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GENERAL COMMITTEES

Public Bill Committee

HEALTH AND SOCIAL CARE (SAFETY AND QUALITY) BILL

First Sitting

Wednesday 10 December 2014

CONTENTS

CLAUSES 1 TO 6 agreed to.

SCHEDULE agreed to.

Title amended.

Bill, as amended, to be reported.

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The Committee consisted of the following Members:

Chair: MR DAVID AMESS

† Bruce, Fiona (*Congleton*) (Con)
Farrelly, Paul (*Newcastle-under-Lyme*) (Lab)
† Jones, Andrew (*Harrogate and Knaresborough*)
(Con)
† Jones, Mr Marcus (*Nuneaton*) (Con)
† Lefroy, Jeremy (*Stafford*) (Con)
† McInnes, Liz (*Heywood and Middleton*) (Lab)
Mann, John (*Bassetlaw*) (Lab)
† Nuttall, Mr David (*Bury North*) (Con)
† Poulter, Dr Daniel (*Parliamentary Under-Secretary
of State for Health*)

† Pugh, John (*Southport*) (LD)
† Reed, Mr Jamie (*Copeland*) (Lab)
† Shannon, Jim (*Strangford*) (DUP)
Simmonds, Mark (*Boston and Skegness*) (Con)
Spelman, Mrs Caroline (*Meriden*) (Con)
Walley, Joan (*Stoke-on-Trent North*) (Lab)
† Woodcock, John (*Barrow and Furness*) (Lab/Co-op)

Kate Emms, *Committee Clerk*
† **attended the Committee**

Public Bill Committee

Wednesday 10 December 2014

[MR DAVID AMESS *in the Chair*]

Health and Social Care (Safety and Quality) Bill

2 pm

The Chair: I welcome everyone to the sitting of this Committee on the private member's Bill promoted by Mr Lefroy. I hope we will proceed with good order and the sitting will be a happy one.

Clause 1

HARM-FREE CARE

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

Jeremy Lefroy (Stafford) (Con): It is a great pleasure to serve under your chairmanship, Mr Amess, and to be in Committee.

First of all, I thank those who have been involved in putting the Bill together with me and who have taken the time and trouble to look at it carefully, and to write to me with various suggestions. I hope I will cover most of those suggestions in my remarks.

As I explained on Second Reading, the clause arises directly from our experiences at the Mid Staffordshire NHS Foundation Trust. It gives the Secretary of State responsibility for putting in place requirements on providers to ensure that activities regulated by the Health and Social Care Act 2008 cause no avoidable harm. The clause amends section 20 of that Act, which states that the regulations

“may in particular make provision with a view to...securing the health, safety and welfare of persons for whom any such service is provided.”

Under the clause, that “may” becomes a “must”. The Secretary of State, through the inspections carried out by the Care Quality Commission, must be assured that regulated providers have the policy, systems and procedures in place to tackle avoidable harm. The CQC registration requirements, which have been redesigned recently, meet that high standard. The clause ensures that they could not reduce the emphasis on patient safety.

Why is it important that the Secretary of State is required to do that? First, because it makes it clear that there will always be a legal duty on health and adult social care providers to run their services in a way that causes no avoidable harm. It requires the Secretary of State to ensure that such a duty is in place. Of course, that duty will be enforced through inspections by the CQC of providers of regulated activities. The clause will ensure that both the registration requirements, and most importantly of all the inspections by the CQC against those requirements, have zero avoidable harm to patients as a primary aim.

The question could be asked: why is this necessary—why would any health care professional do anything other than work in such a way as to ensure that their patients

experience no avoidable harm? Why is that requirement not already covered by the setting and enforcement of professional standards? There are two answers. First, zero avoidable harm is the result not just of health care professionals doing their work to the highest standards, but of the organisations in which they work having policies, systems and procedures that put patient safety at the top of their concerns. It is possible for a health care professional to work in an exemplary manner, with patient safety always at the forefront of her or his mind, and yet for avoidable harm to occur because of a failing in the organisation. For example, there could be insufficient staff on a ward, or medical supplies could be inadequate. It could be that cleaning has not been carried out properly and a patient catches an avoidable infection.

Secondly, the current situation is unsatisfactory. We would not be here today if it were not. Not just at Mid Staffordshire but at several other places—both health care and social care establishments—zero avoidable harm was clearly not a priority for the provider. Professional regulation of health care staff clearly did not prevent that, nor did the existing powers available to the CQC and its three predecessors covering health care, social care and mental health care.

I pay tribute to successive Secretaries of State who, since the problems at Mid Staffordshire first emerged, have shown by their actions that they take the question of patient safety seriously. As I mentioned, the new registration requirements, which come into force next April, meet the requirements of clause 1, but it is vital that such requirements do not depend upon the priorities of individual Secretaries of State. It is also important that both the Secretary of State and the CQC, as the implementer, understand that Parliament, on behalf of those who are users of health and social services, treats the matter with the utmost seriousness. By amending section 20 of the Health and Social Care Act 2008 and putting patients' safety and zero avoidable harm at the top of the list of duties to be provided for when regulating registered activities, clause 1 does precisely that.

Subsection (3) spells out that

“‘cause’ means cause or contribute to, whether directly or indirectly”.

That is important for the reason already stated, which is that it may be a trust's or care home's failure to ensure proper cleanliness or adequate staffing rotas that gives rise to circumstances in which avoidable harm is caused, not simply a direct failure to administer a drug, for instance.

Subsection (3) also defines avoidable harm and clearly is at the heart of the clause. By stating that

“harm is avoidable, in relation to a service, unless the person providing the service cannot reasonably avoid it”,

it rightly applies a test of reasonableness. The clause is not designed to legislate for impossible perfection, but is drafted so as to recognise that some regulated activities have an inherent risk. For instance, as I know from experience, before undertaking a colonoscopy, a patient will always be warned of the risk of a perforated bowel: although the skill of the surgeon and the other staff should and will reduce that risk to a minimum, it is always there. However, one can expect that the trust carrying that out will ensure that all necessary back-up is available so that the unavoidable harm to the patient is addressed immediately, should a problem occur.

Clause 1 gives assurance both to the public and to health care staff. For the public, it ensures that their safety in health and social care must be paramount, and makes the Secretary of State responsible for ensuring that the regulatory framework is in place to achieve that. It gives health care staff the comfort that the organisations in which they work must have in place the policies, procedures and practices that enable them to exercise their skills in an environment dedicated to zero avoidable harm.

John Woodcock (Barrow and Furness) (Lab/Co-op): It is a pleasure to serve under your chairmanship, Mr Amess. I congratulate the hon. Member for Stafford on introducing the Bill and getting it to Committee.

It was important for me, personally, to serve on this Committee and I was glad to get the invitation from the hon. Gentleman and the shadow Minister, my hon. Friend the Member for Copeland (Mr Reed), allowing me to do so. As the hon. Gentleman knows, my local hospital, Furness general, has been through a torrid time over the past few years. It has suffered from failings by the regulators, which were set up to safeguard patients and standards and have aimed to do so. Yet, through failings, partly in the legal regulatory framework, which the Bill will address, and partly through cultural problems in the regulators, they let patients down in key areas. In Furness, we are still dealing with the aftermath of those failings. Whatever the outcome of the Bill and however we legislate—I have full confidence that the Bill will be put into law as quickly as possible—those issues in my local hospital, and across Morecambe bay, must be addressed.

Before I say more on the detail of the Bill, let me make a point to the Minister and the shadow Minister. It is an important point for my hospital and for others. When we are talking about the safety regime and its impact on other hospitals in the country, it is important that we do so as precisely as we can, focusing exactly on specific failings and on shortcomings in regulation. Too often, outside this room, my hospital and others have been talked about as the next Mid Staffs. I know the hon. Gentleman has not wanted that, partly because he does not want the hard work of his hospital staff to be talked down. The Minister has given me assurances on that in the past. I hope that, as the Bill goes through—we know a difficult time lies ahead with the inquiry in Morecambe bay due to report—everybody can keep that in mind and hold to it.

Clause 1 and the Bill as a whole is not a magic bullet. No regulation from the centre can be so. The standards and the regimes in our hospitals will depend largely on the leadership set at the top of those hospitals. It cannot be set in Whitehall, or in the office of the Care Quality Commission or any other regulator, because it comes from the leadership set by hospitals. Management, senior clinicians and senior nurses must be able to show their staff that safety is paramount. How they care for people must be at the forefront of their minds at all times.

Although staff and resources are rightly not the focus of proceedings today, we cannot simply fix a law and hope it works in the absence of adequate staffing and resources. We must not come out of this Committee Room thinking that, because we have sent the Bill further on, we have fixed a problem and everything will

be well. We know the level of pressure under which our hospitals are operating. That will not be changed by the Bill. In some regards, the Bill will create added impetus and pressure on our hospitals, because it puts into law what good regimes know must be in the forefront of minds.

Having said that, clause 1, which sharpens the focus on patient safety and patient care, is important and central to the Bill. I am pleased to be part of the Opposition team supporting it today.

Mr Jamie Reed (Copeland) (Lab): It is a pleasure to serve under your redoubtable chairmanship, Mr Amess. I confess to being almost late, but I was physically stuck behind the Chief Secretary to the Treasury. That is the explanation.

The Bill is exceptionally important and I congratulate the hon. Member for Stafford on introducing it and, as my hon. Friend the Member for Barrow and Furness said, on making it to this stage. Hon. Members know all too well that too many good private Members' Bills do not make it on Second Reading. Hopefully, the Bill will continue to make progress through the House and the upper House before the end of the Session because it does some important things. We have a few groupings to get through and I appreciate that we want to make fairly quick progress. We want the Bill on the statute book as quickly as possible, but some issues need to be addressed, and this is the forum in which to do that in detail.

I want to address a few specific points on clause 1. The principle of harm-free care, as my hon. Friend pointed out, is one that everyone in the country will support, whether patient or medical professional. It is our role as legislators to ensure that we do everything in our power to ensure that patients receive safe care, although it is true that no piece of legislation can ever act as a magic bullet. That is why we will support the Bill.

I would be grateful if the Minister would answer a number of questions on some of the details in the clause. The clause puts a duty on the Secretary of State to

“make regulations imposing requirements on health and social care service providers...to help secure that health and adult social care services in England are provided in a way that causes no avoidable harm.”

Obviously, those regulations will be incredibly important. Will the Minister commit the Government to meaningful and wide-ranging consultation with key stakeholders in the health care sector to ensure that the regulations are as robust as possible? We want to get them right. We do not want to take any missteps if we can avoid them.

Many groups have welcomed the principle behind the clause. The Bill is a good opportunity to bring those groups together and to ensure that we get the detail absolutely right. Clearly, an important component of harm-free care is patient confidence. Of course, a contributory factor is the duty of candour, as recommended by Robert Francis in his report, and in the report into the happenings at Furness general, which my hon. Friend the Member for Barrow and Furness mentioned. I would appreciate it if we could go through the reasons for not pursuing an individual duty of candour.

2.15 pm

I will be grateful if the Minister answers the question raised by the British Medical Association. It is fairly fundamental and I think that all of us who are in favour of effective and efficient legislation would want a clear answer. Do existing regulations and Acts already fulfil the aim of clause 1? We do not want to legislate for the sake of it; none of us wants to do that. The principle of the clause is sound, but I will be grateful if the hon. Member for Stafford and the Minister respond to the points I have raised.

The Parliamentary Under-Secretary of State for Health (Dr Daniel Poulter): It is, as always, a pleasure to serve under your chairmanship, Mr Amess.

I congratulate my hon. Friend the Member for Stafford on a very well thought through private Member's Bill. It will improve the safety of patients, which after all is what everyone engaged in the delivery of health care is primarily concerned about. It was the reason why I became a doctor and I know it is the reason why many people become health care professionals.

Safety is of course paramount in the provision of health and social care services and must be the focus of care providers at all times. The terrible experiences at Mid Staffordshire NHS Foundation Trust, which influenced my hon. Friend the Member for Stafford in no small part in introducing his Bill, underline the importance of patient safety and what can happen when health care providers put other priorities before safety. The hon. Member for Barrow and Furness reinforced that point in relation to his local trust.

The role of the CQC, as the shadow Minister made clear, is vital in protecting the safety of people who use services. CQC regulation currently helps to achieve that in two key ways: by monitoring registered providers against safety requirements and taking enforcement action when those requirements are not met, and by making safety a critical component of the CQC's new inspection regime and one of the five key questions that chief inspectors ask when rating the quality of services. To answer the point made earlier, to enhance and improve the inspection process there is no longer a one-size-fits-all process across hospitals, general practice and social care. There are chief inspectors who oversee different processes for different aspects of health and care delivery, as well as the inspection regimes for those services. That is a big improvement on the previous one-size-fits-all approach. It ensures that proper peer review is part of the inspection process, which is important in delivering good health care on a day-to-day basis but is particularly important when inspecting the quality of services.

Clause 1 will ensure that safety is central to CQC regulation of health and adult social care systems for years to come. In my view—I am glad to hear this from both sides of the Committee—it is an uncontroversial measure that is primarily about protecting patient safety. The clause is fully aligned with the Government's ambition to eliminate harm caused by avoidable safety breaches in the health and care sector. It is currently at the Secretary of State's discretion whether the requirement to register with the CQC should cover safety of care. The clause removes that discretion and instead places a duty on the Secretary of State to impose requirements to ensure that services are provided in a safe way that causes no avoidable harm to patients or service users.

Whereas there has been concern about the Secretary of State's potential ability to interfere politically in the CQC process, this puts it beyond doubt that the CQC's primary aim is always to deliver safety and focus on patient safety in its inspections. That is an important safeguard in the system. If we want an independent regulator, that regulator needs to be free from political interference. That is an important part of why my hon. Friend the Member for Stafford has introduced his Bill and it is at the heart of clause 1.

The shadow Minister mentioned the duty of candour. We plan to lay regulations soon to extend the duty of candour to all providers from 1 April 2015. Finally, as my hon. Friend mentioned at the beginning of his remarks, it is important to outline that the duty in the clause will not impose an obligation on the Secretary of State to ensure that care or treatment is risk-free. Many clinical treatments are intrinsically risky—for example, chemotherapy can be very beneficial for patients, but there are intrinsic risks. A test of reasonableness must be applied in assessing whether harm is avoidable.

The current registration requirements cover safety and will continue to do so when the fundamental standards come into force in April. The clause therefore reinforces what the regulators do, but goes further in ensuring that safety and harm reduction continue to be the key components of CQC regulation in years to come and, importantly, further reinforces the CQC's independence as a regulator.

Jeremy Lefroy: I want to respond to the important question asked by the Member for Copeland about whether the Bill is necessary and whether we are trying to regulate too much. I have wrestled with that question, because I do not want to create law for the sake of it. However, as I said earlier, the current situation legally is unsatisfactory. The incidents that have occurred over the years meant that something needed to be done to tighten up regulation through the CQC and its predecessors. The Government have rightly laid much stricter regulations in respect of patient safety, the primacy of patient safety and zero avoidable harm, but the Bill would ensure that we could never slip back from that, and never again find ourselves in a position where zero avoidable harm was not a priority for the NHS.

Although I am not hugely in favour of legislation stating the obvious, it is important that by making zero avoidable harm the Secretary of State's responsibility, it would always be in the mind of the Secretary of State, among the thousands of other things that he or she has to deal with. Fundamentally, the Bill would ensure that there would always have to be regulations providing for zero avoidable harm.

Question put and agreed to.

Clause 1 accordingly ordered to stand part of the Bill.

Clause 2

CONSISTENT IDENTIFIERS

Mr Reed: I beg to move amendment 2, in clause 2, page 2, line 17, at end insert—

- (i) the regulations in section 1 must include the organisations permitted to have access to the consistent identifier;

- (ii) the regulations in section 1 must include the parameters of permitted uses of the consistent identifier.”

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

Clause stand part.

Amendment 3, in clause 2, page 2, line 27, at end insert—

- “(c) the information to be processed is relevant to the health or social care of the individual.”

Mr Reed: We know that clause 2 would amend part 9 of the Health and Social Care Act 2012, which enables the Secretary of State or NHS England to set information standards in England. The clause would put a duty on the Secretary of State to introduce regulations to specify a description of the consistent identifier, and it sets out where the identifier is applicable and where relevant persons should process information in relation to it. This is an important step forward. The Opposition recognise how essential sharing data between health and care services can be to ensuring high quality, and, most importantly, safe care. None the less, the clause raises some concerns that amendments 2 and 3 are designed to address.

As with clause 1, it is absolutely critical that we get this provision right. The roll-out of care.data has eroded public trust, and patients are rightly concerned about their privacy, particularly in matters of individual personalised health data, but done correctly, the sharing of data can greatly reduce instances of avoidable harm and make health care both more efficient and more effective. Stakeholders have raised concerns in relation to the use of the NHS number as the key identifier. At face value, it is a logical identifier to which to attach patient information, much like a national insurance number in the workplace. Indeed, the NHS England business plan for 2014-15 to 2016-17 states on page 43 that 95% of trusts should:

“be using the NHS number as primary identifier in clinical correspondence by the end of January 2015”—

which is almost upon us—

“with the NHS number to be used in every patient dataset submitted within 5 years.”

That is a commendable aim and would go some way to fulfilling what is being proposed by the clause. Will the Minister outline the progress made to date on both of those targets, particularly given their imminence?

Using the NHS number in this way could allow professionals to identify frequent visitors to various parts of the NHS and social care system and allow underlying causes to be tackled. For example, if a patient is frequently presenting at accident and emergency, are there social or domestic issues that are causing that or underpinning some of their health issues? Using the NHS number will allow that to be highlighted more quickly, and if we can highlight it more quickly, eventually services will be more efficient, more effective and cheaper, I have to say.

The processes in place need to be made consistent. I thank the BMA for preparing a useful and in-depth briefing note on the Bill, which says:

“The inconsistent approach across the healthcare landscape means it has been difficult to join up information about one patient for health professionals and carers.”

A consistent identifier would ameliorate the problem and lead to an improvement in care, which is why the Labour party supports the principles and aims of the clause. However, that does not mean that more cannot be done. There is significant concern among stakeholders that patient privacy could be undermined. In common with many professionals, we are greatly concerned about the potential use of the NHS number outside a health and care setting, which is why I tabled amendments 2 and 3. Although the Bill already contains safeguards about how a patient can opt out of having data attributed to their consistent identifier, and some limited exemptions are built into the proposed framework, we would like them to be extended.

Amendment 2 would ensure that the regulations introduced by the Secretary of State include a list of those permitted to access and use the identifier, as well as the parameters of its use. During the debate on the Care Act 2014, the main concerns that were expressed about data sharing were to do with who would have access to the data. The amendments would clearly lead to regulations that satisfy such concerns. We would know who had access to the data affixed to the identifier, because it would be in black and white and subject to parliamentary scrutiny. Amendment 3 would ensure that information attached to the identifier is used only for health and social care purposes, which would satisfy concerns about its use outside the NHS or health and social care environments. If the Minister is unwilling to support these modest amendments, will he outline the steps that he will take to allay the very real concerns to which they relate?

I will discuss more issues relating to data-sharing principles when we debate the next group, as they are more directly relevant to clause 3, but I want to refresh the Government’s mind about a commitment that they made on data sharing in early November. On the 13 November, the Secretary of State appointed Dame Fiona Caldicott as national data guardian. In a speech to the King’s Fund, he commented on her appointment:

“We need to be as determined to guarantee personal data is protected as we are enthusiastic to reap the benefits of sharing it.”

Who could disagree? According to the Government’s website, he also said:

“I intend to put the National Data Guardian on a legal footing at the earliest opportunity”.

I have no desire to second-guess the Government, but surely today’s sitting would have been the earliest opportunity to do that. The Government have damaged public confidence in data sharing in health care and they have undermined key schemes that would have led to improved care—the care.data programme being the most obvious example. As a result, the Opposition will table an amendment on Report to ensure that the national data guardian is put on a statutory footing. I look forward to the Minister’s response.

Jeremy Lefroy: I thank the hon. Gentleman for his remarks. I share his concerns. I am certainly not one who wishes to tread on people’s privacy in the slightest. The Bill is all about patients, patient safety and care, but confidentiality must also be at the forefront.

Clause 2 deals with the introduction of a consistent identifier for people who are receiving health or social care. Its aim is to help to improve the integration of services and thus the safety and quality of people’s care.

[Jeremy Lefroy]

The clause makes it quite clear, in proposed new section 251A(5) of the Health and Social Care Act 2012, that the inclusion of the consistent identifier in information processed about an individual should be done only if it is

“likely to facilitate the provision to the individual of health services or adult social care in England, and...in the individual’s best interests.”

As I said on Second Reading, this is all about the patient.

2.30 pm

There are three reasons why using a consistent identifier, such as the NHS number, is important. First, it benefits individuals by allowing health and social care professionals readier access to vital health and adult social care information. A consistent identifier is already used in many circumstances in the NHS and is helping with integration, but it is by no means universal and is not widely used in social care. Secondly, it helps to ensure that an individual’s health and adult social care history is readily accessible whenever she or he is in the pathway of care. Hon. Members will no doubt have come across cases of constituents where vital information about their care has not been passed on either within the NHS or between NHS and social care. Thirdly, a consistent identifier such as the NHS number is more efficient than using a name and date of birth to find information. It avoids errors in misspelling names or confusion over people with the same or similar names. Integration of health and social care is an aim that Members of all parties support for very good reason. It will assist better and safer care for our constituents. A consistent identifier will not guarantee that, but it will certainly provide a useful tool.

Clause 2 provides important safeguards for confidentiality of information. First, as I have already mentioned, any information processed using the consistent identifier must be in the individual’s best interests and be likely to facilitate the provision of health services or adult social care. Secondly, the consistent identifier need not be used if, under new section 251A(6)(b),

“the individual objects or would be likely to object to the inclusion of the consistent identifier in the information”.

Thirdly, it need not be used if, under new subsection (6)(c),

“the information concerns, or is connected with, the provision of health services or adult social care by an anonymous access provider”.

That would apply, for instance, to sensitive services such as sexual-health clinics. Fourthly, new subsection (7)

“does not permit the relevant person to do anything which, but for this section, would be inconsistent with—

(a) any provision made by or under the Data Protection Act 1998, or

(b) a common law duty of care or confidence”.

Those are clear and tight safeguards that I trust will reassure those concerned about confidentiality, though I will come on shortly to the points made by the hon. Member for Copeland.

New section 251A(6)(d) addresses the situation where small or voluntary organisations may not have the capacity or infrastructure to comply with the duty to

use a consistent identifier. It states that the identifier need not be used if it is reasonably considered that

“for any other reason, the relevant person is not reasonably able, or should not be required, to comply with subsection (4)”.

Of course, I hope that as many organisations as possible would use the consistent identifier, because the aim of its use is better and more integrated care, but I am determined that it should not become an obstacle for small and voluntary organisations to providing such care.

I welcome all the comments that have been made by, for instance, the BMA, Big Brother Watch, medConfidential and others, and I have considered them all seriously. The point has been raised that the NHS number as a consistent identifier is actually a back-door ID card. I opposed and continue to oppose ID cards and I would not sponsor legislation that I thought might permit their introduction through the back door. The duty in the Bill requires the consistent identifier to be used only by health and adult social care bodies, only for direct care purposes, and only where it is in the individual’s best interests. There are also provisions, which I have already set out, that give a range of circumstances in which a consistent identifier need not be used, even if it could be argued that it was in the patient’s best interests. An ID card is a very different animal. It is universal and compulsory, and it is issued primarily in the interests of the state, not the patient, with some benefits for individuals through easier identification.

The hon. Member for Copeland made a powerful case for the amendments, but I understand that their provisions are already covered by existing legislation—for example, sections 250 and 251 of the 2012 Act. However, it is important that we listen carefully to what the Minister has to say. We must give people confidence that it is all about them, their care and safety, and is not about some kind of Big Brother trying to Hoover up confidential information.

Dr Poulter: I will do my best to answer the points raised by the hon. Member for Copeland.

Clause 2 is about the use of consistent identifiers in health and adult social care. It would place a duty on health care providers and commissioners of publicly funded health and adult social care to include the consistent identifier where it exists in a person’s health and care records and correspondence. The duty applies only to those involved in the direct provision of care and only when it is in the individual’s best interests.

Requiring the use of consistent identifiers in patients’ records and correspondence will facilitate the sharing of information that is necessary to ensure that care is safe, effective and tailored to the needs of each individual. The information sharing provisions in the Bill have no connection with care.data, as they are solely connected with the provision of direct care. I am sure that the hon. Gentleman sees that distinction. The Government support the principles of the clause and its standing part of the Bill.

I thank the hon. Gentleman for his constructive attitude towards the Committee and towards the Bill throughout its passage; it is important to put that on the record. I understand that the amendment he has tabled about the consistent identifier is motivated by a desire to ensure that the use of the NHS number is

limited to health and care purposes. I assure him and the Committee that the duties created by the Bill apply only to the health and adult social care bodies specifically defined in clause 4. That definition makes it clear which public bodies and other persons are covered—namely, those concerned or connected with the provision of health services or adult social care in England. Accordingly, there is no need to limit the use of the consistent identifier to either health and adult social care purposes or to specific organisations, because that is already expressly done through the definition of the bodies covered. The duty to use the consistent identifier is limited not only to health or adult social care commissioners and providers but for the purposes of direct care and in the individual's best interests.

It is the Government's intention to specify the consistent identifier as the NHS number. The NHS number is already widely used for both direct and indirect health and care purposes. The Bill only deals with direct care and maintains all the existing safeguards and protections included in the Data Protection Act and the common law duty of confidentiality. The Bill does not facilitate or apply to the use of the NHS number for purposes beyond direct care. There is already a strong and transparent system of safeguards for how that information is used, so the amendments are unnecessary. Through the definition of the bodies in clause 4 and their functions in clause 2, the duty to use the consistent identifier will apply only if the information concerns or is connected with providing the individual with health services or adult social care in England. The Committee will see that there are additional restrictions to the duty to use the consistent identifier in proposed new section 251A(5) of the 2012 Act. The duty only applies where it is likely to "facilitate the provision" of health or adult care and is in the "individual's best interests." I hope that that is sufficient reassurance for the hon. Gentleman.

This is an important clause. It is about ensuring that we can deliver better care when direct care is being provided to a patient. The hon. Gentleman quite rightly used the example of a patient arriving in A and E with complex care needs and perhaps with dementia. Unfortunately, as things stand, it is sometimes difficult to join up the records that may be in the adult social care system—for example, in a care home—with those in A and E. A lot of staff time is wasted in trying to track down and understand the patient's history when the patient could be being looked after better. Joining those records together in a more effective way to deliver care directly will undoubtedly lead to better care for the patient.

I turn to the final point that the shadow Minister raised about placing the data guardian in law. We absolutely believe that having a data guardian is an important additional safeguard in the system. We want to see that put on to a statutory footing, as the Secretary of State has outlined. In an area as important and complex as this, we need to engage widely to ensure that the data guardian has the right powers and functions. There are, of course, existing protections from the Information Commissioner and the common-law duty that I outlined earlier. Given our clear intent to legislate, it is only right to give Parliament the full opportunity to debate such an important provision. My concern—I hope the hon. Gentleman will reconsider tabling such an amendment later in the Bill—is that the complexity

of putting the data guardian on a statutory footing might mean that we are unable to get through the important measures regarding the CQC and joining up patient data. I would not want us to lose the Bill because of that.

The data guardian, Dame Fiona Caldicott, has already been appointed by the Secretary of State. She has a long, distinguished record of ensuring that data is used appropriately for the benefit of patients. We want to ensure that that is put on to a statutory footing, and I am glad there is unanimity on this issue across the Committee, but let us do it in the right way. Let us give Parliament a proper debate on those issues, and not jeopardise the passage of this Bill as a result of that debate.

Mr Reed: I am grateful for the engagement of both the hon. Member for Stafford and the Minister with the issues I have raised through my amendments. They have provided sufficient food for thought for me to withdraw the amendments and not seek to test the will of the Committee, which, of course, does not prejudice our position on Report. I beg to ask leave to withdraw the amendment.

Amendment, by leave withdrawn.

Clause 2 ordered to stand part of the Bill.

Clause 3

DUTY TO SHARE INFORMATION

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

The Chair: With this it will be convenient to discuss clause 4 stand part.

Jeremy Lefroy: Clauses 3 and 4 deal with the duty to share information. Again, I appreciate that that is a subject of great sensitivity and importance. As with the patient identifier, this is all about the patient, and the same protections as over the patient identifier apply. The duty applies only in so far as the disclosure is, as subsection 3 states,

"in the individual's best interests"

and

"likely to facilitate the provision"

of health and social care services. The clauses ensure that health and social care professionals do not consider themselves inhibited, perhaps through concerns about patient confidentiality, from sharing information directly relevant to a person's care. The duty to share information will, of course, always be balanced by the existing statutory protection provided by the Data Protection Act 1998, other instruments and the common law duties of care and confidence.

I wish to deal in detail with questions that have been raised about this issue because it is important that they are all treated with respect. I have looked into the first question myself because I was concerned about it. GP medical records might contain sensitive, personal, non-clinical information—for example about relationships—which is not relevant for the purposes of that current episode of care. If the sensitive background information is not differentiated, it might be shared inappropriately.

[Jeremy Lefroy]

Records might contain a combination of information relating to the care of the individual and other personal information, for example about relatives and partners.

Clause 3 does not require background information to be shared. Indeed, information should be shared only in support of a person's direct care and in their best interests. Information may only be shared appropriately and legally with others who are providing publically funded health and adult social care. As with the consistent identifier of clause 2, if an individual objects, or is likely to object, even if that information is in support of a person's direct care and in their best interests, the duty to share information will not apply.

The NHS constitution sets out the right for all people to have access to their own health records, to expect the NHS to keep their confidential information safe and secure, to be informed about how their information is used, and to object to the disclosure of personal confidential information and for any objections to be considered. The National Information Board is working towards a whole system consent-based approach, which respects individual's preferences and objections about how their personal and confidential data is used, with the goal of implementing that approach by 2020. I believe that the duty enshrined in clause 3 will result in better and more accurate records that make it easier to separate confidential personal information, which should not be shared with others in the health and social care services, and clinical information regarding someone's condition and treatment which is vital to ensure the highest standards of safety and quality of care.

2.45 pm

I now turn to the briefing paper from the British Medical Association, which asserts that there is no need for the information-sharing provisions contained in these clauses. I recognise that the sharing of information for the purposes of an individual's direct care is already required as part of the professional duties of health and care professionals. Sharing for direct care purposes can be undertaken in accordance with a common law duty of care.

Dame Fiona Caldicott in her 2013 review of information governance across health and social care concluded that implied consent was also a legitimate basis for sharing information for direct care. However, the 2013 review also considered that that sharing was not always happening as it should. The review found that there is a culture of anxiety that prevents information sharing between organisations. The current legislative landscape was found to be a contributory factor with the risk-averse attitude to sharing being cited as a barrier to sharing by staff delivering care directly to individuals. The review recommended that the duty to share information should be as important as the duty to protect patient confidentiality.

The BMA questions whether the Bill may result in the sharing of unnecessary or excessive information, but under these provisions information collected during an episode of treatment or care in a person's health and care records shall be shared only in support of that person's direct care and in their best interests. Information may only be shared appropriately and legally with others providing publicly funded health and adult social care. The provisions will not permit the sharing of unnecessary

or excessive personal data, because all the protections of the Data Protection Act, to which the Bill specifically refers, will continue to apply.

The BMA is also concerned that there is a lack of clarity concerning to whom the information may be disclosed. The Bill would only permit sharing within and between relevant providers and commissioners of—I repeat—publicly funded health and adult social care. Organisations within scope will be required to share such information only with members of staff and other relevant organisations directly involved in that individual's care.

As always, there is a vital balance to be struck between confidentiality, on which I place huge value, and the need for someone's care to be of the highest standard and quality. I believe these clauses strike a fair balance between them.

Mr Reed: We are making good progress today, Mr Amess, and with your permission I would like to address clauses 3 and 4 together. Clause 3 inserts a new section into part 9 of the Health and Social Care Act 2012 and imposes a duty on relevant persons to ensure that the information is disclosed to relevant professionals where it directly facilitates provisions of health or care services and where it is in the individual's best interests, as the hon. Gentleman rightly pointed out.

The clause would not permit any action that is not consistent with the relevant provisions of the DPA or other common law duties of care or confidence. A number of bodies have commented that they are unsure as to the problem that this measure addresses. I would be grateful if the Minister would address those points.

Most of the underlying principles of data sharing and medical privacy were touched on in the debate on the previous clause and the associated amendments, but there are further points of detail that need to be examined in these two clauses. It is clear, through subsection (3) of clause 4, that exemptions to the duty will be created and that goes some way to address inconsistency within existing provisions. It would seem that the unintended consequence of these clauses would be to legislate for a presumption in favour of data sharing that is prevented. Can the Minister explain why that will not result in a number of people getting access to information for which they have no use and no need to see?

If he does not think that would be the case, can he outline why not and what safeguards are in place to ensure that does not happen? As I have said previously, the Opposition want to see good data sharing in the health and care sector. When that is done properly, it can promote better outcomes and improve patient experience and the efficiency of the overall system. That notwithstanding, it is an incredibly complex process and we must exercise caution. Data are like water; if there is a leak, the data are out there and cannot be recaptured. We are seeing more and more examples of personal data being leaked online and we must ensure that patients' privacy is protected.

Will the Minister explain what steps will be taken to ensure the system and framework that is put in place is as robust as possible and how it will be tested before it is rolled out? Again, as with all aspects of the Bill, the Government would be well advised to consult a wide range of stakeholders to ensure that they get this right

the first time, for the benefit of everybody who uses the system. I will not repeat what I have already said with regard to care.data but the lessons ought to be learned. The principle of data sharing to improve care cannot survive any Government riding roughshod over concerns and ignoring those who want to see the scheme succeed, but have concerns about its details.

NHS Providers, formerly the Foundation Trust Network, has expressed a number of concerns. The main one regards the relevance of information shared. They said:

“Clause 3 makes amendments to the Health and Social Care Act 2012 with no reference to relevance of information sharing. Existing obligations to share information for direct patient care do not entail the need to share everything. Only relevant information about a patient should be shared between those providing or supporting their care.”

That is certainly the principle that the hon. Member for Stafford wishes to espouse at the heart of the Bill. I hope the Minister can address that point head on in his remarks.

I turn now to the impact assessment and the cost of the provisions. The explanatory notes accompanying the Bill make reference to the impact assessment and an up-front cost of £11.2 million, with benefits to come annually thereafter. It appears that stakeholders have not had access to that impact assessment as it is seemingly available only in hard copy from the House of Commons Vote Office. Will the Minister be able to put it in the public domain and online so that we can scrutinise the details, and can he explain where the up-front funding for the scheme will come from?

Dr Poulter: I do not wish to detain the Committee too long by repeating the points I made in the previous clause. I have already to some extent addressed some of the concerns raised by the shadow Minister. However, to reassure him and to provide some context, data sharing of this type already happens in the NHS. It is not revolutionary or new. It already happens and is part and parcel of care. Different parts of the hospital—we hope and I know—talk to each other. When the patient is discharged, data is shared with the GP and other parts of the health and care system, as appropriate. However, the free flow of that information is sometimes inhibited by anxieties and concerns, as my hon. Friend the Member for Stafford outlined in his remarks. Indeed, Dame Fiona Caldicott’s review of information governance in 2012 found that there is a culture of anxiety that sometimes prevents information sharing between organisations, so it is wholly appropriate to the examples that I gave, and that the hon. Member for Copeland gave in his examples of accident and emergency. That is simply good care. It happens every day, but we do not want to see barriers to that free passage of information when it is for the direct benefit of patient care, whether it is the direct care of a patient when they come into hospital, when they are discharged, or as they move around the health and care system.

There are safeguards in place. Dame Fiona Caldicott’s role as the national data guardian to oversee the use of information throughout our NHS is an important step forward, as the Secretary of State has already outlined. As I mentioned when speaking to the previous clause, there is the Information Commissioner and a common law duty of confidentiality to protect people from having their information abused.

We are happy to place the impact assessment in the public domain. We are not really changing the system, but removing some of the anxiety that has existed in the system. We are encouraging people to use information for the benefit of patients, as it is already used, and making sure that the anxieties that have sometimes existed in the past are removed. There can be an up-front cost to that, but the better sharing of information often reduces costs later on, because it can reduce some of the bureaucratic burdens on organisations and frees up more money for patient care. Just as importantly, it is about delivering more seamless, better care for patients. We often talk about more integrated joined-up care, and that is exactly what the clauses are aimed at providing. I hope that that has given sufficient reassurance to the hon. Gentleman who raised reasonable concerns and to all members of the Committee. I support clauses 3 and 4 standing part of the Bill.

Clause 3 accordingly ordered to stand part of the Bill.

Clause 4 ordered to stand part of the Bill.

Clause 5

OBJECTIVES IN RELATION TO THE REGULATION OF HEALTH AND SOCIAL CARE PROFESSIONS

Mr Reed: I beg to move amendment 4, in clause 5, page 5, line 15, at end insert—

- (ii) to promote and explain the processes and judgements reached by the Authority in relation to maintaining professional standards.”

The Chair: With this it will be convenient to discuss clause stand part.

Mr Reed: The clause and its accompanying schedule seek to introduce a consistent, overarching objective for regulatory bodies in health and care and ensure that that objective is maintained through the same means across the board. That is a logical and overdue step forward, and I commend the hon. Member for Stafford for including it in the Bill.

The Government were widely expected to introduce a Bill on the regulation of health care workers in the Queen’s Speech, but decided against it. Like many stakeholders throughout the health care sector and, frankly, across the House, I was disappointed by that. Will the Minister explain why such a Bill has not been introduced? It cannot have been because of a limit to the parliamentary time available.

On page 5 of the Bill, lines 8 to 22 set out how the regulatory body will pursue the overarching objective. There is concern among bodies that proposed new subsections (2B)(b) and (2B)(c) could cause some issues when taken together: there are worries that they could be mutually exclusive in a limited number of circumstances. That is what I want to address with my amendment.

Proposed new subsection (2B)(b) will place an objective on regulators to promote and maintain public confidence in the professions, and proposed new subsection (2B)(c) will place an objective to promote and maintain proper professional standards and conduct for members of regulated professions. Those are laudable objectives that the Opposition support, but it is possible that, in

[Mr Jamie Reed]

some events, the action needed to maintain public confidence in the profession may be different from the action needed to maintain standards. That would put the regulator in a difficult position, which none of us wishes to see.

In disciplinary procedures, the public may expect to see a professional dismissed or struck off, even when they pose no risk to patients. The current drafting of the clause may create for the regulator a roadblock through which it cannot navigate. In that regard, which one of the objectives would take precedence? Should a regulator strike off a fit-to-practice professional to satiate public confidence, or should it maintain proper standards, even if that has the added effect of diminishing public confidence?

Amendment 4 would provide a bypass for such an impasse in order to satisfy both objectives. Publicising, explaining and justifying decisions reached under proposed new subsection (2B)(c) would satisfy public confidence, and by making the judgments and the reasons behind them public, the public would be fully aware of the processes and the system. This is precisely what we seek to encourage in the public: faith in both the process and the system. Through such public scrutiny of decisions, there would be confidence that the regulator had acted in a proportionate and logical way.

If the duty of the regulator is to protect the public, it is right that the public have the opportunity to scrutinise its actions. I am very keen for the Minister and the hon. Member for Stafford to address the concerns that I have outlined and explain how they see these issues and their resolution. If the Government cannot accept that there is a problem, what will they say to the professional bodies that have raised an issue of such concern? I look forward to the Minister's reply.

Jeremy Lefroy: I am grateful to the hon. Gentleman for his important remarks, which I will seek to address.

Clause 5 deals with objectives in relation to the regulation of health and social care professions. It seeks to give effect in law to recommendation 13 of the Law Commission's excellent report, "Regulation of Health and Social Care Professionals", which says:

"Given the importance of health and social care professionals regulation, it is a matter of some concern that its UK legal framework is fragmented, inconsistent and poorly understood."

As I said on Second Reading, I am a strong advocate of introducing the Law Commission's entire draft Bill at the first opportunity. However, I believe that introducing the overarching duty to protect the public, together with maintaining public confidence in the professionals and promoting and maintaining proper professional standards and conduct, is a very important matter that should not be left any longer.

I would like to address the important concerns raised by the BMA in its briefing paper. The BMA has particular concerns about the introduction of public confidence to the regulatory bodies' objectives. However, the overarching objective confirms that regulators must act in the interests of public protection. My constituents' experience is that that is vital.

The Bill will make it clear that public protection involves maintaining both public safety and confidence in the professions, and proper professional standards

and conduct. It will simply codify the position that has been established in case law and ensure that those elements of the overarching objective can be considered only where they are relevant to public protection. There are clearly issues, such as confidentiality, where there is no direct risk to patient safety, but where it is none the less right that regulatory bodies should be able to take action in the interests of public protection.

3 pm

The measure ensures consistency across regulatory bodies and the Professional Standards Authority. The intention is to have consistent wording. The phrase "well-being", which the BMA questions, is used in a number of the regulatory bodies' current objectives. In its recent review of the regulation of health professionals, the Law Commission recommended that the phrase should be adopted in the objective for all the regulatory bodies, hence its inclusion in the clause. The commission assesses that "well-being" has operated without difficulty thus far, and sees no difficulty with including it.

The measure will not apply to the General Medical Council, as the Government are already amending the Medical Act 1983 through a section 60 order to introduce the measure for the GMC. The measure will also not apply to the Pharmaceutical Society of Northern Ireland, as the Department of Health, Social Services and Public Safety of Northern Ireland has indicated that it does not wish the measure to be applied at this time.

The hon. Member for Copeland rightly referred to the fact that the BMA has specifically raised the possibility of trial by media as a result of including the phrase,

"promote and maintain public confidence in the professions."

While I understand the concern, I refer again to the fact that this can only be considered where public protection is relevant. However, he has made some relevant comments that should be further considered. In addition, maintaining confidence is far more than a matter of reacting to press reports. Regulators are capable of sifting out the wheat from the chaff. In my experience, lengthy delays in tackling problems have occasionally led to a loss of confidence in professional bodies or regulators, as well as their attempts to defend practices which it would seem extraordinary to defend. Public confidence in the professions is essential. I therefore welcome the Law Commission's recommendation that that general objective should be given effect in clause 5.

The president of the Royal College of Surgeons has kindly written to me and asked that we should consider including in the Bill two further proposals from the Law Commission's review: enabling regulators to annotate registers to note health professionals' specialisms and credentials, and implementing the Law Commission's suggested approach to protected medical titles, with the addition of "oral surgeon" and "orthodontist". There are problems with including those suggestions in the Bill. Although they could be considered in the scope of the Bill, as per its long title, the advice from parliamentary counsel is that it would not be possible to develop those proposals into workable provisions in Committee. However, I understand that the Government will be responding to the Law Commission's recommendations and will include their views on protected titles and functions. With those brief remarks, I conclude on clause 5.

Dr Poulter: The clause introduces an overarching objective for the Professional Standards Authority. It also introduces a schedule to the Bill which makes changes to the objectives of the regulators of certain health and care professionals, including dentists, nurses, midwives and opticians. The Professional Standards Authority is responsible for overseeing the UK's nine health and care professional regulatory bodies. The clause will ensure that public protection is at the heart of what the PSA does.

The points made by the hon. Member for Copeland have been covered to some extent by my hon. Friend the Member for Stafford. The Government support the principle of transparency. For the PSA, that is achieved through its accountability to Parliament. The PSA is required to report annually to Parliament on its performance and is held to account by the Select Committee on Health. The PSA also reports to Parliament on the regulators' performance. The PSA is required, under section 26B(1) of the National Health Service Reform and Health Care Professions Act 2002, to ensure that the public are informed about the PSA and how it exercises its functions by publishing or otherwise providing information to the public—for example, by publishing on its website the outcomes of the fitness-to-practise cases that it refers to higher courts for consideration, sometimes known as the PSA appeal. That provision prompts the question of what the PSA's role is in promoting and maintaining proper professional standards and conduct for members of regulated professions. Under clause 5, that means the PSA considering, when promoting best practice among the regulatory bodies, how proper professional standards and conduct for regulated professionals can be promoted and maintained in the interests of public protection. Regulatory bodies do that by issuing standards for those professionals, assuring themselves that they are appropriate, and that, where standards are not met, action is taken to protect the public through fitness-to-practise processes.

I should clarify that clause 5 does not impose a duty on the PSA directly to promote or maintain such standards and conduct. I am therefore confident that there are sufficient transparency and accountability arrangements in place across the PSA's functions. I hope the hon. Member for Copeland is reassured by that.

On the Law Commission Bill, which the hon. Gentleman mentioned, we have committed to pursuing a Bill when parliamentary time permits. In the meantime, where there are issues that directly affect patient safety in our response to the terrible events in Mid Staffordshire and others that have been raised by health care regulators, we have taken action through a number of section 60 orders. A Nursing and Midwifery Council order was made a statutory instrument two weeks ago. We are currently looking at an order with the General Dental Council, the General Medical Council and other health care regulators in respect of language testing. Many provisions in the Bill strengthen aspects of patient safety, including the clause on the role of the PSA. I hope that is reassuring for hon. Members. I do not wish to rehearse the eloquent points made by my hon. Friend.

Mr Reed: As part of this festival and rejuvenation of parliamentary democracy and, more importantly, our desire to see these measures enacted as quickly as possible, I will not test the will of the Committee and beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clauses 5 and 6 ordered to stand part of the Bill.

Schedule agreed to.

Title

Jeremy Lefroy: I beg to move amendment 1, in title, line 5, leave out from “England;” to “to” in line 8.

This is a technical amendment to make the long title match the contents of the Bill. The Bill does not contain provision about automatically removing individuals convicted of certain serious offences from the registers so the amendment removes the limb about their removal from the long title.

The amendment is necessary to reflect the fact the Bill no longer makes provision about the disposal of cases concerning a person's fitness to practise the health or social care profession. It had been my original intention to include more provisions based on recommendations from the Law Commission's report. However, the extent and complexity were beyond what could reasonably be contained within a private Member's Bill. However, as I have said before, I hope the Government will introduce a Bill at the earliest possible opportunity.

Amendment 1 agreed to.

Mr Reed: On a point of order, Mr Amess. It would be remiss of me if I did not express my sincere thanks to the hon. Member for Stafford for his welcome work in introducing the Bill. I should personally like to thank, on behalf of the long-suffering, incredibly diligent, amazing Ben Miller, Committee Clerk Kate Emms for all her fantastic work during this process—[HON. MEMBERS: “Hear, hear!”] I would also like to thank the Minister for the constructive way in which he has engaged with my comments today. I would also like to thank my hon. Friend the Member for Barrow and Furness for his work, which is really important to the entire Cumbrian health economy. With that, Mr Amess, I wish you all the felicitations of the impending season.

Dr Poulter: Further to that point of order, Mr Amess. I, too, would like to thank you for chairing the Committee, and the Clerks and everybody in my hardworking team of officials who have worked on the Bill for months.

The Bill is uncontroversial and important in improving patient safety. I want to put on record my thanks for the consensual way in which the Bill has been approached by all parties. I particularly thank my hon. Friend the Member for Stafford, who is doing his very best to ensure that the terrible experiences at his local hospital never happen again. That is his motivation for promoting the Bill. It is a welcome Bill—his patients in Stafford and patients all over the country will be grateful to him for introducing it—and I hope we can get it on to the statute book.

Jeremy Lefroy: Further to that point of order, Mr Amess, I want to thank you for your chairmanship of the Committee. I thank Kate Emms and everybody involved in the procedures for private Members' Bills. I have had immaculate advice at every stage. They have been very helpful, courteous and friendly. I also thank all at the Department of Health staff who have worked with me and colleagues on the Bill. Without them, it would not be possible, although I take full responsibility for it.

[Jeremy Lefroy]

I thank the Minister for his support and the work he has put in. I thank the hon. Member for Copeland for his commitment and his work, for the way in which he has come along with us, and for the points he has raised.

I am determined that, whatever happens, the Bill, if it eventually reaches the statute book, should bring advantage, not obstacles. The Bill is all about patient care and safety. If it does not result in that, it is not worth having, so let us make sure that it delivers.

Finally, I thank colleagues who agreed to be members of the Committee for their work and wish everybody a happy Christmas.

The Chair: If there are no further points of order, I wish to join with others in congratulating the hon. Gentleman on his place in history and on the safe passage of his Bill thus far.

Bill, as amended, to be reported.

3.12 pm

Committee rose.