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Public Bill Committee

CARE BILL [*LORDS*]

Twelfth Sitting

Tuesday 28 January 2014

(Afternoon)

CONTENTS

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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, Kate Emms, *Committee Clerks*

† attended the Committee

Public Bill Committee

Tuesday 28 January 2014

(Afternoon)

[Andrew Rosindell *in the Chair*]

Care Bill [*Lords*]

2 pm

The Chair: Before we begin, can I inform the Committee that there has been a change to the selection list from this morning? Amendment 122 is now grouped with amendments 123 and 124 to clause 102. A revised selection list is available in the room.

Clause 89

Reviews and performance assessments

Paul Burstow (Sutton and Cheam) (LD): I beg to move amendment 52, in clause 89, page 80, line 23, at end add—

'in particular indicators relating to specified relevant physical and mental health conditions'.

The Chair: With this it will be convenient to discuss the following:

Amendment 152, in clause 89, page 80, line 30, at end insert—

'(c) including specific reference to the method it will use to evaluate performance in respect of safeguarding issues, including protection from financial abuse.'.

Amendment 155, in clause 89, page 80, line 30, at end insert—

'(c) explaining the reasons for choosing the method described under paragraph (b).'.

Amendment 143, in clause 89, page 80, line 31, leave out 'may' and insert 'must'.

Amendment 144, in clause 89, page 80, line 38, at end insert—

'(a) performance indicators for individual services provided by service providers,'.

Amendment 156, in clause 89, page 80, line 38, at end insert—

'(c) guidance to service providers on how information collected under this section should be made available to the public.'.

Amendment 159, in clause 89, page 80, line 41, at end insert—

'(aa) must consult relevant organisations including—

(i) professional bodies;

(ii) royal colleges;

(iii) trade unions;

(iv) commissioners;

(v) patients' groups; and

Amendment 158, in clause 89, page 80, line 42, at end insert—

'(7A) In respect to subsection (7), the Secretary of State must—

(a) publish the minutes of the consultation with the Commission, and

(b) make a statement to Parliament on the consultation with the Commission.'.

Paul Burstow: Thank you, Mr Rosindell, for the announcement about the small change to the groupings. It will help the presentation of the amendments I will speak to later, so I am grateful.

With amendment 52, I intend to explore the Government's thinking about how inspection might evolve to reflect better the fact that people experience their care not in single institutions but in care pathways. I will also explore how we might ensure that the Government's intentions for integration, which are evident in the Bill, and the changes made in earlier legislation they took through, are reinforced by the inspection system. I would like to tease out those things.

The inspection regime that the Bill develops remains institutionally focused, rather than focused on patient pathways and specific conditions. That could give rise to a situation where a poor rating for an institution that was not performing well could mask high-performing services or pathways within it. Patients could be deterred from being treated there, even though they would be treated through an excellent patient pathway, and, as a result, they would not get the outcomes they wanted. The purpose of the amendment is to encourage the Government to give further thought to how we ensure that the inspection regime is focused on patient pathways and conditions, rather than institutions. Such a focus will help to facilitate choice and service improvement in the way the Government originally intended and in a way that aligns with the recommendations in the original Nuffield Trust review that led to the development of the policy around which this part of the Bill is based.

In the Nuffield Trust report for the Government, "Rating providers for quality: a policy worth pursuing?", it said:

"the goal should be to introduce ratings that drill down to the level of individual departments and clinical services so that patients can have a much truer understanding of the quality of care provided in those departments."

Prostate cancer is the most common cancer among men. We know from the latest cancer patient experience survey that there is significant variation in the quality of services. For example, more than a quarter of patients reported that they did not fully understand the side effects of their treatment. When one considers that the side effects can be lifelong and deeply embarrassing—incontinence and erectile dysfunction, to name but two—and that more than three quarters reported that they were not told about the possibility of being involved in clinical trials, we begin to understand that examining the care pathway for prostate cancer is important. The outcomes that matter for patients are not just surviving the operation, but how they can lead their lives afterwards. Understanding that and inspecting for it, as part of the way the CQC works, would be helpful.

Another risk is that the inspection serves to preserve inefficient, antiquated or outdated models of service delivery, which is an area in which the Government want, through the better care fund, to see transformation. Clinically led commissioning is clearly resulting in the use of different models to improve models of care, such as prime contractor models and outcomes-based contracting, which can facilitate integration. For example, an acute trust might take on responsibility for not just providing acute prostate cancer services but organising community prostate cancer services. However, an institutionally focused model of inspection could lead

to a hospital being rated highly for the prostate cancer services it provides, even if the services that are organised outside the hospital are of poor quality and result in poor outcomes. This is a particular issue for prostate cancer. Again, some interesting results from the cancer patient experience survey show that there is a really significant variation when it comes to people's experience of integrated services. Indeed, the proportion of prostate cancer patients reporting that they experienced integrated cancer services range from 48.1% at Imperial College Healthcare NHS Trust to 93.1% at Frimley Park Hospital Foundation Trust.

For me, this is about measuring outcomes that matter to patients and using an inspection regime to drive that. So a regime focused on institutions may lead to improvement in the care offered to patients in active treatment, but not in the care offered to patients who benefit from such treatment but have chosen not to receive it. An example of this might be a patient with hepatitis C. For years, the lengthy treatments for hepatitis C, which can cause really miserable, flu-like symptoms, have discouraged thousands of patients from being treated, even though they could be cured. Public Health England estimates that just 3% of chronic hepatitis C infections are treated every year. The inspection regime could support the aims of the Government to develop high-quality services which transcend organisational boundaries, something that I know the Minister is very passionate about in taking the agenda of integration forward. I hope that he can offer some reassurances in two ways: first, by confirming that condition-specific measures are on the CQC's agenda; and secondly, by taking steps to ensure that the issues I have spoken about with reference to prostate cancer and hepatitis C are being examined by the Care Quality Commission.

Mr Jamie Reed (Copeland) (Lab): I thank the right hon. Member for Sutton and Cheam for moving his amendment and starting what is an extremely important part of our discussion on the Bill. I have huge sympathy with everything he has just described. This is not really the place to talk about individual ailments and complaints, but I am a type 1 diabetic. Diabetes is, I think, responsible for 26,000 deaths per year in the UK. Everybody diagnosed with type 1 or type 2 diabetes is meant to receive nine key tests every year. It does not happen—I have yet to find anyone with either type who gets those nine key tests. When one looks at the information provided by diabetic-concerned charities and others, nowhere in the country has complete coverage of diabetic patients within their catchment areas who receive those nine key tests. My special pleading is over.

Like the previous discussion, this group has a number of amendments, but it is right that we look at the purpose of clause 89 and its intended aims before moving on to the individual amendments. I am sure that nobody will be surprised to hear that the Opposition support the principle of ensuring that high quality is maintained throughout every service available to patients, and also of providing patients with more information, in greater detail, about their local services and giving them greater access to the state of the art with regard to the information in the wider health economy. These are laudable aims, and I am glad that the Government are committed to them. Yet, as with so many other parts of the Bill, the legislative application of these principles may not yet be up to the mark.

The new powers in proposed new section 46 will allow the Secretary of State to prescribe particular types of services or providers in relation to whom the CQC should publish performance information, so as to enable the public to make informed choices about the quality of services being provided. As I mentioned previously, this is a principle that we must all welcome, but I fear that if only one indicator is published this would mask the true performance of the service. That is a fear on which I will expand soon. Performance ratings could be an effective tool for giving more information to patients and the wider public, but the application, as has been suggested, would have the inverse impact, with a single score hiding more information than it would show. That is in nobody's interest.

First, as the service provider is the one being assessed, as stated in clause 89(2), it suggests that the overall rating will not have sufficient detail to assess individual services. Where a service provider is providing one service, it may be an adequate reflection of what is happening on the ground, but for a hospital trust, where the services are wide-ranging, one aggregate score on the performance of the service provider could do more harm than good. I am sure we all hear from constituents of their experiences of hospital. I am frequently told that intensive care in our local hospital is excellent, but in some cases people get moved out into an unmade bed with a half-drunk glass of water on the bedside table. That is a colloquial way to explain the difficulties of having a single indicator as a guide to the quality of an institution.

The right approach would be to publish more information and to broaden the final conclusions on performance to show a number of factors. Single performance ratings for a restaurant or a hotel may be accurate enough in determining performance, but it is simply too blunt a tool accurately to demonstrate the performance of a health provider offering multiple services containing complex, sophisticated systems. We do not want a system akin to TripAdvisor, though even TripAdvisor uses four separate indicators to rate restaurants—so I am told. Other websites are available.

It is down to the Care Quality Commission to determine its methodology for inspecting and reviewing hospitals. I would be grateful if the Minister could explain how the Government intend to ensure that sufficient detail is published. Will that be through guidance? I believe that the matter is critically important.

Amendment 156 would require the CQC to issue guidance to service providers on how any information collected under this section should be made available to the public to ensure that some uniformity is maintained from service provider to service provider. That would enable the public to compare and contrast performance data for different providers, and would ensure that the public could make more informed choices on a like-for-like basis.

Given the qualified support I have outlined for the principle behind this idea, but the reasoning for criticising the overall application of the principle, I will now discuss each amendment in turn. The right hon. Member for Sutton and Cheam started the debate with amendment 52, which would ensure that the CQC judged different services by different indicators. It is similar in that regard to amendment 143, on which I will expand later.

[Mr Jamie Reed]

Amendment 152 is to ensure that the CQC can do and does do everything it can to spot and highlight instances of financial abuse, whether in residential homes or people's own homes, which, as we have consistently argued, is the key challenge in this sector. Our amendment would place a duty on the CQC to ensure that, when it prepares a statement setting out how often the CQC will undertake reviews and the methods it proposes to evaluate performance, it must include specific reference to how it will evaluate performance on safeguarding, including protection from financial abuse.

Research in 2007, funded jointly by the Department of Health and by Comic Relief, suggested that in that year 57,000 people aged over 66 had experienced financial abuse. That makes it the second most common type of abuse after neglect. That view is supported by research from Action on Elder Abuse, which says that around 20% of calls to its helpline are about financial abuse. Surveys also show that most financial abuse takes place in people's own homes, with abuse in residential care accounting for a fifth of cases. For the fourth fifths of cases that relate to abuse in a person's own home, 70% of the financial abuse is by a family member and 30% by a care worker. We need a system that prevents both; we need to ensure that both residential and domiciliary care providers have proper processes in place to identify, prevent and tackle financial abuse, but also to train care workers to spot signs of financial abuse from family members.

Regulation 11 of the Health and Social Care Act 2008 gave the CQC clear powers to ensure registered providers take reasonable steps to identify financial abuse, prevent it before it occurs and respond appropriately to any allegation. I do not pretend for a second that that is easy. It is an incredibly complex issue, and I entirely understand that some families may well respond negatively.

Providers must be able to show that they keep individual records of all income received, money spent and any valuables held; that money and valuables are not used by the service for the running or management of the service; that people who use the services can access their money and valuables in a timely way; and that the manager also becomes the agent of people who use services only where there is no suitable person outside the service available to undertake that role.

2.15 pm

The CQC inspectors can check for irregularities, but we understand that checks are not undertaken as a matter of course. Will the Minister provide some clarification on that by explaining how irregularities become apparent to the CQC if it does not perform checks on a regular basis? That is an important detail that we need to get right.

The consultation document recently issued by the CQC, "A fresh start for the regulation and inspection of social care" asks about the commission's new methodology for inspecting standards in social care, but says nothing about financial abuse. Indeed, there is a section on "Promoting a culture of quality, safety and openness", but the word "abuse" is absent from that document. Will the Minister talk to the chief inspector of social care about that and ensure that this issue is considered in greater detail? To me, this seems like a missed opportunity—one that we cannot afford to miss.

Amendment 155 is on the methodology that the Care Quality Commission will employ to determine performance levels. It would amend subsection (4) of proposed new section 46. The subsection lists what the CQC must include in its statement: namely that it must publish the frequency of the reviews and set out the methodology it intends to use. The amendment would require the CQC to justify its choice of methodology, which would give more weight to the conclusions that it draws.

Amendments 158 and 159 relate to the consultation process that the CQC must adhere to before publishing its statement on the methodology, as required by subsection (6). As the Bill stands, the Secretary of State must be consulted by the CQC, so to maintain its independence as laid down by clause 88, we tabled an amendment that would require details of that part of the consultation to be published. Much like in the appointment of the trust special administrator, which we discussed earlier, the Secretary of State will have the ear of the CQC in this regard, so we feel it is right and proper that the Secretary of State relays details of the consultation to Parliament by an oral statement, supplemented by a written statement, with opportunities for colleagues to supervise the process.

In line with the principle behind amendment 128, which was tabled by my hon. Friend the Member for South Shields and discussed in the previous debate, we believe that the list of statutory consultees should be extended to include those listed in amendment 159. Proper consultation with wider industry groups would create a system with buy-in from all major stakeholders, thus ensuring much more effective partnerships and trust in the process. A trusted process is likely to stand a better chance of success.

Whether through warning notices under clause 81 or reviews in this part of the Bill, our purpose is to improve care standards. It serves no one simply to point out bad practice and then walk away. It is right that the CQC works with providers to improve care, but it is only through communication, consultation and co-operation at every stage that the necessary relationships can grow. This is iterative, intelligent regulation.

Amendment 143 was tabled to press the Government on the methodology that the commission might use. Subsection (5) is not well written. Will the Minister explain what

"different indicators for different cases"

means in the application of this proposed new section? I am reluctant to offer a blank cheque for that. Does it mean that two accident and emergency departments, or two maternity wards, or two intensive care units may be judged differently? If every service provider is judged against different indicators and benchmarks, how will that promote greater information for the public? It would be impossible to compare and contrast the various strands of information realised with such an approach. It would also make the establishment of universal standards almost impossible.

If, however, the meaning is that different indicators may be used when judging the performance of an A and E department and when judging a maternity ward, we would argue that that does not go far enough. It is essential that different services are judged differently to ensure an accurate description of the service offered. That goes to the heart of understanding risk: a topic

that is almost impossible for anyone to communicate, let alone politicians, but I firmly believe that the public understand risk better than we give them credit for.

Amendment 144 was tabled with the intention of ameliorating the main concern that I outlined at the beginning of my remarks: one performance indicator for a service provider cannot provide an accurate representation of the performance of the individual services. It would put a requirement on the Care Quality Commission to publish all performance indicators for each individual service. One indicator, much like a mean average, can be skewed substantially by services operating at either extreme of that performance scale. That is to say, an extremely poor service can hide a good-quality care service provided elsewhere by the same provider, and an extremely good service could mask poor performing care.

I can put it no better than this. In his superb report on hospital mortality rates last year, which I cite again, Sir Bruce Keogh stated that:

"We found pockets of excellent practice in all 14 of the trusts reviewed".

These trusts were selected for inspection on the basis of one performance indicator, namely mortality rates, but this does not on its own show the full and accurate picture of care in the hospitals reviewed. The fact that in every hospital trust investigated by Sir Bruce Keogh mortality data showed a drop of between 30% and 50% over the previous decade also proves the point.

In his response, I hope that the Minister will go into some detail about how he expects these indicators to work in practice. We must be precise. We want to give patients and public a right to an informed choice, but we need to be entirely accurate and fair. Poor hospitals should not be allowed to masquerade as adequate, and good ones should not be damned by faint praise. As we said in debate on the previous clause, the often cited comparison with Ofsted and failing schools is not accurate or appropriate. Accuracy is key here and this is a point to which we will return.

The Minister of State, Department of Health (Norman Lamb): May I first pick up on a theme raised by my right hon. Friend the Member for Sutton and Cheam about the importance of looking at pathways and seeking to develop more integrated working, sometimes bringing different institutions together, rather than taking an obsessive look at the individual institution? I can tell him that the power exists to carry out thematic reviews under section 46 of the 2008 Act. The current intention is to use the special review under section 48 of that Act, rather than the performance assessment in section 46.

The CQC will be able to carry out such a review without seeking ministerial approval, as it is about service provision and the power in section 48 is very flexible. My right hon. Friend rightly expressed the concern that an obsessive focus on the institution rather than on the whole integrated package of care must not be allowed to frustrate institutions locally, shifting their approach to join up care in the interests of the patient. We must ensure that this does not happen. The provisions that I have referred to and the power in regulations allow us in time to adapt and ensure that we can focus on pathways of care through this regulatory process. However, my right hon. Friend raises an extremely important point.

I will pursue this issue further in my discussions with the Care Quality Commission, because it is really important that everyone, including the regulators and other arm's length bodies, focuses on facilitating joined-up integrated working, rather than putting blockages in the way.

Paul Burstow: I wish the Minister well with those discussions, but as part of them, will he give some thought to the fact that using the thematic inspection route, rather than having a performance element to it—which is what we are debating at the moment—may mean that what gets measured will get done? Measuring on an institutional basis is the old world. We need to start preparing the ground for the new world, in which we measure performance from a patient perspective and that is pathways. Even if we cannot do that for everything to start with, some experiments could be incredibly helpful. Is that an issue that we can discuss?

Norman Lamb: That is a very attractive proposition and I will be sure to include it in my discussions. I have a meeting with the chairman coming up and I know that he is completely committed to the principle of integrated joined-up working, so he will be a receptive audience.

The shadow Minister also raised concerns about the potential risk of single rating. That was looked at by the Nuffield Trust in its work. The way that we are seeking to do this should allay his fears. On the complexity of the rating, the CQC says that it will

"produce ratings and the information on which the ratings are based at a level which recognises the complexity of NHS services and is useful to people who use services as well as those who provide and commission NHS care".

The CQC is to provide ratings for certain individual services, for example emergency or maternity services, as well as for the hospital as a whole. The CQC would also like to provide ratings for each of the key questions: is the service safe, effective, caring, responsive to people's needs and well led? There will be a much richer picture provided of the performance of a hospital, rather than a single rating for the whole institution.

I am aware that sometimes when a hospital is damned by a single rating and that is all anyone hears, many people doing brilliant work in that hospital will be massively demoralised by the sense that that is the only thing that counts and that they are all damned by that one rating. The idea that there could be a fuller picture provided is incredibly helpful in reassuring the staff, quite apart from the patients who use the service, that it is a rich picture. There may be particular failings that are critical for the organisation to address, but pockets of brilliant activity should also be recognised.

Mr Reed: The Minister is making a really important point, and I appreciate every word of his response. To build on it a little further, can he say with certainty that we will not have broad categories, definitions and ratings of hospitals as good, bad or failing? That is the kind of categorisation we have with the Ofsted regime and it does not help. He has almost confirmed that; I am seeking further clarity. Secondly, has any consideration been given to the ratings regime with regard to recruitment at certain trusts? The last thing we want to see is for institutions to be labelled failing and for that to destroy any prospect of those trusts undertaking the necessary recruitment to improve services.

Norman Lamb: It is a balance. We must equally ensure that we do not hide failings from the public. The public as users of NHS services need to know what their local services are like. They need to be able to exercise that choice that the hon. Gentleman's Government rightly introduced. They can only do that if they have a full understanding of the quality of the service. I repeat that, if there is more than the single rating, with an understanding of performance against all five criteria, and how particular departments such as A and E and maternity are performing, we will have a much fuller picture to give the public the information they need in order to make a proper judgment.

Bill Esterson (Sefton Central) (Lab): Will the Minister give way?

Norman Lamb: I will indeed. Welcome back.

2.30 pm

Bill Esterson: I only missed four minutes, though I am sure they were very important ones. My hon. Friend the Member for Copeland mentioned Ofsted and the Education Committee took evidence from the head of Ofsted, Sir Michael Wilshaw, last week. We discussed some of the points my hon. Friend has just made. Sir Michael said that he saw the future for Ofsted not just in regulation but in supporting those it inspects. Does the Minister think the role of inspectors is to look at improvement and support as well? Does he see that as part of the regime he is looking at, in the way that Sir Michael set out in relation to education and children's social care?

Norman Lamb: We will, as we go through these provisions, demonstrate the system that we seek to apply in the health and care system. There is some real merit in the Care Quality Commission's being seen as the nation's whistleblower. It has the ability to identify failings and not get caught up in the difficult task of how one seeks to improve that service. If it is free just to make its clear and independent view of the quality of a service, and, if necessary, Monitor or the Trust Development Authority will undertake the work to improve that service, that is a rational approach to achieving the improvements we are after. The rating system we are introducing, particularly given that it has more granularity than a single rating, as we have just been debating, creates an incentive for improvement.

Things happen with legislation, but ultimately just having a regulator, which determines whether an organisation meets minimum standards creates no incentive for improvement. If an organisation is rated as "good", it will want to achieve "excellent"; that is human nature. The system has been designed, with the brilliant help of Jennifer Dixon and Nuffield, to ensure that the inspections and the basis upon which a rating is achieved are robust and thorough. It is not tick-box, but based on clinicians' judgments, the views of staff who are interviewed when the inspection takes place and the views of users of the service. That creates a dynamic incentive to improve. It has potential power to achieve real improvements for the users of these services.

The amendments that we are now considering relate to the new system for the performance assessment of providers to be operated by the Care Quality Commission and its ability to operate with greater autonomy as the independent regulator. The Bill introduces a new system of regular assessments of registered providers which has no requirement for ministerial approval of the methodology. Ministers will be consulted over the methodology, but will not be able to set or agree the method of ratings or specify what medical conditions should be included in the indicators the CQC devises. That is in the spirit of independence.

That is in line with a wider package of measures designed to give the Care Quality Commission greater operational independence, such as the removal of the Secretary of State's powers to intervene in the day-to-day operation of the CQC and placing a duty on the chief inspectors to operate in a way that ensures the independence of the CQC's judgments. Why is this important? The independence of the CQC from the Government is central to its credibility as an authoritative source of information about the quality and safety of health and adult social care providers.

The system of performance assessment of registered providers that CQC is developing will be central to providing the public with fuller and more reliable information about the quality of care provided by their local hospitals, GP practices and care homes. This system has to be developed by the CQC, and it has to be responsible for its development. We will not achieve this by placing numerous additional requirements on the CQC in developing the methodology, as this series of amendments seeks to do. Let me try to explain why.

The CQC may consider certain indicators to be relevant to and apply equally across both health and adult social care sectors and to different types of services. Amendment 143 would prevent the CQC from adopting the same methodology where appropriate. Equally, the CQC may conclude that different sectors require different indicators. Consultation with stakeholders, including the Secretary of State, will inform the CQC's approach. Once they are devised, the CQC would be required under clause 89 to publish its quality indicators. Amendment 144 is therefore unnecessary.

Amendment 52, which my right hon. Friend the Member for Sutton and Cheam tabled, makes a specific reference to mental health services. I should like to reassure him that the CQC's ratings system will look at that area. Providers of mental health services are registered with the CQC and will receive a rating. The CQC has recently appointed Paul Lelliott as a new deputy chief inspector with expertise in mental health. I met Paul last week and I am confident that the CQC will really focus on mental health.

Amendment 152 would similarly place a specific requirement on the CQC to consider safeguarding issues and financial abuse in rating providers. I am self-evidently a strong advocate of the need to protect vulnerable people from the risk of abuse. Safeguarding against abuse, including financial abuse, is a key feature in the proposed fundamental standards for registration with the CQC, on which we are currently consulting.

We have, through the Bill, set out local authorities' responsibility for adult safeguarding for the first time in primary legislation and we have specifically referenced financial abuse in clause 42 to make it completely clear that financial abuse should be considered as part of a safeguarding inquiry. I would hope that in rating providers, the CQC will consider how it protects patients and service users from the risk of abuse. However, this

decision has to be with the CQC and should not be a requirement in the Bill. The Bill places a requirement on the CQC to publish a statement setting out how often it will inspect providers and the method that it will use.

Amendment 155 would also require it to explain its reasoning for this method. I do not see the purpose of this amendment. The CQC will consult on its performance assessment methodology and set this out in the statement that it will be required to provide. These existing requirements will ensure that the ratings are developed in a collaborative and transparent way, and an additional requirement to explain the reasoning behind the methodology will add nothing to this.

Amendment 156 would require the CQC to issue guidance on how service providers should make information about the results of performance assessments available to the public. Clearly, the rating system will succeed only if the findings are readily available, including being made available by providers themselves. The CQC itself will be required to publish a report of each performance assessment.

There is a risk, of course, that providers which receive a critical rating might simply choose not to publicise this. I am not, however, convinced that guidance issued by the CQC would be effective in preventing this. A provider that was determined to hide a negative rating would not necessarily be persuaded by guidance to come out into the open and declare its inadequacy. Instead, I will ensure that as regulations are developed we consider the issue of a requirement for providers registered with the CQC to make available the results of a performance assessment carried out by the commission.

One interesting development is that any member of the public can go on to NHS Choices and find any provider registered with the CQC, find out what its rating is and a whole host of other information, potentially including TripAdvisor-style comments from users, family members and so forth. The more that this becomes the place to go to find out about the quality of a care provider, a domiciliary provider, a care home, a nursing home and so forth, the better. It will mean that no care provider can hide away unfortunate, embarrassing information. The CQC has provided a widget that enables a provider of care to provide a link directly from the provider's website to the findings of the CQC inspection, but they are not required to do so. Could we require providers to have that link on their websites? These are things we are looking at, but I think ultimately—because I suspect I am addressing the concern that he raises—the hon. Member for Copeland will probably feel more comfortable with the idea of a requirement to publish rather than anything simply in guidelines. I hope I have reassured him in that regard.

Amendment 158 concerns the consultation that the CQC is required to carry out in developing its system of performance assessment. The Bill will require the CQC to consult the Secretary of State and allow it to consult any other bodies and people that it considers appropriate. The amendment would require the Secretary of State to publish minutes of any consultation with CQC and make a statement to Parliament about this consultation. I understand the reasoning behind the amendment, that it is designed to ensure that performance assessment methodology is independent from Ministers. We are already taking major strides in the Bill to ensure the CQC's independence.

Clause 88 removes nine separate powers of the Secretary of State to intervene in the commission's day-to-day work and clause 87 requires chief inspectors to have regard to the independence of the CQC. In addition, the Bill removes a requirement for the CQC's performance assessment methodology to be approved by the Secretary of State. The CQC will not be required to carry out a separate consultation with the Secretary of State, rather, it will carry out a consultation in which the Secretary of State will be one party, along with others, in that consultation process. The outcome of the consultation will be the performance system itself, and here the CQC will be required to publish both a statement setting out the methodology and method it will use and the indicators against which it will assess performance. Requiring the Secretary of State to publish the minutes of any discussions about ratings or to make a statement to Parliament will not enhance what we have designed to be an independent and, critically, a transparent system.

Amendment 159 would require the CQC to consult a number of specific bodies in developing the performance assessment system. I do not argue that any of the organisations mentioned in the amendment should not be consulted—it is clearly a sensible list—but specifying in the Bill which organisations have to be consulted would constrain the CQC's ability to carry out the consultation in the way that it considers most appropriate as an independent body. Hon. Members will, of course, be aware that organisations and people that the CQC must consult can be set out in regulations, so while I am not minded to tie the commission's hands in this respect, it is my view that if we were to do so, regulations would be a more flexible way of doing it than putting it in the Bill. I hope that that is helpful.

Mr Reed: The Minister has engaged, typically, in real detail with the concerns that we have raised. There are two small outstanding areas of concern. Is it the intention that the information on the ratings of hospitals that the CQC makes available to the public will include how often, when, why and how warning notices have been issued to a particular trust? Has any regard been given in the Department—I touched on this earlier—to how this rating system will affect recruitment in challenged trusts? I completely appreciate that that is not the principal aim of the clause, but we do not want to see a spiral of decline in trusts, where we know we need to provide help and instead, we might see what we see in the education sector: good teachers refusing to go to schools which need good teachers.

Norman Lamb: I can certainly confirm, on the latter point, that, as we have been discussing, in the whole framework of the CQC regime, and, indeed, the response to Francis more generally, we have absolutely focused on the importance of getting the balance right.

2.45 pm

Indeed, that is one of the reasons why we chose not to apply the duty of candour to individuals, for example. If individuals in an organisation are faced with the potential for committing a criminal offence almost inadvertently, or there is a fear that this will be the case,

that potentially creates the very negative culture to which my hon. Friend the Member for Totnes, who is not here, referred in an earlier discussion. Getting the right balance between sanctions that can be applied and the attractiveness of the role and so forth is incredibly important, and we need to understand that.

This has been at the forefront of our minds, but overall we feel that a system with great openness and transparency about both the successes and failures of organisations, and which allows us to celebrate brilliant care, creates conditions which are more attractive to professionals. At the moment, beyond anecdote it is very hard to judge which are the great hospitals, where fantastic leadership does brilliant things. That will be very clear to everyone in this new system, and being able to celebrate those leaders in the NHS who are showing the way to others will be a real strength of that system. Risks are always involved, but there are also real potential gains in making the NHS a more rather than less attractive place to work. I hope I have answered that question.

On the earlier point, warning notices will be published and available on the CQC website. Essentially, this is a completely transparent process. We have sought to take an approach of openness and transparency, on the basis that if there is no hiding place for poor care it is less likely that there will be poor care. The openness of publishing the outcomes of inspections and the notices that have been served will again help drive up standards, which ultimately is what we all want to achieve.

Mr Reed: I am grateful to the Minister, and I do not seek to divide the Committee.

Paul Burstow: Briefly, I thank the Minister for his response to the amendment in my name. The changes he outlined today, about the competency of the CQC to make its own decisions about its methodologies and so on, are incredibly welcome. As he was describing it, I was reminded of debates which took place when the previous Government established for the first time a national body to regulate social care. That argument was made then by some now Government Members, who were then in opposition. It is good to see that principle being established now, as it is really important.

I also thank the Minister for what he said on mental health. I did not particularly direct my remarks to this, but again it is an example of the need to look at performance ratings in a way which is not just about institutions. The experience of mental health services necessitates looking at the way in which acute hospital deals with people who attend an A and E department. This may well result in their having a particularly bad outcome and a bad experience, and we also need to look at the way in which long-term conditions—physical and mental—are dealt with together.

I am really grateful that the Minister will raise some of these issues when he next meets with David Prior. Hopefully we will hear the outcome, and with that, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendment made: 154, in clause 89, page 80, line 29, leave out 'or local authority'.—*(Dr Poulter.)*

Clause 89, as amended, ordered to stand part of the Bill.

Clause 90

OFFENCE

Mr Reed: I beg to move amendment 160, in clause 90, page 82, line 9, at end insert—

'(d) it wilfully withholds relevant information with the intention to mislead or misdirect'.

The Chair: With this it will be convenient to discuss amendment 145, in clause 90, page 82, line 24, after 'health service', insert

'and health-related services provided by local authorities.'.

Mr Reed: Clause 90 is a good step forward for the duty of candour, but the Minister will not be surprised to learn that in our opinion it does not go far enough. Committee members, Clerks, officials and you, Mr Rosindell, will be relieved to hear that I do not intend to speak to this clause at the same length that I spoke to clause 80. The points that I made in that debate relate to this clause, and what I said is as applicable now as it was then.

Clause 90 will make it an offence for a care provider to provide false or misleading information. Nobody can deny that that is a positive step towards promoting a culture of openness; it is a welcome, commendable measure. I set out previously why we believe that the duty should be extended to cover individuals, so I will not retread that ground.

Amendment 160 seeks to add an additional offence to the list in clause 90(1) by making it an offence to wilfully withhold relevant information with the intention to mislead or misdirect. That would mean that in the process of exercising their legal requirements care providers would be under an obligation to provide access to information that is relevant to any issue that may arise. That could, for example, be a duty required of them in the regulations that will be set out under clause 80.

It is proper that when under investigation by the regulator or others a provider has a legal duty to supply the relevant information, and that it does not seek to mislead anyone by withholding that information. It would not be right for a provider to be able to withhold information that could assist the regulator in its investigation. That act should be on a par with providing misleading information, because it achieves the same end, although by different means. There should be parity of esteem in the clause for actions that mislead, whether through the circulation or publication of misleading information, or by withholding information that would better allow the regulator to carry out its duties.

The duty to not withhold relevant information is the second pillar that is needed to ensure that the clause encourages openness. The Government argued that an individual duty of candour would create a culture of fear; we heard that argument again from the Minister. They said that people would close ranks and pull down the shutters in the NHS before disclosing information. By creating an offence for publishing misleading information without making it an equal offence to hide information, providers could be perversely incentivised to remain quiet about an issue, rather than be accused of publishing misleading information. Clearly, nobody wants that unintended consequence. We cannot allow that to happen,

which is why we should create a system that puts hiding information on the same level as knowingly providing misleading information.

The Minister talked about the drive to raise standards. He said that transparency is critically important to that, and he is absolutely right. However, he will have heard time and again, as I have, the criticism that the Freedom of Information Act makes it more difficult to get information into the public domain that should be in the public domain. I have never truly bought into that criticism. Sooner or later, the truth does come out. The same would be true with the duty that we seek to incorporate here. That is what amendment 160 would do.

I would appreciate it if the Minister could explain why he believes that it is adequate to have one provision without the other, when they are clearly two sides of the same coin. Will he tell us whether there was a debate within Government about how far the clause should extend, and if so, what was the conclusion? Was legal advice sought? If it was, will the Minister undertake to publish it before Report?

Amendment 145 seeks to do something that a host of other amendments have tried to achieve. It would require health-related services provided by local authorities to be treated in the same way as other health services. It is a welcome inevitability that as a consequence of greater integration, better communication and better co-operation, local authorities will have more responsibility when exercising their functions with regard to health-related services. I am sure we all welcome that. The clause relates to the publication of materials. Local authorities have responsibility for public health, including public awareness campaigns. It is right, therefore, that the duty to ensure information is not false or misleading is also extended to councils. Much of the public health duty will be fulfilled through public awareness campaigns, and they need to be on a par with other health services to which the clause applies.

It is regrettable that the clause, though moving in a welcome direction in one regard, is incomplete in its current form. I hope the Minister can assure us that anyone providing health services and health-related services is subject to a level playing field and that requirements on the providers are clear and robust.

The Parliamentary Under-Secretary of State for Health (Dr Daniel Poulter): The new offence of providing false or misleading information, set out in clause 90 of the Bill, is designed to address the very specific issue of certain types of information supplied or published by providers of treatment or care, as was highlighted in the Mid Staffordshire public inquiry.

It is a direct response to Robert Francis's finding that, in the case of Mid Staffordshire, the trust made inaccurate statements about its mortality rates, which caused regulation and commissioning to be undertaken on inaccurate information and understanding. That resulted, as we are all too well aware, in poor and dangerous care for patients.

Clause 90 puts in place the power to make it a criminal offence for certain types of false or misleading information to be supplied or published by health and adult social care providers. We have drawn up the definition of a care provider carefully in order to limit the possible scope of the offence to specific organisations in primary legislation. The offence could apply to providers of publicly funded health services and adult social care. In that context, health services means both NHS services and public health services. That is an important point that I want to be very clear about. Public health services provided by local authorities are already within the scope of clause 90.

While primary legislation will set the scope of the offence, its application will be limited through regulations in terms of both the types of providers and the types of information to which it applies.

Amendment 145 seems, on the face of it, to be small but it would have major implications for the potential scope of the new offence. It would extend it from health services to include health-related services provided by local authorities. I would like to outline the impact of that change and why we cannot support it.

As I have set out, the offence of providing false or misleading information could, as the clause is currently drafted and subject to regulations, apply to a provider of health services, defined—by reference to section 1 of the National Health Service Act 2006—as services provided as part of the comprehensive health service, which includes public health services provided by local authorities. However, the amendment would extend that to cover health-related services provided by local authorities. The meaning of that is not defined in the amendment. I suspect the interest may be in local authority public health services, which, as I have said, are already covered by the clause.

What would be the effect of extending the offence to health-related services? Section 13N(4) of the National Health Service Act 2006 defines those services, for the purposes of that Act, as

"services that may have an effect on the health of individuals but are not health services or social care services".

As drafted, the amendment could refer to almost any service provided by local authorities, for example, housing services, leisure services or even refuse services. I am sure the hon. Member for Copeland did not intend the amendment to be so far reaching. That would certainly not be in the spirit of the Francis inquiry.

The scope of the offence is deliberately restricted to care providers and is intentionally narrow. The amendment would make the possible scope of the offence too broad. I hope that helps to clarify the Government's position on that aspect.

Amendment 160 would extend the false or misleading information offence to instances where information is withheld with the intent to mislead. I would first like to set out the legislative context within which the offence sits. As the hon. Gentleman outlined, this offence, and that relating to the duty of candour that the Committee considered on Thursday, are both designed to improve openness among providers of care, but they focus on different things.

The duty of candour is about the day-to-day interaction of provider organisations with patients. It will require that health-care providers registered with the CQC do not withhold information from patients, and will require providers to inform patients where there are failings in the care that they have received. This duty will be overseen, as we discussed last week, by the CQC.

3 pm

By contrast, the false and misleading information clauses are about performance and management information that providers are required to supply or publish. They create a new criminal offence, prosecuted by the Crown Prosecution Service, where care providers supply or publish specific false or misleading performance and management information provided under a statutory or other legal obligation. Taken together, the two measures aim to increase openness to patients and service users under the duty of candour and reporting performance of health care providers under false or misleading information.

Amendment 160 refers to information that is wilfully withheld by care providers with the intent to mislead. Establishing wilfulness or intent on the part of an organisation is far from straightforward. For that reason, the false or misleading information offence does not rely on establishing intent on the part of the care provider. It is a strict liability clause in the Bill. The offence as regards care providers is indeed strict liability, which means that the prosecution would have to prove that the information was, as a matter of fact, false or misleading. There is no need to prove intent, wilful or otherwise, to provide false or misleading information on the part of a corporate body or partnership.

There is a precedent for such an approach in other legislation. For example, food description offences in the Food Safety Act 1990 are similarly strict liability offences applicable to corporate bodies. The new power needs to have impact and to be prosecutable. Introducing the concept of intent would make this more difficult, which no member of the Committee would want. Instead, because we are making it a strict liability offence, we are allowing for a defence of due diligence to ensure that providers cannot be prosecuted as a result of a genuine error.

Leaving aside the question of intent, I want to consider the general issue of withholding information in the context of the offence. By that, we mean a total failure to supply or publish the required information, rather than an incomplete return or publication. A partial return of information that would be covered by the clauses would fall within the scope of the offence. However, a total failure to supply information does not. The false or misleading information offence applies to information that a provider is legally required to supply.

Where a provider withholds such information, it is already in breach of that legal obligation. It is then a matter for the organisation to which that duty is owed to pursue the matter with the provider. For example, in the case of information that is withheld from the Care Quality Commission, a provider can be prosecuted, and in the case of information withheld from Monitor, a fine of up to 10% of the provider's turnover can be imposed.

The hon. Member for Copeland will know that when we are dealing with the criminal law—we have been talking about a criminal prosecution in the case of false or misleading information—there is often a distinction between an act and an omission in how the law is applied, and we are applying a similar concept here. Instances of total failure to provide information within the NHS are rare and are usually resolved by a further request that information be sent. There are other mechanisms, as I have already outlined, whereby the information can be forcibly released by the CQC, Monitor and others through the existing legal framework.

Persistent withholding of information is even rarer, because of the incentives on providers to supply the information. For example, much of the information that NHS providers submit to the Health and Social Care Information Centre is used to determine how much they should be paid under payment by results.

I cannot accept the amendment as the drafting does not fit with the strict liability nature of the offence. I am not persuaded that extending the offence to include withholding information would provide a benefit beyond the legal mechanisms that are already in place, and it would be targeted at a practice that does not in reality occur.

Jim Shannon (Strangford) (DUP): I just want to ask the Minister a few questions. The Committee and obviously the Government have a duty to avoid false or misleading information that could cause perverse incentives, or to avoid disproportionate punishments that can also deter capable individuals from taking up leadership roles. So within the section we are looking at, I seek clarity on the threat of imprisonment or fines.

All organisations must be accountable for the information they provide, to protect safety, drive improvement and build public confidence. However, it is not clear that a criminal sanction is required to incentivise this, either corporately or individually, or that it will add value to existing duties. I have some concern about the effect that the clauses about false or misleading information, which include sanctions of imprisonment of up to two years and/or a fine, may have. These clauses would leave individuals acutely vulnerable to liability for complex and ill-defined matters potentially beyond their control.

I asked the Minister—and I hope he can come back to me—how will neglect be proven and how will responsibility be determined? What is the threshold for materiality? That is a significant list of unintended consequences from these clauses. I also asked the Minister about the creation of an offence of wilfully withholding relevant information with the intention to mislead or misdirect. Perhaps the Minister can also give some clarity on this matter. I really seek clarity on this clause and the questions relating to the amendments as well.

I understand that the Government have acknowledged the potential for the clauses to create what could be termed a perverse incentive in their application at a corporate level. None the less, we seek clarity in relation to the position of fines, imprisonment and accountability in the process. It is always about protecting the staff and the patients. Perhaps the Minister in his response could give us some clarity on these matters.

Mr Reed: I am grateful to the Minister for his reasoned objections to the amendment, especially regarding the importance of the notion of strict liability in this Bill. We will no doubt return to that issue, especially with regard to clause 118, but I shall not press the amendment to a Division.

Dr Poulter: As always, the hon. Member for Strangford makes a valuable contribution and asks some important questions. The purpose of the false or misleading

information offence addresses concerns that, as he will be aware, were in the Francis inquiry, specifically looking at the controlling mind of an organisation. There was a failure to present information in a way that was open and honest. Its presentation was, in fact, misleading, which compounded and made worse many of the care failings at the trust. When such failing is at the corporate level—when this applies to the whole care provider and across many patients, not just at the individual level of one patient—it is appropriate that we impose a sanction. For the provider, that is a strict liability offence, which involves a reasonableness test, so the provider has a defence if it has done everything it reasonably can be expected to do to present information conscientiously and appropriately. It is important that we recognise that providers that have made a genuine administrative error would be able to defend themselves against any charge of supplying or publishing false or misleading information. In that case, a provider would have to show that all reasonable steps had been exercised and due diligence taken to avoid supplying or publishing false or misleading information.

That reasonableness and due diligence test is applied to the strict offence. It will help to encourage providers to have appropriate arrangements in place and will act as a deterrent in future to those who knowingly and wilfully provide false or misleading information, or who perhaps do not exercise the due diligence that will be required in presenting information about health care or related matters that affect patients' care. I hope that that reassures hon. Members and helps to explain why the process needs to be taken forward by the Crown Prosecution Service, rather than the CQC, as is the case for the duty of candour.

Mr Reed: As I said earlier, I am grateful to the Minister for his clarification in respect of my points and those made by the hon. Member for Strangford. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 90 ordered to stand part of the Bill.

Clauses 91 and 92 ordered to stand part of the Bill.

Clause 93

TRAINING FOR PERSONS WORKING IN REGULATED ACTIVITY

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

The Chair: With this it will be convenient to consider new clause 27—*Registration of Healthcare Support Workers*—

'(1) The Secretary of State must by regulations provide for a system of registration of healthcare support workers ("the registration system") under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor in a hospital or care home setting.

(2) The system shall apply to healthcare support workers, whether they are working for—

(a) the NHS,

(b) independent healthcare providers,

(c) in the community,

(d) for agencies, or

(e) as independent agents.

(3) Persons care for members of their own family or caring for persons with whom they have a genuine social relationship shall be exempt from the provisions of subsections (1).

(4) The registration system shall include a national code of conduct for healthcare support workers.

(5) The registration system shall include national standards for education and training of healthcare support workers.

(6) The code of conduct, education and training standards and requirements for registration for healthcare support workers shall be prepared and maintained only after consultation with all relevant stakeholders including, but not limited to—

(a) regulatory bodies,

(b) professional representative organisations, and

(c) the public.'.

Mr Reed: Clause 93 will amend section 20 of the Health and Social Care Act 2008 to enable the Secretary of State, through regulations, to specify the bodies or persons who can set training standards in respect of a specific group of workers. It will allow the Government to specify in regulations the person who sets the training standards and to whom those standards apply. Groups to whom the standards could apply include health care assistants and social care support workers.

New clause 27, which my hon. Friend the Member for Leicester West and I tabled, relates to clause 93 precisely. The clause is rather vague and does not sufficiently deal with concerns expressed by the Francis report. It does not put any duty on the Secretary of State to advance provisions immediately and does not say to whom the regulations must apply. It was said in the other place that Robert Francis is widely reported to be disappointed with some aspects of the Government's response to his report, and there is disappointment about clause 93.

During deliberations on the Bill in the other place, my noble Friend Lord Hunt of Kings Heath clearly outlined how the clause is left wanting. Clearly defined parameters determining the mandatory level of training are crucial to maintain standards. If there is to be mandatory training, the logical extension is that there must be a list somewhere of those who have completed that training, which would be by its nature a list of trained health care assistants. Additionally, if someone is trained but not performing at the ability that is required, there needs to be a way of removing the qualification. This is de facto regulation of health care assistants, but without the label.

The Prime Minister's commission on the future of nursing and midwifery noted that training to support workers was variable and recommended that they should be better trained. Earl Howe stated that the Secretary of State would issue a mandate to Health Education England to ensure that minimum training standards for health care assistants would be established by spring this year. Will the Minister update Members on this mandate? I seem to recall its being mentioned earlier in our deliberations, so I hope that he will say that it will be available before Report. If that will not be the case, perhaps he will update us with progress on that.

Will the Minister also answer several questions that were asked in the other place? How far will the mandate go and what will it cover? What impact will it have on existing health care support workers? Will the training extend to them, or will it apply only to new people

[Mr Jamie Reed]

coming into the health care profession? It is unwise to have a two-tier work force in such an important area as health care.

3.15 pm

If a minimum training standard is established, does that become a qualification to be achieved? If so, and a qualification is awarded, will that be recognised nationally and will there be a list of those who have achieved it, much like for any other qualification that anybody in any industry would be expected to hold? A simple, small step along that path takes us towards regulation, yet the details provided do not allow one to assess the proposals properly.

Luckily for the Government, new clause 27 would fill the gap left in the Bill. It is based almost entirely on a recommendation made by Robert Francis—the only difference is that the new clause would place the duty on the Secretary of State to bring forward proposals. We are mindful that the Secretary of State might be from a different party, but the politics of this are irrelevant; it is about the practicality and efficacy of the measure.

Francis recommended that a code of conduct and charters be brought forward by the Nursing and Midwifery Council. Subsection (6) of the new clause would require the Secretary of State to consult a wide range of groups, including the NMC, to ensure that relevant partners could have an input in the process. I shall briefly explain each subsection of the new clause.

Subsection (1) would require the Secretary of State to bring forward regulations to provide for a new system of registration for health care assistants, which would ensure that no unregistered person would be permitted to provide direct care to patients, whether in a hospital, a care home or at home. Subsection (2) outlines the bodies with which health care assistants would need registration to be employed, while subsection (3) would exempt family carers from the registration process. Subsections (4) and (5) expand on what would be required of the registration process—namely a code of conduct, and national standards of training and education—and, as I said, subsection (6) lists statutory stakeholders that would need to be consulted in the development and maintenance of these standards. Given the detail we have been able to set out in the new clause, will the Minister explain why clause 93 is so vague? If there have been further discussions about the scope of the proposed regulations, will he give us an update?

We all agree, I think, that it is unacceptable that the security guard at the door of a hospital is more regulated than the health care assistant attending to a vulnerable patient within it. The care certificate developed by Camilla Cavendish is a welcome step in the right direction, but the questions I have posed still stand. Will action be taken if people fall below the required standards and can their certificate be revoked? If so, this is regulation by another name, which prompts us to ask why the Government have gone only part of the way there. It behoves us all to remove any suggestion that this is a process of public relations rather than the development and implementation of practical solutions.

This important issue needs to be aired fully, so will the Minister commit to informing the Committee of the Government's progress on the matter before we have the opportunity to vote on the new clause at the end of the Committee's proceedings? Perhaps I will not need to press it to a Division, or perhaps we will need to reassess and take a new approach on Report, but I will welcome the Minister giving some assurances about the points I have raised.

Paul Burstow: I have a quick question and a reflection. The reflection is that the issue relevant to the new clause is not new, but long standing. Some Government Members feel—I certainly do—that it was left parked and not dealt with for a long time. One of the reasons why was that although the previous Government undertook to introduce regulation in this area, when it came to implementing it, the scale of the task, alongside many others better to regulate the work force, simply meant that it was never done. A promise was made and repeated several times, but never delivered, so it is important that this Government do not make the same mistake of being beguiled into making a promise on which they fail to deliver. That is why the Government's approach of having a certificate is a much more powerful way of driving an agenda that is about improving the quality of training and standards of staff.

For the tool to be as powerful as it can be, it needs to be a portable, rather than something that a person has in just one place. Once someone has gone to work for a care provider, that care provider invests in them as a person and trains them, and when they move to the next place, their certificate should carry a record of that training with it. It then becomes an asset not only to the individual, but to the whole sector. It becomes valuable, because it reflects the fact that many care providers invest in and train their staff. It will also expose those that do not, which is another reason why the tool would be useful.

It will be helpful if the Minister assures us that the certificate is intended to be portable and that arrangements will be made so that information about skills gained and additional training, through the various accreditation routes, is properly recorded. A subsequent employer will then have the benefit of that knowledge and may make judgments about where it invests its training resources for that individual and their onward professional development. I look forward to his response.

Grahame M. Morris (Easington) (Lab): I do not disagree with any of the comments made by the right hon. Member for Sutton and Cheam, and I support what my Front-Bench colleague said.

There is an overwhelming case for appropriate training for the UK's 1.3 million health care support workers. They do a fantastic job, and not just in hospitals, but in homes and care homes. They are a large and valuable part of our work force and they deserve recognition for their work. For too long, there has been little to regulate because of the lack of a clear standard against which health care support workers could be judged. We should not forget that the measure would require the Secretary of State to provide for the regulation of health care assistants, in line with the Francis report. I welcome it as a further step towards raising the standards of care that people will receive.

Following the recommendations of the Francis and Cavendish reports, regulations would make powers to allow health care assistants and social support workers

to receive the support that they need to provide high-quality and compassionate care. Too many health care support workers are not recognised for their work, and nor do they have adequate contact with supporting bodies, so one would hope that the measure would ensure that health care support workers would get more of the recognition and support that they deserve. I emphasise that organisations such as the Royal College of Nursing have welcomed news of regulation for health care assistants and support workers, which will grant such people recognition for the important roles that they play through being supported by national standards and receiving, as the right hon. Gentleman indicated, a certificate of care once they have completed the mandatory training.

As well as supporting health and social care workers in their training, if employers have a duty to check that all health and social care workers in their employment have completed the necessary training and possess the care certificate, it will allow employees to operate in a more effective, consistent and efficient manner. Most important will be the benefits to those receiving care. The introduction of a code of conduct, education and training standards, and requirements for registration, will help to prevent substandard care and reduce inequalities. I am confident that regulations will help to avoid some of the worst examples of poor care.

It is important not to be complacent. The Minister and our Front-Bench team have said many times that the issue is about culture and changing culture, but such regulation deals with only minimum standards—standards that are already exceeded in many cases. There are examples of very good practice and we should always be striving to achieve the highest possible standards for health care support workers and to deliver the best care for patients.

Bill Esterson: I am really pleased that my hon. Friend is making these points. I completely agree with how welcome the moves are. Does he agree that ultimately what we need to get the best standard of care is to see those people who work in the care sector as professionals and to elevate such workers to having a profession?

Grahame M. Morris: I completely agree with my hon. Friend. Unless we value the people who work in the service, especially the veritable army of care and support workers and health care assistants, we will not achieve the necessary improvements in standards, outputs and care for people being looked after.

Although the legislation will improve the lot of the cared-for, carers and employers, we should note that it is only an advancement from what has previously been a very much unregulated service. There are still a lot of opportunities to improve culture and promote professional development to support our invaluable health care support workers and improve care.

Dr Poulter: I have much sympathy with the sentiments expressed by the hon. Member for Easington and the shadow Minister. Government Members are united in the belief that we need to ensure that 1 million or so health care support workers are in the right place to receive the right training, so that they can deliver high-quality care.

The Francis inquiry flagged up a number of concerns that we have touched on today. It is important to highlight that we all recognise that investing in our health care work force is vital if it is to be properly placed to deliver high-quality care. It is important that training and education of the work force is seen to be everyone's business, but in particular the business of health and care providers. That point was well made in the brief speech of my right hon. Friend the Member for Sutton and Cheam. I hope to give him some reassurance later.

The purpose of new clause 27, which was tabled by the Opposition, is to provide reassurance that health care assistants who care directly for patients are capable and caring. I hope to reassure the Committee that the Government are already taking strong action to provide such reassurance to patients and the public. For that reason, we are also debating clause 93, which will give the Secretary of State a power through regulations to name a person or persons to set training standards for a specific group of workers.

My right hon. Friend the Member for Sutton and Cheam has rightly aired concerns about the number of older people being abused in their own home, including by their carers. Our common aim should be to prevent abuse and to act quickly and effectively when abuse occurs. The best approach is for everyone to see safeguarding as their business, and to know how to respond if they are concerned. As we have discussed throughout the day, clauses 42 to 47 provide for a number of actions on safeguarding aimed at establishing the local authority as the lead co-ordinating organisation for safeguarding locally, as well as providing for a new duty to carry out an inquiry where there is cause to suspect that an adult is at risk of abuse and neglect.

The provision of personal care by health care assistants and social care support workers falls within the definition of a regulated activity relating to vulnerable adults. Under the Safeguarding Vulnerable Groups Act 2006, those workers are subject to checks by the Disclosure and Barring Service—what I would probably refer to as a Criminal Records Bureau check. That provides a further layer of reassurance by helping employers to make safe recruitment decisions and prevents unsuitable people from working with vulnerable groups. Employers have a further role through recruiting, training and supervising staff. Individuals must appreciate that they are responsible not only for delivering safe care and support, but for challenging any poor care, neglect or abuse they witness or discover.

3.30 pm

We must be clear that the regulations covering CQC registration already place a legal obligation on employers in relation to the training of their staff. The regulations state that employers should ensure that their staff receive

"appropriate training, professional development, supervision and appraisal"

to enable them to carry out their responsibilities safely and to an appropriate standard. When providers do not comply with registration requirements, the CQC has a range of enforcement powers that it can use, including prosecution. Statutory guidance on compliance with this registration requirement has been published.

Safeguarding is everyone's business, and many systems are already in place to ensure that, but we know that we need to do more. It is the duty of health care providers to look after not just patients, but their staff, and ensure that they are properly trained to safeguard and care for their patients.

We recognise that there is concern about ensuring levels of training and, sometimes, the competence of the health and care support work force. That is understandable when those workers provide what is often intimate and personal care, sometimes to very vulnerable people. We all want those who provide care to do so safely, effectively and with compassion. Holding a list of people who have completed minimum training and signed up to a code of conduct, as proposed in the new clause, would not be a statutory regulation. Indeed, the accredited voluntary registration scheme, which was envisaged and discussed under the Health and Social Care Act 2012, has proved to be difficult to implement for health care assistants. No one has come forward to set up a scheme, so we have chosen to take a different route—that recommended in the Cavendish report. I will come to that later.

We do not believe that registration is appropriate or proportionate for health care assistants, who are lower-paid workers and may work part time. They would find the cost of registration fees burdensome, and we do not want to dissuade people from a career in caring. Statutory regulation, for which there have been frequent calls, including in the other place, is a much broader process and would be even more burdensome. It involves setting standards of conduct, protecting commonly recognised professional standards, establishing a single list, and providing a way in which complaints can be dealt with fairly and appropriately, including through the ability to strike off an individual.

It is important to draw a distinction between a more regulatory framework and training standards, and the Cavendish review draws out that distinction very well. It makes the point that any form of regulation may focus more on an ethical code of conduct than training standards in the workplace. Although there is obviously an overlap between the two, there is of course a distinction between functions. Even if we considered moving towards a more regulated system for health care assistants, regulation could bring additional burdens, including the possibility of insurance levies being required for people practising as health care assistants and the additional burden of paying to be on a register. That additional burden might deter some of the lowest-paid workers, particularly part-time workers, from providing care and engaging in the work that they enjoy. We do not talk enough about that unintended consequence, but we must be aware of it.

There is an argument that regulation can raise professional standards and esteem, and the hon. Member for Sefton Central touched on that. Other groups that we hold in high esteem are not regulated, or are surrounded by less of a framework; for example, some therapists do not have a rigid regulatory framework. We must recognise that a more rigid framework might bring with it fees and financial burdens for the workers, which could deter people from taking up the kind of work that we are discussing.

I am sure that we would all agree that it is the duty of the health care provider to make sure that it is looking after patients properly—that is the point of view of the Government, and the sentiment has been expressed by the Opposition—and key to that is having skilled and properly trained staff to deliver high-quality care.

The new clause focuses only on health care assistants, and omits to include social care support workers, who are far more numerous and often under less supervision, as my right hon. Friend suggested. It is important that quality assurance in the work force is given across both health and care. Other parts of the Bill focus strongly on the integration of health and care. The Department published the first mandate to Health Education England last year; the next will be published very soon. We often talk about a mobile work force who have to work across a variety of care settings. It is important that the standard of training for that important work force is set across both health and care, and does not focus only on health.

In general, we know that the work force in a hospital—perhaps the one across the river from here, where I trained—will be very well trained by the NHS, but the concern is often raised that although the social care work force provide intimate personal care in the community and in care homes, employers and providers of care do not always pay the same rigorous attention to education and training, which could be to the detriment of patients. We want an approach that raises the game across both health and care for a combined, integrated work force. I am sure that the hon. Member for Copeland would also want that; it must surely be our objective. The Government are taking action, and we consider our approach to be the right one.

I turn to the Cavendish inquiry and report, which followed on from the Francis inquiry and led us to the position that we have adopted in the Bill. The Cavendish inquiry, which reported back on 10 July last year, made a number of recommendations on how the training and support of over 1.3 million health care assistants and social care support workers can be improved to ensure that they provide care to the highest standard. Among other measures, it proposed that health care assistants and social care support workers should undergo the same basic training, based on existing best practice, and should obtain a certificate of fundamental care. We accept Camilla Cavendish's recommendation that a care certificate should be developed.

Clause 93 allows the Secretary of State a power to make regulations to specify a person or persons to set training standards for a specific group of workers. Once the regulations have gone through the parliamentary process and come into force, the person or persons specified will provide a set of common training standards for health care assistants and social care support workers who work for a registered provider of any regulated activity. In the first instance, we envisage that the person specified will be Health Education England, which will work with key partners to deliver the care certificate. An update on that will be delivered in the refreshed second mandate to Health Education England, which will be published in the next few weeks.

The care certificate will need to take full account of the standards set by the person appointed to do so by the regulations made under clause 93—as I said, we

envisage that being Health Education England—and will be key to ensuring that those standards are applied consistently throughout both the health and care sectors. Once the certificate has been launched, the intention is for the CQC to update its guidance about compliance to refer to the certificate. Portability is clearly an issue, as we have discussed, and I hope to reassure my right hon. Friend the Member for Sutton and Cheam on that in a moment. Completion of the certificate by the relevant work force could be used as evidence of compliance with the registration requirement in relation to all CQC-regulated activities, in the same way as completion of the common induction standards is currently used in social care settings.

My right hon. Friend raised the important point of the portability of the certificate. It is our intention that the certificate will be portable between employers, enabling workers to move seamlessly around the system. However, the primary responsibility and duty is for the CQC to inspect the employer, to make sure it has invested in its work force. It will be for the CQC to be satisfied that the work force meet the required standards for training and development.

Paul Burstow: It is reassuring to hear that. Can I be clear that that portability extends to the recording on the certificate of qualifications obtained during a period of work with a particular employer, so that the next one has the benefit of that?

Dr Poulter: These matters will be for the CQC to look at. The important thing is that we also recognise that a care certificate that is valid today may well not be adequate in five or ten years' time. It may be that the CQC would like to see people refresh their training. It may be that the basic standard of care needs to be modified and adapted as we go forward because of advances in care, or because there are other requirements that it is important to put into it. It may be that Health Education England or another body appointed to develop the training certificate will need to modify it as time goes on.

We have to be careful about seeing the certificate as a panacea that always delivers good care. That is why we need to leave the CQC the flexibility to inspect against other training requirements, and the ability to update the certificate of care as time goes on. As with all health care training, a surgeon trained in 1950 may not have the skills to operate in 1980 or today, although they may have the same basic knowledge of anatomy—we certainly hope they do. Similarly, it is important that other aspects of health care training are modified appropriately as time goes on, in order to meet the needs of patients.

Sarah Newton (Truro and Falmouth) (Con): May I press for more clarity on this important point? A lot of very good care providers provide their own in-house training because, as my hon. Friend rightly identified, there is a paucity of high-quality training. Will there be a scheme for accreditation for care providers who have already invested in good quality training, sometimes working with partners?

Dr Poulter: My hon. Friend rightly picks up on the fact that some care providers have very high training standards, and others do not. That variability is the concern that was raised in the Cavendish inquiry, and that is what we are looking to address. The way we envisage the system working will be set out in regulations. Health Education England will very likely be the designated body, and more detail will be published in the mandate about first steps and the timetable for how this will be developed. HEE would look to develop fundamental standards of care. The CQC would then inspect to make sure that training providers had ensured that their work force had that care certificate, and that they had staff with the right training skills across all the aspects of care required. It may be that some of the care that is required for the basic training certificate is not good enough and more things need to be added, depending on the setting and the staff mix required. That is a judgment for the CQC to make.

The fundamental point is that we need the variability in training standards ironed out and the standard to be raised, so that we raise the game of those providers who have not adequately invested in their staff, to the detriment of patients. We must raise the game so that there is, at the very least, a care certificate that we would expect all health care staff to have. It would be for the CQC to inspect health care providers and make sure that their staff comply with that. That is how we envisage this to be delivered, but further regulations will come forward in due course. The Government have made it clear that regulation is no substitute for a culture of compassion and effective supervision. The care certificate aims to improve the consistency and performance of the health and care support workers, without placing a disproportionate additional burden on either employers or the work force.

We have decided to tackle this issue of raising standards in training. By focusing on the right training support and leadership, we will provide the high-quality care that patients deserve. I am confident that right hon. and hon. Members will agree that these actions are proportionate, and I ask Opposition Members not to press the new clause to a Division.

Mr Reed: I genuinely thank the Minister. This is the first time I have ever been involved in any kind of debate where I have advocated a position, only for the Minister to completely, totally and utterly agree with it and then refuse to accept where that logic leads to.

3.45 pm

Portability is critical, and the right hon. Member for Sutton and Cheam is right to mention it. If any kind of certificate is held by anyone at all, a centrally held record will surely exist somewhere. I cannot, for the life of me, determine the difference between a register and a centrally held record that tells us exactly who has a particular certificate, when they got it and whether they are fit to practise. What is the difference between a centrally held record and a register? The Minister made this point passionately and convincingly, so does he believe that it is correct that someone who holds a certificate but fails to meet its standards—or the standard that the certificate suggests—should continue to be able to practise under the auspices of that certificate? I suggest that it is not right.

Does the Minister also agree that a valued, supported, accredited work force will deliver a better standard of care? He is right to point out that there are excellent

examples of care. The kinds of care that we seek to achieve are precisely the kinds of care that we all want for each other, for ourselves, for our parents and for colleagues across the House. Looking to Francis's scathing view of the "gentleman's agreement" type of professional conduct and practice, does that not strongly suggest the need for a register of health care assistants? Finally, is not the scale of the need laid bare by the fact that while 1.3 million people are employed by the NHS, as the Minister says, a further 1.3 million people are employed across the health and social care sector?

Dr Poulter: I welcome those further comments. There is no disagreement on either side of the Committee about what we are trying to achieve, which is a work force in which training standards are consistently better. We also recognise that the failings at Mid Staffs, where the issues that the hon. Member for Copeland raises come from, were failings of regulation and the failures of a purely list-based system. To say that regulating a profession or having a list is a foolproof solution to anything and is the only way to raise standards has, from first principles, been shown not to be the case at Mid Staffs.

The big lesson I take from that is that ensuring that we have a work force best placed to look after care receivers—as well as all the other issues flagged up at Mid Staffs, such as the need to have a more open and transparent culture—is fundamentally about making sure that providers invest in the education and training of their work force. Workers must also be supported to understand what they need to speak up about, such as poor care, and how to speak up.

That is very much the Cavendish review's approach, which is that this is not about regulation, but about raising the group's esteem and potentially breaking through glass ceilings. There is an issue with health care workers sometimes struggling to progress to become nurses even though they have the compassion and other attributes that would make them exceptionally good nurses. The review also recognises that broader issues need to be addressed. Part of the challenge is that we often see things through the prism of the NHS when the vast bulk of the care work force exists in the community providing care in people's homes, care homes, nursing homes and other environments. There is too much variability in the training of that work force. The Cavendish review found that the best way forward is to deal with parity of esteem—to raise the esteem of the health care assistant work force and the care work force—but also, importantly, to raise training standards and make it the business of every health care provider to invest in their work force. We need, at the very least, a de minimis standard of care. The Care Quality Commission must inspect the care provided in a care home or hospital and take a view on it. It is not just about de minimis standards, but about recognising that sometimes, in different care settings, different care standards need to be applied. The CQC must also look at the operation of the work force as part of a multidisciplinary team, which is an important aspect of care.

As part of the portability issue that has been raised, we must also look at how those issued with certificates can be recorded within existing systems. The NHS staff database is one example of how we could do that, to make it much easier to see whether someone has acquired a care certificate. An important difficulty with that—this is exactly why we have introduced revalidation for doctors, and the Nursing and Midwifery Council are looking at doing the same for nurses—is that just because somebody qualified as a doctor in, say, 1995 does not mean that they do not need to prove that their skills and knowledge are still up to date. The same argument would apply with this sort of register, which is why it would not necessarily, as we saw from the Francis inquiry, ensure the quality of services.

Registration with professional groups is part of ensuring the quality of services, but we must also make sure that we have the right training in place. That is why we have followed the Cavendish review recommendation and we believe that the training certificate is the right way to proceed. Through the regulations that we introduce, we will support the development of that certificate to raise the game throughout the care sector and health care sector on education and training standards, and we will support the portability of the assessment and training standard.

Mr Reed: We will return to the matter on Report, but I do not seek to divide the Committee now.

Question put and agreed to.

Clause 93 accordingly ordered to stand part of the Bill.

Clause 94 ordered to stand part of the Bill.

Schedule 5

Health Education England

Paul Burstow: I beg to move amendment 134, in Schedule 5, page 136, line 4, at end add—

'(c) how effectively it discharged its duties under the Equalities Act 2010 or under regulations under that Act.'.

The Chair: With this it will be convenient to discuss the following:

Amendment 161, in clause 96, page 86, line 33, at end insert—

'(1A) HEE must exercise its functions with a view to ensuring that there is a diverse workforce, that includes disabled persons, with the relevant knowledge and skills to work as healthcare workers within the health service in England'

Amendment 133, in clause 98, page 87, line 35, after '105(1)' insert—

'( ) HEE must set out in the document published under subsection (4) the objectives and priorities it has set to meet its duties under the Equalities Act 2010.'.

Amendment 163, in clause 98, page 88, line 10, at end add—

'(11) HEE's Education Outcomes Framework must include development and implementation of anti-discriminatory practices within the health-related provisions.'.

Amendment 165, in clause 99, page 88, line 36, at end insert—

'(k) disabled people who will use health services'.

Amendment 168, in clause 105, page 93, line 12, at end add—

'(9) When HEE or a LETB are commissioning health education courses, they must be inclusive of disabled students.'.

Paul Burstow: We now move on to Health Education England. The Joint Committee had a chance to scrutinise this part of the Bill and make several recommendations, some of which were about integration. We are grateful that those have been picked up and reflected in the revised Bill. A question that did not particularly surface during our consideration of the draft Bill was about diversity and inclusion, and how HEE would fulfil its obligations under the Equality Act 2010. That has come to my attention, and probably to that of other hon. Members, as a result of representations from such organisations as the Alliance for Inclusive Education.

Through amendments 133 and 134, I want to raise two issues. First, I want to consider how we ensure that medical education frames medical practitioners' view of the world in a way that is inclusive and respecting of difference. That has an important effect on how medical staff engage with disabled people, how they engage with older people and, particularly in the area of mental health, how they engage with the black and minority ethnic community. Through the amendments, I wanted to raise how we can build that into medical curricula. Disabled people's experience of health care can be very different from other people's. Medical education needs to embrace, not just a medical model view of the world, but a social model view of the world. That means, in the context of the Bill, taking a view about the well-being of the individual—not just looking at the group of diagnoses and the prognosis, but looking at the person as an individual. I say this because there are some pretty glaring, horrifying statistics that suggest that that is not quite what happens in practice today.

Some 22% of people with learning disabilities are dead by the age of 50, compared with just 9% of the general population. There is a 20-year gap in life expectancy between someone in the general population and someone with a diagnosable, severe and enduring mental health problem, schizophrenia being just one example. These are intolerable, long-standing flaws in our health care system and, while there is no single cause, one of the causes will be attitudes and the approach to the delivery of medicine. Therefore, there is a case for that being much more visible in the way the mandate is written and the way HEE fulfils its obligations under equalities legislation.

The second bit is about people's ability to participate in medical education. This again turns around attitudes, aptitudes, what is deemed to be a necessary attitude, and so on, to be admitted to the profession and whether reasonable adjustments can be made. The British Medical Association in its report, "Equality and diversity in UK medical schools" and the Department of Health in its report "Sharing the challenge, sharing the benefits: Equality and Diversity in the Medical Workforce" recognise that widening the net is a big challenge. I very much welcome the references in the mandate that the Minister mentioned earlier, because that says that there has been progress and I very much commend the Minister for what is written in. I look forward to his response to my remarks, because it will give him a chance to say how important the Government consider those matters to be.

The fact that there has been progress on a number of the characteristics covered by the equalities legislation is good news, as is the focus on saying that HEE must monitor and report on recruitment to all NHS-funded courses against all equalities strands and socio-economic groups. It would be useful if the Minister said how that will be reported, since my two amendments in the group are about reporting. I hope that the Minister will say that, even if the two amendments do not get into the Bill, it would be regarded as strange and out of order if HEE did not, having monitored those things, report on them in its annual report required in schedule 5 and, indeed, in setting out its priorities. I hope that he will say something about that.

Health Education England must also work with the General Medical Council and the Medical Schools Council to develop ways to assess aptitude for medical careers. This is something that ALLFIE, which drew these issues to my attention, has expressed considerable concern about, because the aptitude criteria can exclude people who would be perfectly good clinicians from even being able to get on to courses. I hope that the Minister will be able to say something about the progress there.

The last point I will pick up on is that the mandate splits into two parts in this area—immediate deliverables and longer-term deliverables. On the immediate deliverables, it talks about there being a national framework for action by this spring, but that that was going to be reviewed last autumn. Will the Minister say what that review in the autumn led to and what the current expectation is for the publication of the framework?

Slightly more disappointingly, but I am sure that the Minister will be more than able to reassure us on this point, the long-term deliverables have the very laudable goal of a focus on widening access for people from lower socio-economic groups. I do not want anybody to misunderstand; I think that is a great thing to want to do and we need to see it happen, but there is no reference to a continuing attempt to widen access to people with disabilities and so on. It would be useful if the Minister said a bit about that.

These amendments seek to probe the Government on various aspects of how HEE delivers its obligations under equalities legislation. One of the amendments would add to clause 98 a requirement on HEE to publish a document, and another would make an addition to schedule 5. I look forward to hearing the Minister's response.

4 pm

Grahame M. Morris: I rise to support amendments 163 and 165. I do not disagree with the comments and the case that the right hon. Member for Sutton and Cheam has just made. As usual, he was very accurate and forthright in expressing the views of the Joint Committee and subsequent representations made by various disability groups. I do not propose to repeat those arguments.

Amendment 163 would impose a duty on Health Education England's Outcomes Framework to,

"include development and implementation of anti-discriminatory practices within the health-related provisions".

Amendment 165 addresses issues surrounding people with disabilities. Health Education England has a vital role to play in linking education and learning to improvements in patients' outcomes. Setting objectives, priorities and outcomes for education and training could be instrumental in ensuring that all health care workers have the right attitudes and the right values to ensure that disabled people have the same rights and access to

[Grahame M. Morris]

health care as their non-disabled peers. I refer the Committee to my previous declarations of interest, not least as vice-chair of the all-party parliamentary group on learning disability.

It is a concern that the current legislation does not guarantee this equality. Several disability charities and I share a concern that the Government could do more to safeguard disabled people. Disabilities are often misunderstood, even in health care education, as has been highlighted in numerous reports. Change can be effected, but it is very important for it to be delivered on the ground. Traditionally, a kind of negative—perhaps that is the wrong word—or medicalised approach to disability has been taken. An inadequate understanding of the needs and values of disabled people leads to them being discriminated against, not deliberately but as a consequence of organisations' culture and the lack of training that individuals receive. As a consequence, disabled people receive poorer health care than their non-disabled contemporaries.

Last year Mencap published research based on a confidential inquiry conducted by the university of Bristol and funded by the Department of Health. It estimated that as many as 1,200 people with a learning disability might have died in the NHS because they were not receiving the correct health care. I am pretty sure that the Minister of State attended that launch or a subsequent event, so he is very familiar with the concerns of the community. The inquiry's research team found that more than a third of the deaths of people with a learning disability were considered to be avoidable.

The right hon. Member for Sutton and Cheam has mentioned some of the statistics on premature death, particularly among women. Women with a learning disability die 20 years earlier than those without one. Overall, more than a fifth of the people with a learning disability who were looked at by the inquiry had died under the age of 50, compared to just 9% of the general population. A contributory factor to the poor health outcomes of disabled patients is considered to be the poor understanding and negative perception of some health care workers. A negative perception may affect a health care worker's judgment when deciding on an appropriate treatment or service. Judgment of what treatments are worth while or cost effective may be influenced by prejudice, dare I say, or negative perceptions of disability, particularly of learning disability.

Poor communication and assumptions about the quality of life and a lack of understanding by health care professionals often mean that patients with a learning disability get poorer standards of care and, in some cases, die earlier. It is evident that disabled people suffer disproportionately. It is clear that more could be done to lessen the number of avoidable deaths and improve the poor health outcomes of disabled patients.

Health care professionals need support, encouragement and guidance to make reasonable adjustments for patients with a learning disability. I suggest to the Minister that this lack of understanding of disability that contributes to poor health care for disabled people can be countered by placing a duty on Health Education England to have regard to disabled people when exercising its functions.

This is very much an issue of social justice. I do not seek to divide the Committee on party lines. All right-thinking people would agree that health and care services and education must reduce disadvantage, especially for disabled people, as they must aim to reduce all disadvantages. We should not forget that two thirds of NHS clients are aged 65 and over and that group is likely to include high numbers of disabled people. We know about demographic changes; we know about multiple morbidities and the complications arising from them. We know that health care services will have an increasing number of disabled service users.

Disabled people are already disadvantaged, and a increase in the size of the group of those more likely to be disabled will mean that improving the treatment of disabled people will be a significant challenge. It is imperative that challenge is met through the development of health care education and services. The misconceptions surrounding disability that contribute to poor health outcomes for disabled people make a fuller representation of disabled people in the consultation processes of care and education services all the more important.

While there are examples of good practice, many of them are not embedded far enough into health care provision and are often dependent on individual staff members or a local group. As a result, services for people with a disability still vary substantially, not just across regions and localities, but even within a single organisation and service. According to disability charities, it is a lack of proper understanding of disabled people and a lack of proper regard for the needs and opinions of disabled service users that contribute to poor health outcomes.

I am sure that all members of the Committee would agree that disabled people deserve equal health care treatment, and there is a consensus that the Government should do all they can to address the problem. By implementing the correct health-related education and putting a duty on HEE to have adequate regard to disabled people who will use the health service, we can ensure that all health workers have the right attitudes and values necessary to deliver the health care that disabled people need and deserve.

Mr Reed: It is hard to follow my hon. Friend's tremendous contribution. Once again, I rise to thank the right hon. Member for Sutton and Cheam for his amendment. A recurring theme of today's sitting is that the groups contain significant numbers of amendments. Each is important and needs to be addressed in turn. I am sure all members of the Committee would like to thank the Alliance for Inclusive Education, also known as ALLFIE, and Inclusion London, who have done so much to assist with the drafting of the amendments. The group has immense expertise in the matters that will arise throughout our consideration. It is a national campaigning and information-sharing network led by disabled people, which campaigns on ensuring inclusive access and support in mainstream education. I give particular thanks to Simone. ALLFIE states:

"Education has a fundamental role to play in influencing disabled peoples' experience of healthcare provision. Traditionally, healthcare education has taken a negative and medicalised approach to disability"—

as my hon. Friend the Member for Easington mentioned—

"supporting the idea that disabled people have less to offer than their non-disabled peers."

Every single one of us in this House, regardless of party affiliation, has a duty to ensure that anything that stands in the way of inclusive health care education practices is rectified immediately. The idea that disabled people have less to offer than their non-disabled peers must be challenged at every level of debate, and I am convinced that the Minister will outline how that will be mandated in HEE by the Secretary of State—or, indeed, by himself, as he seems to be in the engine room.

In practice, that perception of disabled people could not be further from the truth. A 2010 General Medical Council report "Gateways to the Professions" followed by "Advising Medical Schools: Encouraging Disabled Students", states clearly, in a quote attributed to a medical teacher:

> "Disabled people add immense value to the student body. They help any group understand and appreciate diversity. It made a huge difference to the medical school when the first student in a wheelchair was admitted."

The GMC later expands on that statement, stating that

> "Disabled people can make a unique contribution to patient care and, indeed, to medical research by providing direct experience and knowledge of particular health conditions or impairments. Patients often identify closely with disabled medical professionals who can offer insight and sensitivity about how a recent diagnosis and ongoing impairment can affect patients. Such experience is invaluable to the medical profession as a whole, and illustrates the importance of attracting and retaining disabled students."

All of us, in all parts of the House, recognise the self-evident truth of that statement. It is clear that there is a great need to be inclusive, both for the sake of the person who wishes to access medical education and, incontestably, for the sake of the profession; the social benefits are writ large, too.

The GMC was specifically commenting on the experience of disabled people in medical education, but the point stands that increased diversity increases experience within a cohort of students, and provides a more rounded education—a better education. That is why I welcome amendment 134 and the very similar amendment 133. It is absolutely right that all non-departmental bodies across Whitehall act in accordance with the functions, duties, aims and objectives of the Equality Act 2010, and I believe that those bodies created by the Bill will do an admirable job in exercising their functions in full accordance with that Act, but it is also right that the non-departmental bodies are able to demonstrate how they have done so.

The proposed measure is not intended to be a stick with which to hit HEE; it is a requirement that could benefit it greatly. By demonstrating its credentials as an inclusive educator, it makes the whole profession more attractive to those who may have felt it was out of reach, and improves the knowledge gained by those already within the service. By setting out how it will meet its objectives under the Equality Act, HEE will be an attractive employer, while giving great confidence, security and peace of mind to those who need inclusive support, as they will be given advance knowledge of what they can expect. On the amendments tabled by the right hon. Member for Sutton and Cheam, is the Minister able to give assurances that HEE will be given a duty to demonstrate its inclusive credentials, and how that will be communicated to the wider student body, to make these careers open to everyone, irrespective of their physical ability?

4.15 pm

Amendments 161, 163, 165 and 168, which stand in my name and that of my hon. Friend the Member for Leicester West, deal with greater inclusivity. I think it important that I explain the reasons behind the amendments and why they are necessary.

Amendment 161 would place a duty on HEE to ensure that it exercises its functions in such a way as to ensure a diverse work force, which includes disabled persons. HEE should be a champion for a diverse health and care work force, to ensure that inclusive education practices are promoted. Amendment 163 would apply a duty to ensure that one of HEE's objectives and priorities is to reduce discriminatory practice when health workers are working with disabled health care service users and disabled people in the work force. ALLFIE argues that the amendment is needed because:

> "Disabled people have recommended that health-related education which champions anti-discrimination practice is central in order for health care workers to have the attitudes and values necessary to ensure that disabled people have the same rights as their non-disabled peers to access health care services as the general population."

The amendment is squarely in the same vein as our repeated attempts throughout the Bill's passage so far and all our considerations to achieve the cultural change that we all know we need to achieve. If the Minister does not believe the amendment is necessary, will he give a robust assurance that the current frameworks and those that will be created under the clause will allay the fears ALLFIE expresses?

Amendment 165 simply puts a duty on HEE to ensure that in the exercise of its functions, adequate thought is given to disabled people who will use health services. Amendment 168 puts a duty on HEE and the relevant local education and training boards to commission only education courses that are demonstrably inclusive of disabled learners. Testimonies that we have received reveal that education providers sometimes lack sufficient experience and the skills needed to work with a diverse range of learners. I am sure we all recognise that.

The amendments make up a package of changes designed to ensure that inclusivity is at the very heart of health education in this country. Why would we want it any other way? They would make sure that every course is open to all and that education courses and training are inclusive of everyone in our society. I understand that the Minister has written to the Alliance for Inclusive Education stating that he does not believe that legislation is the right way to achieve those goals. I hope that he will set out today how we will achieve them.

Dr Poulter: Some thought-provoking and important issues have been raised by Members on both sides of the Committee. At this point, it is perhaps worth exploring and laying out for the Committee the role of HEE more generally, as we are about to consider several clauses that deal with HEE's functions.

It is important to point out that in HEE, we will, for the first time, have a body that is focused and has the specific task of identifying and making recommendations on current and future work force education and training, supported by a £5 billion budget. It covers undergraduate recruitment, undergraduate training and postgraduate training, as well as making sure that there is continuing

[Dr Poulter]

professional development for the existing work force, including the health and care assistants we discussed earlier.

Our health and care work force is our NHS's greatest asset. One of the most important reasons why our NHS and our health care sector work so well and are in many parts of the world held up as a model of good health care is that our health and care work force is properly trained. Of course, to make sure that we deliver high-quality care and will continue to do so in the years ahead, we need to preserve and protect that asset. In that way, we will ensure that our health service remains one of which we can all be justifiably proud. That is why we have put aside £5 billion to invest specifically in the work force, and HEE is placed to oversee that budget. Importantly, this group of clauses also sets out the role of promoting integration across health and care in the training that HEE provides. It is important that we look forward and think about how we need to deliver health and care in the community more proactively and make sure that care is more personalised.

Focusing specifically on the clause, we have heard eloquently outlined a number of health care challenges that face people with long-term disabilities and people with learning disabilities. Emphasis and attention to that issue is long overdue. I know that my hon. Friend the care Minister is particularly focused on ensuring that we deliver the parity of esteem that my right hon. Friend the Member for Sutton and Cheam was so keen to lead on and on which he did so much to begin delivering when he was a Minister. We must focus a lot more on ensuring that we invest in our work force in the right way and on measuring and delivering better outcomes for people with mental health and learning disabilities. I know that all parties agree with that.

There is a clear priority in the first mandate for Health Education England to support people with longer-term conditions and disabilities, but it is important that we build on that. I can reassure Members that when the second mandate is published in the next few weeks, there will be much stronger deliverables—not just a stronger thematic—on supporting education and training and awareness of the needs of people with learning disabilities, as well as greater emphasis on mental health generally. I know that that will reassure my right hon. Friend the Member for Sutton and Cheam, as it builds on much of his excellent work.

I do not wish to create division, but the hon. Member for Easington said that there was potentially prejudice in the work force against people with learning disabilities. I do not recognise that from my own clinical practice or from the hospitals I have worked in. He might wish to clarify that remark in an intervention. It is important to recognise that many health care education and training courses, particularly at undergraduate level, now focus on a more holistic approach to education, recognising that care must be provided in an empathetic and passionate manner. Good communications skills are vital in dealing with people from all different backgrounds, no matter how they present to the health service. I hope that the hon. Gentleman will recognise that.

Grahame M. Morris: I do not want to fall out with the Minister, but the point I was trying to make was that people with learning disabilities in particular, but also disabled people in the round, suffer worse health outcomes and more premature deaths. The statistics back that up. I do not know whether the level of care they receive is an institutional problem, but I am certainly not suggesting that the medical profession is prejudiced against people with learning disabilities. I would not suggest that, but there is definitely a problem with the health outcomes. We do not often have the opportunity to address that, but we do now. I hope that the Minister will take the opportunity, because we might not have another for some time.

Dr Poulter: Indeed. The hon. Gentleman has made a useful clarification. It is absolutely the case that we have unacceptable health inequalities and outcomes for such groups. The Government have clearly recognised that, and bearing in mind what we are doing through education and training, as well as the general emphasis on greater parity of esteem between physical and mental health, I hope we will be in a better place in the months and years ahead.

If we are to get to that better place, it is important that we have a strong emphasis in the education and training framework on the issues that the hon. Gentleman and all Members who spoke have raised. That must not just be at undergraduate level, where many strides forward have been made in better equipping today's medical and nursing students, as well as other health care workers, to meet the needs of people with learning disabilities. We must also ensure that the continuing professional development is there so that the existing work force can recognise what can be a very vulnerable group. That is very much at the heart of what I am writing into the refresh of the Health Education England mandate, and I am sure that all Members support that.

Amendment 134, which my right hon. Friend the Member for Sutton and Cheam tabled, focuses on the importance of Health Education England's promoting quality and diversity in exercising its functions, as do other amendments in the group. We can be proud that, generally speaking, we have a diverse health care work force. We celebrate diversity, whether it is ethnic or cultural, because it adds a lot to the care that can be provided in many communities. We are hugely proud of the fact that we have such a culturally diverse work force in the NHS, and we should never lose sight of that.

We do well on medical recruitment. About 55% of medical undergraduates are women, and we have a good representation of ethnic minorities entering medical training. The big challenge is to encourage greater diversity and provide more opportunities in medicine for people from deprived backgrounds. That is a particular challenge. The best route into medicine for people from poorer backgrounds is through graduate courses. However, we still have a long way to go, and a key objective of Health Education England is to support people from deprived backgrounds who enter medicine at undergraduate level. That objective was outlined clearly in Health Education England's first mandate, and I know we all want to pursue it further.

Former Secretary of State for Health Alan Milburn is the Government's social mobility tsar, and I have been doing what I can to support his work in the important area of social mobility into medicine. We all want to take that further, though it will take time to

raise aspirations in deprived communities where aspiration has historically been low. That is a key part of the challenge.

My right hon. Friend the Member for Sutton and Cheam talked about helping people with mental health problems to have viable careers in medicine. Recognising that health care professionals often suffer from mental health problems themselves can help to destigmatise mental health. Tragically, dentistry is a profession in which there have been high rates of suicide historically. Supporting people with mental health problems at work will be a priority for Health Education England.

Amendment 134 would require HEE to set out in its annual report details of how effectively it has discharged its duties under the Equality Act 2010 or regulations under the Act. Amendment 133 would require HEE to publish the objectives and priorities it has set to promote equality and diversity. I agree that it is important that HEE, a public body, demonstrates compliance with the Equality Act. The principles of equality and diversity are integral to the delivery of all its functions. However, it is not necessary to amend the Bill to achieve that. Paragraph 35 sets out that HEE must be included in part 1 of schedule 19 to the Equality Act as an authority subject to the public sector equality duty. It is intended that Health Education England will be required to publish information annually to demonstrate compliance with the public sector equality duty, and prepare and publish one or more objective that must be achieved to meet the duty.

The public sector equality duty, set out in section 149 of the Equality Act, requires a public body to

"have due regard to the need to…eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act…advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it",

and

"foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

As HEE is clearly a public body covered by the Equality Act, it is not necessary to repeat such requirements in the Bill in the way that is set out in the Equality Act or in the amendment.

For 2012-13, Health Education England, which is currently a special health authority but will be changing its status when the Bill is enacted, has adopted equality, diversity and inclusion objectives that fall into six broad categories, covering a full employee experience of the current and future work force. The categories cover monitoring recruitment and selection; managing information and governance and equality and diversity; building engagement, support and leadership on equality and diversity; enabling development and progression for all staff; monitoring leavers by protected characteristics; and engaging the future work force. I will write to the Committee and clarify if I am incorrect, but I believe that Health Education England published this on its website recently. This is routinely discussed at HEE board level, which shows the strong commitment at the top of that organisation to the agenda that the Committee is talking about today.

4.30 pm

We would also routinely expect Health Education England to repeat these important commitments as part of its annual report. I am sure that it very much has that in mind. I also reassure my right hon. Friend and other hon. Members that this is a matter that the Government take very seriously. The Government's mandate to Health Education England, which is currently being refreshed, includes a specific objective for HEE to ensure that the principles of equality and diversity are integral to education, training and development across the NHS and the public health system.

Amendment 168 aims to ensure that HEE supports disabled students seeking to follow a career in the health service. I am pleased to say that the mandate requires HEE to monitor and report on recruitment to all funded courses against all equality strands and includes an objective to improve applications to NHS-funded courses from groups that are currently under-represented. HEE will work with the Office for Fair Access and the Selecting for Excellence group in taking this work forward. Those objectives will continue to apply to HEE when it becomes a non-departmental public body as a result of the Bill.

Amendment 163, which the hon. Members for Copeland and for Leicester West tabled, would require the education outcomes framework to include development and implementation of anti-discriminatory practices within the health-related provisions. The Department of Health, which publishes the education outcomes framework, is subject to the public sector equality duty that we discussed earlier. The Government's education outcomes framework includes a domain focused on widening participation among the health work force.

This is a specific requirement targeted at the health work force. The domain aims to ensure that talent and leadership flourishes free from discrimination, with fair opportunities to progress, so that everyone can participate to fulfil their potential, recognising individual as well as group differences, treating people as individuals and placing positive value on diversity in the work force. It has two strategic outcomes: to ensure that organisations delivering health care help all staff to meet their potential and meet or exceed their obligations on equality and diversity.

It is also worth highlighting what I specifically wrote into the first mandate for Health Education England, on recruitment into training programmes. This encapsulates much of the discussion that we have had today. In chapter 7, on widening participation and recruiting into training programmes, it states at 7.1.1:

"As a system leader, HEE will ensure that principles of equality and diversity are integral to education, training and workforce development and, as an employer, it will promote equality and diversity".

As an organisation, it does not just promote its training, it is also an employer where these principles are strongly embedded. The other points, on which I will not detain the Committee, talk more broadly about everything that we have already covered—let me emphasise that strongly—in the mandate itself.

Health Education England has a clear duty in clause 100 to seek advice on the exercise of its functions from the people who use health services or their representative organisations. That covers all patients, including those who may have disabilities. I should add that this clause also requires HEE to seek advice from carers or their representative organisations. I am grateful that what we all consider to be an important issue has been raised in our considerations. As the Minister responsible for

education and training, I am clear that Health Education England must fulfil its responsibilities under the Equality Act and will do so in a way that ensures the delivery of a diverse work force capable of meeting the needs of all patients. I hope that my right hon. Friend and Opposition Members will feel reassured by this and not press their amendments.

Mr Reed: I am grateful yet again for the manner of the Minister's engagement. We will not seek to divide the Committee on our amendments.

Paul Burstow: On the same basis, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Schedule 5 agreed to.

Clause 95 ordered to stand part of the Bill.

Clause 96

ENSURING SUFFICIENT SKILLED HEALTH CARE WORKERS FOR THE HEALTH SERVICE

Mr Reed: I beg to move amendment 162, in clause 96, page 86, line 36, at end add—

'(3) HEE must promote inclusive health-related education and training for healthcare workers.

(4) HEE must exercise its functions in this section with a view to ensuring appropriate long-term planning is undertaken to ensure a sufficient number of skilled healthcare workers is maintained.

(5) HEE must exercise its functions in this section with a view to ensuring that the number of skilled healthcare workers is matched closely to the health service's need for them.'.

The Chair: With this it will be convenient to discuss amendment 164, in clause 98, page 88, line 10, at end insert—

'(12) The Secretary of State must make a statement to Parliament if HEE projects that the number of skilled healthcare workers available is lower than the required level.'.

Mr Reed: The amendments seek to improve the framework surrounding Health Education England to ensure that sufficient regard is given to forward planning in work force matters.

Amendment 162 deals with two separate issues, but I will touch on the first only lightly given the airing it received in the previous debate. The amendment seeks to add further functions to the clause and therefore to extend the duties placed on Health Education England. The first new function bestowed on it is to promote an inclusive work force that should include disabled persons.

We have outlined in some detail the manner in which the whole work force benefits from extra inclusivity, and the amendment extends the logic of the argument in the previous debate. That is clear for everyone in Committee to see. This section of the amendment supports the aims of amendment 161, as discussed in the previous grouping, and again I extend my thanks to ALLFIE, which has worked so hard to bring this issue to our attention and to that of Members throughout the House to ensure that inclusive education is at the heart of what Health Education England does. As the Minister's previous response indicated, we are all serious about that. It is a commendable aim, which I wholeheartedly support. I hope that the Minister will echo those sentiments in his remarks.

The rest of amendment 162 would add a further two duties to be placed on Health Education England. Clause 98 as it stands requires the Secretary of State to publish a document that specifies the objectives and priorities that the Secretary of State has set for Health Education England for the year ahead. Incidentally, for a Bill designed to promote the devolution of responsibilities to a local level, the Secretary of State's inbox appears to be filling up rapidly.

Nothing in the Bill ensures that Health Education England takes a long-term approach to work force planning. It must ensure a sufficient number of skilled health care workers, that this sufficiency is maintained and that demand for staff is well matched to supply. To do so, a key focus for Health Education England is to be involved continuously with long-term planning. That is crucial in an industry where it takes years and years to train staff. Amendment 162 would therefore extend the matters to which Health Education England must have regard when exercising its functions. If the Minister opposes the amendment, I should be grateful for an explanation of how long-term work force planning can be guaranteed under the listed provisions.

On amendment 164, another key recommendation of the Francis report is the introduction of minimum staffing benchmarks to ensure a safe service. It is regrettable that the Government are dragging their feet on this, but it is a welcome step forward that Health Education England has a duty to ensure that sufficient staff are well trained. The amendment seeks to ensure sufficient parliamentary scrutiny should Health Education England fall short of that duty. I will elaborate on what the amendment would achieve and why that is necessary.

The amendment would add a subsection to clause 98 that would require the Secretary of State to make a statement to Parliament if Health Education England projected that the number of required skilled health care workers exceeded the numbers available. Therefore, if Health Education England were to project that there are or will be too few doctors, nurses, health care support workers, surgeons and so on, they would have to come to the House of Commons to make a statement on the matter. That would be necessary because hon. Members on both sides of the House would want to express their concern about what would be an extremely worrying scenario—vexatious, even—as well to scrutinise effectively the failure of a non-departmental body for which the Secretary of State had responsibility.

If Parliament's authority is used to give Health Education England the means to function, it is right that it has effective oversight of its functions. Given that one of HEE's key roles is to ensure that there are sufficient skilled workers in the health service, it would not be conducive to responsible governance to allow failure in that role to go by without scrutiny.

Some might argue that that scrutiny and oversight role would be better suited to, and carried out more effectively by, the Health Committee. That might be right, but the amendment would not stop HEE officials from being called to give evidence to that Committee. The amendment refers to the Secretary of State for the simple reason that, under clause 98(1), he or she will have responsibility for setting out objectives and priorities for Health Education England

"in relation to the education and training to be provided for health care workers"

If a shortfall in the number of required workers manifests itself, the Secretary of State will be as culpable as the non-departmental body for which he is responsible. Given the lack of requirement for long-term planning in the Bill, there appears to be the potential that a problem could be stored up for years to come. Indeed, reports are beginning to appear stating that that is the case, such as that from the future hospital commission of the Royal College of Physicians.

We need a system of checks and balances to be built into the system to ensure that there is accountability. The Secretary of State must shoulder at least some responsibility for any shortfall in the number of staff. Last year, the Care Quality Commission reported that 17 hospitals were operating with "unsafe staffing levels". Now that the Government are creating a new quango to ensure that there are sufficient numbers of staff, while retaining influence by making yearly direction to Health Education England, we need scrutiny of the Secretary of State's role in that. Does the Minister agree with Opposition Members that any shortfall in the number of staff needed would be serious and that it would be right for hon. Members to be able to scrutinise those responsible effectively?

Dr Poulter: The Government's mandate to Health Education England sets it a clear objective to ensure that the right numbers of staff, with the right values, skills and competencies, are being trained and developed to meet future needs. HEE will co-ordinate and perform a leadership role in making recommendations more broadly about health education and training and, just as we recognise that there is independence in much of what NHS England does, we anticipate similar independence in HEE's role after the passage of the Bill.

It will be for Health Education England to take on board the views of different groups of providers, commissioners and the Royal Colleges to ensure that it comes up with robust proposals, based on its own evidence, for not just short-term, but medium and longer-term work force needs when developing its plan. Equally, as considerable public money is spent—for very good purpose, of course—on undergraduate training for many health care workers, it is important that we can see that supply and demand are closely aligned. For the first time, we will have what amounts to an independent body taking the short, medium and long-term view about work force education and training for the health service, which is a strong step forward and something of which we should all be proud.

Health Education England's objective is to work through the local education training boards—LETBs, as they are often called—to lead a process of improved work force planning to ensure that sufficient staff are trained with the right skills and are available in the right locations to enable health care providers to deliver their commissioning plans. HEE will take a strategic role on those health care professions for which number controls are determined nationally, including medicine and dentistry. It will work with partners in the Higher Education Funding Council for England, the Department of Health and the Department for Business, Innovation and Skills to determine the number and distribution of undergraduate places. Health Education England will consolidate local work force plans into a national five-year plan for England, which will be published and reviewed annually.

4.45 pm

Amendments 162 and 164 focus on the need for integrated and long-term work force planning. I hope I can reassure the hon. Members for Copeland and for Leicester West that that is already provided for in the Bill as part of the scope of the work that Health Education England performs. Amendment 162 would require Health Education England to exercise its functions with a view to promoting inclusive health-related education and training for health care workers, and to ensuring that appropriate long-term planning is undertaken and that the supply of skilled workers is matched closely to demand for them.

I hope I can reassure hon. Members that the Government's mandate to the Health Education England special health authority includes a specific objective for HEE to ensure that the principles of equality and diversity are integral to education, as we discussed previously, and that there is training and development across the NHS and the public health system. Those objectives will continue to apply to Health Education England when it becomes a non-departmental public body.

I entirely agree that it is fundamental that Health Education England undertakes long-term work force planning. It sometimes takes the best part of a decade or more to train a work force—certainly more than a decade if we look at some of the medical work force from the beginning of undergraduate training through to the completion of specialist training. That training can sometimes take a dozen or so years, so it is important that there is a longer-term view on work force planning. That was why we strengthened the Bill in the other place following feedback, consultation and the pre-legislative scrutiny carried out by my right hon. Friend the Member for Sutton and Cheam.

Clauses 98(5) and 104(3)(e) require HEE and LETBs to have regard to long-term objectives for work force planning and the delivery of education and training. Even if it was not explicit before, following the amendments we have made, and thanks to some excellent pre-legislative scrutiny from my right hon. Friend and further discussions in the other place, we have already strengthened the Bill to ensure that long-term work force planning is at the heart of what Health Education England does.

All work force planning—at national level by HEE, or locally by LETBs—should be based on a well-informed long-term work force strategy that looks at needs over the following five or 10 years—or beyond, when that is required. Health Education England special health authority published its first five-year plan for England in December 2013, and it is considering its longer-term strategy for the work force.

I am sure that members of the Committee will agree that it is not possible to set in primary legislation exact time frames regarding what work force plans should look like. We all recognise that the health care work force is diverse. It is a multidisciplinary work force. While it takes five or six years to train a medical undergraduate, the period of training for nursing or other disciplines may be a shorter. Postgraduate training for medical specialities—for example, very topically, the training of an A and E consultant—will take, following the completion of foundation training, a further six years. A GP requires three more years' training after foundation training, while the training for obstetrics

and gynaecology involves another seven years. That period can be longer in some specialities if people undertake further sub-specialist training.

Owing to such variations, it is not desirable to set out in primary legislation exact time frames for work force planning. We have to recognise the important fact that time frames differ for various groups when developing work force planning. However, there is a clear requirement for HEE to have regard to work force planning, and it has already committed, with a five-year work force plan that it published in December, to give us clarity about its thinking.

As someone who works in the health service, albeit on a part-time basis, I recognise the importance of having the right numbers of staff with the right skills in the right place to deliver safe care locally. That is why we have placed a duty on Health Education England under clause 96 to ensure the supply of sufficient skilled health workers. To underpin that duty, clause 99 places a clear duty on Health Education England to have regard to NHS England's priorities for the provision of health services, likely future demand for those services, and the numbers of skilled and trained staff required to meet those priorities.

The Bill places a strong emphasis on partnership working and, through the LETBs, requires local health care providers to demonstrate strengthened leadership and ownership of work force planning and development. Amendment 164 would require the Secretary of State to make a statement to Parliament should HEE project that the number of skilled health care workers available was lower than the required level. It would be inappropriate to legislate for the Secretary of State to make statements in Parliament about such projections. HEE, as a public body, will publish annual plans and be held to account by its board. It is always possible for parliamentary debates to be held and urgent questions to be tabled on work force planning. Hon. Members may influence what is written into the mandate for HEE through such discussions—not least discussions in Committee—should there be a strong desire to change policy. However, one of the great advantages of HEE is that it can take a more independent view and will not necessarily need to have regard to the short-term political expediency that might have characterised work force planning in the past—it is able to take a more holistic view about what is in the interests of the health service. It is good that we have a body with such a role.

HEE is already obliged to report to Parliament annually on its progress on the exercise of its functions under paragraph 28(3) of schedule 5. The Bill sets out a transparent system for work force planning in clause 104, involving the annual publication of work force plans, and clear systems and processes for working closely with partners to produce such plans. When plans project work force challenges or shortages—they will often be looking ahead five years, 10 years or more—Health Education England will be expected to demonstrate evidence of the action it is taking to address that in partnership with arm's length bodies and partners in the health and care system.

Clause 99 sets out that, in its work force planning, Health Education England must have regard to the likely future demand for health services and for persons to work as health care workers. HEE will, of course, try to match supply to demand as far as possible. As everybody knows, work force planning in the health care system is complex and varies from one work force group to another. As increasingly more care will be delivered—for the right reasons—by multidisciplinary teams, it is important that Health Education England looks at health care more broadly and at how it can be delivered more effectively by those multidisciplinary teams, rather than simply looking at silos of individual work force groups.

Changes in health care service provision, new drugs and technological advances in how care is delivered have a big impact on work force planning. That challenge faces every health care system, but it is one that HEE will look at specifically when it puts in place longer term work force plans. Of course we understand that it is in no one's interests to have an under-supply of health professionals graduating from courses or training programmes, which is why there is a clear duty on Health Education England under clause 96 to ensure security of supply.

Clause 98(8) requires Health Education England to keep its plans under review and to publish any revisions. The first five-year work force plan for England was published in December 2013 and will be subject to ongoing review and revision annually. By drawing on plans developed by local health care providers through the LETBs, Health Education England will be able to identify work force pressures early, so far as is possible.

I hope that hon. Members will feel reassured by those remarks, and I ask the hon. Member for Copeland to withdraw his amendment. He and other Members should be assured that Health Education England will take a longer term view of how it does its business and looks after the future interests of our health and care work force.

Mr Reed: I am, of course, disappointed that the Minister does not crave ministerial statements from the Secretary of State for Health in the same way as I do, nor as frequently, but I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 96 ordered to stand part of the Bill.

Clauses 97 to 99 ordered to stand part of the Bill.

Clause 100

ADVICE

Mr Reed: I beg to move amendment 166, in clause 100, page 89, line 6, at end insert—

'(g) professional bodies;

(h) royal colleges;

(i) trade unions;

(j) commissioners;

(k) patients' groups.'.

The Chair: With this it will be convenient to discuss amendment 167, in clause 104, page 92, line 7, leave out subsection (b) and insert—

'(b) relevant commissioners.'.

Mr Reed: The amendments aim to make the process for consultation clearer under clause 100, which amendment 166 would alter, and clause 104, to which amendment 167 applies.

The aim of the Bill, as we have said time and again, is to improve patient care. I will continue to say that everything we do must be driven by the principle, and seen through the prism, of improving outcomes for those who rely on our health services, which includes us all. It is not enough simply to want it; we must match our ambitions with what we do in Committee. A political consensus is developing alongside support from professionals, patients' groups and others that the way to achieve better outcomes is through better integration and better co-operation. As I have argued consistently, the only path to better integration is through better co-operation, and the only path to that is to ensure that strong relationships are facilitated through effective consultation at all stages.

Good consultation is the foundation for all integrated practices; in fact, it is absolutely essential for all services to work effectively together. They need to buy in to what they jointly would like to achieve and to have ownership of the services within their locality, yet the way in which the Bill lays out the framework and guidance for consultation could and should be improved.

Clause 100 deals with advice. Subsection (2), to which the amendment would apply, puts a duty on Health Education England to

"seek to ensure that it receives representations"

from various groups in respect of fulfilling its duties under subsection (1). Those groups are simply those it must consult and seek advice from when exercising its functions.

Amendment 166 would make essential additions to the groups that must be consulted. Subsection (2) sets out in general terms who should be consulted, but does not give Health Education England any freedom to consult others. Amendment 166 would add to the statutory consultees professional bodies, Royal Colleges, trade unions representing health care workers, relevant commissioners and patients' groups.

I am sure we all agree that those bodies contain a significant amount of expertise. There is a danger that the existing drafting of the clause could exclude those groups from giving advice to HEE to assist it in performing its considerable functions under the Bill. I tabled the amendment to seek assurances from the Minister that the groups it specifies will be included. There are assurances in the explanatory notes, but it is not clear that the Bill's wording matches that intention.

According to the explanatory notes:

"This clause stipulates that HEE must make arrangements for obtaining advice from persons who are involved in, or have an interest in, the provision of education and training. The education and training landscape is multi-faceted, and many organisations have an interest in the development of health professionals, ranging from local employers in the NHS through to national organisations such as the professional regulators like the General Medical Council and professional bodies such as the medical Royal Colleges."

However, the vagueness of the drafting of subsections (2) and (3) could mean that those groups are excluded. I understand that subsection (3) makes it clear that representative groups can be consulted, but the worry is that HEE would be under no obligation to speak to them. Subsection (3) states that Health Education England may fulfil its obligations under subsection (2) by consulting representative groups, but there is no duty to ensure that that happens.

Will the Minister assure us that, in all cases, professional representative bodies will be fully consulted? Will he explain why that omission has occurred and why there is a difference in the application of subsections (2) and (3)? Why is there no duty on Health Education England to seek representations from representative groups? The amendment is designed to ensure that the intention behind the clause is fully realised, so if the Minister can give us those assurances or undertake to write to the Committee to provide greater clarity, I will see no reason to test the Committee's opinion on the amendment.

5 pm

I turn to amendment 167, which has the same underpinning principle as amendment 166. The amendment relates to clause 104(4)(b), which places a duty on a local education and training board to involve the providers that it represents in the preparation of its education and training plans, along with commissioners of health services, health and wellbeing boards and any other organisations that it or Health Education England consider to be appropriate. The explanatory notes state:

"It is important that education and training plans are informed by the local needs of the health and public health system."

That is a sentiment with which I agree entirely. The amendment was tabled with that in mind, and I thank the Royal College of Physicians for its assistance in bringing the amendment forward. The RCP expressed concerns that subsection (4)(b) refers only to local commissioners. It fears that that may impede regional and national planning, which require input from NHS England and clinical commissioning groups outside the geographical remit of the local education and training boards. Amending the subsection to read "relevant commissioners" would place a duty on local education and training boards to ensure that all commissioners' plans in their area are co-ordinated and reflect relevant national commissioning plans.

That, in a similar way to amendment 166, would ensure effective consultation could take place with those who need to have input. Subsection (4)(b) currently prevents commissioners outside the area of an LETB from being involved in consultation over the preparation of its education and training plans, which is wrong. I understand that subsection (4)(b) makes provision for a local education and training board to consult other persons it considers to be appropriate, but why not ensure that relevant commissioners are enumerated earlier in the section to make certain that they are involved in the consultation process? I appreciate that I rattled through that, but it was necessary to do so. I hope the Minister can assure us that relevant commissioners will be able to take part in relevant consultation processes, because the better integration of services relies on that.

Dr Poulter: I rise briefly to respond, and I hope I can quickly give the hon. Gentleman the assurances that he seeks. Amendment 166 is designed to require HEE to ensure that it receives representations from specific bodies and groups. Clause 100 requires HEE to

"make arrangements for obtaining advice on the exercise of its functions from persons who are involved in, or who HEE thinks otherwise have an interest in, the provision of education and training for health care workers."

The clause sets out particular groups from which HEE must ensure that it receives representations, specifically:

"(a) persons who provide health services;

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(b) persons to whom health services are provided;

(c) carers for persons to whom health services are provided;

(d) health care workers;

(e) bodies which regulate health care workers;

(f) persons who provide, or contribute to the provision of, education and training for health care workers."

The additional groups proposed in the amendment are already covered by clause 100(2) in the criteria that I have just outlined. Professional bodies and royal colleges are covered by (2)(f). Trade unions are covered under subsection (2)(b), and patient groups by subsections (2)(b) and (2)(c). Subsection (2)(e) makes it clear that HEE may seek the views of representative groups or organisations when seeking advice on its functions.

The hon. Gentleman mentioned commissioners, and clause 99(1)(d), (e) and (f) make it clear that HEE must have regard to the priorities set by commissioners and Ministers across the NHS and public health system when carrying out its functions. In addition, LETBs must ensure that they involve commissioners in the preparation of LETB education and training plans, as set out in clause 104(4)(b). Under HEE, special health authority advisory groups have already been established for professional groups covering medicine, dentistry, nursing and midwifery, the allied health professions, pharmacy and healthcare science. These bring together partners from the professional bodies, professional regulators and trade unions to look at issues related to work force planning, education and training for the professions. HEE also has a patient forum. At a local level, LETBs have established their own networks and partnership arrangements to inform their planning and education commissioning. I hope that hon. Members will feel reassured by this and will feel able to withdraw their amendments.

Amendment 167 seeks to amend the nature of commissioners of health services with whom the LETB must consult from all those in the LETB's area to those deemed "relevant". It is important that local partners across the health and care system have the ability to be involved in the development of education and training plans. That is why we made provision under clause 104(4) for providers of health services, commissioners of health services and health and wellbeing boards to be involved in their development. That is part of helping to deliver an integrated approach to healthcare and health and care education, which is so important, given the challenges we face in delivering more care in the community and in people's homes.

I should also point out that the Bill allows LETBs to involve such other persons as the LETB itself considers appropriate and enables HEE to direct LETBs to involve other persons in the development of its plans. In addition, the Bill is very clear, in clause 104(3), that LETBs must have regard for the priorities of local health care providers, the priorities of commissioners of health services in the area, any assessment of relevant needs relating to the LETB's area prepared under section 116 of the Local Government and Public Involvement in Health Act 2007 and any joint health and well-being strategy related to the LETB's area.

Clause 102 makes it clear that the criteria that the HEE special health authority has used to appoint LETBs requires them to demonstrate meaningful and effective engagement with a much wider range of partners across health, public health, social care and the education and research sector. This includes patient groups, students and trainees and the range of professional bodies and professional regulators with an interest in education and training.

Finally, I should also point out that HEE has a clear duty in clause 99 to have regard for the needs of national commissioners, such as NHS England, and any priorities set by Public Health England in the exercise of its education and training functions. I hope that hon. Members will feel reassured by this and that the amendments are unnecessary as the duties and the purposes of those amendments are already fulfilled in the Bill as it stands.

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

Amendment, by leave, withdrawn.

Clause 100 ordered to stand part of the Bill.

Clause 101 ordered to stand part of the Bill.

Clause 102

LETBs: APPOINTMENT ETC.

Paul Burstow: I beg to move amendment 122, in clause 102, page 90, line 2, after 'health', insert '-related'.

The Chair: With this it will be convenient to discuss the following:

Amendment 123, in clause 102, page 90, line 2, after 'services', insert '(including nursing homes)'.

Amendment 124, in clause 102, page 90, line 6, after subsection (c) add—

'() a person who will represent the interests of carers.'.

Paul Burstow: The clause is simply about who serves on a LETB. Clause 101, which we have just voted on, gives the boards certain delegated responsibilities to do what they can locally to deliver and commission the appropriate health-related education.

I want quickly to talk about the three amendments in my name. Amendment 122 would simply widen the scope of membership beyond a narrow definition of health, to include health-related functions. The intention is to get a wider range of expertise on the LETBs, not least to help with the delivery of the agenda on integration across health and social care, but also beyond that, into other aspects of public health.

Amendment 123 is an attempt to raise with the Minister that, notwithstanding the fact that LETBs must have a majority of NHS providers on them, others have a legitimate interest in the delivery of training and education, not least those in the private care sector, who are large employers of nursing staff. I hope that the Minister says something about that.

Amendment 124 deals with carers. This has been a running theme in the Committee, as the hon. Member for Copeland has said. I make no apologies for that, not least because, according to the census, carers are twice

as likely as non-carer populations to have bad health. We know, from earlier debates, that all too often carers, even when in front of health care professionals, are not identified and do not get the support that they need to be able to carry on with their caring responsibilities. Given that the Government, in clause 102 recognise that a person representing the interests of patients should serve on a LETB, it is strange that someone representing the interests of carers should not do so.

Indeed, the Government's own Health and Social Care Act 2012, which I helped take through this House, specifically mentions carers and the obligations on other NHS bodies when it comes to the involvement of patients. I hope that principle can be extended here, because we can help carers in no better way than to ensure that as part of their education health professionals are trained, right from the outset, to recognise, value and understand the additional health impacts of a carer's responsibilities. I look forward to the Minister's response.

Mr Reed: I again extend my thanks to the right hon. Member for Sutton and Cheam. I want to speak briefly on this issue and I think that some common thought will emerge, as I think it is extremely important. I will be mercifully brief, the Committee will be pleased to hear.

The amendments seek to make additions to clause 102(3), which sets out the types of person who must be represented on a local education and training board. The provisions contained in the subsection are for persons who provide health services in their local area, those who have clinical expertise and the person who will represent the interests of patients. The amendment tabled by the right hon. Member for Sutton and Cheam would make eminently sensible additions to the clause.

My hon. Friend the Member for Leicester West and other Committee members have spoken at length about the need to recognise carers and ensure that their rights are protected, as well as ensuring that we give them as much support and guidance as possible. With that in mind, it makes perfect sense for someone representing the interests of carers to be included on the local education and training board. To be able to fully perform its duties, Health Education England and the local education and training board should have to include carers' representatives in its membership. That has the double impact of ensuring that carers' needs are properly represented, as they quite clearly should be, and of bringing great expertise to the table, which should be welcomed by us all, particularly HEE, with open arms.

Can the Minister explain this omission? I am eager to hear him reassure us that the provision in subsection 3(b) is sufficient to cover the omission, which would mean that persons who have clinical expertise of a description specified in regulations must be members of a local education and training board. Will the regulations brought forward cover carers in the definition, to enable their membership on the boards? If not, or if he cannot answer, will he commit to looking at the issue in greater detail? It would be of tremendous benefit if he did that.

It is entirely sensible to define health services to include nursing homes. Thousands of people rely on those health services and it is essential that providers of that kind are involved with training and education in the local area and the local health economy. Is the Minister able to give assurances that that will be so in practice? It is right that membership of the boards should be expanded to include as wide a range of professionals, representatives and groups as possible, to ensure that local education and training boards can operate to their maximum potential.

I am confident that the Minister will give assurances in good faith. If the right hon. Gentleman presses his amendment, it would receive the Opposition's support.

5.15 pm

Dr Poulter: With regard specifically to amendment 122, I reassure my right hon. Friend the Member for Sutton and Cheam that Health Education England LETBs will plan in an integrated manner, and forge strong partnerships across the health and care system. We recognise that this is essential to deliver a more joined-up approach to health and care. We all recognise that over time the boundaries between health and care will become blurred, and staff will need to be sufficiently skilled to work across those boundaries.

If we are to reduce the silo working that has sometimes taken place, not only between primary and secondary care in the NHS but across health and care, we need a work force with the skills to work in all care settings. That is very much at the heart of what we do and at the heart of the first mandate of Health Education England. I am sure that my right hon. Friend will be reassured to see that this is also contained in the next mandate. Although HEE does not have specific responsibility for the social care work force, it will be expected to work closely with the social care sector at a local and national level to ensure that work force plans properly align, and training meets the future needs of patients.

Amendments 123 and 124 seek to broaden the membership of LETBs to include persons providing nursing home services and persons representing the interests of carers. The Bill is clear in clause 101 that the primary role of LETBs is to discharge HEE's duties under clauses 95 and 96, in respect of health workers in the health service. In setting up HEE and LETBs, the Government are looking to place greater responsibility on local employers to come together to collectively plan the development of the work force across the NHS and the public health system. For too long, local employers have been distanced from the important work force planning that needs to be undertaken to shape the future work force model and ensure high quality education and training. We hope that LETBs will put this right.

Consequently, the Bill requires LETBs to ensure that the majority of their members are drawn from providers of NHS and public health services in their geographical area. As my right hon. Friend made clear in his speech, this is very important. Clause 102 is clear that LETB boards must include members who provide health services in the LETB area. These people should be in the majority, as the primary purpose of the LETB is to plan and commission on behalf of local health care providers.

However, clause 102 also makes provision for LETBs to include people with clinical expertise, people who can represent the interests of patients, and people with an involvement in the education and training of health care workers, such as people from universities. I hope my right hon. Friend will feel that his amendments are unnecessary, because LETBs may also include partners from other sectors and their boards, as set out in

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clause 102(5). Given that HEE and LETBs are required to have regard to the desirability of integrating health provision with health-related or care and support provision, this provides HEE with the flexibility to enable representatives of such groups to be members where appropriate. I hope that my right hon. Friend can withdraw the amendment.

Paul Burstow: I am grateful to the Minister for his response. His response on amendments 122 and 123 is persuasive, but his response on amendment 124 is not. I have not heard a single indication of why it is appropriate to include patients, but not to have a carer's voice. I wonder if the Minister might answer that.

Dr Poulter: My right hon. Friend is right to pick me up on that. In attempting brevity, I neglected an important point. He is right to highlight the importance of carers in delivering health care and of supporting them to do that. The Bill makes provision for the representation of carers in clause 100(2)(c). That clause requires HEE to ensure that it receives representations on the exercise of its functions from a wide range of stakeholders, including carers for people who receive health services or, as specified in clause 100(3), those organisations that represent carers for persons to whom health services are provided. Clause 100 also requires HEE to seek advice from patients or those groups that represent them.

I should also point out that clause 104 permits HEE to direct the local education and training board to involve specific groups in the preparation of its education and training plan, which will allow carers' organisations to play an appropriately full part. I hope that that is further reassurance for my right hon. Friend.

Paul Burstow: The fact that HEE has those obligations is very helpful, as are the further undertakings on the potential to direct local education and training boards. I hope, however, that the Minister will continue to reflect on the fact that, as a Government, we have an opportunity at a local level not just to pay lip service to the issue of carers, but to ensure that it is part of the remit of one of the bodies that delivers education. With that, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 102 ordered to stand part of the Bill.

Schedule 6 agreed to.

Clauses 103 to 107 ordered to stand part of the Bill.

Schedule 7 agreed to.

Clause 108 ordered to stand part of the Bill.

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

5.24 pm

Adjourned till Thursday 30 January at half-past Eleven o'clock.

Written evidence to be reported to the House

CB 24 British Medical Association
CB 25 Staffordshire County Council
CB 26 Unite the Union
CB 27 Social Landlords Crime and Nuisance Group
CB 28 Chartered Institute of Housing
CB 29 Colin Slasberg