PARLIAMENTARY DEBATES

HOUSE OF COMMONS
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GENERAL COMMITTEES

Public Bill Committee

CARE BILL [*LORDS*]

Fifteenth Sitting

Tuesday 4 February 2014

CONTENTS

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Saturday 8 February 2014

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

The Committee consisted of the following Members:

Chairs: HUGH BAYLEY, †ANDREW ROSINDELL

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

Fergus Reid, *Committee Clerk*

† attended the Committee

Public Bill Committee

Tuesday 4 February 2014

[Andrew Rosindell *in the Chair*]

Care Bill [*Lords*]

8.55 am

The Chair: It may be helpful for Members to know that between now and 11.25 am the Committee proceeds as normal. At 11.25 am, proceedings will be interrupted as per the programme order, and only those questions necessary to dispose of questions already proposed, questions on proposals I have selected for separate decision and proposals made by a Minister of the Crown are put, without further debate. If any Member is seeking a separate decision on a proposal that is likely to be reached after the programme knife has fallen, that Member should let me know.

New Clause 1

Rights of appeal

'(1) In section 26 of the Health and Social Care Act 2008 (registration procedure: notice of proposals), after subsection (4) insert—

"(4A) Where a proposal under subsection (4) names an individual and specifies action that the Commission would require the registered person to take in relation to that individual, the Commission must give that individual notice in writing of the proposal."

(2) In section 28 of that Act (notice of decisions), in subsection (6), for "subsection (7)" substitute "subsections (7) to (9)".

(3) In that section, after subsection (7) insert—

"(8) But in a case where notice of the proposal has been given to an individual under section 26(4A) subsection (7) does not apply unless, by the time the Commission receives the applicant's notification, it has received notification from the individual that he or she does not intend to appeal.

(9) And if the Commission receives notification from the individual after it receives the applicant's notification and before the end of the period mentioned in subsection (6)(a), the decision is to take effect when the Commission receives the individual's notification."'.—*(Norman Lamb.)*

Brought up, and read the First time.

The Minister of State, Department of Health (Norman Lamb): I beg to move, That the clause be read a Second time.

It is so good to be back for the final time. I do not know whether the shadow Minister saw the notice again as he came into the office this morning, "The end is nigh", but it certainly is for this Committee's deliberations.

People at the head of an organisation set the tone for the quality of care provided. Events at Mid Staffordshire hospital and Winterbourne View starkly illustrated that some people in charge of organisations delivering health and social care services did not pay enough attention to the safety and quality of care that the organisation was providing. I think we all agree that this is completely unacceptable, whoever the provider is. The Government have been clear that there needs to be a sharper focus on corporate accountability for failures in care—who let it happen, how were the conditions created that enabled it to happen and how can we hold individuals and boards to account for that failure? We have made it clear that we will introduce a new fit and proper person test for directors of providers registered with the Care Quality Commission. That will allow the CQC to take action against a registered provider that would result in the removal of an individual director.

The Department will shortly consult on a new requirement for registration with the CQC. It will specify that directors of providers registered with the CQC will need to be fit and proper persons to fulfil their role within a registered provider. That new requirement will fill a gap in the current arrangements for accountability to the CQC, and will apply across the board with all registered providers, public, private or third sector. It is our intention that this new regulation will come into force in October alongside the new fundamental standards. The key responsibility for the fitness of directors will continue to lie with providers themselves, but the new requirement will enable the CQC to form its own judgment about the fitness of directors. It will do this when providers apply to the CQC for registration, refusing to register those providers that cannot satisfy the CQC of the fitness of their directors.

In the case of providers that are already registered with the CQC, it will be able to assess the fitness of directors when it inspects providers and when it is notified of the appointment of a new director. There is already an obligation on providers to notify the CQC of the appointment of a new director. In cases where the CQC cannot be assured that a director is fit, it will be able to place a condition on the provider to require that director's removal. It is only right that in such cases the individual director, given that the CQC would in effect be removing their livelihood, as well as the registered service provider, has a right of appeal against the CQC's actions. The new clause introduces a right of appeal to the first tier tribunal for individuals who are removed from their post as a result of action taken by the CQC. I hope that that satisfies the Committee.

Mr Jamie Reed (Copeland) (Lab): I am grateful to the Minister for tabling this new clause. We believe that the principle behind it is eminently sensible, and there is no opposition to it from these Benches. Only two small points require clarification. First, it is absolutely right that protections must be in place for workers at any level to ensure that they can be removed from their position only when it is absolutely just and, sadly, necessary. Can the Minister give assurances that this measure will not allow people who should not be in their positions to hang on indefinitely through lengthy legal procedures?

Secondly, on the opposite side of the coin, we need to ensure that persons in place cannot be removed too easily. Will the Minister assure us that the fit and proper persons test is not a moveable feast, is not open to unnecessarily broad interpretation, and cannot be altered simply to get rid of a person for a reason other than their conduct in their job or their performance?

Norman Lamb: I thank the shadow Minister for those perfectly legitimate questions. We are agreed here about the purpose and principle of this. One cannot have a

situation whereby someone can lose their livelihood without any right of challenge, and the new clause provides for that right of challenge. The aim is absolutely to ensure that there is a robust test for deciding whether someone is a fit and proper person, and that the CQC undertakes that properly when notified of a new director or when a provider first registers. The CQC must not act arbitrarily, and of course it would be challengeable by way of judicial review if it acted in that way. Both extremes are equally to be avoided, and the test must be used properly to prevent people who are not fit and proper from continuing in their role. That would have potential consequences for the care of individuals, which is what this is all about. Yet, equally, someone must not be removed without good reason.

The right of appeal exists in relation to both action by the CQC and also for an individual, such as an employee director or an executive director, who is removed by a company. They still have their normal employment rights, which continue to exist without any disturbance as a result of the new clause. This is an added protection, which ensures that the power to remove is not used inappropriately or arbitrarily, to the unfair disadvantage of an individual. It has to go alongside what I consider to be a very welcome test of whether a director is a fit and proper person to undertake work that is of acute importance in the sector.

Question put and agreed to.

New clause 1 accordingly read a Second time, and added to the Bill.

New Clause 2

INTEGRATION OF CARE AND SUPPORT WITH HEALTH SERVICES ETC: INTEGRATION FUND

'(1) At the end of section 223B of the National Health Service Act 2006 (funding of the National Health Service Commissioning Board) insert—

"(6) Where the mandate specifies objectives relating to service integration, the requirements that may be specified under section 13A(2)(b) include such requirements relating to the use by the Board of an amount of the sums paid to it under this section as the Secretary of State considers it necessary or expedient to impose.

(7) The amount referred to in subsection (6)—

(a) is to be determined in such manner as the Secretary of State considers appropriate, and

(b) must be specified in the mandate.

(8) The reference in subsection (6) to service integration is a reference to the integration of the provision of health services with the provision of health-related services or social care services, as referred to in sections 13N and 14Z1."

(2) After section 223G of that Act (meeting expenditure of clinical commissioning groups out of public funds) insert—

"223GA Expenditure on integration

(1) Where the mandate includes a requirement in reliance on section 223B(6) (requirements relating to use by the Board of an amount paid to the Board where mandate specifies service integration objectives), the Board may direct a clinical commissioning group that an amount (a "designated amount") of the sums paid to the group under section 223G is to be used for purposes relating to service integration.

(2) The designated amount is to be determined—

(a) where the mandate includes a requirement (in reliance on section 223B(6)) that designated amounts are to be determined by the Board in a manner specified in the mandate, in that manner;

(b) in any other case, in such manner as the Board considers appropriate.

(3) The conditions under section 223G(7) subject to which the payment of a designated amount is made must include a condition that the group transfers the amount into one or more funds ("pooled funds") established under arrangements under section 75(2)(a) ("pooling arrangements").

(4) The conditions may also include—

(a) conditions relating to the preparation and agreement by the group and each local authority and other clinical commissioning group that is party to the pooling arrangements of a plan for how to use the designated amount (a "spending plan");

(b) conditions relating to the approval of a spending plan by the Board;

(c) conditions relating to the inclusion of performance objectives in a spending plan;

(d) conditions relating to the meeting of any performance objectives included in a spending plan or specified by the Board.

(5) Where a condition subject to which the payment of a designated amount is made is not met, the Board may—

(a) withhold the payment (in so far as it has not been made);

(b) recover the payment (in so far as it has been made);

(c) direct the clinical commissioning group as to the use of the designated amount for purposes relating to service integration or for making payments under section 256.

(6) Where the Board withholds or recovers a payment under subsection (5)(a) or (b)—

(a) it may use the amount for purposes consistent with such objectives and requirements relating to service integration as are specified in the mandate, and

(b) in so far as the exercise of the power under paragraph (a) involves making a payment to a different clinical commissioning group or some other person, the making of the payment is subject to such conditions as the Board may determine.

(7) The requirements that may be specified in the mandate in reliance on section 223B(6) include requirements to consult the Secretary of State or other specified persons before exercising a power under subsection (5) or (6).

(8) The power under subsection (5)(b) to recover a payment may be exercised in a financial year after the one in respect of which the payment was made.

(9) The payments that may be made out of a pooled fund into which a designated amount is transferred include payments to a local authority which is not party to the pooling arrangements in question in connection with the exercise of its functions under Part 1 of the Housing Grants, Construction and Regeneration Act 1996 (disabilities facilities grants).

(10) In exercising a power under this section, the Board must have regard to the extent to which there is a need for the provision of each of the following—

(a) health services (see subsection (12)),

(b) health-related services (within the meaning given in section 14Z1), and

(c) social care services (within the meaning given in that section).

(11) A reference in this section to service integration is a reference to the integration of the provision of health services with the provision of health-related services or social care services, as referred to in sections 13N and 14Z1.

(12) "Health services" means services provided as part of the health service in England."'.—*(Norman Lamb.)*

Brought up, and read the First time.

Norman Lamb: I beg to move, That the clause be read a Second time.

The Chair: With this it will be convenient to discuss amendment (a), line 74 after 'regard to', insert 'the duty to promote wellbeing in section 1 of the Care Act 2014, and'.

Norman Lamb: New clause 2 establishes the better care fund, to promote joint working between the NHS and care and support services. Disjointed care causes frustration for people who receive it and for their carers, and wastes resources on delays, repeated assessments and avoidable admissions. It is not a sustainable way for the NHS or, indeed, care services to meet the needs of an ageing population living with complex conditions. I suspect that we all agree about that basic principle.

Looking at my hon. Friend the Member for Strangford reminds me that I once visited Northern Ireland as the shadow Liberal Democrat Health Secretary to see their integrated boards and integrated trusts for health and care and to ascertain what lessons we could learn in England from what I thought was a more enlightened approach, which has existed for some time in Northern Ireland. The trend internationally is for recognition that integrated care, as a model of care, is best for a more preventive approach to health care. Joined-up services can transform people's experience of care and increase quality and value.

I recently visited Greenwich, one of the 14 pioneers in integrated care. They have a fantastic community-based emergency response unit, joined up between health and care, to ensure that people do not go unnecessarily to hospital when, with better support in the community, it could be avoided. Since establishing that, they have managed to save 2,000 people going to hospital unnecessarily. We can imagine the impact that that has on the individuals concerned, and also the savings to the system, which can be very substantial.

We can look also at Torbay, which has built an integrated care economy—some of my hon. Friends will be very familiar with the great work that is under way there—and is now experiencing savings and reductions in admissions. I know that my hon. Friend the Member for Totnes will be very familiar with that, as will my hon. Friend the Member for Truro and Falmouth. One reason that there are not more examples like Torbay is because the NHS and local government have separate budgets and objectives, limiting their incentive to work together. In a sense, we have a situation whereby great people, as in Torbay, do brilliant things despite the system, rather than because of it.

In this Parliament, the NHS has transferred more than £2 billion of funding for care and support that benefits health. This has helped protect services and encouraged integration, recognising the importance of care and support to the NHS. It is now time, it seems to me, to go much further. The better care fund combines £3.8 billion of NHS and local authority funding, which will be jointly invested in integrated care. Pooled budgets are a recognised way of improving integration and overcoming traditional silos. They are one of several measures that the previous Government introduced to facilitate joint working. Unfortunately, they were never translated into mainstream use and that is what we are now trying to do.

Both the Dilnot commission and the Health Committee recommended encouraging more areas in which to pool resources. We agree and the new clause will ensure that every area has a pooled budget for integrated health and social care. In every part of the country, the NHS and local government are already sitting down together and agreeing how they will join up services. The plans that they develop will commit to fundamental principles of personalised, integrated, joined-up health and social care. That includes: first, ensuring that health, care and support work together, sharing data critically and improving continuity of care; secondly, acting earlier so that people can stay healthy and independent at home and avoid going into hospital or to accident and emergency; and, thirdly, delivering care that is centred on individual needs, for example, NHS and social care staff working together to provide seven-day services, ending this ridiculous five-day mentality that means that people are more at risk over a weekend than on a weekday if something happens to them, and having a named care co-ordinator.

Chris Ham, from the King's Fund, describes the fund—contrary to the mean-spirited description by the Opposition—as a,

"much more ambitious approach to delivering integrated care and a real opportunity to improve the co-ordination of services for patients and service-users".

Meg Munn (Sheffield, Heeley) (Lab/Co-op): It is not the fund that is the problem, but the fact that it is top-sliced from other budgets.

Norman Lamb: Welcome back to the hon. Lady. I am not sure which side of the bed she got out of this morning. I hope it is her constructive side, whereby she contributes so brilliantly to debates in Committee, rather than on the one occasion when she got out on the slightly grumpy side, which was less constructive.

Meg Munn: Which side did you get out of?

The Chair: Order.

Norman Lamb: We have tried to make the point repeatedly that, yes, of course, this is not new money. It is utilising the existing resources within health and social care so much better. As the hon. Member for Leicester West rightly said, when I intervened on her in one of our early sessions to ask whether it was about new money, it is about using the existing resources to better effect by bringing them together in a more effective way.

The criticism we have heard from the Opposition is that somehow pooling £3.8 billion does not go far enough. I disagree: the fund is the largest financial incentive, by any Government, to ensure that everywhere gets to grips with integrated care. It is not necessary to integrate the entire budget to deliver this change. Remember this is new for most areas. We want to start with an ambitious but realistic amount. We are clear that pooled budgets will be an enduring feature of the health care system. 2015-16 is the first year, the foot in the door that will establish the relationships and framework for integration in every part of the country. We can build upon it in the future. If we talk to people who are doing this at a local level, there is a sense of ambition that people want to

take advantage of the opportunity and that it has triggered discussions that have not happened up until now. That is wholly to be welcomed.

Bill Esterson (Sefton Central) (Lab): We all welcome the move towards joint working and pooled budgets, but the point about the £3.8 billion is that it has been taken from somewhere else, in this case in the NHS. It is the lack of assessment and analysis of the impact of that change on what that money is being spent on at the moment that concerns us.

Norman Lamb: In a sense, I come back to the challenge that I made earlier. If the Labour party is saying that it will give a whole load more money to the NHS, we need to hear it. I have not heard it so far. Indeed, the shadow Chancellor recently made it clear that there would be spending strictures on a possible future Labour Government. It needs to be more than rhetoric about challenging our ambition. If the hon. Gentleman is saying that there needs to be a whole lot more money, he needs to say where it is coming from. For us, as the shadow Minister said, it is about better use of the resources to achieve more from the resources that are available.

Local authorities will have the flexibility to share additional funding. There are signs that this is happening. The London triborough is exploring pooling some £450 million of funding—five times the amount we have asked it to pool—to have integrated residential, domiciliary, community, primary and emergency care. New clause 2 creates the legal framework for NHS involvement in the better care fund by ensuring that clinical commissioning groups pool budgets with local government for use on integrated care. It is primarily enabling legislation because the mandate will include objectives and requirements for how the fund operates.

The new clause enables the mandate to specify what funding the NHS should contribute and the need to work with local government. NHS England will ensure that the pooling happens between CCGs and local authorities. It would have powers to tell CCGs what amount to include in the pooled budget, and would release the funding only once satisfied that there was a robust, locally agreed integration plan. It could also attach conditions to the funding, including performance objectives, such as improved patient experience and reduced emergency admissions so that we achieve something tangible for patients as a result of the pooling arrangement.

A new duty would require NHS England to use those powers in the combined interests of health and social care. My right hon. Friend the Member for Sutton and Cheam tabled amendment (a), which would link that to the duty on a local authority in clause 1 to promote individual well-being. I sympathise with his intention. Joined-up care is fundamentally about personal well-being, and local plans must deliver an improvement in patient experience.

9.15 am

However, when we debated similar amendments earlier this month, I assured him that NHS England and local government have duties to promote well-being that arise from the NHS Act 2006, from the NHS constitution and from part 1 of the Bill. I make the same argument as before, namely that the amendment is not necessary to put well-being at the heart of the better care fund.

Paul Burstow (Sutton and Cheam) (LD): I am grateful to the Minister for setting out the Government's position on my amendment. Can he tell me where in the Bill the new clause will be inserted?

Norman Lamb: I hope that in time, perhaps after my right hon. Friend has spoken, I will have an answer for him. I will ponder the matter and seek guidance from on high.

There is a risk of confusion because the well-being principle in the Bill applies to individuals, whereas NHS England, to which the new clause relates, will assess need for services at population level. I hope, therefore, that my right hon. Friend will withdraw the amendment.

The better care fund is a real opportunity to make integrated care business as usual rather than the exception in every part of the country, which would make better use of public resources for the interests of patients and those who use services. The new clause would make that possible, and I encourage hon. Members—

Liz Kendall (Leicester West) (Lab): The Minister wants local NHS bodies and councils to pool their resources and make them work properly for local people. How does he square that with the fact that the Government are taking money out of the better care fund to set up the new metering system for the cap on care costs? What if local organisations decide that their priority is to improve care for people right here, right now?

Norman Lamb: It seems to me that it is all part of one whole. Our work on the better care fund is part of the same objective as the reforms in the Bill, which include the Dilnot reforms. We will achieve the objectives of better care, better use of available resources and a fairer funding system than we have had hitherto only if we act on all those aspects of the sum total. It is sensible to pool all those resources in the better care fund because they are all aimed at the same objective.

Liz Kendall: I can see how a full and proper assessment of somebody's needs, which considers their well-being and that of their family, is absolutely part of improving the quality of care and support. As I understand it, however, £50 million capital funding is coming out of the better care fund to set up the care accounts, with which people will simply keep a check on how much they have spent on care. How is that central to the better care fund's objectives regarding quality of care? It is essentially an accounting system that allows people to check how much they have spent on care, so that they know when they have hit the cap. Why will the funding for that system come out of the better care fund?

Norman Lamb: Because that is all part of the investment that is required to achieve a much better system. We cannot ignore the need for investment in IT to deliver better care and achieve the objectives in the new clause, in the Bill and in the better care fund proposals.

Liz Kendall: I am all for IT to help people manage their long-term conditions at home and to help check if older people are falling, but this is just an account to check how much has been spent on care. Why are the Government taking that out of the better care fund?

Norman Lamb: Sometimes boring things have to happen in the back office to facilitate great things.

Liz Kendall: If there is to be a cap, people will need to clock up how much it will take to hit that cap. Our concern, however, is that although the Government are right to bring budgets together, they are delving more and more into the better care fund for doing things that it is not designed for. This is about care, not about an accounting system—*[Interruption.]*

Norman Lamb: My hon. Friend the Member for Weston-super-Mare asks from a sedentary position where the money could come from if not there. I repeat—*[Interruption.]*

The Chair: Order.

Norman Lamb: Thank you, Mr Rosindell, for leaping to my defence in the face of the aggressive challenging from a sedentary position by the Opposition. Sometimes, tedious back office things have to happen to facilitate great things. We cannot just will the investment in IT to allow the reforms to happen. They need to be paid for and it is sensible to pool all the resources to achieve all these aims, because they are part of a whole.

I can now give an answer, having thought about it for a while, to my right hon. Friend the Member for Sutton and Cheam. New clause 2 will eventually be inserted as a new part 4 of the Bill. I hope that helps.

Paul Burstow: That does, because it underlines the need for the amendment. I will explain that need a little further and, while doing so, continue to reflect on what the Minister said on why the amendment should not be the subject of a Division.

The new clause establishes the mechanism for the better care fund to develop and grow over time. We are having a debate about one important year: the year in which we start implementing the new system in the legislation that we are debating. It is, therefore, hardly surprising that any Government, faced with a finite amount of money—no matter how much that might be—would decide that the changes should be funded partly in this way. That poses the question: if not in this way, where would the money come from? It cannot be knitted out of thin air; it must be accounted for and this is the vehicle by which it can be made transparent and delivered to local authorities.

The point I wanted to make by tabling the amendment is that while the Minister argued that well-being is part of the way in which the NHS works and an inherent part of the NHS constitution, I do not believe that that is as clear in its practice and organisation as it needs to be. The benefit of the Bill is that it makes explicit for the first time what is meant by individual well-being. That is a principle, purpose and way of organising public services that ought to affect and inform the way in which the NHS works. That is why, certainly when budgets are being pooled and allocated in the way in which the new clause intends, that makes sense.

Norman Lamb: My right hon. Friend knows that I am completely with him in what we are trying to achieve. An individual's well-being is at the heart of decisions taken, once we pool the funds and the money is committed to new ways of working at a local level. I also agree with his comments on the interventions from the Opposition. This is investment in social care information systems. It is clear to me that in order to facilitate joint working and effective sharing of information and data there has to be investment in IT. If that is not there we will not realise the potential of this incredibly exciting development.

Paul Burstow: I agree with the points the Minister has made. Having listened and given further thought to what the Minister said, I will not press the amendment. However, the agenda needs to be returned to, either by this Government or a future one. We will need to legislate to make it clear that the NHS is bound by a well-being principle, just as social care will be in future.

Jim Shannon (Strangford) (DUP): I want to put a question quickly to the Minister. First, I welcome the fact that the Minister has been to Northern Ireland. I knew he had been there to see the system we have that works. It is good to exchange thoughts and ideas on how to do it better. That is good news.

I want to ask about the integration fund. Is there full visibility of the cumulative impact of cost pressures on providers in the system and the level of risk to a financially and clinically sustainable service? The better care fund, with the transfer of money away from NHS services, requires a supported transition. What protection is there for providers who will run into financial difficulties before they realise the benefits of integration?

Norman Lamb: I am grateful to the hon. Gentleman for that question. I very much welcome opportunities for more shared thinking. One thing we are trying to do with the integrated care pioneers is establish international links. The challenges we seek to address with the better care fund and the pioneers face every health economy across the world. All of the best countries in health policy terms are moving in that direction, to a model of joined-up, integrated care, recognising the fact that the greatly increased challenge for the health and care system is that people now live for many years with multiple chronic conditions.

At the moment we have 1.9 million people living with three or more chronic conditions. That figure is likely to rise to 3 million people by 2025. We have a system that we know is under quite a lot of strain now in terms of resource. That is why we are trying to make better use of the resource. Imagine the increased pressure on the system of moving from 1.9 million with three or more chronic conditions to 3 million.

The need for this reform and change is overwhelming. It is absolutely imperative that we find better ways to use the resources available. I say to the hon. Member for Strangford that if we carry on with business as usual, the providers of care will inevitably suffer a greater and greater squeeze. That in turn will pose risk to quality of care. We need to make better use of the resources available, focusing on keeping people out of hospital and reducing the need for people to go into care homes and nursing homes in the first place. Hon. Members who have been to Truro will have seen that the number of people who need to go into care homes and nursing homes has been reduced because they are kept in better

health. The focus is on people's well-being, which my right hon. Friend the Member for Sutton and Cheam has rightly talked about repeatedly.

If the number of people going into care homes and nursing homes is reduced, resource is freed up, which can be spent on helping providers to deliver good quality care. To coin a phrase, there is no alternative but to move away from the traditional ways of working. Care workers should get proper terms and conditions. It is unacceptable that under the traditional approach some of the lowest-paid workers are getting squeezed and many who work in the sector are not paid the minimum wage.

9.30 am

We need to free up resources to properly fund care from providers. Whether they are from the public sector, the private sector or the third sector, we must ensure that we always get high quality care. Good care does not come on the back of exploiting the work force or by putting providers under financial strain. That is an extraordinary existential challenge to the system, which any party in government will face. These changes are therefore essential.

Mr Reed: The Minister is right that business as usual is unconscionable and the status quo is not acceptable. He, like every other Committee member, will have seen the BBC News reports today about providers refusing to be involved in local authorities' provision of adult social care services because they do not want to be associated with 15-minute slots. They think that that time period is shameful and not adequate to cater for people's needs.

The Minister is absolutely right that what we do here today has to be tangible to patients. Like me, he will know that local authorities are concerned that the £130 million that the Government intend to spend on adult safeguarding boards and assessments for carers will come from the better care fund. I would appreciate some clarity on whether that is right; I believe that point came out from the Joint Committee on the draft Bill.

Despite our exchanges this morning, there is still some confusion about exactly where the money for the fund will come from. We need precise details on where the £3.8 billion will come from, and unfortunately that detail has been absent to date. In the long run, as we have said this morning and over the course of the Committee, the Opposition want to go much further on integration. Given that £1.8 billion has been cut from adult social care since 2010, there is a fear that the reality of the Bill will not match the rhetoric surrounding it, notwithstanding the Minister's laudable ambitions. That is a fear not only of care providers, care users, local authorities and the Opposition, but of the Department. NHS England's medical director, Sir Bruce Keogh, said that there is a need to be "absolutely clear" about how the money will be spent. He said that there is "great scepticism" about the fund meeting the needs it is claimed it will be used for. We share Sir Bruce's scepticism, so we seek absolute clarity on this issue. If the Minister cannot provide it today, I hope he will write to us before Report.

Norman Lamb: I thank the shadow Minister for raising those issues. I want to come back at him gently on his challenge about the scale of the ambition. Before 2010, I repeatedly made the case for integrated care and for joining up the system, and it fell on stony ground; I got no reaction from the Labour Government. Yes, there were isolated examples of great practice. As I said earlier, great people were doing brilliant things despite the system, not because of it. I absolutely acknowledge that that Government provided for the opportunity to create care trusts and to pool budgets, both of which were good things, but there was no central commitment or drive to integrated care.

Over the 13-year period of the previous Labour Government, if anything, the fragmentation of the health service grew stronger. The creation of very strong—*[Interruption.]* Let me make my case; I am concerned for the welfare and well-being of the hon. Member for Sheffield, Heeley—she is looking anxious. Very strong foundation trusts were delivering mental health services completely separately from the rest of the health system. From the individual's point of view, it makes no sense institutionally to fragment mental health from physical health. It seems to me, as the shadow Secretary of State now acknowledges, that we should look at the whole health of an individual, rather than seeking to look at their mental health entirely separately from their physical health.

The Government's move to take the biggest ever step to join up the system, in terms of financial incentive, is massively overdue. I acknowledge that good things happened under the shadow Minister's Government, but they were limited. On the big ambition, when I made the case, I got no response suggesting a commitment to that from that Government.

Liz Kendall: I have to say for the record that there were many bold initiatives under the previous Government, including an entire White Paper, "Our health, our care, our say", which was the first time that such a thing had been set out in Government as a broad strategy, covering a whole range of hospital, primary, community and care services. It is simply wrong for the Minister to wipe that off the record. How did he come up with the figure of £3.8 billion? Why is it not more?

Norman Lamb: My comments were in response to the shadow Minister's suggestion that what is proposed is not particularly ambitious. It is incredibly ambitious and really challenges a traditional system. I completely agree that great things were happening in lots of different places, such as in Torbay and north-east Lincolnshire, and there was the brilliant social enterprise in Central Surrey Health. In terms of whole-system change, however, nothing significant happened. Of course, we have to start with small acorns, but the point I am making is that this Government are seeking to implement whole-system change to create the momentum for the entire country to move decisively towards joined-up working.

Meg Munn: It is such nonsense to trash the record not only of the previous Government, but of the Conservative Government back in the late '80s and early '90s. This goal has been sought for a long time. I could perhaps put up with some of what the Minister is saying if the proposals were the perfect answer, but they are not. They are flawed, and that is our concern. People tried to do a great deal. They had ambition for integration in the late '80s and '90s and throughout the

[Meg Munn]

Labour Government, but rewriting history is something that the Liberal Democrats do incredibly well, as we know.

Norman Lamb: Oh dear. I have clearly upset the hon. Lady, and I apologise for that. I tried to acknowledge that good things happened under the previous Government, but when I tried to raise the case for whole-system integrated care, it fell on stony ground. It is just a matter of record that there was not the response I was looking for at that time. My comments are about resisting the claim that the objective lacks ambition. It is extraordinarily ambitious and of course, the amount of money that we have committed to it is a result of the discussions on the spending review. I am delighted that we have managed to secure that amount of money. I say again that that is as a minimum.

Interestingly, Sandie Keene and others in the Association of Directors of Adult Social Services and elsewhere have reported that, in many areas, there is an intention to be more ambitious; people see the measure as a starting point and will potentially go well beyond it. Time will tell whether that becomes fact. It seems that, whoever is in government after the next election, that is here to stay. That is the way of the future. It is something to build on to create a much more rational use of available resources.

Liz Kendall: Not that the Minister needs advice, but I have perhaps a word of warning. The clause will give NHS England quite a lot of power to direct people how to spend the budget. Speaking from my experience of how the Department and NHS management work, the clause could become a top-down measure. It could end up being prescriptive about exactly how the money is to be used. The Minister wants to ensure that the money is spent on integration and change, but I warn him: I think that the measure is a top-down amendment. He and any Minister will need to keep a close eye on NHS England to see that it does not just take over the money; that would stop local players from working together if they were ordered to do something from above, rather than allowed to figure out together how to do it. The risk is that the amendment is a top-down directive.

Norman Lamb: I take the hon. Lady's point. I suspect that she would agree that there is always a tension between seeking to encourage and facilitate change and creating incentives for it from the centre, and empowering local areas to do great things. The clause seeks to get the balance right between ensuring that the fund is there—there has to be a mechanism requiring NHS England to deliver on the Government's objective—and allowing discussions, which are happening at this moment, in local areas between health and social care on developing a local plan with clear objectives in mind, rather than there being prescription about how objectives should be achieved. Take the criteria that I outlined: seeking to reduce avoidable readmissions and delayed discharges, and to improve the experience of service users and patients. Setting clear criteria about good objectives for patients, but allowing the local area to come up with plans on how they achieve them, is the right way forward.

However, I totally accept the warning. The clause is an innovation; it will be a new way of working. Of course, lessons will be learned in the first year, and whoever is in power after 2015 will have to adapt and grow the initiative. I suspect that, despite our debate this morning, we are all agreed on what we are trying to achieve; that this is the way of the future; and that it has to develop further. Of course, lessons will be learned, but the clause is the right way to start. Incidentally, we have resisted the temptation to threaten to remove money from areas that do not achieve the objectives of improved patient care. Areas will not lose money, but will have assistance in improving how they work to achieve those objectives.

Mr Reed: The Minister is being accommodating in taking so many interventions. His latest contribution demonstrates what we are trying to get at: his thinking is far more advanced than that laid down in the clause. Can I tempt him further? He may come on to answer this point, but can he provide in writing, before Report, the clarity that we and Sir Bruce Keogh seek?

9.45 am

Norman Lamb: I was going to say—I have written it down—that I am happy to write to the shadow Minister and other Committee members setting out the breakdown of how the money is made up. *[Interruption.]* Lots of pieces of paper are arriving that I need to look at. I hope I have not said anything wrong.

The shadow Minister mentioned the intervention from Professor Sir Bruce Keogh—wonderful to have two different titles to your name. There is strong support among CCG leaders for our approach. The *Health Service Journal* surveyed commissioners and found strong support for the initiative. There will of course be concerns among acute providers, due to the financial pressure on the acute system, but I suspect that we all agree on the payment-by-results system. I entirely understand why it was introduced. We touched on it earlier. It introduced a degree of transparency in accounting for how money was spent. It was introduced, to start with, because people were waiting a long time for treatment and it created an incentive to get people through to treatment. Ultimately, it created an incentive for more activity in acute hospitals, which is not rational in a system that seeks to prevent ill health and prevent deterioration of health. We must change the system to create an incentive to prevent deterioration of health.

There will be concerns about the financial pressures on acute providers, but they must be involved in the discussions at local level. The impact of different ways of working on the acute sector must be considered to ensure that the system works rationally. The great initiatives for joined-up integrated care by the 14 pioneers have involved the acute trusts, and are in many cases redesigning incentive and payment systems. Monitor and NHS England have given a clear licence for areas to move away from payment by results, to deliver better, more rational payment systems to achieve better prevention of ill health. The acute trusts in those areas are very much part of that reform.

I am enormously proud of this brilliant initiative. There are of course risks in everything ambitious one seeks to do, but if we proceed and are committed to

building on its foundations, we can see a vision of a better health and care system that is better at preventing ill health and maintaining people's well-being—something that my right hon. Friend the Member for Sutton and Cheam repeatedly and rightly focuses on—and better at using the resources available to us.

Question put and agreed to.

New clause 2 accordingly read a Second time, and added to the Bill.

New Clause 28

PART 1 APPEALS

'(1) Regulations may make provision for appeals against decisions taken by a local authority in the exercise of functions under this Part in respect of an individual (including decisions taken before the coming into force of the first regulations made under this subsection).

(2) The regulations may in particular make provision about—

(a) who may (and may not) bring an appeal;

(b) grounds on which an appeal may be brought;

(c) pre-conditions for bringing an appeal;

(d) how an appeal is to be brought and dealt with (including time limits);

(e) who is to consider an appeal;

(f) matters to be taken into account (and disregarded) by the person or body considering an appeal;

(g) powers of the person or body deciding an appeal;

(h) what action is to be taken by a local authority as a result of an appeal decision;

(i) providing information about the right to bring an appeal, appeal procedures and other sources of information and advice;

(j) representation and support for an individual bringing or otherwise involved in an appeal.

(3) Provision about pre-conditions for bringing an appeal may require specified steps to have been taken before an appeal is brought.

(4) Provision about how an appeal is to be dealt with may include provision for—

(a) the appeal to be treated as, or as part of, an appeal brought or complaint made under another procedure;

(b) the appeal to be considered with any such appeal or complaint.

(5) Provision about who is to consider an appeal may include provision—

(a) establishing, or requiring or permitting the establishment of, a panel or other body to consider an appeal;

(b) requiring an appeal to be considered by, or by persons who include, persons with a specified description of expertise or experience.

(6) Provision about representation and support for an individual may include provision applying any provision of or made under section 68, with or without modifications.

(7) The regulations may make provision for—

(a) an appeal brought or complaint made under another procedure to be treated as, or as part of, an appeal brought under the regulations;

(b) an appeal brought or complaint made under another procedure to be considered with an appeal brought under the regulations;

(c) matters raised in an appeal brought under the regulations to be taken into account by the person or body considering an appeal brought or complaint made under another procedure.

(8) The regulations may include provision conferring functions on a person or body established by or under an Act (including an Act passed after the passing of this Act); for that purpose, the regulations may amend, repeal, revoke or otherwise modify an enactment.

(9) Regulations may make provision, in relation to a case where an appeal is brought under regulations under subsection (1)—

(a) for any provision of this Part to apply, for a specified period, as if a decision ("the interim decision") differing from the decision appealed against had been made;

(b) as to what the terms of the interim decision are, or as to how and by whom they are to be determined;

(c) for financial adjustments to be made following a decision on the appeal.

(10) The period specified under subsection (9)(a) may not begin earlier than the date on which the decision appealed against was made, or end later than the date on which the decision on the appeal takes effect.'.—*(Norman Lamb.)*

Brought up, and read the First time.

Norman Lamb: I beg to move, That the clause be read a Second time.

This morning is hard work, but I will continue in the same vein. *[Interruption.]* That was an unnecessary comment from the hon. Member for Leicester West; I will continue none the less. New clause 28 provides for a broad regulation-making power specific to appeals of decisions made under part 1 of the Care Bill. This power gives us the flexibility to provide for a range of options, depending on further work to ensure that we achieve the outcomes that people have told us are important to them. The details of the system that we develop through that work will be set out in regulations.

I know that many hon. Members will join me in welcoming the fact that the Bill establishes a new legal framework that puts the well-being of individuals at the heart of care and support and puts them in control of their own care. The Bill will also put in place a new statutory framework for assessment and care planning, extending the duty to assess carers' needs and allowing people who pay for their own care to count the reasonable cost of meeting their eligible needs towards the cap.

Given those changes, it is important that individuals have confidence in the system, and that they are able to challenge decisions without having to resort to judicial review. Accordingly, we held a wide-ranging consultation during the second half of last year to seek opinions on how best we could ensure that. Following that consultation, we have recognised the need for change in this area, and I have accordingly tabled a new clause that will give us the scope to develop detailed proposals for an appeals system, along with stakeholders, keeping to the spirit of co-production that has characterised our work on other areas of the Bill.

The issue is important and complicated. We need to make sure that we take time to get the detail right, drawing on experience from other sectors where possible, and ensuring that the changes are aligned with the broader changes to NHS and social care complaints, following the Francis report and the Clwyd review. It is possible that we will want to involve an existing statutory body in the appeals arrangements, to bring particular expertise to the process, and so the power is wide enough to enable us to confer functions on such bodies

[Norman Lamb]

if necessary. Of course, if that involves repealing or amending any element of the primary legislation that relates to such a body, we intend that such regulations would be made using the affirmative procedure. We are not yet in a position to share detailed proposals with hon. Members, but in introducing the new clause I should like to set out the principles that will guide us in developing the new appeals system, and I hope that the Committee will agree that those are right.

First, we believe that it is best to have a flexible appeals system that works at a local level in a manner proportionate to the type of dispute, avoiding unnecessary bureaucracy and burdens on local bodies. Secondly, we have heard clearly through the consultation that an appeals system should have an element of independence from the local authority to give people confidence that the appeals process is fair and unbiased. Thirdly, the appeals system will clearly need to take account of the wider arrangements for complaints and redress that are already established in other parts of the health and care system, avoiding duplication and gaps. We are working actively with our various partners and stakeholders to develop our policy on this, and we will consult further, along with our wider programme of consultations on regulations and guidance, later this year.

I hope that I have reassured hon. Members and my right hon. Friend the Member for Sutton and Cheam that the new clause demonstrates our recognition of the need for change and our determination to ensure that there is a clear, flexible and independent appeals system.

Liz Kendall: The new clause is extremely important. As hon. Members know, Opposition members of the Committee have been pressing for an appeals process. New clause 28 very much echoes new clause 8, which was previously tabled by me and my hon. Friend the Member for Copeland. I thought that the Government would inevitably have to institute a proper appeals process, so we welcome the fact that, following representations from hon. Members, the Government have listened and taken action.

There has been concern that under the new system, with more people being assessed, with a new type of assessment regime, with the complicated system of the new cap on care costs, and with people questioning what they are paid and how far they have gone to meet the cap, more people would raise concerns and make appeals. So it is absolutely right that the Government have tabled the new clause. We do not want to end up resorting to judicial review. We want a proper process of appeal for this new—in some ways simpler; in some ways, certainly on the finance side, more complicated—system of assessment. We need to make sure that the appeals process will be carried out by people who are properly qualified to deal with disputes about care packages and finance. A system with people clocking up amounts towards the cap is quite new. We will need a proper system in place and people with the right skills. I hope that when the regulations are introduced, Ministers will bear in mind the range of skills that people will need to carry out an appeals process.

I am sure I am not the only hon. Member who has seen appeals procedures often being conducted with a tick-box approach that makes people feel dissatisfied, so it is worth getting the process right from the start. I hope that the Minister will ensure all the issues are properly looked at in regulations.

Paul Burstow: I rise to thank the Minister for introducing the new clause. It reflects the debate the Committee had on an amendment that I tabled. It was supported by Government Members and called for an appeals mechanism to be put in place. The new clause reflects the recommendation of the Joint Committee, which came to a cross-party consensus on the need for such provision, and it obviously reflects the fact that the Government have taken on board the representations they received in their consultation. I will mention another matter on which that has perhaps not been the outcome.

However, on the new clause, the Minister is right. He has set out clearly a thorough set of regulation-making powers that will enable the design of a proportionate fit-for-purpose appeals system to emerge. We now need the many stakeholders, who have an interest in getting the design right, involved in its design, and it must be implemented in a timely fashion. It needs to be in place and understood as the legislation goes live from 2015, so that it is running in advance of the introduction of the capping system from 2016, because I think aspects of the legislation warrant having it in place at that stage. For those reasons, I am pleased to see the tabling of the new clause. I congratulate the Minister on listening to what the Committee has said and on taking on board the recommendations of the Joint Committee.

Norman Lamb: I am grateful to the shadow Minister and my right hon. Friend for their contributions. The shadow Minister's amendment put the case for an appeal process, as did my right hon. Friend's. There has been a lot of discussion about this, including suggestions for a whole tribunal system. The problem with that is that it takes money away from providing care, which is what, ultimately, we are all after. I think the new clause gets the balance right, and I repeat what I said in my speech: we will work collaboratively with the stakeholders mentioned by the shadow Minister and my right hon. Friend to make sure that we get the detail right through the regulations.

Question put and agreed to.

New clause 28 accordingly read a Second time, and added to the Bill.

New Clause 10

LOCAL AUTHORITIES: DUTIES WITH RESPECT TO YOUNG CARERS

'(1) A local authority must ensure that it takes all reasonable steps to ensure that in relation to—

(a) any school within its area and under its control; and

(b) any functions it discharges in pursuance of its responsibilities as a children's services authority, there is in place a policy that both identifies young carers and makes arrangements for the provision of support for pupils who are young carers.

(2) In discharging its duty under subsection (1), a local authority must have regard to any guidance given from time to time by the Secretary of State.'.—*(Liz Kendall.)*

Brought up, and read the First time.

Liz Kendall: I beg to move, That the clause be read a Second time.

The Chair: With this it will be convenient to discuss new clause 11—*Further and higher education: duties with respect to student carers.*

'(1) The responsible body of an institution to which this section applies must identify or make arrangements to identify student carers and have a policy in place on providing support for student carers.

(2) This section applies to—

(a) a university;

(b) any other institution within the higher education sector; and

(c) an institution within the further education sector.

(3) A responsible body is—

(a) in the case of an institution in subsection (2)(a) or (b), the governing body;

(b) in the case of a college of further education under the management of a board of management, the board of management; and

(c) in the case of any other college of further education, any board of governors of the college or any person responsible for the management of the college, whether or not formally constituted as a governing body or board of governors.'.

10 am

Liz Kendall: New clauses 10 and 11 return to the extremely important issue of ensuring carers are better identified. The two new clauses deal specifically with how we can ensure we identify and get help to young carers. New clause 10 would place a duty on local authorities to take all reasonable steps to ensure that schools in their areas identify young carers and that, through the wider work of children's services, young carers are identified and get the support that they need. New clause 11 would place duties on governing bodies of universities and further and higher education institutions to make sure that student carers are identified and get the help that they need. We have spoken before about new clause 9, also tabled by the Opposition, which is a strong set of amendments to make sure that NHS better identifies adult carers. These need to be taken as a whole. I know that we are not debating new clause 9, but these are specific, practical steps we want to see in the Bill to make sure all carers are identified and get the help that they need.

I pay tribute to my stalwart hon. Friend the Member for Worsley and Eccles South (Barbara Keeley), who included these clauses in her private Member's Bill. I am sure that when the Minister responds he will say that these new clauses are not needed because there are wider duties in the Bill on local councils and NHS authorities to identify carers, but we believe that the duty needs to be on individual organisations. So the head teacher of a school, the principal of a university or college or the person running a hospital or a community care service would know that their organisation had to have the proper processes in place to identify a carer and had to know what to do—who to refer that person to and what support to provide within the school, college, GP practice or hospital.

We have seen attempts in the past to make this a broad duty on councils or the NHS but when I have run an organisation—which I have; a charity, not a provider—I needed to know that my job as leader of that organisation was to make sure that that happens on my watch, in my school, my college or my GP practice. We have tried broader duties and they have not worked. That is why we need to go a step further.

On the specific issue of young carers, the official statistics from the census suggest that about 2% of all children are young carers, but that the figure rises to 6% of all children in families with an illness or disability. That would make the figure around 177,000 nationally, but the BBC did some interesting research and survey work. It surveyed more than 4,000 secondary school children and asked whether they helped—not, "Are you a carer?", because the child might not think they were, but, "Do you help someone get up, get washed, get dressed and do the shopping for them because they are not very well?". That came up with the figure that 8% of all secondary school children have a caring responsibility, which would make the figure around 700,000 nationally. The average age of young carers, we believe, is around 12, but some are as young as eight or nine. We all know that looking after someone who is sick or disabled can rob children of a lot of their childhood. It can make children feel isolated, because they have to go home and look after their parents rather than staying at an after school club or doing sports or other activities.

We know that nearly one third of young carers in secondary school have educational difficulties or miss out on getting the basics in the classroom. Many feel bullied and isolated because they have these other roles and responsibilities. Young carers are also twice as likely as their peers not to be in education, employment or training. If young carers are lucky enough to be able to go on to university, which many are not, that can then create extra stresses and strains. They may decide to go to a university or college close to home, rather than one further away which provides the course which they really want to study. They may feel that they have to keep coming home at weekends to look after their mum or their dad, and so they cannot focus as much on their studies or extracurricular activities.

New clauses 10 and 11 would make it crystal clear that every organisation which works with young people must have in place a proper process. I have not gone through the process of doing this in a school or a college, but I did recently swap GP practices. Bear with me, because this does have a read-across: GP practices are supposed to identify people who are carers. When I signed up at my GP practice, I had to fill out two pages about how much alcohol I drank. This is not a bad thing and I am glad that it is being looked at, but on carers the form said only, "Are you a carer?". It did not ask, "Do you look after someone who is sick?", or ask about this. There was only that one little box to tick.

It is good that GPs are bothered about alcohol, which is a real health problem, but that showed me the mentality. A lot of detail was required on physical health issues—how many units I drank and when, and how I felt, and whether I was drinking on my own and all that stuff—but there was only that one question on being a carer. That showed me that they do not quite get it. I know that the Government have made some steps on the issue of identification but they must go further, because on the ground this is still not in people's minds.

Meg Munn: Sheffield Young Carers project, of which I am privileged to be a patron, has done a lot of work with schools. It is very noticeable that the schools where

[Meg Munn]

they have worked are much better at identifying carers. Having a duty would put this high on the agenda and ensure that schools did this as a matter of course. It is not because carers are not there or because schools do not care, it is just that they are not aware.

Liz Kendall: My hon. Friend is absolutely right. In my own constituency I have seen Leicester city council and Leicester CCG do some great stuff on identifying carers, but when I looked at the carers' strategy it did not include schools, universities or the college. It talked about GPs and not hospitals, but we know from Macmillan Cancer Support that some people who are looking after someone with cancer may not have very much contact with their GP while they are in hospital. It must be institution by institution.

Jim Shannon: As always, the hon. Lady has compassion for those who are less well off, which we appreciate very much. In Newtownards in my constituency, as in both Leeds and Sheffield, Crossroads Young Carers does excellent work with young people. However, there is also a strong relationship between the young carers and our Assembly, which is in place to advise and assist. Does the hon. Lady feel that bodies such as the young carers organisations in Sheffield and elsewhere should have a relationship with government, both local and at a higher level, to enable the delivery of the better system to which she refers?

Liz Kendall: That is a brilliant suggestion. I do not think that organisations, whether central or local government, the Department of Health or local NHS bodies, are purposefully ignoring this issue. Yet when someone who has gone through this tells someone about it directly, face to face, that changes them. It changes their mind and it changes what they actually do. That is why having clear duties in this Bill on individual institutions would make a difference. The boss of a school, college, university or hospital would then know that they have to put in place a proper process. That would make the difference, which is why we urge hon. Members on both sides of the Committee to accept these new clauses today.

Norman Lamb: New clauses 10 and 12, which are about identifying young carers in schools and student carers in further and higher education institutions, fall within the responsibilities of the Department for Education and the Department for Business, Innovation and Skills. The same amendments were tabled at the Committee stage of the Children and Families Bill in the other place. I join the shadow Minister in paying tribute to the work of the hon. Member for Worsley and Eccles South. She has consistently made the case for carers, which forces everyone to focus on thinking about carers' needs and how we can better address them. She has been commendable in that regard.

I echo the comments of the shadow Minister about the experience of young carers. I remember talking to a young carer about her experience in school and how the teacher was dismissive of her caring responsibilities and did not consider them a justifiable excuse for not being able to do something that the teacher wanted her to do. She also made the point that young carers are very high on the list of those who are not in education, employment or training. The paradox is that when I met that young carer and recognised the extraordinary balancing act that she undertakes between education, friendships and her responsibilities at home, caring for her mother, I realised that she was eminently employable. She had the most incredible maturity and the most extraordinary range of skills that most 15-year-olds would never have. Yet the employment prospects of these young carers are clearly diminished.

I also agree about the tick box in the GP practice, indicating that it is not really embedded in culture yet. GP practices, schools, colleges and everyone need always to think about the role of the carer. GP practices need to see carers as partners in the care of an individual. If they work in partnership with the carer as part of a team, everyone benefits, including the GP because the burden is relieved on that general practice. Organisations like those the hon. Member for Sheffield, Heeley mentioned in her home town are also doing fantastic work on the ground. They are changing attitudes and making people realise that this is a serious issue and that addressing it gives opportunities to people that they would not otherwise have.

As Lord Nash, the Parliamentary Under-Secretary for Schools, said in the other place, the Government fully support the need to improve early identification of those with caring responsibilities. However, a legislative approach that compels schools to identify young carers, as set out in new clause 10, is not in keeping with the Government's drive to reduce burdens on schools and free them from central prescription. That is the point that the shadow Minister made in another context about the risks of central prescription.

It is important that head teachers and governors are allowed the necessary local freedom to exercise their welfare responsibilities in the most appropriate way. There are safeguards. For example, OFSTED inspections take particular interest in the experience of more vulnerable children, including young carers, during inspections. I understand that the National Governors Association has put raising awareness of young carers in schools and what schools can do to support them on the agenda of the next meeting of its advisory group on governance on 13 February.

The Children's Society and the Carers Trust have worked since 2011 to share existing tools and good practice, including an e-learning module for school staff to increase awareness in schools of young carers' issues, funded by the Department for Education. The Department of Health has also funded the Royal College of Nursing to revise its school nurse toolkit to capture the needs of young carers and we are funding the Queen's Nursing Institute to work with clinical commissioners to ensure they recognise young carers' needs as integral to any service.

In addition, we have started training school nurses to be champions for young carers. They will speak up on young carers' behalf to help head teachers and governors decide how best to support them at school. More than 70 have been trained to date, and a further cohort will be trained in September this year.

10.15 am

There is already much good practice in schools, such as having a nominated lead teacher to whom young carers can talk and signing up to local young carer charter mark standards. It is important that that good practice now becomes universal, so as a next step, and building on the work that has been done, the Big Lottery Fund has decided to work with the Children's Society on a national awards scheme that will encourage schools to get it right for their young carers. That is a welcome initiative. The Government will continue to support such initiatives and enable schools to exercise their welfare functions in appropriate ways, rather than placing new burdens on them.

On new clause 11, universities are independent and autonomous bodies, and the responsibility for providing adequate support to their students must, obviously, rest with them. Universities are responsible for determining what support to provide to students and having in place mechanisms for identifying need, for example via personal tutor systems, through student surveys or via the students' union. Information on the results of student surveys are now available to help people determine what university is right for them, which can also help a young carer determine where would be best for them.

Nearly all universities have such mechanisms in place and provide a range of support services to their students. Further education colleges are similarly autonomous and have the same responsibilities for supporting their students and enabling them to complete learning and achieve outcomes. The Department of Health has funded the National Institute of Adult Continuing Education to run a three-year project called "WE Care" to improve work and education for young adult carers and develop innovative networks, approaches and resources to access targeted information, advice and support leading to sustainable employment and progress at work.

Legislating to require further education establishments and universities to identify student carers would override the existing arrangements in place in higher education and develop a care policy that goes against the Government's commitments to reduce regulation on the sector. Although I appreciate the wish to improve recognition and support for young carers and student carers, the Government do not agree that a legislative approach compelling schools, colleges and universities to identify them is the right way forward. It could lead to exactly the sort of tick-box culture that the shadow Minister described in her GP's surgery and ultimately achieve nothing for young carers. It is changing culture in such institutions that is critical, and I suspect that the most effective way to do so is through the sort of scheme that they have in Sheffield, where working with schools and colleges forces them to think afresh about what sort of support they need to give young carers.

Grahame M. Morris (Easington) (Lab): The Minister referred in his opening remarks to new clauses 10 and 12; I think that that was a slip of the tongue. It is new clauses 10 and 11 that we are dealing with.

Norman Lamb: I apologise to the hon. Gentleman.

Grahame M. Morris: There is no need to apologise—not for that, anyway—*[Laughter.]*

We are debating important issues. Earlier in the Committee, we debated new clause 9, which seeks to ensure that GPs and other health professionals recognise when a patient is a carer and take their needs into account when treating them, a point well illustrated by my hon. Friend the Member for Leicester West. New clause 10 would require schools and local authorities to have written policies to support young carers. However, if I may, I will speak about new clause 11, which would ensure that universities, and indeed further education institutions, have arrangements in place to identify and support student carers.

Student carers carry a dual burden. They are committed to further or higher education as well as their role as carers. Many student carers find it difficult to balance caring and studying and, in many cases, also working. As we have heard, there are no official statistics on the number of students who are carers, but the best estimates put it at between 3% and 6% of students across the UK.

Student carers are subject to a unique set of demands. They have to manage their living and studying arrangements in a way that most other students do not. Indeed, the majority of student carers do not live in purpose-built student accommodation, unlike most students who go on to further education. The figures I have seen show that two in five student carers live with their parents, and another quarter live in privately rented accommodation. Student carers have to balance sets of demands unfamiliar to most students. Along with their role as carers and as students, three out of five are also in paid employment.

I remind hon. Members that studying on a full-time course disqualifies student carers from being eligible for carer's allowance, which places an extra strain on mostly young people who are often trying to balance studying and caring responsibilities. The emotional and physical strains associated with being a carer have been well stated by right hon. and hon. Members throughout the Committee's sittings. Student carers are subject to the additional strain of their commitments to caring and working potentially disrupting their study and, as a consequence, their future careers.

The quality of care that a student carer is able to provide may also suffer. The academic institutions that they are part of might be affected by the lost potential of a student struggling with extra-curricular demands. There is no carer-specific support for a student, making the identification of student carers, so they can be made aware of the general support that might be available, all the more important.

There is some help available to student carers, as the Minister touched on. Without knowledge of and access to such information, a student carer will struggle. Financial support is available to university undergraduates through the adult dependants' grant from the Student Loans Company. Whatever level of programme the student is studying, they may also be entitled to a grant from the access to learning fund.

Some student carers report unpredictable changes to their caring responsibilities. The health of the relative they care for may deteriorate. That can have an impact on their course work or exams, which is why it is so important that student carers are identified by the responsible body of their institution. Facilitating extensions to coursework or mitigating circumstances allowing a student to delay a module, temporarily suspending studies or switching to a part-time course of study, might all be

[Grahame M. Morris]

vitally important for student carers when they are subject to changes in their caring responsibilities, or indeed find themselves struggling to meet those demands.

The relevant bodies being made aware of the student carer's status and being prepared to offer the appropriate support can provide invaluable help to a student's academic progress. Student carers need to know of the available support to be able to manage financially and have their study accommodated by their commitment to being carers.

Ensuring that the responsible body of an institution identifies or agrees to identify student carers would be of great benefit. The student carers, those they care for, the academic institutions they belong to, and society at large would all reap the rewards of a student carer who was able to balance their commitments while living up to their potential. I hope the Minister will consider those points.

Norman Lamb: I have already given my contribution and response to the shadow Minister. I would only add that I completely agree with everything the hon. Member for Easington said about the importance of identifying young carers and giving them the same opportunities that others benefit from. The only dispute in a sense is the mechanism by which we achieve that and whether a legal duty on the independent institutions that we are talking about achieves that objective, or whether there are better ways of embedding a different culture in these organisations. That is the area of disagreement; the ambition of improving the life chances of young carers is shared, I suspect, by everyone in this Room.

Liz Kendall: I disagree with the Minister; we will not press this issue to a vote, but I am sure that we will come back to it. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 21

ACCOUNTING

'(1) The Secretary of State shall make provision for accounting guidelines for persons and organisations offering care services to be published.

(2) All persons and organisations offering care services shall have a duty to follow guidelines published in accordance with subsection (1) in charging for those services and shall, in particular, ensure that all accounting paperwork is easy to understand, fully explains any interface with the local authority and is complete.'.—*(Liz Kendall.)*

Brought up, and read the First time.

Liz Kendall: I beg to move, That the clause be read a Second time.

I will not delay the Committee for too long on this practical new clause, which deals with the new accounts for care services that people will be getting and reports from councils about how much they have paid towards the so-called cap on care costs. The clause says that there needs to be guidance from the Secretary of State on how people are presented with information such as the amount that they are charged for services. We all have personal experience of getting information from different bodies—usually private sector, but often public sector. I am thinking about pension communications or—God forbid—electricity bills when the information is completely indecipherable and no ordinary person can figure out what on earth is going on. It is important that information about care charges—and, I would argue, anything relating to a cap on care costs—is presented really simply so that people know where they stand. Such information can be complicated at the best of times, but if it is being set out for somebody who is vulnerable or has dementia, or whose charges and services are complicated, it needs to be presented simply and straightforwardly.

This new clause was initially tabled by a Conservative peer, Baroness Byford, to make the point that we need guidance on how to set out information on such an important issue. I make a plea to the Government: let us make this simple and clear for people. The Government should produce guidelines on how best to achieve that so that people do not end up terribly confused about what they have been charged and what they have paid towards their care. If they do not know that information, how will they know that they are going to reach the cap on care costs, and how can families plan for the future? Simplicity and clarity are really important, so guidance is needed.

This is not a question of ordering people to do something; it is about good practice. Such a measure would make a practical difference to people and might end up preventing appeals or concerns from arising later down the line. I therefore urge the Minister to think about this important issue.

Norman Lamb: I agree with the sentiment of what the shadow Minister says. She raises the important issue of protecting vulnerable people from overpaying for the care and support services that they need. I begin with the observation—I hope it is incontrovertible—that it is completely unacceptable for providers to exploit the vulnerability of people purchasing services by overcharging them, so I fully support the new clause's intention. There has been a market in care and support for many years. We are keen that that develops further, as that should not only lead to increased choice and better outcomes for individuals, but drive innovation, which should result in improved quality.

10.30 am

Martin Green, the chief executive of the English Community Care Association, has set out some really interesting ideas about driving innovation, such as the care home becoming a hub in the local community and offering a range of services to people with care needs in the surrounding area who live in their own home. Such innovation is to be welcomed, as providing new services to people in their own homes could provide a new income stream for businesses that provide care and ensure that they remain sustainable.

In this market, the prices agreed with providers as part of a contractual discussion are ultimately for the agreement of the parties involved. To ensure that the process is fair, it is important that individuals purchasing services have clarity about their costs, which is why all providers of health and adult social care registered with the Care Quality Commission must meet a registration requirement relating to fees.

If a service user is responsible for paying the costs of their care or treatment, either in full or partially, the provider must produce a statement that sets out the terms and conditions of the services to be provided, including the amount—and method of payment—of any fees. That statement must be in writing and, as far as practicable, be provided before the commencement of services. In addition, any instances of theft or misappropriation of service users' money could breach the CQC registration requirement on safeguarding service users from abuse, quite apart from being a serious criminal offence.

I am clear that the effective oversight of registered providers is essential to protect service users. The CQC is transforming its regulatory approach so that it will hold providers to account with much greater rigour. Its new specialist inspection teams will know what good care looks like. The inspectors will focus on five key questions: is the service safe; is it effective; is it caring; is it responsive; and is it well led? We now have a chief inspector of social care to focus attention on not only failures in care, but great care, as it is important that we also celebrate examples of great care.

When providers fail to provide an acceptable standard of care, I will expect the CQC to take action including, in the most serious cases, by bringing prosecutions. The Government, along with the CQC, are changing the arrangements to make it possible to bring prosecutions against care providers without having to serve notice first, as that process means that it is often impossible ever to bring a prosecution.

More widely, the Bill includes provisions that will support people to make informed decisions when they purchase care services. Clause 4 requires the local authority to make available to all people in its area information and advice about care and support services.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): I wonder whether the Minister is aware of the problem in the pensions industry due to the lack of transparency when comparing fees and charges for pensioners? Does he think that that might be a problem here? Will he reassure us about how, within the registration parameters, there will be total transparency and an opportunity for fees to be compared?

Norman Lamb: I understand the hon. Lady's concern about pensions. Our objective is to ensure that information is clear. I have already explained what the care provider must set out in the statement, preferably before a person enters care, but in emergency situations when someone has to be brought into a care or nursing home very quickly, that might not be possible. The essence of contract law—I speak as an ex-lawyer—is that terms are known and agreed, and there will be a requirement for transparency about how the charges are calculated.

Debbie Abrahams: Will there be comparability?

Norman Lamb: Of course. The more the local authority focuses on its duty to develop the care market and to provide information and advice about the services that are available locally, the more possible it will be for people to compare what is on offer.

I refer the hon. Lady to the NHS Choices website, which contains details of every provider registered by the Care Quality Commission. People can use the website to find out critical information about those providers, and to make comments about providers in a TripAdvisor fashion. That has the potential to be very powerful, because there will be no hiding place if poor care is exposed. We will be able to provide links on the website to the CQC's findings after inspections and so forth. This whole shift is towards the transparency that the hon. Lady calls for so that people are able to understand what they are agreeing to and to compare different options.

The Joint Committee on the draft Bill rightly raised the importance of helping people to access independent financial information and advice. We accepted that argument and redrafted the Bill accordingly. Clause 4 now makes it clear that local authorities must provide sufficient information and advice to enable adults to consider the financial aspects of meeting their care and support needs, and to make plans for how they might meet any future such needs.

Clause 5 requires local authorities to shape a diverse, high-quality and sustainable market that meets people's needs. The aim is that that market will offer people a range of high-quality services that enable them to exercise choice and control over the services that they use. Critically, that will drive up quality. Although I fully support the intentions behind the new clause, it is not required, because the Bill and regulations will provide for the transparency that the Opposition seek.

Liz Kendall: I am happy to beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 26

ASSESSMENT OF CARE AND SUPPORT NEEDS OF PERSONS DETAINED UNDER MENTAL HEALTH LEGISLATION IN POLICE CELLS

'(1) Police constabularies must record the following information about persons under 18 years of age detained in police cells under section 136 of the Mental Health Act 1983—

(a) the age of each such detainee;

(b) the period of time each detainee was accommodated in a police cell;

(c) what assessments of—

(i) medical; and

(ii) social care and support

needs were made and by whom; and

(d) what the result was in each case.

(2) The Secretary of State must publish an annual report containing the number of persons detained in police cells under the Mental Health Act 1983 broken down by—

(a) police authority area;

(b) age of detainee; and

(c) length of detention.

(3) Within 12 months of this Act coming into force, the Secretary of State must prepare and lay before each House of Parliament a report on the implications for the effective, efficient and economic provision of integrated health and social care arising from the imposition of a charge upon local authorities and NHS commissioning bodies, as appropriate, for the use of police cells for the detention of persons under mental health legislation.'.—*(Paul Burstow.)*

Brought up, and read the First time.

Paul Burstow: I beg to move, That the clause be read a Second time.

I will speak briefly to the new clause, which stands primarily in the name of my hon. Friend the Member for Totnes. Unfortunately, because of the accident that she sustained—the visible evidence of which we have all seen—she cannot be here today, which is a great pity because I know that she would have spoken with authority and passion about this topic. We debated quite recently with a Home Office Minister the unacceptable use of police cells to house people who have committed no crime by dint of section 136 of the Mental Health Act 1983, which allows them to be taken to what is euphemistically termed a "place of safety". People in that position are often taken to a jail cell rather than being treated on a hospital ward. New clause 26 is designed to bring information about that practice—some of the figures are shocking—more clearly into the public domain, and it would be useful to hear the Minister's comments on the proposal.

Some 36% of those subject to place of safety orders—7,761 people—find themselves in police cells rather than in hospital. The average length of stay, according to Her Majesty's inspectorate of constabularies, is 10 hours and 32 minutes, so a person in that situation may be stuck in a cell for more than 10 hours. If we drill down into those figures, the experimental collection of data is starting to provide, for the first time, a much clearer picture across the age range. One of the things revealed is that, in the first year for which figures are available—just last year—263 children and young people were put in police cells as a place of safety. We do not yet know how many hours they were kept in the cells, which is why we need the new clause, which deals with understanding the scale of the scandal that that figure of 263 represents. Each and every one of those people deserved something better; they deserved to be placed in a proper place of safety and to have access to treatment.

Andrew Griffiths (Burton) (Con): I completely agree with what the right hon. Gentleman says. It is a scandal that people with mental health problems find themselves in a police cell rather than a place of safety. Does he recognise the pressure that that puts on the police, as they have to look after those people, as well the massive strain it causes to their budgets?

Paul Burstow: The hon. Gentleman is absolutely right to highlight that. The police themselves say that such a use of their resources is inappropriate. However, as part of effective policing, awareness of mental health, and proper training in first aid for dealing with mental health issues, may result in more people being taken to the right place rather than being kept in a cell in a police station. If someone who had broken their leg was taken to a police cell, everyone would just accept that that was nonsense and that it should not happen, but it seems to be acceptable in our society that that happens to people with mental health problems.

First, will the Minister tell us, even briefly, where we are with liaison and diversion schemes in custody suites? The Treasury was due to sign off on them, but has that happened? Secondly, there have been some good findings from street triage, which is an effective way for psychiatric nurses to work with the police to divert to the right provision in the first place, so where are we on that?

If the Minister does not accept the new clause—I suspect that he has reasons not too—will he indicate what further steps the Government are taking to address the serious problem of children and young people, in particular, finding themselves in the wrong place and not getting the right care? There is nothing like the parity of esteem we expect and should now demand in our health service between physical and mental health.

Norman Lamb: I thank my right hon. Friend for his words. We would probably all agree that the current practice, with so many people ending up in a police cell, is intolerable. It is bad enough when an adult with mental health problems ends up in a police cell when they do not need to and should not be there; it is quite horrific when children end up there. We are taking steps to address that practice.

As my hon. Friend the Member for Burton said, the practice is a crazy waste of police resources. Police officers, with the best will in the world, are not trained to understand and cope with people with mental health problems. For all sorts of reasons, this intolerable practice has to end.

Andrew Griffiths: I thank the Minister for focusing on an issue that is close to my heart. Does he accept that mental health units and beds are closing across the country as there is a movement towards crisis teams and care within the community? While that suits some, it does not suit everyone, and we need to ensure that those crisis teams not only are properly resourced to deal with people at the point of crisis, but have somewhere to refer them if the crisis is so severe that an in-patient bed is needed.

Norman Lamb: My hon. Friend makes that case well. There is a danger that we lump all mental health beds into one category and fail to recognise that we can be dealing with an extraordinary array of circumstances.

10.45 am

The trend, over the past two decades or so, of significantly reducing reliance on long-stay in-patient care in mental health institutions is absolutely right. It happened under the previous Government and it was right that that happened. There you go, Mr Rosindell; I am paying tribute to work done under the previous Government. The extent to which people, either with learning disabilities or with mental health problems, have in the past been hidden away from public view in long-stay institutions is completely wrong. In the vast majority of cases, the objective should be for people to be able to live independently, with support if necessary, in their communities.

That trend is absolutely right, but at the same time it is critical that beds are available for crisis care, so that when someone is in the middle of a mental health crisis and needs to go somewhere safe, therapeutic, caring and compassionate, they do not end up in a police cell. That is intolerable, and although the use of police cells has come down significantly over the past few years, it is still far too high and that has to change.

Liz Kendall: I am sure that the Minister knows what I am going to say, and I really want to echo the words of the hon. Member for Burton. As the Minister knows, I rang him on Friday about a case involving one of my constituents. A young woman, who is under 18, has

already experienced not being able to get a bed in Leicester twice. The first time, she was sent to Woking, and the second time, to Northampton. On Friday, she was told that there was not a single child and adolescent mental health bed in the NHS or the independent sector anywhere in the country. It is at crisis point. The Minister told me that NHS England is reviewing the problem. I hope he can tell me what is happening right here, right now, because a review can take a long time. A number of people contacted me via Twitter saying that exactly the same thing was happening. The police, including my chief constable, who leads for the Association of Chief Police Officers on mental health issues, said that they are increasingly concerned about the number of children being kept for unacceptable periods in police cells. I would really appreciate it if the Minister updated the Committee on what is happening.

Norman Lamb: We did talk on Friday and I have asked NHS England to treat it as a matter of absolute priority. I am not in a position now to give a full response, but I will undertake to contact the hon. Lady before the end of today with as full a response as I am able to provide. For the record, I share the view that this young girl's experience is not acceptable, full stop.

A review by NHS England of CAMHS tier 4 capacity and services that are available is under way. Again, there is a sensible move towards trying to care for children in the community and trying to enable them to remain at home if possible, or perhaps with a therapeutic, supportive foster carer, if that is not possible, rather than putting them into in-patient care, particularly away from home. Sometimes in-patient care is necessary. Sometimes, because of the particular mental health issue, there may not be—and never has been—availability in that particular town of an in-patient facility. That is a reality, I am afraid, because not every town has the level of need for the whole range of different conditions that might emerge at any particular time, but the principle of care close to home, or as close to home as possible, is absolutely paramount, and I share the hon. Lady's concern about the case that she raised.

Debbie Abrahams: All of us would agree with the points that the Minister and my hon. Friend the Member for Leicester West made about the availability of local care, particularly for young people. Other Members have also made the point, with which I wholeheartedly agree, that it is never appropriate to place people with mental health problems in police cells. However, I want to ask the Minister a genuine question: how will the mental health tariff deflator support his aims? I met my local mental health trust on Friday. The 0.3% deflator, which is effectively a cut, has meant that it will lose almost £1 million.

Norman Lamb: I thank the hon. Lady for her intervention. Let me be clear, as I have been already: the decision that was made was not acceptable. We must challenge the lack of parity of esteem between mental and physical health wherever we find it, whether that is in the Department of Health, NHS England, Monitor or at a local level.

The hon. Lady will be aware that the tariff is just one element of the total equation for funding services locally, particularly in mental health, because although we currently have advisory national tariffs, mental health services are still effectively funded in large part through block grant. My view is that there is an urgent need to move away from that approach. I have frequently made the case about the lack of equilibrium between the funding for physical and for mental health. The fact that we have an 18-week target for physical health and no targets or access standards in mental health drives where the money goes in the system. If a local commissioner knows that they must deliver the 18-week target, in which there is intense political interest, that means that money goes into acute hospitals, not into mental health. We must therefore create a better equilibrium.

I will make it clear again: we have written it into the mandate that NHS England must make measurable progress towards parity of esteem by 2015, including in the financing of services. I expect it to deliver that.

Bill Esterson: I am glad the Minister made that point about parity of esteem. On the work force, does he agree that there is a big shortage of trained staff in mental health generally, and particularly in CAMHS, which he mentioned earlier? Does he think that, as part of that parity of esteem, it is vital to recruit and train staff in such areas in order to make the real change that he says he wants to achieve?

Norman Lamb: I agree that there is a shortage. Through the mandate to Health Education England, the Under-Secretary of State for Health, my hon. Friend the Member for Central Suffolk and North Ipswich is putting a much greater focus on mental health in health professionals' training than there has ever been in the past. There is a whole separate section of the mandate to ensure that HEE delivers improvements in the mental health training of all clinical staff. One critical issue involves GPs, who currently deal with substantial numbers of mental health problems as part of their case load and yet in most cases have very little training in mental health, because it is optional in their training. There is an extraordinary mismatch between the nature of their day-to-day work and the training that they receive. We are determined to end that.

We are investing £54 million in CAMHS over this Parliament as part of a programme initiated by my right hon. Friend the Member for Sutton and Cheam to improve the skills of people working in CAMHS so that ultimately—I think it is by 2017—children in all parts of the country will have access to psychological therapies. That is called the IAPT—improving access to psychological therapies—programme. The hon. Member for Sefton Central is right that, in many areas, the work force does not currently have the required skills, so that programme will deliver the necessary change.

Finally, we have been clear in our response to the Francis inquiry that all providers—acute trusts and mental health trusts—will have to publish their performance on staff numbers on wards compared with the safe level, so that we have the transparency that will enable us to hold providers to account.

Andrew Griffiths: I thank the Minister for his detailed knowledge on this topic. On transparency, I am sure he will agree that it is positive that a number of police and crime commissioners and police forces now employ

[Andrew Griffiths]

mental health workers to go out with the police. They recognise that many of the people they encounter have mental health problems, not criminal problems, and that that is the best way to deal with them. However, too many police authorities are not able to send people to a place of safety because there are no beds available, so they have no choice but to keep them locked up in the cells. To make the process more transparent, will the Minister look at how to make it easier for people to find out for themselves whether mental health beds are available in their area?

Norman Lamb: The sort of transparency that I have described will help people find out about the situation in their local area. My hon. Friend is absolutely right about those great, innovative schemes. I will return to them in a moment. The thrust of our approach is to join up more effectively the work of mental health services and the police. They both deal with the same cohort of people, but when somebody has a crisis in a public place, it is often the police who get there first. For them to work in a silo and not deal closely with the mental health practitioners in the local area would be madness, but that is the way in which services have worked hitherto. It is good that we are addressing that problem.

I visited Bethnal Green police station recently when we launched the liaison and diversion service. I can confirm to my right hon. Friend the Member for Sutton and Cheam that the Treasury has approved the first phase of a roll-out of a nationwide liaison and diversion service. It is world leading, and we should be proud of it. If the pilots demonstrate that it works, it will create a national service to ensure that people in the criminal justice system who are arrested or arrive at court have a proper assessment and get access to the care and treatment that they need. We hope it will divert people away from prisons and from reoffending, which is damaging to them and the wider public. My right hon. Friend's points were absolutely right.

I thank my hon. Friend the Member for Totnes and my right hon. Friend the Member for Sutton and Cheam for tabling the new clause, which raises several important issues about section 136 of the Mental Health Act 1983. Section 136 has been discussed in the House, most recently in a Westminster Hall debate last November on police involvement with people with mental health problems. I acknowledge the valuable contribution of my hon. Friend the Member for Totnes to that debate.

The new clause would place duties on the police and the Secretary of State to gather and report information on police use of section 136. The Health and Social Care Information Centre recently included for the first time data collected by police forces on the use of section 136 in police custody suites in its annual report on people detained under the 1983 Act. We are therefore starting to see a degree of transparency. The report included information on the number of detainees who are under 18, although it did not include further detail of their ages.

When I visited Bethnal Green police station, I asked about the use of their police cells under section 136. They said, "In that inner-city area, we have a very good arrangement with local mental health services. We don't use the police cells for section 136 place of safety cases." If it can work there, it can work anywhere. It requires proper collaboration. If police forces and mental health services work properly together, they can crack this problem. It is not beyond the wit of man to do it, but it requires absolute determination to achieve change.

11 am

Andrew Griffiths: My hon. Friend is right, but unfortunately the reality on the ground is that mental health beds are being closed. In my constituency, the Margaret Stanhope facility closed, meaning that police now have to travel to Stafford for a facility, if they are looking for a place of safety, and that can be a two and a half hour round trip. That means two police officers in a police car travelling for two and a half hours, when they should be on the beat, keeping people safe.

Norman Lamb: My hon. Friend makes the point well. That is the wrong way to proceed. Incidentally, the Care Quality Commission will create a Google map of health-based places of safety this year. Its survey of beds, staffing levels and hours of operation will begin shortly. That will enable people to hold to account both police and health services in their local areas and is additional to the data on people going to health-based places of safety that the Information Centre has published for some years.

The Government are not obliged by statute to collect and publish these data, but intend to continue to improve its quality. Having said that, in general neither the Home Office nor I think it appropriate to impose centralised data collection burdens on the police or mental health professionals, when it is important that local commissioners and service providers understand and use their local data to improve mental health services. Ultimately, that is what it is all about. Their aim must be to use those data to ensure that mental health services meet the needs of their local population, so that when police or other emergency services respond to a young person, for example, the right services can rapidly be accessed and police custody can be used minimally as a place of safety, only where it is necessary for the protection of that individual or of others.

We have done a great deal of work already on what we expect from NHS mental health crisis services. We do not expect anyone in mental health crisis to be turned away from the NHS. It is important that services work together to make this a reality locally. At my request, the relevant national organisations for the professions that respond to mental health crises, including NHS England, ACPO, the Association of Police and Crime Commissioners and the Royal College of Psychiatrists have agreed a mental health crises care concordat, which will be published shortly. It will set out, for the first time, the standards of response that people suffering from mental crisis and requiring urgent care should expect, and the key principles that local health and justice partners should follow.

I reassure the Committee that my officials, together with Home Office officials, are working on every aspect of sections 135 and 136 of the Mental Health Act, building on the concordat agreements, to deal with this fundamental issue. That must be done to ensure that vulnerable people receive proper care and support without risks to their safety. The priority must be to radically

reduce the use of section 136 overall, but where it is used people should be taken to appropriate health-based places of safety in all but the most exceptional cases.

The Home Secretary announced last year that there would be a review of sections 135 and 136 of the Act, focusing on the use of police powers. We are jointly considering the scope of that review and I am happy to write to my right hon. Friend the Member for Sutton and Cheam and my hon. Friend the Member for Totnes with more details about what is proposed.

The Government want to drive improvements to mental health crisis care, so that local mental health services are always available when needed. Last year, the Government published the refreshed mandate for NHS England, which included a new requirement for the NHS, so that every community has

"plans to ensure no one in mental health crisis will be turned away from health services."

My hon. Friend the Member for Burton mentioned street triage pilots, when talking about police forces using people with mental health skills as part of their operation. In fact, those pilots are a collaboration between the mental health trust and the police force in a number of areas, nine of which are being funded by the Department of Health this year. They are already showing how closer working between relevant professionals can improve service responses and people's experiences.

I went out with the street triage team in Leicester last summer. I saw them in action dealing with the mental health crisis. An elderly gentleman had his wife in an armlock; he was suffering from the early stages of dementia and there was a medication issue. The police officer told me that in the past they would have had no option: they could not have left him with his wife, because she was at risk, so they would have had no option in the evening but to take him to a police cell. How unacceptable is that? They had a mental health nurse with them in the car, and she was able to access a mental health bed locally and ensure that she could get him into that bed. She talked to him and encouraged him to agree that it was a sensible way forward. Crisis resolved in a brilliant way. I pay tribute to the professionals on both sides. They told me about how they were learning new skills as a result of working with another professional on the other side of the divide. What is going on in the pilot areas is exciting.

We are also currently updating the 1983 Act's code of practice. We will strengthen the chapter on police powers to improve practice so that people in crisis are helped to find the right support. The CQC is increasing its inspection and review of health-based places of safety and mental health crisis services more widely. We have ratings and are introducing them into mental health. If local mental health trusts are not providing proper crisis services, they will not get a good rating. They will be held to account for failures.

Given all the work we are doing, I hope that my right hon. Friend the Member for Sutton and Cheam will agree that it is not necessary to tie the Government, in the Bill, to laying a report before Parliament on the specific suggestion of charging the NHS and local authorities for the use of police cells as a place of safety. My instinct is that charging could bring unintended consequences, such as the potential for perverse incentives. Furthermore, I am not aware of any appetite on the part of the police for such a reform. We could consider the matter further, for example, as part of the review that we will shortly undertake into sections 135 and 136 of the 1983 Act. I hope he feels that this has been a useful debate on incredibly important issues that have a profound effect on the lives of many mentally ill people. In the light of the reassurances I have offered, I hope that he will not press the motion.

Paul Burstow: It has been a useful debate, which has brought live situations to the attention of the Committee. The Minister said that he would write to me and my hon. Friend the Member for Totnes, and I assume the whole Committee by extension. I am grateful for that. On the basis of what he has said, I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 29

DELEGATION OF FUNCTIONS RELATING TO DEFERRED PAYMENT AGREEMENTS AND LOANS

'(1) The Secretary of State may make arrangements for any person or body specified in the arrangements to exercise on behalf of local authorities, to such extent as is so specified, any function exercisable by local authorities by virtue of regulations under section 34.

(2) Any arrangements made under subsection (1) shall not prevent local authorities from exercising the function in question themselves.

(3) The Secretary of State may pay to any body or person by whom any function is exercisable by virtue of subsection (1)—

(a) such amounts as he considers appropriate for the purpose of meeting expenditure incurred or to be incurred by that body or person by way of administrative expenses in, or in connection with, the exercise of that function;

(b) such remuneration as he may determine.

(4) Any payment under subsection (3)(a) may be made subject to such terms and conditions as the Secretary of State may determine; and any such conditions may in particular—

(a) require the provision of returns or other information before any such payment is made;

(b) relate to the use of the amount paid or require the repayment in specified circumstances of all or part of the amount paid.'.—*(Grahame M. Morris.)*

Brought up, and read the First time.

Grahame M. Morris: I beg to move, That the clause be read a Second time.

I appreciate that time is short, but the new clause covers an important issue. I hope that the Minister will at least take away the points I make, reflect on them and consider introducing proposals on Report or, at the very least, meet the Local Government Association and other stakeholders. The clause would create a national body, underwritten by central Government, for a system of deferred payment agreements. It would work in a way similar to the Student Loans Company—the body that administers student finance—and would provide councils with the flexibility to opt into a national framework for deferred payments, should they wish to do so.

The proposed new clause has the support of a range of stakeholders, including the LGA, the Association of Directors of Adult Social Services, the Chartered Institute of Public Finance and Accountancy, Age UK and the

[Grahame M. Morris]

National Association of Financial Assessment Officers. The rationale to support the clause is essentially twofold. First, a national body would provide an important single point of contact and an important degree of consistency for people entering into a deferred payment agreement, irrespective of where they live. I am sure the Minister will agree that it is in the interest of the public purse and the individual that deferred payment agreements are run in the most efficient and consistent way possible. Secondly, it makes good financial sense for a bespoke body to concentrate the financial risk involved, rather than expose 152 councils to such risk.

I have a lot of information here, a detailed assessment of the financial risk to the authorities involved and the advantages of having a single body to provide such a facility, which has been prepared by the LGA but which I have not got time to go into. I will happily share this with the Minister. The proposed new clause is in response to very understandable concerns from local government and from wider stakeholders about the level of financial risk that councils will face. It improves the Bill; I do not seek to undermine it. I am sorry that the Minister is not listening. It is a key part of the Government's proposals to manage risk and improve services for those who need them.

I hope that the Minister will take this proposal away and consider it carefully. I do not propose to push this new clause to a vote, but I would like the Minister to provide reassurances that the Government will treat the proposal seriously and will meet and work closely with LGA and ADASS. I hope that the Minister will be prepared to commit his Department to work with local government to explore how such a body could be set up and managed for the benefit of some of the most vulnerable members of society.

Norman Lamb: My first response to the hon. Gentleman is that I would be happy to meet the LGA. Indeed, I would very much welcome the hon. Gentleman to the meeting—it would be nice to see him in the office. We want to ensure that deferred payment agreements are available universally throughout England, so that people are not forced to sell their home within their lifetime to pay for care. Our approach is to build on the existing local schemes that local authorities are already operating.

Proposed new clause 29 would allow the Secretary of State to appoint a body to administer deferred payment agreements on behalf of local authorities. As the hon. Member for Easington has made clear, it would be something akin to the Student Loans Company, given the clause's similarity to the legislation underpinning those arrangements. My question to the hon. Gentleman is why does he think that this would be desirable and necessary?

First, let us should consider its desirability. Is it desirable to move delicate decisions, which can be heavily affected by local factors, such as local housing markets and the cost of care locally, away from a local organisation and put them in the hands of a national body? I cannot see that it is. Further, I do not think that it is desirable to force individuals and their families, at a point of crisis, to approach an additional national organisation and potentially battle their way through an additional layer of bureaucracy. Not only would this be stressful for the individual and his family but it would also introduce potential delay and an extra body that money has to trickle through before an arrangement is in place. I think everyone would agree that it would not be desirable, in a time of fiscal constraint, to spend money setting up a new body, a new quango, to perform a function that many local authorities already execute. To do so would seem to me to be wasteful.

If we can therefore conclude that this amendment is not desirable, we must consider whether it is necessary. It might be considered necessary because local authorities do not have the skills to administer the universal scheme. I find that hard to believe, given that—as I have already said—many local authorities already offer their own scheme. In addition, we have also committed to providing a model agreement and statutory guidance, which I think the Opposition also suggested, and other implementation support, to help local authorities to expand their offers in line with the national scheme.

Therefore, the proposed new clause does not strike me as being necessary. Perhaps it is considered necessary for reasons of funding, but the Department has committed to funding the expansion of the scheme, including providing £110 million in 2015-16. As local authorities already operate deferred payments, any additional administrative costs would be minimal and they would certainly be significantly less than those required to set up a new body.

Perhaps the proposed new clause is considered necessary to encourage efficiency, but that is simply not the case. Clause 78 already gives local authorities the power to delegate their functions, including deferred payment agreements, and it allows delegation in a far superior way than the new clause would. It does not force a national body that is remote from local conditions and lacking in local knowledge to make decisions that it is ill equipped to make. Instead, it allows local authorities to combine their collective resources and offer a regional solution that is tailored to local conditions and that allows the administrative burden to be shared.

I am sure that this Committee will agree that delegated arrangements set out in clause 78 are infinitely preferable to the provisions in new clause 29, which further renders the new clause unnecessary. However, as I have already said, I am happy to meet the hon. Gentleman and the LGA to discuss their concerns further. To conclude, this proposed new clause is as undesirable as it is unnecessary, and I hope that the hon. Gentleman will withdraw it.

11.15 am

Grahame M. Morris: I am grateful to the Minister for his comments, but I will just respond to some of them. I am grateful that he has agreed to have a meeting, so that we can consider the advantages of such a scheme. He asked, "Why?", and the answer is that it is about managing risk from the local authority's perspective. I did not really have time to go into that because my speech had to be truncated, but the LGA estimates financial exposure in excess of £110 million; indeed, the figure could reach £1.1 billion by 2025. Clearly, central Government can borrow from the markets more cheaply than local government can, so there are arguments about efficiency and consistency.

However, in the interests of time management and so that I do not try your patience, Mr Rosindell, I will withdraw the new clause and take up the Minister's kind offer of a meeting.

I beg to ask leave to withdraw the proposed new clause.

Clause, by leave, withdrawn.

New Clause 30

ADULT SAFEGUARDING ACCESS ORDER

'(1) An authorised officer may apply to a Circuit Judge authorised by the Court of Protection for an order (an adult safeguarding access order) in relation to a person living in any premises within a local authority's area.

(2) The purposes of an adult safeguarding access order are—

(a) to enable the authorised officer and any other person accompanying the officer to speak in private with a person suspected of being an adult at risk of abuse or neglect;

(b) to enable the authorised officer to assess the mental capacity of a person suspected of being an adult at risk of abuse;

(c) to enable the authorised officer to ascertain whether that person is making decisions freely; and

(d) to enable the authorised officer properly to assess whether the person is an adult at risk of abuse or neglect and to make a decision as required by section 42(2) on what, if any, action should be taken.

(3) While an adult safeguarding access order is in force, the authorised officer, a constable and any other specified person accompanying the officer in accordance with the order, may enter the premises specified in the order for the purposes set out in subsection (2).

(4) The authorised Circuit Judge may make an adult safeguarding access order if satisfied that—

(a) all reasonable and practicable steps have been taken to obtain access to a person suspected of being an adult at risk of abuse or neglect before seeking an order under this section;

(b) a notice has been served on any relevant third party who the authorised officer has reasonable cause to suspect is preventing access to allow enquiries to be made under section 42 and for the purposes set out in subsection (2);

(c) the authorised officer has reasonable cause to suspect that a person is an adult who is experiencing or at risk of abuse or neglect;

(d) the authorised officer has reasonable cause to suspect that a person is unable to make decisions freely;

(e) it is necessary for the authorised officer to gain access to the person in order to make the enquiries needed to inform the decision required by section 42(2) on what, if any, action should be taken;

(f) making an order is necessary in order to fulfil the purposes set out in subsection (2); and

(g) exercising the power of access conferred by the order will not result in the person being at greater risk of abuse or neglect.

(5) An adult safeguarding access order must—

(a) specify the premises to which it relates;

(b) provide that the authorised officer shall be accompanied by a constable; and

(c) specify the period for which the order is to be in force.

(6) An adult safeguarding access order may attach other conditions, including—

(a) specifying restrictions on the time that the power of access conferred by the order may be exercised;

(b) providing for the authorised officer to be accompanied by another specified person;

(c) requiring notice of the order to be given to the occupier of the premises and to the person suspected of being an adult at risk of abuse; or

(d) such other conditions as the authorised circuit judge deems it necessary to attach.

(7) A constable accompanying the authorised officer may use reasonable force if necessary in order to fulfil the purposes of an adult safeguarding access order set out in subsection (2).

(8) On entering the premises in accordance with an adult safeguarding access order the authorised officer must—

(a) state the object of the visit;

(b) produce evidence of the authorisation to enter the premises; and

(c) provide an explanation to the occupier of the premises of how to complain about—

(i) the decision to apply for an order; and

(ii) how the order has been exercised.

(9) In this section "an authorised officer" means a person authorised by a local authority for the purposes of this section.

(10) Regulations may set restrictions on the persons or categories of persons who may be authorised.

(11) Subsections (2)(c) and (4)(d) refer to a person under constraint; or subject to coercion or undue influence; or for some other reason deprived of the capacity to make the relevant decision or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.'.—*(Paul Burstow.)*

Brought up, and read the First time.

Paul Burstow: I beg to move, That the clause be read a Second time.

Sadly, I will have to be brief. I want to return to an issue, which I hope will not try the patience of the Minister or the Committee. However, I feel very strongly about it, as do a number of people outside this Committee.

New clause 30 is about creating a statutory power for the courts to authorise local authorities to exercise a power of entry with a police constable in a set of circumstances that are described and prescribed in the new clause. Since we discussed this issue when we debated new clause 3 in our seventh sitting on 21 January, I have given a lot of thought to what the Minister had to say. There is not a lot of time to give full reflection of that, so I suspect that we may come back to this issue on Report; at least, I will attempt to come back to it on Report.

What I have tried to do since that sitting on 21 January is to take on board what the Minister has said, particularly his references to the submission made by Mind. I have taken that submission incredibly seriously and I have had some very constructive dialogue with Mind on these issues; I am grateful to Paul Farmer and his colleagues for giving me their time. However, I will not pretend that I have won over Mind to my view or that of the majority of respondents to the Department's consultation. Nevertheless, it is true to say that Mind's view now is more nuanced than it perhaps was in its original response to the consultation.

New clause 30 attempts to address a number of Mind's concerns. In particular, it would make it clearer that this power relates to circumstances where a third party is preventing access and in some way compromising a person's autonomy; in other words, their ability to exercise their will freely. I will dwell on that point,

[Paul Burstow]

because it is the heart of this debate about whether we should have a provision. It is also about the voice that matters most in a debate such as this one, which is the voice we do not hear at all: the voice of those trapped in abusive relationships, and of those abused or neglected by their family or friends—that is, by the people they trust most.

The Department's own prevalence study found 370,000 people were victims of abuse in the community; to count in those figures somebody had to be the victim of multiple incidents of abuse and also not have dementia. In its disability-related harassment inquiry, which I think is worth reading, the Equality and Human Rights Commission points out a number of issues that go to the heart of why a power of entry is necessary.

We need to consider elder abuse, domestic violence and child protection issues. We are still 10 to 15 years behind where we need to be on these matters. As a result, we are still institutionally blind to them and downplay them too much. I fear that that is reflected in some of the responses to the consultation from some of the organisations involved.

My new clause seeks to take on board a number of the comments the Minister has made; it would require an application to a circuit judge authorised by the Court of Protection and add a notification requirement so that in such a case both parties had the ability to challenge what was being done. It explicitly states that the circuit judge would have to be satisfied that all reasonable steps had been taken to gain access without the benefit of an order. It would make it a requirement that a police constable was present, something about which Mind was very concerned, and would expand the requirements about the notification of complaints procedures.

There is much more I would like to say, but I appreciate the pressures on time. I hope the Minister will continue to give thought to this matter, because I believe that relying simply on inherent jurisdiction is a flawed approach that leaves us open to the charge of failing to address the matter in the way that is needed.

Norman Lamb: My right hon. Friend has been assiduous in pursuing this issue. We all agree about the absolute importance of protecting people who are vulnerable and may be at risk of exploitation. The only thing on which we do not agree is the ultimate solution and whether a new power is required. Although I completely share his view that the thinking on the abuse of vulnerable adults is a long way behind our thinking on abuse of children, we must remember that different issues are in play. Adults with capacity have rights and the state must intervene on those rights with great care or else we will have serious unintended consequences.

In the time available, let me quote from three organisations. First, the Association of Chief Police Officers has said that

"having reviewed the proposal and considered powers of entry in general I am satisfied that the police already have sufficient powers of entry to protect people from harm. Powers of entry are provided to us under both common law and PACE and I am satisfied that these would afford us access to premises where vulnerable individuals are considered to be at risk."

We are, then, talking about not only the inherent jurisdiction of the High Court but the powers under the Police and Criminal Evidence Act 1984. The hon. Member for Sheffield, Heeley, in a very informed speech, discussed the need to have something in the back pocket when negotiating entry. The powers are there in those circumstances.

In its press release responding to the new clause tabled by my right hon. Friend the Member for Sutton and Cheam, Action on Elder Abuse talked about the need to interview people

"being imprisoned in their own homes by their abusers."

That is precisely the sort of situation for which powers are available under PACE to take necessary action where appropriate.

ADASS itself, which represents the directors of social services, has said that

"we have no evidence that the proposed powers of entry would add significantly to the range of tools currently available to practitioners, rather we are concerned that this would encourage a coercive rather than negotiated approach to complex and difficult situations, and"—

this next point is incredibly important—

"increase risk of harm or abuse. Any such power would not assist the complex next steps in assuring and supporting individuals, who have capacity, to stay safe."

Scotland has the whole caboodle, as its Government have introduced not only a power of entry but a power of removal of the person at risk. New clause 30 seeks to introduce only a power of entry. What happens when the people exercising that power then leave? They leave the vulnerable person at potential risk from their abuser. That is precisely what ADASS has said, and it is a real concern for me. There is a balance of risks. I urge hon. Members and my right hon. Friend to recognise that this is a difficult judgment and that there are risks in proceeding.

Paul Burstow: I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

Title

Amendment made: 25, in title, line 5 after 'Authority;' insert 'to make provision about integrating care and support with health services;'.—*(Norman Lamb.)*

Norman Lamb: On a point of order, Mr Rosindell. Before we conclude the Committee stage of the Bill, I would like to put on record my thanks to everyone who has been involved in a variety of ways in ensuring that the Committee has been able to give the Care Bill such thorough scrutiny. I hope right hon. and hon. Members will agree that, aside from a few places where there has been robust debate, we all believe, particularly on the Government Benches, that the Bill represents a hugely significant step forward.

In the view of the shadow Minister, the hon. Member for Copeland, it might be a modest step forward. I would encourage him to be more generous. When he thinks of all of the individual clauses that he supported strongly, he will realise that the sum total is a hugely significant step forward for the health and care system. I think we have done the Bill justice to the appropriate

timetable. That is thanks to the diligence of the Whips, for which I offer thanks, and the foresight of the usual channels. I sincerely thank all members of the Committee for their work and contributions.

I also thank you, Mr Rosindell, and your colleague Mr Bayley, for your guidance and effective stewardship of the Committee. I thank you both for your guidance and wisdom.

The Parliamentary Under-Secretary of State for Health (Dr Daniel Poulter): I echo my hon. Friend's sentiments and comments. I thank you, Mr Rosindell, and Mr Bayley for your stewardship of the Committee in the Chair. I also thank the staff of the House who have supported the Committee: the Clerks, *Hansard* and the Doorkeepers, who have kept the process running so smoothly. I would also like to recognise the efforts of parliamentary counsel in preparing the legislation and the officials from the Department of Health for whose continued support my hon. Friend and I are always very grateful. Thank you to all members of the Committee for their contributions.

Liz Kendall: I also want to thank everyone who has worked so hard, not only hon. Members but the fabulous *Hansard* staff who amaze me every day, the Clerks and Department of Health officials. I would also like to say thank you to the staff of hon. Members here, particularly my staff and those of my hon. Friend the Member for Copeland, who have done a phenomenal amount of work. It is perhaps not an equivalent amount to that provided by civil servants, but they are just a few people who do incredible work.

I also want to thank all the organisations that have bust a gut to provide us with briefings on complicated issues. We rely on them as the Opposition in a democracy to help and support us. I also thank all hon. Members for drawing on their own experience, particularly those who have talked about their professional and personal backgrounds as well as the experiences of their constituents. That is why we are here: to represent our constituents. So, I echo those thanks and to you, Mr Rosindell, and Mr Bayley.

Bill, as amended, to be reported.

11.25 am

Committee rose.

Written evidence reported to the House

CB 32 Craegmoor
CB 33 Social Care Institute for Excellence (SCIE)
CB 34 Ken Lownds
CB 35 Buckinghamshire County Council
CB 36 FirstStop
CB 37 Philip Spiers
CB 38 Partnership Assurance Group plc (Partnership)