Careful consideration was given to this point. The Government's job is to listen to all the other stakeholders involved.

It may be that, if the culture change we are looking for does not take place through the Bill, we have to move towards that. I think a better route to go down in the first instance is letting the GMC make changes and looking at measures that would genuinely protect whistleblowers. I accept that that might not be strong enough and that we might need to move to a statutory individual duty in future. I just think that, in the short term, we would have unintended consequences and could risk going backwards.

Norman Lamb: First, I highlight an injustice. While the shadow Minister, the hon. Member for Leicester West, has been relieved of her duties, I am struggling on.

The Chair: To paraphrase Amy Winehouse, "Dr Poulter's day will come."

Norman Lamb: To be honest, Mr Bayley, I am a bit knackered, if that is parliamentary language. I will carry on. I was reflecting on the fact that, bit by bit, aspects of the hon. Member for Copeland's past life are seeping out and exciting us. We first discovered that he was a benevolent housing officer in a past life. We have now discovered that he twice nearly lost his life and clinicians saved him. I think I speak for everybody on the Government Benches when I say that we are delighted that he is with us, speaking so eloquently and saying some important things.

The Government made the clearest possible commitment to introduce a duty of candour in the Lords. As it stands, clause 80 will place an obligation on the Secretary of State to bring forward a duty of candour as a new requirement for registration with the Care Quality Commission. The amendment seeks to expand on that commitment in two ways: first, it would set a threshold in primary legislation for the duty of candour, requiring health care providers to inform patients if they believe that care has resulted in death or serious injury. Secondly, it would require health care professionals to inform their employers if they suspect that treatment or care had resulted in death or serious injury.

I am sure that all members of the Committee share a desire to have an effective statutory duty of candour. However, I would like to explain why it is not appropriate to place those requirements on the face of the Bill.

There is a broad consensus that increased openness is essential in identifying poor care. That applies equally to health care and social care. I seek clarification from the Opposition on one point. We have been clear that the duty of candour will apply across the whole of health and social care, but the Opposition's amendment is limited to health care. Is the amendment flawed, or are Labour Members actually arguing that it should be limited to health care?

Liz Kendall: The Minister knows that we previously tabled an amendment to place a duty of candour on councils. I am not sure whether that answers his question.

Norman Lamb: It does in part, but the duty of candour on councils was not really a duty, because there are no criminal consequences for breaching it. That is what Robert Francis sought to achieve. When he talks about a statutory duty of candour, he talks about a failure to meet the duty, amounting to a criminal offence.

It is important that we take the time to get the details right. Putting the threshold for the duty in regulations, rather than primary legislation, enables us to do that, and it allows flexibility to be exercised in the future. As we announced in "Hard Truths", we have set up a working group to consider where the threshold for the duty of candour should be set. That expert group is headed by Professor Norman Williams, president of the Royal College of Surgeons, and David Dalton, chief executive of Salford Royal hospital. One of the questions that the group will consider is whether the threshold for the duty of candour to apply should be death and serious injury, or death, serious injury and moderate harm. That important piece of work is under way.

The review is expected to report in March. It would be premature to second-guess the outcome, as the amendment seeks to do by specifying that providers must be candid only in cases of death or serious injury. That would remove the flexibility that regulations allow, which has enabled the current review. My Department will produce regulations that will put in place the duty of candour for consultation in the light of the review's recommendations, so there will be full input into that. They will be subject to the affirmative resolution, and we aim for them to come into force in October. If a provider does not comply with the new duty of candour, the CQC will be able to take enforcement action against them, including bringing a prosecution. The really important point is that it will be able to prosecute directors who have connived or consented in the failure to meet the duty, subject to a successful prosecution of the provider.

The second effect of the amendment would go further than that and would place a requirement on staff to inform their employers if they suspect that care or treatment has resulted in death or serious injury. I am sure that the whole Committee agrees that openness in reporting is desirable, but that duty is not the right way to achieve it.

I want to make two points. My hon. Friend the Member for Totnes—she has disappeared; no doubt she is on the long journey back to Totnes—spoke eloquently about her experiences and the potential for unintended consequences. I suspect that, with this amendment, there is a danger either of unintended consequences or of no consequences at all. If an Act contains a statement setting out a duty, but no consequence results from breaching that duty—no criminal offence and no other sanction of any sort—that does not do much to change culture. It is more important to determine where the real statutory duty of candour, with a criminal sanction going with it, should apply, to get that right, and to get the threshold for it right. That is why we are undertaking this review with Professor Norman Williams and his colleague, Sir David Dalton—to get it right, and to be clear about who it applies to. Having statements of intent with no force behind them carries a real risk.

There is also a risk in stating that staff have responsibility for reporting to their employer a mistake that has led to death or serious injury, because there could be an unintended consequence. Perhaps that openness should also apply to any mistake that has led to injury. Why limit the responsibility of staff to report problems, mistakes and errors only where there is death or serious injury? The amendment is flawed in that respect, although I am with the shadow Minister in his intent.

The CQC does not have any regulatory role in respect of individual staff. That role is—correctly, in my view—for the professional regulator, as my hon. Friends the Minister and the Member for Totnes made clear. It is important to maintain that distinction.

Professional regulators are working to agree consistent approaches to the reporting of errors and to strengthen the references to candour in professional regulation, making clear a requirement to be open, whether the incident is serious or not. Health professionals will have to be candid with patients. Guidance will make it clear that obstructing colleagues in being candid will be a breach of their professional codes. The professional regulators will also review their guidance to panels, taking decisions on professional misconduct, to ensure that they take proper account of whether professionals have raised concerns properly.

The Government have a firm commitment to openness, in both health and adult social care. The new duty of candour is a key component that will underpin the culture change that we are seeking to put in place, alongside an enhanced professional duty of candour. I have set out the steps that we are taking to do this and sounded a cautionary note about the need to take time to reflect, to get the details of the duty of candour right and to preserve the flexibility to review the threshold in future, to ensure that unintended consequences can be dealt with. I hope that the shadow Minister is reassured and feels able to withdraw the amendment.

Mr Reed: I accept that the Government are acting in good faith on this—there are no two ways about that—and I understand what they are trying to achieve. We are all trying to achieve the same end, as we have heard repeatedly.

Before I consider asking the Committee's leave to withdraw the amendment, I should like to make two points. The Minister has indicated that the guidance will not be ready by Report, but if it is, will it be provided to the Committee, in order to help our further deliberations? If that is not possible, will it be possible for the Committee to receive from the Department, in writing, an update on what stage the guidance has reached, what methodology is being used and whose advice is being sought in its production?

Further, to build on a point made by the hon. Member for Totnes, which I would have made in any event, will the Minister consider a sunset clause for clause 80? We heard from the hon. Lady that it might be that an individual duty of candour is required in the future, if the clause does not achieve its intention—an intention that we all support. Might it be that we could revisit the matter by virtue of a sunset clause in 12 months, or another period that we determine? Whether or not the Government consent to the addition of a sunset clause, it might not be appropriate to do so at this sitting, and we are now out of time for tabling amendments for consideration during Tuesday's sitting, so it may be that a manuscript amendment is brought forward on Tuesday.

Norman Lamb: I am grateful to the hon. Gentleman for those remarks. I have the following points to make. First, my concern about a sunset clause is that it would mean the loss of the statutory duty that we are introducing—the duty would disappear but would not be replaced with anything. My view is that the best way forward is to get it right now. We should be deliberative, and we can use regulation. Regulations can be changed,

[Norman Lamb]

which achieves the hon. Gentleman's objective—his concern is that if the clause does not work and so change is necessary, that change can be made. By framing this matter through regulations, we are doing just that. I hope that reassures him.

We will provide an update on our progress with the professional guidance on Report. As I mentioned, the Dalton-Williams report will then be published in March. I hope that helps the hon. Gentleman.

Mr Reed: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 80 ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned. *—(John Penrose.)*

5.2 pm

Adjourned till Tuesday 28 January at five minutes to Nine o'clock.