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The House met at half-past Nine o'clock

PRAYERS

[Mr Speaker *in the Chair*]

Tom Pursglove (Corby) (Con): I beg to move, That the House sit in private.

Question put forthwith (Standing Order No. 163), and negatived.

Access To Medical Treatments (Innovation) Bill

Consideration of Bill, not amended in the Public Bill Committee

New Clause 1

Action plan for an off-patent drug pathway

(1) The Secretary of State shall require the Department of Health to produce an action plan for developing a pathway for off-patent, repurposed drugs where strong evidence of their effectiveness in a new indication exists, with the aim of securing their routine use in such an indication.

(2) The action plan under subsection (1) must be published within 12 months of this Act coming into force.

(3) The Secretary of State shall have a duty to seek to work with the devolved administrations to develop consistent approaches.—*(Nick Thomas-Symonds.)*

Brought up, and read the First time.

9.34 am

Nick Thomas-Symonds (Torfaen) (Lab): I beg to move, That the clause be read a Second time.

Mr Speaker: With this it will be convenient to discuss the following:

New clause 2—*Identifying evidence on off-patent repurposed drugs and passing to relevant bodies*—

(1) The Secretary of State shall require the National Institute for Health Research to develop and introduce a mechanism for—

(a) gathering and recording existing evidence on off-patent, repurposed drugs, including clinical trial evidence, and

(b) passing this information to relevant bodies.

(2) The Secretary of State shall determine the relevant bodies under subsection (1) and may revise that determination from time to time.

New clause 3—*Appraisal in new indications*—

(1) Where there is an off-patent, repurposed drug with strong evidence of its effectiveness in a new indication, the Secretary of State shall direct the National Institute for Health and Care Excellence (NICE) to conduct an appraisal in relation to the drug in its new indication.

(2) An appraisal under subsection (2) should include a cost-effectiveness analysis.

New clause 4—*National commissioning policy for off-patent new drugs*—

Where there is an off-patent, repurposed drug with strong evidence of its effectiveness in a new indication, the Secretary of State shall require NHS England to produce and disseminate a national commissioning policy.

New clause 5—*Accessibility of the licensing process*—

(1) The Secretary of State shall require the Medicines and Healthcare products Regulatory Agency to consult key stakeholders about steps to be taken to make the licensing process more accessible to organisations or individuals other than pharmaceutical companies.

(2) For the purposes of subsection (1), key stakeholders shall include, but not be limited to—

(a) patient organisations,

(b) medical research charities,

(c) relevant academics, and

(d) the British Generic Manufacturers Association.

New clause 6—*British National Formulary: inclusion of off-patent drugs*—

The Secretary of State shall require NICE and the British National Formulary (BNF) to review their processes for registering off-label uses of repurposed drugs where there is strong evidence of their effectiveness.

Amendment 10, in clause 1, page 1, line 3, after "treatments" insert "(including treatments consisting in the off-label use of medicines or the use of unlicensed medicines)"

Amendment 13, in clause 5, page 3, line 44, at end insert—

"(1A) For the purposes of section 2(2), the kinds of medical treatment that may be innovative medical treatments include (amongst other things)—

(a) the off-label use of an authorised medicinal product, and

(b) the use of a medicinal product in respect of which no marketing authorisation is in force.

(1B) In subsection (1A)(a), the reference to the off-label use of an authorised medicinal product is a reference to the use of the product—

(a) for a purpose other than one for which its use is specified,

(b) in relation to a person who is not within a description of persons for whom its use is specified, or

(c) in any other way in which its use is not specified.

(1C) In this section—

(a) 'authorised medicinal product' means a medicinal product in respect of which a marketing authorisation is in force;

(b) 'marketing authorisation' and 'medicinal product' have the same meanings as in the Human Medicines Regulations 2012 (S.I. 2012/1916);

(c) 'specified', in relation to a medicinal product, means specified in its marketing authorisation."

Nick Thomas-Symonds: These new clauses and amendments, which I support, relate to off-patent drugs. I think it would be useful for me briefly to set out the context in which they arise. The Off-patent Drugs Bill, a private Member's Bill that I introduced—it was debated on Second Reading on 6 November—is a UK-wide Bill that would create a duty on the Government to make cheap drugs available when pharmaceutical companies had no incentive to do so. The problem, put simply, is that if a drug is shown to be useful for a new purpose after its original patent has expired, a pharmaceutical company has no financial incentive to sponsor that off-patent treatment through the processes normally used to license it and ensure its adoption on the NHS.

[Nick Thomas-Symonds]

Those off-patent or off-label treatments are certainly available at low cost. The issue is simply that although clinicians can of course prescribe them, they tend not to be prescribed consistently across the medical sector, or indeed geographically.

The Off-patent Drugs Bill ran out of time that day, but I think it is accurate to say that the Government supported its aims but not the mechanism it proposed. None the less, in recognising that there is a problem, and with a shared position on both sides of the House on the need to encourage greater consistency in off-label prescribing, a lot of work has since been done, and on a cross-party basis. I am proud that new clause 1 stands in the name of Members from no fewer than eight political parties. The concept of encouraging greater use of off-patent drugs, and indeed my Bill, have significant support across the House and outside. I pay tribute to Jonathan Evans, the former Member for Cardiff North, who first introduced such a Bill in 2014. His successor, the current Member for Cardiff North (Craig Williams), has also supported my Bill.

Carolyn Harris (Swansea East) (Lab): I congratulate my hon. Friend on the excellent work he has done on the Off-patent Drugs Bill. Given the consensus across the House, does he agree that now is the time for a firm commitment from the Government on that Bill?

Nick Thomas-Symonds: I am grateful to my hon. Friend for that intervention. I hope to hear such a commitment today, so I look forward to what the Minister for Life Sciences has to say in that regard.

That wide support for my Bill was shared by medical research charities, NHS clinical commissioners in England, the British Medical Association, thousands of members of the public who wrote in, and four medical royal colleges. Indeed, 40 eminent clinicians wrote to *The Daily Telegraph* in support of my Bill.

Since then, I am pleased to say that there have been good attempts on both sides of the House to build on that good will in relation to off-patent drugs. I want to thank the hon. Member for Daventry (Chris Heaton-Harris) for the highly constructive and pragmatic way in which he has been willing to take the off-patent agenda forward when speaking about his private Member's Bill. I thank the hon. Member for Bury St Edmunds (Jo Churchill), who brings a strong personal perspective to the debate. Her sense of what is good for patients has been highly constructive in the debates we have had over the winter months. The hon. Member for Central Ayrshire (Dr Whitford), who used to be a breast cancer surgeon—in fact, she still practises—has brought a great level of expertise and experience in recent months, for which we are extraordinarily grateful. I also pay tribute to the Minister, who has been extraordinarily generous with his time and that of his officials in order to try and take this agenda forward, and for that I am extremely grateful.

I want first to make a point about clauses 3 and 4. While there is something of a consensus around responsible innovation, I had strong concerns about those clauses, as did many across the medical profession who thought that they might encourage a more dangerous type of experimentation, if I may put it that way. Looking at the amendments tabled by the hon. Member for Daventry, I can see that his intention is to remove clauses 3 and 4 altogether, which would be a very welcome step. That would mean that the principal remaining part of the Bill relates to the database of innovative medical treatments. The hon. Gentleman's amendments 10 and 13 would bring the off-patent concept firmly into the purpose of this Bill, and therefore into the database. A lack of data was one of the barriers identified to more consistent prescribing of off-label treatments. The amendments would be an extremely welcome step forward, because they would not only enshrine in law the off-label aspect, but bring the data into the database so that it became more widely and readily available, assisting clinicians on the frontline. I sincerely hope that the amendments will be positively received by the Minister.

New clause 1 sets out an action plan for developing a pathway for off-patent repurposed drugs where strong evidence of their effectiveness in a new indication exists, with the aim of securing routine use. Put simply, this is an action plan with clear timeframes for progress. Again, this would be a welcome step forward.

New clause 2 would require the National Institute for Health Research to develop a mechanism for gathering and recording evidence on off-patent repurposed drugs, including clinical trials evidence, and passing it to the relevant bodies. The NIHR already has a dedicated horizon-scanning centre, but this would set up a dedicated stream for off-patent repurposed drugs to speed up getting them to the frontline and into routine use.

New clause 3 proposes that where there is strong evidence of effectiveness in a new indication, the National Institute for Health and Care Excellence should be directed to conduct a technology appraisal, including a cost-effectiveness analysis. While these drugs are extraordinarily cheap, some level of cost-effectiveness analysis would none the less be desirable, since to achieve routine commissioning, in England for a start, a persuasive business case clearly needs to be put to local hospitals and clinical commissioning groups.

New clause 4 is about having a national commissioning policy for off-patent drugs. It also requests that the Minister work with the devolved nations to produce something that is genuinely UK-wide. This has already happened in the case of NHS England working with Prostate Cancer UK to produce a commissioning policy for an off-patent repurposed drug called Docetaxel.

New clause 5 would make the licensing process more accessible. What would that mean in a practical sense? For example, an initial meeting where there is a discussion of the case and the likelihood of successful treatment could be free, a representative of patient organisations could be designated within the Medicines and Healthcare Products Regulatory Agency for patient organisations, and there could be a guidance document for non-pharmaceutical applicants.

9.45 am

New clause 6, which I want to push very strongly with the Minister, would require NICE and the "British National Formulary" to review the process for registering off-label uses of repurposed drugs where there is strong evidence of their effectiveness. The "British National Formulary" is a reference book used by prescribing healthcare professionals. The point has been made frequently and very well by the hon. Member for Central Ayrshire that in the modern-day NHS there are a variety

of prescribers, not just top consultants, and this measure would make a significant difference right across the UK. At the moment, there is something of a chicken and egg situation: the BNF includes what is already routinely used, but for some repurposed drugs to be routinely used, they need to be in the BNF. We would like the BNF to be able to identify treatment indications where there is enough evidence for them to be considered for a licence but they remain unlicensed due to the lack of a pharmaceutical sponsor.

These amendments form a package of measures to encourage greater consistency in off-label prescribing across the UK. I am very pleased with the cross-party work that we have been able to do on this in recent months. The creator of the national health service, Aneurin Bevan, said on 8 June 1949:

"The language of priorities is the religion of socialism."

I do not say for a moment that I have converted other hon. Members to socialism over the winter, but I certainly think that we have all spoken the language of priorities in saying what we really think is important in taking these issues forward. My mother always told me that compassion was everything. These measures certainly do represent compassion, but compassion combined with a common-sense approach to a problem the solving of which has multi-party support. I very much look forward to hearing what the Minister has to say in due course.

Chris Heaton-Harris (Daventry) (Con): Members may be aware that unlike the initial stages of my Bill, the journey of the Off-patent Drugs Bill promoted by the hon. Member for Torfaen (Nick Thomas-Symonds)—which is, coincidentally, further down on the Order Paper today—enjoyed widespread support from Members of this House, and outside this place among a whole host of charities and non-governmental organisations. My old colleague Jonathan Evans, a former Member of the European Parliament and the former Member for Cardiff North, introduced a similar Bill on these matters, which also gained widespread support. I have watched the progress of these Bills closely and read the briefings provided on them by several charities, and I could not help but notice the obvious links with my Bill and the importance of the subject it covers—increasing the use of effective off-label drugs.

The amendments that we are considering seek to work with the ideas of the Off-patent Drugs Bill and meet the same goal of spreading the use of off-label drugs. I am very grateful to the hon. Member for Torfaen for working with me, and others, so closely to include some of his very good ideas and thoughts in my Bill. He deserves a huge amount of credit for the work he has put into this, alongside the hon. Member for Central Ayrshire (Dr Whitford) and my hon. Friend the Member for Bury St Edmunds (Jo Churchill), who have been unbelievably strong champions of these issues.

The new clauses and amendments I am supporting do not reflect exactly the original Bill introduced by the hon. Member for Torfaen. That Bill sought to require the Secretary of State to seek licences for off-patent drugs in their new purposes. As the Government stated at the time, as the licensing authority in the UK, the Secretary of State cannot take up such a duty. However, that does not mean that a similar end result of increasing the use of such drugs cannot be achieved by other means. I very much hope that we can do so through this Bill.

Breakthroughs in research mean that several existing drugs have been found to be highly effective in treating conditions other than the ones for which they were originally produced. They potentially have huge life-saving effects and can alleviate the suffering of many people for many conditions. There are so many well-known examples. They were widely discussed on Second Reading of the Off-patent Drugs Bill, so I will not repeat all of them. The list includes the likes of tamoxifen and zoledronic acid, and of course the simple drug aspirin, which has so many other benefits in so many areas. The examples mentioned when we debated the hon. Gentleman's Bill speak for themselves in showing us why his new clauses and amendments are so important.

As the hon. Gentleman has said in support of his Bill, doctors are nervous of prescribing off-label drugs. Even if a GP strongly believed in prescribing an off-label drug to a patient, they could well be put off. There are several reasons for that, and they were detailed in briefings circulated at the time. One is the matter of personal liability, which I will talk about in relation to other amendments. General Medical Council guidance shows that clinicians can currently prescribe off-label drugs, but that there are significant disincentives to do so. It states that a licensed treatment should be considered before an off-label or unlicensed treatment. It also indicates a greater level of responsibility for the doctor prescribing off-label, and therefore a potentially greater risk of liability, which would be a disincentive for a doctor in prescribing an off-label drug. Before a clinician has even started down this track, they are wary of picking an off-label medicine.

There is little incentive for a pharmaceutical company to pay for a licence when a drug can be manufactured generically. There is no incentive for any company to market the drug for a new indication, and there is no proper guidance for the use of such a drug. Without any stamp of approval, any marketing or any mechanism to provide guidance, there is nothing to encourage clinicians to use an off-label drug, other than their own medical knowledge.

Drugs without a licence for their second use are not marketed, so there is a lack of awareness, and the prescribing of them therefore varies when a new indication arises. There is no trusted and simple way to spread information about off-label drugs that are working. That means that some doctors may use the drug if they know of the indication, but lots may not. Without a system for sharing such information and spreading knowledge about these drugs, medical professionals deciding whether or not to prescribe them have to spend a huge amount of time reading the literature and undertaking research. The explicit mention, through the new clauses and amendments, of the inclusion of such drugs in the database will ensure that information about them is shared and reviewed, and that appropriate evidence is provided. By spreading awareness, the new clauses and amendments will therefore help to make prescribing more consistent.

On Second Reading of the Off-patent Drugs Bill, the hon. Member for Central Ayrshire said that experts in certain fields will prescribe many off-patent drugs whenever they feel it is necessary. For example, off-label prescribing is quite common in the treatment of secondary cancers. Experts in that area will have experience and will be aware of the evidence for use, but many other medical

[Chris Heaton-Harris]

professionals will not be in such a position. If a drug is not in the "British National Formulary", the dose cannot be checked.

When a clinician uses a drug every day or a specialist in a field sees conditions regularly, they know what works and what is best, and will therefore feel very comfortable in prescribing off-label. However, every medical professional is not an expert in every field. For the majority of the time, patients are not with such specialists. Their first point of call is not a clinical physician working in only one field, but a GP in their local practice or a nurse in their local surgery. I believe that the database has huge potential in helping to spread the knowledge and expertise required for better and further use of such drugs.

I hope that the amendments I have tabled will be agreed by the House—I believe they represent common sense—and that the Minister will listen to Members who have tabled the other amendments and new clauses. Although some of them are probing amendments, a huge amount of effort has gone into all of them. He is aware of the time and cross-party work that has gone into getting the Bill to this point. That has basically been driven by the hon. Members for Torfaen and for Central Ayrshire, my hon. Friend the Member for Bury St Edmunds and, to a certain extent, me. I would like to think that we will have got to a certain place by the end of today's sitting, and that we can all leave the Chamber feeling that we have done some good.

Jo Churchill (Bury St Edmunds) (Con): I congratulate my hon. Friend the Member for Daventry (Chris Heaton-Harris) on his success in bringing the Bill so far. The fact that we have reached even this stage is no small testament to his hard work on the Bill, particularly the discussions about the removal of the areas of concern—clauses 3 and 4—and the fact that he has been gracious enough to allow me and the hon. Members for Torfaen (Nick Thomas-Symonds) and for Central Ayrshire (Dr Whitford) to badger or cajole him into allowing us to table new clauses 1 to 6, but specifically my new clauses 4 and 6.

The Minister was not in the Chamber on 6 November to hear the arguments of the Members who proposed and supported the Off-patent Drugs Bill. Since then, however, he has engaged with many of us, for which I thank him. We felt that his Department's response simply was not correct. Doctors may have been able to prescribe medicines for uses outside their licence or off-label where that was in the best interest of their patients, as the guidance says, but they just did not do so, or at least not consistently throughout the medical profession or the field and irrespective of the patient's postcode. The prescribing of such drugs is more common in oncology, paediatrics, pain management and palliative care, which adds to the lottery effect for the patient.

The need for an action plan for an off-patent drug pathway is undeniable. When there is a strong indication of effectiveness, their routine use for an alternative indication should be secured. For example, the use of bisphosphonates, which were originally developed to treat osteoporosis, are now commonly used by 36,000 women living with secondary breast cancer in this country. Those drugs have already been through phased trials. No one in this place is suggesting that the highest levels of safety should not be applied to drug research and licensing at all times, but efficacy should drive clinicians' decision making.

Patients, too, have a voice on this issue. I found my patient's voice after my second primary cancer, and I wanted to use it for the benefit of others. Here I am now asking the Minister—not for the first time—to use his position to find a way to unleash the potential of research in this country and to unblock the system for everyone. My oncologist told me that a second primary cancer was luck—bad luck, but just luck—and I hope that we can all improve the odds just a little bit today.

I believe in the power of patients, clinicians, charities and pharmaceuticals to do the right thing—to increase their knowledge for those whose daily lives are dominated by serious disease and debilitating illnesses, and to ensure that treatments exist to help them. Particularly in the area of off-patent repurposed drugs, they need to be supported by key players, such as NICE, the MHRA, NHS England and medical research charities.

I assure the Minister that it is not mere chance the new clauses and amendments are supported by Members from all four corners of our nation. It is to show solidarity with our constituents—north to south, east to west—who want a co-ordinated approach. One of the most frustrating things for patients is the clogged nature of our drugs pathway. It seems to be beyond us to get drugs licensed, whether repurposed or not, and to the patient in a timely way. I ask the Minister to provide a timeline to support any action that can be taken.

New clauses 2 and 3 would require the National Institute for Health Research to develop and introduce a mechanism for gathering and recording evidence. Last week, I was surprised to learn from Professor Bruce, a clinician at the NIHR working in the musculoskeletal biomedical research unit, that in 50 years only one drug has been licensed for the treatment of lupus. Sadly, that licensed drug has spent four years being considered by NICE and is not available for wider use. To avoid the heavy use of steroids for the condition, rituximab is often used—a drug that was originally developed for lymphoma and rheumatoid arthritis.

10 am

The biomedical research unit is conducting studies in this area and has been successful in drafting an interim policy to provide a framework for governance. The register has been successful in recruiting 400 patients to date. I am hopeful that such an exemplar of best practice may be used to encourage the NIHR to establish a dedicated stream for researching off-patent, repurposed drugs in a more broad-based way.

We need patients and the public to take part in research. The NIHR has a research system that is more inclusive and representative of the population than anywhere else in the world. We need to use it to harness information to benefit patients. Interestingly, it is well documented that those who take part in clinical trials experience better outcomes, so it is a win-win. The opportunities that the NIHR affords us need to be fully explored and, if it is not the most appropriate body, I would like the Minister to commit to finding out what is.

In tandem with any assessment, there will need to be cost-effectiveness to get the drugs into routine commissioning, thereby allowing them to benefit patients.

A lighter-touch approach that makes better use of NICE's resources should be explored, as it could have the benefits of acting as a business case for adoption, reducing duplication and speeding up access to treatments. A commitment from the Minister to introduce such guidance today would be nothing short of great.

New clause 4, which stands in my name and those of my colleagues, states:

"Where there is an off-patent, repurposed drug with strong evidence of its effectiveness in a new indication, the Secretary of State shall require NHS England to produce and disseminate a national commissioning policy."

Let us get treatments that are effective and safe to the patients who can benefit from them. A precedent for this is NHS England's recent work with Prostate Cancer UK to draw up a policy for—you guessed it—an off-patent, repurposed drug. It strikes me that where there's a will, there should be a way. If there is a way for us in England, I am sure that it is possible to ensure that there is a co-ordinated approach for our friends in Wales, Scotland and Northern Ireland.

In this place last November, I referenced the use of tamoxifen and other drugs as a preventive pathway. The purpose of new clause 5 is to look at introducing more accessibility into the system to make organisations such as academia and charities more connected with the licensing process. We are hoping for a commitment that the Department of Health will work with the MHRA to achieve that.

Finally, I will speak to new clause 6. Back in November, when the hon. Member for Torfaen told us why we needed the Off-patent Drugs Bill, I stated that drugs such as tamoxifen, simvastatin and zoledronic acid, among others, were not getting to patients. Tamoxifen and zoledronic acid, in particular, could benefit the women I have spent many years campaigning for, whose fight against breast cancer is often not only one of the most difficult things they endure, but one of the most difficult any member of their family goes through. We still lose 12,000 women a year to this disease. If there is something that we can do to ensure that fewer women die, we should do it.

In November, the hon. Member for Central Ayrshire, with the expert knowledge of a senior clinician, explained that although there was the ability to prescribe, it did not happen. We therefore propose that the "British National Formulary" includes off-patent, repurposed drugs to end the situation whereby experts are prescribing, but other professionals do not feel confident to do so. Like a bilingual dictionary, whichever way someone approaches the BNF—by disease type or drug—it tells them what they need to know as a prescriber, whether they are a pharmacist, a doctor or a nurse practitioner. The BNF generally includes all the licensed indications of a drug. If it supported the adoption of well-evidenced, off-label treatments, it would serve to provide validity. We hope for a commitment that the Minister will fully explore that proposal with NICE and the BNF.

I commend the Minister for his complete openness in engaging with our group of interested, committed MPs from across the House and across the parties to move the situation forward and find solutions. I urge him to look at the accelerated access review, the interim report of which says that we should put the patient "centre stage" and

"accelerate and manage…emerging products".

The AAR did not mention repurposed drugs, so I will call them emerging products. It also speaks of, "Supporting all innovators". We are being innovative. It challenges the NHS to galvanise itself to

"adopt new products and systems".

What we are discussing could be a new system. Finally, it speaks about, "Delivering change". I look to the Minister to make those five commitments work with off-patent, repurposed drugs for everyone in the UK.

Dr Philippa Whitford (Central Ayrshire) (SNP): I rise to support new clauses 1 to 3, 5 and 6 and amendments 10 and 13. The only reason new clause 4 does not stand in my name is that it relates to NHS England, which is outwith my purview.

People are well aware of my objections to clauses 3 and 4. Many Members in this House and medical voices outside the House have real concerns about the danger to patients of doctors having to convince only one colleague before trying a completely unproven approach. As well as the danger to patients, I feel that there is a danger to our clinical trials system. Why would someone go through applications, a year of paperwork and phases 1, 2 and 3, when they could just cut to the chase?

I pay tribute to the hon. Member for Daventry (Chris Heaton-Harris) for being willing to sit around a table with the Members who were named by the hon. Member for Torfaen (Nick Thomas-Symonds) and the Minister, and to start with a blank sheet of paper and work out how we could do something useful. It has been a great procedure. I welcome the fact that later in the day the hon. Member for Daventry will propose the removal of the clauses on innovative practice and litigation.

Turning to the off-patent drugs proposals, 6 November was a very frustrating day in this House. Every single Member who spoke from the Back Benches spoke in favour of the Off-patent Drugs Bill, but the time ran away during the Minister's response—not the Minister who is here today. That debate showed the appetite across the House to get something done on off-patent drugs.

The hon. Member for Bury St Edmunds (Jo Churchill) has explained most of what I was going to explain. There is still the issue that while specialists are steeped in the evidence and used to using drugs off label, those who are not are less sure. There is no automatic place where they can check a dose or an indication. Sometimes, it is the general practitioner who does not carry it through. We have had lots of discussions in this House about the changes in the NHS and the evolution to multidisciplinary teams out in the community. That means that there are far more non-medical prescribers. The further someone is from the expert prescriber, the less comfortable they are. They do not have easy access to somewhere they can check when they think, "Is that just my bad handwriting or is that really what I mean?" That is what new clause 6 on the BNF could achieve.

The BNF is used by everyone and is on every desk in the NHS. As the hon. Member for Bury St Edmunds said, people can either check a drug that they have had a letter about from the hospital or look something up when they think, "I don't have anything for this. What exists?" We will also discuss that when we come to the database proposals. I welcome the fact that the database has been changed from being a registry of people doing their own thing to a place where information is shared.

[Dr Philippa Whitford]

On new clause 5, which I tabled, although the inclusion of off-patent drugs in the BNF will achieve the sharing of information and will, in a sense, give them a slightly informal kite mark, I feel that it is important to look eventually at providing a licence. The reason for my concern relates to the drug simvastatin, which is used all over the place to control people's cholesterol and has been found to be useful in multiple sclerosis—a disease that plagues many people and causes a lot of suffering, and for which, frankly, we do not have a lot to offer. That drug is incredibly cheap, but if a company decides to tweak a little molecule of it, call it something else and put it out as a new wonder-drug for multiple sclerosis, we will be having debates in Westminster Hall about a drug that costs fifty grand and that the NHS cannot afford. Under General Medical Council rules, the cascade is still that a doctor must prescribe a licensed drug over an unlicensed or off-label one, regardless of cost. If a doctor was faced with fifty grand for simvastatin-new versus sixpence for the simvastatin we all know, they would have no choice, and we would be right back in the same position—relentlessly discussing the NHS's access to drugs.

The drugs we are talking about are already safe. They have had a patent and been used for so long that they are now off patent, which means that they have been around for a decade. We know their side effects, the common dosages and what to look out for. They should not have to start at point zero of the licensing process. We need a short licensing system, so that patient groups, academics, charities and the British Generic Manufacturers Association can say, "We think there is something useful here." We have put provisions in new clauses 2 and 3 for the NIHR and NICE to have capacity in their systems to provide a funnel for evidence on such drugs.

These drugs are not developed by big pharma, so there are not huge costs that have to be recouped. The purposes of them are usually found by academics and clinicians, so pharmaceutical companies should not make a massive profit out of them. The benefit should be that the NHS can afford them and patients can access them. We have many debates about access to medical treatments in the House, usually in Westminster Hall and usually about drugs that are eye-wateringly expensive. In this case we are talking about drugs that are proven and cheap. We need to come up with a system that makes them accessible to patients.

I commend the Minister for the time, that, as others have said, he has given the four of us around a few tables, hammering these provisions together. I hope that we will be supported in working them through and actually doing some good for the NHS and our patients.

Anne Marie Morris (Newton Abbot) (Con): It is with great pleasure that I rise to speak in support of this important Bill, introduced by my hon. Friend the Member for Daventry (Chris Heaton-Harris), and the amendments he has tabled. Specifically, I rise to support amendment 13. I am sure that the hon. Member for Torfaen (Nick Thomas-Symonds) will be disappointed that his private Member's Bill did not make it to Committee stage, but I hope that he is happy to see some of it included in this Bill.

I had my reservations about the Bill as it stood originally, and I have reservations about some of the amendments, but I believe that amendment 13 will increase the use of off-label drugs in a safe and secure way. Those drugs can often be a cheaper and quicker way to tackle a disease, as they do not have to go through the rigmarole of being developed and licensed, which can take many years and many billions of pounds. NICE states that an unlicensed medicine is one that

"does not have a UK marketing authorisation and is not expected to do so in the next 2 years",

whereas an off-label medicine is one

"with an existing UK marketing authorisation that is…used outside the terms of its marketing authorisation",

and for which

"it is not expected that the existing UK marketing authorisation will be extended to cover this use in the next 2 years."

The inclusion of off-label use classes in the database as innovative medical treatments will allow the medical profession to see where off-label use has been effective, even if it is at the other end of the country. However, we must be careful not to place off-label uses on a pedestal and allow people to cling on to false hope. They are the most vulnerable people in our society, often looking for any treatment that may help them, but we must ensure that any drug that is prescribed off label is used responsibly and ethically. I believe that the database will help by allowing doctors to see what is effectively a large sample trial that gives them more information on a particular treatment. I therefore support amendments 13 and 10.

Mrs Flick Drummond (Portsmouth South) (Con): I thank my hon. Friend the Member for Daventry (Chris Heaton-Harris) for bringing this important private Member's Bill before the House and for his work in ensuring that all parties agree with it. It seems that a lot of work has gone into it by Members throughout the House, and as someone who was not part of those discussions, I am grateful to them for doing that work for everybody else.

The NHS benefits from one of the most rigorous health technology assessment organisations in the world, which provides clear and robust evidence of the clinical benefits of new interventions. However, the introduction of innovative treatments is complex, not straightforward, and the difficulty for the life sciences industry in getting new treatments to the market means that UK patients are often the last to see the benefits of new innovations in their disease area.

10.15 am

I am not a doctor or a lawyer but a lay person, and I was at first disappointed that clauses 3 and 4 in the Bill as it originally stood were to be removed rather than amended to make them suitable for purpose. A compensation culture has developed, and I fear that it has stopped doctors innovating. In 2014-15, clinical negligence expenditure, including interim payments, cost the NHS more than £1.1 billion, and the NHS Litigation Authority does not expect that bill to fall any time soon.

I am fortunate to have reached the age of 53—[Hon. Members: "Really?"] Thank you, but I have reached the age of 53. However, 14 of my very close friends and family members did not. Some of them would have benefited from innovative treatments, including those

with cancer, and one of them took part in a trial. I hoped that the Bill would help doctors have the confidence to try different treatments. However, it seems that there are ways to innovate, and I hope that new clauses 1 to 6 will ensure that off-label drugs that are found to work in different ways, and new drugs that are found to be effective, are quickly passed through NICE and disseminated throughout the NHS.

I am pleased that the NHS in Portsmouth and Southampton has trialled new hepatitis C treatments. Throughout 2013, a new range of drugs was tested on patients at Queen Alexandra hospital. The trials cured patients with hep C, with success rates of between 90% and 100%—a vast improvement on historical treatments. What is more, the patient experience was improved, as doses were lower and taken over a shorter period. Those transformative hepatitis C trials are now being replicated in other parts of the country, and the evidence gathered has enabled many other people to benefit from new treatments that were previously unavailable to them. I would like to see more such collecting and sharing of evidence, and I expect that is why the database is being established under new clause 2. I hope that the passage of the Bill will lead to more examples such as the groundbreaking work at QA hospital whereby evidence is shared for the good of all.

The interim accelerated access review said that the NHS has one of the most rigorous assessment processes in the world. Decisions are based on a wealth of robust evidence of the clinical and economic benefits of new interventions. The proposed database will strengthen that assessment process and potentially increase the availability of life-saving treatments.

However, if we are to encourage the NHS to embrace more innovation, it is important that it retains the public's trust. Medical trials that go wrong have the potential to undo the enormous trust in and admiration for our NHS, and I know that both professional and voluntary organisations and Members of the House had significant concerns about that in relation to the Bill. I welcome the pragmatic move that my hon. Friend the Member for Daventry has made in removing the clauses that caused those concerns, which will enable the NHS to expand the range of treatments it can offer while retaining the support and backing of all interested parties.

I am sure that a majority of Members support the idea of innovation in our NHS, which will be critical to meeting the increased demand on our health service. As the conditions that our NHS treats become more complex, enabling our doctors to innovate will be key to ensuring that the public receive the very best treatment available. I therefore welcome the Bill and trust that the amendments will ensure that the Government accept it completely.

Heidi Alexander (Lewisham East) (Lab): I congratulate the hon. Member for Daventry (Chris Heaton-Harris) on navigating the Bill to this stage. His pursuit of legislation in this area has sparked an important debate on the Floor of the House about how we can improve access to innovative treatments.

I welcome the opportunity to speak on this group of amendments, and I support the broad thrust of all of them. I commend the hon. Member for Bury St Edmunds (Jo Churchill) for her speech and the contribution that she has made—she spoke with great knowledge and passion.

I am particularly pleased that my hon. Friend the Member for Torfaen (Nick Thomas-Symonds) has tabled new clauses on the important issue of off-patent drugs and off-label uses, which he has championed. I was sorry to see his Bill fall on Second Reading in November and hope we can make more progress with the Government today.

Improving access to off-patent drugs so that people, no matter where they live or by whom they are being treated, are offered well-evidenced treatments that might not be routinely commissioned, is an ambition shared by many in the House, regardless of political persuasion. The Minister shares those objectives. Over the past few weeks and months, he has worked with key stakeholders and discussed the issue with them.

I express my support for new clause 1, which requires the Department of Health to produce an action plan for developing a pathway for off-patent, repurposed drugs, where strong evidence of their effectiveness in a new indication exists, with the aim of securing their routine use in such an indication. I hope the Minister can commit to such an action plan and put forward a clear timetable for progress, which is long overdue. I also hope he can offer the House reassurance on the proposals in new clauses 2 to 6, all of which have merit and deserve proper consideration by the Government.

Rebecca Harris (Castle Point) (Con) *rose—*

Mr Speaker: Order. The hon. Lady had wished to contribute but toddled out of the Chamber at the appropriate moment. I would have called her but did not because she was not here. Does she still wish to speak?

Rebecca Harris: Very briefly, Mr Speaker.

I support the Bill and commend all those who have worked towards it in the many iterations it has been through in this House and the other place—I can see that Members of the other place are taking an interest in our proceedings today.

I am chairman of the all-party parliamentary group on brain tumours. Brain tumour research has desperately lagged behind other areas of cancer research, and we desperately need to find new sources of treatment. Sadly, brain tumour is still the biggest cancer killer of the under-40s—children and young adults. The Bill could be a great step forward in the sharing of information.

I commend the Minister, as all hon. Members have. Without wishing to sound too toadying, we have a Minister who is committed to taking forward progress on research in a way that we have not seen previously.

It should be pointed out that the NHS is a superb innovative organisation that does huge amounts of research. We do not hear that said often enough of the NHS. From my point of view, the most important bit of the Bill is the database, which will mean we can take forward the research we do in the NHS so that people can have access to information—not just patients, but clinicians, who might not know as much as we or they would hope. I very much hope the Bill makes progress.

The Parliamentary Under-Secretary of State for Life Sciences (George Freeman): It is a great pleasure to take part in the debate and to support a package of amendments that have been agreed by Members on a cross-party

[George Freeman]

basis over the past few weeks and months. Very often in private Members' business, the Government take the view that the intentions are fine but the mechanism is flawed, and that the Government legislate while MPs raise issues. However, with this Bill, we have struck a blow for joined-up thinking and cross-party working in pursuit of patients' interests—I will say more about that on Third Reading.

With my hon. Friends the Members for Daventry (Chris Heaton-Harris) and for Bury St Edmunds (Jo Churchill), and the hon. Members for Torfaen (Nick Thomas-Symonds) and for Central Ayrshire (Dr Whitford), and with the help of Opposition Front Benchers, we have managed to deal with three Bills with which the House has been preoccupied in recent months—the Bill initiated by Lord Saatchi, which looked to change the culture of innovation; the Bill introduced by the hon. Member for Torfaen, which promoted the use of off-patent repurposed drugs; and this Bill, introduced by my hon. Friend the Member for Daventry, which seeks to promote access to innovative medicines. With the package of amendments we have agreed, we will end up with a Bill that moves forward on those three areas of concern for Members in all parties of the House. Today is a rare and rather wonderful moment because the amendments are supported by every party in the House—I cannot speak for the United Kingdom Independence party because I have not heard anything from it, but all other parties support the Bill.

We have three groups of amendments to get through so I will try to be brief in dealing with the specific points, many of which have previously been raised and discussed. I should take this opportunity to pay tribute to and thank my officials who, over the past three to six months, have tirelessly worked with Members on both sides of the House in an unusual way to help to draft amendments that we can all support. I thank them for their diligence in doing so.

Broadly, the intention of the package of amendments is to introduce off-label repurposed medicines in the Bill, and to put it four square at the heart of the agenda. As the hon. Member for Torfaen said, I wholeheartedly supported the intention of his Bill and its predecessor, but not the mechanism. We now have a mechanism that will work.

I appreciate that the new clauses are probing and that hon. Members are seeking my reassurance on how the Government will take things forward. New clause 1 is a request for an action plan. Nobody seriously thinks that we should put an action plan in the Bill, but let me set out my commitment and that of the Government to pursuing this agenda with time and rigour. As I have said in other places, the truth is that the world of drug discovery is changing profoundly. The transformational power of genomics and informatics create a wholly new opportunity both to discover new medicines and target them at individual patients much more quickly, and to discover repurposed uses of existing drugs in a way that we have not been able to do previously. The 100,000 Genome Project, which the Government have initiated and funded, has already begun to identify existing drugs that have uses in indications that were not hitherto known. The pace at which new drugs are being developed and discovered is increasing, which is a credit to the creativity of the sector.

That sets the backdrop for the creation of my post and the accelerated access review that I have launched. As all hon. Members know, I am committed to putting in place a landscape that accelerates the use of NHS resources to support research. When we launched the strategy, the Prime Minister said that every patient should be a research patient and that every hospital should be a research hospital. We are determined to ensure that the daily footprint of diagnosis and treatment is used more intelligently to support research.

The accelerated access review is looking at that in a lot of detail and is an extensive piece of work. Colleagues have referred to the interim report—the final recommendations are due to arrive on my desk at Easter. I am very happy to give a commitment that, in our response to that report, we will pick up the points made in the debate and in the Bill on ensuring that we look at repurposing and off-label uses of existing drugs as much as we look at innovative medicines.

In new clauses 2 and 3, hon. Members are probing me to give details on how the National Institute for Health Research and the National Institute for Health and Care Excellence can put into practice the mechanism that we have discussed. On new clause 2, there are very open mechanisms currently for applications to the NIHR to research existing medicines. The NIHR—I am delighted that we have reconfirmed our £1 billion a year funding for it—conducts research every year into existing medicines, and there is a clear process for that. It would not be appropriate to legislate in a Bill to tell organisations that are subject to the Haldane principle, which is sacrosanct for the Government, what to do. We want research to be led by that principle, but I am happy—I will say more about this in a moment—to ensure that, through the process, we explore mechanisms for ensuring the NICE can look at evidence and develop evidence-based guidance on off-label medicines, so that doctors are aware of which drugs are being used in an off-label indication.

On new clause 3, I am delighted to confirm that, after discussions, NICE is now looking at ways to collect evidence on repurposed medicines. It is looking at taking evidence and how it could use, through its existing evidence review process, evidence on repurposed medicines specifically. I have asked whether we might be able to put a mechanism in place to find a way to somehow put that into the "British National Formulary". I would not want to put that mechanism into the Bill, because we need the freedom to evolve the mechanism and to get it right. I hope that is a helpful reassurance.

10.30 am

Clinical staff using the BNF daily—the hon. Member for Central Ayrshire highlighted that it is a really powerful mechanism for getting information to doctors—will ensure that prescribers have information on off-label drugs. I would like to get to a point where we can give busy doctors on the frontline, at the click of a mouse, information on drugs their patients might be eligible for, and which are coming through in clinical trials. That information—on drugs already in use with an evidence-based off-label indication that NICE has looked at, and on unlicensed drugs in early-access-to-medicine schemes, which, with patient and doctor consent, patients might be eligible for—already exists, but I would like to get it to doctors in a way that is very easy. I have asked NICE, the MHRA and my officials to work on the details of that mechanism.

New clause 4 sets out a proposal for the Department of Health and NHS England to implement a new system of national commissioning of repurposed medicines. I think hon. Members understand that I cannot agree in statute, for a whole host of reasons that I will not detain the House with right now, to bind NHS England to that commitment. I will, however, just say this: NHS England is very seized of the need to look at how it can improve the efficiency of the system and deliver the £22 billion efficiency savings it has committed to. Efficiencies in medicine procurement and prescribing sit four square in that. The NHS is hungry to look at all options for promoting off-label and repurposed drug use. I do not think hon. Members need worry that NHS England needs instructions from me to that effect, but we need to ensure we are giving clinicians access to information on both innovative drugs and innovative uses of existing drugs, so that they are able, with confidence, to recommend and prescribe for their patients medicines that may be appropriate for them.

The hon. Member for Central Ayrshire will understand why I am very wary of legislating to interfere in any way with clinical sovereignty. Much as we in this House might want certain things to happen, we need to be careful not to undermine the sovereignty of clinician and patient, which must be absolutely key.

New clause 5 sets out a proposal for the Government to set out a list of statutory stakeholders. This is a familiar issue dealt with in many Bills. I think hon. Members know that it would not be appropriate for us to set out that list in statute, but I am very happy to give the undertaking that the bodies listed in the new clause should, and will be, consulted on and involved in our work plan as we take the proposals forward.

New clause 6, which deals with the question of the "British National Formulary", is very helpful in terms of giving me a chance to talk about the mechanism that I propose and have just touched on. I am reluctant to name the BNF explicitly in the Bill, not least because it is a commercial product that is not in my gift to control. There are no plans to change its format, but I would hate for us to have legislated for one particular mechanism of information and then find in a few years that it has changed in some way and is no longer appropriate. I am, however, very happy to give an undertaking at the Dispatch Box that we are actively exploring this option and have no reason to think it cannot work. NICE tells me it thinks there is a very good mechanism for it to use its existing powers for gathering evidence to pull together, as part of an evidence review, an evidence-based reassurance to clinicians that a drug has a legitimate off-label, off-patent use, and to include that in the appropriate registry. Today I think that would be the BNF, but that may change in due course.

Nick Thomas-Symonds: I would just like to make two points. First, the "British National Formulary" is UK-wide. Secondly, and just to probe the Minister further, is he able to give an approximate timeframe for when he thinks the process might be complete?

George Freeman: The hon. Gentleman makes two good points. This is, of course, UK-wide. One of the challenges, as a UK Minister, is to put in place a framework that will support this across the UK while respecting the different mechanisms in the devolved Administrations. I hope the Bill will provide a basis for a similar mechanism in areas where there are different formats. I believe that in Scotland, Northern Ireland and Wales, but particularly in Scotland and Northern Ireland, there is a hunger to do that. I believe the Bill will support those existing mechanisms.

Dr Philippa Whitford: We have moved on from talking about the BNF. I accept the comments about listing groups that would be considered in new clause 5. Does the Minister accept, however, that we still need to deal with the cascade of prescribing to ensure doctors are not forced to prescribe a licensed medicine, which is actually just a minimal moderation of an off-patent drug at a vastly expensive cost? That means we still need some kind of change to the licensing or short licensing process in the future.

George Freeman: The hon. Lady makes an important point about the classification of different drugs available to clinicians. Without detaining the House with too long a peroration on that classification, it is worth setting out that there is a clear cascade.

Clinicians can use unlicensed medicines in situations where, in their clinical judgment, and with patient consent, they believe it is the right thing to do. They are subject to all their usual professional undertakings. There are then off-label uses of drugs: drugs that do not have a licence for a particular indication but which the clinician, on the basis of evidence, is able to prescribe when they feel that evidence is compelling. The Bill now goes to the heart of that and will help to provide reassurance. For many clinicians, being able to click on a mouse with their patient and say, "For your condition there are one, two, three or no off-label medicines available for which NICE has looked at the evidence," would be a powerful catalyst in helping to promote off-label use. There are generic drugs, which have been patented and brought to market, that are available at a heavily discounted open price.

There are then on-patent drugs, which have been brought to market and are still subject to a patent. The manufacturer has an exclusivity, which is the period in which their sunk costs in bringing the medicine to the system, can be reimbursed. That is an important protection to make sure we continue to have a thriving life science sector that can take the risks of investing in new drugs. Typically, new drugs take 15 years and £2 billion to develop. If there were no patenting mechanism, there would simply be no enthusiasm to do that research, which has a very high failure rate. In law, there is a key point of principle, which is that a licensed drug should be used first and that an unlicensed drug cannot be used purely on the basis of cost. That is a really important principle. An unlicensed drug can, however, be used on the basis of evidence. That is why the mechanism will allow NICE to look at the evidence and to signal to clinicians that they have the evidence basis on which to use the drug in an off-label indication.

One of the issues we have dealt with in discussions is the whole question of the European licensing of medicines. If we were to go down that route—I know the hon. Member for Central Ayrshire understands this—I can assure the House we would be here not just for weeks and months, but years. I am leading for the Government on reforming the European landscape of 21st medical

[George Freeman]

research. The central role of protecting innovators' sunk costs is really important to our life sciences sector, and the new clauses and amendments create a mechanism by which we can accelerate off-label use without running a coach and horses through that.

Dr Whitford: I accept the Minister's points, but my concern remains that if in 10 years we have simvastatin in its current form versus a new name that is just a tweaked simvastatin at a thousand times the price, doctors will, under GMC rules, have to go for the one with the licence, as opposed to the off-patent one, even if it is in the BNF. I accept that the BNF mechanism will absolutely increase usage, but we still need to consider the longer term, given that in the future we might have huge numbers of off-patent drugs with new purposes.

George Freeman: The hon. Lady makes an interesting, important and useful point that I undertake to pick up in our consultation in response to the accelerated access review. The landscape will continue to change fast over the next few years. The Bill, as amended, will promote the greater use of off-label medicines. Crucially, the database mechanism, which, I reassure everybody, is very different from the original registry proposed in a precursor Bill—it is to make clinicians aware of what drugs are available—will generate data that will be incredibly powerful in helping the system to adapt and use the freedoms I hope to give it through the accelerated access review. That will ensure we are better and faster at getting these repurposed medicines into use.

I am delighted to say that the Government are happy to support amendments 10 and 13. Amendment 10 would set out in the Bill that its purpose specifically includes promoting access to the innovative use of licensed medicines outside their licence indications. It puts four square at the heart of the Bill the aims of the Off-patent Drugs Bill, which was promoted by the hon. Member for Torfaen (Nick Thomas-Symonds), and which, as hon. Members across the House have commented, had a lot of in-principle support. I am pleased, therefore, that we have found a form of words that moves it forward. At the heart of it, there is a clever protection for clinical sovereignty. We are not telling clinicians what they have to prescribe or putting in law a requirement that they prescribe in a particular way. We are giving them information on evidence-based off-label drugs. The feedback from clinicians so far is that it genuinely will help them to understand, promote and prescribe off-label uses.

Amendment 13 seeks to clarify the definition in the Bill of innovative medical treatments to make it clear that it includes off-label and unlicensed medicines. I mentioned earlier the pace at which genomics and informatics were uncovering new uses for drugs—some have referred to it as finding diamonds in the dustbin. There are extraordinary applications among the existing pharmacopoeia of tens of thousands of drugs. We now realise that many of them have particular impacts and effects. That is all to the good. It is thanks to the power of our life sciences sector that we are beginning to uncover those, and the Bill will support that.

With those comments in support of amendments 10 and 13, I hope I have given hon. Members enough reassurance and that they feel able to withdraw or not press the probing new clauses. I will be happy, following Third Reading, to put in place, through the accelerated access programme, a clear plan for keeping on top of the system's implementation and tracking the use of repurposed medicines. We will continue with the work we did with charities through the winter and with the very helpful discussions we had with the charitable sector, and the Department will look annually at the data and whether the landscape is changing, and if it is, we will keep that under review.

10.45 am

Nick Thomas-Symonds: I am grateful to Members across the House for their contributions and to the Life Sciences Minister for his clear response to the six probing new clauses. I am pleased to hear that the Government will accept amendments 10 and 13. As I said in my opening speech, having off-label treatments in the Bill and the database will make a significant difference and help move things forward. I was also pleased with his reassurance to the hon. Member for Central Ayrshire (Dr Whitford) that we will continue to review the system, as, I hope, the number of off-label treatments and prescriptions increases.

In view of the Minister's commitments and acceptance of amendments 10 and 13, I do not propose to press new clauses 1, 2 and 3. New clauses 4, 5 and 6 are in the names of the hon. Members for Bury St Edmunds (Jo Churchill) and for Central Ayrshire (Dr Whitford). I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

Clause 1

ACCESS TO INNOVATIVE MEDICAL TREATMENTS

Amendment made: 10, page 1, line 3, after "treatments" insert

"(including treatments consisting in the off-label use of medicines or the use of unlicensed medicines)"—*(Chris Heaton-Harris.)*.

Mr Deputy Speaker (Mr Lindsay Hoyle): We now come to amendment 1—

Chris Heaton-Harris: On a point of order, Mr Deputy Speaker. I am unsure of the process. What happened to amendment 13?

Mr Deputy Speaker: It comes later. It is about three pages further on in the dossier. It has not been lost, and we will be coming to it, so the hon. Gentleman can rest assured. It is there.

Chris Heaton-Harris: I beg to move amendment 1, page 1, leave out lines 7 to 9.

Mr Deputy Speaker: With this it will be convenient to discuss the following:

Amendment 11, page 1, line 18, in clause 2, leave out from beginning to "involves" in line 19 and insert

"In this section, "innovative medical treatment" means medical treatment for a condition that".

Amendment 2, page 2, line 26, leave out clause 3

Amendment 3, page 3, line 19, leave out clause 4

Amendment 4, page 3, line 40, in clause 5, leave out "this Act" and insert "section 2"

Amendment 12, page 3, line 42, in clause 5, leave out paragraph (b)

Amendment 5, page 4, line 1, in clause 5, leave out "this Act" and insert "section 2"

Amendment 6, page 4, line 3, in clause 5, leave out "this Act" and insert "section 2"

Amendment 14, page 4, line 8, in clause 6, leave out "Sections 1 to 5" and insert "Sections 1, 2 and 5"

Chris Heaton-Harris: I just thought I would check about amendment 13, Mr Deputy Speaker. This whole experience has been a steep learning curve when it comes to procedure in the House. Perhaps we have invented a few things on the side as well, given how we have gone about our business here. I do not want to speak too soon, but if we could conduct all our health debates in the positive and constructive tone that has characterised these debates and the process behind the Bill, we might improve our heath service in leaps and bounds, rather than getting caught up in unnecessary politics. But that is where we are.

My amendments 1, 2 and 3 would remove, among other provisions, two clauses on clinical negligence. I want to talk about the reasons for their removal and the original idea behind the clauses. As right. hon. and hon. Members who have been following the progress of my Bill will know, many of the ideas in it came from Lord Saatchi's Medical Innovation Bill in another place. Those ideas have not had the smoothest of journeys in this place. I have been regularly reminded by hon. Members—I thank those here today—and others outside this place that these clauses have not enjoyed the support of stakeholders.

Such concerns have been around since before the Bill was even drafted. Unfortunately, the echoes of those concerns haunted the first mention of the word "innovation" in the clause, and I decided from conversations I have had that those concerns could not be quelled in time. Throughout the process, I was clear that I wanted to listen to everybody with something to say on this matter. I have met and read the briefings of everyone who has contacted me wishing to share their views, and I hope it has been evident that I have been up front, honest and very clear about my intentions. I tried to solve the concerns of Members and the medical community who believed the clause would have negative and unintended consequences. That is why I tabled these amendments.

I hope that this process reflects favourably on Parliament and shows how a piece of possible legislation can evolve with a huge amount of stakeholder engagement and with parliamentary opinion taken on board. Since the beginning, I have focused on the sharing of good practice and transparency—and, indeed, on the failures of treatments through a database. Those ideas are reflected in clause 2 and have received much support.

I wanted to maintain the camaraderie built up around the Bill and have been unable to find the support I needed for the more controversial clauses, 3 and 4. Clause 3 sets out the steps that a doctor would need to take to show that he or she had acted responsibly using the Bill. They were intended to reflect the steps that a responsible doctor could be expected to take under common law when innovating. In relation to a proposed treatment, clause 3 would require the innovating doctor to

"obtain the views of…appropriately qualified doctors"

with

"appropriate expertise and experience in dealing with patients with the condition in question."

Clause 4 expressly preserves the common-law Bolam test, the key precedent for judging whether a doctor has acted negligently.

The two clauses received strong opposition, which I will not go into too much. However, I worked closely with many officials from the Department of Health, and I want to thank them, because I had read the briefings that were so adamant in saying how dangerous parts of the Bill would be, so it was nice to have some of the best and brightest legal and parliamentary counsel remind me again and again that they viewed them as perfectly safe and did not see them as a danger to patients.

Dr Philippa Whitford: Does the hon. Gentleman understand the danger of undermining our clinical trials systems, in that, using the Bill, a doctor would have to convince only one colleague before they could go ahead and try something completely new? The recent tragedy of the patient who died while taking part in a phase 1 trial shows the need for steps and procedures to reduce the risk.

Chris Heaton-Harris: The hon. Lady knows that I would obviously have preferred to retain clauses 3 and 4, but I have to agree with her: the body of opinion stands on her side of the argument, not mine, so the simple answer is yes.

I remind the House, though, that there was a decent and honourable purpose behind clauses 3 and 4. Dr John Hickey, the former head of a primary care trust, contacted me to say that,

"as a registered medical practitioner, a former NHS Trust Chairman and with 30 years' experience in the field of legal medicine with the Medical Protection Society (last five years as Chief Executive), I believe I am adequately qualified to comment on your Bill."

He went on to say:

"Over the last 30 years I have seen how doctors have increasingly practised defensive medicine…because of the fear of litigation and disciplinary action by their regulators; this defensiveness is not in patients' best interests."

In fact, it may interest Members to hear that, in reading the debates on the Bill introduced by the hon. Member for Torfaen (Nick Thomas-Symonds) and the recent debate on the Mesothelioma (Amendment) Bill, I have seen much stated that supports the action I wanted to take in clauses 3 and 4 to reassure doctors who fear litigation. For example, the British Medical Association's parliamentary brief for the Second Reading of the Off-patent Drugs Bill stated that there were

"two barriers to the use of off-patent drugs in a new indication: 1) Clinicians' confidence in prescribing: clinicians take on a personal and professional liability if they prescribe an off-patent drug in a new indication",

and therefore they require reassurance. The brief goes on:

"GMC guidance also indicated a greater level of responsibility for the doctor prescribing off-label and therefore potential greater risk of liability which would be a disincentive for a doctor prescribing off-label drugs".

That is a simple statement of the purpose of clauses 3 and 4: to give doctors a supplementary way to assure themselves that they are doing the right thing where

[Chris Heaton-Harris]

they might want to do something they believe to be in their patients' best interests, in a fully evidenced, responsible and honest way.

Similarly, the Multiple Sclerosis Society's brief on the same subject states:

"Guidance from the General Medical Council is clear that a doctor takes on an extra level of personal liability when prescribing off-label, which would be a significant disincentive to prescribing".

Breast Cancer Now says that, because of personal liability,

"doctors can be unwilling to prescribe drugs for new purposes, even where…clinical evidence is strong".

As Lord Freyberg stated in the mesothelioma debate in the other place,

"The fastest way to save lives is to see if the drugs for common cancers work on the rarer ones as well, given the shared mechanism of disease across cancer. This is off-label research and until we fix the issue of liability, as advocated by the noble Lord, Lord Saatchi, we will continue to send thousands, like my sister, to an early grave."—[*Official Report, House of Lords,* 20 November 2015; Vol. 767, c. 407.]

There was therefore plenty of reason and evidence to support clauses 3 and 4, but I guess politics is all about being pragmatic, and I believe that the provisions that we have already discussed are worthy in themselves of inclusion in a sensible Bill, because they will do some positive things. It is therefore with some reluctance, as I am sure the House will understand, that I have decided to table these amendments, which strike the elements relating to clinical negligence from my Bill.

Anne Marie Morris: I support my hon. Friend's amendment 2, which would remove clause 3—the responsible innovation clause—from the Bill. I know that his heart was absolutely in the right place when he first put the Bill before the House; however, I am glad he has tabled the amendment, as I am sure the majority of us, if not all of us, are present in the Chamber to ensure that the rest of his Bill, particularly the provisions dealing with the database, gets through.

I have received briefings from all manner of medical bodies, as I am sure all colleagues have, stating that the Bill would do more harm than good for patients. A letter signed by nine different medical bodies, including the Academy of Medical Royal Colleges, the British Medical Association and the Patients Association, says that

"this Bill will actually harm good innovation by weakening patient protection, adding unnecessary bureaucracy and undermining good scientific practice."

By removing clause 3, amendment 2, along with amendment 3, will allay those fears. There will no longer be any fears about doctors using quackery, as some people outside the Chamber have put it. Instead, there will merely be a database, set up by the Secretary of State, who may by regulation confer functions on the Health and Social Care Information Centre, although I note that the hon. Member for Lewisham East (Heidi Alexander) has tabled amendments seeking to change who the Secretary of State has to consult before making any regulations.

At a constituency level, a number of concerns have been raised with me by those in the healthcare sector who believe this Bill, or at least this clause, would do more damage than good. There was a misconception among some people that it remained a carbon copy of Lord Saatchi's Medical Innovation Bill, which was introduced in the last Parliament. Although my hon. Friend's Bill is indeed similar to Lord Saatchi's, the amendments he has tabled will completely dispose of any similarity at all. Innovation sounds like such a good idea. To most people in the street, it sounds like a marvellous thing and therefore taking "innovation" out of the Bill must be a bad move. However, innovation must be achieved through the correct means and must not pose any danger to patients.

The argument goes that innovation has decreased in recent years owing to the legal complexities and doctors' fears of negligence claims against them if something goes wrong. There is no evidence of that, according to the Medical Protection Society, the Medical Defence Union, the General Medical Council and various other medical—

Debate interrupted.

Criminal Legal Aid

11 am

Andy Slaughter (Hammersmith) (Lab) *(Urgent Question)*: To ask the Under-Secretary of State for Justice if he will make a statement on the provision of legal aid services.

The Parliamentary Under-Secretary of State for Justice (Mr Shailesh Vara): As the Lord Chancellor and Secretary of State for Justice announced yesterday, the Ministry of Justice has had to play its part in reducing the budget deficit, and economies have had to be made in every area of expenditure. In the last Parliament, spending on legal aid was reduced from £2.4 billion to £1.6 billion. Further changes in the legal aid system were due to be implemented in the current Parliament, with a second reduction in litigation fees in July 2015.

At the time when the fee reduction was proposed, the market was made up of about 1,600 legal aid firms. After careful negotiation, the then Justice Secretary decided to adopt a system of "dual contracting" to drive greater efficiency and consolidation in the market. Over time, however, opposition to that model has increased. Solicitors' firms feared that it would lead to a less competitive market, and barristers feared that choice and quality would diminish. Besides, a process of natural consolidation was already taking place in the market.

Although we understood those arguments, we also needed to deliver reductions in expenditure, but since July 2015 there have been two significant developments. Her Majesty's Treasury has given us a settlement that allows greater flexibility in the allocation of funds for legal aid, and it has become clear that there are real problems with pressing ahead. We currently face 99 legal challenges and a judicial review of the entire process. Litigation will be time consuming and costly for all. We have therefore decided not to go ahead with the introduction of the dual contracting. We have also decided to suspend for 12 months the second fee cut. The Legal Aid Agency will extend current contracts to ensure that the service continues until replacement contracts come into force later this year.

We will review progress on joint work with the profession to improve efficiency and quality before returning to any decisions on the second fee reduction and market consolidation.

Andy Slaughter: This is a happy day. A serious threat to the integrity of the justice system and the livelihoods of thousands of hard-working professional people—the mainly small and local solicitors' firms that are the bedrock of local justice—has been lifted, and we welcome that.

Nothing is more important to securing access to justice than the ability of citizens to obtain competent and timely legal advice when accused of criminal conduct, but that basic human and civil right was put at risk by the Government's ill-conceived plans. What on earth was the Department playing at in the first place? This is the latest in a series of U-turns, and once again a written statement was issued at 3 pm on a Thursday. We are only here today thanks to you, Mr Speaker, because you granted the urgent question.

Everyone who cares about the criminal justice system in our country has been saying that the Government's proposals for new criminal contracts were a disaster from the day on which they were proposed, in June 2013. That was not only my view or that of the Law Society, the Criminal Law Solicitors' Association, the London Criminal Courts Solicitors' Association and the Justice Alliance; it was the view of everyone in the justice system, and I pay tribute to them all for the magnificent campaign they have fought. It was also the view of the Government's own experts, but the former Lord Chancellor still failed to register the chaos over which he was presiding. I credit the current Lord Chancellor with having the common sense to bring this farce to an end, but I wish the Government had listened to my right hon. Friend the Member for Tooting (Sadiq Khan) when he proposed the scrapping of the scheme exactly a year ago.

What we cannot do is draw a line and forget what has happened. Questions remain to be answered, and I ask the Minister to answer the most urgent of them today. How much public money and civil service time have been spent on the abortive tendering processes, the court cases and the consultations in the past three years? Will the Minister refer his own Department to the National Audit Office, so that it can be independently investigated? Will he apologise to the firms that have closed, laid off staff or cut salaries when faced with losing contracts, and also to those who have spent thousands of pounds on bidding and winning contracts and, in many instances, taking on extra staff whom they will not now need? Will he go further, and establish what assistance can be given to those firms? Will he remove the remaining uncertainty over the second fee cut? Given that he imposed it and has now decided to remove it for at least a year, what timescale and criteria will he apply to future fee levels?

Finally for today, given the NAO's and the Public Accounts Committee's scathing criticisms of the civil legal aid cuts—incidentally, I learned just before entering the Chamber that the NAO has also reported a £1.1 million loss by the aborted Just Solutions International, the commercial arm of the Ministry of Justice—will the Minister bring forward the review of the Legal Aid, Sentencing and Punishment of Offenders Act 2012?

This has been an appalling use of taxpayers' money. It has posed an existential threat to a fundamental part of our legal system, and it has caused uncertainty, failure and distress to thousands of hard-working small businesses throughout the country.

Mr Vara: I welcomed the comments made by the hon. Member for Hammersmith (Andy Slaughter), although they were very brief. I must add, however, that his attempt to criticise what has been described as the Lord Chancellor's sensible decision was opportunism, pure and simple. He obviously has a selective memory. I remind him that in 2009, when Jack Straw was Justice Secretary, he abandoned the criminal legal aid best value tendering scheme at a very late stage, just before the 2010 general election. I do not recall the hon. Gentleman's grumbling to his boss at the time, and Jack Straw certainly does not recall hearing his voice. This needs to be put into proportion.

Let me now deal with the hon. Gentleman's questions. When we embarked on the dual contract process, we had the support of the Law Society; the hon. Gentleman

[Mr Vara]

may wish to reflect on that. We have said that we will suspend the second fee cut for a year. We will then work with the professions, and will form a definite view in due course. As for the Legal Aid, Sentencing and Punishment of Offenders Act, the hon. Gentleman knows only too well—because I have said it many times at the Dispatch Box—that a review will take place within three to five years. *[Interruption.]* The hon. Gentleman is chuntering away, as he is wont to do on a regular basis. He says, "How much money?" He knows full well that all shades of Government, both Conservative and Labour, if they listen to people and feel that a decision needs to be changed, will make that change. Just as the Labour Government made decisions to change policies, we have made such a decision. I do not recall previous Governments wasting time and effort in trying to make calculations when they have made a change of direction.

Our decision has been welcomed by the profession, and we are pleased about that. We now want to look forward and move ahead.

Robert Neill (Bromley and Chislehurst) (Con): The intelligent lawyer and the intelligent decision maker are alert to the dictum attributed to Keynes: "When my information changes, I change my conclusions." Surely the Lord Chancellor should be commended rather than criticised for doing that on this occasion.

Will my hon. Friend give us some more details of the particularly welcome initiative to involve the professions themselves through the proposed advisory council?

Mr Vara: My hon. Friend is right to say that the Lord Chancellor should be commended. Mark Fenhalls, QC, the chairman of the Criminal Bar Association, said yesterday:

"It takes courage to make such decisions."

Perhaps the hon. Member for Hammersmith will reflect on that sentiment.

The Lord Chancellor has his advisory board, and he will be working with the profession to ensure that as we progress further, the public will benefit, and the taxpayer who funds the legal aid budget will gain the maximum possible value.

Sarah Champion (Rotherham) (Lab): Steve Hynes, director of the Legal Action group, has said:

"In its planning and execution the MoJ has demonstrated shocking incompetence with this tender exercise."

Will the Minister now launch a review of his own Department's competence?

Mr Vara: I appreciate that the announcement was made a relatively short time ago, and that the hon. Lady has probably not had an opportunity to hear what the profession has said. The profession has wholeheartedly welcomed the proposals, and I think she should note those comments, rather than individual comments.

Oliver Colvile (Plymouth, Sutton and Devonport) (Con): Will my hon. Friend write to me, explaining what impact the proposal will have on lawyers in the west country, especially those in my constituency, which contains, at Charles Cross, the busiest police custody suite in England?

Mr Vara: I urge my hon. Friend to look at the details of the statement made by my right hon. Friend the Justice Secretary yesterday, wherein the way forward is stated, but I will happily write to my hon. Friend with further details.

Nick Thomas-Symonds (Torfaen) (Lab): I should first say that I used to be a barrister before entering Parliament, and remain a non-practising door tenant of Civitas Law in Cardiff.

A year ago, the previous Lord Chancellor said these very reforms were both sustainable and essential. I thought that was completely wrong and I am delighted that the current Lord Chancellor agrees with me, but can the Minister tell us why the previous Lord Chancellor got so many things so badly wrong?

Mr Vara: It lowers the tone of this debate when, not for the first time, the hon. Gentleman takes his lead from the hon. Member for Hammersmith by resorting to personal abuse. There have been two significant developments, which have allowed us to make the announcement. First, thanks to the economies we have made elsewhere in the MOJ, Her Majesty's Treasury has given us a settlement that allows us greater flexibility in the allocation of funds for legal aid; and it has also become clear, as I have said, that there are real problems in pressing ahead as initially proposed. We recognise those issues and we want to do the best for the profession, and that is why we have taken this decision.

Mr Steve Reed (Croydon North) (Lab): The Minister's Department has wasted close to £15 million now on ill-judged projects. What does this latest U-turn bring the running total to?

Mr Vara: The hon. Gentleman talks about millions of pounds; may I just remind him of the billions that were squandered and wasted when his party was in government, and that if it was not for its squandering and mismanagement, this Government would not have had to take the tough decisions we are having to take?

Conor McGinn (St Helens North) (Lab): The Saudi prison contracts, the secure college, the book ban, the outsourcing of the collection of fines by courts, the criminal courts charge, and now two-tier, the latest in the long line of U-turns by the Justice Secretary on measures taken by his predecessor. If he is looking for his next U-turn, may I suggest he looks at the repeal of the Human Rights Act—and, of course, the closure of the court in St Helens?

Mr Vara: I am sure the hon. Gentleman's constituents will be grateful that he managed to slip in that last bit concerning his court. As I have told him previously, no firm decisions have been taken on that issue. On other matters, I am pleased that the hon. Gentleman pays such detailed attention to what is happening in the MOJ.

Carolyn Harris (Swansea East) (Lab): I welcome the Justice Secretary's move to scrap the two-tier system. He said HM Treasury has given him a settlement that

allows him greater flexibility in the allocation of funds for legal aid. Will he give us more detail about the settlement and whether it will extend further than what he has already said?

Mr Vara: I refer the hon. Lady to the Chancellor's autumn statement. He said he would be allowing £700 million-plus for the courts reform programme and there would be £1.3 billion for reforming the Prison Service. We in the MOJ are also consolidating our estates programme generally in terms of the offices and space we use. If the hon. Lady reads the statement, she will also be aware that my Department will be making 50% administration cuts by 2019-20.

Mike Kane (Wythenshawe and Sale East) (Lab): The Justice team must be spinning like tops at the moment. Would the Minister care to estimate how many U-turns there have been since the new Secretary of State took his position?

Mr Vara: I will just mention that Labour's 13 years of squandering taxpayers' money, which has meant that we have to take these decisions, puts into total insignificance the very cheap jibe that the hon. Gentleman seeks to aim at this Government.

Closure of St Paul's Place BIS Office (Sheffield)

11.14 am

Louise Haigh (Sheffield, Heeley) (Lab): *(Urgent Question):* To ask the Secretary of State if he will make a statement on the announcement by the Department for Business, Innovation and Skills online yesterday morning that it is to close its St Paul's Place site in Sheffield, which houses 250 jobs, and relocate them all to central London.

The Minister for Small Business, Industry and Enterprise (Anna Soubry): The Department for Business, Innovation and Skills is committed to delivering efficiency savings and contributing to the Government's deficit reduction targets. As such, we have developed the BIS 2020 strategic plans to modernise the way BIS works, reduce operating costs, and deliver a simpler, smaller Department that is more flexible and responsive to stakeholders and businesses. As part of these plans, the Department has announced its intention to close the BIS office in Sheffield at St Paul's Place by January 2018.

All staff and departmental trade unions were informed of this decision yesterday, 28 January, and the statutory 90-day consultation process will now begin. Those staff most affected by this decision have been fully briefed and comprehensive support to all those facing a potential change or loss of job will be provided. This will include professional, external careers advice; professional outplacement support; working with the Department for Work and Pensions to host a jobs fair; allowed time out of the office to find jobs; and financial advice workshops.

This decision has not been taken lightly. Our current locations are based on what we call legacy decisions—decisions taken some time ago—and what can at best be described as ad hoc organisational changes. In future, our structures need to be designed in a more streamlined, efficient way. To support this effort, we will bring the number of locations we operate down from around 80 now to approximately seven centres, supported by a regional footprint for work at a local level. Each centre will focus on a key business activity and will bring together expertise and help to build our capability.

We have, and will continue to have, many more people based outside London than inside London.

Louise Haigh: Thank you, Mr Speaker, for granting this urgent question on an issue of such importance to people in Sheffield and to the Government's hopes to build a northern powerhouse, because this decision came out of the clear blue sky for my constituents yesterday morning. The first any of them heard of it was when the permanent secretary arrived in their office at 9.30 yesterday morning. It speaks to this Government's London-centric focus and contempt for the north of England that they think a consolidated

"combined central HQ and policy centre"

has to be, by rights, in London rather than in Sheffield where the operating costs are cheaper and the perspective on UK investment is much broader.

So why, despite Lord Maude of Horsham's commitment to end "Whitehall palaces", has the proportion of the civil service workforce in the capital gone up since 2010?

[Louise Haigh]

The House will be aware that this is just the thin end of the wedge, as part of the BIS 2020 strategy, so can the Minister tell the House exactly when she is going to bother to announce which offices are going to be closed—or will civil servants have to wait uneasily at their desks for an appearance from the permanent secretary?

Secondly, the board at BIS must have seen a business case for the BIS 2020 report, prepared by McKinsey & Company at great cost. Will the Minister publish the business case so that we can see how the Government can possibly hope to reduce operating costs by moving to central London?

Indeed, is it not economically irresponsible to create more jobs in central London, which is suffering an incredibly overheated housing crisis? Given that there is a 40% cut to partner organisations coming down the line, can the Minister rule out today, categorically, that the Insolvency Service and the Skills Funding Agency based in Sheffield will not be closed?

Sheffield has already lost 500 jobs at HMRC, 100 jobs at Forgemasters and 400 jobs at the local authority. People in my city will be right to ask: why have the Tories got it in for Sheffield?

Anna Soubry: As somebody who was born and bred only 17 miles from Sheffield, I do not need any lectures from the hon. Lady, and in particular not from the Labour party given that the last Labour Government closed offices in York and Liverpool and axed over 1,500 jobs in Preston and across the Fylde coast as part of a major rationalisation of DWP offices.

The hon. Lady may not be familiar with, and understand the nature of, the Sheffield city regional deal, which was supported by people from all political parties, and rightly so, and I find it very sad, and somewhat shameful, that the hon. Lady seems to in some way criticise the northern powerhouse—*[Interruption.]* She laughs, and I hope *Hansard* will record that. The northern powerhouse has been supported, as I said, notably by some of our outstanding Labour leaders of councils across the whole of the north, and rightly so.

As I have said, there will be six business centres around the United Kingdom, including the following: a business-facing centre, likely to be in south Wales; an institutional and research centre, likely to be in Swindon, but which may initially also include Bristol; a further education funding centre, whose location is yet to be decided, but we are seriously considering Coventry; one or two higher education student finance centres, initially in Glasgow and Darlington; and a regulation centre in Birmingham. Conservative Members understand the need to ensure that taxpayers' money is spent wisely, efficiently and effectively, and that is what we will do. All of this is our clearing up of the mess that was left by the previous Labour Administration.

Mr Gordon Marsden (Blackpool South) (Lab): I congratulate my hon. Friend the Member for Sheffield, Heeley (Louise Haigh) on her urgent question. Today's announcement that the Department for Business, Innovation and Skills is scrapping its office in Sheffield, which has 247 jobs, is a hammer blow to the people there. It is also a huge worry and a warning to the 12 other BIS regional offices, six of which are in the north, that they are at risk from this so-called restructuring. What assurance can the Minister give us that there will be no compulsory redundancies in Sheffield, and will she tell the House what offers of relocation expenses or even relocation itself there will be?

The BIS press statement talked vaguely about six business centres, which the Minister also mentioned in her answer, but they are servicing a centralised headquarters in London. Will the Minister say precisely where those centres will be—we have been told that possibly five will be in the south, and one in the north—and how many people will work in them? Are they simply a hastily drafted afterthought? Will they be just fig leaves, ministerial post boxes or possibly even digital fig leaves?

The BIS statement also said that the closure would reduce operating costs, so will the Minister tell the House what savings there will be from this closure, which comes on the backs of the people of Sheffield? The union, Prospect, said yesterday, that it was given only 30 minutes' notice of this announcement. What discussions did Ministers have with workers and trade unions before the announcement was made?

The announcement comes on the back of the latest Centre for Cities report, which places Sheffield in the low wage, high welfare economy—half of the UK's biggest cities are in that report. The report underlines the stark north-south divide and undermines all the Chancellor's spin and rhetoric about a rebalanced economy. It is no wonder that civil servants told Radio Sheffield that they felt betrayed.

In the light of the 100 jobs lost at Sheffield Forgemasters and HMRC's November announcement, to which my hon. Friend the Member for Sheffield, Heeley has already referred, I have to ask whether this is what the Tory industrial strategy amounts to—cutting and running. This is not a strategic approach; it is a kick in the teeth. The *Financial Times* said that 20% of civil service jobs had been lost in the regions since 2010 as opposed to only 9% in London. With infrastructure spending in the north standing at £539 a head and London's at £3,386, BIS is shifting more jobs to the Chancellor's Whitehall comfort zone and exposing the empty rhetoric of his northern powerhouse.

Did the Minister's Department discuss the decision with the Secretary of State for Communities and Local Government who is busily promising devolution to local authorities while her officials are undermining it, and did the Minister's Secretary of State discuss the closure with the Chancellor and did he approve it? Did BIS speak to council leaders in Sheffield and across West Yorkshire to see whether an alternative package could be put together? This Government need to tackle our skills emergency. *[Interruption.]* Perhaps the Minister should listen. The Government have dithered and missed opportunities—*[Interruption.]* Will the Minister stop chuntering from a sedentary position? They have missed opportunities to save our steel industry—*[Interruption.]*

Mr Speaker: Order. This speech will be heard—*[Interruption.]* Order! Minister, you have had your say, and you will have further says. There is something here about a basic dignity. Just sit and listen. It is not about you; it is about the issue. It is not about the hon. Gentleman either. Be quiet and listen. That is the end of it. It is not a request; it is an instruction.

Mr Marsden: As I was saying, the Government need to tackle our skills emergency and poor productivity, but they have dithered and they have missed opportunities to save our steel industry. They are now abandoning a great historic steel town. They are comprehensively failing to deliver enough of the high-skilled, better paid jobs for England's regions that Labour wants to see. Let me see whether the hon. Lady will be as candid in expressing disappointment about BIS pulling the plug on Sheffield as she was about the Chancellor's poor tax fix for Google.

Anna Soubry: Thank you, Mr Speaker. It is not about me; it is not. It is about the workers. I am very proud of, and pay tribute to, all those civil servants who work in the Department for Business, Innovation and Skills, and indeed I am proud of all our civil servants, which is why Conservative Members understand how important it is to have a sustainable civil service and to spend public money wisely.

There were so many questions in what apparently was a speech that I have not got the time to answer them all. *[Interruption.]* If I have to shut up and listen in silence, so, too, does the hon. Member for Blackpool South (Mr Marsden). What is goose for the gander is also goose for that hon. Gentleman.

Of the 20,000 staff paid for by BIS, only some 2,000 —about 10%—work at No. 1 Victoria Street. The vast majority are spread around the country. I pay particular tribute to the 60 who work in BIS local and provide an outstanding service not only locally, but to us working in the ministerial team at No. 1.

Let me repeat this: members of staff who have been affected have been fully briefed. Comprehensive support will be provided. Some of the staff will be able to transfer and apply for jobs in London; others will of course take voluntary redundancy. Mr Speaker, I do take great exception to Labour Members who stand up and talk down the great city of Sheffield, which has an outstanding city deal. That is recognised locally, which is why it has been supported by political parties of all colours in Sheffield. Labour Members might do well to listen to their own members locally before spouting nonsense and talking down the great city of Sheffield.

Conor McGinn (St Helens North) (Lab): I do not know why the Minister seems to be taking criticism of her decision so personally. The people who should be doing that are the hundreds of workers whose jobs are at risk and who have not heard a shred of sympathy or regret from the Minister. Local government leaders in Sheffield and places such as St Helens do not need to receive the praise of the Conservative party; they are already doing fantastic work in encouraging investment and jobs to come to our areas. Public sector jobs provide the economic ballast for our areas. The Government cannot keep cutting jobs and services and expect us to build a northern powerhouse. We are the people who are working on the ground in communities and we do not need to hear from the Minister on a day when people might be losing their jobs.

Anna Soubry: I am sorry, Mr Speaker, but there was no question there. The hon. Gentleman made a speech. It was not accurate and it was rubbish.

Mr Speaker: It was also perfectly orderly, of which I am the judge. The hon. Lady should stick to the discharge of her responsibilities to the best of her ability. I am the arbiter of good order. I handle those matters, and I certainly do not require any advice from a junior Minister.

Robert Jenrick (Newark) (Con): Representing the Nottinghamshire communities—we are 15 to 20 miles from Sheffield and many of my constituents commute into Sheffield for work or to use public services—which include the childhood home of my right hon. Friend the Minister and of her mother, who is a formidable lady, it gives me no pleasure to hear of the job losses today. None the less, it is surprising to hear Labour Members criticise the Sheffield city deal, because my constituents in Nottinghamshire explicitly want to be part of it, as do the constituents of my friend and neighbour, the hon. Member for Bassetlaw (John Mann), because it is such a good deal, creating as it does both jobs and opportunities.

Anna Soubry: Dare I say it, Mr Speaker, I do not think there was a question there. As it happens, I agree with everything that my hon. Friend said.

Mr Speaker: It was also orderly.

Sarah Champion (Rotherham) (Lab): I do not recognise any of the criticisms that are being laid on my party about Sheffield. We are very proud of it, which is why we are here today. I would like the Minister to explain simply why taking jobs from Sheffield to London is in any way supporting the region or the Government's ideal of a northern powerhouse.

Anna Soubry: I hoped that I had explained that to the hon. Lady. We are having to ensure that we spend public money wisely. Unfortunately, that means that we have to reduce the number of people who are working for us. We must make sure that we use the money to best effect, which is why we considered the decision so very carefully, as I hope that she understands we would. Nobody on the Government Benches takes any pleasure whatsoever when anybody loses their job. That is why we are so keen to make sure that we put the support in. We are confident that many of the workers will choose to take new jobs down in London. The simple truth is that we have to take tough decisions. We took tough decisions during the five years of the previous Government and we saw the fruits of that in the reduction in the deficit, a reduction in debt and our economy once again getting back on its feet so that there are now more than 2 million people in work who did not have a job before.

Neil Coyle (Bermondsey and Old Southwark) (Lab): In my short time in Parliament, this is perhaps the most undignified spectacle at the Dispatch Box that I have seen. Is it not also undignified for the Department for Business, Innovation and Skills to spend £200,000 of taxpayers' money developing a business case to shut down jobs? When will that full business case be published?

Anna Soubry: I shall make inquiries. If I can assist the hon. Gentleman, I will. As I say, in difficult times when we have to make sure that we continue with our long-term economic plan, difficult decisions have to be made, but we take the view that this is the best way to spend public money more efficiently and more effectively.

Mike Kane (Wythenshawe and Sale East) (Lab): I do a lot of training of young people who aspire to public life and I always tell them it is important to comport oneself well in public life. The Minister has fallen below that standard this morning, unfortunately. However, I agree with her that there are great Labour leaders across the north of England. One of those is Julie Dore, who is the leader of Sheffield city council and the driver behind the Sheffield regional deal. In relation to this matter, she said:

"Yet again the actions of this government speak far louder than their empty words about commitment to the north."

Does the right hon. Lady agree with one of our great northern Labour leaders?

Anna Soubry: As I say, the Sheffield city regional deal is an outstanding deal for the people of that city and that area. As a result of it, I understand that the number of people in work in Sheffield has risen and unemployment continues to fall.

Mr Steve Reed (Croydon North) (Lab): May I invite the Minister to do what she has so spectacularly failed to do so far this morning—apologise to the people who are at risk of losing their jobs and just show a little human compassion for people who this morning are fearful for their livelihoods, for themselves and their families?

Anna Soubry: I am sure *Hansard* will record that as I said to the hon. Member for Sheffield, Heeley (Louise Haigh), nobody enjoys it when people lose their jobs and nobody takes any pleasure in it. We will do everything we can to support those people who will have to be made redundant if we reach that stage. It is rich coming from Labour, which brought this country almost to the level of bankruptcy, which resulted in millions of people losing their jobs. I am delighted that we have now got 2 million more people in work, thanks to our long-term economic plan.

Access to Medical Treatments (Innovation) Bill

11.32 am

Debate resumed—

Anne Marie Morris: I shall resume my comments on amendment 2, which would remove clause 3. The argument goes that innovation has fallen in recent years owing to the legal complexities and doctors fearing a negligence claim against them if something goes wrong. There is no evidence of this, according to the Medical Protection Society, the Medical Defence Union, the General Medical Council or various other medical bodies that have spoken out on the issue. They claim that the Bill needs to be completely rethought and that no amount of amendment would make it acceptable. I would like to think that the work that my hon. Friend the Member for Daventry (Chris Heaton-Harris) has done will go some way to meet the concerns expressed before Committee stage.

Those most likely to benefit from innovative medicine are likely to be those most in desperation. Those who have nowhere else to turn will often be allured by the carrot on the end of the proverbial stick, but we must make sure that the treatment is right for that particular person. The UK has a proud history of research through universities, research institutes, the private sector and, of course, the NHS. According to the UK Clinical Trials Gateway, there are currently 3,754 trials recruiting, and that does not include the innovation that goes on day to day in the NHS.

According to the Association of the British Pharmaceutical Industry, it can take over 12 years to develop a new medicine to the standards of quality, efficacy and safety that are laid down in legislation. It will typically cost £1.15 billion to do all the research and development necessary before a new medicine can be licensed for use. For every successful medicine, 25,000 compounds are tested, 25 of these in clinical trials, with five receiving approval for marketing. The pharmaceutical industry invests more in research and development than any other industry—£11.2 million is spent every day—and employs around 23,000 people in R and D. My hon. Friend the Minister for Life Sciences stated in September last year:

"Research and innovation in the NHS are critical for addressing ...challenges."

I agree and therefore wholeheartedly support amendment 2.

Amendment 3, which would remove clause 4, was tabled by my hon. Friend the Member for Daventry, with the support of the hon. Member for Central Ayrshire (Dr Whitford) and my hon. Friend and neighbour the Member for Totnes (Dr Wollaston). It is important to address the legal aspects of the Bill and medical negligence. The common law test, which is the main test for medical negligence, has been around since 1957 and derives from the case of Bolam *v* Friern Hospital Management Committee. The Bolam test states that if a doctor reaches the standard of a responsible body of medical opinion, he is not negligent. This rule has served us well over the past 55 years and I believe it will continue to serve us well. However, if it needs to be amended, our judges are in a suitable position to do that. The 1997 case of Bolitho *v* City and Hackney Health Authority, where the courts refined the Bolam test, is a great example of our common law in action.

Although I am sure some will point out that the Bill does not explicitly change the Bolam test and clause 4(3) appears to address the concerns that were expressed about the Saatchi Bill, I worry that lawyers would still find a way around this. Why tempt fate to change something that is not broken? Judges and lawyers know where they stand with the common law, so maintaining the status quo will give both doctors and patients the protection they need from negligent treatment. If the removal of clause 3 is agreed to, it is right that clause 4 should also be removed as it would no longer be necessary, and the common law of negligence and the Bolam test can continue to operate effectively, as they have done for 55 years. I therefore support amendment 3.

Heidi Alexander: This group of amendments, and in particular those which leave out clauses 3 and 4, are very welcome and have my full support. I appreciate that making such extensive changes to a Bill at this stage is not easy, but the hon. Member for Daventry (Chris Heaton-Harris) has been true to his word, and has rightly decided not to proceed with these clauses in the face of strong opposition.

Members who were present on Second Reading will have heard some of the grave concerns expressed by medical royal colleges, research charities and patient groups. I think it would be fair to the hon. Gentleman if I say that those concerns, which I shared, were more about the unintended consequences of clauses 3 and 4, than about the stated aim of his Bill. However, the effect of these amendments, if they are passed, is that the sole purpose of this Bill is now to give the Secretary of State the power to establish a database. The hon. Gentleman knows that on Second Reading, along with many other hon. Members, I said that I believed the Secretary of State already had this power.

The Association of Medical Research Charities has said that primary legislation is not required to set up a database of innovative medical treatments. According to the House of Commons Library, section 254 of the Health and Social Care Act 2012 gives the Secretary of State power to direct the Health and Social Care Information Centre to establish a system for the collection or analysis of information. Indeed, in Committee, the Minister signalled his intention to introduce such a database, regardless of whether this Bill becomes law. He said at that time:

"If the Bill does not, for whatever reason, reach the statute book, I would happily proceed towards establishing such a database".—[*Official Report, Access to Medical Treatments (Innovation) Public Bill Committee,* 16 December 2015; c. 22.]

With that in mind, I have to question whether what is left of this Bill is needed at all.

There also seems to be some confusion, even in the Minister's own mind, about the purpose of the Bill. *The Daily Telegraph* claimed on 22 January that the Minister had told it that changes in the reworked Bill could help to cut the length of time it took to bring a new drug to market by a third, from 15 years to 10 years. Yet when my hon. Friend the Member for Ellesmere Port and Neston (Justin Madders) received a written answer to a question on this very subject on 28 January, the Minister's reply was:

"The Bill is not specifically designed to reduce the length of time it takes to bring a new drug to market".

I would be grateful if the Minister clarified the apparent contradiction in those remarks. Having said all that, I support all the amendments in this group. Indeed, they represent a positive step forward in terms of the overall Bill.

George Freeman: The amendments seek to remove the part of the Bill that sought to take forward the original proposals put forward by Lord Saatchi to provide reassurance to clinicians that fear of negligence should not be a barrier to innovation. I want to say something about the Government's position on this point, which, as the hon. Member for Lewisham East (Heidi Alexander) has said, has been a point of some contention.

The Government share the ambition that fear of negligence should not be a barrier to innovation. Indeed, we have looked carefully at the provisions of the original Saatchi Bill and of this Bill, and taken legal advice in order to be sure that the proposed mechanism would in no way change medical negligence law, and that is indeed the case. Notwithstanding that, I have also repeatedly made it clear that if the Bill's provisions were to create confusion, undermine patient, public and clinician trust and confidence and trigger a lawyer-fest of discussion about whether the mechanism did or did not have that effect, it would have had the opposite effect to that which it was seeking. In those circumstances, the Bill could trigger more confusion about medical negligence.

My hon. Friend the Member for Daventry (Chris Heaton-Harris) has done a sterling job in the past few months to get round all the various parties and reassure them that, in law, the proposed mechanism does not change the legal framework for medical negligence. However, as he himself has candidly said, such has been the level of opposition—and indeed some misunderstanding, not least because there are three Bills on this subject in the House—that this proposal has started to have the opposite effect. As I said on Second Reading and elsewhere, we would never be able to support a Bill which, despite its intentions, undermined public and patient trust and confidence in our world-class medical and clinical research landscape. The fact that a coalition of lawyers, clinicians, patients and charities was concerned about the clause meant that it would inevitably have to be removed if the Bill was to receive any support from the Government. I congratulate my hon. Friend on doing his very best to develop the debate and, in the end, deciding that it would be better to remove the clause and focus on the areas on which there is agreement.

In accepting the amendments that remove the provisions on medical negligence from the Bill, it is worth pointing out that I do not want the hon. Member for Lewisham East to misrepresent my position on this. Both the chief medical officer and the NHS medical director had advised us that they believed the proposal was safe, and we had no fear that it would in any way endanger patient safety. The point is that if it triggers legal, political or patient concern, it is self-defeating.

As I have said repeatedly at the Dispatch Box, fear of negligence is just one concern in a whole field of barriers to the adoption of innovation. I do not believe that it is the biggest barrier; I never have. The biggest is the difficulty of getting information to clinicians on the busy frontline of our national health service on the pace, scale and volume of innovative medicines that are coming

[George Freeman]

through the system. That is why I believe that my hon. Friend's refocusing the Bill on that, and on the introduction of a new mechanism for getting information on off-label drugs and innovative medicines in development, is very helpful and powerful.

11.45 am

In the consultation on the previous Bill on this subject, we received some evidence from clinicians that there was an issue about fear of negligence. Indeed, some Members have talked about the scale of the negligence bill that now confronts the NHS every year. I want to put on record, notwithstanding my earlier comments, that it is absolutely right to remove this mechanism from the Bill because it is having the opposite effect. There is an issue in our system, and we need to ensure that doctors and clinicians are not operating under the sword of Damocles because of the fear of negligence. It is equally important that patients should know that the system is there to protect them, and we do not want them to fear that medical negligence provisions are being undermined in any way. I strongly welcome the removal of this clause, but in so doing I do not want the hon. Member for Lewisham East to misrepresent our position by saying that we accepted that the mechanisms were in any way dangerous. Patient safety has always been our No. 1 concern.

Heidi Alexander: Will the Minister tell us why it is taken him so long to reach this conclusion? Will he also be clear about the contact that his officials at the Department of Health might have had with the hon. Member for Daventry (Chris Heaton-Harris) or Lord Saatchi on previous incarnations of this Bill? It strikes me that the Department has supported this Bill for a number of months and years in its different incarnations.

George Freeman: I am absolutely delighted that the hon. Lady has asked me that question, because it gives me the chance to deal with this matter directly. I am surprised at her question, in an age in which people want the Government to work in a cross-party way and to support private Members' Bills and enable Back Benchers to get business through, and I have gone out on a limb to work in a cross-party vein. Sadly, however, the hon. Lady seems stuck. I thought this morning might have been a day on which to celebrate that joined-up work. Let me deal with the specific points that she has raised.

Right at the beginning, I said that I supported the aim of Lord Saatchi's Bill to tackle the issue, such as it is, of medical fear of negligence if it is getting in the way of innovation. Indeed, we made it clear that we supported the aims of the Off-patent Drugs Bill, but not the mechanism involved. We also made it clear that we supported the aim of the Bill introduced by my hon. Friend the Member for Daventry to promote access to information about innovative medicines. I am surprised that the hon. Lady cannot get away from wanting to criticise that attempt. I believe that it is a good thing that we have reached joined-up consensus today on a package of amendments.

The hon. Lady should not believe everything that she reads in the papers. The article in *The Daily Telegraph* to which she referred talked about the accelerated access review, which I am leading and which I would like to think she welcomes and supports. My comments on speeding up the pace at which we can get innovative medicines to patients were in connection with that. I read the piece too, and it was misleading because it gave the impression that I thought this Bill would have the effect that I want the accelerated access review to have. I was merely making the point that the Bill in its current form could support the wider accelerated access review and the landscape that I am trying to put in place.

Heidi Alexander: I should like to state for the record that it has never been the Opposition's desire to play political games with this Bill. We have always been concerned about what is in the best interest of patients, and I would like to make that point clear to the Minister and place it on record.

George Freeman: I am grateful to the hon. Lady for that clarification; it is most welcome.

I want to deal with the point that the hon. Lady and one or two others have made about the necessity of the Bill, given the powers that Ministers already have in relation to data. The Health and Social Care Information Centre, created under section 254 of the 2012 Act, can collect data, but there are restrictions on who it can disclose those data to. The Bill will enable disclosure to doctors, which could be limited by using just section 254. The 2012 Act also contains specific provisions relating to the HSCIC having a role in establishing other databases, so this approach is more in keeping with the general approach in the legislation.

The Bill might not pass in its current form, as it still has to go to the House of Lords. However, the point I made in Committee was that although I support the intention of that database provision, the law regarding the use of data in the NHS is complex and difficult, as Members know well. If the House wants the database to be created, having a Bill that makes very clear what it wants the database to do and requires Ministers to come back with proposals for it would be extremely helpful. In conclusion, I support these amendments.

Amendment 1 agreed to.

Clause 2

Database of innovative treatments

Amendment made: 11, page 1, line 18, leave out from beginning to "involves" in line 19 and insert

"In this section, "innovative medical treatment" means medical treatment for a condition that".—*(Chris Heaton-Harris.)*

Heidi Alexander (Lewisham East) (Lab): I beg to move amendment 8, page 2, line 20, at end insert—

"(b) the General Medical Council,

(c) the British Medical Association,

(d) the Association of Medical Research Charities,

(e) the Royal Colleges,

(f) the Academy of Medical Sciences,

(g) the Medical Research Council,

(h) the National Institute for Health and Care Excellence,

(i) the Medicines and Health Products Regulatory Agency, and

(j) any other body or individual that the Secretary of State considers it appropriate to consult."

Mr Deputy Speaker (Mr Lindsay Hoyle): With this it will be convenient to discuss the following: amendment 9, page 2, line 20, at end insert—

"(6A) Regulations under subsection (1) may not be made unless the Secretary of State is satisfied that the regulations have the approval in principle of—

(a) the HSCIC,

(b) the General Medical Council,

(c) the British Medical Association,

(d) the Association of Medical Research Charities,

(e) the Royal Colleges,

(f) the Academy of Medical Sciences,

(g) the Medical Research Council,

(h) the National Institute for Health and Care Excellence,

(i) the Medicines and Health Products Regulatory Agency, and

(j) any other body or individual that the Secretary of State considers it appropriate."

Amendment 15, in clause 5, page 4, line 1, leave out subsection (2) and insert—

"( ) References in section 2 to medical treatment include references to treatment carried out for the purposes of medical research (but nothing in section 2 is to be read as affecting the regulation of medical research)."

This amendment makes it clear that the database for which clause 2 provides may contain information about treatments carried out for the purposes of medical research (including, for example, in the context of a clinical trial).

Heidi Alexander: Setting aside the fact that I question whether what is left of the Bill is necessary, if the database is to be created, it is important that we get its design right. The Association of Medical Research Charities has expressed concern that the database might adversely impact patients and medical research. For such a database to be effective, it will need to be appropriately regulated and quality controlled. I believe that it can command the confidence of the medical profession only if it is developed in consultation with it. With that in mind, amendments 8 and 9 deal with the bodies that the Secretary of State must consult and get approval from before introducing regulations establishing a database of innovative treatments.

As the Bill stands—this is set out in clause 2(1)—to make those regulations the Secretary of State need only consult the Health and Social Care Information Centre. Restricting the statutory consultees to only one organisation seems highly restrictive and is inconsistent with the Bill's explanatory notes, which state:

"The detailed design of the database would be consulted upon with professional bodies and organisations."

Amendments 8 and 9 would make the legislation clearer on which bodies should be consulted.

I note that the Minister was unable to support similar amendments tabled in Committee because he felt that the list was "not exhaustive". Indeed, he went on to say:

"Although it represents a helpful list of consultees, such a provision would need to include many more organisations. While I understand the intention behind the amendment, restricting the process would not be helpful".

The hon. Member for Daventry (Chris Heaton-Harris) then said:

"I know from my consultation on the Bill with stakeholders that we would need longer lists than those in the amendments."–[*Official Report, Access to Medical Treatments (Innovation) Public Bill Committee,* 16 December 2015; c. 22-23.]

With those constructive comments in mind, I have included in the list a provision allowing the Secretary of State to consult

"any other body or individual that the Secretary of State considers it appropriate to consult."

I know that there were concerns that the list of specified organisations could become out of date. However, given that these regulation-making powers would likely be used only once—to create the database—I do not believe that concern is wholly justified. Indeed, if the Minister, or any hon. Member, believes that an inappropriate organisation is on the list set out in my amendments, I would be keen to know which organisation they feel should not have a say in the creation of the database.

I hope that these important amendments will address the concerns raised in Committee and that hon. Members will now be able to support them, because they will ensure that we get the design of the database right.

Anne Marie Morris: I will speak first to amendments 8 and 9 and then turn my attention to amendment 15. As the hon. Member for Lewisham East (Heidi Alexander) explained, amendments 8 and 9 would add a whole host of bodies—I think that I counted eight—that the Secretary of State must consult before making regulations under subsection (1). This relates to the conferring of functions on the Health and Social Care Information Centre in connection with the establishment, maintenance and operation of a database. The hon. Lady has talked articulately about why the two amendments should be made, but I have some concerns.

My main concern, despite everything the hon. Lady said, is that adding all these organisations that the Secretary of State must consult will just add to the complication of the database. The amendments not only ask the Secretary of State to consult, but ask that all these organisations approve the regulations. Adding these extra organisations will just add to the confusion about who is policing the system. Is the consent of all those organisations needed before a treatment can be removed, or can it be removed just by the Health and Social Care Information Centre? If a complaint is made about what is on the database, does it go to the Secretary of State, the NHS or the Health and Social Care Information Centre, or does it have to be put in front of all those organisations again?

I understand that the hon. Lady might not have all the answers to my questions and that these issues go deeper than just her amendments, but I do not think that adding extra layers of consultation will help to simplify the Bill or make it any easier to implement the database, which, if put together correctly, could do much good and help many people across the country and, potentially, the world. I do not support amendments 8 and 9, because I believe that they will add unnecessary complications to the database and impede the good work that it could well achieve.

Amendment 15 has been tabled by the Minister, who has spoken eloquently throughout these debates. Including references to treatments carried out for the purposes of medical research will enhance the database, because it will allow the inclusion of clinical trials and other forms of medical research. Including medical research in the Bill will hopefully help to address the UK DUETS database. Mr Deputy Speaker, you will be glad to hear that that is not a database of UK singers who perform

[Anne Marie Morris]

together; it is the database of uncertainties about the effects of treatment. It publishes treatment uncertainties from a wide range of people, including patients, clinicians and research recommendations, among others. By including medical research on the database, hopefully we can remove a few more treatment uncertainties from the database or, on the flip side, identify treatment uncertainties with greater ease and therefore tackle them head-on.

Clinical trials are vital if we are to put our NHS resources into the right treatments. They can help find out how to prevent illnesses, detect and diagnose illnesses or treat illnesses. The earlier we can do that, the more lives we can save, so I support any move to increase clinical trials, which I believe this amendment will do. It is my belief—I am sure that my hon. Friend the Minister will correct me if I am wrong—that his amendment will also increase knowledge of clinical trials among clinicians by adding them to the database. Sir Francis Bacon said that "knowledge is power", and I do not believe that is any less true when it comes to medicine and saving lives. I fully support the Minister's amendment.

Oliver Colvile (Plymouth, Sutton and Devonport) (Con): I congratulate my hon. Friend the Member for Daventry (Chris Heaton-Harris) on introducing this Bill. Let us hope that it has a successful outcome later. I should remind you, Mr Deputy Speaker, that I am the Government's pharmacy champion and vice-chairman of the all-party pharmacy group. Consequently, the majority of my comments will be based very much on pharmacists as dispensers of medicines that will include off-label ones.

I enter into the debate with some trepidation having listened to the hon. Member for Central Ayrshire (Dr Whitford), who was incredibly well-informed and very persuasive. I hope that my comments will be practical and constructive. I want to concentrate on the data-sharing of summary care records, as well as information to do with these medicines, and the decriminalisation of pharmacists for dispensing errors. I hope that the Minister can clarify his position on some of this stuff when he winds up.

12 pm

To develop a clinically focused community pharmacy service and for pharmacists to succeed in new care settings such as GP practices, we need better information sharing between community pharmacies and GP practices. We also need to make sure that there is a level playing field between the GPs and pharmacists who will be responsible for dispensing these medicines. The Bill refers to doctors not being negligent in prescribing off-label medical treatment if the GP's decision is taken responsibly. I quite agree that patients' safety must be paramount, and I congratulate the Government on their unwavering commitment to improving patient safety and the patient experience. GPs must therefore inform patients of the benefits of taking non-patented medicines and make them aware of any side effects.

I speak from personal experience. When I was 14, in 1974, I contracted shingles, which came perilously close to my eye. If it had got too close, I would have lost the sight in my right eye. I was put into the John Radcliffe eye infirmary, where doctors used me as a guinea pig to try out a new drug before it was put on the open market. After they had tried it with me, they decided not to take it any further. After some while, I contracted regular migraines. I remember this incredibly well, for the simple reason that when my housemaster came to see me to make sure that I was all right, he turned up in the middle of David Lloyd's maiden innings at Lords, when he scored 214 not out against India. Needless to say, I was more interested in listening to John Arlott on "Test Match Special" than in having a conversation with my housemaster, and I was positively delighted when he left.

I welcome the fact that doctors must show that they have taken the necessary steps to ensure that any decisions have been taken responsibly, including with regard to requests expressed by patients. However, if this rule is going to apply to doctors, it must also apply to pharmacists. When deciding to take a medicine, patients must be informed of the benefits but also of any side effects. Certainly, when I ended up having my shingles treatment, I was not aware of what the impact was going to be; my parents just made the decision for me. They are no longer alive, so I can no longer hold them accountable. However, GPs can be struck off only if they make a prescription error, while pharmacists can be sent to prison for doing exactly the same kind of thing. There must be some equality: we need a level playing field. We also need to make sure that any grievances can be considered.

I am going be slightly critical of the Government, I am afraid, because I have been campaigning on this issue for some while. The APPG had hoped that it might have been sorted through secondary legislation before the last general election, but I now understand that the Department of Health will delay introducing the necessary legislation until after the devolved Assembly elections and the new Executives and Governments have had a chance to bring in their own legislation. Legislation is unlikely to be introduced before the summer, so English pharmacists are dependent on legislation being passed for other pharmacists in Scotland, Northern Ireland and Wales—so much for a fair devolution deal. Will the Minister explain what practical steps are in place to safeguards patients' safety and the exact timetable for when English pharmacists will not be reliant on the Welsh, Scottish and Northern Irish Assemblies? He may wish to write to me, rather than covering it today.

The Bill will allow the Secretary of State for Health to enable the Health and Social Care Information Centre to establish a database of innovative medical treatments and their outcomes. I would urge him to share that information with the pharmaceutical organisations as well. The Bill will allow other GPs to have access to the database, so where do pharmacists fit in? I argue that the database should not just be for GPs, but for other care professionals, such as pharmacists and perhaps even some local authorities, especially where they are dealing with social care issues.

Summary care records are an electronic summary of key clinical information about a patient—medicines, allergies, adverse reactions—sourced from GP records. It is hoped that all pharmacists will have access to it by autumn 2017. It is vital not to have the same kind of delay as has happened with the decriminalisation of prescription errors. The all-party group on pharmacy called for that in its document on the Government's first 100 days. I argue that pharmacists should have access to the database of non-patented drugs and medicines.

I fully support the Government's commitment to making sure that GPs share summary care records with other health professionals, such as pharmacists, but in so doing, they must ensure that patients are happy for their medical records to be shared with other health professionals. We must also ensure that insurance companies do not have access to such medical records. I would be grateful if the Minister wrote to me to explain what progress has been made and stated when pharmacies will have access to summary care records.

My great-grandfather, a rural vicar, said that he did not mind his congregation looking at their watches, but got very concerned when they started shaking them. I notice that my hon. Friend the Member for Daventry is just about to start shaking his watch. He is champing at the bit to ensure that he gets the Bill on to the statute book, and I will therefore conclude my remarks.

Mr Deputy Speaker (Mr Lindsay Hoyle): The hon. Member for Daventry (Chris Heaton-Harris) may have to shake his watch a little longer. I call Jo Churchill.

Jo Churchill: I spoke earlier about the new clauses we tabled, but I did not emphasise my own need for us not to paralyse the database. It is vastly important, given the wider horizon of genomics and informatics, and we have not even touched on how it could accelerate the whole system and improve patient outcomes significantly. We need to put patients at the front and centre of the process, and allow enough flex for the system to be the best and the database to be the finest in the world. We have the finest scientists, the greatest charities and some of the best academic minds at our disposal.

The database may also revolutionise the life sciences industry, to which my hon. Friend the Member for Newton Abbot (Anne Marie Morris) has just referred. That industry generates 1% of our export market from one drug. The power for this billion-pound industry to grow and to improve health—not only in our own country, but across the world—has to be seen to be believed. It costs upwards of £1 million to take a drug to market. What on earth would incentivise a company to do that if it could not get some sort of payback? We must not tie the hands of the people who can find the answers. Many such companies start as micro-companies, spun off from the great universities of our country, but many of them fail in what they call "death valley". Our health system needs to modernise, digitise and reform to collect, collate and use our health data in the right way.

I believe that clinical trials are vital. I would take part in one, as a dear friend of mine recently did, to give other people a better chance of beating their disease. That is why we must not constrain the database in a way that, like a straitjacket, would completely constrict the industry and academia. At the same time, we must maintain the rigour in dealing with science for which our country is so famed. I believe that the power behind that science is patient data, and every patient holds an answer. With the support of clinicians and charities, and with a strong sense of purpose from the Government, I want data to be used for the benefit of patients. I will stand here and make my point over and again for these five years if we wreck the ability for a database to be a power for good in this Chamber today.

Dr Philippa Whitford: I wonder whether the hon. Lady will clarify what she is saying. The database that is referred to in the Bill will share information on drugs and trials that ought to be available to anyone, whether a pharmacist, a GP or a doctor. It is simply about information sharing. Is she referring more to a database of patient information from which we can learn in the future? Obviously, that is outwith the scope of the Bill, but it has been held back by the various data challenges that have been faced.

Jo Churchill: I apologise. Yes, I have confused the two, because I really believe that if we are not careful, what we do today will have an effect on our ability to bring that second broader database to fruition, which would give us the information we need to drive the trials, the life science industry and so on. Databases need to be fit for purpose. I could not have put it better than the hon. Lady did. We want the database that we are talking about today to be fit for purpose, but we do not want to put too many constraints or too much rope around it if that will stop us moving forward with clinical trials and with the whole area of genomics and patients.

I want every life to mean or have meant something. A patient should be able to choose to give knowledge as their legacy. Data hold the answers—the answer for my constituent whose two-year-old had a brain tumour; the answer for a family I know who have diabetes in several generations; the answer for a family member whose humour is tested by Parkinson's that attacks his body. Personalised medicine should be a reality. As was pointed out in a paper yesterday, we are doing great things with CRISPR—clustered regularly interspaced short palindromic repeats—and across the piece.

Like me, every patient is somebody's parent, partner, child or friend. That must not be forgotten. If the database we are discussing allows for information to be given that is appropriate to the individual, with care taken by the clinician right through the pipeline, it has to become a force for good. We should not wrap it up in too many constraints, but should allow it to develop. We must allow the Under-Secretary of State for Life Sciences to give us a lead in how to proceed in this field in the most effective manner.

The use of data offers the possibility to accelerate medical trialling from seven to two years and to link research together to find new insights. My glasses are not rose-tinted. I would want assurances about the use of my data, as any sensible person would. I want the recommendations of the accelerated access review to be implemented. The use of health data will be central to solving this country's health challenges, not least in terms of cost, and its economic challenges. Our medical future will be uncertain unless we unleash the potential of information about patients for patients. I therefore support the Minister's proposal.

Chris Heaton-Harris: It is always a pleasure to follow my hon. Friend the Member for Bury St Edmunds (Jo Churchill). Her knowledge and the way she goes about her business in the Chamber on this subject mean that it is always worthwhile to listen to her. What she says is powerful and she beats a trail that many will follow. She will get to the place she wants to get to eventually. I am very hopeful that this process today is one step along

[Chris Heaton-Harris]

the way. I hope she gets some comfort from the fact that she is beginning to open doors, open minds and, in this case, open up information to registered medical practitioners about a host of treatments that they might not have known existed.

First, I will deal with what I perceive to be a Government amendment, amendment 15, which was tabled by my hon. Friend the Minister. I will then deal with the amendments tabled by the hon. Member for Lewisham East (Heidi Alexander).

12.15 pm

We have talked about how the Bill might be able to help research, and there is a ton of innovation going on in the national health service at any given time. Sometimes spreading just a bit of extra knowledge and best practice can do the most amazing things. I guess the best example of innovative medical treatment that I have heard in all my stakeholder meetings was about a lady who, unfortunately, contracted mesothelioma, a sinister condition that can sit unnoticed for decades until it reveals itself. Its prevalence in our country is relatively high—in fact, we have the highest in the world—yet there has been very little research into finding a way to stop or even slow it. The story was given to me when I met the charity Mesothelioma UK, and it is about a lady I will call Emma—she has asked to be anonymised.

Emma was diagnosed five years ago with peritoneal mesothelioma, a cancer of the lining of the abdomen caused by exposure to asbestos. It is somewhat rarer than the version that attacks the lining of the lungs. She contracted it when she was married with two children and two grandchildren. Her first husband had been a building surveyor, and some of his work required him to be present at building demolitions. He remembers being present at one particular demolition when asbestos was found and removed. That was in the 1970s, when we were still being told that asbestos was safe and protective clothing was often not provided. Emma's husband often returned home with dust all over his clothes, and it is thought that she ingested asbestos fibres during the washing of those clothes.

We now fast-forward to 2010, when Emma had just married her second husband and cancer was far from her mind. She was looking forward to a long and happy future. Her stomach had begun swelling, though, and she was putting on a bit of weight. After trying to diet, she decided to go and see her general practitioner. She was referred to a local hospital, and a few weeks later a scan revealed that she had peritoneal mesothelioma. She received five rounds of chemotherapy, with two drugs. I struggle to pronounce them, but if the House will forgive me, I will give it a go—they were pemetrexed and carboplatin. The side effects were extremely unpleasant, and she was given steroids to help take the edge off the worst of them. Unfortunately, the combination of drugs led to her contracting type 2 diabetes, but the cancer was held at bay for two years before it returned. Emma then received more chemotherapy with further rounds of those drugs, and once again the cancer was held at bay.

The disease returned in 2013, and once again funding was sought for pemetrexed. This time it was declined, on the basis that there was no evidence to support its use. Emma was offered palliative care, but was not offered the drug again. She was given none of the drugs that had helped her fight off the disease twice before. Her family therefore carried out their own research, as everybody in such circumstances does, and found a team of surgeons at a particular hospital who could do an operation called cytoreductive surgery. At their request, her oncologist referred her to a team of surgeons, who found her to be a suitable candidate and agreed to carry out the operation. The surgery took four surgeons eight and a half hours, during which they removed her ovaries, peritoneum and gall bladder—a whole host of organs. The surgery is carried out regularly in the United States of America.

Emma spent two weeks in hospital recovering and then returned home. That was two years ago, and she has told the charity:

> "Yes I still get tired easily and I have to be careful what I eat, but hey, I am still here leading a meaningful life. I feel I have experienced the best and the worst of the NHS. The best because of the great care and amazing surgery I have experienced but the worst because of the withdrawal of certain chemotherapy funding on the basis of lack of evidence."

Very few people are diagnosed with peritoneal mesothelioma—about 200 annually in the UK—so it is really hard to obtain evidence that certain drugs, such as those that Emma used and was in the end denied, could work. In July last year, NHS England withdrew its funding for the operation due to its apparent lack of success.

Mrs Drummond: That was a very moving story about Emma. Does my hon. Friend envisage that the database will include international research and data from around the world?

Chris Heaton-Harris: Strangely enough, the Bill confers only a general power on the Secretary of State to provide such a database, and stakeholders and practitioners want clarification on how the database will operate and what sort of thing it might contain. Ideally, in the future, perhaps we could include what my hon. Friend suggests—who knows?—but the Bill confers a very simple power on the Secretary of State at this point in time. The very simple answer is, as it stands, no.

Mrs Drummond: My hon. Friend mentions that Emma got her treatment from the United States, where there is a lot of innovation and research. Would it not be great if we could expand that database to include research from around the world?

Chris Heaton-Harris: Yes, but in responding to amendments 8 and 9, which were tabled by Her Majesty's loyal Opposition, I know that, when the Secretary of State and the Minister choose to use the power conferred on them in the Bill, they will confer far and wide on how the database is set up and used. Perhaps my hon. Friend will have an opportunity at that time to put her point in the consultation on how wide and extensive the database should be.

I mentioned Emma's story because it was about evidence sharing within our existing system, which every single Member would like. Of Emma's treatment, the NHS stated that it could not find evidence to approve the effectiveness of the operation that saved Emma's life, and then withdrew funding for it. However, in its

consultation on the matter, the NHS did not talk to the surgeons at the hospital where Emma was treated. There is a general point. I could tell hundreds if not thousands of stories in which a simple flow of information and data, or innovation or other things in our NHS, could improve the quality and type of care that is given to patients.

Amendment 15—the Minister's amendment—states:

"References in section 2 to medical treatment include references to treatment carried out for the purposes of medical research (but nothing in section 2 is to be read as affecting the regulation of medical research)".

That is an important amendment because it signals the Government's intention to use the database wisely when it comes to dealing with research. Research has come on in leaps and bounds, meaning that a huge number of new treatments are coming into our NHS through clinical trials and innovative ideas everywhere in the system.

Dr Philippa Whitford: Although people who work in an academic unit will be very aware of trials—a lot of trials are UK-wide, but European Organisation for Research and Treatment of Cancer trials are Europe-wide and occasionally there are worldwide trials—people who work in district general hospitals, where there might be greater numbers of certain types of patients, are often less aware. Adding a listing of trials under any disease topic or area of clinical practice could be helpful in attracting clinicians to say, "I am aware that you can access a trial in Birmingham or Manchester." The measure might promote trials to the busy clinician who is not directly involved in academic research.

Chris Heaton-Harris: I thank the hon. Lady, and I completely concur. I can foresee great benefits for those in the outer reaches of the NHS who do not necessarily come across information about many of the trials that are taking place. One of the biggest criticisms of the original formulation of my Bill was the fear in connection with getting people on to clinical trials. I would like to think that we have not just overcome that issue, with the amendments we are discussing and the latest version of the Bill, but have gone some way along the line to help improve the ability of registered medical practitioners to have knowledge of such trials. I completely concur with the hon. Lady's point. We have innovation everywhere, so there is a real purpose behind having a database, regardless of whether the Minister has had the ability to set one up before now.

On research, Lord Winston made a very important point particularly well in the other place on Second Reading of the Mesothelioma Bill. He stated:

"There is no question that in the field of treatment there is a great deal of research."

He had a list of a number of chemotherapeutic agents that were being looked at, saying:

"In recent years I can count at least 10 or 11".

He then went on to name them. They are impossible for me to pronounce, so I will not do so here today. He said that,

"there are various combinations of those therapies with other well-known mitotoxic agents. These have included trials".

He went on to say:

"Other treatments have been researched: of course there is surgery…and there are now attempts to try to reduce the tumour inside the lung membranes."

He spoke about three trials that Cancer Research UK is conducting to emphasise the wide range of "stuff", as he put it, that is going on.

"One is some work with HSV1716, which is a virus that acts against dividing cancer cells. It comes from the herpes virus…a very good example of where we might make a breakthrough in treatment. Then there is a different strand of research with ADI-PEG 20, which in combination with other drugs such as cisplatin affects a particular amino acid in the chain of cell division"—

which could prevent cancer cells from multiplying.

"That has been specifically targeted for the treatment of mesothelioma. A compound, GSK3052230, developed by GSK, is I think about to enter phase 3 trials very shortly. That attacks the FGFR1 gene, and therefore stops cancer cells growing."

This is where he makes the point exactly:

"There is now an increasing emphasis on understanding that, if we are going to improve outcomes for patients with a variety of different cancers, and other chronic long-term conditions, we need to move away from a generalised approach to managing disease towards personalised, precision medicine".—[*Official Report, House of Lords,* 20 November 2015; Vol. 767, c. 395-7.]

Medicine is going to change. Research is going to change. Spreading the information about that across our NHS, and how quickly we can do that and learn from success and failure in our NHS, is a very, very important matter.

Anne Marie Morris: Does my hon. Friend believe that personalised medicine should become a reality over the next little while and not a research project, and that unless we have freedoms within the database we will never have the knowledge to find out that we can truly have personalised medicine?

Chris Heaton-Harris: I truly believe that personalised medicine will become a reality. I would like to think that a database would aid the spread of knowledge about how individual medicines are being used and who they might affect in different ways, so yes, I nearly completely agree with my hon. Friend.

Dr Whitford: I have two small points. First, personalised medicine, particularly for breast cancer, has been evolving for years. Right from when we could tell whether a cancer fed on the female hormone oestrogen or not, we were targeting the treatments towards patients. We have been moving that way and it will accelerate.

I know it is not the subject of the Bill, but I hope that the accelerated access review will consider in general how we get drugs to patients—a subject that we debate relentlessly in Westminster Hall. I see a negative feedback loop coming from among colleagues who used to be trialists, such as myself. We registered patients and did all the work to take part in research, but when the drugs were finally made available, the NHS could not afford them. We need a totally different way of accessing those drugs. The companies want to sell them, and we and patients want them.

12.30 pm

Chris Heaton-Harris: The hon. Lady speaks with way more experience and knowledge than I do, but from everything I found out during my research for the Bill, I completely concur.

Oliver Colvile *rose—*

Chris Heaton-Harris: I give way to my hon. Friend the guinea pig.

Oliver Colvile: Does my hon. Friend also recognise that an enormous amount of research is taking place in many of our medical schools, especially Peninsula medical school in my constituency and the one in Exeter?

Chris Heaton-Harris: Clinical research and innovation is happening across our NHS every day. Would it not be wonderful if every registered medical practitioner could see what was going on, without too much effort or work, by tapping into a database and getting a better understanding of the picture around them?

This is the crux of the matter. Treatments are not what they used to be; there is not a one-size-fits-all policy. As medicine progresses and personalises even further, the mind boggles trying to imagine the sheer number of treatments that will be available in our NHS in the future. How can we expect every clinician to know about all the possible treatment routes? How can we not, therefore, provide them with somewhere to record them and their outcomes?

As Lord Giddens stated in the debate I mentioned earlier, we are experiencing a digital revolution. Given how far technology has come in our lifetimes and what is now possible, we can truly say we are living through a different age of digital capability. It is moving at such a pace that we struggle to keep up with it ourselves. It is not unfounded to say we might be living through a period of unparalleled innovation in medicine and other frontier areas of science more generally. Thanks to the strides in treatment and the speed of technological development, we have an opportunity to create and record life-saving data like never before. It is surprising that we do not have such a database already. The Bill sends an unambiguous political signal to the Government that we would like them to get on with it.

The Bill defines innovation as a situation where a doctor departs from the existing range of accepted medical treatments for a condition. This will be well understood by doctors, who are best placed to know whether treatments are acceptable and responsible. The definition of what can go on the database is deliberately wide because I want the Minister to have as wide an ambit as possible.

I want quickly to mention another stakeholder I met, Nutricia, a company dealing with advanced medical nutrition. It kindly welcomed the Bill:

"This Bill marks an opportunity for patients managing a range of diseases and conditions to get access to the most innovative medical care, and to actively support their inclusion in patient pathways in an on-going manner. This should not simply be confined to pharmaceuticals, as patients can benefit from innovation across a range of sectors, for example medical nutrition."

Medical nutrition—otherwise known as medical foods—describes a special category of foods designed to meet the needs of patients whose disease or health concern requires medically determined nutritional support. Medical nutrition is a scientifically formulated food that is available in many different formats. Applications can range from those with rare conditions, such a child who inherits a metabolic condition meaning that the consumption of a specific amino acid commonly found in normal foods can lead to brain damage, right through to people with common cancers who may as a consequence lose weight rapidly and be at risk of malnutrition for a period of time. Nutricia was therefore keen that we maintained the widest possible definition for how the database could be used.

Medical nutrition also provides benefits in the treatment pathways of other diseases, including various cancers, strokes, cerebral palsy and pressure ulcers. Nutricia has stated that,

"we must seek to streamline the adoption of innovative care of all kinds—not just pharmaceuticals—so that clinicians have a resource which will mean that there are no more missed opportunities, and patients have every available chance to manage their condition."

Bob Stewart (Beckenham) (Con): I am very ignorant compared with a lot of people in this Chamber, so my question is probably a question from a fool. I do not mean it to be, but when I go to a doctor and they are sitting in front of a computer, I make the assumption that if they have a question, they go into the computer and get an answer. Am I wrong in saying that cannot or does not happen, and would this new list work much better?

Chris Heaton-Harris: I will give way to the hon. Member for Central Ayrshire, who will give a much more informed answer.

Dr Philippa Whitford: I think the hon. Member for Beckenham (Bob Stewart) has a much greater admiration for what a computer on a desk can access at that moment when a GP has a 10-minute appointment. What they are actually looking at is the patient's records. They also have the ability to prescribe, but to track something down they would have to shut those systems down and go into something else, as with searching the internet. They cannot do that live, in front of a patient, and that brings up an important point. If the new system is meant to be used live, in front of patients, it will have to interact with the NHS computer systems, which someone can literally click on and use to look things up relatively easily, in the way we look things up in the BNF at the moment.

Chris Heaton-Harris: I thank the hon. Lady for her explanation to my hon. and gallant Friend the Member for Beckenham (Bob Stewart).

It is important that doctors are aware of the changing methods by which care is being delivered. Innovation in the delivery of care must be recognised in the tapestry that is our wonderful national health service. I fully welcome the Minister's amendment to my Bill. It makes it more worth while. The improvements we are making to the Bill today are dramatic, but they have not come out of thin air; they have come from a great deal of work. A great deal of thought has gone into them, which I very much appreciate.

Finally, and briefly, let me turn to amendments 8 and 9, in the name of the right hon. Member for Lewisham East (Heidi Alexander).

Heidi Alexander: Honourable.

Chris Heaton-Harris: Soon to be right honourable—I shall try to get her promoted to that position. I am sure there are some Privy Council positions awaiting on the Labour Benches.

I completely understand where the hon. Lady is coming from in trying to ensure the widest range of consultation on, actually, pretty much anything. Forget this Bill; when the NHS does something, it should try to interact with stakeholders who have direct and indirect concerns. As it stands, the list in her amendments looks like a preferred list of consultees, although I have a range of concerns about the listing, the order and so on. Given the way we have gone about this Bill—there has been a great deal of understanding and working together—I would like to think that when my hon. Friend the Minister answers this point and indicates what the Secretary of State would do with the power, how he would consult and which groups he would consult with, the hon. Lady will perhaps consider not pressing her amendments, in the full knowledge that there will be the widest possible consultation, should this Bill become law.

George Freeman: I shall deal with amendments 8 and 9, tabled by the hon. Member for Lewisham East (Heidi Alexander), and amendment 15, which I tabled on behalf of the Government. I shall also deal with some of the important points that Members have raised.

I have to say that I am not here every Friday, but I think that today's debate is setting a high standard, both in terms of the issues that are being raised and the way in which it is being conducted. I hope that those who take a close interest in the Bill and are watching the debate are observing the cross-party nature of our discussion of some very important issues.

I thank the hon. Member for Lewisham East for her support for the spirit of cross-party working. The sector needs to be confident in the knowledge that the House is paying close attention to the issues that underlie the Bill—issues relating to data, informatics, genomics, drug trials and research—in a cross-party spirit. As the hon. Lady knows, in the course of my work I have paid tribute to the last Labour Government's pioneers, Lord Drayson and David Sainsbury, who did so much to create the Office for Life Sciences. I think the debate reflects that spirit, and I welcome the hon. Lady's restatement of her support for it.

I also welcome amendments 8 and 9, which specify and flag the importance of a wide group of consultees. I entirely agree with the principle of the amendments. Indeed, I would go further and include a range of patients' groups, charities and others. I give the hon. Lady—and the House—a commitment, which I am happy to put in writing, that I will seek to involve all the organisations on her list, and indeed others, in the consultation that will take place following the Bill's enactment.

As an experienced parliamentary operator, the hon. Lady knows that including lists of organisations in a Bill is always a mistake, because in the end it creates more problems than it seeks to resolve. However, I will happily write to all the bodies that she has mentioned, and to all Members as well, with a list of those who I think should be involved in the consultation.

James Morris (Halesowen and Rowley Regis) (Con): I know that the Bill is specifically about access to medical treatments, but, as chair of the all-party parliamentary group on mental health, I know that there is a growing need for the ability to share information about both drug-based and non-drug-based interventions in mental health care. Has any consideration been given to the sharing of information about mental health care in particular, and how would that fit into the framework of the Bill?

George Freeman: My hon. Friend has made a typically interesting and important point. I pay tribute to his work on mental health.

In no area of pharmacology and pharmaceuticals is drug discovery, drug use and prescribing more complex than in mental health. One of the projects on which I worked before entering the House was at the Institute of Psychiatry at King's College London, where Professor Simon Lovestone has pioneered the use of informatics and data to integrate research into mental health conditions and the compiling of patient records information, MRI scans and, latterly, genomic information, to assist understanding of both the causes of disease and the way in which different patients respond to different drugs. As my hon. Friend will know, mental health care involves a wide range of very complex and, in some cases, very powerful drugs, and information about how those drugs work and how different patients respond is therefore crucial. I certainly want to ensure that we do not exclude mental health from the Bill's provisions.

I tabled amendment 15 in connection with clinical research, an issue that received much attention during the Bill's earlier stages. When—before these amendments were tabled—the Bill made provision for medical negligence, the Government were determined to ensure that none of its provisions would in any way undermine the United Kingdom's world-class and world-rated landscape for the regulation of clinical trials. So the previous Bill contained a provision stating that nothing in it applied to clinical research. Now that my hon. Friend the Member for Daventry (Chris Heaton-Harris) has tabled amendments to remove the clauses dealing with medical negligence so as to create instead a Bill focused purely on the provision of data on innovative medicines to clinicians, I suggest that we remove that exclusion of clinical research and make sure that the database—now that it has nothing to do with negligence—actually covers drugs in research. That would make sure that we do not preclude the inclusion of drugs in clinical trials that clinicians may want to recommend to their patients or investigate their patients' eligibility for.

12.45 pm

The aim of this database is to provide clinicians, at the click of a mouse, with information on innovative medicines in trials that their patients may be eligible for, innovative off-label uses of drugs that there is evidence for, and unlicensed medicines in early access to medicines schemes that, with patient and clinical consent, their patients may be eligible for. I hope that amendment 15 is uncontroversial; it is consequent on the changes my hon. Friend has put forward.

I want to pick up a number of the points raised by hon. Members. My hon. Friend the Member for Bury St Edmunds (Jo Churchill) spoke with real passion and authority on this. In case colleagues in the House or those watching are not aware, she is herself a very courageous double survivor of cancer—a survivor of cancer twice—and speaks with real authority on the power of

research and data, and on why we need urgently to develop this new landscape to support the speedier adoption of medicines. I pay tribute to her resourcefulness, and look forward to her challenging me and haranguing me to move faster on the mission we share of accelerating the adoption of innovative medicines.

My hon. Friend made an important point about the centrality of patient voice in this debate, and I want to make sure that, in our consultation, we put patient voice right at the heart of the landscape and this measure. This week I convened and chaired a summit with the Association of Medical Research Charities, who now spend £1.4 billion a year on research in this country—they are a giant in the landscape—which puts them up there with the very largest companies in the world. My offer to them is to come to the top table and help to shape this landscape for the faster adoption of innovative medicines. Indeed, by putting the patient voice and experience—in many cases best expressed by the great research charities—at the heart of this, we can strike a blow for both empowering patients and accelerating innovation.

My hon. Friend made an important point about building into this provision for consultation enough flexibility to work with an ever-wider group of people. She was passionate on the importance of data as the oil that flows through this 21st century research engine.

My hon. Friend the Member for Plymouth, Sutton and Devonport (Oliver Colvile) was eloquent on the important role of pharmacists. I will take him up on his offer to write to him with a detailed answer on the issues to do with devolution that he raised, but I also want to pick up his point about not forgetting the importance of pharmacists as prescribers. One of our central objectives in this digitisation of electronic health records in order to allow 21st century individual care, patient safety and research is to make sure that we are getting information to all those who prescribe. The hon. Member for Central Ayrshire (Dr Whitford), who spoke earlier but has had to return to Scotland, has been passionate about the importance of this database allowing nurses, pharmacists and others who are not perhaps leaders in research to have access to information on innovative medicines. So my hon. Friend's point about the importance of pharmacies is well made. My hon. Friend also highlighted the importance of confidentiality and of having a patient's trust and confidence. It is for that reason that the Secretary of State and I commissioned, and will shortly be receiving, the National Data Guardian, an independent report from Dame Fiona Caldicott. The report advises us on the use of data in the NHS and how to ensure that our systems are the best in the world for protecting patient confidentiality. It also helps us to shift from a system that is currently reliant on paper and cardboard to one that allows electronic information between primary, community and hospital providers, through an integrated patient record, to support individual care, patient safety, system performance and, crucially, research.

That brings me on to my hon. Friend the Member for Newton Abbot (Anne Marie Morris) who was very eloquent about the importance of our research landscape in the UK. Our life sciences industry is a sector that is worth between £50 billion and £60 billion. The digital and genomic sectors are growing fast, not least because of the initiatives that we have tried to take through the life science strategy. We are leading in genomics and informatics, and rapidly becoming a global hub for this new model of research.

I am delighted that, in the autumn statement, we confirmed a £1 billion a year funding commitment for the National Institute of Health Research, which is the jewel in the crown of this landscape. Embedded in the NHS, the institute allows us to lead in this new world of data and genomic-informed research.

In the creation of Genomics UK, we are the first nation on Earth to sequence the entire genome of 100,000 patients, all of whom have volunteered and consented. In that project, we are setting the very highest standards of data protection. Genomics England Ltd is up and running and sequencing genomes and combining with clinical data to form the world's first reference library for genomic information. We are also setting the standard in ensuring that no individual data can be sold or transferred—we are talking about a reference library, not a lending library. Genomics England will then support the NHS with information on traits that might determine disease, new insights into diagnostics and treatments.

As hon. Members have hinted, this space is moving very fast. Some of the extraordinary things that I get to see as Minister speak to the pace of that development. Recently, at Genomics England, I saw an analysis done at speed of a patient with a rare disease that had been undiagnosed. The diagnosis was achieved when large computer power was applied to the genomics database, identifying the very genomic trait that had predisposed the patient to the rare disease, which, in this case, allowed us to identify a treatment. Funnily, it was an off-label use of an existing drug that had already been in use in that indication.

The pace of the development of electronic health records in some parts of our NHS is extraordinary, and the advantages are very powerful. I recently visited the Norfolk and Norwich hospital where the nurse on the pharmaceutical drug round in the ward was using an electronic prescribing system. She was absolutely passionate about the power of it to ensure that she gets the right dose, to cut out mistakes, to allow her to monitor her patients' response, and to drive up the accuracy and precision of prescribing. It also drives up the use of data on patients' response to different drugs to allow the system to improve the way we prescribe.

I recently visited McLaren healthcare group, which is working with the NHS. It provides informatics to the entire Formula 1 fleet, taking 400 data points per second off every Formula 1 car. It leads the world in the handling of massive datasets for insights. It is working with the NHS at Birmingham children's hospital to provide wireless telemetry for constant data feed monitoring with individualised algorithms for children in post-operative cardiac recovery units. I saw toddlers liberated from cables, wires and huge machines that go ping beside their bed, and the look on their parents' faces as the children with huge scars on their chest toddle off happily to the playroom, knowing that all the nurses have in their pockets a device that will ping at the slightest statistical outlier that individually shows whether the child is experiencing any sort of side effect or incident. The system allows the nurses to be absolutely certain that they can provide the right care. This is a stunning application of informatics and the beginning of personalised

medicine. The ability to create much better information flows on the innovative drugs that are available is one part of that landscape.

Patient safety and confidentiality are the Government's absolute priority. We have to make sure that the revolution in informatic medicine and the digitisation of healthcare, which offers such extraordinary benefits for individual care, system safety and research, carries and deserves to carry patient trust and confidence. That is why we eagerly await Dame Fiona Caldicott's report, due imminently, on how best we should take forward consent and make sure that we allow this quiet revolution in medicine to progress and the NHS to lead it in a way that our patients can have trust and confidence in.

A number of colleagues have spoken about the new field of personalised or precision medicine. This country is leading in the field. I had the extraordinary privilege in January last year of being invited to talk to the White House health policy team, which wants to know what we are doing on our precision medicine catapult, on genomics and on informatics. In the past year we saw the US launch a very ambitious programme in precision medicine, many of whose initiatives were initiated here in the UK.

For that reason I have launched the accelerated access review to look at how we can better integrate and speed up our landscape for the adoption of innovative medicines using information on genomics and informatics, so that NICE and NHS England have more freedom to target particular treatments at the right patients.

The traditional silos in the R and D pathway are changing and breaking down. We have traditionally talked about medical research, which goes on in universities, academic research and clinical research at a later stage into particular treatments in development. There is something emerging called research medicine, which is the learning of insights daily from the treatment of patients and the diagnosis of patients. The NHS is a potential world superpower in the application of research medicine, because no other organisation in the world has that diagnostic and treatment footprint day in, day out.

This Bill is a small measure that sits in that emerging landscape for making sure that we build an intelligent healthcare system that can use data on innovative drugs and treatments and, increasingly, data on how different types of patients respond to different drugs, to better target not least off-label medicines—repurposed medicines—to particular patients. Those are smaller markets, niche markets, which are very challenging for the large-scale pharmaceutical industry, which is built up on the model of one-size-fits-all blockbuster drugs, but incredibly exciting for our patients and for the charities and some of the smaller companies developing targeted therapeutics.

It is for that reason that the vision at the heart of the life science strategy is, as the Prime Minister put it when we launched it,

"every hospital a research hospital. Every patient a research patient",

so that the NHS is able to fulfil the dream of its founders, captured not least by Nye Bevan and in the original mandate—to be an organisation that uses the collectivisation of health assets for the prevention of suffering for the next generation.

I hope that, with the reassurances about consultation, the House will support the hon. Lady in not pressing amendments 8 and 9. I will happily follow up on the commitments that I have made to make sure that all her suggested consultees are included and others too. I hope the House will support amendment 15, which seeks to remove the exemption for clinical research so that clinicians will have access under the Bill to drugs in clinical research that their patients may be eligible for.

Heidi Alexander: I have listened carefully to the debate on this group of amendments. Although I know that the hon. Members for Bury St Edmunds (Jo Churchill) and for Newton Abbot (Anne Marie Morris) have concerns about creating excessive bureaucracy, I think those concerns are somewhat overstated. The Bill already requires consultation before regulations are made. I am seeking to ensure that the appropriate organisations are able to have their input into the process. However, in the spirit of cross-party working for which the Minister has developed a fondness this morning, I beg to ask leave to withdraw my amendment 8 and not to press amendment 9.

Amendment, by leave, withdrawn.

Clause 3

RESPONSIBLE INNOVATION

Amendment made: 2, page 2, line 26, leave out clause 3 —*(Chris Heaton-Harris.)*

Clause 4

EFFECT ON EXISTING LAW

Amendment made: 3, page 3, line 19, leave out clause 4 —*(Chris Heaton-Harris.)*

Clause 5

INTERPRETATION

Amendments made: 4, page 3, line 40, leave out "this Act" and insert "section 2".

Amendment 12, page 3, line 42, leave out paragraph (b).

Amendment 13, page 3, line 44, at end insert—

'(1A) For the purposes of section 2(2), the kinds of medical treatment that may be innovative medical treatments include (amongst other things)—

(a) the off-label use of an authorised medicinal product, and

(b) the use of a medicinal product in respect of which no marketing authorisation is in force.

(1B) In subsection (1A)(a), the reference to the off-label use of an authorised medicinal product is a reference to the use of the product—

(a) for a purpose other than one for which its use is specified,

(b) in relation to a person who is not within a description of persons for whom its use is specified, or

(c) in any other way in which its use is not specified.

(1C) In this section—

(a) "authorised medicinal product" means a medicinal product in respect of which a marketing authorisation is in force;

(b) "marketing authorisation" and "medicinal product" have the same meanings as in the Human Medicines Regulations 2012 (S.I. 2012/1916);

(c) "specified", in relation to a medicinal product, means specified in its marketing authorisation."'—*(Chris Heaton-Harris.)*

Amendment 15, page 4, line 1, leave out subsection (2) and insert—

'( ) References in section 2 to medical treatment include references to treatment carried out for the purposes of medical research (but nothing in section 2 is to be read as affecting the regulation of medical research).'"—*(George Freeman.)*

This amendment makes it clear that the database for which clause 2 provides may contain information about treatments carried out for the purposes of medical research (including, for example, in the context of a clinical trial).

Madam Deputy Speaker (Natascha Engel): We now come to amendment 5. With the leave of the House I will put the questions on amendment 5, 6 and 14 together.

Chris Heaton-Harris: On a point of order, Madam Deputy Speaker. I was under the impression that amendment 5 would be called only if amendment 15 was not carried. Please could you give me some clarification on that point?

Madam Deputy Speaker: The hon. Gentleman is right; we will take amendments 6 and 14 together.

Amendment made: 6, page 4, line 3, leave out 'this Act' and insert 'section 2'.—*(Chris Heaton-Harris)*

Clause 6

EXTENT, COMMENCEMENT AND SHORT TITLE

Amendment made: 14, page 4, line 8, leave out 'Sections 1 to 5' and insert 'Sections 1, 2 and 5'.—*(Chris Heaton-Harris.)*

Third Reading

1 pm

Chris Heaton-Harris: I beg to move, That the Bill be now read a Third time.

It is a tiny bit of a relief to get to this point in the proceedings. I guess I should start by thanking a number of people, the first of whom is the inspiration for this Bill. As I explained in my Second Reading speech, I followed in some detail what Lord Saatchi had been doing in another place, especially when his Bill reached its Report stage and Third Reading, and I thought some of his ideas were very much worthy of legislation in this place. Unfortunately, the inspiration for his Bill was the terrible loss that he suffered, but I would like to think that what we have done here today will be a true and lasting legacy for him to remember his wife by.

I should also like to thank the Under-Secretary of State for Life Sciences and all the officials in the Department who have given me advice—nearly always constructive and helpful—especially a gentleman called Peter Knight, who very kindly hosted a round-table for a whole host of organisations, and anyone else who was interested. It was only the people who were being really stroppy about the Bill who refused to come. He kindly explained what the database could and should be doing, and what its potential was, which alleviated a huge amount of concern. He also enlightened a number of people on the direction of travel that we were taking. I thank my hon. Friend the Minister and all his officials for their help and understanding.

Most of all, however, I would like to thank the hon. Members who are in the House today. I was a Member of the European Parliament, and I guess we have Europeanised the system here. I am not a great European—I like to consider myself a decent Eurosceptic—but there are some practices in the place where I used to work that enable you to listen to people on all sides of an argument, and that allow you to evolve and learn from their better experience and knowledge and put that into your own work. I want to thank the hon. Members for Torfaen (Nick Thomas-Symonds) and for Central Ayrshire (Dr Whitford), and of course my hon. Friend the Member for Bury St Edmunds (Jo Churchill), who is an unbelievable force of nature. I am sure that she will make waves for the Minister if he does not stick to some of the promises he has made today. I also thank Her Majesty's loyal Opposition, who all the way through this process have been willing to engage with me, to listen and to criticise, completely and correctly. I therefore thank the hon. Members for Lewisham East (Heidi Alexander) and for Ellesmere Port and Neston (Justin Madders).

Where we have got to now is not a bad place. I have received a briefing from Empower, which is one of the charities that is keen to ensure that patients get the best treatment. I will quote from its briefing, because this is not something I would ever say about myself. It states:

"We are particularly pleased by the ingenious step of absorbing Nick Thomas-Symonds' Off-Patent Drugs Bill into the amendments. Mr Heaton-Harris' database of innovation combined with off-patent access to medicines is a hugely positive step forward, and one Empower fully supports."

The briefing included a note from Graham Silk, a gentleman who was doing some media on this yesterday, having joined Empower's drive for spreading innovation. He said:

"I was diagnosed with leukaemia in 2001, and I'm still here today because of medical research facilitated by the patient data of the leukaemia community. I was one of the lucky ones by being in the right place at the right time. But we need to start taking luck out of the equation by spreading this information faster and wider. This database could have the power to do just that.

Indeed the drug that saved my life has already shown early promise in other conditions, the off-patent provisions in the Bill could also see patients granted access to a far broader set of treatments which would really open up our health system.

I am looking forward to continuing Les Hatpin's legacy"—

Les was the power behind Empower—

"by working with Parliament, policy makers, and frankly anyone who will listen, to see our health service modernise and digitise to the benefit of patients."

Jo Churchill: That clearly encapsulates what we need to be doing: putting the patient at the centre, backed up by a charity, such as that leukaemia charity, and supported by clinicians. We could not want a more virtuous situation.

Chris Heaton-Harris: I completely concur with my hon. Friend. I would like to think that Graham, when he looks at our proceedings today, will be pleased at where we have got to, and the process by which we have got here, and is looking forward to his wishes becoming fact.

There have been some questions about whether the database is required at all. I will talk about this gently, because I do not want the cross-party consensus to break down at such an important moment in proceedings. I know—I have learned a huge amount in this process—that

there are many mechanisms already available for sharing treatments, but they are far from being available to all medical practitioners, and in my view they are insufficient. Besides that, there is no comprehensive database of treatments that are not regulated under the Medicines and Healthcare Products Regulatory Agency; there are just many smaller ones, such as registries for specific diseases or databases for particular regions.

For example, the most recent figure I could find for the total number of registers used by medical professionals is from 2002. Back then the Department of Health commissioned a report into disease registers in support of the White Paper, "Saving Lives: Our Healthier Nation". The report found that there were well over 200 registers in existence in England. The number of disease registers already in existence in England was obviously large, although possibly larger than was generally appreciated. Even though the review was not exhaustive, it identified about 250 registers. The report stated:

"We would not be surprised if there were more than 400 specific registers in existence in England."

That rendered the situation on data collection at best confusing, and at worst it makes finding evidence and navigating through that data almost impossible. I hope that the database set out in the Bill will provide clarity through the vast web of registries, information and data that already exist and help clinicians find evidence for innovative treatments simply and quickly.

That is particularly important today, because research has come on in leaps and bounds, meaning that a huge number of new treatments are coming into the NHS and innovative ideas are everywhere. There is great potential for what this could do. South London and Maudsley NHS Foundation Trust has developed a computer system that allows it to carry out research using the information from the trust's clinical records. The system is known as the clinical record interactive search system, and it is anonymised. It is hoped that it will make a very real and positive difference to future treatments and care. The system allows clinicians and researchers at the hospital to look at real life situations in large quantities. This makes it easier to see patterns and trends such as what works for some and does not work for others. For example, case registers have been used extensively in mental health research, which was commented on earlier. Recent developments in electronic medical records and in computer software to search and analyse these in an anonymised format have the potential to revolutionise this research tool. The case register has been hailed as representing a new generation of this research design, building on a long-running system of fully electronic clinical records and allowing for in-depth analysis of data while preserving anonymity through technical and procedural safeguards.

Historically, medical records of some kind have always been kept. In keeping with the tradition of careful, methodical scientific observation, they have frequently been developed into disease registers through which the incidence, course and health service use of specified diseases can be monitored and investigated. In the context of changing social, political, professional and technological factors, a large number of psychiatric registers were constructed throughout the 20th century. However, owing to the expense of maintenance, often then carried out manually, the limited information available, which relied on data sheets completed by clinicians in addition to their routine workload, the practical difficulties of monitoring data quality, and limited funding, many of these programmes closed, and a vast amount of the information collected, which could have been useful, was lost.

Now we live in a time in which rapid technological advances and other developments over the past decade have led to new possibilities for the development of data-sharing. With electronic clinical records increasingly complementing handwritten notes, large volumes of clinical information are contained in an electronic format. The possibility of what we can do with this is unbelievably exciting. So far, we have not really harnessed the data that we already have. There is so much potential to make great changes, and this Bill is a tiny pigeon step in the right direction.

There has obviously been a huge amount of interest in this Bill from a whole host of groups. Some have concluded that the database is not needed, some have concluded that it is a good idea, and some have raised a number of questions about it. I would like specifically to thank the Association of the British Pharmaceutical Industry for its briefing on my Bill, which was circulated to Members of Parliament this week. It states its concern that the Bill will promote the prescription of unlicensed medicines and says that that is worrisome because there is hierarchy of risk involved with prescribing off-label and unlicensed medicines that makes unlicensed treatments the more risky route. It is completely correct. Promoting the prescription and use of these treatments when that is best thing to do for patients, is, I would like to think, exactly the sort of information that the Bill will share around the place to enable people to do the best thing.

With the amendments tabled today, the Bill promotes treatments in clinical trials, which are by their very nature unlicensed, as well as off-label drugs, other licensed but perhaps underused or very new treatments, and other unlicensed treatments. Clearly, it will not change the fact that, under MHRA guidance, more risk is involved when using unlicensed drugs. This, rightly, will remain the case, as these drugs have not received regulatory approval and are not yet deemed safe for use. No guidance or law of liability is changed at all by this Bill, with the tabled amendments. However, the Bill will spread information behind how these drugs are being used and allow responsible registered medical practitioners to access more information, much more quickly, to make better decisions for themselves.

The ABPI also wrote that the database undermines the UK medicines regulatory system and gives doctors the ability to prescribe unlicensed or off-label medication. As I have said, that is perhaps not terribly bad, but I would like to think that we are not undermining any regulatory system. The Bill simply does not contain provisions that would do so. I want to give the ABPI some help with its questions, and I would like to think that this debate—the points made by the Minister about how he will use the power, and those made by hon. Members on both sides of the Chamber underlining the cross-party nature of the provisions—shows that the Bill is worthy to be sent by this House to the other place and that it will do patients, registered medical practitioners and our NHS the world of good.

1.15 pm

Nick Thomas-Symonds: I echo what the hon. Member for Daventry (Chris Heaton-Harris) has said about the cross-party work, thanks to which the Bill is now in its

[Nick Thomas-Symonds]

current state. I again put on the record my thanks to him for his flexibility, and to the hon. Member for Bury St Edmunds (Jo Churchill) for her impassioned contribution.

I am delighted that amendments 10 and 13 have been agreed to, because it is extremely important to include off-label drugs in the Bill. I am very pleased by the Minister's positive response to those amendments. I want, if I may, to make one request of the Minister. I did not press my new clause 5, on the accessibility of the licensing process. Will he write to me specifically about that? I would be extremely grateful for some clarification about precisely what the measure will be. Will he, in his closing remarks, confirm that he will do so?

I want to put on the record my thanks to the charity Breast Cancer Now, and particularly to Jenny Goodare of that charity, who has done a great deal of the facilitating work. I also thank my parliamentary assistant, Briony Robinson. Her father, who is in fact an oncologist, has also made a great contribution to all the work on the Bill.

Ultimately, the work that has been done, especially during the winter—I made the point earlier that no fewer than eight political parties were represented by those who signed new clause 1—demonstrates the very broad swathe of opinion both in the House and beyond. Whatever side of the House we sit on, we all come into politics to try to make a difference. I sincerely hope that what we have done today will make a significant difference.

I look forward to holding the Minister to the promises he has made. I have no doubt that the hon. Members for Bury St Edmunds and for Central Ayrshire (Dr Whitford) and I will continue to be rigorous in ensuring that that is the case. I just hope that the Minister will be ambitious in the measures he has said he will bring forward.

1.17 pm

Anne Marie Morris: I once again congratulate my hon. Friend the Member for Daventry (Chris Heaton-Harris) on bringing forward the Bill. I am sure I will not be the first to tell him what a feat it is to get a Bill through this House, with all its complexities, to Third Reading. Clauses 1 and 2 will give many people throughout the country hope that there is a cure for many well-known and not so well-known diseases. The database will make it much easier for clinicians up and down the country to find them and provide a better quality of life for many people.

I commend my hon. Friend for the time he has put into the Bill, and the effort he has made to obtain cross-party support on a number of issues. His work with the hon. Member for Torfaen (Nick Thomas-Symonds) to include some of the provisions of his Off-patent Drugs Bill is to be commended. Although I did not support all the hon. Gentleman's amendments, I do believe, as I stated on Report, that amendments 10 and 13 will help many people to live healthier and happier lives for years to come. I therefore congratulate him on his contribution to this Bill.

Some great medicines have been developed through the use of off-label treatment, and I believe that they will continue to be developed, even without the new clauses that the hon. Gentleman tabled. I do not profess to be an expert in the field of off-label treatment, but I know that drugs such as infliximab, adalimumab and methotrexate are now regularly used in the treatment of Crohn's disease and ulcerative colitis, having previously been used to treat rheumatoid arthritis and cancer. The use of those treatments has come on leaps and bounds over the past 10 years, and that in an environment where, it is claimed, doctors are scared to innovate. As I have stated, I do not profess to be an expert in these matters, but I do know that many doctors communicate not just countrywide, but across the boundaries of diseases, and learn from each other. The database that the Bill establishes will allow that to be achieved with much greater ease.

A member of my office staff has been fortunate enough to benefit from the drugs that I have just mentioned. Indeed, he informs me that he was one of the first people, if not the first person, to be given the drug adalimumab to treat Crohn's disease. He was prescribed it in Southampton back in 2007, when it was not licensed for use in children. Had the doctors not taken innovative steps to prescribe a medicine that had not yet been licensed, he would not have had such a fulfilling life—something that many of us take for granted. That is just one example, and I am sure that Members across the House have many more examples of doctors using innovative medicines to help out constituents and loved ones with all manner of diseases. I am therefore delighted to support the Bill on Third Reading and the great work my hon. Friend the Member for Daventry has done to get us here.

1.21 pm

Heidi Alexander: It is a pleasure to follow the hon. Member for Newton Abbot (Anne Marie Morris) and my hon. Friend the Member for Torfaen (Nick Thomas-Symonds).

In opening this debate on Third Reading, the hon. Member for Daventry (Chris Heaton-Harris) said that it was something of a relief to get to this stage. I have to say that I agree with him. I congratulate him on getting his private Member's Bill through to its Third Reading. His commitment to the Bill has ensured that the crucial issue of improving access to innovative treatments and medicines has been debated in detail on the Floor of the House, which is a good thing.

I am conscious that we have already spent considerable time today debating a Bill that is now relatively straightforward, so I will keep my remarks brief. In short, the amendments that have been made today have made the Bill safer and have focused it on the area that the hon. Gentleman feels most passionately about—namely, the power to create a database.

Although I still question whether legislation is needed to give the Secretary of State this new power, the Bill is a vast improvement on what it was previously, and I will not oppose its Third Reading. I am sure that the other place will take a keen interest in scrutinising the Bill, as it has had extensive debates on this subject in the past and, indeed, on similar private Members' Bills.

I urge the Minister to think very carefully about the design of the database. Even if he does not wish to broaden the list of statutory consultees, I hope that he will engage with the medical profession and other stakeholders to ensure that he gets the database right.

I congratulate the hon. Member for Daventry once more on navigating the Bill to this stage and on taking account of the very real concerns that I and many others have expressed to him.

1.23 pm

George Freeman: May I share in the sense of relief? I, too, congratulate my hon. Friend the Member for Daventry (Chris Heaton-Harris). As others have said, it is no mean feat to steer a private Member's Bill through this House. For all sorts of very good reasons, there are many obstacles to doing so. The process is designed to ensure that only those Bills that command a majority, if not unanimous support, and that clearly address something that the House feels is a priority make it on to the statute book. He has achieved something remarkable in getting this far, although he is right to emphasise that he has only come this far and that the Bill now goes on to the upper House. I pay tribute to his work. Everybody here has acknowledged the quiet, careful, considerate decency and tenacity with which he has got around and listened to people.

I genuinely believe that the Bill will be a powerful mechanism in the new landscape of personalised and precision medicines that we are developing in this country. It will help busy clinicians on the frontline of our health and care sector by making easily available at the click of a mouse information on innovative medicines—both new medicines and innovative uses of existing medicines—that they can prescribe or recommend to their patients.

It is a pleasure to have reached this point, having embarked—somewhat bravely, some of my officials might have said—on a process of supporting the intentions behind three Bills that the House has considered over the past 18 months. I have been determined to work with Back Benchers to reach a solution that the House and the Government could support.

The Bill captures the spirit of two others: the Bill tabled in the other House by Lord Saatchi, which was intended to promote a culture of innovation and innovative medicines in our health system, and the Off-patent Drugs Bill tabled by the hon. Member for Torfaen (Nick Thomas-Symonds), which was intended to promote greater use of off-label and repurposed medicines. My hon. Friend the Member for Daventry intends to promote greater access to information. I pay tribute to all three people, because their work in initiating their Bills has led to the House reaching unanimity.

I thank and pay tribute to the hon. Member for Central Ayrshire (Dr Whitford). Ministers do not always agree strongly with Scottish National party Members, but it is nice to be able to do so on this occasion. She brings to the House a lot of expertise in her field as a medical specialist, and she has played an important role in bringing the Bill to this point. I also thank my hon. Friend the Member for Bury St Edmunds (Jo Churchill), who brings her own experience of surviving cancer and a passion for the subject. The Members I have mentioned and others who have spoken today and in earlier debates have brought us to a much better place, with a Bill that commands and deserves respect and support.

I want to say something about Lord Saatchi, who commenced the debate on this subject. Passing legislation through Parliament is always a messy business. The anti-slavery campaigners took years, and all sorts of legislation that we can look back on with great pride had previously fallen at various hurdles. It takes tenacity to make things happen. This is not the same Bill as Lord Saatchi's and it does not tackle the issue that he wanted to tackle of some clinicians fearing negligence cases, but I believe that it tackles the central issue that he was trying to address by creating a culture that promotes greater use of innovative medicines. I believe that he has secured, in his way, a legacy for his late wife Josephine that he can be proud of.

Lord Saatchi and Members who have spoken today have become part of a growing movement of patients, charities and campaigners who want us to accelerate access to innovative medicines. I often hear demonstrations from my window in the Department of Health, with patients sometimes chaining themselves to railings. I have yet to hear a demonstration asking us to take longer to regulate and assess drugs and bring them to market. Indeed, the demonstrations that I have heard in the past year have been by patients asking for quicker access to medicines. Mothers whose children have rare diseases have been asking why we are not moving more quickly to bring genomically and infomatically targeted medicines to their children. I have taken part in more debates on this subject than on any other in the past year.

I want to mention a number of people who, appropriately, have been referred to today, including the late Les Halpin. He founded Empower: Access to Medicine with a passion that his death would not be in vain and that his experience of dying from a rare disease would inspire and motivate others to invest more in research and accelerate innovative medicines being brought to patients. The campaign, which was started for him, is continuing to grow and build support for the agenda that we have discussed today.

Graham Hampson Silk has also been mentioned. Ten years ago, he was given four years to live, but because of the extraordinary work of NHS clinicians and NIHR researchers at the Birmingham Institute of Translational Medicine, led by the inspired Professor Charlie Craddock and supported by Cure Leukaemia, Graham is alive. He is using his life to campaign for quicker access to innovative medicines. He is alive because Charlie Craddock got him access to a drug that was in research in America, raised money and flew Graham to the States, and then got the drug into the Institute of Translational Medicine. In fact, that institute has pulled into the greater midlands area more than £20 million of free drugs in trials.

I should mention Emily and a number of the other mothers who have been to my office on a number of occasions in the past six months to discuss muscular dystrophy and Duchenne. The extraordinary progress of our medical community in genomics and informatics unlocks new treatments, but the mothers and fathers of children with rare diseases look on with frustration that we are unable to get the insights to benefit their children and families more quickly. As the first Minister for Life Sciences, I am driven every bit as much by their advocacy, passion and commitment.

The truth is that a lot of people are not interested in this space until they get a diagnosis or until someone in their family gets a diagnosis, at which point people become very interested in research, data and genetics. I am very pleased that their names and a number of others have been mentioned. My hon. Friend the Member for Daventry has struck a small blow in the march of that army for accelerated access to innovative medicines.

[George Freeman]

I want to say something about the landscape in which the Bill will land, the leadership that the UK is showing to create that landscape and the changes that will benefit patients and our NHS. The truth is that the traditional model of drug discovery is breaking down in front of our very eyes—the very long, 15-year, $2 billion process by which traditional pharmaceutical products are developed and brought to patients. That is too long for the industry and patients, and it is too expensive. Increasingly, the breakthroughs in genomics and informatics mean that drugs can be developed for specific patient groups around specific genetic biomarkers with much greater precision and be brought into the system much more quickly. They do not have to go through 15 years of randomised control trials when there is a genomic biomarker that guarantees they will work in certain patients and informatics to support that claim. That allows us to get medicines into targeted groups much more quickly.

That quiet revolution, which the UK is seeking to develop through our various initiatives, is principally driven by two transformational technologies: genomics and informatics. Genomics allows us to understand the cause of so many diseases—in many cases, the cause is inside the cells in our bodies—and to understand, at scale, why different patients respond to different drugs and why they respond to different diseases in different ways. It also allows us to centre our research on the experience of real patients with real diseases in real time.

Allied with informatics, that allows us to use the NHS to look at huge datasets of patients over the past 20 or 30 years, which is an incredibly powerful resource. Large-scale anonymised data allow us to identify patterns. When we re-analyse the data, we find that many of the drugs that have failed in traditional drug discovery, which could happen because of a side effect, a serious side effect or a death in the late stage of trials when the drug is trialled in the largest number of people, are dream drugs for a small sub-segment of the population. Part of that revolution is about allowing us to identify which patients would have responded much more quickly, which cuts down the time, cost and risk for companies in developing and thus reducing the price. It also cuts down the time that patients have to wait and to have more accurate dosing—we can get the right drug in the right dose to the right patients more quickly.

Mr Peter Bone (Wellingborough) (Con): I put on the record my thanks to my hon. Friend the Member for Daventry (Chris Heaton-Harris) for his success in driving the Bill through. I have heard only today that a constituent of mine is getting a treatment for prostate cancer earlier because of the Minister's intervention. I am sure that that is part of what the Government are driving. I wanted to thank him for that while I had the opportunity.

George Freeman: My hon. Friend is very kind. I thank him for his comment and am very pleased to hear that news.

We are putting in place various initiatives to support the new agenda, and seeing the beginnings of some successes. On the request made by the hon. Member for Torfaen, I will be happy to write to him about the proposals and how we envisage the measure working. There is quite a lot of work to be done on how the process of using a NICE evidence review to assess the evidence for an off-label claim. I am not prevaricating for any reason other than that I do not want to pre-empt that work, which we are getting on with.

Nick Thomas-Symonds: I am grateful to the Minister for that. New clause 5 was also about easier access to the licensing process itself, on which I made a few suggestions on Report. If the Minister addresses that specifically when he writes to me, I will be very grateful.

George Freeman: I will happily come back to the hon. Gentleman on licensing. We have discussed this at some length, but I am happy to confirm the situation. There is a very strong legal set of constraints on how we handle licensing, but I will happily write to him to confirm the position.

I would like to respond to the request, by the hon. Member for Lewisham East (Heidi Alexander) from the Opposition Front Bench, to take very seriously the design of the database. I agree. We need to make sure it works well. Datasets are already available, but we need to connect them up better to give clinicians the right information they need. I am absolutely happy to give an undertaking to engage very closely with the medical profession, and all who have taken an interest in the Bill, to ensure this measure has the intended effect. I also give an undertaking to the House that I want to put the patients' voice right at the heart of this and to invite the Association of Medical Research Charities and others, as we put the proposals together.

I want to take up the point raised by my hon. Friend the Member for Wellingborough (Mr Bone) and update the House on the range of initiatives, which the database will sit in the middle of, that we are putting in place. As the landscape for drug discovery changes profoundly, the Government are intent on making sure the country leads in this new model of personalised, targeted, patient-led research, moving from a world in which a drug is traditionally developed around a notional theoretical target that is normally developed in an academic laboratory and then, if it is lucky, put through a process to raise money and be spun out or partnered. That original target is turned into a drugable target that a pharmaceutical company can make a drug against. The early synthetic chemical compounds are tested against vast libraries. With luck, they are taken through pre-clinical testing and extensive in vitro and in vivo testing. They then go "over the wall" as the industry refers to it, into development to phase 1, phase 2, phase 3 and phase 4 trials, through MHRA and European Medicines Agency safety approval, to NICE for health economic approval and then to the NHS to decide how to best use the drug.

That landscape still works for many drugs and is still the conventional system in which drugs are developed. In truth, however, the breakthroughs in genomics and informatics mean we can, and are, developing a different landscape. The Government are investing in the cell therapy catapult and the precision medicine catapult so that we lead in academic research, working with industry partners on the new model of personalised and precision medicine. It is why we set up the biomedical catalyst to support quick funding for small companies and academic groups developing key technologies in this space.

It is why I am delighted that we announced, in the autumn statement, ring-fenced funding for the Medical Research Council and the other research councils. That budget is now £700 million a year for leading research around the UK. It is why we confirmed the £1 billion-a-year commitment to the National Institute for Health Research, an embedded clinical research network at the heart of our NHS all around the country that is the jewel in the UK crown, and the establishment of the NIHR Office for Clinical Research Infrastructure, allowing innovators internationally to come in and work in our research hospitals. The progress of NIHR means we now have over 200 industrial studies on new medicines in the UK. We are increasing year-on-year the number of patients enrolling on clinical trials, including, importantly, first-in-man and first-in-patient studies. The UK is now going back up the international league for drugs having their first exposure to people, here in the NHS and the NIHR.

It is why, on informatics and genomics, we launched the Genomics England programme. In 2012, the Prime Minister announced that we would be the first nation on earth to sequence 100,000 entire genomes—those of NHS patients—and link them with their hospital records. The project has captured the world's imagination—I have called it the NASA of 21st biomedicine—and triggered phenomenal academic and industrial investment in the UK. It is already driving new diagnostic insights into rare diseases and insights into how we can use existing medicines better.

It is also why we have invested in the clinical practice research datalink and the aggregating of the NHS's long-term cohort studies. These are phenomenal resources for research. Before coming to the House, I was involved in one, funded by the MRC and Cancer Research UK, that involved 250,000 women at risk of ovarian cancer. As a part of that, we collected blood, tissue, genomic and medical record information. I am proud that, after the academic study was finished, a group of medics at University College London, along with MRC Technology, UCL Ventures and CRUK, used that database to form a company called Abcodia Ltd, an ageing biomarker company. The database contains biomarkers that allow us to diagnose not just cancers but a range of diseases in ageing women much earlier. The scale of that dataset allows us to lead.

My hon. Friend the Member for Daventry mentioned Professor Simon Lovestone, at King's College London, who led the world in the use of informatics and integrated medical records in mental health and who has now gone to Oxford University to pioneer that work. The Government are investing in genomics and informatics because it is a transformational technology that is changing the way drugs are developed.

I want to entice the House to think about where this might go and the direction the Bill points us in. This new world is coming fast. The first genome to be sequenced, 10 years ago, cost £10 billion. It now costs $5,000 and can be done in 24 hours. Not least because of the leadership of Genomics England, it will soon be possible to do it in minutes for a few pounds and pence. That will allow the NHS, when patients arrive with cancer, rare diseases and, increasingly, any disease, to identify the right genomic diagnostic and profile the right treatment and drug much more quickly. When a patient arrives, whether at a GP practice, hospital or clinic, we will, in due course, be able to do a quick and easy genomic diagnosis.

Thanks to the Bill, front-line clinicians will be able much more quickly to identify innovative drugs from which their patients might benefit. That will not happen overnight; it will not happen by Easter; it will not happen by the end of this parliamentary Session, but it is a quiet revolution of 21st century medicine that we are leading, and data and information sit right at its heart. My hon. Friend has taken three Bills that were generating more heat than light, crystallised their essential purpose, which was noble and well-intended, and brought them together in one Bill. I hope that it will be treated in the Lords in the way that this debate and cross-party consensus invite and that it will not be significantly re-amended, not least because, if it is, it will probably run out of time to reach the statute book.

Many people comment that the House spends too much time doing yah-boo politics for its own sake. Today, we have struck a blow for joined-up government and parliamentary process. It is wonderful to see MPs from all mainstream parties—I have not heard anything from UKIP—in support of a measure that offers real benefits for patients and front-line clinicians, without undermining the latter's clinical sovereignty over patients. It is about giving them information, so that they can make the exquisite clinical judgment we all want them to make. I am happy to commend the Bill to the House and to congratulate all those involved, and I am delighted to have done my bit to help strike a blow for joined-up government.

Chris Heaton-Harris: On a point of order, Madam Deputy Speaker. Would it be in order for me to thank Abigail Bishop-Laggett, my member of staff who has worked so hard on getting the Bill to this point?

Madam Deputy Speaker (Natascha Engel): That is a very nice comment, but not a point of order.

Question put and agreed to.

Bill accordingly read the Third time and passed, with amendments.

Child Victims of Human Trafficking (Central Government Responsibility) Bill

Second Reading

1.45 pm

Mr Peter Bone (Wellingborough) (Con): I beg to move, That the Bill be now read a Second time.

I am delighted to follow my hon. Friend the Member for Daventry (Chris Heaton-Harris), who has piloted through such a successful Bill. I would like to pick up, in general terms, on what the Minister for Life Sciences said at the end of the previous debate, which is that it proves what Back-Bench MPs can do when they work together to achieve something. I want to talk about that a little more in relation to human trafficking and my Bill. It is only three clauses long, but it goes to the heart of the problem we have with human trafficking and modern-day slavery. However, I need to set it in the wider context of modern-day slavery and human trafficking.

Way back when I was first elected as a new Member of Parliament in 2005, the Labour party was in government, and at one of my constituency surgeries on a Friday I got a note through the door. It was anonymous, but the person who wrote it was a prostitute from Northampton who was very concerned at what was happening to young women who were being brought into this country—we now call it trafficking, but at that time people did not talk about it. I thus became aware of this issue and I then met someone called Anthony Steen, who at the time was Member of Parliament for Totnes—a most extraordinary person. He has changed the view of trafficking and modern-day slavery not only in this country, but across the whole of Europe. He formed the all-party group on human trafficking and modern slavery, and I was one of its officers.

At that time, the Home Office under the Labour Government did not really recognise that trafficking existed.

Mr Alan Campbell (Tynemouth) (Lab) *indicated dissent.*

Mr Bone: I am going back many years. *[Interruption.]* I am going to develop that point. I am not blaming anyone in particular other than the Home Office—of course, everyone will agree with that—and I am not really blaming the Home Office. It was just that people did not understand the issue. Indeed, if we went back to the days of what people might think of as traditional slavery, I am sure people would have denied it existed. It was only because of what William Wilberforce and others did that people got to know more and more about it. Indeed, I quite confess that when I came to Parliament, I had no idea about human trafficking or modern-day slavery, and I certainly did not think I was going to get wrapped up in trying to solve the problem.

Anthony Steen and a small number of us travelled all over Europe, to places such as Moldova—to places that, to be honest, I had not even heard of—and found out about this terrible, terrible crime being committed of people being trafficked across borders. In those days it was mainly for purposes of sexual exploitation, although it has now turned into labour exploitation.

The traditional way for these women—we call them women, but in many cases they were actually young girls, way under the age of 18—in very poor countries such as Moldova to be trafficked would be for somebody of their own age, quite often a female, to befriend them. They would then tell them there was a job in Belfast, say, in a restaurant—this is from a true case, from one of the dependencies of the old USSR. These women would come over expecting to work in a restaurant—and there was, indeed, a genuine restaurant. Because of the free movement rules in the European Union and Schengen, they would not be checked, but could come straight across Europe and into this country, and although I really do not want to make a European Union point, I will. Years and years ago, a long time before all this stuff appeared in the press, we warned that while free movement might have many advantages, it was certainly of great advantage to the traffickers, because there was very little chance of their being caught.

This is what would happen. The girls would arrive, all happy, looking forward to—in this case—a job in a restaurant in Belfast, and looking forward to a better life, more money, and excitement. Those girls never actually made it to the restaurant. They were locked up in a terraced house in Belfast. I say "locked up". One would expect the lock on a bedroom door to be on the inside, but in houses such as that one they were on the outside, so that the young women could be locked in.

Andrew Griffiths (Burton) (Con): I know that my hon. Friend could not resist making the Europe point. Will he explain something to me? I entirely understand his point about Schengen, but how did the girl manage to travel from the Schengen area to the United Kingdom without being stopped at the border?

Mr Bone: My hon. Friend has made a good point. Years ago, before I came to this place, I ran a travel business which had an operation in Florida, and I would quite often fly over there with new members of staff who were young girls. So there was a middle-aged man taking two or three young women across to America. Every time we arrived, we were stopped at immigration, and the women were taken away and interviewed to establish whether this was a genuine operation and I was not actually trafficking people. We used to get parents to write letters, and so on. But those immigration authorities did a proper, thorough job.

As for our borders, citizens of the European Union have a right to come here. It was not as though those girls were breaking any immigration rules. This is not about immigration at all. They had an absolute right to come into this country, because they were EU citizens. I have always argued that, in obvious cases like that, we should be much more willing to take people to one side and find out whether the operation is genuine or not. The trouble with this operation, however, was that it looked as though it was genuine because the girls were going to a Belfast restaurant to work.

I think that about 70 young women went through that process, and were locked into the terrace house. I do not want to use the word "rape" lightly but they were, in effect, being raped repeatedly. They were not in a position to escape, they were not giving permission, and there was no question of their earning any money. Eventually, those young women were rescued. In that instance we did something really well, but I am afraid that we are still doing something rather poorly.

When I was a member of Anthony Steen's group, I discovered that there was a Government-funded centre in London—it was, in fact, funded by the Ministry of Justice—which was run by a left-wing organisation. All the trafficked victims were supposed to be accommodated in 24 beds, which is laughable, because there were so many more victims than 24. There was quite a big row about it at the time, and it is to the Government's credit that they changed the policy. They took the money away from that organisation and gave it to the Salvation Army. They said, "Work with all sorts of different agencies around the country, religious and non-religious, and they will give you added value. If Newcastle, for instance, already has a hostel that is able to look after trafficked victims, why not give it some money, and then you will have that added value."

The system worked terrifically well. The money started with £1 million, and despite the huge economic downturn that we have experienced, that amount has increased to, I believe, about £3 million. Adult victims of human trafficking are really well looked after. We must remember that an 18-year-old girl who has gone through this trauma cannot be just put in a house; they have to be looked after. The trauma is enormous and they must overcome that. We do that really well, and the Government, and the Prime Minister in particular, should take great credit for it. The Prime Minister has shown great courage on the human trafficking issue, but the problem comes with how children are looked after; they do not go into that system, and that is what I am trying to solve with this Bill.

The Parliamentary Under-Secretary of State for Refugees (Richard Harrington): I feel I should say at this stage that Anthony Steen's operation is based in Watford in my constituency, and I am very familiar with it. I was going to say this as part of my concluding remarks but, time being as it is, I felt I should say now that not just he but all the different umbrella groups in the anti-trafficking field are housed in the building above Watford Junction station, so I see him quite a lot. I know my hon. Friend is part of that, and Sir John Randall introduced me to him in the first place, and I think it is a wonderful organisation.

Mr Bone: I am very grateful for the Minister's intervention, and I am very glad that we have this particular Minister at the Dispatch Box, because I know he has worked with Anthony Steen and John Randall on this issue, and I greatly appreciate that.

The Government have done exceptionally well. John Randall is, of course, one of our ex-colleagues in this House. I remember that in the Corridor upstairs we had what we called an exhibition, but it was a role play about human trafficking and his son played a trafficker—very convincingly, as well—and that brought home to Members just how under the radar this situation is.

Mr Steve Reed (Croydon North) (Lab): When the POPPY project, which I believe was the organisation the hon. Gentleman was talking about, lost its funding, some of the successor organisations were criticised for putting rescued women in mixed-sex hostels, which was deeply inappropriate.

Mr Bone: There was a big row about the POPPY project and I am broad-brush about this: I think the Salvation Army operation has been a huge success, and I am absolutely convinced that no other country in Europe looks after rescued adult victims of human trafficking better than ours, and we can be very proud of that.

Let me rewind a bit to when I was traipsing around Europe with Anthony Steen. He is a man it is impossible to say no to; I have seen him blag his way into all sorts of establishments that we had no right to be in, and he did so fearlessly. In some places he talked to traffickers and took great personal risks. His influence is what drives me to continue this fight on this particular issue.

At that time, back in 2005, there was a Council of Europe convention on human trafficking. The COE is a very good body. It brings together 47 countries in Europe. The idea is that if we can get something through the COE that everyone agrees with, it is a really good standard. What happened to this convention happened when a Labour Government were in power, but I am absolutely not blaming the Labour Government because it equally would have happened if a Conservative Government had been in power at that time because of the way people looked upon human trafficking: we could not even get the convention signed. Then, after lots of pressure, the convention was signed, and then that turned out to be no use because until it is ratified, it does not come into force, so then we had a fight on that and it was eventually ratified.

Many of the things that were then discussed became part of the Modern Slavery Act 2015, such as tougher penalties for traffickers, quite rightly. There was originally a problem with the hurdle that had to be mounted to prosecute traffickers. The Crown Prosecution Service had decided that in order to get successful prosecutions, it would have to go for lesser charges. That was sorted out; traffickers can be jailed now for 14 years. Tougher border controls are hugely important, too, because I do not want to be punishing traffickers and rescuing victims, as I do not want them to be victims in the first place. There is a lot to do in Europe on that, but obviously, our border control is important. In a wonderful example of co-operation, the Metropolitan police and the Romanian police worked together and broke up a notorious gang and saved many people from being trafficked. Police operations all come down to intelligence and working together across Europe.

Mr Christopher Chope (Christchurch) (Con): Does my hon. Friend accept that there is not just an issue with border controls, but a lot of concern about forged documents and passports? There is a report in today's press that the United States is thinking of withdrawing its visa waiver scheme for some European countries—for example, for Belgium—because there are up to a million forged EU passports in circulation.

Mr Bone: My hon. Friend is quite right that this is not, as I have portrayed it, just a European Union issue. I wanted to use that example because I did not want to get into the arguments about immigration and migration control. People from the EU have the right to be here and can be trafficked, but of course human traffickers operate across the world. Traffickers bring people in from Nigeria, and use all sorts of terrible things to keep them in prostitution. If someone were in a town and forced into prostitution, one would think that there would be ways for them to escape, and there probably are, but they are under acute mental pressure. They may

[Mr Bone]

be told that their parents will be killed or that their children will be harmed. If they come from Nigeria—this may seem strange to us—voodoo spells may be used. All those things have to be dealt with, and we are beginning to deal with them. The problem of forged passports is important.

I do not accept what the Home Office used to say, which is that if we create a safe environment for people who have been trafficked, it will be a pull factor. That is complete and utter rubbish. People can come in and claim asylum anyway. They do not need to pretend to be trafficked; there is no advantage to that at all, and I really reject the idea. There are more slaves today across the world than there were in Wilberforce's time; it is just that we do not see them on the docks. Great credit should go to the Government for what they have done in this regard.

Going back to the Council of Europe situation, a good convention was eventually signed and ratified. One thing we wanted for the protection of people who have been trafficked was the appointment of a rapporteur —I would say a commissioner because the word rapporteur sounds far too "European Union" for my liking. We had a long battle on that with the Government. By this time, we were in the coalition Government. A cross-ministerial group was appointed, which was complete rubbish. We knew that by how many times the Ministers bothered to turn up. It was a complete farce. We had a battle on that. MPs from both sides of the House and from all parties—the hon. Member for Foyle (Mark Durkan) was a great support—called Westminster Hall debates to put pressure on Ministers and to ask lots of questions. That all followed on from what Anthony Steen did.

When I first came to the House, Anthony Steen was the only person doing anything, and then everybody started to realise that there was a problem. People may think that the Government make all their decisions in Downing Street and that we are just here to tick the boxes, but it was not like that, and we proved that with the previous Bill. On human trafficking, it was absolutely not like that. Private meetings went on, and so on. We finished up with a Modern Slavery Act 2015, which increased the penalties for trafficking, toughened border control and improved the rights of victims to prove that they were victims, which is a complicated thing, but we did not deal with the situation of child victims. We dealt with victims, but forgot that there was a huge loophole.

Members will recognise that probably every week in their constituency advice surgeries, they have someone in front of them who is clearly in need of help and social care. The problem is that the health service says the person needs social care and the local council says the person needs social care, but they blame each other for not funding it. I will develop the argument a little later.

Adult victims of human trafficking are a central Government responsibility, that of the Ministry of Justice. Unbelievably, children who are victims of human trafficking finish up in local authority homes and, bizarrely, are indirectly the responsibility of the Department for Education. How that works I have no idea. In fact, it does not work.

I do not know of any legislation in which we deliberately set out to treat adults better than children. I return to my example of the 18-year-old who was tricked into coming to Belfast and started off in the restaurant but finished up in a terraced house. It must be an horrendous experience to be repeatedly raped, and many of those people come from countries in central Europe that are deeply religious.

Mr Steve Reed: The hon. Gentleman is making a powerful case against what is going on, but is he aware that, according to the police, the most common route by which men who want to abuse women find them is through classified ads—small ads—in local newspapers? Does he agree that Government organisations and publicly funded bodies should seek to exert pressure on those newspapers to abandon carrying such adverts by withdrawing state funding if they refuse to do so?

Mr Bone: I am grateful to the hon. Gentleman for raising that important point. It is interesting that the front of the paper will damn human trafficking, and the back of the paper will advertise it. That used to be true, but now advertising tends to be on the internet.

There has always been an argument—I take no view on this—that if prostitution is banned, as has happened in Sweden, human trafficking will stop, and if prostitution is legalised, if I may use that term, as in Holland, there will be human trafficking galore. The truth is, as the record shows, that it does not matter—there is human trafficking in Sweden and there is human trafficking in the Netherlands. People feel very strongly about the issue of prostitution, which is quite right, but to say that if it is banned it will stop human trafficking does not meet the facts. We have to accept that whatever happens we will have to deal with human trafficking.

The slight worry about the Swedish model is that because it happens underground, there is even less likelihood of prostitution being detected and the girls may be subject to even worse treatment than where prostitution is open. I have no view on that, other than to say that the evidence is clear that trafficking carries on in both countries.

Returning to the Belfast situation, human trafficking is usually discovered by members of the public. Neighbours who live in the street suddenly realise that there are a lot of men going into the building at all hours and they never see the people who live there. So they report it to the police and the police raid the property and rescue the girls, at which point the support kicks in, which is what my Bill deals with. The problem is that although those girls might be rescued, the 70 who went before have been moved on.

The frustrating thing about this is that the gangs that do the human trafficking are the same people who do drugs and guns. They know that human trafficking is a better deal because once drugs have been used, they are used up, but a girl can be sold on, time and again. I will tell the House about something that used to happen at Gatwick airport. A girl would come through border control and be met by someone. They would sit in a coffee shop and other men would bid to buy her. That was happening a few years ago.

What frustrates me—I have had this argument with the Government—is that we put a huge amount of resources into fighting drugs and guns but only a tiny

amount into fighting human trafficking. That needs to be addressed. We need to put more money into police intelligence operations, because that is how they discover where the gangs are. When we break these gangs up, we are breaking up the drug and gun gangs at the same time. These are not nice people. They are extremely evil. Also, there are often family organisations involved.

Let us say that some girls come over from Hungary. They come across Europe without any border checks and into this country without any border checks. They arrive in Belfast and work in a restaurant for perhaps two days before being put into prostitution. The argument the traffickers use is to tell the girls that they have to do this to pay back the debt—a made-up amount—that they have incurred in being brought over to this country. This is patently evil.

It is difficult for me to imagine the trauma that these young women go through, but it is absolutely awful. Many of them have never had sex before. There is a case on record of young girls being brought together in a house by a Russian gang for the purpose of human trafficking and one of them refusing to do as she was told. You know what? They executed that person in front of the rest of the girls. Should we not be putting more money into dealing with these people? I think we should.

Let me talk about the problem as I see it. I really want to praise Members on both sides of the House, and particularly the Prime Minister, for what we have already done on human trafficking and modern slavery. The Modern Slavery Act 2015 would not have become an Act if the Prime Minister had not made it a priority. We did so much, but we missed this one thing and, my goodness, it is the old problem of central Government, local authorities and empires.

Let us take as an example a 19-year-old girl who, having been rescued, is looked after by the Salvation Army. In due course, she will become a responsible citizen of this country. But what happens to a 15-year-old child who has never had sex with anyone before but is now being repeatedly raped? What trauma is she going through? Thankfully, the police rescue her, but what is their duty at that point? They have to hand her over to the local authority. There is no requirement for the local authority to recognise her as having been trafficked. It just treats her like a missing or homeless child. There is no special care for her, and that is wrong. These children have been traumatised. They have not simply run away from home because they have had an argument; they have been through the most brutal experience and they need specialised care.

A few years ago I submitted a freedom of information request to all councils to see what they could tell me about children who have been trafficked. Most of them could tell me nothing, because they did not bother to record them, but some did make an effort and were much better. The frightening thing was that the majority of those children had been re-trafficked within about a week, probably to the same evil gang. What happened to those children when they were back in the hands of those horrible people? I presume that they were beaten up and tortured before being put back into that lifestyle and then sold on to somewhere else in the country.

The first problem is that we do not know what happens to those children. That should be the responsibility of Government, and certainly of local government, as I have argued. I just do not accept that children who have had such a terrible time can be put into local government control. Even the best foster carers, unless they know about human trafficking, cannot possibly deal with them.

I rarely leave this place, because I think that MPs should be here when Parliament is sitting, but I did go to the Philippines with Anthony Steen. The Philippines has a great problem with trafficking, but it deals with child victims so much better than we do. They are put in a safe home, where they could never be discovered, and they are looked after by female staff and they go to school. I had the privilege of meeting a young women—she was then 21—at her wedding. When she was younger she had been trafficked and repeatedly raped, so she had come through on the other side. I also met someone who had just gone into the system. The poor girl was blind and had had the most horrible existence. The great advantage of that system was that those girls would never be re-trafficked.

We can learn from that example. To the Government's credit, Barnardo's has run a similar pilot scheme, which I think has been a huge success. However, that is where we come up against a problem. Central Government do not want to take on another responsibility and extra cost —that is the attitude we come up against—and local government does not want to lose part of its empire. Come on, Government; that is patently absurd. There is no extra cost, because someone is supposed to be looking after those children. Why not make it the responsibility of the Ministry of Justice? We should treat those children the same way we treat adults by having safe homes for them around the country. There is a huge problem with inter-department squabbling and budgeting, but I argue that we must put all that to one side and do for those children what we do for adults. How can it be Government policy that child victims of human trafficking are treated worse than adult victims?

The Bill will probably not make progress today, but I hope that the principle behind it will be considered seriously. Before concluding my remarks, I will go through the Bill so that hon. Members understand it. It contains only three clauses. Clause 1 amends section 17 of the Children Act 1989 so that children who have been trafficked are no longer the responsibility of the local authority. Clause 2 sets out a duty to provide for child victims of human trafficking—it basically states that we should treat them the same way as we treat adults. Clause 3 deals with the formalities.

While I would like this Bill to move into Committee and to the Lords and become an Act of Parliament, I know that in reality it will not, but I hope that by airing the issue I have moved things forward. Given that we have a Minister who is known for his caring and compassionate attitude, a Government who really have done things about human trafficking, and an Opposition who wholeheartedly support improving things for victims of human trafficking, surely we could all work together. This has been a cross-party movement; the APPG was of course cross-party. It would be a crowning moment, and a recognition of what Anthony Steen did, if in due course the principle of child victims of human trafficking being a responsibility of central Government became a reality.

2.20 pm

Sarah Champion (Rotherham) (Lab): I give huge congratulations to the hon. Member for Wellingborough (Mr Bone), who for a very long time has been an

[Sarah Champion]

incredible campaigner on this issue. It is absolutely to his credit that we are debating this Bill, and I wish we had longer to go through it, because it deserves that.

Human trafficking remains a significant and growing problem. It is estimated that there are 20,000 modern-day slaves in this country alone—a terrifying statistic. Members on both sides of the House share a determination that we should do everything that we can to end trafficking, and particularly to support the victims—including children, who are so often overlooked. Recent figures from the National Crime Agency demonstrate all too clearly the scale of the task. In 2014, 3,309 potential victims of human trafficking were reported, of whom 732 were children. That is the highest number since we started recording the figures, and it represents a 22% increase on the number of child victims of human trafficking reported in the previous year.

The impact of exploitation on child victims of trafficking cannot be overstated. I am grateful to the hon. Gentleman for giving some examples. Of the identified child victims in 2014, 32% were trafficked for sexual exploitation. Among trafficked girls, the figure rose to 49%. The exploitation of trafficked children leaves them with highly complex needs that are not being met by current provision. However, despite my concerns, I cannot support the notion of central Government having responsibility for a particular group of children. Transferring this responsibility would leave trafficked children outside mainstream provision of care, which may be discriminatory. Furthermore, I am concerned that it could lead to an even more fragmentary response for victims.

I served on the Modern Slavery Bill Committee, where we heard moving testimony about the dangers faced by trafficked children—in particular, the risk of re-trafficking. Research has shown that 60% of trafficked children in local authority care go missing; most are never found again. Trafficked children who go missing are highly likely to be returned to exploitation. That children identified by the authorities should be allowed to disappear without trace is both shocking and indicative of a failing system.

Despite the passing of the Modern Slavery Act, there has been very little change in the delivery of support to child victims. Only one section of the Act was specifically designed to improve the response to child victims—the introduction of child trafficking advocates—and this is yet to be enacted. In Committee, the Minister clearly recognised the need to implement the provisions as soon as possible, and pointed out that the Government had begun the trial prior to the necessary legislation being passed. It is therefore concerning that despite the passage of the Act and the successful completion of the trial, the Government have delayed the introduction of child trafficking advocates, instead opting to conduct further testing of the model. The need for independent advocates has been accepted by the Government, and the proposals have been trialled and positively evaluated. It is vital, therefore, that the Government now proceed without further delay to implement the scheme nationally.

The Modern Slavery Act was a historic piece of legislation, and the Government should be commended for the commitment they have shown to ending human trafficking, but the task remains incomplete. I urge them to do everything they can to ensure that child victims of trafficking receive the support they so desperately need.

2.24 pm

The Parliamentary Under-Secretary of State for Refugees (Richard Harrington): I, too, pay tribute to my hon. Friend the Member for Wellingborough (Mr Bone) not just for putting forward and speaking for the Bill, but for all the work he has done. As I said when he kindly took an intervention from me, the work that Anthony Steen has done and is still doing is particularly pertinent for me, since it is impossible for anyone to end up at Watford Junction station without seeing his operation there.

I am very short of time, so I will get straight to the point. My hon. Friend's proposal is that the Government should take over dealing with the trafficking of children by placing it under national control in a national organisation, rather than the current situation of dealing with it locally through local authorities. Our contention is that that is not the best way to deal with it. I am afraid I cannot accept his assertion that children are, to use his expression, treated worse than adults.

We have set a clear expectation on local government in caring for children who are trafficked or unaccompanied by making important revisions to the statutory guidance for local authorities. The guidance is clear that unaccompanied asylum-seeking children and child victims of human trafficking are some of the most vulnerable children in the country and that placement decisions

> "should take particular account of protecting the child from any continued risk from traffickers, and from a heightened risk of going missing."

We have also published strengthened statutory guidance on children who run away or go missing from home or care. The guidance clearly sets out the steps that local authorities and their partners should take to prevent children from going missing and to protect them when they do.

The Government have strengthened multi-agency arrangements for co-ordinating and sharing intelligence in relation to vulnerable victims. Such multi-agency safeguarding hubs—or MASHs, as they are called—are being set up across the country and are helping to share information about and to co-ordinate more effectively in safeguarding children and vulnerable adults from harm.

Mr Bone: Will the Minister give way?

Richard Harrington: I will give way, but I have very little time.

Mr Bone: I am sorry that the Minister does not have more time. What he says is really good news, but as the hon. Member for Rotherham (Sarah Champion) said, 60% of such children are re-trafficked. Despite what the Government are doing, local government is therefore failing.

Richard Harrington: I am afraid I do not accept what my hon. Friend says about children who go missing. I am happy to discuss that with him separately. *[Interruption.]* We do not know.

I briefly want to mention one point made by the hon. Member for Rotherham (Sarah Champion) in her very thoughtful speech. I agree with her about bringing in officials to be advocates for such children, but the Home Office is being very careful. It has very recently been decided that further trials are needed. That is not the result of prevarication, as though the Government do not want to act, but because of a fear of not getting it right. We have a one-off chance to do this. The Minister for Children and Families, who is very interested in this subject, is in the Chamber, for which I thank him.

A lot of work is under way. It is not as though the Government are oblivious to the issue. It is most important that children at risk of trafficking and those who have been trafficked do not fall outwith the system or are treated separately from adults. We must continue to deliver at this pace, because the Government will not tolerate the exploitation of any child, whether they are from the UK or foreign-born.

The question my hon. Friend the Member for Wellingborough has asked us is whether we can achieve that aim by transferring responsibility for victims of child trafficking from local to central Government. We believe that that is not the answer, because the work in progress to care for such victims better meets the standards required for vulnerable individuals. We are giving it a lot of resource and doing the work to beef it up—for example, our help for unaccompanied children in Kent—which demonstrates the Government's commitment. There is a ministerial implementation taskforce to consider child protection, so we are not oblivious to the issue.

I have made a careful note of the very good points made by my hon. Friend, but I am afraid that the Government cannot agree to his Bill becoming law for the reasons I have explained. That does not mean that this debate is a spurious use of time, or that he has not made very interesting and relevant points. I hope he does not find it disrespectful that I have to say, reluctantly, that the Government cannot accept his core proposal. He has been in this House for a long time and will understand that it is not possible for us to do so, but he was right to use this opportunity to air the issue. I am sure that some of the points that he raised will be discussed again in the House and be taken into consideration. For that reason—

2.30 pm

The debate stood adjourned (Standing Order No. 11(2)).

Ordered, That the debate be resumed on Friday 11 March.

Business without Debate

FOOD WASTE (REDUCTION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 4 March.

HOMES (FITNESS FOR HUMAN HABITATION) BILL

Resumption of adjourned debate on Question (16 October 2015), That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 11 March.

CIVIL PARTNERSHIPS ACT 2004 (AMENDMENT) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 11 March.

VICTIMS OF CRIME ETC (RIGHTS, ENTITLEMENTS AND RELATED MATTERS) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 11 March.

REPRESENTATION OF THE PEOPLE (YOUNG PERSONS' ENFRANCHISEMENT AND EDUCATION) BILL

Resumption of adjourned debate on Question (11 September 2015), That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 4 March.

MESOTHELIOMA (AMENDMENT) (NO. 2) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 26 February.

WORKING TIME DIRECTIVE (LIMITATION) BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 5 February.

CROWN TENANCIES BILL

Motion made, That the Bill be now read a Second time.

Hon. Members: Object.

Bill to be read a Second time on Friday 5 February.

HOUSE OF COMMONS (ADMINISTRATION) BILL

Bill read a Second time; to stand committed to a Public Bill Committee (Standing Order No. 63).

Gangs and Youth Violence: London

Motion made, and Question proposed, That this House do now adjourn.—*(Simon Kirby.)*

2.32 pm

Mr Chuka Umunna (Streatham) (Lab): I have asked just two questions at Prime Minister's questions on a Wednesday since I was elected in May 2010, although I have had various exchanges with the Prime Minister in this Chamber outside Prime Minister's questions. On 7 July 2010, I told the House during PMQs that my constituent, Zac Olumegbon, had been murdered a few days before in a planned attack close to his school. He was just 15. On 8 June 2011, I came straight to the House from meeting the family of my 18-year-old constituent, Nana Darko-Frempong, who had been fatally shot outside his block of flats on the Tulse Hill estate in my constituency just a few days before.

On both occasions, I told the Prime Minister that this loss of life was totally and completely senseless and unacceptable. I said that I did not feel that we were getting to grips with this problem, which has been blighting our inner-city streets. On both occasions, the Prime Minister said that he agreed with me and that the Government would do all they could to stop the tragic loss of life and violence that we see.

Last Friday, more than five years after I first raised this issue with the Prime Minister, another constituent and his family came to my surgery. Last year, my constituent's younger son was stabbed on the same estate as Nana. He has since been taken into foster care in another part of London for his own safety. In recent weeks, his brother was stabbed on another estate in Streatham, critically injured and taken to hospital. He cannot leave hospital because it is deemed too unsafe for him to return home.

Both those sons are victims, like Zac and Nana, of the serious youth and gang violence that continues to grip parts of my community. My constituent had come to the UK with his sons from Somalia, a country ravaged by lawlessness, extreme violence and civil war, because he wanted a better future for his children and for them to be safe. He is completely bewildered by what has happened. When I asked him whether he felt his sons would be safer in Mogadishu than in London, he told me that he felt it would be less dangerous for them to live there than here. He massively regrets moving them to our capital city. That is a damning indictment of the situation on London's streets.

Ms Karen Buck (Westminster North) (Lab): My hon. Friend is making an incredibly powerful speech. Two days before Christmas, a young man I had last seen when he was doing work experience in my office was surrounded by a group of 20 youths and stabbed through the heart. He was incredibly lucky to survive. That is just one example of what a Home Office report recently indicated—that gang membership is rising, not falling. Does my hon. Friend agree that this is the worst time for the Government to consider creating insecurity through either their policy on tackling gangs and serious youth crime or their resourcing for it?

Mr Umunna: I could not agree more with my hon. Friend. We have worked together on the issue since I have been in the House, and I pay tribute to her for continuously shining a light on what is happening in her constituency and across London.

I do not want to say any more about the case of my Somali constituents, except to highlight that I have written to Ministers about the family in detail, and I ask—I beg—that Ministers exercise their discretion to grant my constituent's two sons in particular the appropriate papers, which they do not have at the moment, so that they may travel back to Somalia to be with their mother, as the family wishes.

The case illustrates that for all the promises that have been made and all the attempts that local government and national Governments of different political persuasions have made to deal with the problem—I am not making party political points today—we still have a major problem of youth violence and gang culture, which is having an impact on a small minority of our youngsters in inner-city areas such as mine. The *Evening Standard*'s "Frontline London" campaign has done a lot to shine a light on that, and it is reporting today yet another murder of one of our teenagers on London's streets.

According to Citizens Report, a not-for-profit independent organisation that carries out data research in this area, 17 teenagers lost their lives to gang and youth violence in London last year. That is an increase on the 11 young people who lost their lives in 2014. It is true that it is not the same level that we saw in about 2008-09—in 2008, 29 teenagers lost their lives on the streets of London—but let us be clear that one life lost is one too many.

Much of the violence is perpetrated by young people who are deemed to be gang-affiliated. Last year's report on gangs and youth crime by the Home Affairs Committee, of which I am a member, noted that there is no comprehensive national figure for the number of gangs or the number of young people affiliated or associated with them. Some question whether we should even use the term "gang". What does it mean? I am grateful to the Centre for Crime and Justice Studies for what it has said about that. However, if we are using that term for the purposes of this debate—I accept that maybe we should not—the Metropolitan police's latest intelligence is that there are 225 recognised gangs in London, comprising about 3,600 gang members. Those people mainly span the ages of 16 to 24, but I know of children much younger than that—I use the word "children" deliberately—who are involved with groups perpetrating acts such as we are discussing.

Mr David Lammy (Tottenham) (Lab): I am grateful to my hon. Friend for championing the issue and securing the debate. Does he recognise that the gangs matrix profile shows that, although older young people are being picked up, that is driving down the profile of those who carry knives? Twelve and 13-year-olds are carrying knives for older individuals. That really needs to be examined.

Mr Umunna: I am grateful to my right hon. Friend for raising that issue. He is absolutely right. In addition to age is the fact that, increasingly, vulnerable girls and young women become wrapped up in this and are used and abused and exploited sexually. In the short time we have this afternoon, it is impossible to set out all the reasons why young people end up getting involved in

serious youth violence, but there are common themes. My right hon. Friend has spoken about that many times.

Mr Steve Reed (Croydon North) (Lab): I am delighted that my hon. Friend has brought this important issue before the House. Does he share my view, which is derived from consulting the communities that are deeply affected by gang violence, that, above all else, they want more of a say and more control over the interventions that are brought to their communities and more control over how resources are used to tackle the problem at source?

Mr Umunna: My hon. Friend is absolutely right, and he did very good work as the leader of Lambeth Council, where my constituency is situated. He is an expert in the matter. We have seen the great work the council is doing with its youth community trust, which seeks to do just what he says.

I am struck by the way in which the gang or group that the young people become involved in has become a surrogate family. There are sometimes parenting issues in their actual families, but sometimes there are not. I know of lots of young people who have been involved who come from very strong families. There is an idea that they are in workless households, but sometimes the problem is that two parents are holding down two jobs just to make ends meet and they do not have the time to be there.

The second issue, which is connected, is the lack of things for our young people to do out of school hours. I lose count of the number of community meetings I go to—all my colleagues who have spoken will have had exactly the same experience—when constituents say, "There are just not enough things for our young people to do." We have to develop the professional occupation of youth work. Youth workers should be seen in the same way as our teachers; they should be put on a pedestal in the same way, because they spend almost as much time, if not more, with our young people.

Often, our young people will want to affiliate with a group because they fear not being affiliated to a group. There is a sense among them that they need to be part of a group for protection.

Another issue is the rampant consumerism that surrounds our young people—my right hon. Friend the Member for Tottenham (Mr Lammy) talked about that in his book following the 2011 riots—and the popular culture that sometimes glamorises the lifestyle that goes with it. I used to be a trustee of a charity, the 409 Project, which unfortunately went under because it did not get funding. We found that money, or specifically a lack of money, was often the cause of the violence and criminality. The young people we dealt with told me how money led to the cycle of robbery and revenge: those who do not have the latest consumer good robbed those who do, but they were equally hard-up. We are not making any excuses—there is no excuse for that kind of violence—but unless we understand why it is happening, how can we hope to prevent it?

Finally, there are not enough jobs for young people, particularly young people who have left education. A disproportionate number of young people who are impacted are people who look like me—black and minority ethnic children. The unemployment rate among our BME youngsters is 25%. For young black males, it is a staggering 35%, in 2016, when we are the fifth largest economy. That is a disgrace.

What are we to do? First, the Government have to reverse their decision to disband the very important ending gang violence and exploitation peer review network, which I know they are planning to do this April. I praise them for setting it up. It is a good network doing important work. It is a retrograde step to disband it; doing so will seriously compromise efforts to reduce gang and youth violence. If it is being done to cost-cut, I say we cannot put a price on the lives of our young people.

Secondly, there needs to be a far more joined-up approach at both local and national levels. It is a constant challenge: there is the youth offending team, children's services, education and health. There needs to be a much more joined-up approach at a national level. One of the good things the previous Labour Government instituted—my hon. Friend the Member for Gedling (Vernon Coaker) was the Minister who set it up—was a cross-departmental working group that brought together Ministers to make sure this issue was being looked at in a holistic, joined-up way at a national level. The Prime Minister should forget that the group was set up by the previous Labour Government and reinstitute it without delay. The chair of the group should submit an annual report to the Home Affairs Committee, which could then call on the chair to give oral evidence.

Thirdly, there has to be an increased focus on the very-hard-to-reach youngsters who are out of work. Clearly, there is still more work to be done—just look at the figures.

Fourthly, we have to do much more intensive work in our schools to educate young people and get into their minds. We need to win the argument about what the lifestyle can lead to. We have to offset the glamorised image of what it is to be in a gang with a proper programme of intensive education. There also has to be much more effective enforcement. Every single lever must be used to send a message to key individuals in gangs that their criminal activities will be dealt with and their violence sanctioned—that is the point: sanctioned. If they are never caught and people do not see them being caught, even for minor infringements, they will carry on doing what they are doing.

Finally, I am sure the Minister would be surprised if I did not mention that this work is costly. It costs money and it requires resource. I agree with my constituency neighbour, my hon. Friend the Member for Croydon North (Mr Reed). We have to do this at a local level, but I do not understand how our local authorities can be expected to do it when their central Government grant has been cut by 56%. Youth services are particularly hit—more than any other.

Mr Steve Reed: My hon. Friend is making excellent proposals, which I hope the Minister will welcome. He has not yet mentioned the effect of domestic violence. As I understand it, one of the single biggest predictors of a young person becoming involved in violence is that they themselves have experienced, or been subject to, domestic violence in the home, leaving them to grow up without a properly formed sense of right and wrong. Does he agree that more work should be done in the home, early doors, particularly where there are instances of domestic violence?

Mr Umunna: I completely agree with my hon. Friend. In addition to domestic violence, we should mention the fact that some issues, particularly in the home and in the family, can arise as a result of substance misuse and mental health issues. Mental health issues are always prevalent in cases like this.

I will finish by saying to the Minister that I do not believe we can put a cost on the life of any young person in London, but ultimately, if the Government invest in this area, they will not have to spend the moneys they would otherwise spend on putting the perpetrators of these acts through the criminal justice system. Once and for all, let us not have to have another debate in the House of Commons—let us deal with the issue.

2.48 pm

The Parliamentary Under-Secretary of State for Refugees (Richard Harrington): I congratulate the hon. Member for Streatham (Mr Umunna) on securing this important debate. He has had a very long-standing interest in tackling gangs in London and in his constituency. He explained the background in an extremely eloquent manner and in a way we could all understand.

Tackling gangs and serious youth violence, in both London and in other areas around the country, is of course a priority for the Government. I am aware, and everyone in the House is aware, that gang and youth violence has a devastating impact not just on their victims and their families, but on the communities in which they live. We see young lives wasted, or worse.

On Wednesday 13 January the Government published their refreshed approach to tackling gangs, in a paper entitled, "Ending gang violence and exploitation". The paper sets out how our approach is focused on both reducing violence, including knife crime, and preventing the exploitation of vulnerable individuals by gangs. The refreshed approach builds on the ending gang and youth violence programme, established by the Home Office in 2012. This was based on a small Home Office front-line team working with an extended network of external experts who would visit a local area and produce a report with recommendations for local action to build local resilience. Since 2012, 52 areas have been part of this programme, including 26 London boroughs.

The programme will end in March, after four years of operation, as the hon. Gentleman said, but it is being replaced by the "Ending gang violence and exploitation" approach, based on what the Government and experts believe is the changing nature of the gang problem. The EGYV programme supports a front-line team of three people and an extended peer review network of more than 80. The peers come from local authorities, the voluntary sector, the police and others with a background in gangs, and are paid to visit local areas and make recommendations. It is then for that area—this brings me to the local point the hon. Gentleman made—to decide how and when to take those forward. As I have said, since 2012, 52 local areas have been visited, reviewed and reported on. Lambeth was subject to one in 2014.

We are now building on that programme. We will not be conducting any Home Office-funded peer reviews, because that has been dealt with, but we have provided the tools for local areas to conduct local assessments based on the same principles. We are committed to keeping peer reviewers, local area leads and other experts together by setting up the ending gang violence and exploitation forum. The forum will meet regularly—two or three times a year—and allow front-line practitioners directly to advise the Home Office officials of the latest issues and challenges; to share best practice with other practitioners; and to help inform the development of the new approach. It will be set out in more detail at the conference the Home Office is convening on 1 March—very soon—and which will be attended by more than 120 people with expertise in gangs.

Mr Umunna: I am grateful to the Minister for touching directly on this point I raised, but the disbanding of the network is a retrograde step. It is not the same as what the Government will reinstitute in its place. The nature of how gangs operate and proliferate changes, which is why we need the constant peer review the network provides. From what I understand and the information local partners have been given, it is basically being replaced by a couple of conferences, two civil servants who have added this to their responsibilities, and a mailbox.

Richard Harrington: I thank the hon. Gentleman for his point, but I think I have covered it already. The network is ending, but it is being replaced, so I cannot accept his point.

The hon. Gentleman said there should be a joined-up approach. I would point out that there is an interministerial committee on gangs, chaired by the Home Secretary, which brings together all the Departments. He made a good point, but one that is being dealt with. These interministerial committees, which I have dealt with in other fields, are taken very seriously and attended at a senior level.

Mr Lammy *rose—*

Richard Harrington: I am sorry; I cannot take an intervention, because of the time.

The Government are moving towards a cross-governmental approach on many things. The Government have identified six priorities to support the refreshed "Ending gang violence and exploitation" approach, based on what has been found and what we have been told—it is not a question of the Government saying, "This is what it will be." Let me briefly go through the six priorities. The first is tackling "county lines", which is the exploitation of vulnerable people by gang members to sell drugs. This is linked to urban gangs operating in drug markets in more suburban areas or surrounding towns. Our second priority is to protect vulnerable locations, which is linked to gang-related exploitation and refers to places where vulnerable young people can be targeted—for example, pupil referral units and children's care homes.

Our third priority is reducing violence, including knife crime, which I will return to in a few moments. Better information sharing is a key part of reducing violence. The fourth priority is safeguarding gang-associated women and girls, who are regarded as being particularly vulnerable. Our fifth priority is to promote early intervention, because we know that intervention can stop young people becoming involved in gang and youth violence in the first place. Our sixth priority is to provide meaningful alternatives to gangs, such as education, training and employment.

Let me turn briefly to knife crime. The Government are aware of concerns about knife crime and we continue to work with the police and other partners to tackle it. Police-recorded knife crime is 14% below what it was in 2010, but it has increased by 9% in the 12 months to September 2015. According to the Office for National Statistics, the picture behind the rise is complex and may be the result of improved recording by the police, a genuine rise in knife crime and a more proactive police response. The Government are reviewing what can be done with the Metropolitan police and other agencies. We have co-ordinated a week of action against knives in February, and the Under-Secretary of State for the Home Department, my hon. Friend the Member for Staffordshire Moorlands (Karen Bradley), is having a round table with retailers, the police and the National Police Chiefs Council on this issue. I should also stress that there are already strict controls on sales of knives to under-18s and how knives can be marketed.

It is also important that we work with the NHS and the voluntary sector, as many victims of knife crime end up in the NHS in our emergency departments. In London alone, the Home Office has awarded more than £1 million to the Mayor's Office for Policing and Crime from the police innovation fund to support information sharing between health services and community safety partnerships. The Home Office has a clear policy, and the funding is being used to extend the youth intervention programmes run by Redthread, a voluntary sector organisation, in the four major trauma centres in London, which include St George's in Tooting. This work is aimed at young people at hospital with knife injuries. Youth workers based in A&E talk to the young people at the "teachable moment" about what brought them there and whether they can be given support to prevent similar incidents from happening again. We are following the project very closely.

To conclude, I should like to repeat my thanks to the hon. Member for Streatham for securing this debate and providing Members with an opportunity to discuss this important issue, which can have such an impact on communities. I can assure the hon. Gentleman that the Government regard gangs and serious youth violence as a continuing priority and, through the new "Ending gang violence and exploitation" approach, we will continue to work with national and local partners to address this issue.

Question put and agreed to.

2.58 pm

House adjourned.

Written Statement

Friday 29 January 2016

BUSINESS, INNOVATION AND SKILLS

National Minimum Wage

The Minister for Skills (Nick Boles): I am pleased to announce that the Government are publishing evidence to support the Low Pay Commission's National Minimum Wage recommendations for 2016. This document contains economic analysis that the Low Pay Commission may want to consider when making its recommendations.

A copy of the evidence will be placed in the Libraries of the House and will be available from the BIS website at: www.bis.gov.uk.

[HCWS500]

Ministerial Correction

Friday 29 January 2016

TRANSPORT

Rail Lines: Flooding

The following is an extract from Questions to the Secretary of State for Transport on 28 January 2016.

Jim McMahon: I share the Minister's appreciation for the staff and for the patience of passengers, but I think the point is being missed. Because money has been taken away from routine maintenance and flood defences, there has been a massive effect on our local economy. If an assessment has been carried out, surely it should be made public.

Claire Perry: I am afraid that I have to disagree with the hon. Gentleman's facts, although I hate to do so at his first Transport questions. The Government have announced that overall flood spending in the next period will be £1.7 billion higher than it was in the previous period. Within the transport budget, about £900 million is dedicated to things like making sure that the banks and cuttings are safe—those things that are often the first to go when there is heavy flooding. Improving the resilience of the rail network and making sure that it is fit for a 21st century climate are at the heart of the record level of investment that this Government are putting into the railways.

[Official Report, 28 January 2016, Vol. 605, c. 402.]

Letter of correction from Claire Perry:

An error has been identified in the response I gave to the hon. Member for Oldham West and Royton (Jim McMahon) during questions to the Secretary of State for Transport.

The correct response should have been:

Claire Perry: I am afraid that I have to disagree with the hon. Gentleman's facts, although I hate to do so at his first Transport questions. The Government have announced that overall flood spending in the next period will be **higher than the £1.7 billion it was in the previous period.** Within the transport budget, about £900 million is dedicated to things like making sure that the banks and cuttings are safe—those things that are often the first to go when there is heavy flooding. Improving the resilience of the rail network and making sure that it is fit for a 21st century climate are at the heart of the record level of investment that this Government are putting into the railways.

WRITTEN STATEMENT

Friday 29 January 2016

MINISTERIAL CORRECTION

Friday 29 January 2016

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