

**Wednesday
11 January 2017**

**Volume 619
No. 88**



**HOUSE OF COMMONS
OFFICIAL REPORT**

**PARLIAMENTARY
DEBATES
(HANSARD)**

Wednesday 11 January 2017

House of Commons

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The House met at half-past Eleven o'clock

PRAYERS

[MR SPEAKER *in the Chair*]

Oral Answers to Questions

INTERNATIONAL DEVELOPMENT

The Secretary of State was asked—

Tajikistan

1. **Nigel Mills** (Amber Valley) (Con): What recent assessment she has made of the effectiveness of her Department's work in Tajikistan. [907997]

The Secretary of State for International Development (Priti Patel): UK development assistance has helped to reduce poverty and promote stability in Tajikistan since 2002. Between 2011 and 2016, DFID's work has improved rural lives, promoted women's economic empowerment, and delivered an important investment climate and managed public financial reforms.

Nigel Mills: I am grateful for that information. During a recent visit to Tajikistan, I saw the good work that DFID had been doing, but many people have expressed concern about the fact that certain projects have been quite slow to be approved. Will my right hon. Friend update the House on the Department's commitment to Tajikistan and on when those projects might be signed off?

Priti Patel: I thank my hon. Friend, both for his question and for going to see DFID's work in-country. The Minister of State, my hon. Friend the Member for Penrith and The Border (Rory Stewart), is overseeing new international development programmes, details of which will be published in due course.

Central Asia, including Tajikistan, represents an important strategic imperative in terms of our wider development objectives. We are, of course, committed to ensuring that commitments are implemented and that we start to deliver on those programmes later in the year.

Kerry McCarthy (Bristol East) (Lab): Tajikistan is very much at risk from climate change, which could threaten all the good work that is being done to improve livelihoods and economic development. Is dealing with that an element of DFID's programme?

Priti Patel: As the hon. Lady will know, a variety of challenges exist in this part of central Asia. Dealing with climate change is one, but others are economic security, financial management and performance issues. DFID's combined approach will help to deliver greater economic security in the long run.

Occupied Palestinian Territories

2. **Louise Haigh** (Sheffield, Heeley) (Lab): What assessment she has made of the implications of demolitions in the occupied Palestinian territories in 2015-16 for her Department's policies in that region. [907998]

4. **Simon Danczuk** (Rochdale) (Ind): What assessment she has made of the implications of demolitions in the Occupied Palestinian Territories in 2015-16 for her Department's policies in that region. [908000]

The Minister of State, Department for International Development (Rory Stewart): The Department's assessment, in line with long-standing British Government policy, is that demolitions are illegal under international humanitarian law, and that they undermine the credibility and viability of a two-state solution.

Louise Haigh: The Bedouin village of Umm-al-Hiran remains under threat from a demolition that would cast out 800 villagers, and the number of demolitions in the occupied territories in the first two weeks of January is almost four times greater than the number at this point last year. What support is being given to the people who are being driven out of their homes, and what message is being sent to the Israeli Government that such demolitions are completely unjustifiable?

Rory Stewart: The hon. Lady raises two important issues, the first of which is long standing. Along with our international partners, we continue to lobby the Israeli Government, who are undertaking the demolitions, to stop doing so, both because they are illegal and because they undermine the two-state solution.

The Under-Secretary of State for Foreign and Commonwealth Affairs, my hon. Friend the Member for Bournemouth East (Mr Ellwood), had a meeting with the Israeli Defence Minister, Mr Lieberman, just before Christmas and raised the issue of demolitions with him directly.

Simon Danczuk: Will the Minister ensure that human rights non-governmental organisations operating on the west bank continue to receive support from the British Government?

Rory Stewart: We are absolutely focused on supporting NGOs, but above all we are focused on investment in health and education. It is getting the natural capital right, and providing opportunities and hope for the Palestinians, that will lead to security and stability for both sides in the conflict.

Mark Pawsey (Rugby) (Con): Many of the demolitions occur because it is virtually impossible for Palestinians to obtain building permits. What legal support can the Department give to those who are contesting the process?

Rory Stewart: As I have said, DFID is focusing on health and education, but the Foreign Office has legal support programmes. This issue goes to the heart of the Israeli planning system and involves controversies with the Israeli Attorney General. As my hon. Friend says, it

is very difficult to obtain planning permission, which is one of the reasons why settlements are built and demolitions then take place.

8. [908004] **Tommy Sheppard** (Edinburgh East) (SNP): Among the buildings that the Israeli authorities have demolished are community facilities, some of which have been funded and developed with money from the Minister's Department. I would welcome his statement, but I think that we need action rather than words. Has the time not come to send Mr Netanyahu the bill for the demolition of structures funded by the British taxpayer?

Rory Stewart: The British taxpayer has not funded any structures that have been demolished by the Israeli Government. The European Union has funded structures that have been demolished by the Israeli Government, but so far it has not decided to seek compensation.

Tom Brake (Carshalton and Wallington) (LD): Will the Minister confirm that DFID, notwithstanding the efforts of a senior Israeli diplomat to "take down" a Minister, will continue to fight against collective punishment, demolitions in the OPTs and the expansion of the illegal settlements?

Rory Stewart: We are conflating two different issues here. As the Foreign Secretary said yesterday, the Israeli ambassador has already apologised for that incident, and the diplomat concerned has been removed from his post and sent home. I think I have dealt with the overall questions of settlements and demolitions in my answers to the other questions.

Kate Osamor (Edmonton) (Lab/Co-op): I thank the Minister for his responses, but I would like him to be a bit clearer and tell us how DFID has supported those people who are now homeless due to the systematic policy of settlement expansion.

Rory Stewart: The central story is that DFID is doing three types of things for Palestinian people. First, we are supporting Palestinian state structures, in particular health and education—doctors, teachers and nurses. Secondly, we are working on making sure that we can create a viable economy and employment, particularly through support to small businesses. Thirdly, we invest in human capital; in other words, we invest in making sure that the Palestinian people are educated, healthy and have opportunities for security and stability in the region in the short term. But in the long term there cannot be a two-state solution unless we address the needs of the Palestinian people.

Aleppo

3. **Craig Williams** (Cardiff North) (Con): What steps the Government are taking to support people in Aleppo. [907999]

The Secretary of State for International Development (Priti Patel): What has happened in Aleppo is a tragedy and underlines the regime's callous tactics of siege, starvation and indiscriminate bombardment. Through the UK's humanitarian leadership and diplomatic efforts, we are doing all we can do to support the protection of civilians and, importantly, ensure that they receive the aid they so desperately need.

1. [Official Report, 8 February 2017, Vol. 621, c. 2MC.]

Craig Williams: I thank the Secretary of State for that answer. The UK committed £510 million in support at the London Syria conference in February last year. Is she on course to hit that target?

Priti Patel: I thank my hon. Friend for his question on this important issue, which gives me the chance to restate to the House the British Government's commitment to, and long-standing support for, Syria. We have surpassed that pledge of £510 million made at the Syria conference last year. It is fair to say not only that the UK can be proud of its support, but that we have ensured that there is the right support in terms of humanitarian supplies and the focus for the region, while at the same time using our international convening power to work with others globally to ensure that we do everything we possibly can to support Syria and the region.

Stephen Twigg (Liverpool, West Derby) (Lab/Co-op): At the world humanitarian summit in Istanbul last year, the United Kingdom committed to the centrality of protection as a fundamental principle. How has that guided DFID's approach to the situation in Aleppo, and what lessons will we learn from the tragedy of Aleppo for future civilian protection?

Priti Patel: The hon. Gentleman makes an important point in relation to the conference last year and how the humanitarian community can come together and not just learn lessons, but understand ways of working in times of severe crisis and of conflict. There are a number of lessons we can learn, including on agencies working together, the pooling of resources, and making sure that Governments across the world are working together strategically in terms of both resource allocation and, importantly, our convening power—the leverage we all have collectively in the international space to challenge Governments where they are inflicting harm and causing grief and devastation, and to make sure that we stand shoulder to shoulder and are united in how we tackle the challenge.

10. [908007] **Victoria Prentis** (Banbury) (Con): People give to Singing for Syrians because they know that 100% of the money they donate will be spent on prosthetic limbs and medical salaries in the region, as close to Aleppo as we can get it. What more can the Secretary of State do to ensure that DFID money is spent in the region and not wasted on advocacy and lobbying in the UK?

Priti Patel: First, I commend my hon. Friend on her work on, and leadership in, Singing for Syrians; it is an incredible organisation and has been very successful in raising important funds. On making sure that the money is not wasted and goes directly into the region and in-country, we not only support, fund and collaborate with trusted partners, but, importantly, measure the outcomes that we are delivering in these essential humanitarian policies.

Alison McGovern (Wirral South) (Lab): The Secretary of State is already talking about Aleppo in the past tense, but the besiegement is still happening right now, and the British Government must do more. What representations has she made to the Foreign Secretary about putting in place more and harder sanctions on Russia?

Priti Patel: The hon. Lady is absolutely right. The situation not only in Aleppo but in Syria full stop is beyond comprehension. She asks about representations. The Foreign Secretary and I work hand in hand on international issues, and the Government are calling for greater collaboration on access to humanitarian routes into besieged areas. This is not a case of one Department versus another; it is the voice of the British Government working together to make public representations and representations behind the scenes.

Dame Caroline Spelman (Meriden) (Con): Before the war, Aleppo had Syria's largest population of Christians. Now it is estimated that 90% of them have fled. In Parliament today, Open Doors will launch its World Watch List, which shows that religious persecution is one of the key drivers of migration. What can my right hon. Friend's Department do to help the poor, persecuted Christians of Aleppo?

Priti Patel: My right hon. Friend is absolutely right to highlight the plight of persecuted Christians, especially in the context of Aleppo and Syria. She asks what we can do. This is not just a matter for DFID; the whole Government must speak out on the issue and constantly make it clear that the persecution of minorities and religious groups is totally unacceptable. That is the right thing to do. We also need to make that case within the international community and work collaboratively with donor countries and other countries across the world.

Patrick Grady (Glasgow North) (SNP): Following the announcement during the Christmas recess that DFID would be piloting the use of drones to deliver medical supplies in Tanzania and to map weather damage in Nepal, what discussions has the Secretary of State had with Ministers in the Ministry of Defence about how drone technology could be used to deliver aid or assess humanitarian need in Aleppo and other parts of Syria?

Priti Patel: The hon. Gentleman is right to highlight the fact that we have been innovating and looking at new technology in relation to aid provision via drones. A lot of work is taking place in that space, and we have had a number of debates in the House about other ways of delivering humanitarian assistance, particularly in besieged areas. In the specific context of besieged areas in Syria, work is taking place and there have been discussions. I can assure the House that we are actively pursuing this issue, not just in DFID but across the Government.

Mr James Gray (North Wiltshire) (Con): The Secretary of State's heart is very much in the right place, as we all know, but the fact is that the greatest humanitarian catastrophe of modern times is taking place in Aleppo, Raqqa and Mosul today. In contrast to the warm words that we have heard in the exchanges of the past few minutes, should we not now admit that there is precious little that we in the liberal west can do to alleviate the appalling circumstances in Aleppo unless we have the support of the United Nations and Russia?

Priti Patel: My hon. Friend makes an important point. In terms of the work that the Government are doing, we must never lose sight of the fact that we are

leading in humanitarian assistance and support. People are in desperate need, and we have the right focus on giving them all the necessary support. The other point is diplomacy. It is the job of the Government to carry on putting on the pressure, and we must use all the avenues of international diplomacy to put that pressure on, where it is needed.

Kate Osamor (Edmonton) (Lab/Co-op): I should like to focus on Idlib in north-western Syria, where civilians who have fled Aleppo are the main target of Government strikes. Will the Secretary of State tell the House how DFID is supporting those wounded and displaced civilians?

Priti Patel: I thank the hon. Lady for her focus on the humanitarian issue in Syria, which is of course associated with Idlib as well. She asks about the work that is taking place. There are extensive humanitarian efforts in terms of relief, food and shelter in what is a desperate situation. As she and the whole House will know, I have spent a great deal of time working with all the agencies that we are directly supporting and funding to ensure that supplies are getting through, and they are. I would add the caveat that this is taking place in a challenging environment and climate. We are getting supplies through, but it is increasingly difficult to do so.

Energy Access: Africa

5. **Steve Double (St Austell and Newquay) (Con):** What steps her Department is taking to improve energy access in Africa. [908001]

The Parliamentary Under-Secretary of State for International Development (James Wharton): Access to energy is a prerequisite driver of economic growth and development. Over 620 million people in sub-Saharan Africa have no access to energy. When able to secure it, the world's poorest people can pay up to 80 times what we pay. That is why the UK and this Department are playing a key role in providing both on and off-grid energy access, such as through the Energy Africa campaign, which will help to secure energy supplies for over 4.5 million of the world's poorest people.

Steve Double: I know from my visits to east Africa that providing access to reliable, sustainable, clean energy is crucial for economic growth and prosperity in Africa. Does the Minister agree that the CDC and its investment in Africa present one of the best opportunities to provide that?

James Wharton: I absolutely agree that the CDC can play a key role. I am pleased that the House showed support for its work only yesterday in a debate led by the Minister of State, my hon. Friend the Member for Penrith and The Border (Rory Stewart), with support from the Secretary of State. A good example is Globeleq, in which the CDC has a majority stake, which will drive forward energy provision of 5,000 MW in Africa—1,000 MW can support 800,000 jobs. That is the scale of the difference we can make when and where we get this right, and that is why we are doing it.

9. [908005] **Carol Monaghan (Glasgow North West) (SNP):** The German Government have called on the World Bank to focus all its work on climate and sustainability

targets and to put an end to investments in obsolete, climate-damaging technologies. Given that the World Bank is the largest recipient of UK aid for energy, will the Government follow Germany's example and use their influence to call on the World Bank to stop investing in fossil fuels?

James Wharton: I have set out some of the reasons why energy supply is so important in driving development. Of course, it is also important that that supply is sustainable and environmentally friendly. In all the projects that DFID pursues, we seek to ensure that that is the case, including in our discussions with the World Bank. Given our contributions and their impact, we recognise that it is particularly important that the World Bank appreciates and works towards that agenda.

Middle-income Countries: Aid Withdrawal

6. **Mike Freer** (Finchley and Golders Green) (Con): What measures her Department plans to put in place to ensure that marginalised groups in middle-income countries are supported in the event of aid from her Department being withdrawn from those countries. [908002]

The Parliamentary Under-Secretary of State for International Development (James Wharton): Programme sustainability is crucial, and all DFID programmes are designed with long-term sustainability and impact in mind. No decisions have been made to exit countries in the context of my hon. Friend's question. When and where that happens, we want to ensure that a positive legacy is left and that the "leave no one behind" agenda is adhered to, so that some of the poorest and most vulnerable people in the world receive the protection and support that they ought to be able to expect.

Mike Freer: The American Government operate the Global Equality Fund to ensure that marginalised groups are not left behind. Will my hon. Friend consider whether the UK should initiate a similar fund?

James Wharton: My hon. Friend is absolutely right. Marginalised groups, particularly in countries that are not the poorest, are sometimes the most vulnerable. We rightly focus our efforts and attention on the world's poorest countries with the largest number of people in greatest need of support, but other groups elsewhere also need support. We must always be aware of that and ensure that our programmes have a sustainable impact. I will be delighted to have further discussions with my hon. Friend about his idea.

12. [908010] **Douglas Chapman** (Dunfermline and West Fife) (SNP): The Independent Commission on Aid Impact concluded in a recent report that there is "no central policy or strategy guiding the objectives of exit and transition".

Will the Minister publish a sustainable transition framework to ensure that no middle-income country is put at risk? If so, when will it be published?

James Wharton: The Department will always consider what we need to do to ensure sustainable and long-lasting transition, and programmes must be designed in that way. That is a common thread that runs through every programme that DFID supports and every decision

that Ministers make. We will continue to work in this area and are happy to consider further proposals for what might improve the quality of the work that is done.

Topical Questions

T1. [908012] **Graham Evans** (Weaver Vale) (Con): If she will make a statement on her departmental responsibilities.

The Secretary of State for International Development (Priti Patel): Whether by giving to Syrian refugees, providing access to food or clean water, or creating jobs across Africa, UK aid helps us to meet our obligations to the world's poorest. Such investment is also firmly in Britain's national interest because it tackles the root causes of global problems while focusing on delivering world-class programmes that deliver value for money for UK taxpayers.

Graham Evans: The Secretary of State has previously said that she is looking at allocating DFID funding to peaceful co-existence projects, including Save a Child's Heart, whose valuable work brings Palestinians and Israelis together. Can she update the House on that very worthy project?

Priti Patel: I am pleased to confirm that we are indeed working on a range of co-existence programmes in Israel and the Occupied Palestinian Territories to support tangible improvements, as my hon. Friend the Minister of State has said. The programme is now in its final design phase and will be launched at the beginning of the financial year. [Interruption.]

Mr Speaker: Order. I understand the air of anticipation in the Chamber just before Prime Minister's questions, but I remind the House that we are discussing matters that affect the poorest people on the face of the planet. They should be treated with respect.

Imran Hussain (Bradford East) (Lab): The protection of civilians in Aleppo must remain our absolute priority, but if we are to provide food, water, shelter and humanitarian relief to civilians who, for four years, have faced the horrors of an inhumane war, we need to ensure that the ceasefire, although currently holding, remains more than a brief pause. Can the Secretary of State therefore say what efforts the Government are making to ensure that conflict does not reignite in Aleppo? What contingency plan does DFID have in place to continue providing aid to civilians should the conflict reignite? We must not see humanity in meltdown again.

Priti Patel: The hon. Gentleman is right that the UK will do everything it possibly can to support the current ceasefire and, importantly, to safeguard humanitarian support in the region, too. That is down to our diplomatic tools and diplomatic efforts, but, importantly, we are also making sure that all agencies work together to deliver the vital humanitarian support that is required.

T3. [908014] **Philip Davies** (Shipley) (Con): No self-respecting Conservative believes that we should be judged simply on how much we spend on something. Spending a guaranteed amount of money each year on overseas

aid leads to waste and excess such as the £1 billion spent each year on consultants. When can we get back to some common sense and stop spending more and more on overseas aid every year when the money could be much better spent at home?

Priti Patel: Like all Conservatives, I, too, want to focus on making sure that every penny of taxpayers' money goes to helping the world's poorest, which is exactly the mission of our Department. At the same time, my hon. Friend will know that overseas development assistance saves lives and transforms lives. He specifically refers to money spent on consultants, which is something that my Department is currently reviewing. *[Interruption.]*

Mr Speaker: Order. The Secretary of State's replies must be heard with courtesy. It is rather alarming when some of her own Back Benchers are not according her the proper respect. She must be accorded the proper respect.

T2. [908013] **Danny Kinahan** (South Antrim) (UUP): We receive much lobbying on the Israeli and Palestinian need for delivery on the ground, but what is the Minister of State's assessment of the effect of terrorism and how difficult it makes it to deliver on the ground to those in real need, whether it is education or humanitarian aid?

The Minister of State, Department for International Development (Rory Stewart): The hon. Gentleman makes a fundamental point. We have talked a great deal about demolitions and settlements, but the only long-term stability in that region requires protecting the security of Israel as an absolutely essential plank, along with guaranteeing an autonomous, independent Palestinian state.

T6. [908017] **Mr Christopher Chope** (Christchurch) (Con): The most sustainable aid is aid through trade. Will the Secretary of State therefore ensure that, when we leave the European Union and the customs union, we give top priority and free access to our markets to exports from the poorest countries?

Priti Patel: My hon. Friend will know that our priority is, of course, economic development and making sure that, through our aid, we are delivering long-term sustainable economic development and prosperity in everything we do. He is also right to note that DFID is working across the Government as we leave the European Union to look at unilateral trade preferences and the work we can do to grow our trade footprint across the world.

T4. [908015] **Deidre Brock** (Edinburgh North and Leith) (SNP): Unlike the hon. Member for Shipley (Philip Davies), we in the Scottish National party welcome the fact that OECD data show that, last year, the UK was one of only six countries to meet the 0.7% aid target. That, of course, includes the Scottish Government's international aid fund. What assurances can the Secretary of State give that her Government's commitment to that target is unwavering and will continue to be fulfilled beyond the next general election?

Priti Patel: We have been unequivocal in our commitment to 0.7% and, in addition, it is a manifesto commitment. Let me restate again, for the benefit of the House, that the focus of my Department is on poverty reduction

and on ensuring that that money is spent to drive taxpayer value and deliver programmes for the poorest in the world.

Mr Speaker: I call Pauline Latham. The hon. Lady wanted to ask a question earlier. Is she no longer inclined to do so?

Pauline Latham (Mid Derbyshire) (Con): I am here. Thank you very much, Mr Speaker. The Select Committee visited the Democratic Republic of the Congo last year and saw the amazing work done by the CDC, which is creating not only more energy for millions of people, but a lot of jobs. May we encourage the CDC to do even more schemes like that?

Rory Stewart: I thank my hon. Friend very much for paying tribute to the incredibly important role of the CDC. By bringing the rigour of the private sector with the genuine values of the public sector, we have demonstrated in the DRC the ability to provide hydro power that benefits thousands of people. I also wish to pay testament to the Chair of the International Development Committee for his tribute to that project in particular.

T5. [908016] **Ian Austin** (Dudley North) (Lab): Will the Secretary of State reconsider her Department's decision to cut every single penny of spending on co-existence projects, which bring the Israelis and Palestinians together and lay the foundations for a peace process and two-state solution?

Priti Patel: I thank the hon. Gentleman for his question. He will have heard in the previous responses our commitment to co-existence programmes and how they will not just drive the right values, but help to bring the two communities together in a very constructive way—this is in addition to our focus on targeted spending on public schemes such as health and education programmes within the region.

PRIME MINISTER

The Prime Minister was asked—

Engagements

Q1. [908080] **Chris Law** (Dundee West) (SNP): If she will list her official engagements for Wednesday 11 January.

The Prime Minister (Mrs Theresa May): This morning, I had meetings with ministerial colleagues and others. In addition to my duties in this House, I shall have further such meetings later today.

Chris Law: A very happy new year to you, Mr Speaker, and I would like to extend that to everyone in this House.

It has been more than six months since the European referendum. Embarrassingly for the Prime Minister, the Scottish Government are the only Administration on these islands to have published a plan on what to do next. Has she read it yet? When will she be publishing her own plan?

The Prime Minister: I join the hon. Gentleman in wishing everybody in the House, not only Members, but all the staff of the House, a very happy new year.

As I said to the Liaison Committee when I appeared in front of it before Christmas, I will, in a matter of weeks, be setting out some more details of our proposals on this issue. I would like just to remind the hon. Gentleman, when he talks about the Scottish Government's plan, that of course it is his party, the Scottish nationalist party, that wants to leave the United Kingdom and therefore leave the European Union.

Q3. [908082] Mark Menzies (Fylde) (Con): Westinghouse's Springfields site in my constituency employs more than 1,200 people in highly skilled jobs manufacturing nuclear fuel, which generates 15% of the UK's electricity. Does my right hon. Friend agree that the nuclear industry is of crucial importance to the north-west economy? Will she continue to support the construction of a new generation of nuclear power stations to guarantee jobs in the region?

The Prime Minister: I certainly agree with my hon. Friend that new nuclear does have a crucial role to play in securing our future energy needs, especially as we are looking to move to a low-carbon society. The industrial strategy that the Government will be setting out will have a strong emphasis on the role of regions in supporting economic growth and ensuring that the economy works for everyone. Like him, I very much welcome the proposals from NuGen and Toshiba to develop a new nuclear power station at Moorside in Cumbria. The Department for Business, Energy and Industrial Strategy continues to work closely with NuGen and other developers as they bring their proposals forward.

Mr Speaker: I call Jeremy Corbyn.

HON. MEMBERS: "Hear, hear!"

Jeremy Corbyn (Islington North) (Lab): Thank you, Mr Speaker. It is nice to get such a warm welcome, and may I wish all Members, as well as all members of staff in the House, a happy new year?

I hope the whole House will join me—I am sure it will—in paying tribute to 22-year-old Lance Corporal Scott Hetherington, who died in a non-combat incident in Iraq last Monday. I am sure the whole House will also join in sending its heartfelt condolences to the family and friends of seven-year-old Katie Rough, who tragically died in York earlier this week. I think it is right that we send condolences to her family.

Last week, 485 people in England spent more than 12 hours on trolleys in hospital corridors. The Red Cross described this as a "humanitarian crisis". I called on the Prime Minister to come to Parliament on Monday, but she did not—she sent the Health Secretary. But does she agree with him that the best way to solve the crisis of the four-hour wait is to fiddle the figures, so that people are not seen to be waiting so long on trolleys in NHS hospitals?

The Prime Minister: First, may I join the right hon. Gentleman in sending our condolences to the family of Lance Corporal Hetherington, who, as he said, died in a non-combat incident in Iraq? From everything I have seen and read about Lance Corporal Hetherington, he

was a very fine young man. He delighted in being in the armed forces, and we are proud that such a fine young man was in our armed forces. I also join the right hon. Gentleman in expressing condolences to the family and friends of little Katie, who died so tragically.

The right hon. Gentleman talks about the pressures on the NHS, and we acknowledge that there are pressures on the national health service. There are always extra pressures on the NHS during the winter, but, of course, we have at the moment those added pressures of the ageing population and the growing complex needs of the population. He also refers to the British Red Cross's term, "humanitarian crisis." I have to say to him that I think we have all seen humanitarian crises around the world, and to use that description of a national health service that last year saw 2.5 million more people treated in accident and emergency than six years ago was irresponsible and overblown.

Jeremy Corbyn: Some 1.8 million people had to wait longer than four hours in A&E departments last year. The Prime Minister might not like what the Red Cross said, but on the same day the British Medical Association said that

"conditions in hospitals across the country are reaching a dangerous level."

The Royal College of Nursing has said that NHS conditions are the worst ever. The Royal College of Physicians has told the Prime Minister that the NHS is

"under-funded, under-doctored and overstretched."

If she will not listen to the Red Cross, who will she listen to?

The Prime Minister: I have said to the right hon. Gentleman that I of course acknowledge that there are pressures on the national health service. The Government have put extra funding into the national health service. The fact is that we are seeing more people being treated in our NHS: 2,500 more people are treated within four hours every day in the national health service because of the Government putting in extra funding and because of the hard work of medical professionals in our national health service. It is not just a question of targets for the health service, although we continue to have a commitment to the four-hour target, as the Health Secretary has made clear. It is a question of making sure that people are provided with the appropriate care for them, and the best possible care for them in their circumstances.

Jeremy Corbyn: The right hon. Lady seems to be in some degree of denial about this. She will not listen to professional organisations that have spent their whole lifetimes doing their best for the NHS, but will she listen to Sian, who works for the NHS? She has a 22-month-old nephew. He went into hospital, but there was no bed. He was treated on two plastic chairs pushed together with a blanket. Sian says that

"one of the nurses told my sister that it's always like this nowadays".

She says to us all:

"Surely we should strive to do better than this."

Do the Prime Minister and the Health Secretary think that is an acceptable way to treat a 22-month-old child in need of help?

The Prime Minister: I accept that there have been a small number of incidents in which unacceptable practices have taken place. We do not want those things to happen, but what matters is how you deal with them, which is why it is so important that the NHS looks into the issues when unacceptable incidents have taken place and learns lessons from them. I come back to the point that I was making earlier: the right hon. Gentleman talks about the hard-working healthcare professionals, like Sian, in the national health service, and indeed we should be grateful for all those who are working in the NHS, but on the Tuesday after Christmas we saw the busiest day ever in the national health service, and over the few weeks around Christmas we saw the day on which more people were treated in accident and emergency within four hours than ever before. That is the reality of our national health service.

Jeremy Corbyn: We all thank NHS staff and we all praise NHS staff, but the Prime Minister's Government are proposing, through sustainability and transformation, to cut one third of the beds in all our hospitals in the very near future. On Monday, she spoke about mental health and doing more to help people, particularly young people, with those conditions, which I welcome, except that last night the BBC revealed that, over five years, there had been an 89% increase in young people with mental health issues having to go to A&E departments. Does she not agree that the £1.25 billion committed to child and adolescent mental health in 2015 should have been ring-fenced rather than used as a resource to be raided to plug other holes in other budgets in the NHS?

The Prime Minister: If we look at what is happening with mental health treatment in the national health service, we see 1,400 more people every day accessing mental health services. When I spoke about this issue on Monday, I said that there is of course more for us to do—this is not a problem that will be resolved overnight. I have set out ways in which we will see an improvement in the services in relation to mental health, but it is about the appropriate care for the individual. As I mentioned earlier, that is not just about accident and emergency. When I was in Aldershot on Monday, I spoke to service users with mental health problems who said that they did not want to go to A&E. The provision of alternative services has meant that the A&E locally has seen its numbers stabilising rather than going up. It is about the appropriate care for the individual. We want to see that good practice spread across the whole country.

Jeremy Corbyn: Nobody wants people with mental health conditions to go to A&E departments—the A&E departments do not want them to go there. Under this Government, there are 6,000 fewer nurses and 400 fewer doctors working in mental health. It is obvious that these people will go somewhere to try to get help when they are in a desperate situation. Our NHS is under huge pressure. Much of that is caused by cuts to social care, which the Royal College of Physicians says “are pushing more people into our hospitals and trapping them there for longer.”

Will the Prime Minister do what my hon. Friend the Member for Leicester South (Jonathan Ashworth) has called for and bring forward now the extra £700 million allocated in 2019 and put it into social care, so that we

do not have this problem of people staying too long in hospital when they should be cared for by a social care system?

The Prime Minister: The right hon. Gentleman asked me those questions in the last PMQs before Christmas. *[Interruption.]* He may find it difficult to believe that somebody will say the same thing that they said a few weeks ago, but we have put extra money into social care. In the medium term, we are ensuring that best practice is spread across the country. He talks about delayed discharges. Some local authorities, which work with their health service locally, have virtually no delayed discharges. Some 50%—half of the delayed discharges—are in only 24 local authority areas. What does that tell us? It tells us that it is about not just funding, but best practice. If he comes back to me and talks to me about funding again, he should think on this: we can only fund social care and the NHS if we have a strong economy, and we will only have that with the Conservatives.

Jeremy Corbyn: I am sorry to have to bring the Prime Minister back to the subject of social care, which I raised before Christmas. The reason I did so, and will continue to do so, is that she has not addressed the problem. The Government have cut £4.6 billion from the social care budget. The King's Fund says that there is a social care funding gap of almost £2 billion this year.

Earlier this week, the Prime Minister said that she wanted to create a “shared society”. Well, we certainly have that: more people sharing hospital corridors on trolleys; more people sharing waiting areas in A&E departments; and more people sharing in the anxiety created by this Government. Our NHS is in crisis, but the Prime Minister is in denial. May I suggest to her that, on the economic question, she should cancel the corporate tax cuts, and spend the money where it is needed—on people in desperate need in social care and in our hospitals?

The Prime Minister: The right hon. Gentleman talks about a crisis. I suggest he listen to the right hon. Member for Don Valley (Caroline Flint), a former Labour Health Minister, who said that, with Labour,

“It's always about ‘crisis...the NHS is on its knees’... We've got to be a bit more grown up about this.”

And he talks to me about restoring the cuts in corporation tax. The Labour party has already spent that money eight times. The last thing the NHS needs is a cheque from Labour that bounces. The only way that we can ensure that we have funding for the national health service is with a strong economy. Yesterday, the right hon. Gentleman proved that he is not only incompetent, but that he would destroy our economy, and that would devastate our national health service.

Q4. [908083] Mrs Maria Miller (Basingstoke) (Con): Cyber-bullying, sexting and revenge pornography are part of British teenage life today; so is a rapid increase in mental health problems among our teenagers. How is the Prime Minister helping to tackle the pressures that teenagers face in Britain today?

The Prime Minister: My right hon. Friend raises an important point. One of the things I spoke about, when I spoke about mental health on Monday, was trying to ensure that we can provide some better training for staff

and teachers in schools to identify the early stages of mental health problems for young people, so that those problems can be addressed. Something like half of all mental health problems start before the age of 14, so this is a real issue that we need to address. We are going to look at how we can provide that training. We will also review the mental health services provided for young people to ensure that we can identify what is working and make sure that good practice is spread across the country.

Angus Robertson (Moray) (SNP): May I begin with a tribute to Father George Thompson, who died shortly before Christmas? He led a remarkable life as a teacher, as a priest and as the Scottish National party Member of Parliament for Galloway. We extend our sympathies to his family.

All of us in this House and across these islands care about the peace process and about the democratic institutions in Northern Ireland, so may I wish the Prime Minister well and the Taoiseach, the Northern Ireland Secretary and the political parties all the best in trying to resolve the serious political difficulties there? Will the Prime Minister tell us what the consequences will be if no agreement can be found?

The Prime Minister: First, may I join the right hon. Gentleman in offering condolences to the family and friends of the Rev. George Thompson, who, as he says, was the MP for Galloway between 1974 and 1979 and, I believe, was the first former MP in modern times to be ordained a Roman Catholic priest.

On the issue that the right hon. Gentleman raises about the political situation in Northern Ireland, we are obviously treating this with the utmost seriousness. As he will know, my right hon. Friend the Northern Ireland Secretary made a statement in the House earlier this week on this issue. He has spoken to the First Minister and the former Deputy First Minister, and he is urging all parties to work together to find a way forward. I have also spoken to the Taoiseach about this issue, so we are putting every effort into this. The legislation says that if, within seven days, we do not have a nomination for a Deputy First Minister, the matter would go to an election.

Angus Robertson: The Prime Minister has indicated that she wants to take the views of the elected representatives and the devolved institutions on Brexit seriously. So it stands to reason then that if there is no Northern Ireland Assembly and no Northern Ireland Executive for much of the time before the March timetable that she has set for invoking article 50, she will be unable to consult properly, to discuss fully and to find agreement on the complex issues during this period. In these circumstances, will the Prime Minister postpone invoking article 50—[*Interruption*]*—*or will she just plough on regardless?

The Prime Minister: As the right hon. Gentleman says, we want to ensure that we do hear the views from all parts of the United Kingdom. That is why we have established the JMC European committee specifically to take views and the JMC plenary, which is also obviously meeting more frequently than previously. I am clear that, first of all, we want to try to ensure that,

within this period of seven days, we can find a resolution to the political situation in Northern Ireland, so that we can see the Assembly Government continuing. But I am also clear that, in the discussions that we have, it will be possible—it is still the case that Ministers are in place and that, obviously, there are executives in place—that we are still able to take the views of the Northern Ireland people.

Economy/Public Services (Staffordshire)

Q5. [908084] **Michael Fabricant** (Lichfield) (Con): What recent assessment she has made of the (a) performance of the economy and (b) adequacy of provision of public services in Staffordshire; and if she will make a statement.

The Prime Minister: The fundamentals of the UK's economy are strong, including in Staffordshire and the west midlands. Employment in Staffordshire has risen by over 20,000 since 2010. We have protected schools and police budgets. We see more doctors and more nurses in the Burton hospitals trust. Of course, we are going further than this in the west midlands by giving new powers to the west midlands with the devolution deal and with the election of a directly elected Mayor. I have to say that I think Andy Street, with his business and local experience, would be a very good Mayor for the west midlands.

Michael Fabricant: I thank my right hon. Friend the Prime Minister for that answer. Unemployment in my constituency—my beautiful Lichfield constituency—is around 0.7%, and that is fantastic, but I want it even lower. I found out that 24% of my constituents work in the area of the West Midlands Combined Authority, so can I press my right hon. Friend just a little further about what she thinks is needed in the West Midlands Combined Authority to improve employment still more?

The Prime Minister: I thank my hon. Friend, and, of course, I have had the advantage of having visited his beautiful constituency. But in relation to the midlands, we have a very strong ambition to make the midlands an engine for growth in the UK. That is why we have plans for the midlands engine that demonstrate that, when we say we are going to build an economy that works for everyone, we actually mean it. In the autumn statement, my right hon. Friend the Chancellor confirmed things such as the £5 million for a Birmingham rail hub and a £250 million midlands engine investment fund, and we will shortly be publishing a strategy for the midlands engine. But I repeat the point that I made: for the west midlands, having the devolution deal, having the Mayor and having the right person elected as Mayor, who I think will be Andy Street, is absolutely crucial.

Engagements

Q2. [908081] **Ian Murray** (Edinburgh South) (Lab): Happy new year, Mr Speaker. Sir Ivan Rogers, in his resignation letter, said that people may have to deliver messages to the Government that Ministers may find disagreeable. So here is a message that the Prime Minister may find disagreeable: her lack of priority for the single market is putting jobs in Scotland and the economy at risk. That means her Government are as

big a threat to the Union as the SNP. Her Government are not worthy of the trust of Scots, let alone their blind trust, so will the Prime Minister take this opportunity to apologise for threatening the Union and give a solemn promise to every single person in this country that they will not be a penny worse off after a Tory Brexit?

The Prime Minister: The hon. Gentleman will be very well aware that I want to see the best possible trade deal for the United Kingdom with the EU and the best possible deal for trading with and operating within the single European market. When we enter the negotiations, obviously, that is one of the issues that I have said that I want to see, and we will be out there and be delivering on it. Unlike the sort of downplaying that the hon. Gentleman does about the approach that we are taking, I have to say that it is this Government who are ambitious for the opportunities that are available to this country once we leave the European Union.

Q8. [908087] **Antoinette Sandbach** (Eddisbury) (Con): Cheshire schools in areas of rurality and areas of high deprivation will receive some of the lowest per-pupil funding rates in the country under the new proposed funding formula. Does the Prime Minister agree that these discrepancies must be addressed to ensure that Eddisbury pupils get the best possible start in life?

The Prime Minister: I think everybody recognises that the way that schools have been funded in the past has been unfair and many pupils have been missing out. That is why I think it is right for us to look at bringing forward a new fair funding formula, making sure that funding is attached to children's needs. Of course we recognise the particular issues of rural areas in this, and that is why, within the fair funding formula, additional funding for such schools has been included. But, of course, the Department for Education has this out for consultation at the moment, and I would urge my hon. Friend to make her representations as part of that consultation.

Q6. [908085] **Tracy Brabin** (Batley and Spen) (Lab): Dewsbury hospital A&E is set for a downgrade this year. Over Christmas, I had constituents who were waiting 20 hours for a bed in a facility that might not even exist next year. Will the Prime Minister please face reality and act now to stop this vital A&E service from disappearing?

The Prime Minister: What the hon. Lady is referring to, of course, is the plans that are being put forward at local level to consider—[*Interruption.*]

Mr Speaker: Order. There is far too much noise. I must say to the hon. Member for Dewsbury (Paula Sherriff) that if she were behaving like this in another public place she would probably be subject to an antisocial behaviour order.

The Prime Minister: I return to the point, Mr Speaker. Decisions about services in the local area are rightly taken by the local national health service, because we believe that it is local clinicians, and also local patients and leaders, who know what is best for their areas. So it is about trying to tailor the services to provide the best possible services for the needs of local people, modernising the care and facilities and making services appropriate

to the local area. This trust has an extensive improvement plan to ensure that both hospitals within it can care for patients attending accident and emergency in as timely a way as possible.

Q9. [908088] **Richard Fuller** (Bedford) (Con): Next Thursday evening, I will host the first session of the Bedford community business school, free of charge and open to all, with 250 local people sharing a passion for entrepreneurship and learning tips about business from national and local business leaders. Will my right hon. Friend ensure that her forthcoming industrial strategy has at its heart the passion and the interest of Britain's small business leaders and entrepreneurs?

The Prime Minister: I can absolutely give my hon. Friend that commitment. What is important is that the industrial strategy will be looking to the economy of the future—what sort of economy we want in this country. Crucial to that will be the growth that is generated by entrepreneurs and by small businesses—by the very passion that he has spoken about. We want to see an environment in which those who can grow can emerge and develop to provide future jobs for people and contribute to the strength of our economy. That is what the industrial strategy is about; I absolutely agree with my hon. Friend.

Q7. [908086] **Norman Lamb** (North Norfolk) (LD): The Prime Minister, I am sure, will understand, despite the reassurances, that there are genuine and really serious concerns among staff across the NHS and the care system, and patients and their families, about the pressure that they are under. For that reason, MPs from her own party, from the Labour party and from my party have come together to call for the Government to establish an NHS and care convention to engage with the public, so that we can come up with a long-term settlement for the NHS and care. Would the Prime Minister be prepared to meet us to discuss it, so that she can hear our case?

The Prime Minister: I recognise, obviously, the interest and the attention that the right hon. Gentleman has given to these issues—of course, he is a former Health Minister—and I would be happy to meet him and others, as he suggests.

Q12. [908091] **Edward Argar** (Charnwood) (Con): There can be nothing so distressing for a parent as the death of their child, particularly where that child has been murdered. That is what happened to the two ladies, one of them a constituent of mine, who set up Justice After Acquittal, successfully campaigning for voluntary national standards of support by the Crown Prosecution Service and by the police for the families of murder victims following an acquittal. Those standards are due to be launched here next Tuesday. Will the Prime Minister join me in paying tribute to the determination and energy with which they have campaigned for their cause, and will she continue to ensure, as she always has done, that the voices of the victims of crime and their families are always listened to?

The Prime Minister: My hon. Friend raises a very important point. I am very happy to join him in paying tribute to these two campaigners. Indeed, I am sure that the whole House would want to pay tribute to the work

that they are doing. As he says, I remain committed to ensuring that the voices of victims are heard. That is what I did when I was Home Secretary, if we look at issues such as introducing new measures to tackle modern slavery, strengthening the Independent Police Complaints Commission and legislating in relation to police complaints and discipline systems to strengthen public confidence in policing, and a number of other actions that I took. I am very pleased to say that my right hon. Friend the current Home Secretary is taking that same passion to ensuring that the voices of the victims of crime are heard and is taking that forward.

Q10. [908089] Joanna Cherry (Edinburgh South West) (SNP): Across the United Kingdom, many banks are accelerating their closure of local branches, with adverse effects on vulnerable and older people and adverse effects on the high street. The Royal Bank of Scotland is closing down branches across Scotland, including those at Juniper Green and Chesser in my constituency. Local convenience stores are taking the strain of processing bills and often face exorbitant bank charges for the privilege of doing so. Will the Prime Minister meet me to discuss how we can realise a situation where banking across the UK services customers and the real economy?

The Prime Minister: The issue of bank branches and, indeed, of the accessibility of bank services is one that is for individual banks themselves to take and consider, and of course there are many ways in which people are now accessing bank services other than by going physically into an actual bank branch, but I will certainly look at the issue that the hon. and learned Lady has raised.

Q14. [908093] Dr James Davies (Vale of Clwyd) (Con): Building a country that works for everyone means doing even more to tackle the economic and social deprivation that has come to afflict pockets of seaside towns such as Rhyl in my constituency. Will my right hon. Friend therefore support Growth Track 360, a locally developed plan to invest in rail infrastructure to help unlock the true potential of the north Wales and Mersey-Dee economic region as an integral part of the northern powerhouse, connected to the rest of the country via the proposed HS2 hub at Crewe?

The Prime Minister: I welcome the establishment of the north Wales and Mersey-Dee rail taskforce and the work that it is doing. The plan that my hon. Friend mentions sets out an ambitious programme of improvements for the area, and I am sure it will be prioritising the most promising options. I can say to him that the Department for Transport will continue to work closely with the taskforce and with the Welsh Government to consider what can be jointly accomplished.

Q11. [908090] Alan Brown (Kilmarnock and Loudoun) (SNP): As Pensions Minister, Steve Webb misled the public about the value of the single-rate pension. He also gave us the Pensions Act 2011. He was rightly booted out by the voters, yet is now deemed suitable for a knighthood. Does the Prime Minister not understand that, unless this Government take action to help the struggling WASPI women, that knighthood will be the final insult to these women?

The Prime Minister: Action has been taken on the issue in relation to women's pensions. The Government took action to ensure that the number of people who were affected and the period for which they were affected would be reduced, and money was put in to ensure that that was possible. If the hon. Gentleman looks at the new structure that is being put in place for pensions, he will see that women will actually be some of the greater beneficiaries of the new structure.

Q15. [908094] Chris White (Warwick and Leamington) (Con): I welcome the fact that the Prime Minister has raised awareness of the importance of child mental health this week, not least because 65% of young people requiring mental health support in south Warwickshire last year had to wait over 12 weeks before starting treatment. Will my right hon. Friend outline how the new proposals will improve our support network for such vulnerable young people?

The Prime Minister: My hon. Friend raises an important issue, which was of course alluded to earlier in this session of Prime Minister's questions. We are investing more in mental health than ever before—we are spending a record £11.4 billion a year—and it was of course the Conservative-led Government that introduced parity of esteem between mental and physical health, but as I said earlier, there is more for us to do in ensuring that appropriate care is available for people. I cited an example earlier of where I saw excellent work being done to provide care and support for people in the community, which was relieving pressure on accident and emergency, but also ensuring that people were getting the best possible care for them, and that is obviously what we want to see.

Q13. [908092] John Woodcock (Barrow and Furness) (Lab/Co-op): The strained accident and emergency provision in my constituency is under review, and the community further up the Cumbrian coast risks losing 24-hour access to accident and emergency and to consultant-led maternity from its local hospital. I understand that the Prime Minister will say that these decisions are to be made locally, but will she at least say that she can understand the anxiety of expectant mums who face a 40-mile journey on difficult roads, which are often blocked, if they have a difficult birth?

The Prime Minister: The problems that are facing the health service in Cumbria are widely recognised, and I do understand the concerns of local people about the services that will be available for them. We have put robust national support in place to address some of the long-standing challenges in Cumbria, and we are developing a lasting plan to deliver the high-quality, sustainable services that patients rightly expect.

The hon. Gentleman is right that these specific decisions are being taken locally, and no final decisions have been taken. I recognise the concern that he has raised previously, particularly about services at West Cumberland hospital. There will be considerable involvement in taking those decisions, but as I say, we do recognise the local concerns about some of the long-standing challenges for health service provision in Cumbria.

Dr Caroline Johnson (Sleaford and North Hykeham) (Con): I know from my career in medicine that the men and women of our East Midlands ambulance service do a brave and sterling job for the people of Sleaford and

North Hykeham and others, saving people's lives every day. East Midlands ambulance service responded to a total of 11,662 999 calls over the Christmas bank holiday weekend alone, 2,500 of which were in Lincolnshire. Will the Prime Minister join me in paying tribute to their dedication, particularly over the busy winter period, and tell the House what more the Government can do to support our ambulance services and improve response times in rural areas such as Sleaford and North Hykeham?

The Prime Minister: May I thank my hon. Friend for her question, and also for bringing her personal experience as a medical professional to this issue? I am very happy to join her in paying tribute to the men and women of the ambulance service for the dedication and commitment that they show. She asks what the Government have been doing. We recognise that ambulance services are very busy, which is why we see over 2,000 more paramedics now compared with 2010, and we are increasing paramedic training places by over 60% this year. Also, the Department of Health, NHS Employers and ambulance unions have agreed changes to the compensation for paramedics, potentially giving them a pay increase of up to £14,000 as they progress. We recognise the excellent work that they do.

Gavin Robinson (Belfast East) (DUP): May I commend the Prime Minister for her considered statement last night and, indeed, for the words that she has given this afternoon? She knows our commitment to the institutions in Northern Ireland, but does she agree that nothing can be, or should be, gained from threatening the peace process, the progress that we have made or the institutions that we have fought so hard to sustain in Northern Ireland?

The Prime Minister: The progress that has been made in Northern Ireland has been hard won, and we must all recognise that we do not want to put that progress in jeopardy. That is why it is so important for the Government, and for all parties, to work as hard as we can to see a resolution to this issue, so that we can see a return to the power-sharing institutions and ensure that the hard-won progress can be continued.

Nicky Morgan (Loughborough) (Con): I warmly welcome what my right hon. Friend said about children's mental health earlier this week, but may I draw her attention to another burning injustice? My constituent, Paula Edwards, has been battling cancer for four years. She is recovering from an operation and has taken 28 weeks off work. She is still employed and is on half pay, yet her working tax credits have been stopped, which means that she is worrying about how to make ends meet rather than focusing on her recovery. Will my right hon. Friend ask the Treasury to look at this, perhaps in the course of Budget preparations?

The Prime Minister: I thank my right hon. Friend for her comments about the mental health announcements that I have made. I am sorry to hear of the particular difficulties that her constituent is experiencing and the distress that they have caused her. Of course, working tax credits provide support for low-income families in work and are designed to incentivise people to increase their working hours. With the new universal credit system, we will obviously have a system of benefits with single, streamlined payments that encourages work, but I am sure the Financial Secretary to the Treasury would be happy to look at the individual case that my right hon. Friend has raised and the issue that she has set out.

Green Investment Bank

12.40 pm

Caroline Lucas (Brighton, Pavilion) (Green): (*Urgent Question*): To ask the Secretary of State for Business, Energy and Industrial Strategy if he will make a statement on the sale of the Green Investment Bank.

The Minister for Climate Change and Industry (Mr Nick Hurd): The Government set out their plans for the sale of the Green Investment Bank in the document “Green Investment Bank: Sale of Shares” laid before Parliament on 3 March 2016. The Government intend to move the GIB into the private sector, so that it can increase its access to private capital and increase its green impact free from the constraints of Government ownership. Potential bidders are interested in the GIB precisely because of its green specialism. We are asking potential investors to confirm their commitment to GIB’s green values and investment principles, and how they propose to protect them, as part of their bids for the company. In addition, the Government have approved the creation of a special share, held by independent trustees, to protect GIB’s green purposes in future.

As I am sure the House will appreciate, the sale is commercially sensitive, so I cannot comment on the identity of any bidders or the discussions taking place between the Government and potential bidders. All parties have been required to sign confidentiality agreements that place strict restrictions on the disclosure of information. The restrictions apply both to bidders and the Government.

Caroline Lucas: I thank the Minister for his reply, but it gives very little reassurance, given that everybody knows who the preferred bidder is. The preferred bidder, Macquarie, has a very, very worrying and dubious track record. I am putting this question today with support from across the House.

This week, we heard that the Green Investment Bank stands on the brink not just of being flogged off but broken up, with its green purposes discarded. Founded in 2012, the GIB has been widely recognised as a true success story, kick-starting truly innovative low-carbon projects across the UK, yet the preferred bidder—Macquarie—not only has a dismal and terrible environmental record but an appalling track record of asset stripping. So why have the Government given preferred bidder status to this company? What assessment have the Government made of Macquarie’s record, given that in 2005 the board of the London stock exchange deemed Macquarie unfit to conduct a takeover?

Furthermore, research this week uncovered changes to the GIB’s corporate structure. Between 22 November and 1 December, 10 new companies were incorporated and registered to the GIB’s London offices. The changes suggest that Macquarie is planning to fundamentally hollow out the GIB. Why have the 10 new companies been set up? Will the Minister confirm whether the changes made at the end of last year were made at the behest of Macquarie? Why are the Government setting up a structure to invite in a property asset stripper? If the GIB has been restructured in such a way as to allow it to be stripped of its assets, how can the Government guarantee that the special share, supposedly introduced to protect the future of the GIB, will have the intended effect?

Is this not exactly the wrong time to be selling off the GIB, given that the Government have decided to embark on a new industrial strategy, which must, to be in accord with our own climate change commitments, have low-carbon projects at its core? Finally, will the Minister admit that this selling off could lead to the bank being fatally undermined as an enduring institution? Will he stop the killing off of the Green Investment Bank? Will he halt the sale process with immediate effect?

Mr Hurd: As I think the hon. Lady knows, she has asked a stream of questions to which I cannot give direct answers. She will also know, being an experienced Member, that I cannot comment publicly on the identity of bidders or the process under way, for the reasons I elaborated at the start. She draws a lot of conclusions from media speculation, on which it would be irresponsible for me to comment, but I will try to give her some reassurance, flowing back to the objectives behind the sale that I set out in my answer. It is precisely because we want the GIB to be able to do more, unfettered by the constraints of the state, that we are seeking to put it into the private sector.

The objectives that we set out in the sale could not have been clearer and have been discussed in the House, and they include clear objectives around securing value for money for the taxpayer, which must be our primary responsibility. We want to ensure that the GIB can be reclassified to the private sector, but we have also been clear that we want to move it into the private sector to enable the business to grow and continue as an institution that supports investment in the green economy. We are selling it as a going concern, and potential investors would have to buy into the company’s green business plan and project pipeline. These are the criteria that we have set and against which we are evaluating the proposals before us.

Peter Aldous (Waveney) (Con): The GIB is a tremendous Conservative success story. It was devised by the Conservatives pre-2010, probably by my hon. Friend the Minister, and was introduced by a Conservative-led Government, and it has been a great catalyst for investment in the green economy—I am thinking, in particular, of the Galloper wind farm off the East Anglian coast. There is a concern, however, if the press stories regarding asset stripping and job losses are to be believed, that it will not be able to perform that role in the future. In that light, will he consider a pause in the process, so that we can ensure that the GIB continues to perform the great role it has played since 2012?

Mr Hurd: I agree with my hon. Friend’s opening comments about saluting what has been a great success story of the coalition—let us maintain the season of good will—but Conservative-led Government. It was the right thing to set up; it was we who did it; and it has been a great success, having mobilised £8 billion of private capital into a critical area of infrastructure, according to the last figures. I can, however, assure him—he is far too experienced to be drawn or influenced too much by media speculation—that we are not being naive in this process. We have set clear criteria for the sale. We have run a genuinely competitive process, and we are now evaluating the proposals before us, through the lens of the criteria we have set, which include value for money and reclassification. We are selling a going

concern, and what we want to hear about are forward plans for a dynamic, ongoing concern seeking to mobilise more private capital into the green economy. He knows as well as anyone in the House that we need to mobilise a lot of private sector capital to get the clean energy we need.

Clive Lewis (Norwich South) (Lab): I hope the Minister would agree that the GIB is a great British success story—he has already said as much—but let us put the record straight: it is also a Labour success story, having first appeared in our 2010 manifesto, and I am glad that the coalition Government took it up. If it is a success story, however, why are they selling it off? Is it simply a case of “public good, private bad”? That is what we think on the Opposition Benches, but Conservatives think it is “private good, public bad”. I am telling the House, quite simply, that from the assessment of Macquarie and what we have seen of it, we see that it has a history of asset stripping, so how exactly will the Minister protect this valuable public institution from having its assets sold off? That is a very fair question.

We know that the Government had planned to hold a share in the bank, which would have helped to maintain its green purposes, but new evidence has shown that Macquarie has already set up new companies that will control the GIB’s major assets. Will the Minister elaborate on the purpose of those companies and what oversight the Government will have of them once the sale goes through? The Prime Minister told us that the industrial strategy would be at the heart of her Government, yet the Government are now selling off an institution that has succeeded, from scratch and against the odds, in attracting capital for our green infrastructure on commercial lines. The Minister has already been outmanoeuvred by Macquarie bank and, frankly, we do not have much confidence that it will not happen again. Will the Government agree to stop the sale of the Green Investment Bank today until such time as its green purpose and core assets can be genuinely protected? If the Minister will not, does he accept that the GIB’s fate rests on his shoulders?

Mr Hurd: I will pass over the bizarre claim that the GIB is a Labour success story by virtue of its simply being mentioned in a 2010 manifesto, with nothing done for 13 years in government prior to that. This meant that in 2010, we started with far too low levels of clean energy in this country—a situation transformed by the coalition Government.

Again, I caution Members against making assumptions on the basis of speculation in the media, and I am not going to comment on that or identify any bidders.

The hon. Gentleman reflects the different view across the House about the benefits and values of the private sector. He should be aware, holding the position that he does, that we need to mobilise a huge amount of private capital. It is private capital, not public capital, that is going to make the difference when it comes to the big shift in infrastructure. What he misses is the critical role that the state has played in setting up the GIB to correct a market failure.

The fact that we have run a competitive process and that private sector bidders have come up and said, “We want to buy this as a going concern because of its green specialism,” indicates that the market failure has, to a

large extent, been corrected. The fact that this institution has mobilised billions of pounds of private capital into this critically important area of infrastructure is a success story. Our whole instinct now is that because we want it to do more, it will do more and be an even more successful institution in the private sector as a going concern.

Rebecca Pow (Taunton Deane) (Con): The Government have always been clear that the GIB was designed with a view to a possible transfer to the private sector, so will the Minister assure the House that the purpose of the GIB is, and will remain, green investment? I know that the Minister is dedicated to environmental issues, so will he also assure us that we will stick to our laudable manifesto pledge of leaving the environment in a better situation than we found it?

Mr Hurd: I thank my hon. Friend for her positive observation, and I pay tribute to her record and her absolute integrity and authenticity on protection of the environment and climate change, which are well respected across the House. I can give her this assurance. We have put before Parliament the whole procedure for protecting the green purpose of the GIB through the special share arrangements. It will be held by an independent company and it will have the power to approve or reject any proposed changes to the GIB’s green purposes. This is going to be set in company law. The five trustees were announced on 31 October 2016, selected through a genuinely independent process. If my hon. Friend looks at the names, she will see that they are independent and extremely credible. That is the mechanism that we have set out. I return to the point about the objectives of the sale. We want this to go into the private sector, so that it can do more of what it is doing—unfettered by the inevitable restrictions that the state has to put on it at this stage.

Callum McCaig (Aberdeen South) (SNP): I thank you for granting this urgent question, Mr Speaker, and I thank the hon. Member for Brighton, Pavilion (Caroline Lucas) for putting it. We support it wholeheartedly. The Minister has repeatedly said that he wants to see more money raised through this, but it will not happen if the assets are stripped from the company and taken abroad. Also, this is happening at precisely the worst possible time. There are reports that we will see a 90% fall in renewables investment. That must be addressed, and the GIB should be the vehicle for doing that.

What assurances can the Minister provide that capital from existing assets will be reinvested in green projects in the UK? How will the golden share work when it comes to subsidiaries and, in particular, to having a say over asset sales? What reassurances can he give us that the headquarters in Edinburgh will continue? How will the Government ensure that the shortfall in investment in renewables will be met? Finally, in the light of the forthcoming industrial strategy and emissions reduction plan, will the Minister pause this sale, so that Parliament can properly look at these and see what role the GIB can play in that process?

Mr Hurd: The hon. Gentleman quite rightly talks about the need for investment in renewables, but it would be nice if he could give more recognition of the extraordinary progress this country has made in respect of the profound transition to clean energy and the fact

[Mr Hurd]

that we have generated more electricity from renewable energy than from coal this year, which is a pivotal moment in our history. Investment continues to flow, and the GIB has played and I am sure will continue to play a very important role as a catalyst for all that.

I understand that the hon. Gentleman seeks reassurances and share his sentiments, but this is part of our process of evaluating the proposals before us against the criteria transparently set out and agreed through the House. It is through that lens that we now evaluate the proposals, which obviously includes attitudes to the workforce and sensitivities around jobs in Scotland. This is all part of the criteria and is, as I say, the lens through which we look at the proposals. Beyond that, I cannot say much because of confidentiality, and I hope the hon. Gentleman will respect that.

Huw Merriman (Bexhill and Battle) (Con): For the Opposition business spokesman to make the sweeping generalisation that “private is bad” is, I find, an appalling indictment, which provides evidence of why millions of private sector workers cannot rely on the Opposition. When the Minister looks at the golden share, will he consider whether some guarantees could be provided for future investment and in relation to the existing portfolio, perhaps for the first couple of years during the transfer to any bidder?

Mr Hurd: I thank my hon. Friend for that constructive observation. He is quite right in his first point—“public good, private bad” could not have been clearer from the Opposition Front Bench. That will have been noted in the business community and across the country, reinforcing the question mark that the country’s business community has about the Labour party’s attitudes towards it.

On the green share and the maintenance of assets, I have set out the mechanisms; I think they are robust, and Parliament agreed that they were. As for so-called asset stripping and the freedom to sell assets, let us not get ourselves into a position in which we view holding assets for ever as a good in itself. I do not think we would want that for the GIB under its current structure. The management of the organisation has to be free to manage a portfolio. As a Government, we have to be practical about the limitations we would place on a private sector bid. I come back to the point that we have been very clear about the criteria we are setting for this sale, and we are looking at proposals by taking a holistic view of those criteria, which include the need for reassurance about the forward plans for the organisation and the level of ambition for mobilising private sector capital into this critical area of clean infrastructure.

Edward Miliband (Doncaster North) (Lab): In the interests of consensus, we can agree that there was cross-party support for the Green Investment Bank right from the get-go. I would say to the Minister that there is also cross-party concern about this sale—and I could mention Lord Barker, who was a Minister in the last Parliament, Vince Cable and of course people on the Labour side. Is not the key question for the Minister and the Secretary of State this one? They promised a new approach to industrial strategy with a new Department, by contrast with their predecessors who did not even

use the phrase “industrial strategy”. The question to the Minister is: what has changed since they took over? If there is a moment to prove commitment to the new industrial strategy, it is this one in respect of their plans for the GIB.

Mr Hurd: The right hon. Gentleman may be right about the cross-party agreement on the need for a GIB; the difference is that we did it, and he did not. His party had plenty of opportunity to do it. He talks about the need for a continued commitment to investment in renewables, and I think we have shown that. In fact, one of the most decisive steps this Department has taken in the short time we have been in power is the announcement of the new contract for difference auctions, which will be the next stage of support for the more mature renewable tech choice. There is no issue about this Government’s commitment to the low-carbon economy and the green infrastructure that needs to underpin it. The Secretary of State could not have been clearer about that. Where I think there is a divergence of view is that the Labour party seems to think that state ownership is a good in itself, whereas in this situation we feel we have moved on from that. When it comes to this very important organisation, which has done a great job, we want to liberate it so that it can do more in future. It is partly through that lens that we are looking at the proposals before us.

Sir Oliver Letwin (West Dorset) (Con): Does my hon. Friend agree that the test—the proof of the pudding—lies not in how many existing assets of a given kind are owned, but in whether there will be a greater or smaller amount of investment in renewable and other green energy projects in the future? Does he agree that this privatisation will prove to have been a success if investment in new projects increases as a result?

Mr Hurd: I am delighted to respond to that question from my right hon. Friend, who was, in many respects, the guardian angel of the coalition Government, and who was intricately involved in the deliberations that led to the establishment of the Green Investment Bank. He is absolutely right, and he has made a fundamental point. We should not necessarily judge the bank on the basis of what it is at the moment; this is about what it can become, about levels of future investment and about commitment to the green purpose of the organisation. I do not think that the Government could have been clearer about the priority that we attach to those considerations. This is about the future.

Mr Iain Wright (Hartlepool) (Lab): May I give the Minister another opportunity to answer the question that I asked him in the Select Committee yesterday? How can he reconcile insisting on preserving the green purposes of the bank and preventing asset stripping from a new buyer with satisfying the classifications of the Office for National Statistics in respect of public sector control and balance-sheet requirements post disposal?

Mr Hurd: I have great respect for the Chairman of the Business, Energy and Industrial Strategy Committee, and we had a useful exchange about this issue yesterday, but he is again making assumptions about asset stripping. He is aware of the structure that we have established,

having doubtless been involved in the parliamentary debate about it. There is a great deal of concern on both sides of the House about protecting the integrity of the green purpose of the GIB, which is why we have gone through the process—which I think is robust—of setting up what is effectively a green share, along with the mechanism for its governance. That system was, I think, agreed to by Parliament and was introduced formally with the protection of corporate law.

I return, however, to the human motive of those who want to buy this organisation, which is to enable it to grow and do more. It is the authenticity, sincerity and integrity of those proposals that we are now evaluating.

Kevin Foster (Torbay) (Con): I am sure the Minister shares my slight amusement at the Opposition's argument that we can believe everything we read in the press about the Green Investment Bank, given that they spent all yesterday afternoon arguing that we cannot believe everything we read in the press. Does he agree that the Green Investment Bank was set up to deal with a market failure, that the fact that private investors are now keen to come in demonstrates the purpose it has served and, in particular, that without the restrictions imposed by EU state aid it can deliver more investment, not less?

Mr Hurd: My hon. Friend has made—much more eloquently than I have so far succeeded in doing—exactly the fundamental point that we are trying to convey. The test of an organisation that was set up to correct a market failure is whether that failure has indeed been corrected. We believe that it has, and our view is supported by the large amounts of private sector investment that are flowing into green infrastructure in the United Kingdom and around the world. What we must do now is ensure that the GIB is free and unfettered by the state, so that it can do more.

Mary Creagh (Wakefield) (Lab): The Environmental Audit Committee's report on the sale of the bank stated that Ministers had rushed to privatise it without consultation or proper consideration of the alternatives, and that either it should continue to exist as a low-carbon investor or its sale should not proceed. Taxpayers do not want a repeat of the Royal Mail debacle, when a public asset was sold off at £1.4 billion below its true value, and they do not want this landmark British institution to be sold off to an asset stripper.

Is it not extraordinary that the bank's assets were restructured in November? Can the Minister tell us whether that was done at the request of the UK Shareholder Executive, to facilitate its sale to the preferred bidder?

Mr Hurd: I do not believe that that was the case at all, although I understand the points that the hon. Lady has made. Like any other Government, we have a responsibility to deliver value for money to taxpayers, and we are very conscious of the need for this deal, if it materialises, to present itself well to the public whom we serve and represent. That is why, as one would expect, value for money is at the top of our list of criteria. We are embarking on a very good process, and we are setting ourselves very high standards for the presentation of the deal.

Kevin Brennan (Cardiff West) (Lab): I remind the Minister that during the passage of the Bill that became the Enterprise Act 2016, the Government rejected a Labour amendment that would have guaranteed the green purpose of the bank. Will he give an assurance today? After privatisation, will the bank be free to invest in fracking projects?

Mr Hurd: Let me respond to the hon. Gentleman's substantive point about the protection of the green purpose. If he doubts the integrity of the mechanism that we have established, that is fine, but I think Parliament has recognised that it is a robust mechanism, whereby the green purpose is set in the articles of association and any change must to be given effect by an affirmative resolution of the trustees. It is worth our noting the integrity of those people: James Curran MBE, Trevor Hutchings, Tushita Ranchan, Robin Lord Teverson—a very public sceptic of this process—and Peter Young. That is a very good group of people, selected by a rigorously independent process to safeguard the integrity of the green purpose, which is a priority for the Government.

Luciana Berger (Liverpool, Wavertree) (Lab/Co-op): We were told that we were to have the greenest Government ever, but the failed green deal collapsed, investment in renewable sources has been slashed, and we have slipped in the world rankings for investment in the low-carbon economy. If the Minister is not persuaded by the moral and environmental reasons why supporting the green economy is vital, will he consider, as a matter of urgency, the financial and economic reasons why it is crucial for us to invest in it, and will he then reverse his decision on the Green Investment Bank?

Mr Hurd: The hon. Lady is flogging rather an old horse, and, if I may say so, that is completely misplaced. Significant investment is being made in clean energy in this country and around the world. Indeed, with the Hinkley deal, the Government made one of the biggest commitments in the world to low-carbon energy. There is no question about our commitment to the transition to a low-carbon economy and a clean energy structure, and we are well along the track. I would add that we inherited an arrangement whereby we were operating on far too low a base in terms of renewable energy. It was a coalition Government led by Conservatives who changed that.

Alex Salmond (Gordon) (SNP): The Minister refused to name the bidders for the Green Investment Bank, but went on to tell us that private companies were saying that they wanted to buy the bank because of its success. Will the Minister tell us which private companies were saying that, or did he make up the quotation?

Mr Hurd: The right hon. Gentleman is extremely experienced, and I am not sure what part of a confidentiality agreement he does not understand. As I have said, the Government's criteria could not be clearer: we are selling a going concern, and we are not interested in proposals that do not respect that.

Mr Dennis Skinner (Bolsover) (Lab): When are the Government going to learn the lessons of the past when it comes to selling off public assets? I was here when Mrs Thatcher decided to sell off not only electricity but

[Mr Dennis Skinner]

gas, and then, finally, water. She said we were going to be a British share-owning democracy: that was the phrase. If we look at the list now, we find that some of those companies are owned in Germany and some are owned in France—and Macquarie, in Australia, bought the Birmingham toll road in a flash under a Tory Government.

Today we are being given another lecture on how the Minister will preserve the identity of the Green Investment Bank. History tells us that that is not possible. The bank will go to those who are bidding for it, and they will not be just in Britain. We are in the process of leaving the EU, and the chances are that somebody in the EU will be buying up British assets—although maybe not this one. Why don't you learn the lessons?

Mr Hurd: Of course, one of the lessons of privatisation can be seen in the record levels of investment that have flowed into those organisations since they were privatised. I respect the hon. Gentleman's experience, and I respect his sincerity and integrity, but I think he is totally wrong. All I will say is that I have a strong instinct that he would like British Telecom still to be a public company. I will leave it at that.

Kerry McCarthy (Bristol East) (Lab): The Minister is being very dismissive about speculation in the press. However, in the *Financial Times* the former Business Secretary, Vince Cable, has expressed concern about asset stripping, which he thinks was Macquarie's objective, and Ed Davey, the former Energy and Climate Change Secretary, has said he considers it unlikely that the golden share would give Ministers enough clout to influence the bank's investment strategy. Does the Minister not think that those two people—who, after all, were very much involved in the setting up of the bank—should be taken seriously and that we should act on their concerns?

Mr Hurd: Let me assure the hon. Lady that I take seriously all the concerns expressed by politicians past and present. It is important that through this urgent question the concerns that people have go from this House to potential bidders. I absolutely respect that and the individuals she mentions, but she says I am dismissing media speculation. I am not; I am just not commenting on it, because Ministers should not.

Mr Mark Williams (Ceredigion) (LD): I thank the hon. Member for Bristol East (Kerry McCarthy) for reminding the House of the involvement of Liberal Democrats in initiating the Green Investment Bank. Can the Minister address the point raised by Sir Vince Cable in a letter to the Secretary of State that he remains unconvinced that the golden share will prevent the asset stripping of the company and therefore the original intentions of the green bank at its inception will be under threat?

Mr Hurd: There was a whole set of arrangements under which the special share solution was reached. It was debated through Parliament and settled through that process. My personal view is that it is a robust mechanism in itself, given its legal underpinning and the integrity and independence of the people selected to

be the trustees and guardians of the process. I also come back to the fundamental point about the motivation of people who might want to buy this organisation, and the lens, criteria and disciplines we will have in evaluating their proposals and deciding whether or not to go ahead.

Ian Murray (Edinburgh South) (Lab): I, along with many colleagues, fought for the headquarters of the GIB to come to Edinburgh, where it now has more than 50 staff. Can the Minister tell us how many of those 50 staff will remain in Edinburgh after privatisation?

Many people have mentioned Vince Cable, but the legacy of Vince Cable as Business Secretary is the botched privatisation of Royal Mail, and that is why people have concerns about the GIB. The reason why we have concerns about the sale of assets is that by its nature the GIB invests in projects that the market will not touch, and therefore when those projects come on-stream they are much more profitable than normal projects, and if a preferred bidder then sells them off, they will sell them at great profit at the taxpayer's expense.

Mr Hurd: I recognise the importance of the GIB to Edinburgh and have agreed to meet with the Members of Parliament for that area to discuss this process. It was entirely the right decision to locate part of the organisation there, and jobs are a part of what we want to hear from bidders; we want to hear about commitment to staff and the ongoing organisation.

As the hon. Gentleman has mentioned staff, let me place on record—I hope this is shared by Members across the House—the Government's admiration and respect for the senior management team and all staff at the GIB, led by Lord Smith and Shaun Kingsbury, not just for what they have achieved in a relatively short period, but for the professionalism with which they have conducted themselves during this process.

Hywel Williams (Arfon) (PC): The GIB has made substantial investments in Wales, most recently at Parc Adfer on Deeside in partnership with five local authorities. That model works pretty well. What guarantees can the Minister give that the new owners will continue to invest in that sort of way, and invest in the regions and nations of the UK rather than abroad, or possibly even in the golden south-east?

Mr Hurd: I return again to the main point about the questions we ask of bidders and the criteria we set. We want to achieve value for money; we are selling an ongoing concern, and we are determined to protect the integrity of the green purpose of the organisation, so we want to hear plans for the mobilisation of future investment and future capital. If models are working, I am sure that any bidders that are professional organisations that view the GIB as a business will have regard to them. That is what we want to hear from bidders, and we are at the point in the process where we are evaluating that. I am afraid I cannot say a great deal more beyond that.

Jenny Chapman (Darlington) (Lab): For the sake of transparency, can the Minister tell the House whether the GIB will be able to invest in fracking in the future?

Mr Hurd: The GIB will be required under this process to continue to respect the green purpose of the organisation, as set out in the articles of association. The degree to which investment proposals fit those criteria is a judgment to be made by management and the trustees that we have set up to be independent guardians of this process.

Mark Durkan (Foyle) (SDLP): When Vince Cable was legislating for the GIB, we got assurances that it would operate throughout the UK and support projects in Northern Ireland, and, importantly, would not be precluded from supporting cross-border projects. In fairness, one of its first investments was in Northern Ireland, and indeed in my constituency. However, many of us are concerned that the quality of its investments, reach and support will be lost in this sell-off. The Minister talks about integrity but that is not something people associate readily with the preferred bidder.

Mr Hurd: I am not going to comment on either the identity, character or values of any bidder at this stage, but I join the hon. Gentleman in recognising the good work done and the approach taken by the GIB in making sure its investments are spread across the country. I come back to the point that the motivation for our wanting the GIB to be in the private sector is to enable the business to grow and continue as an institution supporting investment in the UK green economy—the reference to the UK there is important.

Julie Elliott (Sunderland Central) (Lab): I have been listening to the Minister rewrite the history of this Government's appalling record in this area since 2010, but the GIB is the one success story, and it did have cross-party support. It does a magnificent job in supporting risky businesses that the rest of the market will not invest in. Without breaking any confidentiality around the ongoing negotiations, what guarantees can he give to this House that such risky investments will continue and that green investment will be in as good a state as now, or even better, in five years?

Mr Hurd: I am forced to repeat myself again. We have set up, in a process agreed through Parliament, a mechanism for protecting the integrity of the green purpose of the organisation. Beyond that, because we are serious about selling the bank as a going concern and want to see positive proposals for growth and future investment, we are evaluating proposals from bidders through that lens. We are, and will continue to be, influenced in that process by the attitudes of the senior management team and what they feel about the proposals.

George Kerevan (East Lothian) (SNP): Last year, Macquarie—to cite a company at random—made its largest ever profit, and it did so, as the markets will tell the Minister, by selling off Moto, Britain's largest motorway service company, taking the cash out of the company and giving it to shareholders. Will the Minister tell us what in the current safeguards will prevent the future buyer, whoever they may be, from doing what Macquarie has always done: selling assets, taking the money out of the company and using it to pay its shareholders?

Mr Hurd: Again, I must repeat myself. The hon. Gentleman has chosen a company at random, but I am not going to talk about any companies. What I have tried to labour is the seriousness of purpose behind this

process and the safeguards we have set up, which are protected in law and also by the criteria we have set in evaluating any bids. An important part of that is the forward intention and the intention to mobilise private capital in future.

Diana Johnson (Kingston upon Hull North) (Lab): Given Brexit and the uncertainty around it, is it not risky to sell the GIB at this time? How does the Minister envisage the Government ensuring that money will be available for the new innovative technologies that will be very important for areas such as mine in Hull and the Humber?

Mr Hurd: With respect to the hon. Lady, I am not entirely sure why Brexit is relevant to this process or to the decisions underpinning it. I agree 110% with her fundamental point about the need to invest in energy innovation, which is why our Department has a £500 million spending review portfolio dedicated to energy innovation that sits in a wider system of budgetary support for energy efficiency. The point she makes is entirely the right one: if we are to achieve what we want to achieve in decarbonisation and the transition to abundant sources of affordable low-carbon energy, we have to continue to innovate. The Government have a role in that, which is why budgetary support is available for it.

Joanna Cherry (Edinburgh South West) (SNP): The Green Investment Bank employs 55 people at its head office in my constituency. When it was set up in 2012, the then Business Secretary, Vince Cable, said:

“Edinburgh has a lot going for it, both in terms of its asset management and finance sectors...also its proximity to green energy activity”.

He also said that choosing Edinburgh supported what he described as the “wider narrative” of binding Scotland into the UK in the run-up to the independence referendum. Will the Minister meet me to discuss how such promises can now be delivered to those 55 employees who work in the head office in my constituency?

Mr Hurd: I extend to the hon. and learned Lady the same offer that I made to a colleague earlier. Of course I will meet any colleagues whose constituencies may be affected by this process.

Catherine West (Hornsey and Wood Green) (Lab): My question relates to the bidding process. What is the Minister's view of the Macquarie bank, the potential bidder also known as the “cuff-linked buccaneers”? What is his opinion of the bank's recent activity as the owner of Thames Water when it shipped off hundreds of millions in dividend payments to investors, paid minimal taxes and made disappointing investment in the network?

Mr Hurd: The hon. Lady has made her point, and she will know what point I am going to make. I cannot possibly comment on the identity of any bidder at this stage.

Sammy Wilson (East Antrim) (DUP): Does the Minister agree that, if green investments are as profitable, sound and attractive as their supporters have claimed in the House today, there should be no concern about the introduction of private finance for such projects? Indeed,

[Sammy Wilson]

given the pressure on the public purse at the moment, is he not surprised that the House is not welcoming another source of funding for these activities?

Mr Hurd: The hon. Gentleman makes an important point about the increased attractiveness of investment in renewable energy and low-carbon infrastructure. Governments in the UK and around the world have helped to facilitate that investment over the years and have seen dramatic falls in the cost of those technologies and the cost of the capital attached to them, making them a more investable proposition. This helps to reinforce our argument that this is the right time to liberate the GIB from state control to enable it to play a bigger part in the market.

Margaret Greenwood (Wirral West) (Lab): The Aldersgate Group has highlighted the fact that the strength of the Green Investment Bank is that it has supported innovative projects throughout the UK that help us not only to tackle climate change but to drive down costs in the NHS and local government through energy efficiency. Will the Government heed the warning of the former Conservative Energy Minister, Lord Barker, that the bank is heading for break-up? Will they halt the sale to ensure that the bank remains a single public institution that is one step ahead of the market in the green projects that it backs?

Mr Hurd: Lord Barker is a good friend of mine for whom I have great respect. I would like to reassure him and, I hope, the House that the Government are not being naive. We are very clear about the criteria we have set, and we are in the process of a robust and rigorous evaluation of the proposals against those criteria.

Matthew Pennycook (Greenwich and Woolwich) (Lab): The Minister has been very clear that the creation of a special share in the governance arrangements will protect the integrity of the bank's green purpose and future investments, but may I press him for a little more detail on precisely how that special share would prevent successful bidders—Macquarie or others—from offloading current projects?

Mr Hurd: I want to make two points on that. First, the special share is being set up to protect the integrity of the green purpose, which is set out in the articles of association. It is there for all to read. Any proposed changes would need to be approved by the trustees, who have been selected independently. That is the mechanism involved. Secondly, I made the point earlier that I do not think it is sensible for investment institutions to hold on to assets forever. Part of their role is to manage

a portfolio, and if they get attractive offers to divest assets we expect them to look at those offers seriously. We are interested in the plans for future investment, and in what this organisation could become under private ownership. That is what we are evaluating.

Hannah Bardell (Livingston) (SNP): The Minister was right to say that there was cross-party support for the Green Investment Bank. There was, however, no such cross-party support—or support in Scotland—for the removal of support for carbon capture and wind energy. The fact that his party's policies have been so disastrous in Scotland might explain why it does not do so well with the electorate there. Will he absolutely commit to all the projects that the Green Investment Bank has invested in—totalling hundreds of millions of pounds in Scotland—and assure us that, regardless of who the buyer is, they will continue?

Mr Hurd: I dispute the hon. Lady's analysis. This country has made enormous progress in the shift to clean energy, and Scotland has been a big part of that. I point her to the recent commitment to the next round of contract for difference auctions and to the fact that last year I think we generated 25% of our energy from renewable sources. If she looks at the starting point of 2010, I think her argument falls away. On her point about continued investment in Scotland, I repeat what I have already said to colleagues.

Ms Margaret Ritchie (South Down) (SDLP): When taken alongside the cuts to renewable energy and the abolition of the Department of Energy and Climate Change last year, does not the sell-off of the Green Investment Bank show that the Government are no longer committed to being a world leader on climate change and sustainability?

Mr Hurd: No. I am afraid that that is total nonsense. If the hon. Lady wants proof points on that, I can tell her that one of the first actions of this Department, within days of the new Government being formed, was to put into law the fifth carbon budget. I am sure that she knows the detail of that, so she will know how ambitious it is. That was not the action of a Government who are shirking their responsibilities in relation to Britain's role in mitigating climate change.

Alan Brown (Kilmarnock and Loudoun) (SNP): Is the Minister seeking assurances that 100% of the return on any sales of existing assets will be reinvested in green energy in the UK?

Mr Hurd: I think I have laboured to exhaustion the point that one of our priorities is to protect the integrity of the green purpose of the organisation. What we want to hear from bidders is their plan for future investment.

Point of Order

1.27 pm

Tom Brake (Carshalton and Wallington) (LD): On a point of order, Mr Speaker. The Attorney General is making a speech today—indeed, he might already have made it—that will apparently pave the way for more military drone strikes against jihadis. This looks like, smells like and walks like a policy announcement. You, Mr Speaker, will be aware of the concerns that have been expressed in the House about the use of drones, about the lack of parliamentary scrutiny of their use and terms of engagement and about the risk—acknowledged by the Attorney General—of civilian casualties associated with their deployment. Given the controversial nature of drones, do you agree that any step change in their use—in other words, a policy shift—should be raised and debated in this House, not trailed in a speech?

Mr Speaker: I am grateful to the right hon. Gentleman for his courtesy in giving me notice of his intention to raise this point of order. I certainly share his view that significant policy announcements by the Government should first be made in this House rather than outside it. I am not familiar with the contents of the Attorney General's speech today, and I am not in a position to pronounce on whether it amounts to such an announcement of policy change. That said, the right hon. Gentleman has made his concern clear, and it will no doubt have been heard by those on the Treasury Bench. He can be sure that it will be conveyed to the relevant Ministers. The fairest thing I can say is: let us await events. I might add that as the right hon. Gentleman is a former Deputy Leader of the House, he will be well aware of—and personally closely familiar with—the instruments available for Back-Bench scrutiny of the Executive in this place.

Guardianship (Missing Persons)

Motion for leave to bring in a Bill (Standing Order No. 23)

1.29 pm

Kevin Hollinrake (Thirsk and Malton) (Con): I beg to move,

That leave be given to bring in a bill to make provision about the property and affairs of missing persons; and for connected purposes.

Sooner or later, all parents come to a certain realisation: our children are gradually slipping away from us—first crawling, then toddling, then running. The gentle, guiding hand is no longer needed as, with great delight, they discover the trick of balancing on two wheels and there they go pedalling off down the lane. There is that first day at school and then, a few years later, their hand starts to slip from ours when they get anywhere near the school gates. The teenage bedroom years are spent in self-imposed solitary confinement. Then comes the day when they cram all their stuff into the boot of the car and are off to university or the first job or to move into their first home.

All are bittersweet moments for most parents, because most of us know that our children will return. That is not so for Mr and Mrs Lawrence, parents of Claudia, a missing person since 18 March 2009—nearly eight years ago. We can never imagine the rising panic of those first minutes, hours and days when they realised something was wrong. Increasingly frantic calls and prayers go unanswered. Voicemails are never retrieved. Days turn into weeks, weeks into months, and months into years. Claudia's fate is still unknown and still the subject of a police investigation. Many false hopes have been raised over the years. A lead? A prosecution? Nothing. Hopes raised; hopes dashed.

When a person disappears with no explanation, all the unanswered questions and difficult emotions leave their friends and family an unbelievable amount to cope with. Such desperate situations are worsened by the need to pick up the pieces of their lives, such as paying the mortgage, the rent, the car loan or insurance. Data protection and financial services contract law currently prevent even the closest relative from dealing with their finances. Mr Lawrence told me:

“Banks, insurance companies, mortgage lenders, all say, ‘We can't accept your instructions, as you're not our customer’.”

He went on to say:

“You're at your lowest ebb and you have to fight all these problems... it's terribly distressing.”

I believe that the vast majority of Members join this House because they want a better world for all our children, but there are some problems that we will never be able to solve. The flaws of mankind will always exist. Our police forces cannot prevent and solve all crimes, but we can help by easing the burden in a small but important way.

Under current English and Welsh law, when a person disappears their property is effectively left ownerless. No one has the legal authority to protect it on their behalf. That can lead to assets depreciating and property falling into disrepair and leaves those left behind without access to the resources that the missing person would have provided. The creation of a new status of guardian

[Kevin Hollinrake]

of the property and affairs of a missing person will fill that void and provide a sensible and helpful solution to the practical and financial difficulties faced by families and others following a disappearance.

The core of the proposal is that the court will have power to appoint a guardian on the application of a person with sufficient interest in the property and affairs of someone who is missing. The Bill provides that the person will generally have to have been missing for at least 90 days and that the guardian will take control of the property and financial affairs of the missing person and will have authority to act on behalf of the missing person. The guardian will be able to use the property of the missing person to help those left behind, will be accountable for his or her actions and will be supervised by the Office of the Public Guardian. The terms of the appointment will be for a period of up to four years but will be renewable by application to the court. The small fee involved will be payable by the missing person's estate, so there will be little or no cost to the taxpayer. Crucially, the guardian will be required to act in the best interests of the missing person.

The proposals draw on the precedents of systems used in other countries, particularly certain states in Australia, and for deputies appointed under the Mental Capacity Act 2005. Many of us have benefited from similar powers in other difficult circumstances, such as when someone passes away or when someone close to us is no longer able to manage their own affairs due to dementia or other mental capacity issues. Quite simply, this Bill fills a gap in the law that few people know exists.

There are some 4,000 missing-people occurrences every year, and I thank everyone connected to Missing People, a support and campaign organisation, many of

whom are involved because they have lost a loved one. I offer particular thanks to Mr and Mrs Lawrence, who have a deep connection with my constituency and have championed the cause of guardianship even though it can no longer help their situation. I am also grateful to Members from across the House and from the other place who have pledged their support for this motion, particularly my hon. Friends the Members for York Outer (Julian Sturdy) and for Selby and Ainsty (Nigel Adams) and the hon. Member for York Central (Rachael Maskell), who have done so much work on this topic already.

Missing People has many tragic stories of loved ones lost and those left behind having their hearts broken: husbands, wives, fathers, mothers, brothers, sisters and children. This is possibly one of those all too rare occasions when Members can make a huge difference simply by supporting this straightforward Bill.

I am grateful to the Justice Committee, for the work of the all-party parliamentary group on runaway and missing children and adults, and, crucially, to Ministers, who have pledged their full support for the Bill. All I respectfully ask for is the support of all hon. Members to guarantee the Bill's passage through the House and into legislation.

Question put and agreed to.

Ordered,

That Kevin Hollinrake, Ann Coffey, Julian Sturdy, Christian Matheson, Sir David Amess, Christina Rees, Nigel Adams, David Warburton, Liz Saville Roberts, Rebecca Pow, Amanda Solloway and Dr Philippa Whitford present the Bill.

Kevin Hollinrake accordingly presented the Bill.

Bill read the First time; to be read a Second time on Friday 3 February, and to be printed (Bill 120).

Opposition Day

[17TH ALLOTTED DAY]

NHS and Social Care Funding

Madam Deputy Speaker (Natascha Engel): I advise the House that Mr Speaker has selected amendment (a) in the name of the Prime Minister.

1.38 pm

Jonathan Ashworth (Leicester South) (Lab): I beg to move,

That this House supports NHS England's four-hour standard, which sets out that a minimum of 95 per cent of all patients to A&E will be treated within four hours; notes the widespread public and medical professional support for this standard; further notes that £4.6 billion has been cut from the social care budget since 2010 and that NHS funding will fall per head of population in 2018-19 and 2019-20; and calls on the Government to bring forward extra funding now for social care to help hospitals cope this winter, and to pledge a new improved funding settlement for the NHS and social care in the March 2017 Budget.

I begin by paying tribute to the staff working in the NHS. To nurses, midwives, GPs, consultants, junior doctors, paramedics—all staff—we say thank you for your hard work, goodwill, commitment and dedication though this winter crisis. I had the pleasure of meeting some of those hard-working staff with my hon. Friend the Member for Tooting (Dr Allin-Khan) at St George's hospital on Monday, and they told me of the pressures they face. Last night, I convened a summit of representatives of various royal colleges and trade unions working in the health service to meet staff and hear directly from the frontline of the pressures we now see in hospitals every day. Many royal colleges have spoken out today, warning of underfunding and understaffing. Over the past few days, I have received messages from doctors and clinicians from across the country who tell of the immense pressure, strain and, yes, crisis that we face this winter.

Let me share with the House some of the stories that I have been told, and I deliberately exclude the names of hospitals and trusts so as not to cause undue stress and alarm. This is a flavour of what I have heard. One doctor told me:

"There was a point when A&E was completely full and we had no space for a major trauma call that was coming in. The trauma case was going to have to be put into a corridor because the resuscitation area was full."

Another story:

"In my A&E 'Corridor Care' isn't unusual, it's now the norm. Patient buzzers have actually been installed on the walls in said corridor."

How about this:

"We're...trying our best to keep patients safe but there aren't enough of us and we're on our knees. Doctor and nurses in tears?"

Another story:

"Over the weekend my bosses repeatedly asked for ambulances to be diverted away from our hospital because we had no beds, but we had multiple requests denied."

Finally, another one:

"The A&E is perpetually rammed with the corridor full of ambulance trolleys and paramedics."

I have many more examples, but I am sure the House understands the broader point that I am trying to make.

Ms Angela Eagle (Wallasey) (Lab): There is unprecedented pressure in Wirral, too. As recently as last week A&E attendances and GP referrals were massively up. Unprecedentedly, 84 additional beds are being laid on, and they are now full. Last week, all elective in-patient appointments were cancelled and ambulance turnarounds reached up to five hours. At Prime Minister's questions, the Prime Minister did not seem to think that there is a crisis in the NHS. If this is not a crisis, can my hon. Friend tell us what is?

Jonathan Ashworth: My hon. Friend makes her point eloquently and represents her constituents powerfully, as she always does in this place. I hope the Secretary of State will respond to some of those points.

Robert Ffello (Stoke-on-Trent South) (Lab): The Royal Stoke in my city is under intense pressure. No doubt, we will hear shortly from the Secretary of State that that is winter pressure. Winter has not really started. We have not really had a winter, yet we have been under this pressure not for a few weeks but for months. The whole NHS system is broken. That is the problem that we really face.

Jonathan Ashworth: My hon. Friend makes an eloquent point about the particular situation that has been facing Stoke for some time, of which many of us are aware. I hope the Secretary of State will touch on the situation in Stoke, because sadly it is one that we have had to raise previously.

Several hon. Members rose—

Jonathan Ashworth: If I may, I will make a little progress. I promise to try to give way to as many hon. Members as possible.

I assure the Secretary of State that I will pass on the names of the trusts and hospitals that I highlighted, so perhaps he can look into them. Let us be absolutely clear that these desperate stories are not the words of politicians trying to score political points but are the honest, heartfelt, considered testimonies of doctors and clinicians on the frontline in our hospitals. They simply want to do the very best for their patients. Indeed, many clinicians want to speak out but feel that they cannot, which is why the remarks were made anonymously.

According to reports on the BBC's "You and Yours", the Prime Minister has sent instructions to hospital trust chief executives telling them not to speak out. I would be grateful if the Secretary of State verified those reports.

Maria Caulfield (Lewes) (Con): I worked in the NHS over the Christmas period. Although it has been a very tough winter so far, this is nothing new. I have worked in the NHS for more than 20 years, and under previous Governments we had ambulances queuing around the block to get into A&E. Major incidents were declared in A&Es because they were too full. Will the hon. Gentleman accept that this is not a new problem?

Jonathan Ashworth: I entirely respect the hon. Lady's work as a nurse before she came into this place—[HON. MEMBERS: "She still is."] I beg her pardon. She is still a nurse, and I genuinely respect her, but if we are not

[Jonathan Ashworth]

raising these matters on behalf of our constituents, we are failing in our responsibility as Members of Parliament. We must never forget that this is not just about the staff in our NHS; it is about patients and their safety, which must always be our absolute priority.

Luciana Berger (Liverpool, Wavertree) (Lab/Co-op): I am grateful to my hon. Friend for kindly giving way and for his important remarks. I echo his point that this is about patients across the country. My constituent's mother, Angela, has been waiting for an acute mental health bed for more than a week. She was taken in an ambulance to A&E, but she could not be treated locally in Liverpool because the department was full. She was treated for the physical effects of her mental health condition in an ambulance and sent home. Her family are devastated and are concerned about her condition. Her story is one of countless stories across the country, and we need to recollect and focus on those stories today.

Jonathan Ashworth: My hon. Friend speaks passionately, as she always does, on behalf of her constituents and, more broadly, on mental health provision. Again, I hope the Secretary of State will respond to her on the specifics of that case.

My hon. Friend talks about patient care, and she is absolutely right. All of us, or at least many of us, in this House will have been getting stories from constituents telling us of their recent experiences in hospitals. I have been given a few, and I will share some heart-breaking examples with the House. Again, I will not reveal the names of trusts and hospitals, but I will pass them on to the Secretary of State after the debate.

Example No. 1 is of a mum of four children under 10 years old who has a secondary tumour in her liver. She was due to go into hospital this Thursday to have the tumour removed. Her surgery has been delayed for at least two weeks, so that the hospital could cope with the winter crisis and because no beds are available. She has not yet been given a new date.

Someone else got in touch with me this morning. Their wife has been on the waiting list for a knee replacement since April last year. An appointment for early December was cancelled owing to the hospital being on black alert. A few weeks later, the hospital phoned with an appointment for today, which was cancelled yesterday.

Again, these patients are not trying to score political points or to politicise matters. They are decent, hard-working people who are simply desperate for something to be done.

Helen Whately (Faversham and Mid Kent) (Con): Conservative Members care deeply about patients. I personally follow up on the individual stories and challenges experienced by my constituents, but the hon. Gentleman has surely seen the guidance this week from NHS Providers, which is not always a friend of the Government, that said that we need to be careful when extrapolating from individual incidents in hospitals that are under particular pressure and implying that they constitute a wider trend. Yes, times are tough in the NHS, and there are winter pressures, but he should not make inappropriate use of individual stories.

Jonathan Ashworth: The hon. Lady should be careful. I will be charitable, but she would not want to give the impression that she is dismissing the stories and examples that I am highlighting. NHS Providers has continually warned of the chronic underfunding of the NHS under this Government, and it has continually warned that, head for head, spending in this country will fall next year. If she wants to quote NHS Providers, she should quote all the facts from NHS Providers.

Stephen Doughty (Cardiff South and Penarth) (Lab/Co-op): My hon. Friend is telling some shocking stories. Was he as shocked as I was to hear Government Members shouting at and heckling the Leader of the Opposition during Prime Minister's questions? They shouted, "What about Wales?" Does my hon. Friend agree that there is actually a stark contrast in Wales? Welsh Labour is delivering 6% more funding than in England for the NHS and social care. We have brand new hospitals, including in my constituency, and an £80 million new treatment fund was announced yesterday to allow better access to treatments.

Jonathan Ashworth: My hon. Friend makes a powerful point about Wales. As a Member for Cardiff, he understands what is happening in the Welsh health service. I wish Conservative Members understood that better.

Mr Kenneth Clarke (Rushcliffe) (Con): Will the hon. Gentleman give way?

Jonathan Ashworth: I will give way to the right hon. and learned Gentleman, but I will then make some progress.

Mr Clarke: Does the hon. Gentleman accept that every winter, for as long as I can recall, we have had a winter crisis in the NHS? It usually happens after Christmas. In winter the demands on the service become unpredictable, infections spread and the NHS starts losing staff. There are bound to be parts of the system that come under very real strain, and no one is trying to minimise the fact that they do. Apart from just producing this year's crop of stories of very unfortunate incidents in various places, does he have any policy proposal at all, apart from simply spending more money wherever the reports are coming from?

Jonathan Ashworth: I am very grateful to the right hon. and learned Gentleman, who is a very experienced parliamentarian, for his intervention, but he will know that this is one of the worst winters for probably 20 years. He casually suggests that this happens every year, but I remember the years of a Labour Government when it did not happen. I remember the years of a Labour Government when we went further than the financial settlements he delivered as Chancellor of the Exchequer and were more than doubling the money going into the NHS—and tripling it in cash terms.

Several hon. Members rose—

Jonathan Ashworth: If I may, I would like to make a bit of progress. I promise my hon. Friends, and indeed Conservative Members, that I will try to give way as much as possible, but I am very aware that many Members have put in to speak.

We are all becoming familiar—far too familiar perhaps—with the grim statistics: in December, 50 of the 152 English hospital trusts called for urgent action to cope with demand; the number of patients being turned away from A&E and sent to other hospitals is at a record high; A&E departments have turned patients away more than 140 times; and 15 hospitals ran out of beds in one day in December. Last night, the BBC revealed that leaked documents from NHS Improvement showed that there were more than 18,000 trolley waits of four hours or more; that almost a quarter of patients waited longer than four hours in A&E last week, with just one hospital—just one—hitting its target; and that since the start of December, hospitals have seen only 82.3% of patients who attended A&E within the four-hour target. We will return to the four-hour target in a few moments.

Ministers can try to deny what is going on, but they cannot deny these facts about what is happening this winter in the NHS on their watch. We know that what happens in the NHS in the winter is a signifier of a wider crisis, because across the piece bed occupancy levels now routinely exceed the recommended maximum level of 85%—often to levels higher than 95%. As I have said, the NHS is going through the largest financial squeeze in its history. Indeed, the former Secretary of State, Lord Lansley, said that five years of NHS austerity had been planned for, but having 10 years of it was never expected. We have seen £4.6 billion cut from social care budgets—

Tom Pursglove (Corby) (Con) rose—

Jonathan Ashworth: I will give way in a moment. As the King's Fund said, the reason there is a problem is quite simply because there is a

“mismatch between funding and activity”

affecting our hospitals. The response of Ministers, from the Prime Minister downwards, has been one of utter complacency. The Secretary of State told “Sky News” on Monday that things had only been

“falling over in a couple of places”.

When he came to the House on Monday to make his statement, he did not commit to extra emergency funding for social care and he did not promise that the financial settlements would be reassessed in the March Budget. It is worse than that, because while he was making his statement, his spin doctors were telling the *Health Service Journal*—this on the day when the winter crisis is leading the news and he is making a statement in the House—and letting it be known that there is “no prospect” of

“additional funding to support emergency care any time before the next election.”

So there is nothing for social care, nothing for emergency care, nothing to tackle understaffing and nothing to tackle underfunding—well thank you very much. What did we get as a response? We got a downgrade of the four-hour A&E target.

The Secretary of State for Health (Mr Jeremy Hunt) indicated dissent.

Jonathan Ashworth: The Secretary of State shakes his head and says, “Nonsense”, but let me remind him of what he said in the House on Monday:

“we need to have an honest discussion with the public about the purpose of A&E departments.”

He began by saying he wanted to provoke a discussion. He has certainly provoked a backlash, not least by blaming the public, it seems, for turning up at A&E departments. He went on to say that the four-hour target

“is a promise to sort out all urgent health problems within four hours”,

but he added a little clarification, continuing:

“but not all health problems, however minor.”—[*Official Report*, 9 January 2017; Vol. 619, c. 38.]

That is what he said in the House, and now we have seen the letter from NHS Improvement to trusts a few weeks ago, which talks of

“broadening our oversight of A&E”.

On the four-hour standard, it said that it believed

“there is merit in broadening our oversight approach, beyond a single metric”.

So in the interests of that discussion the Secretary of State wants to engage in, perhaps he can answer our questions, although I know he avoided the questions on Sky yesterday. Does he recall that in 2015, when he asked Sir Bruce Keogh to review these matters on waiting times, Sir Bruce said:

“The A&E standard has been an important means of ensuring people who need it get rapid access to urgent and emergency care and we must not lose this focus”?

Henry Smith (Crawley) (Con) rose—

Jonathan Ashworth: I will give way in a few moments. Sir Bruce continued:

“I do not consider that there is a case for changing the 4 hour standard at this time.”

Does the Secretary of State still agree with Bruce Keogh? If he does, why did he make his remarks on Monday about needing to have a discussion about the future of the A&E standard?

Seema Kennedy (South Ribble) (Con) rose—

Jonathan Ashworth: I will give way in a few moments. If the Secretary of State wants to lead a discussion about the future of the four-hour A&E standard, will he tell us what discussions he has had with the Royal College of Emergency Medicine? It argues that the four-hour standard is a vital measure of performance and safety, and believes the standard should apply to at least 95% of all patients attending emergency departments. If he says he is still committed to that four-hour standard, is he still committed to maintaining it at 95%?

Robert Flello: Will my hon. Friend give way?

Jonathan Ashworth: My hon. Friend has had one bite of the cherry, so if he does not mind I shall make a little progress and then I will do my best to get as many people in as possible.

Does the Secretary of State agree—

Mr Mark Harper (Forest of Dean) (Con) rose—

Jonathan Ashworth: I will give way in a few moments.

[Jonathan Ashworth]

Does the Secretary of State agree that the four-hour standard is a reasonable proxy for patient safety? Does he agree that every breach of the four-hour standard can be regarded as a potentially elevated risk?

Seema Kennedy *rose*—

Jonathan Ashworth: I will give way to the hon. Lady, as she has been very persistent.

Seema Kennedy: If the hon. Gentleman were to read the Government amendment, he would see that the Secretary of State says he “supports and endorses” the 95% target for A&E waiting times.

Jonathan Ashworth: I pay tribute to the hon. Lady for the work she is doing on tackling loneliness. I know that all Labour Members very much appreciate the work she is doing on that, along with my hon. Friend the Member for Leeds West (Rachel Reeves). The Government amendment is conspicuous in not referring to all patients.

The Secretary of State did distinguish between “urgent” and “minor”—[*Interruption.*] The hon. Member for Beverley and Holderness (Graham Stuart) says I should get a haircut. Did he say that? No? I beg his pardon, but he heckles so much it is sometimes difficult to hear what he is saying. Can the Secretary of State tell us how he would define the difference between urgent and minor care for instances relating to this four-hour standard? Can he tell us what will be the minimum severity of physical injury or other medical problem which will be needed for a patient to qualify for access to an A&E? How will we determine these new access standards? How quickly will they be available? Will patients with visible injuries be exempt from a new triage system? If so, which injuries will qualify? If the Secretary of State is not moving away from this four-hour standard, he needs to clarify matters urgently, because the impression has been given that he is doing so. [*Interruption.*] Not by me, but by his own remarks in the House on Monday. If he is not moving away from that standard, will he guarantee that he will not shift away at all from it throughout this Parliament and that it will remain at its current rate?

Mr Harper *rose*—

Jonathan Ashworth: I will give way to the former Government Chief Whip.

Mr Harper: I, too, was in the Chamber on Monday and I listened carefully to the Secretary of State then. He was challenged by the right hon. Member for Exeter (Mr Bradshaw) on the target and was asked whether he was watering it down. He said explicitly that “far from watering down” he was recommitting the Government to it. He was generous to the Labour party in saying that it was one of the best things the NHS did. I think that was very clear.

Jonathan Ashworth: Let me say to the former Chief Whip that the Secretary of State said that

“we need to be clear that it is a promise to sort out all urgent health problems within four hours, but not all health problems, however minor.”—[*Official Report*, 9 January 2017; Vol. 619, c. 38.]

The Secretary of State did not need to come to the House to make those remarks and set these various hares running, so the right hon. Member for Forest of Dean (Mr Harper) should make his objections not to me, but to the Secretary of State—

Several hon. Members *rose*—

Jonathan Ashworth: I am going to move on a little.

If the Secretary of State is not abandoning the four-hour standard, as he insists he is not, we look forward to hearing him make that absolutely clear. He also said and has implied that we need to educate the public better, so that they do not turn up at A&E departments. That was the implication of his remarks on Monday. Will he tell us how he is going to do that? What will be the cost implications of explaining to the public that they must not turn up at A&E departments? Are we expecting to see a large advertising campaign? Will the cost fall on local authorities’ public health budgets, which have already been cut? Will local authorities be given more resources for this new public education campaign?

Derek Twigg (Halton) (Lab): My hon. Friend is making an important point. The key similarity is that back in 1997, when Labour took over, the health service was in crisis, and it is again today. Is not part of the problem that people are having to go to A&E because they cannot get in to see their GP?

Jonathan Ashworth: Absolutely. It is so difficult to get to a GP, which is why there are all these pressures on our A&Es. Of course, it is only going to get worse, because this year we are going to see cuts to community pharmacies—3,000 will be lost from our towns and streets because of the cuts that are being pursued. Let us not forget that the figure of 3,000 community pharmacies being lost was what the previous Minister, the right hon. Member for North East Bedfordshire (Alistair Burt), told MPs.

Mrs Anne Main (St Albans) (Con): Will the hon. Gentleman give way?

Jonathan Ashworth: I will give way one last time, but then I really must make some progress.

Mrs Main: I led a debate in Westminster Hall this morning on pharmacies and integrated services in the NHS, and not one Back-Bench Labour MP could be bothered to take part—not one!

Jonathan Ashworth: Labour MPs have been raising these matters in this House for weeks, including at urgent questions and in Opposition day debates.

Bill Esterson (Sefton Central) (Lab): I presume what the hon. Member for St Albans (Mrs Main) meant to say was that two Back-Bench Labour Members took part in the debate—I was one of them. Does my hon. Friend agree that the point about community pharmacies, GPs and investment in social care is that they save the Government money? That is why they should invest in them now to take pressure off A&Es.

Jonathan Ashworth: I thank my hon. Friend for correcting the record about that debate in Westminster Hall.

The Secretary of State denies that he is going to water down the A&E target; we welcome that, but we will watch carefully to ensure that he does not sneakily water it down throughout the remaining years of the Parliament. Will he tell us what he expects to happen next as we go through the winter? Weather warnings have been issued, and we could be heading for a cold snap. Will he update us on what urgent preparations he is putting in place to ensure that the NHS can cope? Is the NHS prepared for a flu outbreak, and what is his assessment of whether overstretched hospitals will be able to cope if there is one? It appears that, so far, Ministers have been burying their heads in the sand, but that will no longer do.

Lucy Frazer (South East Cambridgeshire) (Con): My right hon. and learned Friend the Member for Rushcliffe (Mr Clarke) and my hon. Friend the Member for Lewes (Maria Caulfield) both made the point that the issues in the NHS are historical. On Radio 4 this morning the right hon. Member for Leigh (Andy Burnham) said he accepted that the previous Labour Government had not spent the right amount of money on social care. Will the hon. Gentleman accept that these issues are historical—they are not new—and that Labour does not have all the answers?

Jonathan Ashworth: The hon. Lady refers to history; under this Government the NHS is going through the largest financial squeeze in its history. When we had a Labour Government, we more than doubled investment into the NHS.

Tom Pursglove: Will the hon. Gentleman give way?

Jonathan Ashworth: Because he is a Member from the east midlands, I shall give way to the hon. Gentleman from Corby.

Tom Pursglove: I agree with the shadow Secretary of State that we need to have an honest debate, so does he accept that he stood on a general election manifesto that would have seen Labour spend billions less on our national health service? Will he set out for the House exactly what NHS services he would be spending less on now?

Jonathan Ashworth: We stood on a manifesto that would have delivered more doctors and nurses for our NHS; the hon. Gentleman stood on a manifesto that said the Conservatives would cut the deficit and not the NHS. They are cutting the NHS and failing on the deficit.

I have a few direct questions for the Secretary of State about Royal Worcestershire hospital. I was grateful for his remarks on Monday, but I want to press him a little further. It has been reported that NHS England was warned of a bed crisis as early as 22 December. Will he update the House on what urgent meetings he is having on Royal Worcestershire? When will we be closer to knowing the outcome of an inquiry? In that context, there is a proposal in the sustainability and transformation plan for the Worcestershire area for a significant reduction in the number of acute beds. The Secretary of State will

say that these are local plans and so on, but in the context of the issues in Worcestershire, will he comment on whether he thinks that is the right proposal to follow?

On STPs more generally, the NHS is going through a winter crisis, and it is about to go through another top-down reorganisation—[*Interruption.*] Someone says it is bottom-up, but it is not; we know it is coming from the top. Those making the STPs are being told that they have to fill a financial gap of £21.764 billion—that is the reality that STPs throughout the country now have to face. We have seen the plans, so we know that that is going to mean a number of community hospitals being closed, a number of A&Es being downgraded, and acute beds being lost.

In places such as Devon, where the STP talks of an over-reliance on hospital beds, the implication is that beds will be lost. Closures and downgrades are being considered throughout Somerset, with their priority list of vulnerable services including maternity and paediatrics. In London, a city with the very worst health inequalities, the STPs are expected to deliver better health outcomes for the city's growing 10 million residents with £4.3 billion less to spend. Will the Secretary of State explain to the House how he expects the NHS to perform in future winters, when we have a growing elderly population and STPs are pursuing multibillion-pound cuts to beds, A&Es and wider services?

James Heapey (Wells) (Con): I was recently briefed by an excellent and well-respected local GP and a clinical psychiatrist, who were the authors of our county's STP. Will the shadow Secretary of State explain how on earth they are responsible for a top-down reorganisation?

Jonathan Ashworth: Because they were being told by NHS England, which was in turn told by the Secretary of State.

Neil Coyle (Bermondsey and Old Southwark) (Lab): The right hon. and learned Member for Rushcliffe (Mr Clarke) mentioned infections spreading in the NHS. Does my hon. Friend share my concern about the infection that is spreading on the Government Benches? It is the infection of arrogance, complacency and being completely out of touch with the patients and their families who are suffering under the current crisis. We are witnessing inaction on an epic scale.

Jonathan Ashworth: My hon. Friend makes his point extremely well, although I would not want to be so mean about the Secretary of State—[HON. MEMBERS: "Go on!"] No, I am not going to be mean about the Secretary of State.

Toby Perkins (Chesterfield) (Lab): In the past few moments, we have heard the ludicrous suggestion that Labour did not deliver on either spending or performance, but in fact our track record was excellent. That is not just my opinion; the former Prime Minister, David Cameron, said in 2011:

"I refuse to go back to the days when people had to wait for hours on end to be seen in A&E, or months and months to have surgery done. So let me be absolutely clear: we won't."

[Toby Perkins]

He knew that Labour had a good record and that the NHS used to be good; why will these Tories not admit it?

Jonathan Ashworth: My hon. Friend makes a powerful point. Indeed, I remember, when we were in government, shadow Health Secretaries standing at this Dispatch Box opposing every penny piece of money that Labour was putting into the NHS. I remember a shadow Health Secretary, who now sits in the Cabinet as the Secretary of State for International Trade, standing at this Dispatch Box and saying that the A&E target was “indecent.” That was the Tories’ attitude when we were in government, so it is no wonder that we are sceptical about the Government’s intentions for the A&E target when we look at their history.

Henry Smith: The shadow Secretary of State is talking about the Labour record on the NHS. Does he recall Labour closing not only maternity at Crawley hospital, but accident and emergency in 2005?

Jonathan Ashworth: I do not have the details of the Sussex STP to hand, but presumably if it contains any suggested closures the hon. Gentleman will be campaigning against them and knocking on the door of the Secretary of State, if those remarks are an indication of his point of view on these matters.

James Cartlidge (South Suffolk) (Con): The hon. Gentleman is saying that everything was rosy under Labour, but he should remember that it was 10 years ago when the scandal at Mid Staffs broke, in which hundreds more elderly patients died than was projected. It was a terrible scandal and he should remember that. What our shadow team was doing at the time was holding the Labour Government to account.

Jonathan Ashworth: I take all deaths in hospitals seriously. My commitment to patient safety is unswerving. I will continue to raise matters, whether it is at Royal Worcestershire or elsewhere, but not in a partisan way with the Secretary of State—[*Interruption.*] I was not being partisan when I was asking questions about the Royal Worcestershire. The Government Whip, the hon. Member for Beverley and Holderness (Graham Stuart), really needs to calm down. I will raise these matters, because that is the responsible thing to do. It is unbecoming to play politics with patients in that way.

Culpability for the state that the NHS is in today lies at the door of Downing Street. The Government promised to protect the NHS and to cut the deficit, and they have not done so. The Government give away billion-pound tax cuts to corporations—[*Interruption.*] Yes, this Government. The Government waste billions, pushing the NHS in the direction of fragmentation and greater outsourcing, while ignoring the ever-lengthening queues of the sick and the elderly in all our constituencies.

Yesterday, we saw the Secretary of State on Sky losing his ministerial car and being chased down the street. It was his whole approach laid bare: not a clue where he is going; nothing to say; and not facing up to the problems. Last year, he blamed the junior doctors. On Monday, he blamed the patients. Today, he blames

Simon Stevens. Tomorrow, he will blame the weather. It is time that the Health Secretary started pointing the finger at himself and not at everybody else. The NHS is in crisis, and Ministers are in denial. I say to the Government, on behalf of patients, their families and NHS staff, please get a grip. I commend our motion to the House.

2.11 pm

The Secretary of State for Health (Mr Jeremy Hunt): I beg to move an amendment, to leave out from “House” in line 1 to the end and add:

“commends NHS staff for their hard work in ensuring record numbers of patients are being seen in A&E; supports and endorses the target for 95 per cent of patients using A&E to be seen and discharged or admitted within four hours; welcomes the Government’s support for the Five Year Forward View, the NHS’s own plan to reduce pressure on hospitals by expanding community provision; notes that improvements to 111 and ensuring evening and weekend access to GPs, already covering 17 million people, will further help to relieve that pressure; and believes that funding for the NHS and social care is underpinned by the maintenance of a strong economy, which under this administration is now the fastest growing in the G7.”

I thank the shadow Health Secretary for bringing this afternoon’s debate to the House. He is right to draw attention to the pressures in the NHS, but, regrettably, I will have to spend much of my time correcting some totally inaccurate assertions that he has made, and that is a shame. This is an important debate for our constituents—for his and for mine—and for the NHS. The country deserves a proper debate, but that is difficult when we are given misinformation at a time when the NHS is under sustained pressure.

I am also very pleased to see the Leader of the Opposition in his place. I think that he has become rather a fan of my parliamentary appearances—[*Interruption.*] It is a Jeremy thing, he says—if only. I wish to address one part of my speech to him, because it is an area of policy for which he is perhaps more personally responsible.

Winter is always challenging period, and I want to repeat the thanks of the shadow Health Secretary and the thanks that I gave on Monday to NHS staff. According to NHS Improvement, on the Tuesday after Christmas the NHS had its busiest day ever. Earlier in December, it treated a record number of patients within four hours. Overall, as the Prime Minister said this morning, we are seeing 2,500 more patients within the four-hour standard every single day compared with what happened in 2010. As we discussed on Monday, the NHS made record numbers of preparations for this winter, because it is always a difficult time, including having 3,000 more nurses and 1,600 more doctors in full-time employment.

Let me address what the shadow Health Secretary said with regard to Worcestershire. I met colleagues from Worcestershire on Monday. A huge number of actions are now being taken, but we must say right up front that it is totally unacceptable for anyone to wait 35 hours on a trolley and that we expect the hospital to ensure that that does not happen again. There are plans in place to open additional bed capacity this week. We have already had capacity made available by Worcester Community Trust to support the flow. The trust has deployed its chief operating officer on the task of facilitating discharges. The trust is in special measures, so we have a big management change, and a new chief executive will be starting later on in the spring.

What is wrong with what the shadow Health Secretary has just said is the suggestion that winter problems are entirely unusual. As my right hon. and learned Friend the Member for Rushcliffe (Mr Clarke) said, the NHS had difficult winters in 1999, 2008, and 2009. He remembers difficult winters from his time as Health Secretary, but there are things that are different today. One of them is that, compared with six years ago, we have 340,000 more over-80s, many of whom are highly vulnerable or have dementia. We know that when people of that age go to an A&E at this time of year, there is an 80% chance that they will be admitted to hospital.

Derek Twigg: The Secretary of State talks about correcting the points that have been made so that the House has the right information. May I repeat the question that I asked him on Monday? What are the latest figures—he should have them up to this week—for the number of people who could be discharged but have to remain in hospital because there is no community support available for them? Can he give us that figure now? He said that he would write to me, but he must know that figure now.

Mr Hunt: Last year, on average, it involved around 7,000 beds, which is far too many. That is why the Secretary of State for Communities and Local Government announced in December a new package of support worth around £400 million—

Derek Twigg *rose—*

Mr Hunt: Let me answer the hon. Gentleman's question. I said that I would write to him, and I will do so. He may have noticed that there are other issues that we are dealing with, which is why I may not have had time to sign the letter. The £400 million extra for local authorities over the next two years will make a significant difference and he should recognise that.

Richard Fuller (Bedford) (Con): I am attending this debate because there will be constituents in Bedford and Kent who are concerned about the headlines that they have read. I am pleased that the Secretary of State will correct some of the points that have been made. What our constituents want to know is what is being done, or what should be done. I listened for 33 minutes to the shadow Secretary of State—the Labour spokesman on the NHS—on this issue, and there was not a single new idea other than spending money. Will my right hon. Friend please provide some practical answers to the problems that are being raised in the papers?

Mr Hunt: My hon. Friend is absolutely right, which is why I will be talking later about our solutions to these problems.

Several hon. Members *rose—*

Mr Hunt: I will give way, but first I want to make some progress.

I want to talk about something else that is different in our A&E departments today compared with six years ago. Although we are sticking to the four-hour target, we also insist on much higher standards of safety and quality.

On Monday, I congratulated Labour on the introduction of the four-hour target—I support it—but we should also remember that four years after that standard was introduced, we started to see some horrific problems at Mid Staffs, many of which were in the A&E department. Some were caused because people thought they would be fired if they missed the target. Robert Francis said that the failures at Mid Staffs were

“in part the consequence of allowing a focus on reaching national access targets.”

Therefore, although we retain targets, we will not allow them to be followed slavishly in a way that damages patient care.

Derek Twigg: Will the Secretary of State give way?

Mr Hunt: I have already given way to the hon. Gentleman. There are many other Members who want to intervene.

That is why we have a new inspection regime that makes it harder to cut corners in the way that used to happen when beds were not being washed, there was poor infection control and ambulances were being used as waiting rooms.

Toby Perkins: I am grateful to the Health Secretary for outlining some of the steps that he is taking in the face of this immediate emergency. Does he also recognise that the major cause of the problems in A&E is simply a lack of staff? Consequently, does he regret the huge cuts to training budgets in 2010, 2011 and 2012, which are having a real impact now on the number of nurses and doctors in our NHS?

Mr Hunt: I agree that staff numbers are critical, but we have, since 2010, 1,500 more doctors in our A&E departments and 600 more consultants. Across the NHS, we have more than 11,000 additional doctors, so we do recognise the pressures that the NHS faces. Indeed, we have 1,600 more doctors than this time last year, so we are doing a great deal to solve the problem.

Graham Evans (Weaver Vale) (Con): Does my right hon. Friend agree that we need to learn best practice in the NHS? The hospitals that manage to integrate health and social care, such as those in Wigan and Salford which have managed to create those beds, are providing examples of best practice from which the whole NHS can learn.

Mr Hunt: My hon. Friend is absolutely right. It is a mistake in this debate to try—as I understand Opposition parties want to do—to boil this all down to the issue of Government funding when there is actually a lot of variability in the country. At this time of year, which is always difficult, some hospitals are doing superbly well in extremely challenging circumstances. We have just heard about some of the hospitals that are doing well, and there are a number of them.

Several hon. Members *rose—*

Mr Hunt: I will give way to as many people as I can, but I also want to address the substantive points made by the shadow Health Secretary. He talked about the four-hour target. In his motion and his speech, he made

[Mr Jeremy Hunt]

the totally spurious suggestion that we are not committed to that target. I remind him what my right hon. Friend the former Chief Whip quoted me as saying on Monday. I did not just commit the Government to the target; I said that it was one of the best things that the NHS does. However, I also said that we need to find different ways to offer treatment to people who do not need to be in A&E. It is hardly rocket science. When there is pressure in A&E, it is sensible—indeed, I would argue that it is the duty of the Health Secretary—to suggest that people who can relieve pressure on A&E by using other facilities do so.

Henry Smith: Just yesterday at Crawley hospital, an acute care unit was opened, which is designed precisely to ensure that people who do not need to attend A&E are properly directed to the most appropriate care, which is good for them as individual patients and good for the whole system.

Mr Hunt: That is absolutely right. To back up my hon. Friend's point, yesterday's OECD report said that in Australia, Belgium, Canada, France, Italy and Portugal, at least 20% of A&E visits are inappropriate. NHS England's figure is up to 30%, which is why we need the public's help to relieve pressure and that is what I meant when I talked about an honest discussion.

Luciana Berger: The Secretary of State told us just a moment ago that there are now over 300,000 more people over the age of 80. Surely he would have known that information from census and Office for National Statistics data when his Government took over seven years ago, so why is it that we are now seeing on the front pages of our newspapers that one in four of our A&E wards is unsafe and that we have so many challenges across the country, including in my constituency?

Mr Hunt: We did know that information and that is why we thought it was totally irresponsible to want to cut the NHS budget in 2010, and not to back the NHS's own plan in 2015. As a result, we have 11,000 more doctors. In the hon. Lady's local hospital, 243 more people are being treated within four hours every single day.

Owen Smith (Pontypridd) (Lab) *rose*—

Mr Hunt: I will make some progress and then give way. I could have put what I said on Monday another way. I could have said:

"We have to persuade those people not in medical emergencies to use other parts of the system to get the help they need".

I did not actually say that, but I will tell the House who did. It was the then Labour Health Minister in Wales, Mark Drakeford, in January 2015. Frankly, when the NHS is under such pressure, it is totally irresponsible for the Labour party to criticise the Health Secretary in England for saying exactly the same thing that a Labour Health Minister in Wales also says.

Owen Smith: Will the Secretary of State give way to a Welshman?

Mr Hunt: I would be privileged and honoured to give way to a Welshman.

Owen Smith: The Secretary of State has sowed confusion in the House and in the country on this question this week, and he is doing so again today. If he is saying the same as my friend the former Health Minister in Wales—that we want to divert people who do not need to go to A&E from doing so—I am sure that everybody in this House would support him. But we suspect that he is saying that the four-hour wait target will be disappplied to some people turning up to A&E, and that that is the downgrading he is talking about. If that is the case, the Secretary of State should come clean, and he should be clear about whose job it will be to disapply the target to some people with minor ailments.

Mr Hunt: I did not say that because we are not going to do it. As we have had an intervention from a Welshman, let me tell the hon. Gentleman a rather inconvenient truth about what is happening in Wales. Last year, A&E performance in Wales was 10% lower than in England, and Wales has not hit the A&E target for eight years. We will not let that happen in England.

I noticed that the shadow Health Secretary quoted a number of people, but one that he did not quote was the Royal College of Emergency Medicine. I wonder whether that was because of what it said about Wales this week. It said:

"Emergency care in Wales is in a state of crisis...Performance is as bad, if not worse, as England, in some areas."

There we have it: in the areas in which Labour is in control, these problems are worse.

Several hon. Members *rose*—

Mr Hunt: Let me make my point. I do not say that to make a political point, but to show that it is patently ridiculous to try to play politics when there are winter pressures in the NHS. This happens in the whole NHS—in Wales as well as in England.

Several hon. Members *rose*—

Mr Hunt: I want to make some progress but I will give way to my hon. Friend the Member for Lewes (Maria Caulfield), who is a serving nurse.

Maria Caulfield: May I reiterate the Secretary of State's point about the four-hour target? During the Labour Government, I was working in the NHS. Significant pressure was put on us by managers to meet the four-hour target, negating clinical need. Patients were often prioritised according to meeting the target, rather than by clinical need. That was a disgrace.

Mr Hunt: That is exactly the problem we had with Mid Staffs. We had a culture in the NHS where people were hitting the target and missing the point. Although targets are important management tools in all organisations, it is important that they are followed in a sensible way that puts the interests of patients first.

Several hon. Members *rose*—

Mr Hunt: I would just like to make another point about Wales while we have the privilege of having someone here who aspired to lead the Labour party, as the current leader of the Labour party is no longer in his place.

Something that Wales and England have in common is the need to ensure that, if we want alternatives to A&E, people are able to see their GPs. I have said many times that people wait too long to see their GPs. In all honesty, I think that the GP contract changes in 2004 were a disaster. The result was that 90% of GPs opted out of out-of-hours care. But we have been putting that right. Now 17 million people in England—about 30% of the population—have access to weekend and evening GP appointments. More than that, we have committed to a 14% real-terms increase in the GP budget by the end of this Parliament. That is an extra £2.4 billion and we expect that to mean an extra 5,000 doctors working in general practice.

Margaret Greenwood (Wirral West) (Lab): I can see Wales from my constituency, to continue the theme. I received an email this morning from a very distressed senior NHS manager, who says:

“I truly despair that there will not be an NHS this time next year”—[*Interruption.*]

You need to listen on the Government Benches, and understand what your Secretary of State is doing to the health service. I will give a precis of what my constituent is talking about.

Madam Deputy Speaker (Natascha Engel): Order. The hon. Lady will resume her seat. First, when she says “you”, she is addressing the Chair. Secondly, she is making an intervention. There are 33 Members who wish to speak in this very important debate. If she can keep her intervention very brief, I will let her continue.

Margaret Greenwood: Apologies, Madam Deputy Speaker. I should not have used the word “you.”

My constituent has written to me saying:

“The NHS is in crisis, the government knows this, CCGs have failed, foundation trusts are failing. GPs are on their knees. So they’re”—

the Government—

“handing it back to local areas and saying, ‘you fix it, and by the way there’s no money.’ It’s a whole system reorganisation”, and there is no money.

Mr Hunt: All I would say is that I hope that people in the NHS do not listen too much to what the Labour party says about the state of the NHS and that they listen to what the Government are saying, which gives a much more accurate picture, as I will go on to explain.

Neil Coyle: Will the Secretary of State give way?

Mr Hunt: I will make some progress before giving way again.

The second part of the motion talks about funding. There is no doubt at all that we will need to look after 1 million more over-65s in five years’ time and we will need to continue to increase investment in the NHS and social care system. That is happening with an extra £3.8 billion going into the NHS this year. Can I just remind Labour Members that that is £1.3 billion more than they promised when they stood for election last year? I just say this: it is not enough to talk about extra funding—you have to actually deliver it. Labour Members have to answer to their constituents as to why, for two elections in a row, they have promised less money for

the NHS than the Conservatives, and why, in the one area where they are responsible for the NHS, they have cut funding.

Julian Knight (Solihull) (Con): The Secretary of State is taking exactly the right, measured tone, which was absent earlier in the debate. We recognise that many trusts are under financial pressures, but some of these situations are historic, and in my area they reflect very poor private finance initiative contracts, which were thrust on them in a Gordon Brown sleight of hand.

Mr Hunt: My hon. Friend is right. What we did not hear from the Labour party is that, in 2010, we inherited a £70 billion PFI overhang, which is making it incredibly difficult for hospitals to recruit enough staff, because they are having to pay so much money to financiers.

Victoria Atkins (Louth and Horncastle) (Con): An example of how we are spending money practically on the ground to make sure patients get a better deal is in Lincolnshire, where, because there is a shortage of GPs, the local health authority is offering £20,000 as a golden hello to new GPs. Is that not the way to manage resources, to attract the best medical talent into our areas and to help ensure that patients get the best care?

Mr Hunt: My hon. Friend is absolutely right, and I talked about these issues when I visited her in her constituency. The truth is that, to solve this problem, we are going to have to have a dramatic increase in the number of people working in general practice, which is why we are funding the second biggest increase in the number of GPs in the NHS’s history.

It is a great shame that the Leader of the Opposition is not here, because this is the bit that I wanted to address to him—his proposal to put extra funding into the NHS by scrapping the corporation tax cuts. That reveals, I am afraid, a fundamental misunderstanding of how we fund the NHS. Corporation taxes are being cut so that we can boost jobs, strengthen the economy and fund the NHS. The reason we have been able to protect and increase funding in the NHS in the last six years, when the Labour party was not willing to do so, is precisely that we have created 2 million jobs and given this country the fastest growing economy in the G7, and that is even more important post-Brexit. To risk that growth, which is what the Labour party’s proposal would do, would not just risk funding for the NHS, but be dangerous for the economy and mortally dangerous for the NHS.

Norman Lamb (North Norfolk) (LD): I just want to understand exactly what the Secretary of State was saying on Monday about the four-hour A&E target. Is it conceivable that some of the people who are currently within the A&E target will, at some stage, fall outside the A&E target?

Mr Hunt: I am committed to people using A&Es falling within the four-hour target, but I also think that we need to be much more effective at diverting people who do not need to go to A&E to other places, as is happening in Wales, as is happening in Scotland and which, frankly, is the only sensible thing to do.

[Mr Jeremy Hunt]

However, going back to the funding issue, I just want to make this point: for all the heat in this Chamber in debates on the NHS, probably the biggest difference between the two sides of the House is not on NHS policy but on the ability to deliver the strong economy that the NHS needs to give it the funding that it requires. I am afraid that the proposals in the motion today reveal that divide even more starkly.

Several hon. Members *rose*—

Mr Hunt: I will give way on funding one more time.

Mr Harper: We had the debate at the election about the need for a strong economy to pay for the NHS, and the public decided that the Conservative party won that argument. May I give my right hon. Friend another example, from yesterday, from his friend Jeremy—the Leader of the Opposition? He proposed to cap high pay, but the top 1% of taxpayers pay 27% of income tax revenues. That proposal would cut the funding available to the NHS and damage the services that hard-working members of staff produce.

Mr Hunt: My right hon. Friend is right. That is the worst kind of gesture politics, because it may get the Leader of the Opposition a few votes or a few more Momentum supporters, but it would damage the NHS.

Helen Whately: Does my right hon. Friend agree that Opposition Members, rather than making meaningless and totally unfunded promises of more money for the NHS, contrary to their manifesto back in 2015, would do better to recognise demographic changes, such as the ageing population, and the need for the NHS to change, and support the locally developed plans for change in the national health service—the sustainability and transformation plans?

Mr Hunt: My hon. Friend is absolutely right. I think people in the country will find it hugely ironic that the party that spent so much energy in the last Parliament campaigning against top-down reorganisations is now campaigning against locally driven changes.

Several hon. Members *rose*—

Mr Hunt: I will give way a couple more times, and then I am going to conclude my comments.

John Woodcock (Barrow and Furness) (Lab/Co-op): As the Government often point out, they want to hand decisions to local groups, but could the Secretary of State explain to worried patients in the south and west of Cumbria why local health services are suggesting the changes to A&E in the west and potentially the south? I know he has spent a lot of time looking at this area.

Mr Hunt: First, I would like to use this moment to congratulate the hon. Gentleman's local trust on coming out of special measures last year and on the progress it is making. In a way, that is the answer to his point. His local trust was in special measures, and North Cumbria is still in special measures. We had some profound worries about patient care in both trusts, and we still do in the North Cumbria trust. That is why the status quo

is not an option, but we understand the concerns of his constituents and many others about some of the proposals being made.

Catherine West (Hornsey and Wood Green) (Lab): What does the Secretary of State make of the talk among professionals at the moment about the potential for a flu epidemic? What does he make of the comments by the doctor who wrote to me on Sunday saying that she is extremely concerned that staff are too busy to isolate patients who are coming in—who need oxygen—so that others do not potentially catch flu?

Mr Hunt: There is a concern at the moment about a growth in respiratory infections, and that is causing capacity constraints. We are watching what is happening on flu very carefully, but we have a record 13 million people vaccinated against flu, and I hope that that will put the NHS in a good position.

Robert Jenrick (Newark) (Con): Money is of course important, but may I support the Health Secretary in not viewing these issues solely through that lens? My local trust, Sherwood Forest, which has some of the worst finances of any trust in the country—almost all due to a PFI deal signed by Gordon Brown—is actually improving. It is under pressure this winter, but the management have said it is definitely not in crisis. That is an example of a trust improving due to quality management, reform and good-quality processes.

Mr Hunt: That is absolutely the point, and the last point I want to make before concluding on funding is that we miss a trick—I think the shadow Health Secretary is in some ways more reasonable than his leader on these issues, which is probably terminal for his career—if we say that this is just about money. We forget the debate we went through on schools in this country 20 years ago, when there was, again, a debate about money, but we realised that the issue is actually also about standards and quality. That is what has happened in Sherwood Forest, and I congratulate the trust. It is important that we do not let debates about funding eclipse that very important progress that we need to make on standards.

Dr Tania Mathias (Twickenham) (Con) *rose*—

Mr Hunt: I am going to conclude now because lots of people want to come in, I am afraid.

The shadow Health Secretary's central claim—these are his words—was that the culpability for what is happening in the NHS “lies at the door of Downing Street”. I owe it to the country and this House to set the record straight on this Government's record on the NHS. It is not just the fact that there are 11,000 more nurses and 11,000 more doctors; not just the fact that, on cancer, we are starting treatment for 130 more people every single day, and have record cancer survival rates; not just the fact that we have 1,400 more people getting mental health treatment every day and some of the highest dementia diagnosis rates in the world; and not just the fact that we are doing 5,000 more operations every day and that, despite those 5,000 more operations every day, MRSA rates have halved. We have an NHS with more doctors and more nurses, and despite difficult winters, with patients saying they have never been treated more safely and with more dignity and more respect.

Next year the NHS will be 70 years old. This Government's vision is simple: we want it to offer the safest, highest quality care anywhere in the world. When we have difficult winters and an ageing population, of course that makes things more challenging, but it also makes us more determined. It means that we are backing the NHS's plan; it means more GPs and better mental health provision; and it means an NHS turning heads in the 21st century just as it did when it was founded in the 20th century.

2.40 pm

Dr Philippa Whitford (Central Ayrshire) (SNP): Here we are again debating the NHS. [*Interruption.*] I am all on my own because obviously this is predominantly a crisis in NHS England, not a crisis in NHS Scotland, as I will discuss as we go on.

The problem is that we are talking about patients who are suffering—who may suffer from more infections, as we have heard. We are talking about staff who are in tears and who are desperate, and who feel that they cannot deliver the care they would expect to deliver. This is not just a matter of isolated stories of “Joe from Wiltshire” and “Mike from Leeds”: it is happening on a major scale. We hear from NHS Improvement that only one trust out of 152 met the four-hour target in December, and only nine made it to over 90%. Fifty out of 152 trusts declared a black or red situation over December, and there were 158 diversions of ambulances over that time. This is not just about normal winter pressures. It is not what the hon. Member for Lewes (Maria Caulfield), who is an A&E nurse, and people like me and other medics in the Chamber have seen in our careers—it is a really bad winter. Yet we have not had bitter weather and we have not had a flu epidemic.

The most recent four-hour data were published in October, when NHS England managed to achieve the four-hour target for 83.7% of the time. That is 5% down on the same time in the previous year, and it compares with 93.9% in Scotland. Scotland managed 93.5% in Christmas week. We have our challenges in Scotland, but the crisis is not the same as what is being discussed here.

Sir Simon Burns (Chelmsford) (Con): Will the hon. Lady confirm, though, that throughout the whole of 2016, which includes winter, summer, autumn and spring, the Scottish Government's A&E target was met in only seven out of the 52 weeks?

Dr Whitford: I would be delighted to agree with that, but NHS England did not make it over 90% at any point in 2016, so perhaps the right hon. Gentleman might want to check the NHS England figures before having a punt at me.

NHS England is performing 8% to 10% lower than NHS Scotland, which has been the top performing of the nations for the past 19 months. We have not done that by magic. We face exactly the same ageing population, exactly the same increased demand and complexity, and exactly the same—indeed, often worse—shortages of doctors as NHS England does, because of our rurality. We are not using a different measure—we use exactly the same measure—but the data show that there is a significant difference, and it is being maintained.

The Secretary of State is right: winter is always challenging. Summer is often busier for attendances at A&E, because the kids are on the trampolines and people go out and do silly things, but hospitals are under pressure in winter because of the nature of admissions—the people who go to A&E are sicker, older and more complicated. However, we have not seen any summer respite in NHS England. The worst performance in the summer was 80.8%; the best was 86.4%. NHS England is under pressure in the summer, and when winter is added on top of that, it is no wonder that we are talking about the situations that doctors, nurses, patients and relatives are describing to us.

My first health debate after my maiden speech in this House was an Opposition day debate on the four-hour target. At the time, I commented, and still maintain, that this target is not a stick for each party to hit each other over the head with, but it is a thermometer to take the temperature of the acute service, and it does that really well, because it measures not just people coming in through the front door but how they are moving through the hospital and out the other end. At the moment, the system is completely overheated. The comments about this not being anything unusual but just a normal winter, and everyone whingeing, show that the Government are not recognising the problem. The first step to dealing with any problem is to recognise it, because then we can look at how we want to tackle it.

Victoria Atkins: I remind the hon. Lady of the point the Prime Minister made in Prime Minister's questions, which is that on the Tuesday after Christmas, A&E received the highest number of visitors it has ever received in its history. Does that not show the challenges facing the NHS both nationally and locally? These are extraordinary figures, and the Secretary of State is very much doing his best to help the NHS, with the professionals, to deal with them.

Dr Whitford: I totally accept that the NHS has been under inordinate pressure with, absolutely, the busiest day in its history, but given an ageing population that has been discussed for years, we should have been able to see this coming.

If, in the next couple of months, we get a massive flu epidemic, we are going to see things keel over. We have already had debates in this Chamber about STPs taking more beds away. I totally agree with the Secretary of State that part of the issue is that patients could be seen somewhere else. However, it is not a matter of changing the four-hour target and saying to someone who turns up, “You're not going to count;” it is simply a matter of providing better alternatives. If we provide better alternatives, people will go to them. The House has discussed community pharmacy use, and it has been recognised that the minor ailments services we have in Scotland can deal with 5% to 10% of those patients. We have co-located out-of-hours GP units beside our A&Es, so someone is very easily sent along the corridor or into the next-door building if they need a GP and not A&E. We do need to educate the public, but the public will use an alternative service if it is there. If it is not, they know that if they turn up at A&E and just keep sitting there, eventually someone will see them, and we should not blame them for that.

Toby Perkins: The hon. Lady is right to say that we have an ageing population but that is predictable. Does she think it is also significant that in 2008 the UK was spending about the same as all the major EU nations, whereas the OECD now says that we are spending considerably less than most of the other major nations? Is that not actually causing this problem?

Dr Whitford: Money is not the only problem. I accept that part of it is about how things are done. The Secretary of State talks about variations and many hospitals performing well, but, as I said, only one trust is meeting the target and only nine are at over 90%, so it is not that the majority are doing well and a few are failing.

The ability to look at how we deliver the NHS is crucial, but change costs money. We must therefore invest in our alternatives so that our community services and primary care services can step up and step down to take the pressure off. One of the concerns about the STPs is that because people do not have enough money, a lot of them start by thinking that they will shut an A&E, shut a couple of wards, or shut community beds—even though those are what we need more of—to fund change in primary and social care. Then the system will fall over. We need to have double running and develop our alternatives and then we will gradually be able to send the patients there.

Dr Andrew Murrison (South West Wiltshire) (Con): I always enjoy listening to the hon. Lady's well-informed remarks. I agree that most people do not want to go to A&E if they can avoid it. Does she agree that part of the problem is that when people phone general practices, they tend not to be offered an appointment that they regard as being within a reasonable timeframe, or they cannot get to see the doctor with whom they are closely associated, which particularly applies to people with chronic and long-term conditions? As today's National Audit Office report makes clear, we need to address that as a matter of urgency. Paradoxically, seven-day-a-week general practice may militate against being able to provide people with such continuity of care during core hours.

Dr Whitford: Many doctors in general practice would accept the argument for having access to a GP on Saturday morning, particularly for people who are otherwise at work. However, someone who cannot see their favourite doctor is very unlikely to go to A&E and wait eight hours to see a doctor they have never seen before in their life. This is not about that; this is about the fact that people feel they cannot find an alternative. If it takes three or four weeks to get any appointment with their GP and they do not yet have a community pharmacy offering such a service, they will eventually end up at A&E. It is therefore the service of last resort for people who go there and just stay there. We have to develop alternatives first, but as the hon. Gentleman says, no one in their right mind would choose to go and wait four hours in A&E if they could be seen in half an hour in a community pharmacy.

Dr Murrison: The hon. Lady is being very generous in giving way. I have to disagree with her, because winter pressures and the pressures we are seeing at the moment tend to involve not people with short-term, self-limiting

conditions, but the chronically sick. Those people in particular, and with good reason, want to have a relationship with a particular practitioner who understands their needs and their family context. That is surely the essence of general practice.

Dr Whitford: I totally agree, but in fact the chance that their doctor will be on duty would actually be lower on a Saturday morning or a Sunday afternoon. One of the things we have done in Scotland with SPARRA—Scottish patients at risk of readmission and admission—data is to identify that 40% of admissions involve 5% of the patients. Those patients are all automatically flagged and will get a double appointment no matter what they ring up about, because it will not just be a case of a chest infection or a urine infection, but of having to look at all their other comorbidities.

That is the challenge we face; it is not a catastrophe of people living longer. All of us in the House with a medical background will remember that that was definitely the point of why we went into medicine, and it is the point of the NHS. However, we are not ageing very well. From about 40 or 50 onwards, people start to accumulate conditions that they may not have survived in the past, so that by the time they are 70 they have four or five comorbidities that make it a challenge to treat even something quite simple. My colleagues and friends who are still working on the frontline say that it is a question not just of numbers, but of complexity. Someone may come in with what sounds like an easy issue, but given their diabetes, renal failure and previous heart attack, it is in fact a complex issue.

That is part of the problem we face, and we need to look forward to prepare for it. We need to think about designing STPs around older people, not around young people who can come in and have an operation as a day case and then go away, because that is not what we are facing. Older people need longer in hospital, even medically, before they reach the point of being able to go home. It takes them a couple of days longer to be strong enough to do so. They probably live alone and do not have family near them, so they will need a degree of convalescent support and they may need social care. That is really where the nub of the problem lies. Social care funding has gone down, and therefore more people are stuck in hospital or more people end up in hospital who did not actually need to be there in the first place.

Andrew Selous (South West Bedfordshire) (Con): On the frailties of older people, does the hon. Lady think that just as Scotland led the way with St Ninian's primary school in Stirling introducing the daily mile, there is something we could learn from countries, such as Andorra, that have a real focus on exercise for older people, so that they are a lot less frail in their 70s and 80s?

Dr Whitford: The whole prevention and public health message is crucial, and that is one of our other challenges. I am very grateful to the Secretary of State for no longer talking about a figure of £10 billion, because the increase in the Department of Health's budget is actually £4.5 billion. Part of that relates to the reduction in public health funding, just at a time when we need to move it on to a totally different scale. Whether that is children or, indeed, adults doing the daily mile—perhaps we should run up

to Trafalgar Square and back every lunchtime, which I am sure would do us all a power of good—we need to invest in such preventive measures. One of my points is that when we end up desperate—patching up how the NHS runs, or dealing with illnesses we did not bother to prevent—we always end up spending more money.

Graham Evans: The hon. Lady knows how much I respect her and what she says. As the chairman of the all-party group on running, I endorse the daily mile and encourage all adults to do it. Park runs, which happen across the nation, are a good example. There is huge expertise in Scotland, so can NHS England learn from Scotland? What is best practice, and will she give us some examples of it in hospitals and hospital trusts in Scotland that we can take away and learn from?

Dr Whitford: The whole issue comes down to sustainability, which is obviously the idea behind the sustainability and transformation plans. As those who have heard me speak about STPs will know, I support the idea in principle. The idea is to go back to place-based planning on an integrated basis for a community. The difference in Scotland is that we have focused on integration. We got rid of hospital trusts in 2004, and we got rid of primary care trusts in the late 2000s—in 2009 or 2010. Since April 2014, we have set up integration joint boards, where a bag of money from the NHS and a bag of money from the local authority are put on the table and a group sit around it and work out the best way to deal with the interface and to support social care. Anyone in the Chamber or elsewhere with family members who have been stuck in hospital will know that people get into a bickering situation: Mrs Bloggs is in a bed so the local authority is not interested, because she is safe there, and the local authority is instead busy with Mrs Smith, who has fallen off a ladder trying to put up her curtains and who is not considered safe because she is leaving the gas on. Such boards get rid of all that perverse obstruction.

David Rutley (Macclesfield) (Con): The hon. Lady is making an important point, and I welcome the tone that she, unlike the shadow Secretary of State, has brought to this debate. She makes the point that the integration of care—social and health—is important, but does she agree that, with further devolution to the sub-regions and major cities in England, there is a huge opportunity to move forward that agenda south of the border?

Dr Whitford: The whole idea of STPs is to go back to areas. We simply have geographical health boards—the only layer we have—so we are not wasting huge amounts of money on having layers and layers, which could be integrated. For an STP to work it must make sense geographically, which might be a county or something bigger or smaller. I think that they should be put on a statutory footing. We have 211 CCGs. There will be an average of six CCGs for every STP, so that is a waste of layers, and it will be very difficult to integrate.

One of the biggest differences is that, in 2004, we got rid of the purchaser-provider split. In the past 25 years, there has been no evidence of any clinical benefit from the purchaser-provider split, the internal market or, as it now is, the external market. It is estimated that the costs of running that market are between

£5 billion and £10 billion a year. That money does not actually go to healthcare, but on bidding, tendering, administration or profits. We cannot have an overnight change, but if we simply made a principled decision to work our way back to having the NHS as the main provider of public health treatment and to integrate care through the STPs, we could reach a point of sustainability.

As I said earlier, we must protect things such as community hospitals and community services and, indeed, invest in them. Our health board has rebuilt three cottage hospitals as modern hospitals, because that is where we should put an older person who is on their own and has a chest infection, who just needs a few days of antibiotics, TLC and decent feeding. We do not want them in big acute hospitals; we want them to be close to home. The danger is that under the STPs people will see community hospitals as easy to get rid of, but that is an efficiency saving only if it gets rid of inefficiency. If we slash and burn, we will end up spending more money in the end.

Victoria Prentis (Banbury) (Con): Much of what the hon. Lady says is music to my ears as somebody who is campaigning to save their local general hospital. May we have the benefit of her views on the role of consultation with patients and the wider community when sustainability and transformation plans are being considered?

Dr Whitford: Public consultation is important, and not just in the way it has often been done in the past—“We’ve made a decision, it’s a fait accompli, and we’re coming and telling you about it.” Unfortunately, that is very much what we have heard about the STP process, partly because it has been so short and partly, I am afraid, because it is about budget-centred care, not patient-centred care. Areas have been given a number and told, “If you’re not reaching this number, don’t bother submitting your plan,” and they are working back from that. That will not achieve an efficient, integrated service, so the public must be involved.

Frontline clinicians must also be involved. They work in a service and know exactly what the bottlenecks are and exactly what horseshoe nail is missing and holding a service back. If we have clinician-led redesign, such as I was involved in for breast cancer in my health board 17 years ago, we can track a patient’s path. We can quickly imagine ourselves as a patient, see the bottlenecks and focus investment on them.

I read an article yesterday stating that three hospitals in Manchester have spent £6 million on management consultants to say, “Shut a ward, sack hundreds of people and jack up the parking charges.” I am sorry, but that was not good value for £2 million each.

Jo Churchill (Bury St Edmunds) (Con): I thank the hon. Lady for, as ever, eloquently expressing issues that face us all, no matter where we come from and who we are. Does she agree that having good healthcare data for clinicians enables patients to be put through the system seamlessly? Many individuals do not realise that their data do not go from their GP into acute care and then back into social care. If we could improve that—I make a plug for my private Member’s Bill on Friday—it would help patients.

Dr Whitford: I would not say that we are super IT wizards in Scotland, but we did not get involved in care.data, which unfortunately is a black shadow over the whole issue of NHS data in England, and now all our referrals are electronic, so nothing goes in the post. All our letters back are also electronic—I dock my dictation machine during a clinic, and when I finish I sit and check it, and the letters go off. After a Friday morning bad news clinic, the letters are on their way by 2 o'clock. A GP can email my colleagues and say, "I don't know whether you need to see this person." I have heard clinicians here in England say, "No, we can't email about a patient." Unfortunately, the wrong move that was made on care.data has ended up holding people back.

Our GPs in Scotland use a care summary. If they have a palliative care patient who has been accepted as being in terminal care, that patient's care summary will be put on the out-of-hours system. If there is a call about the person, the doctor who goes to see them knows that they will not be throwing them in an ambulance but will be keeping them comfortable. The discussion has already been had, and the aim is for them to be at home. England has to gain the ability not just to analyse data at a later point but to share information as a first step.

In finishing off my speech—*[Interruption.]* I am sorry if I was taking too long for an hon. Lady at the back of the Opposition Benches. Integration is the key, and it is possible to get it through the STPs—but only if they are designed around patients, safety and services, rather than just starting with the bottom line and working backwards.

Several hon. Members *rose*—

Madam Deputy Speaker (Mrs Eleanor Laing): Order. Before I call the next speaker, it will be obvious to colleagues that a great many Members wish to speak this afternoon and that although the debate has advanced a long way in time, it has not advanced very far in the number of Members called. We therefore now have to have a time limit of 10 minutes. *[Interruption.]* I can see that there is some surprise about that; it is 10 minutes for the moment, but anyone who can do any arithmetic will be aware that it will have to be reduced later, so I suggest that Members start working on their speeches now.

3.5 pm

Dr Sarah Wollaston (Totnes) (Con): I will try to be mindful of those comments, Madam Deputy Speaker, as I follow the hon. Member for Central Ayrshire (Dr Whitford), my colleague on the Health Committee. As always, she made thoughtful and thought-provoking comments, and I would like to endorse her points and expand on some of them.

First, I thank NHS and care staff. We have heard that they are facing unprecedented demand over the winter, but it is not just winter pressures that they face now—the pressures extend into the summer. As we have heard, that is not just about numbers but about the complexity of conditions and the frailty of those presenting in our accident and emergency departments. The Health Committee heard in its recent inquiry that the trusts that are most successful in getting close to the four-hour

target are those that see it as an entire-system issue, and in which both health and care staff contribute to the effort, not as a tick-box exercise but because they recognise that it is fundamentally about patient safety and the quality of patients' experiences. That is why the four-hour target matters, and the Secretary of State is right to endorse it.

The Secretary of State is also right that we sometimes need to be more nuanced about our targets and that he needs to be open to listening to what clinicians are telling him about how we can improve the way in which targets are applied. It would be a great shame if we in this House prevented those sensible discussions from taking place because of political furore. I urge him to continue to have them and to take advice and listen to clinicians about how we can improve the use of targets, but he is absolutely right in being clear that he will keep the four-hour target.

We must talk about this as a whole-system issue. Accident and emergency is a barometer of wider system pressures, as has been pointed out, and I want to focus my remarks on the integration of health and social care.

I agree with colleagues throughout the House who have called for a convention on reviewing funding as a whole-system issue. We have heard that next year is the 70th birthday of the NHS, and what could be a better present than politicians changing the debate and the way in which we talk about the funding of health and social care, so that we do so in a collaborative manner that works towards the right solution for our patients? The consequences of our not doing that would be profound for our constituents, who would not thank us for not being prepared to put aside party differences and work towards the right solution.

Ultimately, this issue is about a demographic change that we are simply not preparing for adequately. In the case of the pension age, we recognised that there had to be a different debate given the change in longevity. Over the decade to 2015, we saw a 31% increase in the number of people living to 85 and older. Of course, that is a cause for celebration, but there has not been a matching increase in disease-free life expectancy.

I welcome the Prime Minister's focus on tackling inequality, but unfortunately we are not making sufficient progress on that, either. In her very first speech in the job, she talked about tackling the "burning injustice" of health inequality. We in this House have a role in doing that together in a consensual manner.

Norman Lamb: I very much agree with the hon. Lady. Does she share my welcome for the Prime Minister's response today in which she stated that she was prepared to meet us and other Members of Parliament from across the House and my hope that it might start a more constructive approach?

Dr Wollaston: Absolutely. It was extraordinarily encouraging to hear the Prime Minister say that she was prepared to consider that and to meet Members from across the House. I urge colleagues who feel that this is a better way forward to sign up to it, speak to their party Whips and make it clear that it has widespread support.

Barbara Keeley (Worsley and Eccles South) (Lab): I wonder, on this vital issue, whether the hon. Lady wants to say something about what her own party did on the

two previous times we tried to get important cross-party working on health and social care: it made it an election issue, producing posters about a “death tax”; and on the second occasion the Secretary of State just walked away from the talks.

Dr Wollaston: I am afraid that that intervention is exactly not the kind of debate we want to be having. Let us look to the future. We are in a different part of the electoral cycle. I accept the hon. Lady’s comments—I was still an NHS clinician when that happened and, like many of those working in health or social care, I looked at the yah-boo debate in this place and thought that surely there had to be a better way—but I ask her to put them aside and to look to the future rather than backwards, otherwise we will not get anywhere. I think our constituents want us, as politicians, to recognise the scale of the challenge and to get to grips with it.

Mr Jim Cunningham (Coventry South) (Lab): Looking to the future, does the hon. Lady not agree that there should be a new funding settlement for the NHS and social care budgets that brings both together? At the moment, there have been cuts of £4.6 billion.

Dr Wollaston: That is exactly what I am hoping. We must end the silos of health and social care. We should stop thinking about money as a social care pound or a health pound, and instead think about a patient pound and a taxpayer pound, and how we get the very best from that.

That brings me on to a point I would like to raise directly with the Secretary of State. There is an example of where this has happened: in my constituency, Torbay and South Devon NHS Foundation Trust has formed an ICO—an integrated care organisation. Across health and care, passionate people recognised the benefits and sweated blood to get the organisation off the ground. Torbay’s integration is talked about not just nationally but internationally as a recognised way of doing this better. I regret to say, however, that because of the scale of the financial pressure on the ICO, we are now hearing that next year the NHS will be pulling out of the risk-sharing agreement.

That is totally unacceptable. I hope the Secretary of State will meet me to discuss the pressures facing the ICO, which has achieved exactly what we are talking about in this debate. It is able to pool finances better through risk sharing and to work together to get people out of hospital who do not need to be there more rapidly than happens in other areas. It can put people from social care into hospitals to see how we can speed up that process. Unfortunately, if that risk-share falls apart, one of the key pillars of how we want to improve the flow through hospitals and out the other end will break down. Part of the reason, as I understand it, is that unless the control totals are met the funding it hopes to use to improve the facilities in the A&E department will be at risk. The challenge for Torbay is not how it works together to get people out of hospital; it is the facilities at the front door, and it could do so much to improve the facilities. We have the odd paradox whereby we could end up improving A&E infrastructure but worsening the ability of the system to respond at the point where we are trying to get people cared for in the community.

A certain degree of financial challenge can have the effect of bringing health and social care organisations to work more closely together because they know it makes sense, but when unrealistic targets are set it can go the other way. It can start to mean that people have to retreat to protect their budget silos. I hope that the Secretary of State will look closely at what is happening and meet me to discuss whether we cannot just get this back on track for next year. I am confident that the local authority and the NHS staff across the CCG and the provider trust will continue to work together—they have an extraordinary tradition of doing so—but there are threats, which I hope can be addressed. This is about the entire flow from the front door right the way through to getting people cared for back at home.

More widely, we now have more than 1 million people in communities who are unable to receive the care they need. Mears, the prime provider in my area, is in special measures. These are financial issues. Yes, there is much that the NHS can do that is not about money—we know there is a lot of variation that cannot be explained by financial challenge and demographic changes alone—but finance and the workforce inevitably are the key challenges we have to face, and we have to work together across all political parties to resolve them.

In closing, I would like to raise with the Secretary of State the front page of today’s *Times*, which is extraordinarily disappointing. This is the second time a major national newspaper has reported briefing against the chief executive of the NHS, Simon Stevens. I invite the Secretary of State or the Minister closing the debate unequivocally to support the chief executive of the NHS. When the chief executive appears before the Health Committee and I, as the Chair of the Committee, ask him to respond to questions, I expect him to be truthful and transparent in his answers. He should be commended for doing so and not find himself the subject of negative briefings. I therefore invite the Minister unequivocally to support him and ask for this to stop.

3.16 pm

Dame Rosie Winterton (Doncaster Central) (Lab): The debate so far has shown the huge level of concern from the public and NHS staff about the crisis in the NHS and social care. The hon. Member for Totnes (Dr Wollaston) reflected some of the views of the Select Committee, but I ask all Government Members to take those concerns seriously and not to dismiss them. All hon. Members must surely be receiving representations from staff and patients about what is happening locally.

I want to pay tribute to all the health and social care staff in Doncaster, in particular those at Doncaster royal infirmary whose work I have seen at first hand. I know how dedicated and committed they are to caring for patients in these most difficult of circumstances. At the end of December, they had managed to achieve 90% against the 95% target and had good ambulance handover times, as well as good support from the council and community partners, but they are facing real pressures and they are fearful about the pressures still to come, especially if, as predicted, there is a cold spell. That is why the mixed messages from the Secretary of State have been extremely damaging.

I was a Health Minister for four years and had responsibility for emergency care. I know how important it is to work with NHS staff to help to implement

[*Dame Rosie Winterton*]

targets, and not to give the impression that the NHS is somehow giving up on those targets. The lead from the top is incredibly important. There has always been controversy about targets, but as a Health Minister I visited many, many A&E departments. There is absolutely no doubt in my mind that the A&E target led to improved care for patients and that it reduced waiting times dramatically. The evidence is clear: it shows that that is what happened. One striking thing about those visits was seeing how consultants, nurses, ambulance teams and all members of the healthcare team worked together. For example, they would work out protocols so that emergency nurse practitioners could take over some of the work previously done by consultants, to ease the burden and share the work among the team. Triaging—seeing who needed urgent treatment by a consultant and who could be seen by a nurse practitioner—became the norm.

I would ask staff, “Is the target getting in the way, or is it helping?”, and invariably the answer would come back, “It helps us to work together more effectively.” I vividly remember a nurse practitioner saying, “Please don’t abandon the target, because it is making the consultants sit down with us and look at the whole team.” For patients, the difference was crucial, as it was for practitioners’ working lives, because they were not having to see patients who had been sitting around for hours and were feeling thoroughly depressed and demoralised. That made a difference to the healthcare team as well, because it improved their working life as well as patient care.

Dr Murrison: Does the right hon. Lady agree that it is not so much meeting the target that is important as getting patients seen expeditiously and well? There is not an A&E department in this country that does not want to improve its position in the league table of response times. The difference that now applies, and which perhaps did not apply quite so much when she was a Minister, is that the level of informatics and comparison is much improved. I suggest to her, ever so gently, that while the four-hour target was important when she was a Minister, its importance has degraded over time, because everybody is trying to see patients more quickly.

Dame Rosie Winterton: I do not agree with the hon. Gentleman. The four-hour target led to much better diagnoses and much improved provision of the type of treatment that people needed, as well as better interaction with communities. And I want to come on to that point because the Secretary of State has been trying—perhaps the hon. Gentleman is guilty of this as well—to separate the target for A&E departments from what happens outside, whereas I see the importance of putting the two together. Providing alternative treatment, which is perhaps part of what the hon. Gentleman was getting at, means having proper support in the community. It was bringing those two things together that made it possible to achieve the target, so it was a driver.

Maria Caulfield: Will the right hon. Lady give way?

Dame Rosie Winterton: I give way to the hon. Lady, who I know has some experience of this.

Maria Caulfield: In my experience of trying to meet the four-hour target, it is often—or was in the past—prioritised over everything else, including patient care and clinical need. It was sometimes abused, with huge pressure put on staff to meet the target, and as a result patient care suffered. I saw that myself.

Dame Rosie Winterton: It is always important to look at the feedback from clinicians, and I did that as a Health Minister. It started during my time as a Minister, and I remember that we had constantly to consider whether there was a clinical reason for reducing the 95% target. It became clear that some patients needed longer to be assessed owing to their particular condition. In such cases, I could see why the target might need to be reduced, but that was based on clinical need. By contrast, the impression given last week was, “My goodness! We’re going to have to cope with some winter pressures. Let’s reduce the target in order to meet it,” rather than there being an assessment of clinical need. That sent completely the wrong message to the NHS. I think it was the wrong thing to do.

I want briefly to set out some areas in which we can bring the community input together with what is happening in emergency departments to reduce some of the pressures. The first point was that made by my hon. Friend the Member for Leicester South (Jonathan Ashworth), who spoke from the Front Bench. Good social care is vital to ensuring that people do not end up in A&E. I have previously raised problems with the Government’s current proposition to, in a sense, move responsibility for raising money to local councils. That is particularly unfair in areas such as mine, which simply cannot raise the same amount of money through a council precept as better-off areas can. It simply does not work. We need it probably more than any other area, but we will be less able to raise the money.

On shortages, I have been talking to senior NHS staff in Doncaster, and there are real problems with emergency care staffing. They tell me that although more doctors are being trained—I accept that—it will take years for them to come through. The single most effective step we can take to ease pressure on A&E departments is immediately to increase funding for social care, because it would keep people out of A&E departments, and it could be done straightaway. The personnel are out there; the Government just need to increase the funding, as my hon. Friend said from the Front Bench.

We also have to look seriously at the problem of GP shortages. As others have said, if patients are waiting three weeks to get an appointment with a GP, they are bound to end up in A&E. This needs to be addressed very quickly, with proper forward looks at exactly where the gaps are in GP services. I have said before that PCTs—now clinical commissioning groups—or NHS England should be able to take over practices and employ salaried GPs. That would make a huge difference.

Furthermore, on community pharmacies, if people are confident that going to a pharmacy will save them a visit to A&E, again that will relieve pressure on the system. I hope, therefore, that the Minister will assure us that he is looking seriously at the community pharmacy forward view, which sets out how pharmacies can be integrated into the NHS and social care.

Briefly on mental health, the Prime Minister answered a question today about mental health and the crises that people can get into, which mean that they end up in

A&E. She talked, in particular, about young people. I urge the Minister to consider the role that educational psychologists can play in children's mental health and in keeping them out of A&E.

It was my experience as a Health Minister that we needed people on the ground locally to help organisations across the spectrum—local government through to social care, pharmacies, GPs and ambulances—to work with A&E departments, yet the £2 billion reorganisation that removed PCTs and strategic health authorities has made it much more difficult to drive through the necessary changes. I hope, therefore, that the Minister will look very seriously at what has happened, because local knowledge can be vital.

On the basis of the Secretary of State's contributions, it seemed that he was trying to use every excuse not to face up to the reality of what is happening. I think that sends a terrible message to NHS staff. I hope that, as a result of today's debate, the concerns raised will be taken on board by Ministers and the Secretary of State and that they will come back to us with a proper plan that recognises the problems and offers real solutions.

Several hon. Members *rose*—

Madam Deputy Speaker (Mrs Eleanor Laing): Order. The House was right to assume that 10 minutes per person is unsustainable. After the next speaker, I shall reduce the time limit to seven minutes. The House will be glad to know, however, that the time limit remains 10 minutes for Sir Simon Burns.

3.29 pm

Sir Simon Burns (Chelmsford) (Con): Thank you very much, Madam Deputy Speaker.

I certainly welcome today's debate and the opportunity to discuss an issue that is extremely important to all hon. Members in all parts of the House. During recent weeks, there has been a significant problem because of the increasing number of people needing services at A&E and from local health services. I would like to pay tribute to the magnificent work, often in very difficult circumstances, that doctors, nurses, consultants, ancillary staff and people in general practice carry out on a day-to-day basis—not simply during a winter crisis period, but throughout the year—looking after people to the best of their abilities.

My own hospital, Broomfield hospital in Chelmsford, is doing a fantastic job, in difficult circumstances, to provide the best possible care in good times and in more difficult times. As a constituency MP, I am certainly aware that there have been some problems for some of my constituents over the last week or so, because of the demand and the pressure.

We have to look at what we can do to move forward in a positive—not a partisan, politicised—way to make sure that our constituents get the best treatments possible. There is no point in just shouting. As the Chair of the Health Select Committee, my hon. Friend the Member for Totnes (Dr Wollaston), said, it is no good engaging in yah-boo politics. We have to be mature and come up with sensible suggestions.

Funding is, of course, a key issue. I am extremely proud of this Government's record and commitment to funding the NHS over the last seven years and their

commitments for the next three to four years. We made sure when we came into office, at a time of austerity when Departments' budgets were cut, that the Health Department's budget was one of the few to be protected, so that we got a real-terms increase in funding every year we were in power—albeit, I accept, a modest real-terms increase. It nevertheless showed our commitment and our intent to invest in improving the national health service.

I am also proud of the fact that I and all my right hon. and hon. Friends fought the last general election on a commitment that over the five-year period of this Parliament, we were going to increase NHS funding substantially—to what has turned out to be to the tune of £10 billion. That is more, I say in a very gentle way, than was on offer to the country from certain other parties. I am pleased, too, that my right hon. Friend the Secretary of State and the Minister of State have been planning for any potential strains of demand during this winter period with the provision of £400 million to local health economies and other measures such as the vaccination programme, a preventive health measure that has got a record number of 13 million people vaccinated to try to offset some of the potential health problems that can flow during a winter period. That is using foresight and planning to try to minimise problems, while at the same time providing funding to back up their actions. That is what a responsible Department of Health should do and has done.

Now, people can demand as much money as they like for the health service, but my argument is this. Yes, the health service does need extra money—year in, year out—but it should not just be thrown at an issue. A far bigger part of the equation is building on the performance, standards and quality of care that the health service will provide to our constituents.

Dr Mathias: I entirely agree with what my right hon. Friend is saying about the increased resources, but does he not agree with me that we now need more resources for integrated health and social care and that this is the time to stop using the NHS as a political football and engage in a cross-party review?

Sir Simon Burns: I certainly agree that, under the leadership of the Department of Health, we should work with anyone and everyone to come up with a solution.

I was the Social Care Minister in the late 1990s, before we left office. Integrating health and social care was then at a very early, formative stage, and the ambitions were immense and tremendous. I am afraid that the reality has not matched the ambitious nature of what was being said in the 1990s, which is why I was particularly interested by the comments of my hon. Friend the Member for Totnes. Yes, we must think about that, but what we must also think about—let me push the funding element to one side for the moment—is building on the work of my right hon. Friend the Secretary of State for Health, particularly his investment in patient safety, the raising of standards, dignity for patients in our hospitals and throughout the health system, and the cutting out of waste and inefficiencies.

In 2010, when I was at the Department of Health for the second time, we had the Nicholson challenge, which was to save £20 billion over three or four years by

[Sir Simon Burns]

cutting out waste and sharing best practice to improve the quality of care. I know from a debate that we had just before Christmas that the NHS achieved £19.4 billion of those savings. The beauty of that was not just that it created greater effectiveness and efficiency in the delivery of healthcare and the sharing of best practice, but that the Treasury did not receive £19.4 billion with which it could do as it wished. The £19.4 billion was reinvested in patient care.

Dr Whitford: Was not a significant proportion of that saving due to wage freezes for NHS medical and nursing staff? That is not something that can easily be repeated.

Sir Simon Burns: The hon. Lady is absolutely right. There was a wage freeze for those who were earning more than £20,000 a year, but that was in keeping with the policy throughout the public sector, which included Ministers and other Members of Parliament.

The important point is that it was possible to achieve that saving by a variety of means. One of them was a pay freeze, but others were improving the delivery of service, cutting out inefficiencies and ineffective ways of operating and getting rid of nearly 20,000 surplus managers, so that the NHS could concentrate on enabling clinicians, nurses, ancillary workers and everyone else to work on patient care. That is the right way forward, and we cannot give up on it. We must continue to think about where we can make savings.

Dr Murrison: Will my right hon. Friend give way?

Sir Simon Burns: I am afraid not, because I am about to finish.

Much has been said about the STP programme. We have an STP in Mid and South Essex, and I strongly support it, because it is completely focused on improving and enhancing the quality of accident and emergency care. What annoys me is that people wish to politicise it for grubby political reasons. [Interruption.] Funnily enough, I am not talking about Opposition Members.

Our STP involves three hospitals with three A&E departments. Not one of those departments is to be closed under the proposals, yet as soon as they were published, and on the assumption—correct, I suspect—that most people had not read them, word went out that my local A&E department was to be closed down by the Department of Health because of this nasty Government's proposals to save money. The exact opposite was the case. If one read the document, one could see that all three A&Es are remaining open.

What will happen is building on what happens now. If someone has a heart attack, they are immediately taken to Basildon hospital, because that is the specialist for cardiothoracic treatment. If someone needs treatment for burns or plastic surgery, they come to Broomfield hospital in Chelmsford, because it has one of the finest units in the whole of Europe. If someone has a head injury, they will go down to Romford in the east of London, because that is the specialist area for people with head injuries. If I had any of those conditions, I would want—and I would want for my constituents—the best possible treatment from the best experts available. That is what is happening and that is going to be built on, enhanced and improved. That is an improvement.

That is not a cut; that is not taking away services from local communities. Those people who have an agenda and want to play politics will tell people anything in the hope that they believe it, or to frighten them by trying to discredit the work of the NHS.

I am pleased we have had the opportunity to discuss this matter. It is very tricky, and there is no simple answer—what is happening is not unique; we frequently have winter crises, particularly because of the ageing population and the increasing demands on health services in recent years—but we must not lose sight of the fact that we have an NHS and a Government who are determined to improve further and enhance the quality of care and the safety and standards of care for all our constituents, aided and abetted by a first-class workforce who are often working under very difficult circumstances.

3.41 pm

Mrs Louise Ellman (Liverpool, Riverside) (Lab/Co-op): It is important to talk more widely about the NHS—about its importance and its funding and perhaps about its organisation, too—but the purpose of today's debate is to highlight the current crisis in many parts of our national health service and to ask the Government to do something about it.

Our national health service is undoubtedly highly valued, has dedicated staff and provides excellent services. In many parts of the country it is under pressure, however, and today's debate calls for specific actions to address that crisis. It calls for more funding for social care now, and for an improved settlement for both the NHS and social care in the next Budget. So in our general discussion about how things might be reorganised and changed in the future it is important not to lose focus on the current problems, and those are the reasons for today's debate.

There has been a lot of discussion about what is happening in hospitals—that will inevitably be the case, as in many areas there is a crisis in A&E and great pressure on hospital services—but reference has also been made to services provided by our NHS outside hospitals, in the community. It is important that we focus on those as well, not just because they are important in their own right, but because if they are working effectively they can prevent hospital admissions from occurring and improve people's health. Those services include community health services, which involve GP practices—the bedrock of our NHS—and the nurses, physios and pharmacists. They also include social care, where the NHS has some responsibility, although local authorities, which are under ever-increasing pressure, are primarily responsible.

I am extremely concerned about the cuts that the Government have imposed on community pharmacists. Pharmacists are essential to our NHS. They are part of the NHS, but in the main are privately run. They offer advice as well as specific services, and where pharmacists can give proper advice and services they can often prevent people from having to go to their GP, let alone to hospital. It is a matter of great concern that the Government's plan for cuts to community pharmacies will put pharmacies in areas such as mine in Liverpool at risk. I also deplore the reduction in independent pharmacies, which provide an excellent service. I ask the Government to think again about their cuts to community pharmacies, which form a vital part of our health

service. Once they are closed, it will be far too late. The Government should act now. They should not go ahead with those cuts, which will have a dramatic effect in Liverpool and elsewhere in the country.

I also ask hon. Members to think a little more about what is happening in social care. In Liverpool, we are facing a major crisis in social care, as local authority funding has been cut severely and is to be cut again. Liverpool City Council's budget has already been cut by 58%, and £90 million of further savings have been demanded over the next three years—half of that to be achieved in the next year. One result of that has been a severe reduction in social care provision: 40,000 social care packages have been reduced to 9,000, and there are many more cuts in the pipeline.

Providing social care is essential not just to enable people to leave hospital when they are healthy enough to do so—although that is important—but to enable them to live a constructive life. Many people are now fearful of possible cuts to their social care packages. They believe that they will be unable to lead a reasonable life in their own home if their essential services are cut. I ask the Government to think again about what they are doing. They tell us that the better care fund is an answer, but that is simply not the case. In Liverpool, £39 million has been proposed for the social care fund for the coming years, but that will simply scratch the surface of the problem. In poor areas such as Liverpool where it is difficult to raise money, a 1% increase in the council tax fund would raise only £1.4 million. Neither of those measures, either singly or put together, will address the looming and very real crisis in social care. I urge the Government to look again at this, rather than offering platitudes about other funding being available. That funding is not there, and there are no plans for it to be there. A new approach needs to be taken to this urgently; something needs to be done.

The subject of mental health has been raised by a number of Members. I should like to mention two instances from my constituency. The first involves someone who can live a reasonable life at home with some assistance, but that assistance has now been withdrawn. Among other things, it involved helping the person to open letters to deal with normal queries, but that has now gone and she is facing great problems.

The second example involves Mr B, who faces very serious mental health conditions. Indeed, he has an incapacitating condition, which means that he cannot work. He was promised specialist help at the Tuke Centre in York, but that offer was withdrawn because it was made in error. That is unforgivable. I have followed this through, and Mr B was promised local treatment, although it was unclear whether that treatment would be appropriate. However, that treatment is not now being offered in the way that was previously suggested. I have followed that up, but 14 months on from the time when Mr B was first offered help for his incapacitating and extremely serious mental health condition, nothing has happened. That is simply not good enough, and I shall be pursuing the matter further.

Those are just two illustrations of how the cruel cuts in mental health services are affecting individuals. I agree that we should perhaps look more generally at funding for our national health service, but the crisis in local services is happening today. The Government are responsible now, and they must act.

3.48 pm

Mr Mark Harper (Forest of Dean) (Con): I am very pleased to follow the hon. Member for Liverpool, Riverside (Mrs Ellman). I am sorry that the hon. Member for Central Ayrshire (Dr Whitford) is no longer in her place. I particularly enjoyed her remarks, in which she set out a number of constructive policy suggestions, drawing on experience in Scotland, and suggested that we could reflect on them and improve the situation here.

It was disappointing to hear not a single policy suggestion in the shadow Secretary of State's 33-minute contribution. He might reflect on that because the debate will not move forward otherwise.

The hon. Member for Central Ayrshire drew upon her clinical experience, but I also enjoyed the contribution of the right hon. Member for Doncaster Central (Dame Rosie Winterton) who, after a period of enforced silence as Opposition Chief Whip, drew upon her ministerial experience, demonstrating the value of ex-Ministers contributing from the Back Benches and bringing something to the debate.

I have reflected on the Labour motion before us today, which specifically talks about the four-hour target and funding issues, which I will touch on in my inevitably brief speech. As I said in an earlier intervention, I was in the House on Monday when the Secretary of State was clear in what he said and I do not understand why Labour Members fail to see that. He did not in any way water down the target. The right hon. Member for Exeter (Mr Bradshaw) challenged him and the Secretary of State specifically "recommitted the Government" to the target. He was actually generous in paying tribute to the Labour Government for having introduced it, saying that it was

"one of the best things about the NHS"—[*Official Report*, 9 January 2017; Vol. 619, c. 46.]—

and in no way resiled from it.

Indeed, I think the shadow Secretary of State said in his remarks that the Secretary of State had somehow talked about ensuring that the target applied only to those with urgent health problems and that he had somehow said that secretly outside the House. However, I have looked carefully at the Secretary of State's oral statement, given in the House just two days ago, and he was explicit about ensuring that the four-hour standard related to urgent health problems. He specifically referenced Professor Keith Willett, NHS England's medical director for acute care, and said that

"no country in the world has a"—

four-hour—

"standard for all health problems".—[*Official Report*, 9 January 2017; Vol. 619, c. 38.]

The target is for urgent health problems, and if we are to protect vulnerable patients, that is what we need to ensure—it is incredibly valuable.

The motion also relates to social care funding, so I want to talk about the charge that the Opposition keep making about local authority decisions. It is entirely true that the coalition Government had to make savings from local government budgets in the previous Parliament owing to the previous Labour Government's lack of preparation following the dramatic financial crisis. We inherited a budget deficit of 11% and had to make such savings, but local councils had choices in the decisions

[Mr Mark Harper]

they made about where the cuts fell. Gloucestershire County Council prioritised spending on adult social care, stating that it was the single most important service that it delivered. The budget related not only to older people; a third of it went on provision for adults with disabilities, including learning disabilities. The council protected that budget in cash terms, which is one reason why we are one of the best performers in the region and have low delayed patient discharge from the acute sector. While I do not pretend that there are no problems—of course there are challenges—the hard-working health and social care staff do an excellent job.

Toby Perkins: I am grateful to the right hon. Gentleman for giving way, but his comments about local government are ludicrous. The cuts that local government faced were far greater than those to any Department. The Government cannot introduce that level of cuts and then say to local government, “You have to decide what you cut.” Of course that was going to lead to social care cuts.

Mr Harper: The point that I was making is that my local authority also faced significant cuts and had to make choices. It chose to prioritise adult social care as the single most important service that it delivered, so it had to make difficult cuts in other areas. However, the choice to put adult social care at the top of the list of priorities was the right choice six years ago and remains the right choice today. If councils chose to put adult social care at the bottom of their list, that was not the right decision.

There is no acute A&E department in my constituency, but it is served by A&E departments in Gloucester and Cheltenham. I visited the new chief executive at Gloucestershire Hospitals NHS Foundation Trust and met some of the staff in the A&E department—the hospital has had its challenges—and she is working hard with her management team on turning around the performance of A&E, which has not been up to scratch. I talked to her about the processes they are putting in place, and I am confident that, with the hospital’s hard-working staff and improved leadership, they will be able to hit the targets that the Government have asked them to meet.

Alex Chalk (Cheltenham) (Con): I joined Gloucestershire police on a night shift last Saturday, and I went to Gloucestershire royal hospital A&E, too. I saw professional and compassionate staff offering care in no doubt pressured circumstances. Does my right hon. Friend agree that the current STP process in Gloucestershire must be the occasion to enhance capacity elsewhere in the county and that that must include bolstering and enhancing A&E provision at Cheltenham general hospital?

Mr Harper: The whole point of the STP process is to ensure that we have capacity across the health sector. One important thing that the Secretary of State talked about is the other changes to the health and social care system—indeed, that is mentioned in the Prime Minister’s amendment, which is why I will support it. In that I agree completely with the Chair of the Select Committee. We have to look at the two things together.

Unlike what the hon. Member for Central Ayrshire (Dr Whitford) said, in Gloucestershire we are lucky to have a single CCG and a single county council, which work well together with lots of joint working, and they increasingly want to bring health and social care together. That is exactly what the Chair of the Select Committee said, it is the right thing to do and it is what the hon. Member for Central Ayrshire said is being done in Scotland to help deliver a better service.

My hon. Friend the Member for Cheltenham (Alex Chalk) is right that, the more we can improve capacity in the system to ensure that people can access primary care where they need it and can access social care where they need it, we will take pressure off the accident and emergency system. Indeed, when I visited the A&E department, it had a good triage system in place, with general practitioners based in the department to ensure that people with conditions that can be treated by general practice are signposted and treated in an appropriate setting, rather than damaging the service’s ability properly to deliver acute care to those who really need it. We need to consider such steps, going forward.

Dr Murrison: Would those people fall within the four-hour target? That lies at the heart of the debate. Should the four-hour target cover both urgent and more elective problems that people present to casualty departments?

Mr Harper: I do not know the detail of how the statistics are measured, but the important thing is to ensure that people who walk through the front door of an A&E department but who do not need urgent care receive care in the appropriate setting and are properly signposted, whether to community pharmacies, general practice or the information services that the NHS provides online or on the telephone. It is about making sure that people go to the right setting. The Government acknowledge that that is not perfect at the moment, and they are doing a lot of work to improve it in the future.

Finally, the Government’s moves to devolve spending power and decision making to local areas, particularly given what will happen in Greater Manchester, to bring health and social care together is the way forward, and I have certainly encouraged my local authority, as it leads the formulation of our devolution proposals, to make an ambitious ask of the Government on health. I hope the Government will look at that very seriously in the months ahead.

3.58 pm

Catherine West (Hornsey and Wood Green) (Lab): I do not know the collective noun for Government Chief Whips and Opposition Chief Whips, but I believe it is a crop of Whips. Anyway, it is an honour to follow two esteemed former Chief Whips.

I begin on a slightly less happy note by quoting from an educational psychologist who wrote to me this week:

“I and my colleagues are frequently overwhelmed, frustrated and in disbelief about the amount of work we need to manage, the difficulties in working across services because of cuts and

changes to policy. Everyone is perpetually exhausted and burnt out. When we're not at work because of training, illness or leave we feel simultaneously guilty and relieved."

Her email went on to describe how she is the only clinical psychologist on duty in the whole of a very busy inner-London constituency.

I wish to comment briefly on the juncture between primary and secondary care, and on acute care. In the past 18 months, many of us have had the experience of fighting for a general practitioner's service. The Westbury clinic, which lies just between my constituency and that of my right hon. Friend the Member for Tottenham (Mr Lammy), has been quite a battleground in the past 12 months. He and I have had to really fight for basic GP services for our constituents. I believe this situation is replicated across the country, and it is obviously what is leading to the build-up of individuals; as the Secretary of State has said, we have so many people turning up to A&E who probably could be seen by a GP but simply cannot get an appointment.

Robert Flello: One problem we face in Stoke-on-Trent is that we are about half a dozen GPs away from the whole GP system collapsing, because as GPs are retiring or leaving for other reasons, their patients are then going to the ever-smaller number of GPs that there are. Two GPs are due to retire shortly, but if we lose half a dozen the whole GP system in Stoke-on-Trent is liable to collapse completely. What will that do to A&E?

Catherine West: That leads to an individual patient waiting 35 hours on a trolley to be seen, as happened this weekend. I know that a number of Members have made this point, but it bears repeating: it is disgraceful that staff are blamed when this is going wrong, given that the responsibility clearly lies with politicians—with the Government. I was upset to see that today's front page of *The Times* blames the senior civil servant at the heart of the NHS, as this is really down to poor Government planning.

Stephen Pound (Ealing North) (Lab): On the subject of poor planning, I am sure that my hon. Friend will, like the rest of the House, have heard James O'Brien speaking on LBC yesterday describing his experience of having conjunctivitis over the Christmas holiday and having to go to a community pharmacist because he could not get a doctor's appointment and did not want to go to A&E. Is this not the maddest time ever to be considering closing thousands of community pharmacies? Is this not the time when we should be supporting them, not closing them?

Catherine West: I do not know whether a Brexit-fever madness took over, but there was a moment when cutting community pharmacies seemed like the right thing to do. Clearly, it was the wrong thing to do at such a crucial time, particularly given the impact of the illnesses to which we all fall prey during the winter months.

In my earlier intervention, I asked the Secretary of State about the flu epidemic. He assured me on the number of vaccinations, and I am pleased that more people have been vaccinated against seasonal flu. However, let me return to the point I was making. I understand that there has been quite an increase in the number of

young people getting the flu, so we are not talking about people in the herd group who would have been advised to be inoculated against it. When people, tragically, get the flu they suffer, and doctors do not have time to isolate those individual cases. That creates a real risk, given how busy staff are, that that flu could become an epidemic. Having given us assurances today, I hope the Secretary of State will take that point up further with chief executives of acute trusts.

I want to give colleagues an idea of what is happening on social care. In 2010, I was a council leader and we had a social care budget for children—this is nothing to do with schools, just children—of £102 million. The same local authority now, in a busy London area, has for 2017-18 got a budget of £46 million. If someone is really telling me that the needs are half as much as they were in 2010 or that somehow families need less help and support, which is what children's social care provides, I would be very surprised. A cut from £102 million to £46 million in 2017-18 is deeply worrying for the children who are in desperate need of social care.

Adult social care is equally worrying. The Secretary of State told us on Monday that we should not worry because £600 million is going into social care. I would not worry, except that I happen to know that, between 2010 and 2015, £4.8 billion was taken out. Anyone who has even key stage 2 maths will know that that does not add up. If £4.8 billion is taken out over a five-year Parliament, putting in £600 million 18 months later is not going to help.

I feel sorry for councils. If they increase tax, that is quite unpopular, but if they do not the Government blame them for not wanting to sort out the social care crisis. Even where the precept does bring the local authority quite a lot of money, the amounts raised do not help in the longer term because they just go towards a short-term fix—we are not actually fixing the problem that we need to be looking at: we need more homes in which older people can live comfortably, have fewer falls and accidents, be warmer so that they are not suffering from fuel poverty, and stay out of A&Es.

It is all about long-term planning, but we have built hardly any new homes, even for older folk. If we did so we could start a chain and enable their families to move into their old homes, thereby solving another problem. We have reached a crisis in which older folk end up in A&E and, on occasion, have to wait on a trolley for 35 hours, which I still cannot quite believe. I am sure that the newspapers are telling the truth, but 35 hours is an awfully long time to be on a trolley and not be seen.

Last year, my right hon. Friend the Member for Tottenham and I had a debate on mental health in this very Chamber, which was followed by a meeting of Members of Parliament from the local sub-region. We were very worried about people suffering from mental health problems, for whom there is currently a perfect storm. First, there have been benefits cuts. We are now in our seventh year of austerity, and there is no doubt that people with mental health problems have been right at the bottom of the pile. Secondly, we have seen cuts to supported housing and all the programmes that helped people suffering with mental health problems to keep their tenancies. That is all being cut, so people have no one to support them, which is part of the reason they fall ill. Thirdly, we have seen cuts to the

[Catherine West]

number of nurses. There are fewer mental health nurses in the system than there were two years ago and, of course, fewer beds.

A constituent came to see me at my surgery in November to say that he had fallen ill with a mental health problem. He was very surprised because he had never suffered in such a way before and was amazed by the poor care he received, in part because no one was available to diagnose him properly. He spent more than 24 hours in a padded cell, with no explanation and no indication of what sort of service he could expect. There were so few beds that he was sent about 20 miles away to be cared for at another hospital, leading to a great deal of stress and worry for his family.

The whole health system is in crisis and needs our urgent attention. Despite all the demands, political and otherwise, that the Brexit process is going to create, I hope we will not forget not only the most vulnerable—those with mental health problems or in social care and so on—but our basic, universal NHS for all.

4.8 pm

Andrea Jenkyns (Morley and Outwood) (Con): I begin by objecting to the exaggerated language used over the weekend by Mike Adamson, the chief executive of the British Red Cross. What he said does a huge disservice to our hard-working healthcare professionals in the NHS. Such language was ill-thought-out, sloppy and irresponsible. The Red Cross does some fantastic work, as I am sure both sides of the House agree, but as a registered charity it is legally obliged to be apolitical. If Mike Adamson cannot remain neutral, I suggest that he examines his position carefully.

As a member of the Health Committee and chair and co-founder of the patient safety all-party group, healthcare is extremely important to me, and I am proud to be a Conservative Member of Parliament under this Government. It is thanks to this Government and this Health Secretary that NHS funding is at record levels.

The Government are committed to delivering a seven-day NHS and to expanding access to GP surgeries and hospital-based consultants at evenings and weekends. This winter, the NHS has made more extensive preparations than ever before. As the Secretary of State mentioned earlier, in the run-up to the winter period, there were over 1,600 more doctors and 3,000 more nurses than just a year ago. That is a record of which to be proud, and it would not have been achieved had we had the Opposition party running our national health service.

As chair of the patient safety APPG, I am pleased to say that the Government have introduced a new Ofsted-style inspection regime for the Care Quality Commission to improve patient safety. Hospital infections have been halved since 2010, with the level of MRSA down by virtually 50% and *Clostridium difficile* by more than 50%. It is this Health Secretary who has taken the lead on this issue and put patients at the heart of the NHS.

Record numbers of people are being treated in our NHS and there are pressures on the service, but it is not this Conservative Government who are a threat to the NHS. If we look at the appalling situation of the NHS in Labour-controlled Wales, we will see that funding is being cut. As the latest statistics show, the NHS in Wales is failing to meet the four-hour A&E targets by a

wide margin. It is clear to see who is rarely the defender of our national health service and who would cut investment.

In conclusion, it is this Government who are increasing spending on our NHS, who are focusing on improving patient safety and who are dedicated to providing the best possible service.

4.11 pm

Naz Shah (Bradford West) (Lab): I am grateful for this opportunity to raise some of the serious concerns that have been caused by this Government's refusal to fully fund our NHS. The Government are running out of places to cut corners to save money on the NHS. They are showing a lack of respect and compassion as they fail to provide the healthcare that people need and deserve. Those who need care at home are having to make do with 15-minute flying visits.

We have seen the pressure in A&E departments building over the past six years and yet every year we reach a winter crisis that is somehow a surprise to the Government. We have seen an increase in A&E waiting times, with more than 1.8 million people waiting more than four hours in 2015-16—an increase of over 400% since 2010.

Bed-blocking is increasing as our underfunded social care services struggle to deal with demand. We have seen an increase in the number of patients waiting on trolleys to be treated or admitted, and an increase in the number of hospitals running out of beds. We are also about to see a 12% cut to community pharmacies, which will lead to the closure or reduction in services of our local pharmacies. The time it takes to get a GP appointment is also increasing.

This is not the most complex of problems. If we want a proper functioning full person-centred care system that works with compassion and treats those in need professionally and efficiently, this Government must fund it.

Alex Chalk: In 2015, the head of the NHS, Sir Simon Stevens, said that the NHS needed £8 billion. It was this party that committed to fund it; the Labour party did not. If the hon. Lady is so keen on funding the NHS, why did the Labour party not pledge to do so back in 2015?

Naz Shah: I thank the hon. Gentleman for his intervention.

Let me turn now to pharmacies. This Government fail to grasp the fact that cuts to one service will have a direct impact on another. Let me be clear: only two months ago, I stood on the Floor of this House to condemn the proposed 12% cut to community pharmacies, which could mean the closure of 25% of the 42 pharmacies in my Bradford West constituency. That highlights the short-sighted approach taken by this Government. They are attacking all forms of primary healthcare and frontline services on which people rely.

If the figures are correct, nearly 30% of people who attended A&E services in Bradford royal infirmary over the past month could have been treated elsewhere for minor ailments. Many of them could go to their local pharmacy, through our local ailments scheme, or see their GP. What is the Government's long-term approach to these systemic issues if they continue to water down

primary care services? All we will see is an increase in the number of visitors unnecessarily attending A&E and an increase in the problems faced by those needing access to services.

The impact of the reduction in GP services is the same. Only a few months ago, I campaigned with the local community to save Manningham health practice. The proposal was temporarily put on hold, although we still have fears. Thankfully, we managed to prevent that centre from being closed down in the short term, but others in my constituency are at risk. Many other MPs have GP surgeries in their constituencies that face uncertain futures due to the funding restraints. This paints a picture not only of the underfunding of primary care services, but of a strategy that simply does not work together. Even a simple understanding of healthcare provision would allow us to see that if we decrease NHS services in one sector, there is an impact on the rest of it and an increased pressure on other service providers. But this Government continue to underfund and cut funding to all aspects of frontline services, and they expect the quality of care to remain the same. Where is the long-term planning that will ensure that people get access to the care that they deserve and are entitled to?

The Government's strategy is the same when it comes to local government social care funding. The cuts to local social care funding have been dramatic. As many other hon. Members have highlighted, nearly £4.6 billion has been taken out of the social care sector since 2010, mainly through local government funding cuts. My district of Bradford has just had to announce that it will need to find another £8 million in savings from its social care budget. The authority is trying to be innovative and trying to find ways to ensure that there is no effect on frontline care by putting its resources into prevention. For me, the Government still fail to recognise the impact of deprivation on care needs. In one of the four most deprived constituencies, health issues go hand in hand with deprivation. The cuts to local government funding make that even more evident. It is not the work of our exceptional healthcare staff that has caused this crisis. It is the reduction in funding and the short-term strategy of this Government that are responsible. It is time for them to wake up and provide the healthcare provision people deserve.

4.17 pm

Andrew Selous (South West Bedfordshire) (Con): Many of my constituents are extremely fortunate to be served by Luton and Dunstable hospital—the hospital that was name-checked twice by the Secretary of State in his statement on Monday. One thing it does extremely well is its excellent streaming process in A&E, with good alternatives when A&E provision is not appropriate. That has helped the hospital to provide very high standards. I am also fortunate that my constituents' social care is provided by Central Bedfordshire Council, which has been extremely innovative in building extra care court provision for older people. I visited those provisions, which are hugely popular and in central locations. They are much cheaper than residential care and provide a much better living environment for older people. That is exactly the sort of thing that we need a lot more of across the country. Those are two examples of really good individual practice within the NHS and social

care. We need to be much better at spreading that good practice across the whole country.

It is worth putting on the record that since this time last year, we have more than 1,600 more doctors and 3,100 more hospital nurses. Since 2010, we have over 11,000 more doctors and 11,000 more nurses. The proportion of patients harmed by the NHS fell by more than a third between 2012 and 2015, and cases of infection are 50% lower than they were one year ago, which is a tremendous achievement. Health spending in England is actually 1% higher than the OECD average and the UK is spending more on long-term care as a percentage of GDP than Germany, Canada and the USA. The King's Fund has said that STPs are the “best hope” for the future of the NHS in England, and Chris Hopson, the head of NHS Providers, has said that the system as a whole is doing “slightly better” than this time last year.

All that is dependent on having a strong economy, and I would argue that the Conservative party has demonstrated its competence in running the economy. Of course, I am not complacent, and I recognise that there is, in a sense, an arms race between the extra provision I am proud the Government have put in and the increasing demands on the NHS.

One issue that continually disappoints me is that we do not have enough of a focus on quality in these debates—they are always about funding. However, I draw attention again to the “Getting it Right First Time” initiative brought in by the Government just before Christmas, which is projected to save £1.5 billion that could be redirected back towards frontline patient care across 18 specialties. That will result in fewer infections and fewer revision operations, and we are using the data to shine a spotlight on variability, which is absolutely key for our constituents.

On mental health and the very welcome statement by the Prime Minister on Monday, I was delighted to hear the emphasis on first aid for mental health—something that will take place in our schools. However, as important, if not more important, is the issue of keeping fit for mental health. What do we all need to do to maintain good mental health? The Mental Health Foundation says we need to talk about our feelings, eat well, keep in touch with family and friends, take a break, accept who we are, keep active, drink sensibly, ask for help, do something we are good at and care for others. I do not think those 10 pointers from the Mental Health Foundation are as well known as they should be, so I am pleased to have put them on the record. It is crucial that we all look after our mental health, and that will help to reduce the stigma in this area.

Another issue I am passionate about is doing something about obesity, because although we have a national health service, we do not do enough to keep our fellow citizens healthy. I would like to see more emphasis placed on the excellent work of Dr Susan Jebb, an academic at the University of Oxford. She published an article in *The Lancet* just before Christmas showing that where GPs offered obese patients a referral to 12 weekly one-hour sessions, there was a significant reduction in the patients' obesity.

Stephen Pound: I am sure the hon. Gentleman, like me, is a regular reader of the *Daily Mail*, and he will have noticed the proposal in yesterday's paper that people who are obese, heavy smokers or even, God

[Stephen Pound]

forbid, both should be denied medical treatment until they lose weight or stop the filthy habit of smoking. Would he like to recommend to those on his Front Bench the adoption of that policy?

Andrew Selous: What I am focusing on is what we can do to keep ourselves healthy and to reduce the demands on the NHS by behaving responsibly, and that is what I want to put the emphasis on.

That is important because a quarter of adults are obese, as are 14% of children between the ages of two and 15, and 18% of children in lower income households. Those figures should shame us all, and that is why I intervened on the hon. Member for Central Ayrshire (Dr Whitford) and mentioned the daily mile, which was brought in by St Ninian's Primary School in Stirling. We need to see more of that and, frankly, a strengthened obesity policy.

My daily newspaper at the moment is the *China Daily*—it happens to be delivered free to my office. I was intrigued to see that students at universities in China actually have to take a physical fitness test lasting 50 minutes at the beginning of each new semester or they will not be given a graduation certificate. I am not necessarily suggesting that we introduce that here, but we should look around the world to see what other countries are doing to promote the health of their populations—to keep them fit and healthy—and to reduce the pressure on health services.

At the other end of the age spectrum, we need to do a lot more to keep older people fit and healthy, as many of the issues with social care would be greatly lessened if older people were able to stay healthier into later life. I am proud to be associated with the Buzzards 50+ organisation in my constituency, which helps older people to take regular exercise at our local leisure centres. In Andorra, which I mentioned earlier, that is normal for the whole population. Older people in their 70s and 80s will regularly take part in water aerobics classes and go to the gym. When a BBC correspondent went there a few years ago, women in their 70s taking part in these exercises said, "There's no point in spending your retirement shut up at home. What's more important than keeping yourself fit? If you don't keep your body moving, you won't keep your mind in shape." Frankly, we need a lot more of that type of activity in our own country to lessen the pressures on our social care system.

4.25 pm

Mr Mark Hendrick (Preston) (Lab/Co-op): We have heard from Conservative Members about the so-called annual winter crisis, as though the situation we are in at the moment has always existed. Well, there have been crises in the past, but nothing like on the scale that we have seen recently. We are hearing about corridors being used as wards. I saw this in my own local hospital when I had to take my young son there. We went through into the ward and saw queues of trolleys with patients on them before my little son was seen to.

Last December, I wrote to the Department with a question—it was answered by the Minister of State, the hon. Member for Ludlow (Mr Dunne), who is in his place—about whether the Government could give the figures for the number of patients left queuing in corridors.

I was told that there were no such figures. The Government and the Minister are well aware that this is going on in hospitals up and down the country. If the Government do not collect those figures centrally, but hospitals themselves collect them, the Government should ask for them; and if hospitals do not collect them, they are not carrying out their duty of care to our constituents, because it is important that people know how many patients are being held in corridors.

We hear stories about ambulances being redirected and bed occupancies being well over the 85% recommended level, and in many cases well over 95%. We have heard about the £4.6 billion of cuts in social care funding. Already, while it has not been made explicit, we are hearing talk of downgrading the four-hour A&E wait. In Preston, as I know myself, it is difficult to get GP appointments. If I ring and ask to see the doctor I want to see, I am often told that I will have to wait two to three hours—I mean weeks—to see that doctor. It probably will be two to three hours, at the very least, if I go to the hospital and it is a serious case. It is no wonder A&E is in crisis. A whole cohort of doctors in their mid-to-late 50s are looking forward to retirement. The number of doctors has increased, as we heard from the Health Secretary today, but that increase is nowhere near matching the number of doctors who are leaving the service or going to work elsewhere.

On the social care sector, we have seen tens of millions of pounds of Government cuts forced on Lancashire County Council. That is leaving the elderly vulnerable and more likely to have accidents at home, putting pressure on A&E as well. The mental health services—the Cinderella services—continue not to get the support they deserve. Since the closure of the acute mental health ward in Royal Preston hospital, the Avondale unit, I have seen mental health patients being decanted around Lancashire because they cannot get the care and support that they need in Preston.

Over a five-month period to August last year, we saw a 16% increase in attendance at A&E at Royal Preston hospital. Over the same period, average daily patient attendance increased from 217 per day to 255 per day. A small percentage of that increase was due to the closure of Chorley and South Ribble hospital's A&E. I am sure that if the Deputy Speaker, my right hon. Friend the Member for Chorley (Mr Hoyle), were here, he would echo what I have said. However, it is not all due to the closure of Chorley's A&E. Many patients who would have gone to Chorley are now attending the A&E in Wigan, or elsewhere. The Government should not be allowing wards to close when the demand is so high. The daily average for the number of ambulance arrivals has increased from 68 to 91, according to the North West Ambulance Service. In the meantime, a return to a 24-hour accident and emergency service at Chorley hospital has been ruled out. At best, there will be a 12-hour A&E service sometime later this month.

Preston has one of the 134 of 138 A&E departments up and down the country in which 95% of patients are not seen within four hours. I believe it is an absolute disgrace that only four A&Es in the country are meeting the four-hour standard. It is testimony to the cuts and austerity being forced on the NHS and local government social services departments up and down the country. I call on the Government to increase spending on social care and to fund the NHS further in this year's Budget as a matter of urgency.

4.30 pm

Wendy Morton (Aldridge-Brownhills) (Con): It is a pleasure to follow the hon. Member for Preston (Mr Hendrick) in this debate. I am very conscious that I am following many Members on both sides of the Chamber who are far more learned about health matters and who bring with them very valuable experience from the frontline in the NHS.

Like all Members in the Chamber, I receive letters and visits from constituents who have concerns about the NHS and issues with their own health. As we all know, some of those issues can be very sad and emotive, and we all do our utmost to help them in what can be very difficult situations. However, let us not forget the many positive stories and experiences that we also hear about. Many of us will have had very positive experiences with the NHS in relation to how it has helped and continues to help us and our own families. It would be very wrong and unfair of us not to recognise those experiences.

I thank all NHS staff and those who work in the health and social care sectors for the work they do not just during the hard times, such as now, when there are winter pressures, but day in and day out throughout the year. In my family—my mother was a home carer for many years, and my sister is currently a practice nurse—I often hear about what it is like to work on the frontline. I also thank our local hospital in Walsall, the Manor hospital, which serves the constituents of Aldridge-Brownhills. Like many other hospitals, it faces many pressures. As we have heard today, A&Es saw the highest number of patients on the Tuesday after Christmas. I believe that all those involved in healthcare are working extremely hard to tackle this problem, and that includes the Secretary of State and his Ministers, with their work to do that and to move us towards a better and more sustainable future.

Hospitals across the country face huge pressures as we enter the winter period, as I have said. We increasingly have an ageing population, but the population is also increasing in numbers and many more treatment options are available than ever before. As we all know, many of those treatments come at a very high cost, but we would like to be able to meet that cost to help those patients. All these factors place challenges and pressures on the NHS, its staff and its resources. The impact of the ageing population has been raised with me by some of my local GPs, and we need to recognise and tackle this issue. I know that GPs in my surgeries would very much welcome the Minister if he were to drop by Aldridge-Brownhills on his way back to Shropshire one Friday for what would be a very useful and constructive roundtable discussion. That is an invitation to the Minister.

It is important to develop effective and integrated health and social care, but although money is an important factor, I do not believe this is just about money. In fact, the Secretary of State said in his speech today that we miss a trick if we say that it is. We forget that it is also about making progress on safety, standards and quality. I recall that a number of years ago, the headlines in the papers were always about really nasty hospital bugs and infections such as MRSA and clostridium difficile, and we have come a long way in working to combat those.

I am proud that the Government are committed to the NHS, and that as we enter the winter period we have nearly 1,800 more doctors and nearly 3,000 more hospital nurses than we had a year ago. We have launched the largest ever flu vaccine programme and allocated £400 million to local health systems for winter preparedness, and we have bolstered support outside A&E with 12,000 additional GP sessions over the festive period. Of course, there is and always will be more to do, but I believe that we are rising to the challenge and will continue to do so. I am sure that the Secretary of State and his team will continue to rise to that challenge as well.

4.35 pm

Owen Smith (Pontypridd) (Lab): I do not intend to take too long, because I am mindful of the fact that the motion refers largely to NHS England, but I am goaded to speak by the repeated references by the current Secretary of State, the previous Prime Minister and the current Prime Minister to the relative performance of the NHS in Wales. I want to take a few minutes to set the record straight and give a clearer illustration of the relative performance of the two NHS systems.

Before I do that, I want to reflect on the interesting, thoughtful speech that the Prime Minister gave earlier this week about her desire to create a “shared society”, as she put it, in Britain. I read the speech, as many Members did, and felt that it set out precisely what all Governments ought to be doing at all times. In one passage, the Prime Minister said:

“That is why I believe that...the central challenge of our times is to overcome division and bring our country together.”

She said that she wanted to create

“a society that respects the bonds that we share as a union of people and nations.”

I completely agree with her about that, but I find it impossible to reconcile that stated objective and rhetoric with how she and, in particular, her predecessor have sought to divide this country on the NHS. They have illegitimately demeaned the performance of the NHS in Wales, demoralised its staff and destroyed confidence and faith in it among Welsh citizens. With a few statistics, I hope to illustrate how misleading some of the representations in recent years have been.

The first statistic is that the previous Prime Minister referred to the NHS in Wales in a disparaging fashion 37 times, on every occasion as a political attempt to militate against criticism of the NHS in England. That broke the important bonds between different parts of the UK. I will state a few of the facts. The entire budget for Wales is about £15 billion per annum, and £7.1 billion of that is spent on the NHS. That is 48% of all spending by the Government in Wales. The difference between that and the situation in England is enormous. In England, the NHS budget is £120 billion, and the entire budget of the country is about £750 billion, so 16% of the budget is spent on the NHS in England and 48% in Wales. The Welsh Government's headroom to expand spending on the NHS instead of other areas is therefore dramatically less than in England. That is the first illegitimate way in which the Government have manipulated statistics on the issue.

Secondly, over the past six years, the Government have repeatedly referred to the lesser spending on the NHS in Wales than in England per head or in percentage

[Owen Smith]

terms. We have heard that three times today already. The truth is that in 2010 the Welsh Government, with the lower headroom that I have mentioned, chose to reduce spending on the NHS by 1% compared with the previous year. In England, there was flat cash spending. That 1% reduction was made to increase and prioritise spending on education in Wales. Since then, we have seen successive rounds of investment by the Welsh Government: £80 million was announced this week for a new treatment fund; last week, there was £40 million for capital spending. It is now broadly comparable in percentage terms. In fact, last year in Wales we spent £2,026 per head, while England spent £2,028. The difference is negligible. If we add health and social care together, we find that Wales spent 6% more per head than England. These are the realities of the comparative spending.

What has this given us in outputs? There are some things that the Welsh NHS does worse. In Wales, we wait longer for some diagnostic treatment. There is a need to spend more on more MRI scanners and CT scanners. Part of the issue, however, relates to an older and sicker post-industrial population, rural sparsity and a lesser ability to attract people to some of the more far-flung hospitals—all perfectly explicable and reasonable. In England, over the past nine months, we have seen the biggest rise in waiting lists for nine years.

In other areas, Wales does well. On the crucial eight-minute ambulance response time, 77% of calls meet it in Wales, against only 67% in England. Most would agree that the 62-day cancer treatment target is vital, but in England it is consistently missed. In England, on average, 81% of people are treated within the target time; in Wales, the figure is currently 86%. There are other areas I could turn to. A&E is the crucial area we are looking at today. In Wales, 83% of patients are currently seen within the four-hour target. In England, the figure is 88%. There are 150 A&E departments in England and only six or seven in Wales, so this is another completely ludicrous and, in many respects, meaningless statistical comparison. Thirty seven of the 150 A&E departments in England are below the Welsh average. Several of the Welsh trusts are up at the 95% or 98% mark. This is a further illustration of how meaningless, misleading and frankly abusive it has been of the Tories to use the Welsh NHS as a stick to score political points.

In conclusion, the truth about the Welsh NHS is that it performs excellently in some areas and that it could be improved in others. As the OECD said, in a 10-year study of all the healthcare systems across the country, no one part of Britain performs demonstrably better or worse than any other. That is the truth about the differences between our NHS in this country. The Minister, the Prime Minister and the Secretary of State need to remember that they are Ministers for the whole United Kingdom, not just England. Their duty is to increase the bonds of solidarity, not destroy them.

4.42 pm

Dr Andrew Murrison (South West Wiltshire) (Con): This has been an absolutely first-rate debate, with a number of extremely fine contributions. I was particularly taken, as ever, by the remarks of my hon. Friend the Member for Totnes (Dr Wollaston), the Chairman of the Select Committee. She rightly pointed out that we are all living longer, which is a great thing, but that

unfortunately our healthy lives are not expanding. This causes real problems for A&E, which has to deal with that. Although we talk about large numbers of people passing through A&E departments—they are dealing with more people all the time—the truth of the matter is that it is those with chronic long-term and complicated conditions who tend to assume the lion's share of A&E resources and those of the rest of the secondary care system. As we get older, there will be more and more of such cases. We need to prepare for them.

We also need to militate against those cases. One thing that has not been discussed very much this afternoon is prevention and public health: our need to ensure that we deal with things that are avoidable. The Prime Minister, in her excellent speech on Monday on the shared society, rightly said:

“We live in a country where if you're born poor, you will die on average 9 years earlier than others.”

That is absolutely appalling and we should all be ashamed. Half that health inequality is due to tobacco consumption. Someone in a manual occupation is far more likely to be a smoker or to smoke more than a professional or managerial person. We have to be serious about controlling the scourge of tobacco. I encourage Ministers to produce the tobacco control plan, which is now overdue, as soon as possible, as we need to deal with this issue. I hope that the plan will contain some helpful remarks on the tobacco duty escalator and the licensing of retailers and involve serious conversations with supermarkets. The aim must be to reduce the availability of tobacco, reduce consumption and therefore reduce the burden of diseases that are affecting our NHS and having appalling consequences for citizens.

I very much support the Government's amendment to the motion. I was not present when the hon. Member for Central Ayrshire (Dr Whitford), who speaks for the SNP, was speaking about community hospitals. I am sorry about that, because community hospitals are particularly important to me and I would have liked to respond to some of her remarks. I have community hospitals in my area. In particular, there is one serving my constituency at Shaftesbury that is threatened with bed closures under the STP. We need to be very careful about short-term funding cuts that might appear expedient, when we have not properly costed the service. Providing that the case mix is right—and traditionally case mixes have been pretty appalling in the NHS—community hospital beds can provide a cost-effective means of treating people, particularly the elderly, in a setting close to their homes rather than in large acute hospitals, which are the wrong places for elderly sick people. Community hospitals can deal quite effectively with some of the delayed discharge problems currently afflicting our system. As Members of Parliament, we are all sometimes faced with the political choice of whether to oppose, for our own expediency, the closure or reorganisation of services. I have faced that in my constituency. I was pleased to hear my right hon. Friend the Member for Chelmsford (Sir Simon Burns) say that sometimes we need to be brave when approaching such matters.

If we want to drive up standards and outcomes in our NHS, we will have to look increasingly at specialist centres, which will inevitably mean service reconfiguration and probably some closures. That will be disagreeable to many colleagues, but specialist centres certainly improve

standards and outcomes for things such as cancer, strokes and heart attacks, and that implies regional and sub-regional services. I would not be one to oppose a closure, reorganisation or reconfiguration for its own sake. We have always to understand that resources are finite and that we need to get the best service and outcomes for the money available.

I say gently to the Minister that we need to look at funding. He will be aware of the campaign by the right hon. Member for North Norfolk (Norman Lamb), which I support, in relation to a commission or convention. It seems a non-partisan way of trying to approach the very difficult conundrum of how we will fund the NHS going forward. I commend it to the Minister. I was pleased to hear the Prime Minister say at lunchtime that she was prepared to meet colleagues concerned about the issue to see whether this proposal could be a productive and helpful way forward. We do not spend as much on the NHS as we need to. That is the bottom line. It is no good people saying we spend 1% above the OECD average. That is not good enough, given that the OECD includes countries with which most people in this country would not wish to be compared. As the Government of the day made clear several years ago now, we need to close the gap with the EU 15, particularly with countries such as Germany, France and the Netherlands, whose outcomes are much better than ours. It is no coincidence that they spend much more on healthcare.

Today, the chief executive of the NHS is being examined by the Public Accounts Committee. I hope he will be examined on the £22 billion efficiency measures that he felt might be achievable in the five year forward view. Two years in and it is clear that those savings will not be met—they never were going to be met. We need to determine how we are going to make up the delta—the difference—between the efficiency measures that the NHS can reasonably achieve and those projected two years ago.

I want to finish by congratulating the Minister and the Government on achieving what they have. We have heard how things have improved in recent years, particularly in relation to such things as activity and hospital infections, but there is much more to do. In particular, I hope he will look closely at the funding issue.

4.50 pm

Toby Perkins (Chesterfield) (Lab): This is a vital issue, and I congratulate my hon. Friend the Member for Leicester South (Jonathan Ashworth) on bringing it before the House. The pressures on our national health service have a multitude of causes. Many of them are societal: whoever was in power would be dealing with an ageing population, limited financial resources and global competition for skills. However, many aspects of the crisis have a political origin, and the Government cannot continue to avert their eyes from that.

In my contribution today, I want to talk about my own experience of the pressures that our NHS staff, and particularly those in A&E, are facing and ask Members to walk a mile in the shoes of those who are on the frontline, making life-and-death decisions every single day. My exposure to these pressures is both professional and personal. Professionally, in common with many other MPs, I have recently spent time in the A&E department of my local hospital, the Chesterfield royal, shadowing staff on the watch.

I have said that my exposure to these issues was also a personal one. Last year, on Friday 15 July, my father died of an aneurysm. Four days earlier, he had been sent home from the A&E department at Coventry and Warwickshire hospital with what a vascular surgeon described at my father's inquest as "classical aneurysm symptoms". With a history of vascular problems and a previous near-fatal aneurysm, he presented at the hospital's A&E department, suffering extreme pain in his right groin, radiating to side and back. He was described as being confused and uncommunicative. Yet, after five hours in A&E, he was sent home in a taxi. Four days later, he died in my arms.

Although individual mistakes by an experienced and, I believe, respected A&E registrar were clearly made in this case, what was particularly haunting was his response to questions during the inquest about why my father was sent home. He recounted the pressures in the A&E department that day, and said that it was non-stop and particularly busy on that Friday afternoon, so that from one case to another, he was constantly having to decide, as he did most days, which sick patients, all of whom needed to be in a hospital bed, to send home this time. He said:

"There simply aren't enough beds for those who need to be in them, so every day we have to make these choices. I probably sent home 5 people that day who should have been in a hospital bed, but those are the choices we are left with, when there aren't enough beds".

He asked if my father minded going home and when he did not object, he stuck him in a cab.

These pressures and these life-or-death decisions are not unique to that registrar or that hospital. Dr Stephen Hitchin, an out-of-hours doctor and an A&E doctor at Chesterfield royal said:

"Chesterfield Royal Hospital have confirmed to the CCG today that they are experiencing SEVERE pressure (RED STATUS) in A&E, Emergency Management Unit, Clinical Decision Unit and critical care beds...This has come from a toxic combination of underinvestment, social care cuts, staff cuts, poor planning and GP surgery shortages. This is a failure of policy from this Government plain & simple. They are to blame & must take responsibility & action to correct this crisis".

Another consultant said:

"The only thing keeping the wheels even vaguely on is a grim determination and professionalism. Any good will to the system was eroded months ago. The government have thought that Emergency Departments can just soak up exploitation and abuse ad infinitum but we can't. We have exceeded 'acceptable tolerances' long ago."

If that is the experience of people working within the system, how can we be surprised when it leads to personal catastrophes? How can we be surprised when doctors on whom we have spent tens of thousands of pounds to train, take the expensive training and move to other countries where they feel they are better appreciated? The experiences of those consultants and registrars were echoed by those I met when shadowing the A&E department at Chesterfield royal. Other issues emerged. Certainly there were people in the A&E department who were not urgent cases and should have been at their GP. When I asked one of them why he had come to A&E, he said it was because he had been trying to get a doctor's appointment for three days at his GP surgery and just could not get one.

[Toby Perkins]

The scale of the GP crisis is adding to our A&E crisis, not just because people present who should be seeing a GP, but because problems that could have been sorted out or identified if they were seen early enough escalate without access to primary care. The Government must take responsibility. The cuts in training budgets in 2010-11 and 2011-12 were catastrophic for the provision of the next generation of staff, and we are now reaping the full cost of that decision. Quite apart from the ethics of having to rely on overseas staff to keep our NHS sustainable and the impact that has on health services in developing countries, it is crazy that, at a time of a global shortage of trained medical staff, the Government deliberately cut off the flow of new home-grown recruits.

The story is similar in nursing. In 2010-11, 25,525 students enrolled on a nursing degree course, but owing to budget cuts, that number had been reduced by nearly 15% within two years of a Tory Government, and even now it is more than 10% down. The staff shortages have also led to a ballooning of agency costs: in the past two years, an additional £2 billion has been spent on agency staff. More and more money is being spent on extra staff and not, as it should be, on patient care.

We need to remind ourselves that things were different under a Labour Government. A Labour Government led to record NHS satisfaction levels, achievement of the 98% waiting target, a sustainable GP and A&E system, and, in the words of the King's Fund, the most efficient health service in the world. The Labour Government led to much higher patient expectations, but under the present Government that progress is being eroded. By 2008, after 11 years of Labour investment, the UK's health spending had finally caught up with that of leading EU nations, but OECD figures show that, once again, our spending is now "significantly below" theirs.

I am ashamed to say that I am grateful that my father experienced his first life-threatening aneurysm on holiday in Germany. The quality of the emergency care that he received in Munich saved his life and gave us, his family, three more years with him. I regret that the same could not be said of our NHS last year.

We have it in our hands to make our NHS once again a service admired around the world. Although the challenges that it faces are substantial, they are also predictable. If the Government had listened to those who questioned their cuts in training, the impact of pension reforms on GP retention, the impact of GP shortages on A&E departments and the impact of care cuts in the poorest areas on our health service, we would not be facing the crisis that we face today. The call for further action on A&E waiting times and investment in our care system cannot be ignored.

The Government seem to be presiding over the managed decline of our NHS, but the scale of this crisis will engulf them if action is not taken now. It means old people struggling to cope; it means the disabled being left in their homes rather than being able to take advantage of things that we all take for granted; and it means people being sent home from A&E departments to die. We must do better.

4.57 pm

Henry Smith (Crawley) (Con): There is no NHS A&E waiting crisis in my constituency, because there is no A&E unit. It was closed a dozen years ago by the

then Labour Government, and people who need to access emergency services must now travel nearly 10 miles on single-carriageway roads to East Surrey hospital. That is the legacy of the Labour Government in my constituency.

I am pleased to say that since 2010 services have been returning to Crawley hospital as a direct consequence of the protection and, indeed, enhancement of the health budget to which the Government have committed themselves, and to which they are still committed. I know that this is often dismissed by the Labour Opposition and by others, but it is quite significant that the NHS asked for an additional £8 billion for the coming period and the Conservative Government are delivering £10 billion of extra investment. That has a very real effect.

I do not deny that there are huge pressures on our health service. As many Members have pointed out today, we have an ageing and a growing population. It is fortunate that people are living longer because new drugs are available to treat conditions that were previously not very treatable, but that puts additional pressure on the health service, although, in a way, those are nice problems to have.

We should not use this issue as some sort of political tit-for-tat. Concern for the health service and our wellbeing is felt by us all, both for ourselves and, of course, for our families and loved ones. I think that, when discussing how to address the increasing health needs of our nation, we should focus on constructive arguments rather than the political point-scoring of which we have heard so much today. I have to say that, as other Members have mentioned, in the 33 minutes of the shadow Health spokesman's speech we did not hear a single policy suggestion on how under a Labour Administration there would be a different approach to the NHS.

I am delighted to say that Crawley this week celebrates the 70th anniversary of being designated a new town. One of the most disastrous decisions in those 70 years was the loss of the A&E in 2005, although, as I have said, some services are returning. Just yesterday, a new clinical assessment unit was opened that seeks to do precisely what we have been discussing: take pressure off A&E whereby those who should not be treated in an emergency environment are triaged and signposted to better support services. That unit is to be welcomed. In recent years, a new 24-hour, seven-day-a-week urgent care centre opened in Crawley hospital as well as an out-of-hours GP surgery. As we strive to achieve that 24/7 NHS, all these steps are ways we can better serve patients and relieve pressure on emergency care in the whole system, which almost every winter comes under additional strain.

I will support the Government amendment this evening, because we need to recognise the hard work done by our NHS staff and the additional investment. This is not just about funding, however; it is also about the way we deliver healthcare in an acute setting when people present.

Finally, I want to touch on social care, because, of course, health and social care are inextricably interlinked. We have an ageing population, as many Members have mentioned, and it has increasing health needs. One of the areas of increased health need is dementia, and I am pleased to say Crawley was one of the first designated dementia-friendly towns. That is not just a label; it means multi-agency working between health and local

authorities, and indeed the voluntary and private sector, to ensure those with dementia are better supported. I am delighted to announce that recently a new ward, the Piper ward, was opened in Crawley hospital. It is a dementia-friendly ward specifically to better treat the health and social care needs of our elderly population.

I could say much more in this debate, which is of importance not just today but throughout this Parliament, but as we have limited time I will let other Members contribute, too.

5.3 pm

Paula Sherriff (Dewsbury) (Lab): First, may I pay tribute to my hon. Friend the Member for Chesterfield (Toby Perkins) for his incredibly moving speech?

People are dying—literally. We are no longer saying people will die unnecessarily; we are now in the present tense, and we are hearing horror stories from around the country of people dying on hospital trolleys and at home waiting for ambulances to arrive. These are lives that could have been saved had it not been for this crisis.

People are dying in hospitals undetected by overworked nurses and other members of our amazing medical staff. A constituent of mine went to visit her grandad in hospital and, very sadly, found him dead in his bed on the ward. The overworked nurses had missed the fact that he was at the end of his life and had passed away. He died alone while his relatives were at home, unaware of how seriously ill he was.

I am bemused to hear Member after Member on the Government Benches standing up to defend the Government, when the facts are absolutely clear. They seem to be in severe denial. How can this be normal? How can the Government sit back and say that the solution is to discard the waiting time target? It is not the people who turn up with sore throats who are clogging up the system; it is genuinely sick people who desperately need medical attention.

Another constituent of mine arrived at A&E just last week, only to be told that she would have to wait at least 10 hours to see a doctor. That is not good enough. We are one of the richest nations in the world. It transpired that she had sepsis, a potentially fatal illness, and it is only because an overworked and stressed triage nurse recognised her symptoms and immediately instigated treatment that she is alive today and is able to tell me her horrendous story. Her treatment was started in the hospital corridor, where she sat on a chair while on an intravenous drip, because there were no beds available, not only in that hospital but in any of the neighbouring hospitals in the trust.

The theme is the same from all my constituents who come to me with their horrendous experiences. The doctors, nurses and other healthcare staff are doing absolutely everything they can. They are on their knees. No one wants to blame them, because they can see that what is being asked of them is far beyond what anyone would ever be asked to do in any other profession, but they can all see that the system is at breaking point. Instead of berating the Red Cross for suggesting that our NHS is in the midst of a humanitarian crisis, let us stop for a moment and think about why it had to use that term. Let us talk about what we can do.

We owe our incredible junior doctors so much, and they have been treated appallingly recently. A friend of mine recently attended an outpatient appointment at our local hospital and mentioned to the overworked junior doctor that I was an MP. He pleaded with her to tell me how bad things were, how overworked they were, how the NHS was crumbling around us, and how he and his colleagues could not perform to the best of their abilities due to the horrendous pressure they were under. He talked about working 12 to 14-hour shifts with a 10-minute break. He told her that he loved his job, saying that it was a vocation, never just a job. He said that he was proud of this country and its national health service, and that the only thing that kept him working here instead of fleeing abroad, as many of his friends had done, was that he cared so much for his NHS.

When is the Secretary of State going to stand up and take responsibility for what is going on? People are waiting hours for ambulances and waiting for hours in A&E. They are being treated on trolleys in seminar rooms and in corridors. Where does this end? We are already seeing the creeping privatisation of our NHS, with companies such as the dreadful Virgin Care putting profits before patients. Perhaps the end goal is for us to move to an American-style system where people are literally dying on the streets and where someone turns up at A&E and the first question is, "Have you got insurance, and can you prove it?"

My constituency is served by two hospitals: Dewsbury and district hospital and Huddersfield royal infirmary. Both are due to be downgraded, losing vital services and beds as their respective trusts struggle to meet the financial pressures that have been placed on them. One of the hospitals that is supposed to pick up the resulting demand from the downgrades, Pinderfields hospital in Wakefield, was last week warning people against attending its A&E, and this is before the downgrades have even taken place. I am in absolutely no doubt that if the downgrades go ahead, lives will be lost. I plead with the Ministers and the Secretary of State to stop those downgrades now and to bring forward the much-needed funds that could save the lives of my constituents. It was interesting to hear the Prime Minister refer to those hospitals today at Prime Minister's questions. She said that there were two hospitals in the trust. Perhaps someone could pass on to her the fact that there are three.

I have quoted Nye Bevan, the founder of our great national health service, before, but I feel that this is more relevant today than ever. He said:

"The NHS will last as long as there are folk left with the faith to fight for it."

As those on the Conservative Benches appear to have lost faith and stopped fighting, it is our duty on the Labour Benches, now more than ever, to step up that fight. I would not like to speculate about when a Government Member last set foot in an NHS hospital outside of an official visit—[*Interruption.*]

Henry Smith: Between Christmas and new year.

Paula Sherriff: I thank the hon. Gentleman for his intervention. Perhaps he should show some more empathy for the patients who are waiting on trolleys for up to 10 hours just to be seen. One thing I know for sure is

[Paula Sherriff]

that many thousands of my constituents rely on such services every day and the message from them is unequivocal: the NHS needs funds, and needs them now.

I was admonished by Mr Speaker today for berating the Prime Minister during PMQs, but let me be absolutely clear: I will continue to do that while this mismanagement of our national health service is ongoing. I will never, ever stop fighting for our NHS.

5.10 pm

Maria Caulfield (Lewes) (Con): I appreciate the opportunity to speak in this debate. For the record, the last time I was in an NHS hospital was when I was working a night shift on Saturday. I declare an interest in that I am a nurse who has worked during this year's winter crisis, but I have also worked during winter for the past 20 years.

James Heappey: I apologise for intervening so early in my hon. Friend's speech, but the hon. Member for Dewsbury (Paula Sherriff) is too busy congratulating herself on her own speech to note that my hon. Friend was working in an NHS hospital on Saturday night.

Maria Caulfield: I thank my hon. Friend, but that is obviously not of interest to Labour Members. I have been a nurse for over 20 years and have seen 20 years' worth of winter crises. They are not unusual. There is no doubt that there is more pressure this year than ever before—we have heard about record numbers of people attending A&E—but there have been winter crises under many previous Governments. It was not unusual when I worked in A&E for patients to be treated in corridors or on chairs—wherever there was space. It was not unusual for ambulances to be queued up around the block, waiting for hours to unload patients—[*Interruption.*] I still work in the NHS and disagree with the chuntering from the Opposition Benches.

Dr Rosena Allin-Khan (Tooting) (Lab): Will the hon. Lady give way?

Maria Caulfield: I will not. I must make progress and others want to speak.

It was not unusual for my hospital to declare a major incident because we could not take any more patients. It was not unusual for us to take on the extra work when neighbouring hospitals declared major incidents. The truth hurts, but that is what has happened over my 20 years of working in the NHS and what has happened over the past few days of this winter crisis. It is outrageous for Labour Members to suggest that it is something new. They are in denial if they believe that it has not been happening for many years.

The Labour Government was so fixated on the four-hour rule that managers used to bully us and tell us which patients would get a bed based not on clinical need, but on the need to meet a target that was about to expire. I want to tell the House a story. One night I was working in a busy A&E when an elderly gentleman was admitted. He had fallen at home and broken his hip and had to be nursed on a trolley in the middle of a busy corridor. The four-hour target was looming, and at three and a half hours he called out to me and said, "Nurse, I

desperately need to go to the toilet." I had no cubicle to put that man in. He could not get off his trolley owing to his broken hip. The best that I could do under that Labour Government was to wheel a curtain around him and he went to the toilet there in the middle of a busy hospital corridor, with his war medals on his chest. Now, he got to a ward within four hours—his target was met—but that was not good care. If Labour Members think that it was and think that this is a new problem, they have buried their heads in the sand.

Dr Allin-Khan: Will the hon. Lady give way?

Liz McInnes (Heywood and Middleton) (Lab): Will the hon. Lady give way?

Maria Caulfield: I will not.

Mr Deputy Speaker (Mr Lindsay Hoyle): Order. If the hon. Lady wants to give way, she will. Unfortunately, she is not, but Members cannot just stand there—two at once—shouting all the time. It is recognised that if a Member is to give way, they will, but it is up to them.

Maria Caulfield: These problems are not new. I have also worked in out-patient settings where A&E targets have had an impact on patients waiting for elective surgery. The sheer determination to meet those targets due to pressure from the Labour Government led to patients with breast cancer having their elective operations cancelled time after time owing to emergency admissions. I had to tell a young mum, whose mastectomy operation following breast cancer had been cancelled three times while her young family were waiting for Christmas, that the only bed we had left was in a post-natal ward, where she woke up and recovered from her operation next to young mums learning to breastfeed. That was in an attempt to meet four-hour targets, so do not tell me that services have reduced. Targets were met, but staff were put under severe pressure not with quality of care but with targets in mind. I make no apologies in making that clear.

I am a supporter of four-hour targets. I was enthusiastic when they were introduced as a way of monitoring performance and improving the service, but they became the absolute king, above everything else. I congratulate the Secretary of State on introducing the consideration of outcomes. What happens to a patient when they are admitted? If they have to stay for four and a half hours to avoid admission or to get full care, what is the problem with that? If they can leave within two hours because they have been adequately treated, fantastic, but we should not be held to account by an arbitrary four-hour rule that has no clinical significance. I support the four-hour rule, but there are other measures that we also need to be aware of and that should be treated with equal status to the four-hour target.

Of course money is important. As our ageing population and our ability to treat more patients grows, we will need more funding for both healthcare and social care. It is worth noting that the trusts either side of my constituency receive the same funding and look after the same types and numbers of people. One is in special measures, is unable to deal with its discharges, has queues and is unable to meet its four-hour targets; the other, five miles along the coast, is rated outstanding, does not have the same pressures or four-hour waits and is able to discharge its patients speedily. There is something

about what happens to the money, as well as about how much the money amounts to.

Labour did put huge amounts of money into the NHS over the years, but much of it was squandered—£10 billion on a failed IT project that never saw the light of day, and PFI deals that are still costing the NHS £2 billion a year. How much could be done with that £2 billion?

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): Will my hon. Friend give way?

Maria Caulfield: I will take one brief intervention.

Dr Poulter: I commend my hon. Friend for making a balanced speech and for rightly saying that meeting targets does not necessarily equate to delivering good healthcare, although they do have their place. Does she agree that one of the biggest challenges is the consistent inability of a number of A&Es across the country to recruit middle-grade doctors? That is one of the biggest problems that has not been addressed to date.

Maria Caulfield: I absolutely agree that there is a problem in recruiting staff, particularly in the south-east—including in my constituency—in all healthcare professions because it is an expensive place to live. I agree that there is an issue with recruitment, but if we are to move forward, we need to work in a more cross-party way. Continually using four-hour targets as a stick to beat the Government with does nothing for cross-party working, so we need to stop the political cheap shots and recognise that money is not always the solution—it is about how the money is spent and the difference it can make. This also has to be clinically led. We can work together as politicians, but if we do not work with healthcare professionals, in both primary care and secondary care, I fear that we will be sitting here again in the years to come to talk about another winter crisis.

5.18 pm

Norman Lamb (North Norfolk) (LD): I join many others in commending those who work in our NHS and in our care system, including the hon. Members for Lewes (Maria Caulfield) and for Central Suffolk and North Ipswich (Dr Poulter) both of whom continue to work in the NHS, I think without payment—[*Interruption.*] Not any longer. It is important that we acknowledge that many people in the NHS are working under incredible strain, and we owe them a debt of real gratitude.

I make it clear that I support the Labour motion, and I recognise the importance of access standards in our health service. After arriving here in 2001, my first Westminster Hall debate was on waiting time standards in Norfolk for orthopaedic cases. People in those days were sometimes waiting three years for treatment. So the waiting time standards that were introduced dramatically changed people's experience of healthcare, and we should celebrate that. But it is also right to say that sometimes the standards distort behaviour, and those distortions need to be addressed, as the hon. Member for Lewes made clear. Another example to cite is that of the ambulance standards, where I am concerned about a very serious distortion of behaviour, which often causes

enormous frustration for paramedics, who are also working under ludicrous amounts of pressure.

The other point I wish to make on access standards is that although I totally applaud the Labour Government for introducing them, they did not introduce them for mental health. That is why we now have to complete the picture. This Government have confirmed that they accept in full the Paul Farmer taskforce report on mental health, but it includes the proposal to roll out comprehensive maximum waiting time standards in mental health, so that someone with mental ill health has exactly the same right as anyone else to get access to good-quality, evidence-based treatment on a timely basis. We put this in an amendment that we tabled for this debate but which was not selected, but I urge the Government, as they have accepted that report, to make sure it is now implemented. The current situation amounts to a discrimination in the health service; how can we possibly justify the fact that someone with mental ill health does not have the right to timely treatment that other people enjoy? We have to end that discrimination.

The final thing I wish to address relates to the question I asked the Prime Minister today. I asked her to meet a group of cross-party MPs who are proposing that the Government should establish what we are calling an NHS and care convention. We feel that is an opportunity to engage with the public in a mature debate about the scale of the challenge we all face. We can trade insults across this Chamber, but we all know in our heart of hearts that the system is under unsustainable pressure—that is the truth of it, and we know it. At some point, as the hon. Member for Lewes conceded, we will need extra resources in the future, so let us plan now. Let us get everybody on board and get cross-party support, because sometimes, just as we saw with Adair Turner in the last decade under the Labour Government, we need a process to unlock a problem that ordinary partisan politics has not been able to resolve.

I welcome the fact that the Prime Minister agreed today to meet a group of us who are making this call. We have also set up a petition on the Parliament website, so that any member of the public can join this call. I urge hon. Members from across this House who support this call to join in, because not only is it in the Government's political interest to do this, but it is fundamentally in the interests of the citizens of this country that we in this House collectively address an enormous existential challenge to the NHS and the care system. We surely cannot tolerate more than 1 million older people not getting access to the care and support they need. I do not want to live in a country where someone's access to care and support in old age depends on whether they can pay for it, but we are at genuine risk of slipping towards that situation. If we all believe that that is not tolerable, we have a duty to act. We must be prepared to act together, not just trade insults at each other. There is a real opportunity now to do what the public are desperately pleading for us to do: bury our differences and work together to achieve a long-term, sustainable settlement for the NHS and the care system.

5.23 pm

Derek Thomas (St Ives) (Con): There is no doubt in my mind that the meaningful integration of health and social care is the most important issue facing the NHS today. The most productive way to address the issue of

[Derek Thomas]

bed-blocking is by integrating services, pooling resources, and dramatically raising the profile of and support for community health professionals and care and support providers. We often hear of the problems facing the health services, but I am going to try to concentrate on the solutions.

Last November, I set up a local inquiry, identifying a number of people across the constituency and getting them together to investigate what health and social care could and should look like in west Cornwall—this is all part of the STP process in Cornwall and the Isles of Scilly. Together we are asking that question of representatives of health and social care providers. We are talking to GPs, NHS providers and managers, health campaigners, care providers, day-care managers, pharmacists, mental health clinicians, hospital matrons, Age UK and others. I am even including my predecessor in the discussions. All the clinicians we have met have identified savings that can be made through integration that they believe would improve patient care.

The results of the local inquiry will set out clear recommendations to be considered as part of the sustainability and planning process in Cornwall and the Isles of Scilly; however, it is clear from the evidence we have heard that extra funding will be required to implement the planned transformation. The health services in Cornwall and on the Isles of Scilly already have a deficit that runs into tens of millions of pounds. Delivering rural health services is an expensive and underfunded exercise in Cornwall and the Isles of Scilly, and we in that part of the country long for a fair funding agreement for health and social care. People in my constituency agree that we must integrate health and social care. They also agree that extra funds are urgently needed to fund that integration.

In the autumn statement, the Chancellor confirmed Government plans to continue to increase the tax allowance threshold for workers. I completely agree with efforts to lower the tax burden, but my constituents have asked me to look at how we might raise taxes to help the integration of health and social care. On that basis, would the Government consider pausing the increase announced in the autumn statement and using the revenue generated to fund the transformation of integrated services? That could provide just shy of £6 billion over the rest of the Parliament to help health and social care providers to make the improvements they need and to reduce costs in the long run, while improving patient care.

One example of where extra funding would have dramatic results is if the pay and support for care and support workers was increased. In west Cornwall, some community care workers are paid as little as £7.20 per hour, yet they do incredibly important work in keeping people at home and in safe and good conditions. Because of such low pay and the pressure on care workers, we struggle to recruit and retain such valuable employees. Were we to look at pausing the increase in the tax allowance threshold for just a short time, the money saved could help to integrate the services to which we are all committed, thereby helping to make the savings and improvements in patient care that we all want to see.

5.27 pm

Sue Hayman (Workington) (Lab): The Government say that their success regime for the NHS in Cumbria is about transforming health and social care to create a

“centre of excellence for integrated health and social care provision in rural, remote and dispersed communities.”

That sounds fantastic—it sounds like exactly what we need. If that is the case, though, why are local people are so concerned about the actual proposals that there is a petition for a vote of no confidence in the regime? Why did the Secretary of State himself say earlier in the debate that he has profound concerns about the quality of care in Cumbria?

West Cumbria is set to see rapid population growth, owing to the proposed nuclear new build at Moorside, alongside proposed coal mining and tidal energy projects. There are concerns that none of this is being taken into account. Nevertheless, I shall focus on my particular concerns about the proposals for maternity services and community hospitals.

First, on maternity, the highly skilled and experienced midwives in west Cumbria have told me that the success regime’s preferred maternity option is not their preferred option. The idea behind the success regime is to

“bring more care closer to home”,

with a model that would

“ensure provision of safe, high quality care and provide a first class experience”.

But the midwives ask how that can be achieved through the proposals to change maternity care at West Cumberland hospital when the success regime’s preferred option sees the choice of birthplace removed from hundreds of women and would potentially see severe delays in women and babies receiving life-saving assistance. The clinical outcomes and satisfaction rates at West Cumberland hospital under the current maternity care system are excellent and show that safe, high-quality care is being provided. The proposed changes would bring inequality, preventing fair access to maternity services across the county, and discriminate against west Cumbrian women who would no longer have a choice in maternity care, particularly those who are vulnerable owing to deprivation and social isolation.

The proposals will mean that around 700 additional women will deliver their babies at Carlisle every year, but where will they be cared for? The Cumberland infirmary in Carlisle already struggles with its current workload. West Cumbrian mothers need proper answers on this. In addition, a proposed new garden village is to be built south of Carlisle with 12,000 new homes. How on earth is the Cumberland infirmary expected to cope?

I am particularly disappointed that there is no option in the current consultation document to keep beds at Maryport and Wigton community hospitals. All the proposals remove all the beds at those hospitals. This will be particularly difficult for the relatives of patients who are having end-of-life care, because they may be elderly and have their own medical conditions. With no transport of their own, travelling to visit family members can be particularly arduous.

Both hospitals serve areas with considerable deprivation and very poor local transport links. Patients and families in Maryport may have to travel to the community

hospitals or the acute hospitals. Journey times would be long with poor bus links, making it difficult for elderly and disabled people.

The people of Maryport feel very strongly about the changes and have run a passionate campaign to show people involved in the success regime just how much the community hospital means to them and how it is an integral part of the local community. They are deeply upset at the removal of the beds.

It is imperative that all services are delivered as close to people's homes as possible. This must include the retention of beds at all our community hospitals and the retention of consultant-led maternity services at West Cumberland hospital.

I shall finish with a very personal experience, which relates in particular to beds in community hospitals. Not long before Christmas, my father was taken seriously ill. We managed to get him transferred from the acute hospital to his local community hospital, which was within walking distance of his home. He knew the staff at the hospital, and the district nurse was able to call in to see him. When it became clear that he was at the end of his life, we tried very hard to get him moved home—we had a hospital bed set up in the living room. Unfortunately, the move was not possible. However, unlike the experience of my hon. Friend the Member for Chesterfield (Toby Perkins), my father had a good death in his community hospital. All my constituents should have the same opportunity that my family had. We were able to be with my father at the local community hospital where he knew the staff and the district nurse who came to see him. If we remove palliative care from our community hospitals, we will be making a terrible mistake.

5.33 pm

James Heappey (Wells) (Con): The Wells constituency faces some real challenges in healthcare. We have an ageing population, and demand for the local NHS is growing rapidly. There is no doubt that our primary healthcare system is under considerable strain, as is our adult social care system. Our hospitals, too, face record demand. However, to call this a crisis does a disservice to those in the clinical commissioning group and our local hospital trust who have worked so hard to prepare for the incredible challenges that they face this winter.

Demand in the four A&Es that serve my constituency was significantly higher in the week between Christmas and the new year than in the same week the previous year. In two A&Es, demand almost doubled. I know that the A&E staff had to work extraordinarily hard to meet that demand and I know, too, from some constituents who contacted me that some people were not seen within the time that they might expect. However, I have heard from others who arrived at A&E expecting bedlam, only to be seen in well under four hours. Indeed, during last year's Christmas recess, I spent the early hours of Christmas eve in Weston general hospital's A&E with my then three-year-old. Like this year, the Labour Front Benchers were claiming crisis, yet I saw some incredible clinicians doing an incredible job well within the required timelines. Moreover, an outpatient appointment needed in the week between Christmas and new year was easily arranged and kept. My personal experience is just one of the millions of experiences within our NHS each year, but I highlight it because if we are to have an honest, factual debate about our health system, we should

caution against the emotion of individual experiences, for there will always be at least one that illustrates whatever point we seek to make.

Further into the hospital system, three of the four hospitals that serve the Wells constituency had more beds available in the last week of 2016 and the first week of 2017 than they did in the corresponding period in the previous year. Although occupancy at Taunton and Yeovil was 81% and 82% respectively last week, it is true that occupancy in Bath was 93%, and in Weston-super-Mare 100%. Make no mistake: occupancy levels such as those are a cause for real concern. But it is also important to note that although things are tight, so far the trusts are managing. However, I know that in all four of those hospitals, particularly in Weston, far too many beds are blocked by those who would be discharged if care at home could be arranged.

The Government have made more money available for adult social care and have given councils greater flexibility to increase council tax in the interim, but Somerset County Council and our local NHS organisations are justifiably still very concerned. I encourage the Government to look again at the local government funding settlement and adjust it to ensure that the funding gap between urban and rural areas does not widen and that funding for adult social care clearly and fully reflects the places in the country where the demographic is most top-heavy and where rurality increases the costs of delivering that support.

Finally there is the challenge that we face locally in primary healthcare. Local practices have assured me that anyone requiring an emergency appointment is seen on the day. However, it is true that my constituents are too often expected to wait a week or more if they ask to see their regular GP. Quite understandably for those with longstanding and complex health issues, they expect to see the doctor they know, so these waits are unacceptable, but it is wrong to connect the waits solely with funding. The greater challenge in Somerset is not the primary healthcare budget, which has risen for each of the past three years, but our ability to recruit new GPs.

The Secretary of State has worked hard to deliver more GPs into the whole system, but now rural CCGs such as Somerset's will need to look at what initiatives could be developed to encourage new GPs to ply their trade in rural general practice. Furthermore, we must listen to and support those responsible for our STPs. We have called again and again for politicians to keep our noses out of NHS planning. Now that we have and local clinicians are now at the helm, the Opposition dismiss their work as well because it is politically expedient to do so.

The STP in Somerset has been written by people who really know their craft. When I asked them whether they would have written the plan as it is, even if there were no resource constraints, they told me that they would. They say that the demand has changed and that the thinking on public health has changed, and they tell me that the clinical view of how and where people should recover after they have been in hospital has changed too. Things will change still further over the years ahead.

Some of the things that the STP proposes are very challenging to me and some will be very unpopular with the community I serve, but the analysis is based on an

[James Heappey]

expertise that far outstrips mine, so unless I am being implored now to reassert the supremacy of politicians in these matters—we have, after all, apparently had enough of experts—I think we owe it to the clinicians empowered to now design and run our local healthcare systems to scrutinise, of course, and to support them. Moreover, those clinicians deserve to do that work without the partisan hullabaloo being stirred up by the Opposition. Our inboxes give us a great feel for how things are. Our conversations with constituents, clinicians and patient participation groups, such as the one in Cheddar that I will see tomorrow night, shape that view, too. To claim that all is perfect right now is not true, but to claim that there is a crisis is not true either. Our population and the practice of medicine are changing. This debate needs to happen—not in a partisan furore, but in an honest, constructive and supportive way.

5.40 pm

Thangam Debbonaire (Bristol West) (Lab): I was going to speak about the effects of cuts to health and social care funding on hospitals and healthcare in the south-west, but all the things I wanted to say have been eloquently said by other hon. Members. So, in keeping with other speeches I have made recently, I have decided not to repeat what has already been said, to scrub all that from my speech and to talk about something completely different: the health consequences of loneliness in older people; the impact of funding cuts to NHS and social care systems on loneliness; and the impact of older people's loneliness, in turn, on the healthcare system.

In the run-up to Christmas, I was regularly blinking back tears on the underground whenever I saw the advert from Age UK, which I am sure many hon. Members will have seen, which had the slogan, "No one should have no one at Christmas". For Members who might not remember it, it looked something like the Age UK report "No one should have no one", which I have here and which I re-read yesterday. It was published in December last year and is about loneliness in old age. Reading that report brought home to me just how much loneliness affects older people and how funding cuts that may appear small and insignificant can have a cumulative effect on older people.

A constituent illustrated that to me recently when she came to talk to me about her worries for the older people she cares for as a very low-paid care assistant. She was not complaining about her pay, by the way—I am just making that observation. She told me that she regularly stays well beyond her low-paid hours because she feels the people she is working with need her. That is partly because they have greater care needs than can be dealt with in the time allowed, and because they are lonely. As I said, she was not complaining, but if we starve social care of funding, such people will be subsidising the health and social care system. She is doing that voluntarily, but things should not be left to chance like that.

The Age UK report mentions the survey that it carried out of 1,000 GP practices as part of its campaign in 2013 to end loneliness, which found that nearly 90% of GP practices felt that some patients were coming in because they were lonely. The report also points out that funding cuts mean that meals on wheels, day centres,

libraries, community centres, lunch clubs and public toilets have been cut or closed in recent years. It points out that all that decreases the opportunities for older people to get out, socialise, take care of their health, eat well and exercise, which increases their loneliness and isolation and damages their health.

What does that have to do with chronic serious illnesses? Age UK carried out an evidence-based review for its loneliness report, and it found that chronic loneliness increases the risk of serious illnesses such as diabetes, stroke, depression and dementia, as well as making it much harder for people to get out and receive help or do things that might prevent those conditions from getting worse, such as exercise or having a good diet.

I pay tribute today to all the people across the country who give their time as volunteers, staff and fundraisers for charities such as Age UK nationally and locally, and in Bristol, for Bristol Ageing Better, which does so much to combat loneliness in older people.

Let me read one example from the Age UK report:

"Arthur's son was worried that his health was deteriorating because of the many hours he was spending alone in his flat in sheltered accommodation. He was unwilling to participate in group activities because of difficulties hearing. He had had a busy social life, but most of his friends had died...Age UK introduced him to Paul, who had had to retire early after an accident and was feeling increasingly isolated...They play dominoes and cribbage. They dissect the latest football match and reminisce about their time in the building trade—swapping funny stories of mishaps and adventures. Paul has provided Arthur with good company and a 'link' back to the job he loved. Arthur has helped restore Paul's sense of purpose and self-worth."

That example and the many others in the report show just how much work on loneliness can help to improve older people's health and to reduce the costs on our health and social care system.

It is vital for the Secretary of State to address what the CEOs and staff in NHS hospitals and primary care in my area have told me about the impact that cuts to social care have on delaying discharge from hospital, and I hope that he does so. I also want the Minister to tell us exactly how he and the Secretary of State are going to lead the way in providing us with a fully integrated and fully funded health and social care and mental healthcare service.

I want us all to read Age UK's report and follow the recommendations that it makes for MPs, among others. It asks Members of Parliament to

"Find out...about loneliness among older people in your constituency...raise awareness...Become an Age Champion", and to encourage our own political parties to do more. It asks us to

"Take steps to put loneliness in later life on the Government's agenda"—

I hereby do that—

"and hold them to account for progress",

which I will continue to do. It asks us to

"Make the case for investment in local community resources to support sustainable, long term action to help lonely older people, wherever they may be."

I urge the Government to take note of that. Finally, it asks us to

"Support the work of the Jo Cox Commission on Loneliness",

which is launching shortly. I would like us all to take those words to heart.

5.46 pm

Helen Whately (Faversham and Mid Kent) (Con): It is a pleasure to speak in this debate and to follow hon. Members who have made very thoughtful contributions. The hon. Member for Bristol West (Thangam Debbonaire) spoke about loneliness, which is a problem across the country, and the very important work that is being done on that. It is also a pleasure to follow colleagues who have spoken about their personal and family experiences. My hon. Friend the Member for Wells (James Heappey), the hon. Member for Chesterfield (Toby Perkins), who is no longer in his place, and the hon. Member for Workington (Sue Hayman) spoke about their experiences, both good and bad, of the national health service.

I, too, have personal experiences both good and bad. Three years ago, I spent Christmas night in A&E with my son, who was five at the time, and who had his appendix taken out first thing in the morning on Boxing day. He had absolutely exemplary care and was home within two days, eagerly making up for the quantity of sausages that he had omitted to eat on Christmas day because of his tummy ache. Last Christmas, my grandmother, then aged 100, was in hospital—she was there for several months—and she had a much, much worse experience; it was not the NHS at its best. We all have good and bad experiences to draw on. We hear from our constituents, as well, about these good and bad experiences. It is important to recognise what the NHS does well, and is doing well, but also where the system is failing, and to focus on supporting the good and tackling the bad.

I very much understand why this debate has been called, because there is no question but that the NHS is under extraordinary pressure this winter. We have heard that last week it had the busiest week ever. However, I am quite disappointed by the tone of some of the contributions and more significantly by the lack of proposals from those who just said that there is no money and made no suggestions as to where the money will come from. That is fundamentally unhelpful.

Barbara Keeley: It is very clear where the money is to come from—we are asking for £700 million to be brought forward from the better care fund from 2019. It is already allocated.

Helen Whately: I appreciate the hon. Lady's point, but bringing money forward still requires it to be found. This is set against a backdrop of Labour, in 2015—less than two years ago—not committing to fund the NHS with the money that it was asking for, as this Conservative Government are now doing. Labour is in rather a shocking position.

I want to seize this opportunity to say a very heartfelt thank you to all members of NHS staff—nurses, doctors, allied health professionals, porters, care assistants—and those in social services, particularly those in and around my constituency in Kent, who I know are working extremely hard to deal with the pressure on the frontline. I also thank patients and their families who are being thoughtful and taking care to make the best use of the NHS.

We know that there is great variation in how the NHS is coping. I have just been told that the waiting time in Maidstone A&E is—as we speak—only 37 minutes, so Maidstone is coping pretty well right now, but at the

nearby William Harvey hospital in Ashford it is over four hours, so there is variation. I do not say that so that people listening can divert from where they are going; there may be a case for that and for greater transparency, but that is for another day.

We talked earlier about money. There is no question but that this issue is partly about the need for more funding and more staff, but the Government are doing exactly that: they are giving the NHS more money and investing in significant increases in the workforce. However, money is not the whole answer. If the NHS just continued doing all it does in the way that it does without any change, we would find ourselves with a system that was unaffordable and that used a proportion of GDP for which there would not be public support. We know that we have an ageing population—people are living longer and have multiple complex conditions—and that high-cost treatments are becoming available that people want, so the NHS itself recognises that this is not just about more money but about changing the way in which services are delivered.

Such changes are being worked on and are actually happening at the moment. Earlier today, I spoke to the hospital trust chief executive who is the lead for the Kent and Medway sustainability and transformation plan. STPs have come up several times today. As I have seen, under him and the group around him, there has been a coming together across Kent and Medway of NHS organisations that have not tended to work closely together. The coming together of the NHS and social services is so important, so necessary and so right if we are to work out how to provide a better health service in a more sustainable way. We need to break down the barriers between organisations, as it just does not make sense to have a split between the NHS and social care in who provides what. We should look at how we can genuinely move care out of acute hospitals and closer to home, which we know is good for patients. It is exactly what the hon. Member for Workington hoped for her father and what we wanted for my grandmother as she neared the end of her life.

We need to enable people to be looked after closer to home or preferably at home, and to improve prevention and—I feel particularly strongly about this—mental health care. The Prime Minister has taken a personal lead on mental healthcare with her announcements on Monday. In the light of the pressure on A&E, I particularly value the commitment to psychiatric liaison in A&E departments, which we know is helpful in the prevention of suicide, is good for people who go to A&E with mental health problems and helps A&Es look after the people who need to be seen for physical health problems. I welcome the fact that my area of Kent is looking at bringing that forward and having psychiatric liaison in all A&Es by 2018. Really important work is therefore going on at local level.

I encourage Labour Members not to make the knee-jerk or even tear-jerk speeches that some have made, but to take a longer view of the situation. That would help us to have a more mature conversation about what the NHS needs and to talk about policies and concrete proposals, rather than just about having more money, to solve the problems. It would also enable us to get behind what the NHS is doing at local level, where the NHS and local authorities are coming together to draw up plans across their areas for better care for patients in an affordable and sustainable way.

5.54 pm

Dr Rosena Allin-Khan (Tooting) (Lab): After four years of having responsibility for the national health service, the Secretary of State for Health has declared:

“We need to have an honest discussion with the public about the purpose of A&E departments”.

We, who have seen his work from this House, and those who have felt the effects of his work on the frontline know exactly what he means:—“Let me tell you why everyone is to blame except for me.”

Earlier this week, the Secretary of State told the UK that nearly one in three visits to accident and emergency do not need to be made. That was his reasoning for weakening the target that every patient should be seen within four hours. That target applies only to people whose condition is serious and urgent enough, so I find staggering the sheer hubris of those comments, the avoidance of accountability in that decision and the danger inherent in both. As an A&E specialist doctor, I have treated patients who arrive in A&E with what seem like minor injuries or illnesses but develop into much more serious and life-threatening issues. The fact that the Secretary of State, both in his words and in that decision, is telling the people of the UK that they should self-diagnose before heading to A&E could have disastrous consequences, for which he would be responsible.

What if, because of the Secretary of State's words, patients decided to stay at home after a serious bang on the head that turns out to be a life-threatening bleed to the brain? What about a potentially deteriorating case of pneumonia that is not serious enough to warrant being in A&E but eventually results in somebody becoming severely septic and dying?

As a citizen of this country and a patient of the NHS, I find the Secretary of State's refusal to accept responsibility for the state of A&E departments deplorable. Instead, he blames patients for visits that “do not need to be made”. However, patients do not go to A&E for fun. They go because they are ill and cannot get a doctor's appointment for two weeks. We have heard today from Members on both sides of the House who have taken their own young children to A&E. Did they do so for fun, or because they felt there was a need for their child to be treated? People go to A&E because their GP does not have resources at their practice, in some cases for something as simple as handing out crutches. They go to A&E because there is something wrong and they are worried sick and simply desperate to speak to somebody professional about their health.

Victoria Atkins: Will the hon. Lady give way?

Dr Allin-Khan: No, I will not. [*Interruption.*]

Mr Deputy Speaker (Mr Lindsay Hoyle): Order. Let us just calm it down. Government Members did not give way before, and let us not get into the habit of shouting at each other. Let us have a nice, sensible debate.

Dr Allin-Khan: Many people who go to A&E know that they should not be there. I have had elderly patients saying to me, “I'm so sorry, doctor, for wasting your time.” But what other option are the Government leaving them? That is what we are debating today. The Secretary of State wants an honest conversation—well, let us have it. Let us talk about the impact that the current state of

the national health service, which he has been in charge of for four years, is having on accident and emergency departments and throughout hospitals in this country. Let us talk about rock-bottom staff morale. Let us talk about the breakdown of staff marriages, a rise in depression among staff and the fact that waiting times are not the responsibility of patients. They are not to blame.

Rising waiting times are the Secretary of State's responsibility, yet he blames them on the number of people going to A&E since the target was set. It is his responsibility to lead a national health service that can meet the needs of its people, but again he pleads innocence. He says that no other countries have such stringent targets, suggesting that it is unfair that we do. The meeting of the A&E target in particular, not watered down but in full, is what establishes the NHS as the best health service in the world, and one that we can, should and would be proud of under a Labour Government. After all, emergency departments' ability to meet the four-hour target is directly related to the health of the NHS itself. It is simple: more people go to A&E when they have no other options available.

Sue Hayman: On those options, the use of A&E in my area of Cumbria is entirely down to the lack of GPs. With so many GPs reaching retirement age, the situation is only going to become more acute. Does my hon. Friend agree that the Government need to tackle this matter urgently?

Dr Allin-Khan: I wholeheartedly agree with my hon. Friend. She makes an eloquent point about the lack of GPs and the problems we will face when more retire. Three GPs in my constituency contacted me this week to say that they had been offered jobs that were subsequently retracted due to financial pressures.

The Secretary of State pleads innocence. He says no other countries have such stringent targets. We should not compare ourselves to the worst; we should be leading as the best. The explosion of waiting times is his failure and a sign of the dangerous erosion of one of the country's greatest institutions. As we saw last week when the British Red Cross had to be drafted in to our hospitals, our NHS is in crisis. Yet instead of listening to doctors and fixing the systemic problems they have created, our Government are repackaging the A&E four-hour target to try to save face and take attention away from the real challenges: the challenge of social care packages not being in place, prohibiting flow through A&E departments; the lack of access to GPs across the country, making A&E the only resort; the chronic underfunding and significant cuts in funding at local authority level; doctors and nurses being forced to miss breaks, as we heard earlier today, and working 14 hours, some without a break, sleep-deprived and unsafe to practise clinical work; and an NHS staff who do not feel supported, encouraged or motivated by the Government. None of these things will be addressed by a watered down four-hour target.

Having spoken to the Royal College of Emergency Medicine, those working on the frontline at all levels, and those who are training our junior doctors, I would like to put forward questions for the Secretary of State to think about. Why has it been decided that the four-hour target will now be downgraded? Who has been consulted on that? Which body said it would be beneficial to

patients and A&E staff across the trusts? How will he define major and minor health problems? How are doctors and nurses magically meant to know, at first sight without proper assessment, whether it is a major or minor health problem? Who is responsible if a seemingly minor condition is actually life-threatening? Will it be him? Who will be responsible? How will the Government explain that we will be going back to the days when patients could wait over 12 hours if they were not considered ill enough?

The Secretary of State must recognise the impact of this systemic crisis on A&E rooms across the country in his words and in this decision. In downgrading the target, the Secretary of State does neither, instead placing blame on patients and putting patients at risk. Let me tell it straight: I have been an A&E specialist doctor under a Labour Government and under a Conservative Government. There has been a change under this Government—and for sure it has not been for the better.

6.3 pm

Lucy Allan (Telford) (Con): There have been very many excellent and constructive contributions to this debate. I welcome the valuable input from those who have real life experience in the NHS. In particular, I congratulate my hon. Friend the Member for Lewes (Maria Caulfield) on her excellent speech. It was very disappointing indeed to see an Opposition Member behave with such disrespect for a fellow Member during that speech. We all owe a debt of gratitude to those on the frontline. None of them would thank us for reducing this debate to an ill-tempered party political act of posturing.

I know there are many sensible Opposition Members who fully understand that no complex problem is ever solved by just increasing funding in response to ever-increasing demand. There are some very strong Opposition Members who want to work in a constructive fashion with Members across the House to tackle the challenges our NHS faces. I welcome that. The right hon. Member for Don Valley (Caroline Flint) is one such sensible Member. She made a point earlier this week, on the BBC Radio 4 programme “Westminster Hour”, that it is not even electorally advantageous for the Labour party to treat the NHS in the way it so often does—we have just heard an example of it. It is for the benefit of all our constituents that we must all encourage a more constructive approach.

The four-hour target was introduced for those with urgent health problems. I am sure that all Members agree that those in need should get access to care as soon as possible, and not find their needs eclipsed by someone with a minor ailment just because targets must be met. The Secretary of State has spoken this week about his commitment to protecting the four-hour promise for those who need it, and he is absolutely right to say this, because today, if we talk to those who work in our local A&Es, as all Members do regularly, they often say that there are people going to A&E who do not need to do so, and clinicians will express the desire to be able to prioritise need, rather than simply meeting targets.

As a constituency MP, I fully understand that it can be incredibly difficult to see a GP when one wants to, and it can be equally difficult to navigate the system—ringing at the right moment to get an appointment on the right day—but the answer is not simply to

circumnavigate the system and turn up at A&E to get fast-tracked irrespective of need. We should not be encouraging the expectation that whatever the ailment, no matter what the demands on A&E staff, if someone goes to A&E, they will get seen within four hours. If people are going to A&E who do not need to be there, why are we offering them the four-hour service?

I would be grateful if the Minister told us more about what can be done to tackle this issue. Perhaps he could mention what proposals there are for GPs in A&E or different mechanisms for triaging or managing the expectations of our constituents. What matters most is that those in need get access to the appropriate treatment as soon as possible. That is what the target is for. It must be about safety for those with critical and urgent health conditions.

We must never lose sight, either, of the fact that our health and wellbeing are often dependent on our lifestyle, and with the right help and support we can all make the right choices to help us live healthy and happy lives. Diet, stress management, sleep hygiene, exercise, alcohol use and smoking are all key determinants of our physical and mental health and wellbeing. I would like a much greater emphasis to be placed on self-care and self-help, because we can all play our part and because no amount of funding will ever compensate for a lack of self-care.

Yes, we need to take a grown-up and honest approach to this incredibly important issue, which matters to all of us who have spoken so passionately today—I respect the passion of all Members on both sides of the House—but we must avoid falling into the trap that some have fallen into today of approaching this debate in a way that lets ourselves and the House down and does not benefit those we most wish to assist. So, yes, let us keep on exploring a sensible and collaborative approach, as articulated so eloquently by the right hon. Member for North Norfolk (Norman Lamb) and my hon. Friend the Member for Totnes (Dr Wollaston), who has echoed the sentiments of others and is doing excellent work in working together across the House. None of us should ever play politics with the NHS; it matters far too much for simple games.

6.8 pm

Jenny Chapman (Darlington) (Lab): It is a pleasure to follow the hon. Member for Telford (Lucy Allan). I have not heard her speak before, and I look forward to hearing many more speeches from her in the future, but I completely disagree with her implication that we are letting ourselves, the House and our constituents down by standing up and championing health services in our constituencies. It is an essential part of our work and the reason many of us sought election to this place, particularly those such as my hon. Friend the Member for Tooting (Dr Allin-Khan), who has such relevant experience of this subject and made a tremendous speech. I listened with great interest to what she had to say, and I think that Ministers ought to be doing the same.

We have had a lot of debate about whether the NHS is in crisis and whether it is a humanitarian crisis, an ordinary crisis or a winter crisis. I looked the word up and found that a crisis is “a period of intense difficulty or danger”, which strikes me as a good description of where the NHS is today. Intense difficulty is what I am seeing in my local hospital, and it is what my constituents are coming to tell me about.

[Jenny Chapman]

I have been an MP for nearly seven years, and I keep track of the topics people come to talk to me about in my local surgeries. I am sure many of us do that; it is not hard to do. Someone comes to see me every week either about an experience at the hospital or, more often still, because of an experience in adult social care. That is not something that has occurred suddenly over the last few weeks; it has been growing over time. I would say that the crisis we are witnessing today has been long predicted and is something that we have all felt happening over time.

The Government have chosen—they made a decision—not to act to prevent the worsening of the crisis, which is why there is such anger on the Opposition Benches. When a quarter of patients wait longer than four hours in A&E, that is a crisis. I do not really care whether they are there with an minor ailment or a more serious one, because four hours is too long to wait. The fact that people are there with minor ailments is a very clear demonstration of the problems that exist elsewhere in the system.

When people cannot get a GP appointment they sometimes phone 111, and, more often than not, they will be directed to A&E. I think we need a selection of services available at a central point, whereby if people need a GP, they can see a GP; if they need a practice nurse, they can see a practice nurse; and if they need to be admitted, they can be admitted.

Victoria Atkins: In an effort to reassure her colleagues, I want to ask a genuine question—one that I would have asked the hon. Member for Tooting (Dr Allin-Khan). What impact does the hon. Lady believe the 2004 GP contract has had on out-of-hours care? This seems to be the nub of many of the issues discussed this afternoon.

Jenny Chapman: The GP contract was changed in 2004, but I did not notice the sort of issues that we face today until far more recently. I am not a scientist or a doctor, but I understand cause and effect, and it does not ring true to say that something that happened six years prior to the change in government can be blamed for something that is happening six years after the change in government. I am not saying that there were no consequences, but I believe that ample opportunity has been provided to put measures in place that would have prevented us from being where we are now.

The hon. Lady's intervention leads me nicely to my next point, which is about the Secretary of State. I had not intended to speak today, but I was so frustrated listening to him on the "Today" programme, trying to blame anybody but himself, that I decided to do so. He has a pattern. The first thing he does is blame the Labour Government, who were in government until 2010. His party has been in government since then, but he will blame Labour for anything he possibly can. He will find something that happened, perhaps at a particular trust and say that that is why something has gone wrong today. If that does not work and cannot be evidenced, he will say, "Well, that particular trust is a basket case. It is the trust's fault or the fault of the local managers and local clinicians who have not organised themselves right."

If that does not work, he will then blame the public, and tell them that they are going to the wrong place, accessing their care in a way that he does not think they should. He might call them "frequent flyers" or point to a problem that is the public's fault. He will say, "They do not look after themselves properly; it is clearly their fault." If that does not work, he will blame the local council, and I think that is the worst thing that I have heard him do—blame the local authority.

My local authority has prioritised adult social care, but the pressures are not going away. They are going to get worse and more difficult to manage—and it is running out of things to cut. It is closing our central library in Darlington and making other hideous cuts, and I do not know where the next round will come from.

Robert Courts (Witney) (Con): I am sure the hon. Lady agrees that it is incumbent on us all to discuss the future of our NHS and our healthcare services responsibly. Does she not accept that when the Secretary of State is talking about where people go for their services, it is not a question of blame? We ought to move away from that blame culture. However, there is a benefit in trying to educate people. If their illnesses are not best served by A&E departments and are best served elsewhere, they ought to realise that they should go elsewhere. That would help us all. It would help the people who are seeking the services, and it would help the people who are providing them.

Jenny Chapman: Yes indeed, so why does the hon. Gentleman not say that to his right hon. Friend the Secretary of State? He is the one who is blaming people, not me. I should welcome a programme that involved explaining to people and making it easier for members of the public, including me, to decide where we should go when we need assistance.

One solution that the Government have come up with seems to involve watering down the four-hour target, although, interestingly, not even Conservative Members seem to be able to agree on—or explain—what change will be made, or even whether there will be a change. Their other solution is to close A&E departments, and, as part of the STP, the A&E department at Darlington memorial hospital is one of those that may be downgraded or closed. I do not think the local community will accept that. Part of our purpose in doing our job is to give a voice to local communities, but, so far, our local community has been completely shut out of the STP process. We would not have even known what was contained in the plan had it not been leaked by Hartlepool Borough Council on its website. That is a shocking way in which to conduct a dialogue with a local community.

In parallel with the STP process is the Better Health programme, which started about three years ago and which operates in the region that contains my constituency. I was shocked to discover from responses to parliamentary questions that local health managers had spent £4.6 million that could and should have been spent on frontline health services for my constituents on a consultation on whether or not to downgrade A&E. I could have spent that money a great deal better, and I could also have told those health managers what the local population thinks about the proposal. They are very angry and

upset about it, and it is right for us to express such anger, disappointment, outrage and fears for safety in the House.

Many Members have spoken about their families and relatives today. My hon. Friends the Member for Chesterfield (Toby Perkins) and for Workington (Sue Hayman) spoke about their fathers. My dad died in 1994. He had had a heart condition. He was 48, and I was 20. Since then, I have taken a keen interest in cardiac health and services for people with heart disease. I was shocked to find that, before 1997, it was not uncommon for people to die while waiting for heart treatment and that people would often wait 18 months. The Labour Government changed that: we made it a matter of weeks, and we saved countless lives as a consequence.

When people say that the Labour party did not do a good job with the NHS, and when Conservative Members try to imply that we have a fake, dewy-eyed, sentimental attachment to the NHS, they are completely wrong to do so. We will fight for the NHS. We created it, but we also did a good job running it in government. We saved lives, cut waiting times and introduced targets, and that made a difference. It made things better for patients. We will never stop making that case, in the House and outside.

Several hon. Members *rose*—

Madam Deputy Speaker (Mrs Eleanor Laing): Order. I am afraid that this is rather unfair on those who have waited all day and have not yet spoken, but some Members have taken much more than seven minutes, and I must now reduce the time limit to five minutes.

6.19 pm

Jo Churchill (Bury St Edmunds) (Con): I pay tribute to all who work in our national health service and welcome this important debate. I hear the Secretary of State not blaming, but looking for solutions; that is more what we should be about. I have called for an honest debate about the NHS since I came to this place. The NHS is 70 years old next year, and if it is going to reach 100 we need to look after it.

But I want to start with the positive. My own hospital, West Suffolk, saw a 20% increase between Christmas and new year in the number of patients admitted. Those patients were poorly—very poorly; that point was made earlier. The hospital had prepared a resilience plan for a 5% uplift in patient numbers, but it has coped spectacularly well. To refer to a point made by the hon. Member for Tooting (Dr Allin-Khan), who is no longer present, people come into A&E with ingrowing toenails and dry skin, and it is important that we make sure we see the most poorly people in the most appropriate way and use resources most effectively.

My constituency has the second oldest population in the country. There is an ageing population with comorbidities, and in the next 10 years the number of those aged 85-plus will rise by 45%, so the allocation of resources as we go forward is important.

But my hospital has been one of the most resilient in the east, at 85%, and its resilience is in most part due to its fantastic staff. West Suffolk hospital has been innovative. It pays for 20 beds in Glastonbury court, a facility owned by Care UK to provide a step-down facility. In

January, it will be doing a bridging care service with the councils. Improvement will come through prevention and integration, and not always by shouting for more money.

My hon. Friend the Member for Faversham and Mid Kent (Helen Whately) said that what we need is good integration. Good working in Suffolk needs to be copied. As my hon. Friend the Member for Wells (James Heappey) and the hon. Member for Central Ayrshire (Dr Whitford) said, STPs need to be looked at as a force for good, and I urge Labour not to knock them, but to work with them. They are clinician-led, which is what everybody was asking for.

We cannot have everything we want in life—we never can—and we cannot have everything we want out of the NHS. That is why we need an honest conversation. With rising expectations and an ageing population, the private sector has been in use in the NHS since 1948. If we are going to get more bang for our buck, we should perhaps look at parts of the private sector, to be able to enhance what we give patients through these critical periods.

Simon Hoare (North Dorset) (Con): My hon. Friend is absolutely right about the need for a grown-up debate about integration and about learning from best practice. Does she share my concern that as Labour Members fan the flames of their artificial indignation, all they are doing is proving yet again that they are either unwilling, ill-equipped or ideologically—

Madam Deputy Speaker (Mrs Eleanor Laing): Thank you. Jo Churchill.

Jo Churchill: I agree in that since we last debated this with the Opposition on 23 November, apart from asking for £700 million to be brought forward, they have put forward very little in the way of tangible plans. We are talking about everybody here, and just slinging bows and arrows across the Chamber will not get us to the solution we need.

If this is about money, why do some areas do better than others? It is actually about the allocation of resources and good leadership. I have received three letters about good healthcare. A resident in my constituency saw the GP on 28 October, the consultant on 8 November, and had their operation on the 29th. That was at my district general hospital that used the private facility locally to enhance the patient experience.

We need a long-term solution. I am pleased that the Prime Minister has spoken about tackling the difficulties of mental health. The right hon. Member for North Norfolk (Norman Lamb) has championed that and shares a mental health trust with me. I am pleased to see that another 49,000 people are being treated for cancer—that is something that I came to this place to champion—and another 822,000 people are receiving specialist cancer treatment. We have seen huge increases in demand, and we need to admit that we cannot just carry on. There have been advances in drugs, but we need to take into account comorbidities and an ageing population.

We need to understand what is wrong, and we will do that by having better data throughout the system. The Richmond Group wrote in support of my private Member's Bill that information held in healthcare records has a huge potential to provide better care and improve health

[Jo Churchill]

service delivery within the service. Paramedics have asked me for better access to data so that, when they find someone on the floor, they will know what meds they are on and what the most beneficial treatment would be. GPs want their information to flow through the system to help social care and the hospital sector. Pharmacies need to be able to read and write, and those working in social care need to be able to look at someone's pathway. Patient outcomes should be the thing that we are all talking about, but we have to make decisions. At the centre of all this, we need to support those colleagues who are working above and beyond at this time. We need to behave in a grown-up, responsible way, just as they are, in caring for our NHS.

6.26 pm

Margaret Greenwood (Wirral West) (Lab): The fact that an organisation as highly respected as the Red Cross should describe our NHS as facing a "humanitarian crisis" is absolutely shocking. It goes to the heart of this Government's failure to provide a reliable, properly resourced national health service free at the point of need. That should be a source of shame for the Government. Reports last week that two patients died on trolleys in corridors—one having waited 35 hours to be seen—are truly shocking. Can this really be the face of the NHS in England in 2017? Under the Tories, it seems that it is. The Health Secretary responded by suggesting that the four-hour target should apply only to the most urgent cases and that it was estimated that 30% of patients in A&E did not really need to be there. In other words, he blamed patients and suggested a downgrade of A&E services. He should hang his head in shame.

It is this Tory Government who have decided to cut funding to the health service, asking it to make savings of £22 billion. In Cheshire and Merseyside, the NHS has to find savings of £1 billion. Wirral clinical commissioning group calculates that it will have a £12 million deficit for the year 2015-16, nearly a third higher than the original £9 million forecast, but NHS England has asked it to maintain the forecast at £9 million. I would be interested to hear why this curious request has been made. Patients in Wirral West are concerned about the impact that these savings—or cuts—will have at Arrowe Park hospital and in general practice, and they are right to be concerned. The biggest financial squeeze in the history of the NHS is putting services at risk.

Let us be clear: there is nothing inevitable about these Tory cuts. This is a political decision and it is being used to drive through changes including the introduction of accountable care organisations, borrowing a model from America where such organisations are used to deliver private insurance-based healthcare. An NHS manager from my constituency has written to me saying:

"The STPs and national policy are currently pushing for a redesign of services—primary care at scale and a move to make system-wide organisations. The real punch line is there is no funding to make these changes. Locally there is talk about an Accountable Care Organisation for Wirral—meetings of senior managers across health and social care are being held on almost a weekly basis to create a roadmap for this to happen. With no money with which to do it. Having fragmented services and finally recognised the failure and destruction caused by the faux 'internal market' in the NHS, they are now making services use

what pitiful resources they have to try and put it all back together. I truly despair that there will not be an NHS this time next year."

That is a stark warning and a damning indictment of the Government's failure. The Secretary of State should be addressing the crisis by giving the NHS and social care the funding they need, to make up for this crisis of the Government's own making around access to GP appointments, a failure to train enough nursing staff, a failure to fund social care, and cuts to community pharmacies when communities need them most.

I have long been aware of the Tories' agenda for the national health service. The Health and Social Care Act 2012 opened it up to the private sector, so that profit-hungry companies can cherry-pick the work that they want to deliver and allowed NHS hospitals to give half their beds to private patients. I believe that this Government and previous Tory Governments are seeking to move us to a two-tier system in which those who can afford to do so have private health insurance and the rest are left with a bargain-basement NHS. The arc of NHS history during the Tories' time in office since the Thatcher period shows this, and we now appear to be reaching the end game.

The Government are cutting the supply of healthcare in the public sector to create demand in the private sector. The Secretary of State may believe in an ideological drive to introduce a system in which the individual pays their own way through individual private insurance—he is of course entitled to that view—but that is an entirely different concept from a national health service, of which Labour Members are so proud. He must be honest about that. In the process of trying to transfer us to a two-tier, insurance-based model, did he not pause to think about the human suffering he would unleash in the process? Patients wait for hours on trolleys while anxious relatives watch on helplessly, and dedicated staff are stressed out day after day.

Now is the time for a decision. It is not too late for the Government to review their approach. They can face the facts and admit to themselves that English people want a state-managed, state-funded national health service that is free at the point of use and paid for through direct taxation—just like the one created after the second world war by a Labour Government with such vision and which became the envy of the world. The Government should swallow their ideological pride and say, "Okay, we get it. We will fund the national health service." Anything less will be a betrayal of all that the NHS stands for.

6.30 pm

Huw Merriman (Bexhill and Battle) (Con): We need to look afresh at the entire health and social care pathway, which is why I am delighted to be able to contribute today. From visiting the pharmacist, to attending a GP appointment, to spending time in hospital, whether planned or through A&E, to being able to reside beforehand and afterwards at home or in a care home, we need to find the most efficient and dignified way to treat and look after people. We must avoid using one treatment centre as a default option—that is not the best option either for the individual or for the public purse—because it is the only one available owing to difficulties with individual funding pots, opening hours or lack of access to better forms of provision. We must also be encouraged to speak freely about the pressures in the system and to

provide ideas. It has frustrated me for years that anyone who thinks aloud about ideas that could change health and social care for the better is denigrated as seeking to harm it when the opposite is true.

To that end, I listened with interest to the Secretary of State's interview on Radio 4 on Monday morning. It struck me as measured and thoughtful about new ideas. I was particularly interested in the suggestion about how we could deliver more capacity in the GP system, because an increasing number of people attending A&E are neither accident victims nor in need of emergency treatment; they do, however, need some form of medical intervention, as the Secretary of State mentioned. It was then thoroughly depressing to read the Secretary of State's words taken out of context. I hope that he will continue to think outside the box and that all Members will recognise the benefits of his so doing.

Speaking of ideas, I have the following suggestions for each of the treatment centres in the health pathway, starting with pharmacies. In the event that we have too many pharmacy clusters, I completely agree with the need to ensure that they are spread out across the country, with the money saved being recycled. At the same time, we should find ways to help pharmacies deliver more interventions to free up capacity at GP surgeries. We must do more to signpost patients to pharmacies before they go to their GP. A recent report costed common ailment treatment in community pharmacies at £29 a patient. The cost rises to £82 for GP practices and to £147 for A&E. Treatment results across all three were equally good. The research estimated that 5% of GP consultations for common ailments could be managed by community pharmacies, equating to more than 18 million GP consultations that could be diverted.

I was buoyed by the Secretary of State's suggestion that more GPs should be placed in A&E departments and in care homes. The new NHS pilot requiring GPs to undertake weekly ward rounds in care homes is the right type of thinking to prevent emergency treatment in our hospitals. I welcome GP surgeries opening on Sundays, but surely only one surgery in each area needs to be open. I do not believe that having all GP surgeries open seven days a week is a good use of scarce resources, in the same way that Government funding of two pharmacies across the road from each other is not a good use of such resources.

I have long taken the view that we need to find ways to free up our GPs' time, so that they can focus on the patients who need them most. There are too many wasted or cancelled appointments because the service is free. If there was a cost to unjustifiably failing to keep an appointment, it may demonstrate how precious this resource is—just as NHS dentists would charge for a missed appointment when I was younger.

Some of the reforms of pharmacies and GPs are designed to ensure that patients only attend A&E if they have had an accident or in an emergency, which is clearly not the case for some who are now attending. We are also facing demand for hospital places because of a need to reform the way we look after an ageing population.

Time does not allow me to talk about social care, which is so important in my constituency, but the Government's delivery of more social care funding before Christmas is welcome. However, it is crucial that we

question the operating model in social care. The NHS benefits from a national funding programme, but social care is largely the responsibility of local authorities and local rate payers in areas where retirement rates may be high but employment and council tax receipts are not. We have to think radically to ensure that we get the best out of our health and social care system. To do so will not only make resources stretch further but will deliver innovation that improves the lives of the sick and infirm, who are most in need of our care.

6.35 pm

Liz McInnes (Heywood and Middleton) (Lab): Two days ago, the Health Secretary read out a statement in this Chamber on the crisis in our NHS. His answer to his Government's failure to meet A&E waiting time targets is to downgrade those targets, rather than seeking to take any action to treat the malaise at the heart of our NHS.

The Health Secretary heaped praise on our hard-working and dedicated NHS staff—praise they richly deserve—but it will ring hollow with many of them. I speak from years of experience working in the NHS as a clinical scientist with staff of all grades, skills and experience. The simple truth is that NHS staff are demoralised, and, as I said two days ago, they continue to work with care and compassion in spite of, not because of, his action.

Since that statement, I have been inundated by NHS staff wanting to tell me their stories: of how the service they were once proud to work in is now in perpetual crisis; of the strain of wanting to do their best for their patients but being prevented from doing so because of short staffing, overcrowding, delayed discharges and underfunding; of the emails they get from Ministers demanding to know what they will do about the failure to meet targets; and of their listening to the same Ministers telling the public that the NHS does not have a problem.

Health managers are saying that we have a perfect storm of ageing patients who need more care just at the time when social care has been cut to the bone, leaving hospitals to pick up the pieces. An A&E doctor at Manchester royal infirmary told me:

“Crisis is the new normal”.

The doctor said that it has become usual to have 10 patients waiting in a corridor.

In my constituency of Heywood and Middleton, the Pennine Acute Hospitals NHS Trust has just been the subject of a damning report revealing appalling neglect in maternity care that led to the avoidable deaths of mothers and babies. The trust had the most 12-hour A&E waits in October and the second most cancelled urgent operations in November. In December, it was forced to divert ambulances 14 times in total, one of the highest figures in the country.

Social care across Greater Manchester faces collapse. That is borne out by the delayed discharge figures for Greater Manchester, which doubled in the year to October. Greater Manchester asked for £200 million for social care in the autumn statement, but the issue was not even mentioned. Some see Greater Manchester's devolved healthcare system as a solution, but even its chief officer, Jon Rouse, says that although devolution can help closer working it is not “magic dust”.

[Liz McInnes]

I remind the Health Secretary of the NHS constitution for England, which was updated in October 2015 and establishes the principles and values of the NHS in England. It sets out rights to which patients, the public and staff are entitled, and it sets out pledges that the NHS has committed to achieve. Enshrined in the constitution is the patient's right to be cared for in a clean, safe, secure and suitable environment and their right to be protected from abuse and neglect—in other words, not to have to wait in an A&E corridor.

Patients and the public have the right to be involved in the planning of healthcare services, in changes to the way that healthcare services are provided and in decisions affecting the operation of those services. For NHS staff, one of the pledges is to engage staff in decisions that affect them and the services they provide, yet I see precious little evidence of staff, patients or the public having any input into the 44 STPs covering the regions of England, which appear to have been drawn up behind closed doors and are shrouded in secrecy. Their impact on healthcare in our regions could be huge, but where is the public involvement?

Patients are being failed on this Government's watch and their rights to safe care are being neglected. All the Health Secretary has for NHS staff is the occasional flurry of warm words, yet the war he waged over the junior doctors' contract showed his real attitude towards NHS staff. Nye Bevan said:

"no government that attempts to destroy the Health Service can hope to command the support of the British people."

That is from Bevan's book of essays "In place of Fear". Sadly, the current Health Secretary has managed to achieve "replacing the fear".

6.40 pm

Barbara Keeley (Worsley and Eccles South) (Lab): I want to start by paying tribute to our hard-working staff in the NHS and those in the care sector. The best way to thank those staff would be by giving them the resources they need to do the job we want them to do.

I welcome the contributions made by hon. Members today, particularly the moving contribution from my hon. Friend the Member for Chesterfield (Toby Perkins), who bravely told us about the personal catastrophe for him and his family when his father was sent home from a pressured A&E, sadly to die from an aneurysm. My hon. Friend the Member for Workington (Sue Hayman) was able to tell us about the happy death her father had with the end-of-life care at the local community hospital.

The hon. Members for Central Ayrshire (Dr Whitford) and for Totnes (Dr Wollaston) both emphasised the complexity and frailty of patients needing care in the winter months. We should remember that in terms of the scale of pressures facing the NHS. Both those Members supported the four-hour target for A&E as a barometer of the wider system pressures in the NHS: a measure of how the system is managing to process those frail and complex patients. My right hon. Friend the Member for Doncaster Central (Dame Rosie Winterton), as a former Minister for emergency care, urged the Government not to give the NHS the impression of giving up on the four-hour target, as that sends the

wrong message. At our NHS leaders' summit yesterday, we heard a real concern that, for instance, parents might be discouraged from taking their children to A&E.

Conservative Members have cited both Simon Stevens and Chris Hopson in support of their claims on NHS funding, but I would like to update them, because in the House this afternoon Simon Stevens said that

"we got less than we asked for"

and that the Government are

"stretching it to say the NHS...got more".

He also said that it does not help anybody to pretend there are not financial gaps. Chris Hopson, of NHS Providers, said:

"No, we don't believe the NHS has got all the money it needs"

and that the NHS is not sustainable on current funding.

I turn now to the pressures on the NHS caused by social care. The crisis in our hospitals has been made much worse by the Government's continued failure to fund social care properly. The care crisis is caused by insufficient funding in the face of growing demand, and Ministers have ignored warnings from a wide group of doctors and from leaders and professionals in the health and care sectors. The Government failed to produce a single penny of extra funding for social care in the autumn settlement. Then they told us that extra funding was being made available for social care in the local government funding settlement, but this was not the extra funding so desperately needed from central Government—what Ministers did was to shift the burden on to council tax payers. That was made worse by the fact that the £240 million adult social care grant was actually money recycled within local government budgets, from the new homes bonus. One third of councils will be worse off as a result of this settlement; my own local authority, Salford, will have £2.3 million less in its budgets. This is not a boost to social care.

What health and social care leaders had pleaded for was for Ministers to bring forward funding promised for 2019 to address the current crisis in social care, and that is what today's motion proposes. That would provide some breathing space, which is needed because the lack of social care means that thousands of older people are stuck in hospital waiting for a care package in their own home. That was the most common cause of delayed discharges caused by social care. More than a third of the record 200,000 delayed days most recently reported were due to lack of social care. Being stuck in hospital not only affects patient morale and mobility; it increases the risk of the patient getting hospital-acquired infections. The major impact, though, is the knock-on effect on people in A&E who are waiting for a bed for an emergency admission.

Health Ministers like to blame local authorities for the lack of social care, but there are problems with that. When NHS chief executive, Simon Stevens, gave evidence to the Communities and Local Government Committee's recent inquiry into social care, he was asked by the Chair, my hon. Friend the Member for Sheffield South East (Mr Betts), what extra resources would be needed if every local authority performed as well on delayed discharge as the best local authority. He said:

"Even having sorted that out, if we have a widening gap between the availability of social care and the rising number of frail old people, that is going to show up as extra pressure on them, their families, carers and of course the NHS."

Of course we want to reach a position where the best practice in tackling delays is spread throughout the country, but Ministers have to start to reflect on what their Government have done through the cuts they have inflicted on local authority budgets. Figures from the Local Government Association show that the hardest hit local authority has had cuts to its budget of 53% over the past five years; the average cut is 39%.

The budget cut for Surrey was at the lower end of the scale, at 29%. Even so, the cabinet member for social care in Surrey, Councillor Mel Few, wrote a letter to *The Guardian* about the issues faced by his local authority. He said:

“The Care Quality Commission is not the only organisation with worries about inadequate adult social care funding and the impact on already clogged-up hospitals.”

He went on to say that although the social care precept was

“a welcome move, it falls many millions of pounds short of what is needed now—let alone in two decades.”

I suggest that the Health Secretary and the Chancellor talk to social care leaders such as Councillor Few to understand the needs that they see in local communities and the impact of the lack of social care on NHS hospitals. Ministers have been warned and warned about the impact of cuts on social care, but they have ignored those warnings. The Royal College of Emergency Medicine has said that emergency care is

“on its knees...mainly due to a lack of investment in both social and acute health care beds”.

Sir Nicholas Soames (Mid Sussex) (Con): Will the hon. Lady give way on that point?

Barbara Keeley: No, I will not.

The BBC has reported that last week there were 18,000 trolley waits—that is, people waiting on a trolley in a hospital corridor—of more than four hours, and there were 485 cases of patients waiting more than 12 hours. My hon. Friend the Member for Preston (Mr Hendrick) rightly said that we do not even know the figures for patients waiting in corridors, or being treated and waiting on a chair because of a lack of trolleys.

The figures do not tell us about the misery for patients and their family members waiting with them. Last night, a senior A&E consultant said on “ITV News” that patients can be left with absolutely no dignity during these waits. He said:

“We have got patients with severe illnesses on chairs receiving drips, antibiotics, medications, and patients with cardiac problems on chairs because there are no trolleys for them to go on to.”

The senior doctor talked about patients who were left unable to move off their trolleys or who were stuck on chairs and about a lack of shutters and blinds, meaning that patients can be left in full view of others while they are being treated. He also reported that some patients were incontinent in front of relatives and strangers because hospital staff could not reach them in time. He said:

“Patients have absolutely no dignity left.”

That is what the lack of social care and acute beds can lead to. How would any of us feel if that was our relative?

The situation may get worse with the expected cold weather, when more major incidents may be declared and more hospitals are put on black alert—the most severe warning level, which means that they cannot cope with the number of patients.

Downgrading the four-hour waiting time target for A&E misses the point that the problems in emergency departments are a symptom of a much wider problem. As has been discussed in the debate, that four-hour target is a proxy for patient safety. It is miserable for a sick patient to lose their dignity through being incontinent during a trolley wait in a hospital corridor. It is also miserable and frightening for a vulnerable patient to be discharged in the middle of the night to a cold home with no care package. That is why we repeat in the motion our call for the Government to bring forward £700 million of the funding promised to social care in 2019 to help the NHS and social care systems to cope with the extra pressures this winter. We are also calling for a new, improved settlement for the NHS and social care to be included in the Budget in March, so that we avoid this sort of crisis in future.

Staff in emergency departments are at the sharp end of saving lives. Many other NHS staff save lives, too, but A&E staff are so directly on the frontline. Whether they are working in people's homes or in care or nursing homes, care staff make a huge difference to the lives of millions of older and vulnerable people, people with disabilities and people with mental health conditions. Those should be the best jobs in the UK, but without the right investment in the funding they need, the people doing them feel undervalued and overstretched. I urge Members to vote for the motion tonight.

6.49 pm

The Minister of State, Department of Health (Mr Philip Dunne): I am pleased to follow the hon. Member for Worsley and Eccles South (Barbara Keeley) and to be able to close this debate. I thank all 34 hon. Members for their contributions, some of whom—mostly those on the Government Benches—managed to rise above party politics and make some constructive comments.

I join my right hon. Friend the Secretary of State in thanking the 2.7 million staff working in our NHS and social care system. As the Prime Minister said earlier, we recognise that they have never worked harder to keep patients safe, with A&Es across the country seeing a record number of patients within four hours in one day last month.

Regrettably, after five and a half hours of debate and criticism from Labour Members, we have heard little, if anything, about how to provide solutions to the challenges that our A&Es face.

Once again, the Opposition have touted more funding as their only answer to solve public sector challenges. In fact, they have pledged to raise corporation tax eight times, promising an unspecified amount from an unspecified source. That will not help our NHS and it will not fool the public. There is much to do to protect the system and ensure a sustainable future, but it is this Government who have plans in place to get through this extremely challenging period and sustain the NHS for the future.

The shadow Secretary of State, the hon. Member for Leicester South (Jonathan Ashworth), spoke for about three quarters of an hour without making a single suggestion about how to solve the problems that face

[Mr Philip Dunne]

the NHS—not one. He should have stayed to listen—he may have done and I apologise if I did not pay enough attention to his presence in the Chamber.

The former Health Minister, the right hon. Member for Doncaster Central (Dame Rosie Winterton), asked specifically for community pharmacists to be paid for providing minor ailments services. I am pleased to be able to tell her that that is precisely what we are doing. The Under-Secretary of State for Health, my hon. Friend the Member for Warrington South (David Mowat), was discussing that only this morning in Westminster Hall, and I regret to say that not a single Labour Member was present to hear what he had to say. [Interruption.]

Madam Deputy Speaker (Mrs Eleanor Laing): Order. Surely the House wants to hear the Minister after this long debate—with courtesy.

Mr Dunne: We have heard a number of comments from Opposition Members—I am pleased to say that they were outnumbered in this Opposition day debate by Government Members—rehearsing some tired phrases to mislead the public over alleged increasing independent provision in the health service and also misrepresenting what my right hon. Friend the Secretary of State was saying in his remarks about A&E targets. Having said that, I wish to pay tribute to the hon. Member for Chesterfield (Toby Perkins), who is in his place, and the hon. Member for Workington (Sue Hayman), both of whom showed considerable personal courage in explaining the circumstances surrounding the death of each of their fathers, and they did so in an entirely honourable and sensible way, and I am grateful to them for sharing that experience.

I congratulate my hon. Friend the Member for Faversham and Mid Kent (Helen Whately) on managing to get her son into hospital to have his appendix treated on Boxing day. As she said, that showed that that service was working well.

The Opposition sought to take the moral high ground in this debate. The hon. Member for Dewsbury (Paula Sherriff) challenged Government Members on whether they had visited hospitals over the Christmas period other than on an official visit. Her position was completely punctured by my hon. Friend the Member for Lewes (Maria Caulfield) who pointed out that she was doing a night shift between Christmas and new year in her role as a nurse—she was not on an official visit.

There have been some impressive contributions. I thank the Chair of the Select Committee on Health, my hon. Friend the Member for Totnes (Dr Wollaston), who was supportive of a more nuanced target for A&E, and for her calm and generally constructive comments, and my right hon. Friend the Member for Chelmsford (Sir Simon Burns) for his support for the success regime in Essex and for pointing out that it is not closing any of the three A&E departments in the hospitals there. I also thank my hon. Friend the Member for Crawley (Henry Smith), who made a very thoughtful speech and welcomed the opening of an assessment unit in Crawley to help to relieve pressure on the A&Es nearby. Finally, I thank my right hon. Friend the Member for Forest of Dean (Mr Harper) for another thoughtful contribution from the Back Benches.

Of course, the Conservative party and the Government recognise that our NHS faces the immediate pressures of the colder weather and the wider pressures of an ageing and growing population. There were nearly 9 million more visits last year to our A&Es compared with 2002-03—the year before the four-hour commitment was made. That is more than 2 million A&E attendances every month, and our emergency departments are now seeing, within the four-hour target, 2,500 more people every single day compared with 2010.

Luciana Berger: Will the Minister give way?

Mr Dunne: I will not give way. The hon. Lady did not give way and I have a very short time left in which to speak.

Compared to when the Conservative party came into office in May 2010, in 2015-16 there were 2.4 million more A&E attendances. That is in the context of a much busier NHS overall. The NHS is delivering 5.9 million more diagnostic tests. Some 822,000 more people are seen by a specialist for suspected cancer and 49,000 more patients start treatment for cancer every year compared with the year before we came to office. It is therefore the case that a Government of any colour would be faced with the same problems, but it is this Government who have committed to funding the NHS's own plan for a sustainable future. Had we followed Labour's plans, the NHS would have £1.3 billion a year less, which is equivalent to 13,000 fewer doctors or 30,000 fewer nurses.

We remain committed to the vital four-hour A&E promise for those patients who need to be there. We are proud to be the only country in the world to commit to all patients that we will sort out any urgent health need within four hours. Only three other countries—New Zealand, Australia and Canada—have similar national standards, but none of theirs is as stringent as ours.

Today it is the Conservative party that is the party of the NHS. That is why we pledged more than Labour did and why we are delivering more funding with a higher proportion of total Government spending going into health in each year since 2010. Funding for the NHS will rise in real terms by £10 billion by 2020-21 compared with 2014-15. That sum is front-loaded with £6 billion being delivered by the end of this year, as the NHS asked for. It was this Government who established an independent NHS with an independent chief executive. It was this NHS that came up with its own plan and we were the only party to back it. We agree that the NHS and social care face huge pressure and, yes, there is more for us as a Government to do. However, we entered winter with a more comprehensive plan than ever before, and we have confidence that plans are in place to cope with the current pressures we face—winter, A&E and delayed discharges—and to sustain the system for the future.

I conclude by saying a huge thank you to the 1.3 million staff in the NHS and the 1.4 million people who provide social care. They are the ones who continue to make this possible. We are aware of the pressures they are under, especially during winter. We have increased the number of doctors and nurses, as the Secretary of State said earlier, especially in A&E, and we have launched plans to recruit more doctors and nurses. Without them, we would not have a national health service that provides such a high level of care.

Mr Nicholas Brown (Newcastle upon Tyne East) (Lab)
claimed to move the closure (Standing Order No. 36).

Question put forthwith, That the Question be now put.

Question agreed to.

*Question put accordingly (Standing Order No. 31(2)),
That the original words stand part of the Question.*

The House divided: Ayes 209, Noes 295.

Division No. 122]

[6.59 pm

AYES

Abbott, Ms Diane
Abrahams, Debbie
Alexander, Heidi
Ali, Rushanara
Allin-Khan, Dr Rosena
Anderson, Mr David
Ashworth, Jonathan
Austin, Ian
Bailey, Mr Adrian
Barron, rh Sir Kevin
Beckett, rh Margaret
Benn, rh Hilary
Berger, Luciana
Betts, Mr Clive
Blenkinsop, Tom
Blomfield, Paul
Brabin, Tracy
Bradshaw, rh Mr Ben
Brake, rh Tom
Brown, Lyn
Brown, rh Mr Nicholas
Bryant, Chris
Buck, Ms Karen
Burgon, Richard
Burnham, rh Andy
Butler, Dawn
Byrne, rh Liam
Campbell, rh Mr Alan
Carmichael, rh Mr Alistair
Champion, Sarah
Chapman, Jenny
Coaker, Vernon
Coffey, Ann
Cooper, Julie
Cooper, rh Yvette
Corbyn, rh Jeremy
Coyle, Neil
Crausby, Sir David
Creagh, Mary
Creasy, Stella
Cruddas, Jon
Cryer, John
Cunningham, Alex
Cunningham, Mr Jim
Dakin, Nic
Danczuk, Simon
David, Wayne
Davies, Geraint
De Piero, Gloria
Debbonaire, Thangam
Doughty, Stephen
Dowd, Jim
Dowd, Peter
Dugher, Michael
Durkan, Mark
Eagle, Ms Angela
Eagle, Maria
Edwards, Jonathan
Efford, Clive
Elliott, Julie
Ellman, Mrs Louise
Elmore, Chris
Esterson, Bill
Evans, Chris
Farrelly, Paul
Farron, Tim
Field, rh Frank
Fitzpatrick, Jim
Fleelo, Robert
Fletcher, Colleen
Flint, rh Caroline
Flynn, Paul
Fovargue, Yvonne
Furniss, Gill
Gapes, Mike
Gardiner, Barry
Glass, Pat
Glindon, Mary
Godsiff, Mr Roger
Goodman, Helen
Green, Kate
Greenwood, Lilian
Greenwood, Margaret
Griffith, Nia
Haigh, Louise
Hamilton, Fabian
Hanson, rh Mr David
Harris, Carolyn
Hayes, Helen
Hayman, Sue
Healey, rh John
Hendrick, Mr Mark
Hepburn, Mr Stephen
Hillier, Meg
Hodgson, Mrs Sharon
Hopkins, Kelvin
Howarth, rh Mr George
Huq, Dr Rupa
Hussain, Imran
Jarvis, Dan
Johnson, rh Alan
Jones, Gerald
Jones, Graham
Jones, Helen
Jones, Mr Kevan
Jones, Susan Elan
Kane, Mike
Keeley, Barbara
Kendall, Liz
Kinahan, Danny
Kinnock, Stephen
Kyle, Peter
Lamb, rh Norman
Lammy, rh Mr David
Lavery, Ian
Leslie, Chris

Lewell-Buck, Mrs Emma
Lewis, Clive
Long Bailey, Rebecca
Lucas, Ian C.
Lynch, Holly
Mactaggart, rh Fiona
Madders, Justin
Mahmood, Mr Khalid
Mahmood, Shabana
Malhotra, Seema
Mann, John
Marris, Rob
Marsden, Gordon
Maskell, Rachael
Matheson, Christian
McCarthy, Kerry
McDonald, Andy
McDonnell, rh John
McFadden, rh Mr Pat
McGinn, Conor
McInnes, Liz
McKinnell, Catherine
McMahon, Jim
Meale, Sir Alan
Mearns, Ian
Miliband, rh Edward
Moon, Mrs Madeleine
Morden, Jessica
Mulholland, Greg
Murray, Ian
Olney, Sarah
Onn, Melanie
Onwurah, Chi
Osamor, Kate
Owen, Albert
Pearce, Teresa
Pennycook, Matthew
Perkins, Toby
Phillips, Jess
Pound, Stephen
Pugh, John
Rayner, Angela
Reed, Mr Steve
Rees, Christina
Reynolds, Emma
Reynolds, Jonathan
Ritchie, Ms Margaret
Robinson, Mr Geoffrey
Rotheram, Steve

Ryan, rh Joan
Saville Roberts, Liz
Shah, Naz
Sharma, Mr Virendra
Sheerman, Mr Barry
Sherriff, Paula
Shuker, Mr Gavin
Siddiq, Tulip
Skinner, Mr Dennis
Smeeth, Ruth
Smith, rh Mr Andrew
Smith, Angela
Smith, Cat
Smith, Jeff
Smith, Owen
Spellar, rh Mr John
Starmer, Keir
Stevens, Jo
Streeting, Wes
Stringer, Graham
Stuart, rh Ms Gisela
Tami, Mark
Thomas, Mr Gareth
Thomas-Symonds, Nick
Thornberry, Emily
Timms, rh Stephen
Trickett, Jon
Turley, Anna
Turner, Karl
Twigg, Derek
Twigg, Stephen
Vaz, rh Keith
Vaz, Valerie
Watson, Mr Tom
West, Catherine
Whitehead, Dr Alan
Whitford, Dr Philippa
Williams, Hywel
Williams, Mr Mark
Winnick, Mr David
Winterton, rh Dame Rosie
Woodcock, John
Wright, Mr Iain
Zeichner, Daniel

Tellers for the Ayes:

**Vicky Foxcroft and
Nick Smith**

NOES

Adams, Nigel
Afriyie, Adam
Aldous, Peter
Allan, Lucy
Allen, Heidi
Amess, Sir David
Andrew, Stuart
Ansell, Caroline
Argar, Edward
Atkins, Victoria
Bacon, Mr Richard
Baker, Mr Steve
Baldwin, Harriett
Barclay, Stephen
Baron, Mr John
Barwell, Gavin
Bellingham, Sir Henry
Benyon, Richard
Beresford, Sir Paul
Berry, Jake
Berry, James
Bingham, Andrew
Blackman, Bob
Blackwood, Nicola
Blunt, Crispin
Bone, Mr Peter
Borwick, Victoria
Bottomley, Sir Peter
Bradley, rh Karen
Brady, Mr Graham
Brazier, Sir Julian
Bridgen, Andrew
Brine, Steve
Bruce, Fiona
Buckland, Robert
Burns, Conor
Burns, rh Sir Simon
Burrowes, Mr David
Burt, rh Alistair
Cairns, rh Alun

Carmichael, Neil
 Cartlidge, James
 Cash, Sir William
 Caulfield, Maria
 Chalk, Alex
 Chishti, Rehman
 Chope, Mr Christopher
 Churchill, Jo
 Clarke, rh Mr Kenneth
 Cleverly, James
 Clifton-Brown, Geoffrey
 Coffey, Dr Thérèse
 Collins, Damian
 Colvile, Oliver
 Courts, Robert
 Cox, Mr Geoffrey
 Crabb, rh Stephen
 Crouch, Tracey
 Davies, Chris
 Davies, David T. C.
 Davies, Glyn
 Davies, Dr James
 Davies, Mims
 Davies, Philip
 Davis, rh Mr David
 Donelan, Michelle
 Dorries, Nadine
 Double, Steve
 Dowden, Oliver
 Doyle-Price, Jackie
 Drax, Richard
 Drummond, Mrs Flick
 Duncan Smith, rh Mr Iain
 Dunne, Mr Philip
 Ellis, Michael
 Ellison, Jane
 Ellwood, Mr Tobias
 Elphicke, Charlie
 Eustice, George
 Evans, Graham
 Evans, Mr Nigel
 Evennett, rh David
 Fabricant, Michael
 Fallon, rh Sir Michael
 Fernandes, Suella
 Field, rh Mark
 Foster, Kevin
 Fox, rh Dr Liam
 Francois, rh Mr Mark
 Frazer, Lucy
 Freeman, George
 Freer, Mike
 Fuller, Richard
 Fysh, Marcus
 Gale, Sir Roger
 Garnier, rh Sir Edward
 Garnier, Mark
 Gauke, rh Mr David
 Gibb, Mr Nick
 Gillan, rh Mrs Cheryl
 Glen, John
 Goodwill, Mr Robert
 Gove, rh Michael
 Graham, Richard
 Grant, Mrs Helen
 Gray, Mr James
 Grayling, rh Chris
 Green, Chris
 Green, rh Damian
 Greening, rh Justine
 Grieve, rh Mr Dominic
 Gummer, rh Ben

Gyimah, Mr Sam
 Halfon, rh Robert
 Hall, Luke
 Hammond, rh Mr Philip
 Hancock, rh Matt
 Hands, rh Greg
 Harper, rh Mr Mark
 Harrington, Richard
 Harris, Rebecca
 Hart, Simon
 Haselhurst, rh Sir Alan
 Hayes, rh Mr John
 Heald, rh Sir Oliver
 Heappey, James
 Heaton-Harris, Chris
 Heaton-Jones, Peter
 Henderson, Gordon
 Herbert, rh Nick
 Hinds, Damian
 Hoare, Simon
 Hollingbery, George
 Hollinrake, Kevin
 Hollobone, Mr Philip
 Holloway, Mr Adam
 Howarth, Sir Gerald
 Howell, John
 Howlett, Ben
 Huddleston, Nigel
 Hunt, rh Mr Jeremy
 Hurd, Mr Nick
 Jackson, Mr Stewart
 James, Margot
 Javid, rh Sajid
 Jayawardena, Mr Ranil
 Jenkin, Mr Bernard
 Jenkyns, Andrea
 Jenrick, Robert
 Johnson, Dr Caroline
 Johnson, Gareth
 Johnson, Joseph
 Jones, Andrew
 Jones, rh Mr David
 Jones, Mr Marcus
 Kawczynski, Daniel
 Kennedy, Seema
 Kirby, Simon
 Knight, Julian
 Kwarteng, Kwasi
 Lancaster, Mark
 Latham, Pauline
 Leadsom, rh Andrea
 Lee, Dr Phillip
 Lefroy, Jeremy
 Leigh, Sir Edward
 Leslie, Charlotte
 Letwin, rh Sir Oliver
 Lewis, rh Brandon
 Lewis, rh Dr Julian
 Liddell-Grainger, Mr Ian
 Lidington, rh Mr David
 Lilley, rh Mr Peter
 Lopresti, Jack
 Lord, Jonathan
 Loughton, Tim
 Mackinlay, Craig
 Mackintosh, David
 Main, Mrs Anne
 Mak, Mr Alan
 Malthouse, Kit
 Mann, Scott
 Maynard, Paul
 McCartney, Karl

McLoughlin, rh Sir Patrick
 McPartland, Stephen
 Menzies, Mark
 Mercer, Johnny
 Merriman, Huw
 Metcalfe, Stephen
 Miller, rh Mrs Maria
 Milling, Amanda
 Mills, Nigel
 Milton, rh Anne
 Mordaunt, Penny
 Morgan, rh Nicky
 Morris, Anne Marie
 Morris, David
 Morris, James
 Morton, Wendy
 Mowat, David
 Mundell, rh David
 Murray, Mrs Sheryll
 Murrison, Dr Andrew
 Neill, Robert
 Newton, Sarah
 Nokes, Caroline
 Norman, Jesse
 Nuttall, Mr David
 Offord, Dr Matthew
 Osborne, rh Mr George
 Patel, rh Priti
 Paterson, rh Mr Owen
 Pawsey, Mark
 Penning, rh Mike
 Penrose, John
 Percy, Andrew
 Perry, Claire
 Philp, Chris
 Pickles, rh Sir Eric
 Pow, Rebecca
 Prentis, Victoria
 Prisk, Mr Mark
 Pritchard, Mark
 Pursglove, Tom
 Quin, Jeremy
 Quince, Will
 Raab, Mr Dominic
 Redwood, rh John
 Rees-Mogg, Mr Jacob
 Robertson, Mr Laurence
 Rosindell, Andrew
 Rudd, rh Amber
 Rutley, David
 Sandbach, Antoinette
 Scully, Paul
 Selous, Andrew
 Sharma, Alok
 Shelbrooke, Alec
 Simpson, rh Mr Keith
 Skidmore, Chris
 Smith, Henry

Smith, Julian
 Smith, Royston
 Soames, rh Sir Nicholas
 Solloway, Amanda
 Spelman, rh Dame Caroline
 Spencer, Mark
 Stephenson, Andrew
 Stevenson, John
 Stewart, Bob
 Stewart, Iain
 Stewart, Rory
 Streeter, Mr Gary
 Stride, Mel
 Stuart, Graham
 Sturdy, Julian
 Sunak, Rishi
 Swayne, rh Sir Desmond
 Swire, rh Sir Hugo
 Syms, Mr Robert
 Thomas, Derek
 Throup, Maggie
 Timpson, Edward
 Tolhurst, Kelly
 Tomlinson, Justin
 Tomlinson, Michael
 Tracey, Craig
 Tredinnick, David
 Trevelyan, Mrs Anne-Marie
 Truss, rh Elizabeth
 Turner, Mr Andrew
 Tyrie, rh Mr Andrew
 Vaizey, rh Mr Edward
 Vara, Mr Shailesh
 Vickers, Martin
 Villiers, rh Mrs Theresa
 Walker, Mr Charles
 Walker, Mr Robin
 Wallace, Mr Ben
 Warman, Matt
 Wharton, James
 Whately, Helen
 Wheeler, Heather
 White, Chris
 Whittaker, Craig
 Whittingdale, rh Mr John
 Wiggin, Bill
 Williams, Craig
 Williamson, rh Gavin
 Wilson, Mr Rob
 Wollaston, Dr Sarah
 Wood, Mike
 Wragg, William
 Zahawi, Nadhim

Tellers for the Noes:
Christopher Pincher and
Andrew Griffiths

Question accordingly negated.

Question put forthwith (Standing Order No. 31(2)).
 That the proposed words be there added.

Question agreed to.

The Deputy Speaker declared the main Question, as amended, to be agreed to (Standing Order No. 31(2)).

Resolved,

That this House commends NHS staff for their hard work in ensuring record numbers of patients are being seen in A&E; supports and endorses the target for 95 per cent of patients using A&E to be seen and discharged or admitted within four hours;

welcomes the Government's support for the Five Year Forward View, the NHS's own plan to reduce pressure on hospitals by expanding community provision; notes that improvements to 111 and ensuring evening and weekend access to GPs, already covering 17 million people, will further help to relieve that pressure; and believes that funding for the NHS and social care is underpinned by the maintenance of a strong economy, which under this administration is now the fastest growing in the G7.

Margaret Greenwood: On a point of order, Madam Deputy Speaker—[*Interruption.*]

Madam Deputy Speaker (Mrs Eleanor Laing): Order. If Members wish to have conversations, they should go somewhere else. The hon. Lady is making a point of order.

Margaret Greenwood: The Minister told the House that there were no Labour Back Benchers in this morning's debate on community pharmacies. In fact, he has inadvertently misled the House in that regard, because I was in Westminster Hall and I spoke in the debate, as was my hon. Friend the Member for Sefton Central (Bill Esterson), who also spoke in the debate. I just wanted to put the record straight.

Madam Deputy Speaker: I understand the hon. Lady's point of order. It is not a matter for the Chair, but I understand why she wished to make the point.

Mr Dunne rose—

Madam Deputy Speaker: It looks as though the Minister would like to say something further to that point of order.

Mr Dunne: Further to that point of order, Madam Deputy Speaker. To give the House complete clarity, I understand that two Labour Back Benchers were present and made minor interventions in the Westminster Hall debate, but there were no speeches or substantive contributions by those Labour Members.

Madam Deputy Speaker: I am sure that the House is grateful to the Minister for clarifying what he said in his speech, and to the hon. Lady for clarifying the position. The matter is now closed.

Business without Debate

DELEGATED LEGISLATION

Motion made, and Question put forthwith (Standing Order No. 118(6)),

LOCAL GOVERNMENT

That the draft Combined Authorities (Mayoral Elections) Order 2017, which was laid before this House on 28 November, be approved.—(*Christopher Pincher.*)

The Deputy Speaker's opinion as to the decision of the Question being challenged, the Division was deferred until Wednesday 18 January (Standing Order No. 41A).

Motion made, and Question put forthwith (Standing Order No. 118(6)),

That the draft Combined Authorities (Mayors) (Filling of Vacancies) Order 2017, which was laid before this House on 28 November, be approved.—(*Christopher Pincher.*)

Question agreed to.

PETITIONS

7.15 pm

Mary Creagh (Wakefield) (Lab): I rise to present a petition of 2,000 residents of Wakefield on the future of the King Street health centre in my constituency, whose GP service is under threat of being withdrawn—a very important issue for my constituents.

The petition states that the petitioners

request the House of Commons to urge the Government and Wakefield Clinical Commissioning Group to take all necessary steps to ensure that King Street Health Centre remains open and has the current contract for GP-led services extended to allow Wakefield residents continued access to health care.

Following is the full text of the petition:

[The petition of residents of Wakefield,

Declares that King Street Health Centre is a vital service for Wakefield, and helps to ease the pressures on local GP surgeries, pharmacies, and Pinderfields Hospital; further that Wakefield Clinical Commissioning Group is reviewing the future of the GP-led services at King Street Health Centre, as the contract is up for renewal in March 2017; further that the petitioners are concerned that closure or removal of services from King Street Health Centre would put at risk the future of the King Street Walk-in Service, which shares the same facilities, staff and building; and further that 1955 persons have signed an online petition in similar terms.

The petitioners therefore request the House of Commons to urge the Government and Wakefield Clinical Commissioning Group to take all necessary steps to ensure that King Street Health Centre remains open and has the current contract for GP-led services extended to allow Wakefield residents continued access to health care.

And the petitioners remain, etc.]

[P002001]

Boat Moorings on the River Avon

7.16 pm

Mr Jacob Rees-Mogg (North East Somerset) (Con): My petition comes from dozens of residents of Saltford in Somerset.

The petition states:

The Humble Petition of residents of Saltford, Sheweth,

That the petitioners would prefer the inhabitants of some boats moored on the River Avon in Mead Lane to refrain from staying for long periods of time.

Wherefore your Petitioners pray that your Honourable House ask Her Majesty's Government to consider the opinions of local residents and other boat owners in this regard.

And your Petitioners, as in duty bound, will ever pray, &c.

[P002002]

A&E Provision: Shropshire and Mid-Wales

Motion made, and Question proposed, That this House do now adjourn.—(Christopher Pincher.)

7.17 pm

Daniel Kawczynski (Shrewsbury and Atcham) (Con): In the previous Parliament, we took action to empower local doctors, surgeons and clinicians to think about the optimum way of providing hospital services under ever-changing circumstances, namely the demographic and other changes that are taking place in our society. That was the right step to take. Rather than remote civil servants in Whitehall making those decisions, we wanted to ensure that the people at the coalface provided those services—people who already provide services to our constituents; people with medical expertise; people who have dedicated their lives to improving the care and safety of others. We wanted to empower them to make those decisions.

I stand by the decision that we took, but I want to tell the Minister this evening about some of the practical problems that have ensued in Shropshire as a result of that devolution of power. I do so because I believe in the process and want to ensure that it is retained and protected for future programmes.

We have two hospitals in Shropshire: one in Shrewsbury and one in Telford. They do not just look after the people in those two towns; they look after all the people throughout the whole of Shropshire and mid-Wales. I am not going to go into all the specifics of the Future Fit programme with the Minister, as I and the other Shropshire MPs have briefed him repeatedly about the process over the past few days, weeks and months. However, I would like to thank, in a genuine and heartfelt way, the 300 surgeons, doctors, GPs and medical consultants in our community in Shropshire, who, despite the extraordinary pressures they face already in their day-to-day work in the NHS, have been able to dedicate themselves to and persevere with, despite the many problems and obstacles in their way, coming up with the Future Fit proposals for a reconfiguration of accident and emergency services in Shropshire and mid-Wales. A decision has been achieved after three years and £3 million of taxpayers' money.

There was going to be a public consultation on that decision. Unfortunately, it has been blocked by Telford clinical commissioning group and Telford Council. Telford CCG has been a part of the process from its inception and it was consulted throughout. At the eleventh hour, however, when the decision did not go the way it thought it would or the way it wanted it to go, it decided, to a man, to vote against the proposals—even though it was party to the whole methodology and process.

In addition to Telford CCG voting against the changes, Telford Council—an esteemed body no doubt, but one, I would argue, with somewhat limited medical experience—has decided to threaten the Future Fit programme with a judicial review if the public are allowed to have the final public consultation. Of course, in a democracy Telford Council has the right to challenge things. Of course, in a democracy Telford Council may even have the right to use taxpayers' money to instigate a judicial review. What the Minister must remember and retain from our experience, however, is that these two parties were a part and parcel of the whole process from its

inception. I have a real and genuine concern about the integrity of the process if we do not back the local clinicians and doctors.

Lucy Allan (Telford) (Con): Will my hon. Friend give way?

Daniel Kawczynski: I will of course give way to my hard-working neighbour from Telford.

Lucy Allan: I thank my hon. Friend for securing this debate. I tried to secure a debate with a very similar title. Does he agree that the Telford clinicians have an absolute right to express their views, just as the Shropshire clinicians do? The fact that they did not come to the same view is no indication that the Shropshire clinicians came to the wrong view.

Daniel Kawczynski: As I said earlier, of course they have the right to do so. Let me take this opportunity to acknowledge the work my hon. Friend has done since she became a Member of Parliament to campaign for Telford, and to campaign very strongly and effectively on this issue without being overtly political or personal, unlike some other people. I will come on to talk about the CCG a little later.

I reiterate that my concern is for us all to put our cards on the table. We all went along with the Future Fit process. The decision could have gone against Shrewsbury. Ultimately, the decision has been made to have the urgent care centre in Telford and that the main A&E service should be provided by Shrewsbury. That decision could have gone the other way. It could have gone to Telford, and we would have lost out. At the end of the day, it should not be about winning or losing—that is the biggest problem.

My right hon. Friend the Member for North Shropshire (Mr Paterson) has talked about the pillow fight that has gone on between Shrewsbury and Telford ever since he became an MP. Over the past 11 years, I have lost more sleepless nights over the constant fighting between Shrewsbury and Telford about hospital services than over anything else. At the end of the day, we are one county and we must fight collectively as one county for all the people of Shropshire, and of course for our friends across the border in Wales.

Mr Owen Paterson (North Shropshire) (Con): I congratulate my hon. Friend on landing this debate. He is absolutely right. This bickering between Shrewsbury and Telford has dogged my nearly 20 years in Parliament. I thoroughly back Future Fit because it provides a solution that benefits everybody. I like the idea that the two existing A&Es carry on doing 80% of their current work, albeit—possibly—having been renamed as urgent care centres, while we get a £300 million emergency care centre. Some of my rural areas look to Shrewsbury, some look to Telford, but we will also gain from urgent care centres being built in the rural areas. What is utterly exasperating for my constituents is this indecision. We have had three years and £3 million spent, and still no decision. I am delighted that the Minister is listening so carefully and I very much hope that at the end of the debate we will have a clear recommendation for a decisive mechanism to deliver the will of the local commissions.

Daniel Kawczynski: I could not agree with my right hon. Friend more, and I pay tribute to him for the work he has done on this over the last few years.

I would like the Minister to intervene to ensure that the process allows for a decision. In our case, all six members of the Shropshire CCG voted for the proposals and all six members in Telford voted against. I am very concerned—I want him to take this away—about this. What sort of a process is it when we can get a tie? There needs to be a casting vote or perhaps some independent third party who can arbitrate in such a hotly contested issue where the two local CCGs cannot come to an agreement. So I would like to hear from him on that.

I appeal to constituents from the whole of Shropshire and mid Wales to lobby Telford Council, to get behind the concept of us all working together, as my right hon. Friend said, and to lobby the Government more effectively for more resources, rather than fighting one another in a rather parochial way over where these services are going to be. Let us not forget how close these two hospitals are to one another. We are not talking about 50 miles, 30 miles or 20 miles. Somebody might correct me if I am wrong, but I think they are only 13 miles apart. We ought to be thinking about how to improve and modernise the provision of healthcare for all the people of Shropshire and mid-Wales and listening to the proposals of the medical experts, who have done so much work to put these proposals together.

Chris Davies (Brecon and Radnorshire) (Con): I thank my hon. Friend for bringing this debate forward. Both my hon. Friend the Member for Montgomeryshire (Glyn Davies) and I represent seats in Powys, in mid-Wales, which, as he said, does not have a general hospital. It is one of the few councils not to have one. We rely heavily on both Telford and Shrewsbury, certainly in the top end of my constituency. I appeal to the Minister: our constituents are very concerned. Even though health is devolved in Wales, many of our constituents travel across the border, and for them this is a vital issue.

Daniel Kawczynski: I thank my hon. Friend for his intervention. He is absolutely right. In fact, my colleague from just across the border, my hon. Friend the Member for Montgomeryshire (Glyn Davies), always joins us at our meetings with our hospital trust. We almost think of him as a Salopian. [HON. MEMBERS: “Steady!”] Not quite, but he does so much to represent his constituents in Wales, who already have to travel long distances to get to the Royal Shrewsbury hospital. He might correct me if I am wrong, but I think that some of them, from the extreme west of his constituency, already have to travel for over an hour to access A&E services in Shrewsbury. So any movement even further away from Shrewsbury would be completely unacceptable to his constituents.

Mr Mark Williams (Ceredigion) (LD): I come from a peripheral position, further to the west of Montgomeryshire. I congratulate the hon. Gentleman on securing this debate and stress the importance of getting this right, because it has an impact further to the west. If this issue is not resolved, it will impact on the capacity of my district general hospital in Aberystwyth to serve the people of mid-Wales as well. It is crucial to address this issue.

Daniel Kawczynski: I concur with the hon. Gentleman, and I am grateful for his intervention.

I shall start to end because I want to give the Minister as much time as possible to answer these questions. Let us not forget that if we get this right, it could result in an investment of £300 million into the NHS in Shropshire. I do not know about all my colleagues—I know that my right hon. Friend the Member for North Shropshire has been an MP for longer than me—but I certainly do not remember a time during my 11 years as an MP when we have had such an investment in the local NHS. As I say, if we get this right, we could see an investment of £300 million in Shropshire to implement these changes.

I know that there is more work to be done to secure this money. I know that more work will have to be done in innovative ways, both locally and nationally, to secure all the funding. If we do not sort ourselves out, however, we are going to get further and further behind, while other areas in the United Kingdom—this is not an issue peculiar to Shropshire—that are going through this process in a more cordial and mutually effective way are going to jump the queue, and Shropshire will be left right at the end. I am not prepared to see that happen.

Finally, Telford Council would obviously have us believe that as part of this programme, women and children’s services have to be moved from Telford to Shrewsbury, because the main A&E will need to have women’s and children’s services next to the main A&E provider at the Royal Shrewsbury hospital. The council says—this is an important point that I want the Minister to note—that because these services were moved from Shrewsbury to Telford a few years ago, such a move would lead to the waste of £28 million. It repeatedly talks about this through the local media. No, no, no. It is not a waste. The building will be used for other purposes, and all the equipment in it, which is easily moved, will be moved to Royal Shrewsbury hospital. So I refute any proposal that there has been a waste of the £28 million invested in women’s and children’s services because of the changes that will take place.

Lucy Allan: I thank my hon. Friend for giving way on that incredibly important point. Will he accept that the brand-new women and children’s unit in Telford has been there only since 2015 when it was opened and that the proposal to close it is of huge concern to all my constituents? I am sure he will understand why that is.

Daniel Kawczynski: I do understand that concern, and the previous chief executive of the trust responsible for those changes is, I believe, now working in Qatar. It caused a great deal of controversy at the time. Of course, the Government, Ministers and Future Fit will have to do more to alleviate those concerns, but at the end of the day, as my right hon. Friend the Member for North Shropshire has stated, a decision has to be made.

With that, I end my speech and thank you, Madam Deputy Speaker.

7.33 pm

Glyn Davies (Montgomeryshire) (Con): Thank you, Madam Deputy Speaker, for allowing me to speak on what is the most important and concerning issue in my constituency over recent years—and it is certainly particularly acute at this moment. I would love to make

[Glyn Davies]

several points and make a full speech at some stage, but on this occasion, I shall restrict myself to making just three points that I hope the Minister will address.

First, I emphasise the importance of the title chosen for the debate: A&E Provision: Shropshire and Mid-Wales. We so often assume that health is devolved, but the reality is that it is a devolved form of government, but it is not independence. The position is that in much of Wales, the system and the financial arrangements between the Governments allow for people to come to Shropshire. Nearly all Montgomeryshire's patients who want secondary care, elective care and emergency care go to Shropshire. We depend absolutely on Shropshire, so I am hugely grateful that this debate is about Shropshire and mid-Wales.

My second point concerns the position of A&E units throughout Britain. We know perfectly well what the problem is: too many people are going to A&E without what we think of as reasons to need emergency treatment. We know that about 20% of the people who go to the A&E units in Shropshire should be going to the emergency centre because their conditions are life-threatening, with the remaining 80% going to the two centres in Telford and Shrewsbury. They will still effectively be A&E units, but they may well be referred to as urgent care centres. We know that that system will work.

This is my final point. Our two clinical commissioning groups set up a Future Fit programme board to make recommendations. It spent three years and £2 million—it could have been £3 million—producing a report which made it clear that the emergency centre should be based at Shrewsbury. It was a huge shock to my constituents when that recommendation was not accepted. Everyone is flabbergasted. I merely ask the Minister to give us some idea of how we can move forward from the shambles that is putting the interests and the care of my constituents—who are already having to travel for an hour to Shrewsbury for treatment—at the centre of the plans for Shropshire. That is vital to us. I hope the Minister will tell us how we can provide safe care for the people of Shropshire and the people of mid-Wales, which is our duty.

7.36 pm

The Parliamentary Under-Secretary of State for Health (David Mowat): In the few minutes available I shall give the House a recap, describing the process that we have undergone, the impasse that we have reached, and what it has been suggested we do to bring about a decision. I agree with my hon. Friend the Member for Shrewsbury and Atcham (Daniel Kawczynski) that it is important for us to make that decision and to get it right. The provision of better A&E services for the whole county in a way that works for everyone should not be the divisive issue that it has become.

First, however, I think it appropriate to reflect on the 2.7 million people who work in the NHS and the care system and to acknowledge and congratulate them on the work that they do. Today, as every day, some 2 million people have used A&E services across the country. Let me also say that my hon. Friend the Member for Shrewsbury and Atcham has worked diligently on this issue, as have other Members, including my hon.

Friend the Member for Telford (Lucy Allan). I know that it is difficult for them to get this right for their constituents.

At the beginning of his speech, my hon. Friend the Member for Shrewsbury and Atcham made the important point that, ultimately, this must be a local decision. It is not a decision for Ministers, and it will not be imposed. It will be made by the local governance bodies that have been established, notwithstanding the present impasse.

Let me summarise what has been happening. This is a tale of two CCGs and a hospital trust providing services across Shropshire—in Ludlow, Bridgnorth, Oswestry and Shrewsbury—and, indeed, in mid-Wales, including Powys. I agree with my hon. Friend the Member for Montgomeryshire (Glyn Davies) that we need to get this right for the people of Wales as well. The process has been going on for a long time, but the driver for change is not financial. We are finding it increasingly difficult to staff the two A&E centres in Telford and Shrewsbury. Rotas are not being filled, and it is feared that unless we find a robust solution, there will be safety issues and it will not be possible to keep the centres open for as long as we want.

My hon. Friend the Member for Shrewsbury and Atcham observed that this was not a new issue, and that is certainly true. I understand that it is being discussed locally and that projects have been reviewing it since about 2005 without a solution being found. The Future Fit project was set up in 2013. As has been said, the process ended at the end of last year with a preferred option, which was, in broad terms, that emergency care should be centralised in Shrewsbury, with urgent care continuing to be in both locations. I heard it said in the debate earlier that that would mean most patients would continue to be served closer to where they are, either at Telford or Shrewsbury.

On the governance issue, the report of the Future Fit process was voted on by members of the two CCGs, who have broadly a 50% share in that decision, and the result was a tie. Indeed, Telford CCG raised concerns about the methodology of the process and the appraisal techniques used and whether it was robust and fair. As a consequence, there has been no agreement and we have reached our current impasse.

I understand that at the end of December an editorial in the *Shrewsbury Star*—

Daniel Kawczynski: *Shropshire Star*.

David Mowat: Sorry, an editorial in the *Shropshire Star*—it is not a newspaper I read—made the point that we now need to get this right; we need to make a decision and to stick by it. I think everybody in the Chamber would agree with that, with the caveat that in the end it has to be a local decision. There are very real battle lines here; I think my hon. Friend the Member for Telford met the Secretary of State yesterday on this with other Members and council leaders.

What is the proposed way forward? My briefing from the CCGs is that a week today there will be a meeting at which the intention is that two things happen. The joint committee will be reconstituted and an independent chair appointed who will have a casting vote. In parallel with that, there will be an appraisal, or review of the appraisal process, that Future Fit takes, with the intent to address the concerns raised by Telford about whether

it was robust. At the end of the review—depending on the outcome, I guess—there will be a new vote with a view to potentially having a majority on one side or the other and therefore there will be a local direction. That is my understanding of the way forward.

Mr Paterson: It is tremendous news that there will be a mechanism that will give us the ability to come up with a clear answer. Does the Minister have any idea of the timescale for this new process?

David Mowat: I have been advised that the timescale is in the order of eight to 12 weeks, but it remains a local decision. That is what we hope and expect to be the case.

In finalising my comments, I want to make a couple of observations.

Daniel Kawczynski: I am pleased with the Minister's announcement; hopefully we will see a conclusion to this. May I appeal to him to take an active interest in the process in these eight to 12 weeks because the integrity of this devolution of power is at stake unless we empower the clinicians to take the decisions we have ultimately empowered them to take?

David Mowat: I am happy to agree to that, although I should have said at the start of my remarks that in the normal course of events this debate would have been answered by my ministerial colleague, my hon. Friend the Member for Ludlow (Mr Dunne), as he is the Minister with this responsibility, although he is not independent on this, so it is appropriate that I answer for the Government.

Once the decision has been taken and a consultation occurs, a component of the proposal will require capital. Various numbers have been floated around, one of which is £300 million. I do not believe that NHS England has yet confirmed that that capital is available, so there is a hurdle to be overcome once a local decision has been taken. I do not want to raise expectations that the process will necessarily be straightforward. This is the way in which the process will occur, as I am sure colleagues would expect. If, as a result of that stage, capital is awarded, there is the potential for those on either side of this discussion to take the configuration proposal to the independent reconfiguration panel. That is always the case in such processes, and the panel can accept or not accept what has been suggested. That is the normal process in the NHS.

I want to make one final point to all my colleagues, who are so keen to get this right for their constituents in Telford and in Shrewsbury. I ask them to remember that the NHS is not just about bricks and mortar. We often have discussions about the bricks and mortar, but I want gently to point out to right hon. and hon. Members that there are other things that they should be holding their clinical commissioning groups to account for. They should be looking at cancer performance, cancer survival rates and maternity performance, for example. There are many aspects of the NHS that are not about bricks and mortar, and it is important that Members should recognise that when we debate these matters.

Question put and agreed to.

7.46 pm

House adjourned.

Westminster Hall

Wednesday 11 January 2017

[MR ADRIAN BAILEY *in the Chair*]

Pharmacies and Integrated Healthcare: England

9.30 am

Mrs Anne Main (St Albans) (Con): I beg to move,

That this House has considered pharmacies and integrated healthcare in England.

It is a delight to serve under your chairmanship, Mr Bailey. In the light of the extreme pressures on our health services, particularly in the winter months—much has been made of this recently in the media, although it is not dissimilar to many other years—with our overburdened frontline services, clogged up A&E departments and congested GP services, I believe it is vital that we explore new models of delivering patient care, particularly an integrated model of patient care.

In 2016, there was an average of 2,500 more attendances at major A&Es a day compared with 2015, which is a 6% increase. People aged 80-plus have the highest rates of A&E attendance. As a country, compared with only a few decades ago, we are now fortunate enough to benefit from innovative drug treatments, greater survival rates from complex surgery, better nutrition and better education; but, as a population, many of our residents are living longer. For example, in my constituency of St Albans, the average life expectancy for a pensioner is over 89 years—it is nearly 89 and a half years. However, for far too many of our constituents, the latter part of their lives brings a prolonged period of frail health, with dementia and diabetes on the rise and an increased incidence of ill health linked to lifestyle choices such as lack of exercise, alcohol, obesity and smoking. That period at the end of our lives is often not characterised as a period of good health.

We need to come up with a seamless, flexible model that makes the best use of precious resources and benefits patients. It is therefore timely to explore in this debate the role that local pharmacies play in local health services and the potential role that they might play to ease the strain on more congested frontline services. I also want to make the Government aware of the continuing importance of pharmacies in communities and their potential to do so much more.

In an ever-changing world, we have a duty continuously to challenge the old models of health delivery systems. In October, the Government proposed to reallocate money to NHS frontline services. We all accept that the NHS is labouring under huge financial pressures, so any areas in which precious resources are dissipated due to inefficiencies or duplications ought to be considered. It is important to integrate community pharmacies into the NHS urgent care system and GP services. We need to promote a pharmacy-first culture for minor ailments to take pressure off frontline services.

Community pharmacies currently see some 1.6 million people a day in the UK. It is worth noting that the recent standard patient experience report for the East of

England Ambulance Service NHS Trust in 2016 showed that 0% of respondents in my county of Hertfordshire had contacted a walk-in service, an out-of-hours GP service or a pharmacy service before contacting the ambulance service. I think we can agree that a lot more can be done to take the pressure off emergency frontline services.

Pharmacies are the most accessible health services in most communities: they are found on high streets, in supermarkets and in shopping centres. In St Albans, we have some great independent local pharmacists who want to get more involved and we even have the headquarters of the National Pharmacy Association, which supports independent pharmacies and helps them grow their businesses. We need to look at the current pharmacy model. In St Albans, patients can choose from five dispensing pharmacies within a half-mile area of the high street. Some pharmacies are just over the road from each other, and some have only yards between them. Given the Government's financial support of £25,000 for those dispensing 2,500 prescriptions per annum, which comes directly out of our NHS budget, it is easy to see why we need to look at the model of provision and ask how we can get a better bang for the NHS buck.

I accept the Government's assertion that a balance must be struck to ensure that pharmacies remain accessible but are not excessive in number and, importantly, that we have a range of offering. All the local pharmacies on the high street in St Albans are closed on Sunday, whereas the big supermarket pharmacies are open, in line with their shopping experience. It is worth noting that Sunday is the busiest day for most A&E services. However, a recent survey showed that 50% of people prefer, for a variety of reasons, not to use a pharmacy in a supermarket, particularly the retired, the elderly and other frequent pharmacy users. We therefore need to examine the model of opening hours, as well as location and the type of provision on offer. Given that many supermarkets are located outside the town centre, their pharmacies are not accessible to everyone, particularly the most vulnerable in society. Diversity and accessibility of provision are key to integrating pharmacy and health services.

Let us explore what pharmacies could do. Pharmacies should be capable of providing general health services. They could increasingly work beyond the traditional role and offer services to promote sexual health, increase physical wellbeing and give advice on flu immunisations and drug-harm prevention, for example. However, if we expect pharmacies to do more, we need the funding formula to reflect the quality of service they provide. That is what the pharmacies want. Local pharmacists in St Albans believe that they should be the first point of contact for advice on medicines, minor illnesses, healthy living and wellbeing. To facilitate that, the Quadrant pharmacy in St Albans has undertaken a major refit, with a brand new consulting room, and invested heavily in technology, including an expensive automated robot for dispensing medicine.

I visited the Quadrant—I am sure that many hon. Members made similar visits after the Government's pronouncements in October—in November last year to discuss the opportunities and challenges facing small independent pharmacies. The pharmacy is a friendly, attractive place to pop into and is well regarded by local

[Mrs Anne Main]

people. It has the potential to do so much more, but that extra service does not come without a cost. If people spend time talking to their local pharmacist, the pharmacy gains nothing if they then walk out of the door and go off to see their GP. It is important that we recognise the role pharmacies are being asked to play in giving advice, holding consultations and, potentially, dispensing services. There must be some reflection of the cost involved in the staff time that it takes to do those things.

Rachel Solanki, the director of the Quadrant pharmacy, told me:

“General Practice will need to continue to be the gate keeper of referral to secondary care.”

However, she helpfully suggested

“a whole raft of services and support for self-limiting and long-term conditions”,

such as dealing with uncomplicated urinary tract infections in women, impetigo and bacterial skin infections; managing non-complex patients with high blood pressure; performing healthy heart and cholesterol checks; and supporting patients diagnosed with diabetes. The list was quite exhaustive. She proposed that pharmacies could and should act as wellbeing hubs for the communities they serve. She went on to say:

“The community pharmacist, a highly-skilled and trained individual, is the most accessible healthcare professional and is available without an appointment. If a mechanism could be found to incentivise and remunerate, we are confident the mutual agendas would be achieved.”

That is her view, and that of many other local pharmacists. There is a mutual agenda for providing good healthcare for patients that could be achieved if pharmacies were brought into play.

The Government’s proposals in October last year were a step in the right direction, but we need more detail. I want to ask the Minister a series of questions, and hopefully he will be able to answer some of them. How can the Government make smaller and local pharmacies more attractive and accessible for everyone? How can the Government encourage GPs to offload services such as flu jabs on to pharmacies? In saying “offload”, I recognise that where there is a cost to the pharmacy and the GP is in receipt of payment for that flu jab service, that needs to be considered, but I would like to hear the Minister’s views on that. How can the Government promote the pharmacy as an alternative local health provider that can be trusted and deliver a quality service? This is not just about having a shop that you take your prescription to and maybe pick up a few aspirin; it is about the pharmacy being a health provider. How can the Government increase pharmacy capacity to provide a broader range of health services and ensure the correct remuneration for the service provided?

Responding to an oral question on 2 March 2016, the then Health Minister, Lord Prior, stated:

“The big driving force going through healthcare and community pharmacy today is one of integration, which means that community pharmacies must in future work more closely with their local hospitals and GPs.”—[*Official Report, House of Lords*, 2 March 2016; Vol. 769, c. 817.]

That is the point of today’s debate. The Government have pursued several policies that are intended to lead to better integration of community pharmacies, including

the introduction of a pharmacy integration fund as part of the 2016-17 community pharmacy settlement.

Last month, Richard Murray of the King’s Fund published a paper looking into the role of community pharmacies in the NHS. In December 2016, the Minister described that review as

“an essential road map that sets out how we are going to move the community pharmacy network away from a remuneration model based just on dispensing and on to services as well.”—[*Official Report*, 20 December 2016; Vol. 618, c. 1301.]

When can we expect a response to that incisive review?

The NHS “Five Year Forward View”, which was published in 2014, recognised that GPs are “under severe strain”, and many of us will have met GPs locally who have restated that view to us. It also states that steps will be taken to:

“Build the public’s understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.”

I urge the Government to listen to pharmacists when considering how to take that integration forward, as we do not want to lose what is good in the system, especially where it works well for our local patients. For example, I know that the Government are piloting an urgent medicine supply service. Rachel Solanki, the director of the Quadrant pharmacy, tells me that in Hertfordshire there is a local scheme that is so well regarded that it has now been rolled out again. Her concern is that the proposed national service does not necessarily promote a pharmacy-first culture. The Minister may wish to clarify that that is not the case, but that was the view she expressed to me. She was worried that there might be a perverse incentive to encourage patients to phone NHS 111 in order to get a referral to the pharmacy service.

In an email Rachel wrote to me recently, her view was that the change could have the unintended consequence

“of actually increasing NHS 111 calls for emergency medicines when they should be directed to community pharmacies first. Our local service offers both the facility to help the patients get their medicine but, more importantly; also offers incentivisation of the community pharmacy to promote ordering medicines in a timely way to reduce medicines waste, and hopefully therefore preventing a further incident of need.”

She thinks it unlikely that the proposed 111 service will operate both the services that we have locally and the new model, and she worries about losing the existing local scheme. Will the Minister reassure me by saying whether schemes such as the one operating in my county of Hertfordshire could still operate in tandem, or will they be mutually exclusive?

Julian Sturdy (York Outer) (Con): My hon. Friend is making a very powerful speech. Does she agree that although we must encourage clinical commissioning groups to work closely with community pharmacies—she has highlighted some good examples of that—the practice is patchy across the country? There is reluctance in some areas for clinical commissioning groups to engage with their local pharmacies. We have had that problem in York, where the CCG has been very reluctant to talk to local pharmacies. Local MPs, across parties, have written to it and finally got it to engage but it has been very slow, and we have to speed that up. We have great examples in some parts of the country, but poor examples in others.

Mrs Main: My hon. Friend is absolutely right and completely backs up the point I was making. There is evidence of good practice but other areas could do much better. Without bringing pharmacies to the table and into the ongoing dialogue about this issue, we risk not having the new model that we would all like to see—one that operates consistently wherever people go.

There must be a consistent model in the drop-in pharmacy service that we are envisaging. Of course, people often use pharmacies away from where they live, such as where they work or when they are on holiday or visiting friends. If the model is patchy, as my hon. Friend says, the system will not improve and we will end up with a situation like the one that is found in many holiday towns. A few years ago, the Select Committee on Communities and Local Government looked into the fact that many seaside and holiday towns have enormous pressures on their frontline services. If something goes wrong when people are on holiday, although what happens is not necessarily catastrophic, they all end up at the local A&E services in hospitals. That huge problem was recognised, I think, in the 2006 seaside towns report by the CLG Committee. This is all part of evening out the stresses and strains on the system, which for many seaside holiday and tourist destinations are often huge.

Jo Churchill (Bury St Edmunds) (Con): Does my hon. Friend agree that that was largely the point of the Murray review, which she alluded to earlier? Integration throughout the whole of the NHS is vital, so that everybody knows what everybody else is doing and so that there are seamless pathways that everybody knows how to follow. That will ultimately give us benefits not only in pharmacies, but right across the NHS.

Mrs Main: Absolutely. Rachel Solanki and her colleagues are not necessarily critical of change—that is important. Pharmacies are nervous about some of the things that may be coming along, but they are not critical of change. Indeed, they would welcome a debate on the innovative services that other pharmacies are operating around the country. The fact that we do not all know about these services in other places shows that there is not an integrated approach. The services include anticoagulation monitoring in Knowsley; medicines optimisation work for respiratory diseases in South Central; sexual health screening, including for hepatitis, syphilis and HIV, on the Isle of Wight; oral contraceptive supply in Manchester and other contraceptive provision in Newcastle; alcohol screening and brief intervention on the Wirral; healthy lung screening in Essex; pneumococcal immunisation in Sheffield; a reablement service on the Isle of Wight; and phlebotomy services in Coventry and Manchester. That is a long, diverse list of services that are provided by pharmacies in those areas.

Oliver Colville (Plymouth, Sutton and Devonport) (Con): Will my hon. Friend recognise that some innovative things are taking place in the west country, especially in my constituency?

Mrs Main: I am happy to acknowledge that some fabulous things are happening in the west country. That list was given to me. I make no excuse for the fact that I thought it seemed fairly long already, but I am certain that there are a lot more services that hon. Members do

not realise are out there—perhaps even in pharmacies in their own constituency or the one next-door that they go shopping in or visit with their families. The fact that we do not know about them shows that there is no integration in the system. We should be aware of it if these services are being rolled out. Perhaps there should be a directory that we could consult to find out what is going on in certain areas.

That list shows hon. Members the exciting possibilities that could be open to pharmacies, including those in the west country that were just referred to, if we just gave them the chance to embrace them. Rachel, the director of the Quadrant pharmacy, ended her observations with a positive endorsement of the “Community Pharmacy Forward View”. She told me that it has

“been developed and signed up to by all national community pharmacy organisations about the types of services that either need to be commissioned at a national level or pressure put on Sustainable Transformation Plans (STP) leaders locally to commission a service package to patients”.

My hon. Friend the Member for York Outer (Julian Sturdy) said that there is reluctance in some areas to embrace this. We need a strong steer from the Government that this is where we are going and that they had better wise up, get around the table and come up with a suitable model.

James Cartlidge (South Suffolk) (Con): My hon. Friend is making an excellent point and I congratulate her on securing this debate. I have discovered the same thing as my hon. Friend the Member for York Outer (Julian Sturdy) in Suffolk. It is about trying to get the CCG to talk to the pharmacists. The interest of the NHS is our interest—it is a national interest—and not that of acute hospitals, the primary care sector or any particular sector. The NHS must operate in the national interest, and if that means involving pharmacists much more heavily and that we have to be the ones pushing for innovation, it is our job to do that.

Mrs Main: My hon. Friend is absolutely right. I shall conclude my remarks soon, because I know that other hon. Members want to take part in this debate. If there is resistance in the system, I ask the Minister to find out what can be done to sort that out. How aware is he of resistance in the system? How much input have pharmacies had into highlighting what they would be prepared to do and their concerns about the fact that they are sometimes not being listened to in this debate? There seems to be broad agreement in the NHS “Five Year Forward View”, the “Community Pharmacy Forward View” and at the King’s Fund that the integration of pharmacies into NHS healthcare is the direction of travel.

Margaret Greenwood (Wirral West) (Lab): The hon. Lady is making a really interesting speech. I have had such a big postbag on this issue because of the threats to pharmacies in my constituency. The fact that local community pharmacies are facing cuts is threatening the level of healthcare that people receive, particularly elderly people who cannot drive, people with children who need to be able to pop in with them after school and people with mobility issues. The cuts imposed by the Government are threatening the quality of the service that is being delivered. They need to address that before they look at further integration.

Mrs Main: I agree that there are concerns. As I mentioned earlier, there are five dispensing pharmacies within half a mile in St Albans. Some are literally over the road from each other, although I know that model is not repeated everywhere. None of them is open on a Sunday and the only pharmacy that is open is in a big out-of-town superstore. We need to look at a model that addresses their proximity to the populations that need to use them and the hours that people are looking for pharmacies to be open. It is no good if people can access the seven-day-a-week pharmacy service only by getting in their car and driving two or three miles out of town. It is all part of the same thing.

That is why I support the point made in the Government's proposals in October about models such as the one in St Albans, although this is not the case everywhere, where there are the big boys and smaller independents all in the same area. If the hon. Lady were to walk into Boots in my constituency—I have nothing against Boots, which is one of the pharmacies on my high street, as on many others—she could pick up sandwiches for her lunch, as well as a variety of health and beauty products, perfumes and so on. It is a one-stop shop for many things, a bit like a supermarket.

My concern is that we must not lose community pharmacies such as the Quadrant, which is a single pharmacy in a small shopping precinct that many people walk to and use locally. We have to have a balance of availability and opening hours. If we are truly to embrace an integrated system, some pharmacies may need to consider their opening hours and sign up to being open when they would not normally be. They will have to be remunerated for that as well. We need to look at the whole model. I understand that there are concerns, but our current model cannot continue. I want integration, and I want more money and more services directed towards pharmacies to make them viable and to make them the first hub for the community.

There is broad agreement that the direction of travel we need is towards getting people to use the most accessible health provider, which is the local pharmacy. That would keep many smaller pharmacies going. They cannot compete with all the other offerings from supermarkets such as Sainsbury's, which has a pharmacy in its out-of-town store in London Colney, so we need to ensure that they compete as health hubs.

I look forward to hearing what the Minister has to say about these issues. I am sure that many other Members will make contributions about their local models, because the provision and the pharmacies on offer vary throughout the country. I accept that, in areas such as mine, the current model cannot continue, particularly if it asks for NHS funding, but we must not throw out the baby with the bathwater. I ask the Minister to say what more the Government will do to ensure that pharmacies have a real role in the integrated health service.

9.51 am

Oliver Colville (Plymouth, Sutton and Devonport) (Con): May I say what a pleasure and a delight it is to serve under your chairmanship, Mr Bailey? I congratulate my hon. Friend the Member for St Albans (Mrs Main) on securing the debate. I should warn the House that I am the Government's pharmacy champion. I have been

following this issue quite closely for about the last 20 years—not that I have been in the House of Commons for the last 20 years, but I have followed it consistently since being involved in the community pharmacy group action campaign, which was to do with resale price maintenance on non-prescription medicines in the 1990s, when I was doing a commercial job. I became a vice-chairman of the all-party pharmacy group when I was elected to the House, so this is an issue I feel quite strongly about and have been very involved in.

To put things in context, Plymouth, Sutton and Devonport is, uniquely for a Conservative constituency, an inner-city seat. Indeed, I am one of very few Members of Parliament outside London to represent a totally inner-city seat. The only countryside I have in my constituency is the Ponderosa pony sanctuary, which is a rather muddy field. How we can integrate pharmacies is a really important issue. There is an 11-year life expectancy difference between the north-east of my patch—I could probably walk from one end to the other in a couple of hours or so—down to the south-west in Devonport, which is a very deprived community that has real issues with homelessness, drug taking and smoking. People certainly need to be referred to pharmacies for smoking cessation too.

There are several areas of the debate that I am particularly interested in exploring, and I hope the Minister will respond on them. The first is summary care records. A lot of pharmacies want to be able to access the care records for their patients. They also want to be able to populate those records, so that they can review the medicines given to patients. We need to make sure that happens throughout the whole of England. I was very concerned by something I discovered over the Christmas recess. I did not take masses of time off over Christmas, but I did speak to a number of GPs; needless to say, I also did a surgery, with one of my local GPs in the Devonport ward. He told me that GPs—and, I suspect, pharmacies too—cannot access the medical records at Derriford hospital, because it uses a completely different system from the GPs and the pharmacies. The Minister needs to look at that.

The second issue we should look at is using pharmacies much more for minor ailments—a point that my hon. Friend the Member for St Albans made very clearly—so that people are signposted to the pharmacy rather than necessarily going to the GP. I was watching breakfast television this morning while I was getting ready to come and speak in this debate—I think it was Sky television, so I should declare an interest, because my brother is the cricket correspondent for Sky television and I do not want to be accused of doing anything wrong. I was interested to hear the person reviewing the newspapers say that she was doing a programme tomorrow evening on Radio 4 at 9 o'clock—I am giving her a plug—on how, rather than having lots of patients come to see them, some GPs in Plymouth have ended up talking to patients on the phone. Patients do not necessarily always need physically to go to a GP to seek help, which is a useful way of taking some of the pressure off GPs.

I should also make a point about the decriminalisation of prescription errors. At the moment, GPs can get a slap on the wrist or be struck off, whereas pharmacists who fail to give prescriptions properly can face criminal charges. I had thought that the Government were very keen to address that. I was led to understand by the

Minister that the matter might have been sorted out before Christmas, but that there were problems to do with the devolved Administrations needing to deal with it first. However, it seems very odd: here we are, at the beginning of the year, and we still have not dealt with it. I must warn my hon. Friend that I have tabled a parliamentary question about it.

My final point is that a great deal of pressure has been placed on the Government and the national health service, especially during the winter. There has been a great deal of discussion about how pharmacies need funding and so on, but in my opinion this is not just about money; it is about ensuring that we use the systems properly, so that we can deliver a better quality of care. We could get pharmacists to go into residential care homes for the elderly, too. It is not just about money; it is about the structure, too. We need to take that into account, because we need to ensure that budgets sweat.

9.58 am

Steve Double (St Austell and Newquay) (Con): It is a pleasure to serve under your chairmanship, Mr Bailey. I congratulate my hon. Friend the Member for St Albans (Mrs Main) on securing this debate on what I believe is a very important issue.

There is no doubt that our health service is currently under great pressure, as we have heard already. People are living longer and we are able to treat far more conditions than we could in the past, which adds to the demand on our health services. Although more money is always welcome, I am sure that many of us would agree that simply throwing more money at the health service is not the solution. We need to find better, smarter, more efficient and more effective ways of working to provide the healthcare that our growing population so desperately needs.

I have no doubt that pharmacies, particularly community pharmacies, can play an important role in finding better and smarter ways of providing healthcare to the people of this country. Community pharmacies continue to be an undervalued and underutilised section of our health service. As a country, we really need to embrace the role that community pharmacies can play in delivering health services. They have much more to offer than they are currently seen to be offering.

The Government have started to recognise that, with the current pilot scheme, started in 2015, to increase the presence of clinical pharmacists in general practice. That is clearly a step in the right direction, but I propose that we should also look the other way. We should not only look at integrating pharmacies into GPs' surgeries; we should be looking to integrate GP services into our community pharmacies. It is quite clear that many of the routine services that people typically go to their local GP for could be provided by their local pharmacists in a much more cost-effective way.

Oliver Colville *rose—*

Jake Berry (Rossendale and Darwen) (Con) *rose—*

Steve Double: I will give way to my hon. Friend the Member for Plymouth, Sutton and Devonport (Oliver Colville) first.

Oliver Colville: I thank my hon. Friend for giving way. He makes a very powerful point. I have thought for some while that we should be trying to put GP surgeries into pharmacies, so that when someone goes to their GP and says, "I have got this ailment and I need some help," he can say, "Don't come and talk to me; go and talk to the pharmacist, because he or she can manage the thing properly." To my mind, that seems a very clever way in which we could take some of the pressure off the finances of GPs, as they would not necessarily have their own lease, but could get the likes of Boots or others to provide facilities.

Steve Double: I thank my hon. Friend for that intervention and I agree with him. Clearly, part of the answer is getting GPs and pharmacies working much more closely together, and co-locating can often be one way to help with that.

Jake Berry: My hon. Friend is making an excellent speech. Does he accept that the demand for prescribing pharmacies can be demonstrated by the recent proliferation of adverts we have seen on television for "pay to see your GP" services, which I was very surprised to see so many of on TV over Christmas? For £20, someone can pay to have a Skype consultation with a GP, who will then email or contact the local pharmacy to issue them with a prescription. An NHS that is free at the point of use should be absolutely fundamental to us in this country, but the fact that people are now paying to see GPs rather than waiting to see them shows that there is huge demand for people to have minor ailments prescribed for by a pharmacist.

Steve Double: I thank my hon. Friend for that intervention; he clearly watches far more TV than I do, because I was not aware of that. However, he makes the point well that there has been a huge increase in the demand being placed on our GP services, and people are therefore looking for other ways to meet that demand when it cannot be met in the usual ways.

I applaud and support the Government in their desire to create a truly seven-day-a-week health service. Part of the way to achieve that is by making far better use of our community pharmacies. Many are already open for longer hours than GP surgeries, typically on a Saturday, and my hon. Friend the Member for St Albans made the point that maybe some need to consider opening for longer still. That is something the Government could certainly help with. If we are to achieve a truly seven-day-a-week health service, we need to make more effective use of our pharmacy services.

Margaret Greenwood: The hon. Gentleman is making a strong case for the importance of community pharmacies. Pharmacies in my constituency of Wirral West that will be unable to receive money under the planning access scheme have written to me to say they are very concerned that they face closure. Does the hon. Gentleman agree that it would make sense for the Government to pull back from those cuts while they consider the whole issue of integrating services?

Steve Double: I thank the hon. Lady for that intervention, and in many ways I share her concerns. While I respect the desire of Department of Health's to ensure that money is well spent and delivers value for money, there

[*Steve Double*]

are cases of over-duplication, as we have already heard. Some changes need to be made to the funding models. I agree that we need to do all we can to protect our community pharmacies, particularly in more rural areas such as my constituency in Cornwall, where they play such a vital role for rural communities. I was pleased that the Department was able to do something to help—certainly many pharmacies in my area benefited from the changes to the funding—but I respect the fact that that may not have been the case in her constituency, and I will be urging the Minister to do all we can to ensure that these vital services in our rural areas are protected as much as possible.

With the right support, and indeed the right funding streams, our pharmacies could play a role that would take pressure off the parts of our health service that are clearly under severe pressure, in particular primary care and acute and urgent care. We are all aware of the pressure that our A&E departments are under at the moment. I believe that many times, when people go to A&E—perhaps because they cannot get to see their GP as quickly as they would like or feel they need to—they could actually get what they need from their local pharmacy.

Part of this is about increasing people's awareness of what our pharmacies can offer. Part of the learning curve that I have been on since becoming an MP has involved going to see our local community pharmacies and getting a better understanding of exactly what services they provide, which I was not aware of before. More could be done to promote the role that pharmacies can play and the services that they can offer by making the public more aware of those services. That in itself would take pressure off our GPs.

Mrs Main: I did not make this point in my speech, but my hon. Friend is almost making it for me—it is that our pharmacists are hugely qualified, but too often they are the most under-utilised highly qualified local health professional. It is nonsense that their expertise is not being used routinely, challenged or made available, because people do not seek to use it and are not even necessarily aware that it is there for them to utilise.

Steve Double: I thank my hon. Friend for making that point, which I completely agree with. There is much more we could do to increase the general public's awareness of exactly how highly qualified our pharmacies' staff are and of the excellent services that pharmacies can provide.

My hon. Friend the Member for Plymouth, Sutton and Devonport talked about the need to integrate IT systems better, which I believe is part of the solution we seek. My understanding is that community pharmacies can access summary care records, but on a read-only basis. Many pharmacists I talk to say that if they had read-write access to that information, so that they could input data about treatments they have given to patients, that would be better. For example, if they could take a patient's blood pressure and input that reading into the patient's care record, that would save the patient time as they would not then have to go their GP to have the same reading taken and put into their record. I urge the Government to consider carefully whether read-write

access could be granted to pharmacies, because I believe it would save a huge amount of time and reduce what I believe is often duplication of work within our health system.

An interesting fact that I discovered in my discussions on this subject is that the average time that someone waits when they go to see their pharmacist—that is, the time between entering the pharmacy and actually getting to see the pharmacist—is eight minutes. Many people in this country would be absolutely delighted if they could see a health professional within eight minutes of asking to see one. I am sure that many hon. Members here today have in-boxes full of people's complaints about how long it takes them to see their GP. If people were aware that if they went to see their local pharmacist they would only have to wait eight minutes on average to see a very well qualified health professional who has a good chance of providing them with what they are looking for, I believe they would be delighted. That is another example of how we can promote the work of pharmacists, which would provide a far better service to the people of this country and take pressure off the other parts of our health system.

Bill Esterson (Sefton Central) (Lab): I am grateful to the hon. Gentleman for giving way and I apologise, Mr Bailey, for missing the start of the debate.

The excellent pharmacies in my constituency do much of the fine work that the hon. Gentleman and other speakers have described, but it struck me as I was sitting here listening to him that he is making a very powerful case for investment in our pharmacies, rather than the cuts that the Government have proposed. Does he accept that point? Will he and his hon. Friends take this opportunity to call on the Health Secretary to think again about pharmacies and the important role they play and to see them as an investment, so that they can play their part, particularly in taking pressure off A&E?

Steve Double: Although I agree with some of what the hon. Gentleman says, I believe the funding model for pharmacies needs to be looked at because there is a great deal of duplication. The money spent could be better utilised, so the funding model needs to be reviewed. Some of the recent changes are a step in the right direction, but I will always make the case that, particularly in our rural communities, we need to be careful how those changes are applied so that our local pharmacies continue to be viable and able to provide the services that are needed.

James Cartlidge: My hon. Friend is making an excellent speech. I understand why Labour Members want to focus on the potential savings that once again the Government are having to make, but I point out that the two pharmacies that I visited in Clare and Hadleigh in my constituency accept the changes, provided they are balanced by their having a more positive role in the healthcare system and doing more for our communities. That is what they want.

Steve Double: I agree absolutely. This is not only about money; it is about reviewing the way we provide our healthcare services, embracing a greater role for our pharmacies, and understanding and promoting the role that they can play.

I want to pick up on the point about tourist areas made by my hon. Friend the Member for St Albans. I represent the constituency of St Austell and Newquay in mid-Cornwall, and tourism is the biggest part of our economy. Hundreds of thousands of tourists come every year, which puts a great deal of pressure on our A&E and local GPs, because if people fall ill on holiday, they try to get to see a GP.

I commend the work of one of my local pharmacists, Nick Kaye, in Newquay. The Secretary of State visited a couple of years ago and saw the excellent work that he does working closely with the local GP surgery to provide a frontline service particularly for tourists. By doing so, he takes pressure off the other parts of the health service. We could see more of that if we supported pharmacists and promoted the excellent work that they can do.

We have already touched on my final point. We cannot have a one-size-fits-all approach. The services provided in urban metropolitan areas are very different from those provided in more rural parts of the country. As we have heard, there might be multiple pharmacies in a town, all falling over one another to compete for business—so different from the many rural villages that have one local pharmacy, which is struggling to make ends meet and to provide an ongoing service to the community. Another fact I have learnt is that there is an oversupply of qualified pharmacists in many areas, whereas in Cornwall we have a shortage. We cannot get enough into Cornwall to meet demand, so we cannot have a one-size-fits-all solution. I encourage the Minister to look carefully at the specific needs of different parts of the country, particularly with regard to pharmacies, to make sure that funding streams meet need and that we can sustain the vital role that community pharmacies play in our rural towns and villages.

I am pleased to have been able to contribute to this important debate. As we continue down the path of integrating pharmacies into the health service, we must value and promote the role they play and make sure they are able to provide a service. They are part of the solution that we need to make sure our health service is fit for purpose.

Mr Adrian Bailey (in the Chair): I intend to bring the Front-Bench spokesperson in at 10.30.

10.14 am

Jo Churchill (Bury St Edmunds) (Con): It is a pleasure to serve under your chairmanship, Mr Bailey. I add my congratulations to my hon. Friend the Member for St Albans (Mrs Main) on securing not only a timely debate, given the current circumstances, but one that is important because we need to look at the whole system and integration, rather than at each specific service.

Interestingly, on 6 December, Lord Prior said:

“The Government recognise the vital importance of community pharmacy.”—[*Official Report, House of Lords*, 6 December 2016; Vol. 777, c. 593.]

It is from that positive stance that I wish to make my points. Pharmacists have been identified as one of the professions that are highly qualified and not in short supply. Some very advanced GPs are bringing pharmacists into their surgeries to help to alleviate some of the pressure. Some clever thinking is going on out there.

I hope the Minister can tell us how we are capturing that innovative thinking and how it is being spread throughout the system.

The “Five Year Forward View” identified that the British public need to be made more aware of what pharmacies can do and how they can help people keep healthy. However, the Government need to give a steer and ensure that people with minor ailments understand that the pharmacist should be their first port of call.

When I visited my pharmacist there was concern about the 111 service, which was my hon. Friend the Member for St Albans mentioned. We need to keep an eye on that so that we do not unintentionally put pressure on different parts of the service. We need to look at it in the round and incorporate all key roles into pharmacies in order to provide additional services. I had my flu jab at a pharmacy this year, which is a useful use of resources within the system and within the community. We could make that more available and perhaps incentivise individual pharmacists to go out into care homes, which have a proliferation of need because of age and comorbidities, and give flu jabs and so on. Moving our workforce around, rather than driving ever-greater demand into smaller places such as hospitals, must be a consideration.

The Murray review, which has been mentioned, found that poor integration with other parts of the NHS was a significant barrier, and the Royal Pharmaceutical Society agreed. I like to think that the Government are taking a good look at what was said in the review and taking the issues on board.

I love the term “pharmacy-first culture”, which is a good motto for everybody to live by. I want to concentrate on my Bury St Edmunds constituency for a couple of minutes. We have 21 pharmacies and a cluster of Superdrug and Boots shops, which are volume providers that have other things such as make-up and lunches; they have optical services and Boots has audiology services. They provide everything needed from the cradle to the grave and they have considerably greater footfall than my excellent independent pharmacist, who puts more prescriptions through than any other pharmacist in the town. The 100-hours rule meant that I got local surgeries with pharmacies dispensing in them. We need to take a little bit of care, step back and get the right things in the right place. The last thing my local community wants is my independent pharmacy not being able to survive through these important transitions.

An ageing population is a challenge in rural areas such as Bury St Edmunds. Within the next decade, 40% of Suffolk’s population will be over 85. We know that that age group lives with comorbidities that need a degree of monitoring. That can be done most effectively in the pharmacy and in the GP’s surgery, but out of the big NHS pie the GPs get only about 8% and the acute sector gets about 92%. We need to show that we are spreading the money throughout the system, because a lot of the pressure will be coming down on the pharmacies, the GPs and the care sector.

Pharmacists are often not used to their full value. Delayed discharge from hospital often comes about because people do not get their meds, and pharmacies in some hospitals are not available throughout the weekends. There could be more joined-up thinking.

Bill Esterson: I do not think I disagree with anything the hon. Lady has said. She is making a very good case for the excellent practice in her constituency and for pharmacists more generally. Does she agree that the logic of her argument is that money is saved by investing in pharmacies? That is a strong argument. She is arguing that cuts should not be made and that the Government should invest in pharmacies to support the whole health system, which is what this debate is about.

Jo Churchill: I thank the hon. Gentleman for his intervention and agree with his final point. This is about the whole system and making efficiencies. We are talking about evolution. We are no longer looking at the service as it was perceived in 1948. There was a private element to it even back then, because that is what GPs wanted. We need a 2017 solution to the challenges of a larger population, an ageing population and so on. Pharmacists must play their part in that. They are really keen to step up and deliver more for the Government and more for the patients and people in their communities.

There are issues in the town, but there is an interesting rural situation, where there are rural payments for Elmswell and Thurston, but the GP surgery in Woolpit, which dispenses more scripts, does not get one. There seems to be a bit of discrepancy. I echo the point made by my hon. Friend the Member for St Austell and Newquay (Steve Double): looking at rural constituencies is a very different thing from looking at the whole ecosystem.

There is a Day Lewis pharmacy in my town. An exceptional local resident, Ernie Broom, is keen to note that that pharmacy, because of its location, cannot offer a lot of peripheral things. The local residents are largely mature or on lower incomes, which means that the pharmacy is vital to the community. We also have really poor bus services into town—it would take a young mum or an elderly person nearly an hour and a half to cross town. I want the Government to look at a weighting system, which takes into account what local pharmacies can deliver. They would get points for being in certain areas, or incentives for delivering more. I know that is something that is being looked at.

My questions are similar to those posed by my hon. Friend the Member for St Albans. What more can pharmacies be incentivised to do? How much more capacity can they provide? With people living longer and with comorbidities, how can we remunerate for services? How can we ensure that that is included as part of sustainable transformation plans? It is not something that should be added at the end as an afterthought, but is a hugely integral part of how we make our NHS better and more able to look after the health of us all.

10.22 am

Martyn Day (Linlithgow and East Falkirk) (SNP): It is a pleasure to serve under your chairmanship, Mr Bailey. I thank the hon. Member for St Albans (Mrs Main) for securing the debate. I found much that I agreed with in her contribution, and I echo her call for a pharmacy-first culture.

It is a pleasure to take part in the debate, although I must admit to feeling a bit of an observer, as the debate

is about pharmacies and integrated healthcare in England. We have heard from a number of speakers about the different practices that affect their parts of England; I hope that my observations from Scotland may also be of interest to Members. I have commented in a few debates that there are often lessons that we can learn from one another and good practices that can be shared. This issue provides an excellent case in point.

Community pharmacies were developed in Scotland 10 years ago and are there for minor ailments, chronic medication and public health services. The Scottish Pharmacy Board has stated that more than one in 10 GP consultations and more than 1 in 20 accident and emergency attendances could be managed by community pharmacists using the minor ailments service; that represents huge potential for the future. Although we await the full evaluation of the minor ailment service later in the year, estimates suggest that as much as £110 million could be saved. Further expansion of the MAS is planned.

Mrs Main: I do not often agree with what is said by Scottish National party Members, but I looked at the Scottish service, and one of the key things, which I think other hon. Members have raised, is the software functionality that in Scottish pharmacies are obliged to have. That is something we do not have in England—I do not know about Wales—and I wonder if the hon. Gentleman could let the Minister know about that. The ability to input into scripts and the remuneration that comes through that software functionality in Scotland is something that I found very interesting.

Martyn Day: The hon. Lady has emphasised the point very well. There is a considerable degree of integration in the Scottish service. It has been around for 10 years and is a fairly mature service.

The Scottish Government work side by side with the medical professions in Scotland and recognise just how important community pharmacies are. They are interested in exploring new ways for pharmacies to offer primary care services to help deliver care across our communities. There are some 1,200 pharmacies throughout Scotland, providing a range of services on behalf of the NHS. As well as dispensing prescriptions, they offer four NHS pharmaceutical care services, which have been gradually introduced since 2006. These are the minor ailment service, which I have mentioned, the public health service, the acute medication service and the chronic medication service. Those new services involve pharmacists more in the community in the provision of direct, patient-centred care, with every community pharmacy in Scotland having patients registered for the minor ailment service by March 2015.

Patients register with a pharmacist in the same way as they register with a GP. The aim is for all people to be registered with their local pharmacist, wherever they consider that to be, by 2020, and for all our pharmacists to be independent prescribers by 2023. Approximately 18% of the population of Scotland are registered for the minor ailment service—a total of 913,483 people. More than 2.1 million items have been dispensed under the service, which is some 2.2% of all items dispensed by community pharmacies in Scotland. Almost 500,000 patients are registered under the chronic medication service.

It is important that retail and dispensing pharmacies in England be encouraged to go in a similar direction to Scotland, because that would bring great benefit for the NHS. In Scotland, we recognise just how important community pharmacies are. We are committed to supporting and developing local GP and primary care services and have recently announced a three-year, £85 million primary care fund to help develop new ways of delivering healthcare in the community, which will involve pharmacists delivering aspects of patient care.

Looking at pharmaceutical services across the two nations, one of the significant differences appears to be how the services have developed, partly as a result of the funding structures. In Scotland, pharmacists do not get a large payment merely for existing, such as the £25,000 in England. Instead, they receive a modest establishment payment of £1,730. However, payments are based on needs that reflect a population's age, vulnerability and deprivation. That model will see funding in Scotland rise by approximately 1.2%, while it looks likely to decrease by around 4% in England.

Another difference is the almost random way in which pharmacies in England appear to have opened, as a result of anyone being allowed to do so if they open 100 hours a week. A concern must be that there could equally be unplanned random closures, if they are allowed to shut down simply because they can no longer afford to survive. In Scotland we have a system of controlled entry for those who want to open a community pharmacy. Need must be demonstrated and applications approved by health boards. Consequently, we find community pharmacies in areas of deprivation, serving those most in need. Often health boards refuse applications because demand is already met.

Pharmacists are located throughout communities in Scotland, from rural areas to deprived inner-city areas, providing pharmaceutical care on behalf of NHS Scotland. The Scottish Government policy remains that, wherever possible, people across Scotland should have local access to NHS pharmaceutical care. There is much in the Scottish model that is working well and may provide a useful example for study on this side of the border. It is imperative that this successful model of community pharmacies across Scotland should not be put under threat by UK Government health budget cuts, which would impact on the Scottish Barnett formula.

10.28 am

Julie Cooper (Burnley) (Lab): It is a pleasure to serve under your chairmanship, Mr Bailey. I thank the hon. Member for St Albans (Mrs Main) for securing this debate on a very important subject. It is pleasing to hear so much agreement around the room; I hope that the Minister is listening. I agree with most of what hon. Members have said.

This subject is very dear to my heart. My husband is a community pharmacist, and I worked with him for 24 years in our own community pharmacy in my constituency of Burnley; I have to add that we no longer have any financial interest in community pharmacy, but what I retain is a very deep understanding of the value of community pharmacy to patients, the community and the wider NHS, so I appreciate the hon. Member for St Albans securing this important debate.

I cannot think of a better way to demonstrate the value of community pharmacies than to talk about my

experience. Coopers chemist in Burnley—a deprived constituency in many ways, where life expectancy is closer to 80 than 90—serves a community along with four other pharmacies in very close proximity, all of which are really busy and serve a big demand. On a typical day, we dealt with 600 prescriptions and 100 minor ailments, and ran many other services—forgive me if I forget some, because there were so many—including medication use reviews designed to maximise our use of medication, make sure patients understood it, encourage compliance and save money on wastage; smoking cessation programmes; dietary advice; emergency hormonal contraception; methadone programmes; and support for diabetics and asthmatics. It was an ever-increasing list. Those are the kinds of services that are at risk if the Government pursue their plans.

I appreciate the value of community pharmacies. I am also a former private business owner. Let us not forget that that is what community pharmacies are; they are not provided for and paid for by the NHS.

Oliver Colville: That is a very good example of how the private sector, working in the national health service, can deliver good-quality services.

Julie Cooper: I do not disagree with the hon. Gentleman's point.

It is important that we recognise that community pharmacies provide their own premises and train their own staff. As a former business person, I totally get the point about value for money, but this is not just about money; it is about the efficient use of money. We all understand the pressures that our NHS face, and we have to look at that. There are a lot of myths floating around, so it is important that we clarify that.

There has been a lot of talk about the clusters. Again, because pharmacies are private businesses, they respond to demand in the community.

Julian Knight (Solihull) (Con): The hon. Lady brings her expertise to the debate. Does she agree that we need more innovative approaches? The Grove surgery in Solihull has a symbiotic relationship with its local GP services, but in parts of the UK we seem to have run into the sand. We need greater public awareness and encouragement to take such innovative approaches forward.

Julie Cooper: I will come on to that very point in a moment.

To return to value for money, it is important that the Government take a responsible attitude and review funding for pharmacies, and I think that professional community pharmacists across the country accept that. Much has been made of the clusters. Pharmacies are independent businesses that arise and stay in business where there is demand. I do not know whether this is widely understood—hon. Members will have to forgive me if they already know this—but the global sum allocated to pharmacies is what pharmacies cost the Government. The Government know what community pharmacies are going to cost. If a new one opens, it does not cost the Government any more; it just means that the same amount of money is shared out more thinly. That is a bit of a red herring. We can be sure that if there is no demand for the services that a pharmacy provides, it will close.

[Julie Cooper]

Much has been made of the £25,000 payment, but that does not cover the cost of putting a van on the road and paying for a driver to deliver and administer a prescription delivery service. Those services are absolutely invaluable to communities with many elderly people. I had a conversation with practice managers and general practitioners in my constituency recently, and they were absolutely horrified because they use that service—there is a lot of repeat ordering—and if it were lost, they could not cope.

The Government are suggesting that in-surgery pharmacists are a substitute, but that is another red herring. I welcome the use of well-qualified pharmacists in GP surgeries, but that is a totally separate issue. It is like comparing hospital doctors with GPs. Community pharmacists are at the heart of the community and are accessible for many hours. The hon. Member for St Austell and Newquay (Steve Double) made the point very well earlier when he said that eight minutes is the average wait to see a qualified professional who can help with most things. We have got to embrace that and use what is already there.

I have had conversations with the National Pharmacy Association and the Royal Pharmaceutical Society, and just last night the chair of the English Pharmacy Board said, “We want to work with the Government. We want to sit down and look at how we can do more.” There is the idea that integration is a new thing waiting to happen, but we were proud as community pharmacists to be at the heart of the primary care team, working with GP surgeries, hospital discharge teams, community nurses and district nurses. They often came to us. GPs came and went—that is even more the case now, given the problems with retention in GP practices—so we provided the only continuity in healthcare for many chronically ill people. Particularly for the elderly, that was a vital part of the service, and we were really proud to provide it.

Many community pharmacies are proactive. When this business of moving towards a clinical approach was suggested, community pharmacies accepted it without it needing to be mandated. We invested in a purpose-built consulting room to provide a more clinical environment. That is the way forward, and most community pharmacies accept that.

What is the alternative to what the Government are proposing? For a start, we need a proper assessment of what the cuts will mean. There has been no impact assessment of which pharmacies will close. I agree with the hon. Member for Bury St Edmunds (Jo Churchill) that it will not be the multiples that will close; it will be the independent pharmacies that rely on the £25,000 to provide their core services. That is an absolute fact. Not a single pharmacy in my constituency qualifies for access payments, and only three in the entire city of London do. I can say with absolute confidence that in my constituency it will not be Boots that closes or cuts its hours; because of the volume of business, it has other ways of covering its overheads.

I ask the Government not to throw money willy-nilly at pharmacies, but to look at their value and assess the impact of the cuts. If they think that the best way forward is for some pharmacies to close, they must ensure that the right ones close. We must do what the

professional organisations are asking for and come to the table. Pharmacies are begging to take on extended roles. There is so much good will there. The minor ailment scheme, which we were privileged to provide, is an important service. Busy families who have children with minor ailments do not have time to be at the GP surgery. GPs accept that, without that service, they could not manage. We all know that GPs work hard and are overstretched. This is not about criticising the work they do; it is about supporting them, saving the NHS money and taking off pressure.

I ask the Minister not to reconsider the funding, but to look at the way he works with pharmacies in the NHS. I ask him to look at their role, as many Conservative Members have said, and at how they can work with the Government to support other areas of the NHS, thereby saving money. Let us avoid a knee-jerk reaction with no proper assessment of the impact. Let us deliver a better integrated service. The way to do that is not to make blind cuts with no proper assessment.

10.39 am

The Parliamentary Under-Secretary of State for Health (David Mowat): It is a pleasure to serve under your chairmanship, Mr Bailey. I congratulate my hon. Friend the Member for St Albans (Mrs Main) on leading the charge on what we all agree is an important subject. We have heard some very useful speeches, although I would make the point in passing that the subject is apparently so important to the Opposition that there have been no speeches from their Back Benchers on any aspect of the reforms during the last hour and a half.

My hon. Friend used an important word in introducing the debate: integration. I will talk about that, because if we are to fulfil the potential of the sector, which we need to do, it needs to be integrated. We have heard other important words too. We have heard about “pharmacy first” and also the phrase “wellbeing hub”, which I think sums up where we want to be in time. I will try to address many of the points made in all parts of the Chamber, but I will also set out what the Government are planning. When we boil it down, however, there is a huge amount of agreement about where we need to get to and the direction of travel. We also heard about Scotland, which is not perfect—the Murray review made some points about IT integration in Scotland, which is not yet working as well as it might—but as I have said in the past, I think we have things to learn from Scotland.

Everyone in the Chamber, Government or Opposition, can agree on three things. First, we need to move funding and the profession from a model based principally on dispensing to one based much more on services. Of course it is true that, to an extent, we are already going in that direction, but the funding model is not facilitating that, and it needs to. The Government must address that and take it forward.

Secondly, we all agree that services are a good thing per se, but that they are better if integrated with the primary care pathway much more than has been the case historically, and that is about working much more closely with GPs. I do not agree that employing more clinical pharmacists in GP practices is a “red herring”; it is part of how we bring the professions together, although I accept historically there have been difficulties doing that.

The third thing we all agree on—this must apply to the Opposition as well—is that we need to get value for money for the £2.8 billion that we spend on dispensing around £8 billion-worth of drugs. It is right to look at doing that as efficiently and effectively as possible. For example, the existing funding model encourages clusters to develop. I note that the establishment payment in Scotland is £1,700 per annum—I think I heard that right—while ours is £25,000, which has encouraged clustering, so that NHS money is not being spent on frontline services.

It is worth reminding the House that none of the efficiency changes that we announced before Christmas represents a cut of money going back to Treasury; the money is being reallocated to other areas of the NHS. The impact analysis talks in some detail about how money can potentially be spent more efficiently. In parallel with that, we need to make progress on services. I completely agree with that, and I will talk about the pharmacy integration fund and the Murray report, an important piece of work which my hon. Friend the Member for St Albans talked about and which will inform our policy.

We all agree not only on those three things, but on others. For example, there is a big benefit in diverting activity away from GPs. Various reports have been produced by the sector itself, and the Government accept that up to 30% or 40% of GP appointments could possibly be handled by pharmacists. That is a massive number. If we can achieve that, it will be of great benefit to us all. More can be done in pharmacies, such as medicine reviews and medicine optimisation, let alone how they can help us with the public health agenda, which we have not covered in particular today. A lot could be done with smoking cessation, obesity and sexual health programmes.

Julie Cooper: The Minister is contradicting himself. Pharmacists are already planning to reduce the hours that they are available to provide these services—the very services that he tells us he values and wants to see more of. Does he accept that if he persists with the cuts, there will be less of them? Some pharmacies will close, while others will reduce services, and are already planning to cut opening hours and reduce staff.

David Mowat: What we are not reducing is the amount of money available for services, as opposed to dispensing. Some pharmacies use part of their dispensing money to provide services on a discretionary and ad hoc basis, but I make this point again: overpaying for dispensing is not a good vehicle for getting more and better services.

I want to talk about some of what is already happening. We have heard about flu jabs this morning—I, too, had a flu jab at a pharmacy—and at the end of last year, we had had more flu jabs in pharmacies by October than we had in all of the previous year. The money available for that and similar service-based allocations has not been affected by the changes we announced. The community pharmacy sector has received £10 million for flu jabs up to the end of October. We want to see more of that happening, and that direction of travel is important.

A number of hon. Members made the point, which I agree with, that the public need to understand that pharmacies represent an important first port of call—it

should not always be GPs. The Government can do more to make that clear. When I was preparing for this debate last night, I saw a television advert from NHS England for its “Stay well this winter” campaign. The campaign is running TV and newspaper adverts, and its theme is for people to visit their pharmacy as soon as they feel unwell. The people running the campaign have told us they think the advertising campaign has generated about 1.2 million additional pharmacy visits that would not have happened otherwise. That was a good challenge and we need to do more of that.

We also need to go further with services. There are two approaches. I recommend that anyone interested in this subject—as everyone present clearly is—reads the Murray review, which was produced by the King’s Fund. NHS England commissioned the review to inform it and us on how to spend the integration fund, the budget available to drive services more deeply into the system. I will talk about some aspects of that and about some announcements that I made in October as part of the package we are discussing.

One of the announcements was about urgent or repeat prescriptions. At the moment, NHS 111 gets about 200,000 phone calls a year asking for a further prescription, and those callers are told to see an out-of-hours GP to issue a prescription, which in due course goes to the pharmacy. We are changing that so that people will be directed to a pharmacy immediately. That is a stream of revenue for the pharmacy, which will provide both a consultation, for which it will be paid, and then the drug or prescription, as necessary.

My hon. Friend the Member for St Albans asked whether that scheme would somehow affect a good local scheme in her area. There is no reason why that should be the case. The new scheme is supplementary to anything that might have been commissioned already. It sounds as if her scheme was commissioned by the CCG, and that is good, although it takes us to the fact that things are patchy—different CCGs do different things in different areas, which I will come to. However, that is an example of where we need to be.

Another example is the minor ailments scheme. As I have said, 30% to 40% of GP appointments could be dealt with in pharmacies. Parts of England already have minor ailments schemes, but the service is very patchy and it need not be. It is true that different CCGs and indeed different GPs have different attitudes to such schemes, but NHS England has made a commitment that by March 2018 it will have encouraged all CCGs to be commissioning minor ailment schemes in pharmacies across their patch.

Oliver Colvile: Is the Minister aware that in Devon about £5 million a year is apparently being wasted on unused medicines? Something needs to happen with that to ensure that the NHS has enough money with which to do things.

David Mowat: Yes. Throughout the country, the number is far more than £5 million—

Julie Cooper: Will the Minister give way?

David Mowat: If I may answer the previous intervention, I will certainly give way again. I have talked about medicine optimisation and pharmacies doing reviews,

[David Mowat]

in particular in people's homes, for example, and they are part of that solution. Pharmacists in GP surgeries are part of the solution too, and a way of achieving that—as I said earlier, I do not agree that that is an irrelevancy.

Julie Cooper: I thank the Minister for giving way. A highly trained pharmacist, who often has a trusted relationship with his patients in the community, is better placed than any other health professional to lead on saving money on wasted drugs. Patients quite often say in a close conversation when they collect their prescription, "Actually, I've not been taking that," but they quite often do not say that to their GP. The pharmacist will then take it upon themselves to say either, "Actually, do you realise you should be taking this?" or, "Let's speak to your GP and, effectively, avoid waste." The pharmacist is best placed to do that.

David Mowat: I completely agree. Pharmacists have a big role to play in saving money, and medicines optimisation is very important in that. NHS England has established an integration fund, which will provide £42 million—a significant amount, even in the context of the rebalancing that has occurred—of seed money between now and the end of the next financial year to address just those sorts of things and take that work further.

The Murray review, which was commissioned by Dr Ridge, the chief pharmaceutical officer at NHS England, and published in December, sets out in some detail what we believe the direction of travel should be. Someone asked earlier when the Government will respond to that review. I expect NHS England to respond this month—if I may put that on the record in that way. NHS England will respond, not me, but there is not a lot in the review that is controversial. There are a lot of very good points, many of them about IT integration and the care record. I agree completely that some of the progress we need to make with services involves the ability to both read and write to the summary care record. That will be part of where we have to get to. Frankly, technology is an area in which the NHS could improve. That is true in Scotland—it is true everywhere. I will not spend a lot of time talking about what we need to do, but we could facilitate an awful lot of progress on integration between pharmacy and primary care, and primary care and secondary care, if we had stronger technological and IT solutions.

Colleagues have talked about the need to have more pharmacy involvement in medicines optimisation, and care homes are part of that. Pharmacists could do an awful lot with a more structured approach to care homes. One strand of work that has come out of the integration fund is a care homes taskforce, which is chaired jointly by the Royal Pharmaceutical Society and NHS England and is setting out a direction of travel for doing the sorts of things we have talked about, such as medicines optimisation, in a more structured way in care homes right across the country. There are more than 50,000 qualified pharmacists across our country. There are also 23,000 qualified pharmacy technicians, who are part of this too. The pharmacist profession is not as short as some, and it can and needs to do more to make progress in this area.

One part of the Government's approach to this whole area that has been mentioned and I do not think

enough is made of is the GP forward view. Everyone understands how much pressure GPs are under. There are something like 400 clinical pharmacists working in GP practices. We have committed and budgeted £112 million to increase that to 2,000 clinical pharmacists, many of them dispensing pharmacists. Parts of the community pharmacy network, which we have heard a little about, regard that as potentially in conflict with what they do. I think that is wrong. It is not in conflict; it is a way of breaking down the barriers that I accept there have occasionally been between CCGs and GPs and the pharmacy profession. Those are not in anyone's interests, and we need to get over them.

Mrs Main: The only concern I have about too much of a drift towards putting pharmacists in GP surgeries is that GP surgeries have limited opening hours. Many pharmacies have a drop-in service. My hon. Friend the Member for St Austell and Newquay (Steve Double) mentioned the average waiting time of eight minutes. Having a link between booking a GP appointment and going to the pharmacy would start to bring people back into GP services rather than keeping them outside those services. That is the only concern I have about that matter.

David Mowat: That is of course a valid concern. We are trying to make progress on having GP services open for much longer than they have been historically, including weekend opening. Several colleagues have made the point—the Murray review also addressed this—that there is occasionally a barrier between the attitudes of some GPs and what can be done by pharmacists. That is true. We must be conscious that it behoves us to try to encourage the breaking down of that barrier, and misplaced professional pride must not prevent us from doing things to the best extent. Putting some pharmacists in GP practices—particularly with new models of working in which more disciplines tend to work together and a GP does not just work on his own—is an important part of that.

Jo Churchill: There is a barrier, but again, those services are used in different ways. My independent community pharmacist in Bury St Edmunds dispenses around 18,000 or 19,000 prescriptions in the town and provides all these ancillary services. He also has a dispensing practice in a GP surgery, which he is looking to automate, to make it more streamlined and cost-effective. Those services are two slightly different things, and I would worry if there were too much of an idea that they service the same thing.

David Mowat: They are different, but my point was somewhat different: optimising the use of the pharmacist profession could facilitate the breaking down of barriers and some of the care home activities that have to happen.

I will leave a couple of minutes for my hon. Friend the Member for St Albans to respond, so I will not talk in detail about the value for money aspect, other than to repeat the point—Opposition Members made a couple of interventions about this—that overpaying for a dispensing service is not the way to facilitate a much more clinically-based and service-based approach. The way to facilitate that is to get the appropriate remuneration models and revenue streams in place, and that is what

we are determined to do. In the end, that is what we expect to be judged on, and I hope that we will be judged on it. With that, I will let my hon. Friend summarise.

10.57 am

Mrs Main: This has been an excellent debate. I echo the Minister's sadness about the fact that the two Opposition Members who made interventions did not stay for the whole debate. Unfortunately, some did not even arrive for the beginning of the debate, let alone stay for it all. That is disappointing, because this issue has filled my postbag and this debate is timely. There has been a lot of news about whether the NHS is under massive strain now more than ever. The reality is that we need a new model of working. Many hon. Members have put forward positive suggestions and have obviously been engaging with their local pharmacists. I am pleased that so many Government Members have made that effort and are so knowledgeable about their pharmacies.

The very fact that many private independent pharmacies like Quadrant have put money into their businesses—the hon. Member for Burnley (Julie Cooper), who leads for the Opposition, stressed her role in that—shows that there is a private model that can work with the NHS. It shows that those two models can be mutually beneficial and can learn from and give to each other. I am delighted that the Minister said that the emergency prescription system would not necessarily rule out the excellent system that Quadrant pharmacy operates, and I am delighted that we will soon hear the response to the Murray review, which contains many positive aspects about the way forward for pharmacies.

I am glad that there is so much consensus that keeping the model in which small, private independent pharmacies support the public NHS is an excellent way forward, and long may it reign. I am just concerned that we must ensure that small independent pharmacies in rural areas like the one that my hon. Friend the Member for Bury St Edmunds (Jo Churchill) represents are supported, perhaps with a weighting system. It is hard for them to compete with the big boys on the high street and the concessions in out-of-town supermarkets with parking and Sunday opening. I am glad that the Minister has been so frank with us, I am glad that there is so much consensus, and I am really looking forward to a great future for the NHS.

Motion lapsed (Standing Order No. 10(6)).

Asylum Seekers: Right to Work

11 am

Mr Adrian Bailey (in the Chair): Before I call Alison Thewliss to move the motion, I have had a request from Stuart McDonald to participate in the debate. May I confirm that both the mover of the motion and the Minister are happy for him to do so?

Alison Thewliss (Glasgow Central) (SNP) *indicated assent.*

The Parliamentary Under-Secretary of State for the Home Department (Sarah Newton) *indicated assent.*

Alison Thewliss (Glasgow Central) (SNP): I beg to move,

That this House has considered asylum seekers and the right to work.

It is a pleasure to see you in the Chair, Mr Bailey. I have taken an interest in the rights of asylum seekers for some years now. One of the very first events I attended as a councillor in Glasgow in 2007 was the opening of Refugee Week, the inspirational and ever-growing festival co-ordinated by the Scottish Refugee Council. That was the first time I heard directly the testimonies, experiences and views of those who had fled violence and persecution. They told their stories through music and dance as well as in words, because the trauma they were expressing was often beyond description.

The right to seek asylum is set out in the universal declaration on human rights, and it is one of the most important obligations in international law. However, it has become clear to me over the past few years that sadly in the UK we are not fulfilling our duties to asylum seekers. We often keep them in a situation of destitution and danger, with little acknowledgement of the difficulties that led them to flee. Worse still, we are devaluing these precious human beings. Asylum seekers have skills they could bring and talents they could share. These are people who have overcome everything and lost so much. The very least we should do as a nation is give them a means of living in dignity, and I believe, as I will lay out, that there are circumstances in which they should have the right to work. That is consistent with the position that the Scottish National party took, along with Labour Members, in proposing amendments to the Immigration Act 2016 to enable asylum seekers to work if they had been waiting more than six months for a decision. The UK Government sadly rejected the amendments.

With no permission to work, asylum seekers survive—it is barely survival in many cases—on £5 a day. That affects more than 8,000 asylum seekers in the UK. The right to work was withdrawn by the Labour Government in 2002. At present, asylum seekers can work only if they have been waiting for a decision for longer than one year and they have skills relevant to the occupations on the shortage occupation list, which covers only jobs that few or no UK nationals are able to perform. Those are often very specific jobs, such as various types of scientists and engineers, as well as trades such as professional dancer or musician, which require specific qualifications

[*Alison Thewliss*]

and experience, as well as an employer who is willing to take a person on when they do not know how long they may be in the UK.

Julian Knight (Solihull) (Con): I congratulate the hon. Lady on securing this important debate. I know she does a great deal of work in this area. I want to focus briefly on volunteering. In Solihull, many volunteers provide an outstanding service to our communities. Solihull Welcome, for example, supports new asylum seekers with great information, food and clothes. Does she agree that to integrate asylum seekers further into society, we must promote voluntary work?

Alison Thewliss: I agree, and I congratulate the organisation in Solihull on doing that. However, I have found in some of my casework that there are barriers even to volunteering. The Home Office has held that against one of my constituents, whom I had intended to mention later, who was volunteering for the British Red Cross. When he applied for naturalisation as a British citizen, that was held against him as a means of demonstrating bad character. It is bizarre, but his volunteering and his good work in an attempt to integrate into the community in Glasgow was held against him.

It can also be difficult for asylum seekers to prove that they have professional qualifications and so should have access to the shortage occupation list. Depending on the circumstances in which they fled, they may not have documentation, and it may cost to transfer or update their qualifications. That approach prohibits asylum seekers from offering their skills while they are still waiting on decisions. Many asylum seekers have been waiting for longer than six months. The latest figures that I can find suggest that more than 20% of asylum seekers wait longer than six months to have a decision made. During that time, they cannot bring in any money, and they find it difficult to support their family.

The recent working paper, “Restricting the economic rights of asylum seekers: cost implications,” published by Dr Lucy Mayblin and Poppy James at the University of Warwick, outlines the significant savings there would be to the public purse should asylum seekers be given the right to work. There would be a benefit to the UK if they were allowed to do so. Dr Mayblin’s research indicates that significant savings could be made on asylum support payments—both section 95 and section 4—if asylum seekers were given the right to work. If just 25% of all asylum seekers currently receiving asylum support participated in the labour market, that would reduce the overall asylum support bill, both in cash and for accommodation, under sections 94 and 4, excluding staffing and admin costs, from more than £173.5 million to just over £130 million. That would save about—I rounded the figures up, because some of them are lengthy—£43 million in asylum support payments, without making asylum seekers destitute. If 25% of all asylum seekers were able to obtain employment, section 95 payments would decrease from about £63 million to £47 million, and section 4 cash payments would decrease from more than £9 million to just less than £7 million, based on 2014-15 figures.

Even with increases in the asylum support rate to 70% of the jobseeker’s allowance rate, if we enabled 25% labour market participation, savings could be made to the asylum support bill. Estimates suggest that the total asylum support bill—again in cash and for accommodation, under sections 94 and 4, and excluding staffing and admin costs—could decrease from £173.5 million to £152 million, a saving of about £21 million. The Government are always looking to make savings, so I offer helpful suggestions for where those might be made.

Those figures, however, represent more than just money. Case studies available on a host of websites, such as that of the Scottish Refugee Council and the Regional Refugee Forum North East, speak of dignity, and of the impact on family life of not being able to work. I quote from one of the testimonies on the RRF website:

“It’s a degrading situation. You feel useless in a place that sings democracy. Not being able to work is degrading to me. It is something that has been taken away from me, something that I believe is a right that nobody should lose. It’s depressing because my background is feeding my own family. We have very strong family values. I have a big duty of care that has been stripped away. And not being able to do that for myself I feel a failure in life. I feel very much a failure in life. The kids, I would have loved to do anything that the children would ask me for. But this position is a crippled life.

As a volunteer with the refugee service and as a leader for my own community, which is the Zimbabwean Community in the North East, I have witnessed people who are so depressed, who I can say they are now mentally disturbed, people who had skills but cannot use them anymore. It’s like somebody taking a certain measure of power away from you. If you lose that something, it won’t just go, it will go with a part of yourself that makes the You inside you.”

That is a powerful statement. There is appalling waste of human potential during that time; people can wait for years without working and contributing as they would dearly like to do.

Chris Stephens (Glasgow South West) (SNP): I congratulate my hon. Friend on obtaining the debate. Is there not another problem, in that the shortage occupation list does not recognise degrees from countries such as Iraq, Syria and Afghanistan, which many asylum seekers have come from? The Government should have a look at that situation so that they can allow asylum seekers to work.

Alison Thewliss: I agree. There are many ways in which verification becomes quite difficult when countries have been in a state of chaos.

I have one of the largest immigration case loads in Scotland in my constituency of Glasgow Central, and I regularly have asylum seekers at my surgery who are in dire straits as a direct result of Home Office policy. One constituent who came to me had fled political persecution in Sri Lanka in 2013. On claiming asylum in 2014, she was detained in Dungavel detention centre, where she was sexually assaulted by another detainee. She is now destitute and relies on charities for support. That bright young woman could be using the qualifications in business, which she gained, as it happens, from a UK further education college, to get a job and support herself. Instead, she has been so emotionally ground down by her experience of the system that she is deeply fearful for the future. Her heartbreaking case is part of a pattern of behaviour by the Home Office that in many cases treats those fleeing persecution with contempt.

Simon Danczuk (Rochdale) (Ind): The hon. Lady is making a good and important speech. There are far too many asylum seekers in Rochdale—more than 1,000—which is unfair in terms of how they are shared out across the country, but I completely agree with the point that she makes about work. Does she agree that if more were allowed to work, it would help with community cohesion in places such as Rochdale?

Alison Thewliss: I agree. People often do not understand that asylum seekers are not allowed to work. Media perceptions can be hugely damaging, including, as I mentioned earlier, to asylum seekers' mental health. Many are keen to contribute but also scared, as I described in the example of my constituent whose volunteering was held against him. That puts fear into organisations that might take volunteers: they do not want to be caught out by the Home Office and get into trouble. Some of them employ people via the visa process. However, volunteers also do not want to come forward; they say, "If it is going to count against me, I am not going to volunteer. I am not going to help with interpreting." If an organisation such as the Red Cross is seen as giving someone a bad character, that is difficult, and it definitely puts people off.

Another of my constituents has endeavoured to learn English to a high standard, and has taken up volunteering, supporting elderly people at a community centre. She has a clear aptitude for community work, but is unable to develop it because of the ban on work for asylum seekers. My constituent has two children, who go to a local school, but she is held back. She would love to do that work but cannot.

I am lucky to have the organisation Radiant and Brighter, founded by Pheona and Micheal Matovu, in my constituency. They came from Uganda to the UK and were unable to work for years, because of immigration controls. They were a couple with a family, used to working for a living, and found it very hard to be dependent on help from churches, family and friends. Pheona once told me how determined the two of them were not to let their children know they did not have a job, even when they were not permitted to work. Their experiences led them to find others in similar situations, and to discover the support that some asylum seekers and refugees required to transfer the skills they brought from their home countries and take up UK opportunities when they could. Radiant and Brighter provides practical day-to-day support and assistance, including personal coaching, advice on legal and financial matters and help with CVs—something that people might not be familiar with in their own countries—and job applications.

Crucially, Radiant and Brighter recognises the skills, talents and potential of asylum seekers and refugees beyond the narrow bounds of the shortage occupation list, appreciating the fact that asylum seekers can be a bonus to the UK, not a burden; the Minister would do well to speak to Pheona and Micheal and see for herself the work that they do in Glasgow to integrate and support asylum seekers. They have a good model for allowing people to make the jump to being productive members of Scottish and British society, as they want to be, and for supporting them in that.

Allowing asylum seekers to work would enable them to integrate better into society, develop their English and make friends in what can be a lonely environment—and

a strange one, depending on where they have come from. Many are professionals, with skills that they would love to put to use and which would benefit our economy. By making a modest change to the immigration rules, so that they are similar to those of other European countries, and by relaxing the restrictions on working, we can give asylum seekers back a sense of dignity and self-confidence, while saving money for the public purse in the long run.

My hon. Friend the Member for Cumbernauld, Kilsyth and Kirkintilloch East (Stuart C. McDonald) is sponsoring an exhibition by the Joint Council for the Welfare of Immigrants in the Upper Waiting Hall this week. That organisation has campaigned for fair asylum and immigration law since 1967. I urge the Minister and other hon. Members to see the exhibition, if they have not already. It clearly demonstrates the contribution of people who have sought asylum in the UK over the years. Examples include the co-founder of Marks & Spencer, Michael Marks. There is nothing more British than Marks & Spencer. Michael Marks was born in 1859 in Slonim in what is now Belarus, which was then part of the Russian empire, and fled to England in 1882. It cannot be argued that he did not make a lasting contribution to the UK.

The children's author and illustrator Judith Kerr fled Germany with her family in 1933 aged nine, just days before the Nazi party came to power. It cannot be argued that she is not a beloved part of British society. The supermodel, designer and refugee campaigner Alek Wek was born in 1977 in what is now South Sudan. The singer and actress Rita Ora arrived in the UK in 1991 aboard the last plane to accept Kosovan refugees. There are so many people who have come to our shores seeking safety. We should take pride in that and treat them with the dignity and respect they so greatly deserve. I appeal to the Minister to see the human potential in those whom we have made a commitment to protect.

11.14 am

Stuart C. McDonald (Cumbernauld, Kilsyth and Kirkintilloch East) (SNP): It is a pleasure to serve under your chairmanship, Mr Bailey. I congratulate my hon. Friend the Member for Glasgow Central (Alison Thewliss) on bringing this important debate to the Chamber and on her fantastic speech, and I thank you, Mr Bailey, my hon. Friend and the Minister for allowing me to make a short speech. I was keen to take up the opportunity, because the matter is important to the Scottish National party. We have campaigned for change for a long time, and that is why we divided the House on the issue during the ping-pong stage of the Immigration Act 2016.

The Government's position is to deny asylum seekers the right to work. The idea that after one year, an asylum seeker can apply for a shortage occupation job is just a small footnote, for a series of reasons, including the one pointed out by my hon. Friend the Member for Glasgow South West (Chris Stephens). It would be interesting if the Government would tell us how many asylum seekers have enjoyed that right. I understand that they have previously failed to answer written questions on that point.

Sadly, and typically for UK Government policy on asylum and migration issues in general, the position has little to do with principle and nothing to do with

[*Stuart C. McDonald*]

evidence, but everything to do with political posturing. Excluding people from the right to work is a lose-lose situation. It is bad for the individual, for the family, for the UK citizens who could benefit from the people in question using their skills, for community cohesion, as the hon. Member for Rochdale (Simon Danczuk) pointed out, and for the public purse, as my hon. Friend the Member for Glasgow Central pointed out.

We are warned by the Government of the danger of creating a pull factor, but are we really to believe that people will decide to up sticks and come to the UK on the off-chance of claiming asylum, becoming one of the minority of people who must wait longer than six months—outside the Government target—and then having the possibility of working? If so, where is the evidence for that? There is no evidence for it. Also, why do those asylum seekers not go to other European countries where there is such a right to work, and a more generous one? Yet again, we are the EU outlier. The whole proposition is nonsense, and I think that the Government know that.

Another argument that the Government sometimes use is that there would be a danger of asylum seekers deliberately frustrating the process, so that their claims would take longer than six months. However, that argument does not stack up. The Government have the power to refuse asylum claims on the basis of non-compliance. The argument does not make any sense.

We are dealing with human beings who have asked for international protection. That is an important right, whatever the outcome of the claim. Whether or not the claims are found to be sound in law, the applicants deserve dignity and fair treatment, so we ask the Government to think again.

11.17 am

The Parliamentary Under-Secretary of State for the Home Department (Sarah Newton): It is a pleasure to serve under your chairmanship, Mr Bailey. I thank the hon. Member for Glasgow Central (Alison Thewliss) for raising such an important issue, and I commend her passionate speech. She is clearly pursuing the issue in the House with great vigour and determination. I also thank the hon. Member for Cumbernauld, Kilsyth and Kirkintilloch East (Stuart C. McDonald) for his speech. I am sure to have said the name of his constituency wrongly, so I apologise. I noted also the remarks of the hon. Member for Rochdale (Simon Danczuk). It is disappointing that the shadow Minister did not bother to come to the debate. I see that the hon. Gentleman agrees with me that that is a sad reflection.

It is right to say that, as a general rule, we do not believe it is appropriate to allow asylum seekers to work in the UK. However, we will grant an asylum seeker permission to work in one of the jobs on the shortage occupation list if their claim has not been decided after 12 months, through no fault of their own. We believe that that is fair and reasonable; it protects the resident labour market and ensures that access to jobs is prioritised for British citizens and those with leave to remain, including refugees.

The immigration rules for non-EEA nationals wishing to work in the UK are designed to meet our needs for skilled labour and to benefit our economy. That approach

would be undermined if non-EEA nationals could bypass the rules by lodging unfounded asylum claims. It is an unfortunate reality that some individuals make such claims in an attempt to stay in the UK. It is reasonable to assume that some do that because of the benefits—real or perceived—that they think they will gain.

Stuart C. McDonald: Will the Minister give way?

Sarah Newton: I will not; I have been generous in allowing the hon. Gentleman to make his speech. So that I have the opportunity to answer the serious points that have been raised, I will need to make my whole speech. If he feels that I do not address his concerns, I ask him to write to me.

Allowing asylum seekers earlier access to work risks undermining our asylum system by encouraging unfounded claims from those seeking employment opportunities for which they would not otherwise be eligible. We also must not create further incentives for asylum seekers to risk their lives attempting to travel here illegally. We instead want to encourage genuine refugees to claim asylum in the first safe country they reach.

I know there are those who say, as has been said today, that there is little evidence of a pull factor. I do not agree. We have seen the effect that policies in Europe have had in driving migrant behaviour. In 2015, following a shift in policy, Germany saw its asylum intake increase by 155%. More than 20% of those claims were from countries in the Balkans, which, mercifully and thankfully, have not seen conflict for more than 20 years.

There has been much debate, as has been referred to, about past delays in decision making by the Home Office, but that has been brought under control. In most cases, asylum seekers receive a decision within six months. While they are awaiting that decision, asylum seekers, who would otherwise be destitute, are entitled to free, furnished accommodation that is safe and of a good standard. In preparation for the debate, I met a Home Office official who personally inspects that accommodation in the constituency of the hon. Member for Glasgow Central and was assured of its quality and safety.

A cash allowance is given to asylum seekers to cover essential living needs. It is worth noting that in October, the High Court agreed that the methodology used by the Home Office for assessing the adequacy of payment rates is rational and lawful. The judgment also rightly rejected the argument that the rate should be the same or similar to that paid to benefit recipients by the Department for Work and Pensions. I do not accept that we are in some way treating people in an appalling or degrading way by providing that accommodation.

Alison Thewliss: Will the Minister take an intervention?

Sarah Newton: I will not, because I want to address the points that the hon. Lady has raised.

It is worth noting that we encourage asylum seekers to undertake volunteering activities, so that they can benefit the community. That supports integration if they are granted protection, and addresses some of the self-esteem and respect issues that the hon. Lady rightly referred to. Opportunities will be provided in communities

for people who are used to being providers for their families or community leaders in the countries from which they fled.

I was pleased to hear the intervention from my hon. Friend the Member for Solihull (Julian Knight), who made an excellent point about the role the voluntary sector is playing in his community in supporting asylum seekers. For clarity, it is important to understand that those volunteering activities must not amount to unpaid work or job substitution. The Home Office recently published revised guidance to help clarify that issue, in case there is any uncertainty.

The current policy strikes the right balance. It is fair and reasonable towards genuine asylum seekers, it is consistent with our international obligations, and it takes into account the rights and needs of asylum seekers and our whole society.

Question put and agreed to.

11.24 am

Sitting suspended.

Access to Justice

[GERAINT DAVIES *in the Chair*]

2.30 pm

Rob Marris (Wolverhampton South West) (Lab): I beg to move,

That this House has considered access to justice.

It is a pleasure to appear in front of you, Mr Davies. I thank all those who sent in briefings and background information, which have been most helpful. I especially thank the law firm where I was a partner for several years, Thompsons. In fact, two other Members who are Thompsons alumni are with us today. Thompsons supported my campaign for re-election 18 months ago financially. I also thank the Law Society of England and Wales, of which I have been a member for three decades or more, and the Association of British Insurers.

Access to justice is a pillar of the welfare state. To me, it is no coincidence that in 1948, the legal aid system in England and Wales was introduced—the same year as the introduction of national insurance and the national health service. It is one leg of a three-legged stool called the welfare state. This afternoon, I will not have time to cover as much information and as many matters as I would like. I hope to run around the block on the small claims limit for personal injuries, soft tissue injuries and whiplash claims, and to touch on employment tribunal fees, legal aid deserts and court closures.

I will start with the small claims limit. In recent years, other jurisdictions with similar systems to ours have looked at raising their small claims limit. In Scotland, the small claims limit was raised in 2007, but all personal injury claims were specifically excluded from that, as colleagues from the Scottish National party who are here today will know. They were excluded principally on the grounds of complexity, because of the need for those claiming for a personal injury to instruct solicitors to obtain expert medical evidence and, quite often, other expert evidence—for example, from an engineer.

When the Scottish system was reformed in 2014, personal injury was still treated differently. In 2014, a new procedure was introduced in Scotland called, simply, the simple procedure, to replace small claims and summary causes for cases with a value of less than £5,000. However, most personal injury claims, while proceeding under simple procedure, have special rules. Employers' liability claims, where someone is injured at work, are entirely excluded from simple procedure.

Whether to raise the small claims limit has been looked at repeatedly in England and Wales. For example, in 2009 Lord Justice Jackson recommended in his report that the limit be retained at £1,000 for small claims relating to personal injury, with a fast-track system. Looking back on that in 2016, he said:

"The fixed costs regime for fast track personal injury cases is working reasonably well."

I appreciate that people could say he is biased: he suggested one course of action, which was followed, and then seven years later said it was working well.

However, in July 2016, less than a year ago, Lord Justice Briggs in the final report of his civil courts structure review concluded that

"a fixed or budgeted recoverable costs regime, backed by Qualified One-way Costs Shifting...plus uplifted damages has, in the sphere of personal injury (including clinical negligence) litigation been a

[*Rob Marris*]

powerful promoter of access to justice, in an area where the playing field is at first sight sharply tilted against the individual claimant, facing a sophisticated insurance company as the real (even if not nominal) defendant.”

That sets the scene, because there is an asymmetry between many victims who are claiming that they were injured as a result of someone else’s negligence and the effective body against whom they are claiming. For example, following a car accident between two individual drivers, the victim will be claiming against the other driver. That is often an individual, but behind that driver sits the insurance company, which will run the claim and has to do so under the compulsory policy of insurance that all drivers have to take out.

Graham Stringer (Blackley and Broughton) (Lab): My hon. Friend is doing a great service to the House of Commons by bringing this issue before it. He is beginning to make the case that access to justice is fundamental to the welfare state. In one sense, he underestimates its importance. Does he agree that it is fundamental to democracy? A democracy relies on freedom of speech, freedom of the press, the right to vote and access to justice. If there is not the money for access to justice, we do not have the rule of law.

Rob Marris: I entirely agree. It is little use having rights if one cannot afford to enforce them. That entrenches inequality.

The consultation came out under the rubric of whiplash. I have to say to the Minister that the consultation somewhat sneakily was announced on 17 November and closed on 6 January. That is a short consultation period over Christmas, which is not helpful.

The Government’s own figures on the whiplash proposals, which may well be a gross underestimate, suggest that if implemented, they will see the NHS lose at least £9 million a year and the Treasury lose £135 million a year. But here is the stinger: insurance companies will get at least £200 million more per year. That is likely to be an underestimate. That figure is due to a methodology that is biased towards insurance companies and has been severely questioned by the Association of Personal Injury Lawyers, of which I think I used to be a member.

The methodology for who gains and who loses under the proposals counts as a gain the extra moneys that insurance companies will get but does not take into account the loss to solicitors. We can all weep crocodile tears about solicitors, but when talking about commercial arrangements, if we are looking at them dispassionately, we have to weigh in the balance where one commercial sector gains and another loses.

Chris Philp (Croydon South) (Con): Will the hon. Gentleman join me in welcoming the UK’s largest insurance company’s commitment to pass on in full any savings realised to consumers? That means, I hope, that the transfer of value, if it occurs, is from the personal injury law community to everyday consumers.

Rob Marris: I will get on to that. It is interesting and a great declaration, but of course other changes in the past five years or so have led to an increase in insurance company savings of £8 billion in claims costs. That has not been passed on in terms of reduced premiums, which have continued to go up, so I will believe it when I

see it. The Government’s own calculations suggest that at least 90% of the money has to be passed through—the term for returning money to policy holders—for there to be any benefit at all.

The Minister for Courts and Justice (Sir Oliver Heald):

As the hon. Gentleman will know, the small claims limit is being put up in all the other jurisdictions, apart from this one, to £10,000. Is it really right that motorists should each pay £40 a year extra, simply so that the sort of solicitors firms he referred to can continue to do work on these very small claims?

Rob Marris: The limit has not gone up in Scotland for personal injury claims. I will get on to the figure of £40 a year and whether it is accurate or not.

So much of this information comes from the insurance companies, which are making huge profits. Premiums have gone up 17.2% in the past year, which I regard as unacceptable. I asked the Association of British Insurers about that on 3 January, and it kindly replied a week later. I am not a statistician, but I have knocked around statistics a lot, and its approach is strange, to say the least. It says:

“Given there is no objective medical evidence for whiplash type injuries, with diagnosis often being made on the basis of the claimant’s word, the ability to prove beyond all reasonable doubt that the claimant has not sustained an injury is both incredibly challenging and expensive.”

That is typically misleading of the Association of British Insurers. The Minister will know, as a distinguished lawyer, that if the insurers refuse to pay out on a claim and the policy holder says the insurers are wrong, the policy holder makes a claim in the civil courts against his insurers, where the test is not about proving something beyond reasonable doubt, but based on the balance of probabilities, which is a much easier test to pass. So that is a straw man, but it is true in terms of criminal actions.

The ABI also states that

“actual criminal convictions clearly only represent the tip of the iceberg, and are not in any way a true reflection of the level of fraud that insurers and wider society face on a daily basis... While some of those cases may have an innocent explanation, many more cases of successful fraud go undetected, especially for whiplash.”

The ABI is assuming what it is trying to prove. It is assuming that there is fraud, but it admits that if there are such cases, they are going undetected. We do not know whether there are undetected cases of fraud or there never was a case of fraud. If it assumes what it is trying to prove, I certainly hope my insurance premiums are not set by insurance company actuaries who take such an approach.

Sir Oliver Heald: That is all very well and good, but the hon. Gentleman must know that the number of road claims has gone up from 460,000 in 2005-06 to 770,000 in 2015-16, and that 90% of them are for whiplash at a time when our roads are getting safer and our cars have seen huge road safety improvements in their manufacture. How can this be?

Rob Marris: It cannot be because the Minister has the figures wrong. The Government’s compensation recovery unit indeed talks of 771,000 claims in round terms, of which 441,000 are for whiplash. That figure has come down by 7% since 2011-12. The overall figure is already coming down, so it is not going in the direction the Minister thinks it is and perhaps he will rethink the proposals.

The ABI says that its statistics

“are therefore intended to provide an indication of the volume and value of fraud detected by the industry. These statistics do not include claims which involve exaggerated personal injury, particularly for whiplash, where the claim has been paid.”

However, it also says that insurers pay out on 99% of claims, so apparently we are talking about the 1% and that is what all these assumptions are based on. That is not a good basis for creating public policy.

Chris Philp: Does the hon. Gentleman agree that the qualified, one-way costs-shifting arrangements that were introduced three or four years ago, whereby the defendant bears their own costs, even if they are successful, creates a perverse incentive for insurance companies to settle claims even when they have a very good prospect of defending them?

Rob Marris: That regime was introduced as part of other changes which have led to £8 billion more for the insurance companies. One must look at the matter in the round.

The ABI says:

“Previous reforms aimed at tackling the compensation culture have not had the desired effect because claims frequency has not been addressed. As such, the removal of general damages for minor soft tissue injuries is by far the most effective way to address claims frequency.”

What sort of minor injuries are we talking about? The Law Society helpfully provided me with some examples from a public briefing:

“A fractured rib (up to £3,300)—
that is well below the £5,000—

“Food poisoning symptoms continuing for weeks (up to £3,300)—

Chris Philp: Will the hon. Gentleman give way?

Rob Marris: No, I will not. The Law Society continued:
“Neck injuries lasting”

for up to

“12 months (Maximum £3,630)... Back injury lasting up to 3 months (up to £2,050)... Minor wrist fracture (£3,960 maximum)”.

I would venture that such injuries would not seem minor to most of our constituents. Most of them would not say a broken wrist was minor. *[Interruption.]* Well, they certainly would not in a Labour constituency; perhaps they would in Conservative constituencies. *[Interruption.]* The Minister is chuntering, “It’s not whiplash”; part of the problem is that the proposals in the consultation paper do not cover just whiplash, with which, I have said, there is not a problem. They cover all personal injuries, including accidents at work. Someone who breaks their wrist at work would not be able to instruct a solicitor, but they would almost certainly have to get a medical report and so on. I just do not think that these are what most of my constituents would call minor soft tissue injuries.

That is one reason why the Law Society has come out against the proposals, saying that:

“the government does not appear to have a robust evidential basis for undertaking the reform”.

So, too, has Cycling UK—it used to be the CTC or the Cyclists’ Tourist Club—which says:

“This change doesn’t target whiplash claims or claimants: it impacts most on those who end up in casualty with broken limbs due to the negligence of others.”

It talks about

“A reform which denies”

the injured

“justice, and sends a message to motorised road users that vulnerable road users’ injuries are a trifling matter”.

The Government have said in their propaganda that most road users have legal expenses insurance as part of their car insurance policy—I do not—so they will be able to get legal representation under that policy. That may be true for many if not most car drivers, but most of us cyclists do not have such insurance, nor do most pedestrians. That is why Cycling UK and its partners—RoadPeace, a national charity for victims, and Living Streets, a national charity for everyday walking—have come out against these changes.

Chris Philp: Will the hon. Gentleman give way?

Rob Marris: No, I will not. I have already given way to the hon. Gentleman. I was going to talk about employment tribunal fees, but I have taken up quite some time, and some of my colleagues wish to talk about that. Of course, employment tribunal fees have dissuaded huge numbers of people from bringing employment claims. If the Government really think that 67% of previous claims were frivolous—that is how much the figure has dropped by—they are living in a different world from me. Again, the Law Society, which of course has a vested interest, is against those fees. It said:

“In our members’ experience the remission system”—

for remission of fees for those who cannot afford to pay tribunal fees—

“is confusing, uses complicated language, and is hard to navigate”, and that is for Law Society members, who are solicitors, let alone the lay person who may have just lost their job and perforce be broke. Only 21% of claimants—far fewer than the Ministry of Justice predicted—have benefited from any fee remission at all. Early conciliation was put forward as another approach, but ACAS says that 70% of claimants who entered into early conciliation did not reach a formal settlement.

Mr Jim Cunningham (Coventry South) (Lab): I congratulate my hon. Friend on bringing forward this debate. There is another dimension to tribunals and legal aid in general. Many people come to us, although we are not allowed to give legal advice, because they cannot afford to pay for it. Secondly, citizens advice bureaux and bodies such as the Coventry Law Centre are overloaded with work, because the Government have cut the grants to those organisations, and as a result, they have had to reduce staff. There is an endless vicious circle when people try to get justice in this country.

Rob Marris: My hon. Friend is quite right. It is a matter of playing catch-up following the changes to legal aid. There are now legal aid deserts. Recent figures from the Legal Aid Agency show that large areas of England and Wales have little or no provision for legal aid services for housing. That is rather ironic on a day when the Homelessness Reduction Bill, introduced by the hon. Member for Harrow East (Bob Blackman), is being debated. In the south-west, over half of areas have only one provider of legal aid for housing advice. In Wales, half of areas have only one provider. In the west midlands, where my hon. Friend the Member for

[Rob Marris]

Coventry South (Mr Cunningham), who just intervened, and I come from, over half of areas have one or no provider. Shropshire, which is not far from my constituency, has no provider. When there is one provider, families on low incomes often cannot afford to travel to see them.

My hon. Friend the Member for Coventry South adverted to the fact that we have a catch-up system, because there are cuts in the number of courts. In Shropshire, people cannot get to Shrewsbury Crown court for a hearing at 9.30 in the morning by public transport from Ludlow, another major population centre. Cases are collapsing as a result; witnesses will not travel, and people are pleading guilty because they do not want to take even more time off work. That is not justice.

Mr Cunningham: Solicitors in Coventry and Warwickshire are looking at the possibility of getting local law students at the University of Warwick to assist with some cases.

Rob Marris: Indeed—that is, when they can get to a court, because there are plans to close 86 courts and tribunal centres and to cut Ministry of Justice staff by between 5,000 and 6,000. That has led to the courts getting clogged up with litigants in person who cannot afford to pay for legal representation. Judges, quite properly, try to assist litigants in person and to be flexible, so cases take longer. The Government end up with a false saving, because we spend more on the remaining courts to deal with litigants in person, and we have a worse justice system with less access to justice.

Ian C. Lucas (Wrexham) (Lab): Is that not particularly acute in family law cases, and difficult cases relating to children and finance, when litigants in person appear before district judges, who have problems resolving the cases?

Rob Marris: My hon. Friend is entirely right and anticipates what I am going to say. There is, as he will know as a distinguished lawyer, an exceptional case fund, which was established to help people such as survivors of domestic violence to get free legal assistance. *The Independent*, which admittedly is a newspaper and not the Ministry of Justice, reported in 2015 that from April to December 2013 there were 617 applications to the exceptional case fund—that will be for all of England and Wales—and eight were successful. In the three-month period from April to June 2015, five out of 125 applications were successful. The people applying are some of the most disadvantaged in society and face some of the most grievous personal circumstances.

Liz Saville Roberts (Dwyfor Meirionnydd) (PC): Legal aid has been eroded particularly, perhaps, for victims of domestic abuse, and many now have to present their cases in the family court. Regardless of recently announced Government proposals in relation to abuse of process, surely domestic abuse victims must have their own lawyers in family courts to avoid abuse by proxy.

Rob Marris: The hon. Lady is—

Sir Oliver Heald: Will the hon. Gentleman give way on that point?

Rob Marris: I will reply to the hon. Lady first. I agree entirely with her. I will give way to the right hon. and learned Gentleman, as the Minister, but I will just say that the Ministry of Justice anticipated between 5,000 and 7,000 applications annually. The actual figures are far lower than that. One reason—perhaps the Minister, when he intervenes, can promise to do something about this—is that, understandably, many solicitors are unwilling to make applications to the ECF because it is so bureaucratic, even though this Government say that they do not like bureaucracy; it takes between six and 10 hours just to make the application. The cuts have had far-reaching negative implications for children and vulnerable young people as well.

Sir Oliver Heald: I was just going to ask whether the hon. Gentleman agrees that domestic violence cases are within scope, and that a victim would have legal aid in the way that I outline. As for the exceptional cases fund, which the hon. Gentleman has challenged me to say something about, 1,200 cases a year is the current rate, and 53% are being granted; that is the latest.

Rob Marris: That is helpful, but it kind of makes my point for me. The right hon. and learned Gentleman's own Ministry—before he was there, I have to say—anticipated between 5,000 and 6,000 such applications. A 53% success rate seems to me, on the face of it, to mean very stringent criteria, given how long a solicitor will spend preparing the application—and they will not get paid for that preparation, which suggests that the solicitor making the application on behalf of the vulnerable individual thinks that there is a very good chance of success. But what do they find? It is about half.

In time-honoured tradition, I will ask the Minister some questions, which I hope he will be able to answer. I did give him some notice of them, but only at noon today, so although he is a hard-working Minister, he may not have had the chance to get on top of them all. On small claims, does the Minister accept that there will not be a level playing field if the proposed changes are introduced, because they will remove funding currently available for injured people to instruct lawyers, leaving them having to act as litigants in person on personal injury small claims?

Does the Minister seriously contend that there is a fraud crisis in relation to workplace injury claims, which the proposed changes would cover, and if he does, which he may, what independent evidence, not from the insurance industry, does he have of such a crisis?

The impact assessment for the proposals says that there will be a cost to the NHS of at least £13 million a year and to the Treasury of at least £135 million a year, and an increase in insurance company profits of £200 million a year. Does the Minister accept that that means that the Treasury will lose out while the insurance industry gains? If he does not accept that, perhaps he could explain why.

Can the Minister say by what date the Department will publish its review of the impact of employment tribunal fees, and what data the Department has on how such fees have affected the use of alternative dispute resolution services? What steps will the Government take to try to ensure that all children and vulnerable young people can get legal aid? The Minister has already mentioned some changes in that regard. Following on

from that, will he give a commitment to review the exceptional cases funding system to make it much more accessible, and if he will not, can he explain why not?

Several hon. Members rose—

Geraint Davies (in the Chair): Order. I think that we have five Back-Bench speakers, as well as the Front Benchers, so I will impose an immediate time limit of six minutes on speeches.

2.55 pm

Chris Philp (Croydon South) (Con): It is a pleasure to serve under your chairmanship, Mr Davies, particularly given your previous association with Croydon.

I would like to talk specifically about the Government's consultation on whiplash claims, and the reason for that is an experience that I had two or three years ago. After a very minor road traffic accident in which no one was injured, I was bombarded with phone calls to my personal mobile every week for about a year from a claims management company. It explicitly asked me to pretend to have an injury that did not exist in order to claim compensation.

I have no issue with the more general points that the hon. Member for Wolverhampton South West (Rob Marris) makes about access to justice and the court system. I am talking specifically about whiplash. It is as a result of practices such as the one that I have described that this country has more than two times more whiplash claims than the rest of Europe, and the total number of claims for soft tissue injuries—whiplash and neck and back—has been static, at about 800,000, for the last few years.

One reason for that is the perverse incentives in the system. As I mentioned in an intervention, under qualified one-way costs shifting, when a claim is made, even if the defendant—the insurance company—is successful in defending the claim, it must bear its own costs, which are quite often up to £10,000, so it is easier for the insurance company to stump up £3,000 in insurance and pay some costs to the prosecuting or claiming solicitors firms—some of those costs go to the claims management company—than to dispute the claim. That is why claims here have grown to proportions that are vastly higher than obtain in the rest of Europe and why, as my right hon. and learned Friend the Minister said, at a time when accidents have declined by 30%, claims have gone up by 50%.

In *The Sunday Times* a year or so ago, there was a shocking report about a company called Complete Claim Solutions—one of the most notorious CMCs, which makes 7 million outbound cold calls a year. Its trainers were covertly recorded by *The Sunday Times* encouraging or telling—instructing—its staff to get the public basically to lie and make fraudulent claims. I have myself been on the receiving end of those phone calls.

On the point made by the hon. Member for Wolverhampton South West about broken bones, I have looked at the consultation document, and it specifically refers to soft tissue claims. I fully accept that where a cyclist or motorist has broken a rib, wrist or leg, their claim is perfectly valid and verifiable and should be allowed to proceed. We are talking about soft tissue injuries, where there is no objective medical evidence

other than the claimant's own claim. Those claims add, I believe, about £40 to everyone's motor insurance policy, but more worryingly in my view, they are morally corrosive because large numbers of the public are being incited to commit fraud. That is a bad thing for the fabric of our society.

Rob Marris: The Government's press release announcing the consultation on 17 November said that measures include

"raising the limit for cases in the small claims court for all personal injury claims from £1,000 to £5,000".

It said nothing about soft tissue injuries.

Chris Philp: Well, certainly the consultation document refers on its front page to soft tissue injuries. I am sure that the Minister will consider how that might apply to broken bones, but the title of the consultation refers to soft tissue injuries only.

In my response to the Ministry of Justice consultation, I made a number of proposals, several of which I would like to elaborate on here. I believe that there should be a blanket ban on outbound cold calls in relation to soft tissue injuries. There should be a ban on pre-medical offers. Insurance companies should be required to conduct face-to-face medical examinations, and those examinations should produce independently verifiable evidence. That should be more than just someone saying, "My neck hurts." The injury should be capable of verification by a third party, so in the case of a broken bone, that would clearly involve an X-ray.

I believe that there should be a ban on general damages for minor soft tissue injuries—not broken bones, but minor soft tissue injuries, where there is no evidence of the kind to which I have just referred. For those injuries, I fully support a threshold of £5,000.

There should also be a duty on claims management companies and solicitors to explain explicitly to prospective claimants that fabricating evidence is an unlawful act. They currently do the reverse; they actually encourage false claims. The Ministry should look again at qualified one-way costs shifting, because it creates a very perverse incentive for insurance companies to settle even when they could win a case in court.

On the point raised by the hon. Member for Wolverhampton South West about where the money ends up, I think that the saving could be more like a billion pounds a year, not £200 million. I would expect that to be passed on to ordinary members of the public and not pocketed by insurance companies. Aviva has committed to do that, but if, after a year, it turns out that the insurance companies have simply pocketed the extra money and not passed it on, I would expect the Competition and Markets Authority to be encouraged by the Government—or even required, if the Government have that power—to conduct an investigation to make sure that those savings are passed on to the hon. Gentleman's constituents and mine. I do not expect these savings to end up in the back pockets of the insurance industry.

I would also like to see another practice ended. Again, this is a point for the insurance industry. A few years ago, there was a ban on referral fees, which is money that a claims management company would pay an insurance company to hand over the details of

[Chris Philp]

somebody who had been involved in a motor traffic accident. They are circumventing that ban through what they call alternative business structures. That is where the insurance company has some form of equity or profit share stake in a claims management company, the details still get passed on, and the insurance company effectively gets paid via the equity stake as a means of circumventing the referral fee ban. That is clearly an abuse and we should take steps to end it.

Finally, there are many examples of insurance companies procuring services such as car hire, legal services or vehicle repair services very cheaply, and they get recharged to the at-fault party's insurance company at a significantly marked-up price. That is profiteering and, again, steps should be taken to prevent it happening.

In summary, I very strongly support the measures proposed in relation to soft tissue injuries. They will end a whole cottage industry that is morally corrosive because it is encouraging huge numbers of people to commit fraud, and costing our constituents £40 each per year, per car insurance policy. I welcome these proposals. I hope to see them brought on to the statute book at the earliest opportunity, and look forward to supporting them on the Floor of the House when that happens.

3.2 pm

Justin Madders (Ellesmere Port and Neston) (Lab): It is a pleasure to serve under your chairmanship, Mr Davies. First, I congratulate my hon. Friend the Member for Wolverhampton South West (Rob Marris) on calling this incredibly important debate. Although it is a broad debate, I will focus on an area that I have spoken about many times before and sadly find myself having to speak about again—one that, as a former employment lawyer, I know well: the devastating impact that the introduction of employment tribunal fees has had on access to justice.

I will not repeat the entire history of this issue—the Minister knows the landscape well—but I will summarise. In July 2013, for the first time a person had to pay a fee before they could proceed with an employment tribunal claim—two fees, in fact: one at the commencement of the claim and one before the final hearing. Following the introduction of fees, the number of single employment tribunal claims plummeted by 67%, from an average of 13,500 per quarter to just 4,400 per quarter. One of the oft-cited reasons for the introduction of fees was that it would deter vexatious and weak claims, yet the proportion of unsuccessful claims has remained stable. It is therefore clear that all that the fees system has done is deter people who have valid claims from upholding their rights. That conclusion is shared by the cross-party Select Committee on Justice and a range of specialist organisations that submitted evidence to it, including Citizens Advice, Maternity Action and the Bar Council.

The Justice Committee reported that many judges say that they now hear no money claims at all. The report says:

“Prior to the introduction of fees money claims were often brought by low paid workers in sectors such as care, security, hospitality or cleaning and the sums at stake were small in litigation terms but significant to the individual involved. There are few defences to such claims and they often succeeded.”

Have all those employers suddenly changed their behaviour and is everyone now getting paid correctly? No. What is far more likely is that those whose wages are being

docked are simply saying, “Well, it will cost me more to go to a tribunal to recover this money than the amount I have lost, so I can’t afford to take that risk.” That, to quote the Prime Minister from just a few days ago, is an example of the

“everyday injustices that ordinary working class families feel are too often overlooked.”

Sir Oliver Heald: Is the hon. Gentleman not forgetting the other measure that was taken, which was to require claimants to go to ACAS? Is he not aware that the number of cases going to ACAS has gone up from 23,000 a year to 92,000 a year, and that the effect has been that about half of the cases have been resolved or dealt with in a way that meant they no longer need to go to the tribunal—so 45,000 cases are dealt with for free?

Justin Madders: The Minister presents those statistics but forgets to mention that the arbitration system with ACAS was actually introduced some time after employment tribunal fees were introduced, so it does not explain the initial drop-off. The Justice Committee said the claim that this has diverted more people to mediation was

“even on the most favourable construction, superficial.”

It is true that there has been an increase in the number of cases going to conciliation, but just 16% have been formally settled by ACAS, 19% proceeded to a tribunal case and 65% were neither settled nor proceeded to a tribunal. What has happened to all those cases?

Despite the overwhelming evidence, the Government refuse to acknowledge the problem, as we have just heard. Last month, I challenged the Under-Secretary of State for Women and Equalities over the outrageous fact that only 1% of women discriminated against at work brought a claim to tribunal. I asked whether she would make representations to the Ministry of Justice about the raft of evidence suggesting that tribunal fees deter genuine complaints. The reply I got was:

“There is no doubt that the number of tribunals has gone down, but in actual fact there is good news here”.—[*Official Report*, 8 December 2016; Vol. 618, c. 363.]

I fail to see what that good news is.

Perhaps the Government’s own internal review will tell us what has happened to the many complaints that have disappeared through ACAS, if they ever decide to release it. It was commissioned in July 2015; the review was completed within a few months, and it has been gathering dust for over a year now.

Sir Oliver Heald: On a point of order, Mr Davies. The hon. Gentleman is putting forward as an assertion of fact something that is completely incorrect. Is that in order?

Geraint Davies (in the Chair): It is in order, because it is a matter of debate. Back to you, Justin Madders.

Justin Madders: I am only referring to what the previous Minister for Justice said in evidence to the Select Committee about the report being completed, but if I am wrong about that, that is fine. What we are more interested in is the Government actually releasing it. I hope that when the Minister responds he will confirm a final date for when we will see the Government’s own internal review.

Mr Davies, your rights are only as good as your ability to exercise them. Be in no doubt that every year now, thousands of people are unable to do this. Employment rights are not just about dignity and respect in the workplace. They bring important social and economic benefits to this country. They ensure that more people can participate in the labour market without facing unfair discrimination. They give vulnerable workers more job security and stability of income. They help to encourage a committed and engaged workforce and the retention of skilled workers. They allow people to plan their life, plan for a future, knowing that if they do a good job, if their employer runs its business well, they are likely to stay in work.

What we have instead is a hire-and-fire culture where workers are seen as disposable commodities—figures on a spreadsheet—rather than real people with real lives who matter. For most people in the UK, the concept of secure employment no longer exists. Even for those who are lucky enough to avoid the pervasive traps of zero-hours contracts, agency work, bogus self-employment and the gig economy, workplace protections are now so watered down they are virtually worthless. During the referendum campaign, we saw that telling someone on a zero-hours contract or in agency work that there is a risk to their job from Brexit was futile. Until we begin to address these issues and reinstate the concept of secure employment, we will stand no chance of rebuilding our fractured society.

At the moment, we have a system where justice exists only for those who can afford it. A banker on a six-figure salary who is unfairly dismissed can still take their employer to a tribunal, while a factory worker on the minimum wage is much less likely to have the option and ability to uphold their rights. This situation is an embarrassment; it is an injustice and it must come to an end.

I will conclude with another quote from the Prime Minister, who said only three days ago:

“when you try to raise your concerns but they fall on deaf ears; when you feel locked out of the political and social discourse and feel no one is on your side, resentments grow”.

She also said that

“it is the job of government...to correct the injustice and unfairness that divides us wherever it is found.”

I say that it is time that those words were put into action.

3.9 pm

Craig Tracey (North Warwickshire) (Con): It is a pleasure to serve under your chairmanship, Mr Davies. I will speak about reforming the soft tissue claims process. I have a special interest in the subject: I am chairman of the all-party group on insurance and financial services, and I spent 25 years as an insurance broker, 20 of those running my own business, so it is fair to say I have seen the evolution of these claims. When I first started in the industry, whiplash or soft tissue injury claims were non-existent, but over time they have grown to be a significant industry which, as we have heard, costs motorists anywhere between £40 and £90 extra on their policy. Critically, it is an industry where in many instances the claimant is not the main beneficiary.

Although the amounts of compensation paid out in soft tissue claims are relatively small, the associated claims handling costs, including the costs of investigation,

processing, lawyers' fees and medical reports, are disproportionately large. For example, a claimant claiming about £1,000 may ultimately cost the insurer two or three times that amount. As such claims are pretty common—there are about 800,000 a year—the effect on motor insurance premiums is significant.

I will focus on two key areas of the reform proposals, the first of which is general damages. It is clear that the reforms in the Legal Aid, Sentencing and Punishment of Offenders Act 2012 have not had the desired effect of tackling the compensation culture. They went some way to tackling issues such as referral fees, but frequency of claims has not been tackled as claimants can still enter into a no win, no fee agreement and a substantial portion of their claim is taken by the lawyer or claims management company to cover legal fees, so claimants sometimes get only half of the amount awarded to them. Is it access to justice when somebody else benefits more than the person who was injured in the first place?

To highlight the scale, although it is fair to say that the number of claims described as whiplash registered with the DWP's compensation recovery unit has decreased, as mentioned by the hon. Member for Wolverhampton South West (Rob Marris), that is coupled with a corresponding dramatic increase in the number of soft tissue injury claims for neck and back injuries. In 2015-16, the number of road traffic accident soft tissue injury claims rose by 5.8% from the pre-LASPO level of 2012-13. However, in the period before LASPO was introduced, there was a particularly high volume of claims as claimant lawyers rushed to submit claims to avoid the reforms. This can be seen when looking at the total number of soft tissue injury claims in 2013-14, with the total number of claims in 2015-16 decreasing by only 0.3% over the previous two years, and in fact increasing by 1.2% from the previous year.

The claims portal, which is used to process low value personal injury claims in road traffic accidents, demonstrates even more clearly the rising number of claims following the LASPO reforms. On the portal, although the number of claims notified decreased by 3% from the pre-LASPO high in 2012-13 to 2015-16, the number of claims notified actually increased by 11% in the two-year period of 2013-14 and 2015-16. It highlights how the number of people claiming whiplash injuries in 2011-12 was 543,899 and the number of people who had neck, back and soft tissue injuries in the same period was 285,000. The number of people claiming neck, back and soft tissue injuries increased to 441,000 in the period 2015-16, so we can see it has been displaced.

My second point relates to the small claims track. The threshold needs to increase for whiplash, as the current limit has not been increased for 25 years. Figures from the ABI show that in 1991 50% of claims would have been valued within the SCT limit. That dropped to 9% in 2012, which highlights that an increase is well overdue as 91% of pain, suffering and loss of amenity claims now fall outside its remit, which cannot be in the best interests of the consumer.

From my discussions with the insurance industry, it is clear to me that it supports the principle that full compensation should be given for more serious injuries, and it is committed to simplifying and streamlining the process so that savings will be passed on to the consumer and the policyholder. Critically, there will be access to justice for everyone. Claimants with more minor injuries

[Craig Tracey]

will still get their vehicle repaired, there will still be access to loss of earnings compensation and, rightly, there will be a focus on rehabilitation. Having dealt with such injuries for many years, that is what most people want. They want to be back in the position they were in before the claim. It is right to ask why there should be a link to a cash settlement on top of this when many of the minor injuries that we are talking about are similar to those sustained on sports pitches around the country day in, day out, where no one would give a second thought to making a claim against an opponent.

The UK is still one of the safest places to drive in the EU and vehicles are safer, so it is important that we go ahead with the proposals made in the former Chancellor's autumn statement.

3.16 pm

Anne McLaughlin (Glasgow North East) (SNP): I congratulate the hon. Member for Wolverhampton South West (Rob Marris) on securing this debate and giving us the opportunity to take stock of the human impact of the reforms to access to justice. Every time I think about the way in which this Government have ensured that ordinary people are denied even the opportunity to try to get justice, I cannot help but think of the words my parents used to dread: it's not fair—and it really isn't, Mr Davies.

One of the four objectives of the reforms was apparently to

"discourage unnecessary and adversarial litigation at the public expense".

I cannot disagree with that sentiment, but I have been working with a constituent who some people would argue falls into that category. Indeed, some have written him off as vexatious. There is a Scots word we use when someone has not had access to justice and is like a dog with a bone: the word is "thrawn", and my constituent has had to be. He is a whistleblower: someone who tried to do the right thing—and trust me, he was doing the right thing. He is someone who believes in justice.

Sir Oliver Heald: Will the hon. Lady give way?

Anne McLaughlin: If the right hon. and learned Gentleman does not mind, I will struggle to get to the end of my speech without fainting. I am not well today. Unless he wants a medical emergency, I will carry on and try to get to the end—do not worry, I am not actually going to faint.

As I was saying, my constituent is a whistleblower trying to do the right thing. In trying to help others find their voice and hold power to account, he appears to have become a victim of it. He told me of repeated bullying in the workplace as a result of the whistleblowing, which continued when he was on statutory sick leave, undermining his already deteriorating mental health. Access to an employment tribunal, secured by legal aid, has been a lifeline, but it has taken long, thrawn years to get to a position where the might of an institution can be questioned. He will have his day in court, but had he lived in England or Wales he simply would not be able to afford it. That is not me saying, "Scotland good, England and Wales bad"; what I am saying is that it is not fair.

It is not fair on the people who in 2015 found themselves unable to access justice. Statistics provided by the TUC and Unison comparing cases brought in the first three months of 2013 with cases brought in the first three months of 2015 showed the following reductions—I think some have been mentioned already—in the number of cases for the most common types of claims: working time directive, down 78%; unauthorised deductions from wages, down 56%; unfair dismissal, down 72%; equal pay, down 58%; breach of contract, down 75%; and sex discrimination, down 68%.

Maternity Action said that since the fees were introduced there has been a 40% drop in claims for pregnancy-related detriment or dismissal. Is the Minister proud of that record? Does he truly believe that all those additional people in previous years were bringing vexatious—or frivolous, as the hon. Member for Wolverhampton South West said—claims?

Another area of law removed from legal aid was housing. My constituent, Maisie, is an elderly woman with a range of health issues that have negatively impacted on her ability to care for herself and sustain her tenancy. After a small house fire, her son moved in to support her. John balanced his own parenting responsibilities to his son from a past marriage with his commitment to his studies and his mother. They lived in cramped and totally unsuitable conditions and found themselves more or less ignored by their housing association, which refused to put in the disability adaptations they so badly needed because they had asked three years previously to be moved. For the housing association, it was simply not worth the money because they were going to move, anyway.

Offers of accommodation were not forthcoming and this 80-year-old woman and her carer son were trapped. They have now been rehoused in far superior accommodation and are very happy, but the housing association did what they could have done three years previously for two reasons. First, my team and the Legal Services Agency, a wonderful Glasgow charitable law centre, quoted the relevant provisions of the Human Rights Act to remind it of its responsibilities; and, secondly, there was a threat of legal action. That was possible because my constituents could claim legal aid, as they lived in Scotland. As it happens, the housing association saw sense and things did not get that far, but if a similar thing were to happen to a constituent of the hon. Member for Wolverhampton South West, the threat of legal action would be taken with a pinch of salt. That is not right. I thank the Legal Services Agency and my team, because now the 80-year-old woman in question can live out her days with her son in comfort and dignity.

On Sunday, the Prime Minister promised to introduce wide-ranging reforms to correct what she called the "burning injustices" in modern society. She proposed a "shared society"; she also proposed to lead a "one-nation" Government, working for all and not the "privileged few". She said that the Government's role is to

"encourage and nurture these relationships and institutions where it can, and to correct the injustice and unfairness that divides us wherever it is found."

How on earth can she square that with taking away the means to correct those burning injustices from all but those who can afford to pay high legal fees? There are many people relying on us in Parliament and willing us to make the right decisions. I want to be able to tell

them confidently that when something is unfair, it will be condemned by us in this place and changed. The situation I have outlined needs to be changed.

3.20 pm

Yvonne Fovargue (Makerfield) (Lab): It is a pleasure to serve under your chairmanship, Mr Davies. I congratulate my hon. Friend the Member for Wolverhampton South West (Rob Marris) on obtaining the debate. I was going to go quite thoroughly into the subject of employment tribunals, but I feel that there is no need to do that. As an employment lawyer, my hon. Friend dealt with it comprehensively. However, I want to say that I managed a citizens advice bureau where we saw many people who were very reluctant to take action against their employers; any barriers put in the way will deter people from getting what is rightfully theirs. In fact, Citizens Advice recently revealed that 82% of people say the fee increase will deter them from taking a case against their employer.

The statistics bear that out. Why would someone pay £390 for a £200 wage claim when they know that only 49% of claims are paid in full? It is appalling to put another barrier in the way and impose such fees, which appear horrendous. There has been a decrease in claims. I warned when the change was first debated that a decrease would not mean success, but merely that the individuals concerned had given up, and had not gained what they were entitled to. I would be interested to know why people have not pursued ACAS claims. According to evidence from Citizens Advice, 90% of people would consider a reduced fee limit of £50 reasonable and thought that they could perhaps afford that when making a claim. I wonder whether the Minister has looked at the question of reducing the fee.

My hon. Friend the Member for Wolverhampton South West and other hon. Members dealt extremely well with the issue of whiplash. However, I am concerned about the raising of the small claim limits—and that, not whiplash, is what the consultation specifies. Why were workplace injuries included in that? What evidence is there of fraudulent claims against employers? In my experience, it is difficult to encourage people to make a claim even when the employer has been negligent, because they are extremely worried about the possible consequences. When that is coupled with the fact that if someone is unfairly sacked, there is a tribunal fee, I feel that people are beginning to lose faith in the justice system.

I want to mention the advice deserts, particularly in housing law, which my hon. Friend the Member for Wolverhampton South West also covered. Many small providers—including not-for-profit providers—are giving up their contracts as unviable. That has recently happened in one case in my area. Where are people to go about housing issues, such as severe disrepair, that they cannot get dealt with and that are giving them health problems? People can only have a housing claim if their case is at the severe end. How are people to get justice and avoid further illness, which will put more strain on our already overstretched health system, if they cannot get advice at a place they want to go to and can afford to travel to?

There is a risk that the civil legal aid system is becoming unsustainable. Will the Minister commission an independent review into the system's sustainability? It is at risk of falling over. Even with sufficient providers, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 reduced the possibility of obtaining early

advice on housing and family law. Having been the manager of a citizens advice bureau, I cannot stress enough that early advice relieves the pressure on families, who will probably go to other services if they do not get it, which means they will put pressure on local authorities, housing associations and medical professionals. That is why it saves money. In the case of welfare benefits, £8.80 is saved for every case of early advice; in the case of housing advice, more than £5 is saved. Leaving everything to the last minute is simply the wrong way to deal with people's problems, not only for them and their families, but for the state.

We must ensure that ordinary people are given an even chance in the justice system. Where is the equality of arms that solicitors always talk about? We need to ensure that people can receive the compensation they are entitled to, and timely advice—the right advice as to whether their claim is viable. I have often found that telling someone at an early stage that they did not have a case prevented them from going as a litigant in person. If they cannot get such early advice, they will be clogging up the court system. Many of the most recent reforms have had the opposite effect and deterred people from getting what they are entitled to. I agree with the hon. Member for Croydon South (Chris Philp) that we need to stop the cold calling. If the proposed changes to the small claims limit are included with the range of proposals, in addition to what has already happened to take access to justice away from ordinary people, I do not believe that people will any longer have faith that ours is a fair and just society.

Geraint Davies (in the Chair): We are making good time. I invite Stuart McDonald to speak from the Front Bench on behalf of the SNP.

3.26 pm

Stuart C. McDonald (Cumbernauld, Kilsyth and Kirkintilloch East) (SNP): It is a pleasure to serve under your chairmanship, Mr Davies. I congratulate the hon. Member for Wolverhampton South West (Rob Marris) on securing an important and timely debate. We have enjoyed some thoughtful, passionate and wide-ranging speeches, not least of which was his own tour de force.

As hon. Members have stated, access to justice is fundamental to our society, a key principle of the rule of law and an important component of the right to a fair hearing under article 6 of the wonderful European convention on human rights. It is almost exactly a year ago that we had a debate here, introduced by the hon. Member for Aberavon (Stephen Kinnock), on the same subject. Many of the points raised then still apply every bit as much now, because I do not think there is much doubt that under the present Government and their coalition predecessor, access to justice has become significantly more difficult.

Much of that debate focused, as did the remarks of my hon. Friend the Member for Glasgow North East (Anne McLaughlin) today, on legal aid restrictions imposed under the Legal Aid, Sentencing and Punishment of Offenders Act 2012 and the subsequent cuts to the legal aid budget. I continue to find the thinking behind some of those cuts hard to comprehend. They are indeed counterproductive. The drastic fall in the number of legal aid-funded cases has once again been highlighted today, including even for victims of domestic violence,

[Stuart C. McDonald]

who in theory should not be excluded. Amnesty International's recent report, "Cuts that Hurt", highlighted the particularly poor situation of children and vulnerable people in fields such as social welfare law, immigration law and family law.

As we have heard, the Justice Committee, the National Audit Office and the Public Accounts Committee have all been critical of some of the reforms. One of the most powerful points made by the Justice Committee was:

"The Ministry's efforts to target legal aid at those who most need it have suffered from the weakness that they have often been aimed at the point after a crisis has already developed, such as in housing repossession cases, rather than being preventive."

I suspect the Chamber is largely filled with lawyers at the moment, and I am sure that most of us get the point. Surely a better way to reduce legal aid spending is to invest in avoiding expensive crises in the first place.

Ministers argue that it is better to encourage mediation than to provide legal aid for adversarial proceedings. I am all for encouraging mediation. However, legal aid spending should fall as a result of successful voluntary mediation, and it cannot be said that mediation is successful or voluntary if someone is forced into an agreement because they cannot afford to go to court, and perhaps do not even have a proper understanding of their legal rights at that stage.

The other key Government contention in such debates is that the legal aid system in England and Wales has been one of the most expensive in the world. Of course I accept that all Governments have to look carefully at ways to ensure that the budget remains affordable. However, in making that claim, the Government are to an extent comparing apples and oranges. As hon. Members are fully aware, continental legal systems are inquisitorial systems in which less input from legal representatives is generally required but significantly more resources are spent on prosecution services and the courts. Taking all those factors into account, although we can say that England and Wales has one of the more expensive legal aid bills in Europe, the court system overall comes about a third of the way down the European league table.

Equally, there are other ways to keep the legal aid budget under control without having to slice and dice the scope and slash availability. I point to Scotland as an example, because as I understand it, legal aid spending per capita there is less than in England and Wales, but at the same time, the coverage and scope of the legal aid system is more generous. There are numerous reasons for that. For example, England and Wales have far more very expensive fraud trials, and so on. However, a key point is that the focus in Scotland has been on simplifying procedures so that the cost of court proceedings is much less than it was, so there are different ways to go about doing things.

Hon. Members have all rightly pointed out that access to justice goes beyond questions of legal aid. On fees, we shared opposition to criminal court fees and their predictable consequences and we welcome their withdrawal. We also welcome cancellation of the ludicrous 500% increase in fees for the asylum and immigration tribunal, although who knows how many people have had to leave the country as a result in the meantime? Employment tribunal fees have had a drastic effect on access to

justice, as other hon. Members have pointed out, and they too should be withdrawn. I am pleased that the Scottish Government propose to do just that when the powers are devolved.

However, the fact that the Government have to make and consider those U-turns suggests that they need a much more fundamental rethink of their approach. Other speeches have covered the changes to personal injury rules and the small claims limit—I should have predicted that and looked into the issue in more detail. The hon. Member for Wolverhampton South West kindly pointed out the different system that exists in Scotland.

I share hon. Members' general scepticism and concern about what exactly the proposed changes will achieve. I say that, having had to confess to colleagues who have worked for Thompsons, that I previously trained with an insurance-financed defenders firm—I do apologise. None of that is to say that the problem does not need to be addressed. The hon. Member for Croydon South (Chris Philp) highlighted the issue of horrendous cold-calling. I had a similar issue when I managed to reverse into my garage wall—quite how I was supposed to sue the garage wall I am not sure. All I would say to him is that some of what the Government propose to solve the problem would surely mean throwing the baby out with the bathwater. There must be other ways of tackling that without having to go as far as the Government suggest.

Sir Oliver Heald: In Scotland there are significantly fewer personal injury claims, and there has never been the problem of the industrialisation of such claims as has happened in England and Wales. Scotland has therefore not had the same sort of problem of a claims culture that we are trying to address.

Stuart C. McDonald: That is an interesting point. I suppose we have to examine why that is the case, because we have not managed to get rid of that in Scotland by excluding all sorts of cases from courts, so it would be interesting to look into that further.

There are a lot of access to justice issues that we could speak about, but before finishing, I will focus on something that has not been spoken about yet: the particular barriers to justice that the Government are putting in place for those who are seeking asylum or who are migrants. Last year Opposition MPs highlighted that the Immigration Bill, which was then making its way through the House, would make people have to leave their families and jobs in order to conduct appeals against Home Office decisions from abroad, would cut back on appeal rights against refusal of asylum support, leaving vulnerable, destitute people without any legal recourse, and would introduce procedures allowing families with children to be summarily evicted without so much as a court order, never mind a court hearing.

I know that MPs here today have disparate views on immigration and the rights that migrants should have, but I cannot understand how anyone can say that migrants should be deprived of proper access to a court in order to vindicate the rights that they do enjoy. Denying access to justice should not be a means of trying to control immigration. Various other significant concerns arise right across the sphere of immigration and asylum law, and I will mention three or four before concluding.

Geraint Davies (in the Chair): Just so you are aware, Mr McDonald, I have allowed up to 10 minutes for Front Benchers, so you have a reasonable amount of time left.

Stuart C. McDonald: Thank you, Mr Davies. The first concern is about the massive restrictions on appeal rights, previously introduced by the coalition Government and now replaced by an administrative review scheme that the chief inspector of borders and immigration said was operating very poorly. The second concern is about the difficulties in accessing legal aid-funded solicitors. As an important example, that includes unaccompanied asylum-seeking children who are transferred under the national transfer scheme, who may find themselves moved to a part of the country where there is simply no face-to-face advice available. A third challenge is the lack of legal aid—in contrast to Scotland—for too many immigration and asylum issues, including for too many children, detainees, mentally ill and other vulnerable persons. All that is exacerbated by a difficult fee remission scheme. Finally, I highlight the slow speed of justice, with huge waiting times for a hearing at the asylum and immigration tribunal.

The scale of the problems caused by all these cuts and changes is hard to be precise about, even if the anecdotal evidence is very worrying. The Government have so far refused to measure the number of people appearing as party litigants at the asylum and immigration tribunal. That prevents us from properly assessing what is going on as a result of Government policy. The Lord Chancellor and Secretary of State for Justice is receiving representations from the Joint Council for the Welfare of Immigrants on this matter, and I hope that she will listen.

In conclusion, the Government can talk about sustainably funding the justice system, but if funding decisions are preventing access to justice, then justice itself is not being sustained.

3.36 pm

Richard Burgon (Leeds East) (Lab): It is a pleasure to serve under your chairmanship, Mr Davies. I thank my hon. Friend the Member for Wolverhampton South West (Rob Marris) for securing the debate and for his typically persuasive speech. Such speeches are what earned him his reputation as a fantastic lawyer and then a fantastic MP. I certainly agree with his description of access to justice as a pillar of the welfare state—how right he is.

I pay tribute to all hon. Members who have spoken today from all parties, not only for their contributions, but for the work they do in their constituencies. Each and every Member of Parliament in Westminster Hall today—and of course, in the main Chamber earlier—has experience of attending advice surgeries, to which constituents come who are unable to get the legal representation they so desperately need. That is often why they end up at our advice surgeries. Sadly, much of that is because of the Conservative Government's cuts to legal aid since 2010.

My hon. Friend gave a comprehensive analysis of the problems with the Government's proposals for the small claims limit. I will not retread the ground that he covered, but to pick up on a point made by my hon. Friend the Member for Makerfield (Yvonne Fovargue), this is not just about so-called soft tissue claims.

I recommend that all Members on both sides of the House, including the hon. Member for Croydon South (Chris Philp), read the full title of the consultation, which is: "Reforming the Soft Tissue Injury ('whiplash') Claims Process: A consultation on arrangements concerning personal injury claims in England and Wales". It is not just about whiplash claims and includes injuries in the workplace, as other hon. Members have said.

I am concerned that the proposals will affect the lower-paid most adversely. In assessing claims, their value includes the lost wages arising from any injury, so those who are paid higher wages might more easily surpass the £5,000 limit, leaving the lower-paid less likely to be able to cover their costs. To borrow a phrase used by the hon. Member for Croydon South, I consider that to be morally corrosive.

It is almost a year to the day since the publication of the annual report to Parliament from the Lord Chief Justice, Lord Thomas, in which he said:

"Our system of justice has become unaffordable to most."

That is as clear and authoritative a judgment on the state of access to justice as could be hoped for. The reasons for that assessment are clear: employment tribunal fees, LASPO—the Legal Aid, Sentencing and Punishment of Offenders Act 2012—and "Transforming Legal Aid".

It was the coalition Government who introduced employment tribunal fees. As I have said before, I will never forget the first time I lodged an employment tribunal case after they introduced those fees, when I was an employment tribunal lawyer at Thompsons. The message flashed up on the employment tribunals service website: "Customer, please enter your credit card details". It says a lot about the Government's view of workers seeking justice that citizens attempting to assert their workplace rights are viewed as consumers or customers. Employment tribunal fees have resulted in a 70% reduction in the number of cases.

Richard Arkless (Dumfries and Galloway) (SNP): The hon. Gentleman makes a passionate and persuasive argument. Does he agree that if the purpose of hiking employment tribunal fees was to get rid of vexatious claims in the system, it has failed entirely? The win-loss ratio is exactly the same as it was before the fees were hiked. That is the evidence that the Justice Committee heard, and it makes the policy redundant.

Richard Burgon: The hon. Gentleman is correct. I put it to hon. Members that the real purpose of introducing employment tribunal fees was not to reduce vexatious claims, but to reduce claims full stop. Employment tribunals received about 60,000 cases in the year before fees were introduced, but that fell to below 20,000 the year after. As my hon. Friend the Member for Ellesmere Port and Neston (Justin Madders) indicated, that is not because of a reduction in illegal or unfair treatment by employers in that time—if only!

In June 2016, the Justice Committee released its report on court and tribunal fees, which complained that it was "unacceptable that the Government has not reported the results of its review one year after it began and six months after the Government said it would be completed."

Unbelievably, seven months later, the Government continue to sit on a review of the fees. We can only suppose what the reason for that is, but perhaps the Minister will enlighten us.

[Richard Burgon]

LASPO, which was enacted by the coalition Government, removed most social welfare law cases from eligibility for legal aid assistance. Those seeking assistance for debt advice, housing—apart from in homelessness cases—and welfare benefits advice were left with few places to turn, as my hon. Friend the Member for Makerfield knows from her experience running a citizens advice bureau. The barrier that has been put up in such cases has hurt some of the most vulnerable people in our society. The lack of benefits advice is of particular concern because many appeals against the Department for Work and Pensions succeed. Between December 2014 and June 2015, 53% of those who appealed “fit to work” decisions had them reversed. Removing advice on such cases risks people missing out on benefits to which they are eligible.

Last year, the Law Society launched its campaign to end legal aid deserts—areas of the country in which legal aid advice for housing cases is disappearing. In a Westminster Hall debate on 30 November 2016, the Minister denied that such legal aid deserts exist. I wonder whether he has told the Law Society that its research is wrong. In July last year, Young Legal Aid Lawyers, the Legal Action Group and the Legal Aid Practitioners Group wrote to the Prime Minister, highlighting the huge drop in civil legal aid cases since LASPO. In 2012-13, before LASPO, 724,243 civil law cases were publicly funded, but in 2015-16 there were just 258,460. They described that, correctly in my view, as “a picture of justice denied”.

Last week, the Justice Secretary’s own actions confirmed the need for a review. LASPO removed most private family law matters from the scope of legal aid, which naturally led to an increase in people representing themselves, as has been described. The increased number of litigants in person led in turn to violent and abusive people cross-examining their victims—usually their former partners—in court. Recently, the senior family court judge, Sir James Munby, said:

“I have been raising since 2014 the pressing need to reform the way in which vulnerable people give evidence in family proceedings. I have made clear my view that the family justice system lags woefully behind the criminal justice system.”

Well, last week that reform was promised: apparently the Justice Secretary will review the situation. That is as good as an admission that the legal aid reforms to the family courts have caused the problem that now needs a solution. Although the Government’s initiative would be a step in the right direction and provide some measure of comfort to victims of domestic violence, it is no substitute for both parties in family proceedings having representation.

When the coalition Government passed LASPO, they committed to reviewing its effects in three to five years, and we are now well within that timetable. The review ought to have begun a long time ago—the words of the Lord Chief Justice last January, which I quoted earlier, make that clear. However, that is not the only barrier to access to justice that has been erected and maintained by the Government.

Yvonne Fovargue: Does my hon. Friend agree that the review needs to take place urgently, because the impact assessment of LASPO said that it would disproportionately affect women and the disabled, but that that was a price worth paying?

Richard Burgon: I agree that this is a matter of the utmost urgency; I also agree that such a detrimental impact on some of the most vulnerable people and minorities in our society is never a price worth paying.

In 2013, the then Justice Secretary, the right hon. Member for Epsom and Ewell (Chris Grayling), introduced other reforms. In summary, they involved restrictions on the availability of judicial review; restrictions on the ability of foreign nationals to receive publicly funded legal assistance; removing publicly funded legal assistance for nearly every area of prison law; further cuts to immigration law and family law; and cuts to fees for litigation in criminal cases. However, plans to tender criminal defence representation to competition were abandoned.

The right hon. Member for Surrey Heath (Michael Gove) then became Justice Secretary and, thankfully, reversed some of his immediate predecessor’s worst policy blunders. He also postponed a planned further cut of 8.75% to the fees of criminal solicitors until April 2017, which is now just around the corner. I am sure it would be welcomed, both in the House and outside, if the Minister confirmed today that that 8.75% cut will not happen.

When the right hon. Member for Epsom and Ewell was in post as Justice Secretary, he wrongly asserted that the legal aid bill was spiralling. He claimed that the public had lost confidence in the legal aid system and he dismissed many who rely on judicial review to hold the state to account as “left-wing campaigners” using the courts as a “promotional tool”. He provided no objective evidence or serious substance for those claims. He, too, holds responsibility for the crisis in access to justice that we face.

When my right hon. Friend the Member for Islington North (Jeremy Corbyn) became Leader of the Opposition in 2015, he promoted and set up an independent review, the Bach review, into access to justice. He has long understood the place of legal aid and access to justice in a civilised society, as we all do in the Opposition. The Bach review is considering how the justice system should operate in the 21st century: it should harness new technology without compromising fairness or due process. The Government need to act now to reverse their most botched reforms, so that access to justice is no longer “unaffordable to most”.

Geraint Davies (in the Chair): You have 10 minutes, Minister, if you are to allow a minute for Mr Marris at the end.

3.49 pm

The Minister for Courts and Justice (Sir Oliver Heald): I congratulate the hon. Member for Wolverhampton South West (Rob Marris) on securing this debate, and I thank Members who have contributed to it. Some important points were made. However, regarding the hon. Gentleman’s criticism that the impact assessment on the whiplash changes does not show a saving, I must say that it makes it very clear that the saving is £1 billion, which, of course, accounts for the £40 cut in premiums for every motorist in the land that I mentioned. Are we to sacrifice that simply to uphold a threshold that has been in place for so many years, since 1991, and in the interests of solicitors?

The hon. Gentleman very fairly made the point that he was from Thompsons Solicitors. I think that the Labour party spokesman, the hon. Member for Leeds East (Richard Burgon), is also from Thompsons. There was one other who did not reveal himself, but I suspect that it is the hon. Member for Ellesmere Port and Neston (Justin Madders). They are the three musketeers of the Thompsons world. Anyway, it is a very fine firm, and I have to confess that I have been instructed by it on one occasion in the past, and it prepared the brief very well.

My hon. Friend the Member for Croydon South (Chris Philp) made a very important speech, explaining the industrial nature of the problem we face with these whiplash claims and the dubious practices that go with it. For those from Scotland, such as the hon. Member for Cumbernauld, Kilsyth and Kirkintilloch East (Stuart C. McDonald), the Scottish National party spokesman, it will be hard to understand this claims culture; Scotland does not have it. It is hard for people to understand it if it has not developed in their part of the UK. It has got to the point at which it is a massive problem. I will cover the point made about employment fees in a moment.

My hon. Friend the Member for North Warwickshire (Craig Tracey) made a very knowledgeable speech. He pointed out that we have to consider not just the pure whiplash claims, but those that are whiplash-related—those described as a back or neck injury, but that are, in effect, whiplash cases. That, of course, explains the figures that I outlined earlier.

It has been a good debate, and I wanted to make the point at the start that the Government are committed to ensuring that the justice system works for everyone. I will describe some of the actions that we are taking. The SNP spokesman made the good point that this is not just about legal aid; it is also about simplifying procedures and changing the way that the legal system works. Of course, that is what we are doing. The Lord Chancellor, the Lord Chief Justice and the Senior President of Tribunals jointly announced plans that are about renewing and transforming our justice system. Of course, we are putting in a massive investment of £1 billion to reform and digitise our courts, to make sure that this vital public service reflects modern needs and expectations.

The reforms will deliver swifter justice and, I hope, a less stressful experience for those involved. We will get cases out of court that do not need to be there, whether by using online procedures or through more alternative dispute resolution. We will apply the full force of judge and courtroom only in those cases that require it, and will strip away unnecessary hearings, redundant paper forms and all the duplication in the system, because we have the best legal system in the world but it also needs to be the most modern. That is what we aim to achieve. The guiding principle is to have a system that is proportionate and accessible, and is there for the vulnerable, victims of crime, members of the public, legal professionals, witnesses and litigants. We want a system that is a statement of our values as a country and leads the world.

Our legal aid system is important. The coalition Government faced unprecedented financial challenges; it is all very well people talking as though there were no pressures, but there were huge financial pressures at the time, and the Government had to reform. They concentrated legal aid on the most important areas—on cases where

an individual's liberty or home is at stake; where children might be taken into care; or where there is domestic violence. Although the reforms were substantial, it is right to follow through on our intention, which we set out at the beginning, which is that there should be a proper review. We have said that it will take place by April 2018 at the latest. We are well within the period during which we could start the review, and we will announce our intentions on it in the coming period.

I want to emphasise that we have made sure that litigants in person get help and support. Since 2015, we have provided £3.5 million to the litigants in person support strategy, through which we are working closely with the advice sector, voluntary partners and the pro bono sector; they are enhancing the local signposting of local and national legal support services and co-ordinating their work. We have seen a fast-expanding number of personal support units. The citizens advice bureaux do a fantastic job, and I pay tribute to the hon. Member for Makerfield (Yvonne Fovargue) for mentioning them. We also have many pro bono providers and local law clinics. This strategy has momentum, and it is wrong for the hon. Member for Wolverhampton South West to say that the result of having litigants in person is longer cases. That is not what the evidence shows; in fact, the average length of a civil case is becoming shorter, year by year.

I want to make family court processes safer for victims of domestic abuse, and our recent announcement contributes to that. It is right to have a system in which the victims of domestic abuse do not face cross-examination by their abusers. That sort of cross-examination is illegal in criminal courts, and we would like to see it outlawed in family courts. I have mentioned alternative dispute resolution.

Both the hon. Members for Ellesmere Port and Neston, and for Wolverhampton South West, mentioned employment tribunal fees. The Government are reviewing the impact of the introduction of fees in those tribunals. There is not a report gathering dust on my desk or anything like that; we are completing the work. I explained all this when I appeared before the Justice Committee recently. The work that we are completing is about the categories in the discrimination field; we are looking at the implications for each of those groups. We are getting to the point at which we will soon be able to produce a report; it will not take much longer. I said that I would produce it as soon as possible in the new year and I meant it.

Since it has been mandatory to go to ACAS, it has been resolving far more cases. The effect is that there are now 92,000 cases going to ACAS, whereas previously there were only 23,000. There used to be about 17,000 cases that did not then go on to the tribunal; now, it is something like 45,000 cases, so ACAS is having a big effect in this area. I understand the frustrations of those who say that the review has taken too long, but it will be comprehensive and it is not far away.

We face whiplash cases on an industrial scale. The number and cost of those cases, and their adverse impact on the price of motor insurance, is a concern for Government. There have been huge improvements in car safety, so how can it be that 770,000 road traffic accident claims were made in 2015-16, compared with only 460,000 in 2005-06, with around 90% of the claims in 2015-16 being whiplash-related? That figure is too

[Sir Oliver Heald]

high and the Government must take action to tackle this issue and protect consumers.

The previous Prime Minister held a Downing Street summit on this issue and we have recently made changes, such as introducing the new MedCo system, which improves the medical expert side of things. There was also a recent consultation on raising the small claims limit for personal injury claims to £5,000, and on damages for road traffic cases involving whiplash—soft tissue injury. If we can save £40 per head on motor insurance policies, clearly those are issues that we should be consulting on and considering very seriously. Also, it is worth bearing in mind that the £1,000 limit for these cases was set in 1991, more than 25 years ago. Since then, the small claims limit for everything else has gone up to £10,000, so the review is very much needed.

Finally, to provide reassurance to Members, people can still employ a lawyer to help them with a case that is in front of the small claims court, and they can try to reach an agreement with their lawyer about how their case is funded. Of course, the point is that they cannot recover costs, but there is no ban on taking legal advice, though clearly people would need to look at the economics of that. The other point to make is that if someone has a complex case that should perhaps be dealt with by the county court in its full setting, that is possible; they can make an application to that court, which can transfer—

Geraint Davies (in the Chair): Order.

Motion lapsed (Standing Order No. 10(6)).

Musculoskeletal Services: Greenwich

[MR DAVID HANSON *in the Chair*]

4 pm

Clive Efford (Eltham) (Lab): I beg to move,

That this House has considered musculoskeletal services in Greenwich.

What a great pleasure it is to serve under your chairmanship for the first time, Mr Hanson.

In 2016, Greenwich clinical commissioning group decided at an inquorate meeting to allocate a £73 million contract for musculoskeletal services to Circle Holdings plc. There were two rival bids at that time: one from Circle and one from a consortium of local providers led by Lewisham and Greenwich NHS Trust and involving local GPs and Oxleas NHS Foundation Trust.

A freedom of information request has exposed the fact that neither NHS England nor Greenwich CCG undertook an impact assessment prior to making requests for tenders or when allocating the contract to Circle. The purpose of an impact assessment is to ensure that no minority or vulnerable group is disadvantaged as a consequence of a decision to let a contract, and it is legally binding. How did Greenwich CCG satisfy itself that no one would be disadvantaged? Responses to the FOI requests to the CCG and NHS England have confirmed that neither party had answers to those questions at that time. As a result of local campaigning, which was led by the local authority, local Members of Parliament and the local community, we now have a review and an impact assessment being carried out subsequent to the contract being let.

The Minister was told by NHS England that it had reviewed the process by which the contract was let, but that is not satisfactory. She may have received assurances that the contract process had been reviewed, but what has not been reviewed is the impact on vital services that had nothing to do with the contract. They may be undermined by the fact that the NHS is so heavily cross-subsidised for providing vital services.

Because members of one of the rival bids were members of the clinical commissioning group, they were required to leave the meeting. That is custom and practice and happens in many fields, but it made the meeting inquorate. In order to allocate a £73 million contract, people who remained in the room were allowed to be double-counted in order to make the meeting quorate. I happen to have a friend who is a lawyer and an expert in health law, and I asked him whether what happened was within the rules. His answer was simple: “No, it is illegal.” At a subsequent health scrutiny panel meeting at Greenwich Borough Council, which was held to investigate the circumstances surrounding the allocation of the contract to a private provider, a representative of NHS England passed the procedure off as common practice. Can the Minister tell me whether it is common practice? Is it acceptable procedure? Is the advice that I have been given—that it is illegal—correct? Does she believe it to be a satisfactory way for such contracts to be allocated? If she is not satisfied, what do the Government intend to do?

The Minister will be aware that it is not permissible to pay anything other than the NHS tariff for services. Circle promised savings of £12 million as part of its successful bid for the contract. We do not know how

much Circle intends to take out of the £73 million for its profits, but she will be aware that it is required to be paid the national tariff. If that is the case, will Circle be treating the same volume of patients as are currently being treated under the MSK process? If not, where are the savings and the profit for Circle going to come from?

I asked the Minister some questions to satisfy myself that the Government were happy with the procedure that had been followed. Were NHS England or the Minister informed of how Greenwich CCG achieved its quorum and the fact that the required number of GPs were not present? It was the GPs who were part of the consortium that was bidding who were required to leave the room. When the White Paper was launched by Andrew Lansley, he made it clear that local clinicians should be at the heart of decision making. In this case, we see that local clinicians were anything but at the heart of decision making.

I asked whether the local healthcare trust had been consulted at all in the process, and the Minister told me in an answer that it had been discussed at a meeting in March 2016 and as part of an assurance procurement process in August. That did not happen. Lewisham and Greenwich NHS Trust managers have no recollection of a meeting in August where the matter was discussed. Who told the Minister that the meeting had taken place when it clearly had not? It was not possible for anyone to give that assertion to the Government when the meeting simply had not taken place.

The Minister was also told that Circle was engaging with Lewisham and Greenwich NHS Trust, but the trust says there is no clarity around the clinical model and no commercial offer. That was still the case in November at the council's scrutiny meeting, with the contract then due to begin on 1 December. The trust had no idea of the money or business that would come its way as a result of the Circle contract.

The Circle contract is a prime contractor model. That means that all patients will be directed to Circle, which will triage them and direct them to whichever services. Lewisham and Greenwich NHS Trust receives something in the region of £10 million for MSK services. It has nothing in its future budget for that service, because it is simply unaware of what it can expect from the contract that will be managed by Circle. How is that acceptable? The trust has to plan ahead for other services, and it is finding that impossible.

The trust has been through a couple of scenarios of what would happen if it was forced to cut its services as a result of losing elements of the MSK contract. It currently has a team of surgeons and some 45% of their surgical workload comes through the MSK contract. Those surgeons are vital to the support of other services, such as A&E. If those surgeons are lost, it will have an impact on other services in the trust. Activity could be reduced in consultant trauma services at Queen Elizabeth hospital which support the A&E. There would be an impact on doctors' training and rotas; on the quality of training provided to junior doctors and other staff; on related professional services and posts such as nursing and physiotherapy; and, in the longer term, on recruitment at Queen Elizabeth hospital and specifically to its trauma service, including the emergency department, which is a

designated trauma unit. It is disgraceful that no impact assessment was carried out to assess these impacts on other services.

The new Eltham community hospital was very much welcomed by my local community. Lots of lobbying has gone on. The local community watched the much loved and admired local building, the Eltham and Mottingham community hospital, being knocked down because they had been told they were going to get a walk-in GP service and a new hospital in the heart of their community, which they could attend for blood transfusions, X-rays and other diagnostics; more importantly, there were to be 40 rehabilitation beds for people leaving hospital and returning to the community. The community were very supportive of that scheme, which started in 2007. I and others in the local community lobbied very hard to make sure that the project stayed on track, and it finally opened in 2014.

Within 18 months of the opening, 20 beds were closed temporarily, to save money during the summer period when there was allegedly a low level of demand, but they were due to open again when winter came along. Now we are told that the beds are not opening. Lewisham and Greenwich NHS Trust is lobbying very hard because it desperately needs the beds back—it is now running at more than 100% occupancy for beds in its hospitals. We are now told that the space available for those 20 beds is part of the MSK project. That is not what my local community signed up for. It is not acceptable that the whole business plan for that hospital and the services to be provided there has been completely changed without any consideration of the local community.

I accept that there is a need for change in the NHS. I do not accept that we need the private sector to do it. If we continue to privatise services like this on the pretext of saving money, we will see a lot of money that should be being spent on patients going out in private profit. It is time to call a halt to the drip, drip of privatisation in our national health service.

If we want to modernise the NHS we need to find ways of doing that, but I wonder how someone could come to the conclusion that Circle is the organisation to take us forward. We know what happened at Hinchingsbrooke hospital—Circle walked away the day before the Care Quality Commission was to put the hospital in special measures. At the Nottingham NHS treatment centre, a dermatological national centre of excellence, the consultants walked out. Chris Clough, who was appointed to investigate what was going on there, described it as “an unmitigated disaster”. To keep that service going, Circle brought in locums from overseas costing £300,000 a year. Today, the centre is no longer a centre of excellence.

The Government and NHS England did not learn a single lesson from what happened with the Cambridgeshire and Peterborough social care contract, where the private provider handed the contract back after eight months, saying that it was not viable. They ignored warnings from the National Audit Office about that in July 2016. It seems that the Government are happy to see any process go forward as long as the services are being privatised.

The process is completely and utterly flawed and is completely unsafe. The meeting in June last year was inquorate. It let a £73 million contract without any consideration of the knock-on effects on other vital

[Clive Efford]

health services, particularly A&E. The illegality of the process was disregarded and Ministers were given false assurances about the process and the consultation with Lewisham and Greenwich NHS Trust. There was no proper assessment of the suitability of Circle as a health provider. It provides not one clinician in the process—it is purely a management operation and another tier of bureaucracy. We hear endlessly from the Government about the need to cut back bureaucracy, but Circle is simply a signposter in the process, and for the pleasure of doing that it will take private profit out. It contracts with existing private services. In Bedford, there has been a 30% reduction in its contracting with the local Bedford hospital for MSK services and the private services in that area are brimming with profitable elective MSK surgery.

The process for awarding the contract is unsafe and has put patients at risk. Worse still, it has put at risk patients who are not in need of MSK services, due to the knock-on effect on other services. It cannot be that patients will unwittingly attend their local hospital and find that services have been cut because another service in the local health economy has been privatised. It is time to call a halt to this process. I hope that the Minister will step in, stop the process and stop the contract being let to Circle plc, because it is clearly flawed and not in the interests of patients in Greenwich.

4.17 pm

The Parliamentary Under-Secretary of State for Health (Nicola Blackwood): It is a great pleasure to serve under your chairmanship, Mr Hanson. I congratulate the hon. Member for Eltham (Clive Efford) on securing this debate. I know that the subject is extremely important to him and his constituents. He has very eloquently raised the different concerns, which is no less than I would expect of him from our shared days on home affairs matters. I would warn him, however, that I doubt whether I will be able to answer every single one of his questions in detail. I will endeavour to get through the best I can and then reply with further detail in writing.

First, I would like to pay tribute to the many staff who work exceptionally hard every day for our NHS and deliver high-quality care for patients. As the daughter of an NHS doctor and nurse, who are now retired, I have seen at first hand how much personal sacrifice that involves from both NHS workers and their families, who often have to spend a lot of time apart from their dedicated NHS family members. It is a sacrifice that I am sure all of us here today would like to honour, especially during this busy time.

It is important to say at the outset—I know the hon. Gentleman is aware of this—that procurement of local health services by means of competitive tendering is a matter for the local NHS. Greenwich clinical commissioning group, which is the deciding body in this case, is a clinically-led independent statutory organisation. We believe it is right that local NHS systems are best placed to understand the health needs of their local populations and to use that knowledge to commission services for local people, to ensure the best clinical outcomes for all patients at the highest quality and best value to the taxpayer.

I know the hon. Gentleman knows that musculoskeletal services are currently provided to about 9,500 Greenwich patients by the four NHS trusts and one private provider, but despite the hard work of local health workers, the

latest data show that Greenwich CCG's referral rate to treatment trauma and orthopaedics performance is only 80.8%, against a target of 92%. It also shows a high number of out-patient appointments—more than 50% higher than the national average—with many seeing a consultant surgeon and then not having surgery. That paints a clear picture of too many patients waiting for too long. Even when they do get an appointment, they do not always see the right health professional, which means another wait for physio or other interventions.

As someone who has a chronic, complex illness and was misdiagnosed for more than a decade, I understand how dispiriting it is to wait in pain only to endure the disappointment of inappropriate or unnecessary appointments or tests and to end up on a new waiting list still in pain, just more frustrated. I know that because I lived it. We have to do better to get the right care to the right patients in the first place.

Taking such steps not only improves patient care and their experience of the NHS, but cuts out wasted appointments and tests, and frees up hugely valuable consultant and technician time, saving money that can be spent on appropriate care instead. That is why the CCG identified the musculoskeletal hub model, which has been successfully implemented using a range of different kinds of providers, private and public—I am agnostic on that point—across the country. It concluded that it would secure better value for money from that more streamlined service model, especially at the point of referral.

Given the hon. Gentleman's description, I think he knows this, but I will say it anyway: the hub model means identifying one healthcare provider to act as a single point of access for all Greenwich musculoskeletal patients. That healthcare provider then offers patients who need an in-patient operation a choice of where the operation takes place. It is also able to triage patients more effectively into physio and other non-surgical treatments sooner, which means that surgery can often be prevented because it is possible to intervene quicker, which is better for patients.

The hon. Gentleman expressed concern in his parliamentary questions about the procurement process. However, I am sure he welcomes the fact that there was some consultation prior to procurement. He questioned the information that has come to me, and I will double-check it, but I have been told that the draft specification was shared with the CCG patient reference group and the pensioners forum for their comments prior to finalisation. When the musculoskeletal service was put out to tender in April 2016 in an open procurement process, the prospective bidders were required to put forward a programme budget within the range of £14 million to £14.8 million a year.

Clive Efford: Lewisham and Greenwich NHS Trust made about 50 requests for information about the scope of the contract it was being asked to bid for during that process, and it received very few responses from Greenwich CCG. It is very difficult to say that there was adequate information or consultation about the impact of the service, because very little information came from the CCG.

Nicola Blackwood: I am sure more information could have been made available, but there certainly were attempts to engage with patients to ensure the contract was shaped to meet patient need.

In the end, two bids were received. They were anonymised and evaluated by a panel that included clinicians. According to the information I have received, the CCG had at least four GP members in attendance at the governing body meeting of 29 June, as well as three other voting members. The musculoskeletal specialist was from another area, specifically so that the panel could benefit from his experience without risk of conflict. Following the evaluation section of the meeting, all members with a conflict of interest were asked to leave the room, as the hon. Gentleman said. Those members' votes were transferred to other governing body members, in line with the CCG's constitution. I am not sure where the hon. Gentleman's information about the numbers in the meeting comes from. According to the information I have received—which I will check—the remaining members of the CCG governing body then voted, and the meeting was quorate, in line with the actual numbers in the room. They voted on the still anonymised bids. Following that process, the five-year contract was awarded to Circle Health. The bid was assessed by NHS England to be according to the NHS standard procurement process, which is obviously legal.

As the hon. Gentleman said, under the proposed model, Circle will triage all patients registered with a Greenwich GP who require physiotherapy or planned orthopaedic surgery to ensure they receive the most appropriate medical professional support the first time to avoid inappropriate patient experiences. The aim is to reduce the number of first out-patient appointments, because many have been found clinically unnecessary. Further, if the trust experiences fewer unnecessary out-patient appointments, surgeons will have more time to carry out elective surgery, which will reduce waiting times for those who really need it. Over the lifetime of the contract, the CCG expects the average waiting time at Lewisham and Greenwich NHS Trust to reduce from 7.8 weeks to below 7 weeks.

As I said, regardless of the details of the procurement, which we will check, ensuring that patients are better served with the right care at the right time must be something that colleagues from across the House support. I heard the hon. Gentleman's concerns about the impact on existing services and his view that the assessment should have been carried out further. At any rate, I am pleased it is being carried out now. As I understand it,

Greenwich CCG discussed the procurement with Greenwich Council's healthier communities and adult social care scrutiny panel—which is very snappily named—at a meeting on 3 November. The panel accepted that the process had been correct, but due to the level of public concern it requested that the CCG and the trust co-commission an independent assessment of the likely impact on orthopaedic activity at Lewisham and Greenwich NHS Trust and also that the outcome of that assessment be shared with the HCASC prior to the CCG's signing the contract. That is what is happening, and it is clearly the right thing to do.

The main concern raised by the HCASC is that the trust may see a reduction in elective orthopaedic activity, as the hon. Gentleman said, which would affect trauma services. The impact assessment will review the likelihood of a range of impacts—from a minus 40% shift in elective orthopaedic surgery to a plus 40% shift—and the resulting effect on local trauma services, emergency department services and other interdependent services at Queen Elizabeth hospital, as well as the risk to the clinical and financial viability of the trust. It will also consider the potential impact, should there be such a shift in orthopaedic surgery, on sustaining undergraduate and postgraduate training, capacity plans and backlogs, interdependent clinical services, the delivery of the national constitution standards for referral to treatment, and the implications on future recruitment of orthopaedic clinicians and support staff. Those are the parameters that were requested by the trust and others, so I think we can be confident that it will achieve its purpose.

The impact assessment is due to be presented to the Greenwich CCG board on 22 February. The report will be shared with the healthier communities and adult social care scrutiny panel the following day and published on the CCG website. The outcome of the assessment remains to be seen, but I am sure the hon. Gentleman agrees that it is essential that the CCG proceeds with what has clearly become a highly politicised decision with the best interests of patients as its core priority. As I said, the data show that we need to work to improve care for musculoskeletal patients in Greenwich, to ensure that all patients are getting the right care at the right time.

Question put and agreed to.

Crown Prosecution Service: Funding

4.27 pm

Mr David Hanson (in the Chair): The previous debate finished a couple of minutes early, but as the proposer of the next debate and the Minister are both present, if Members are content, we will commence the debate.

Karl Turner (Kingston upon Hull East) (Lab): I beg to move,

That this House has considered the funding of the Crown Prosecution Service.

It is always a pleasure to serve under your chairmanship, Mr Hanson. Before I begin, I must declare my interests. I am a member of Wilberforce barristers' chambers in Hull, but am not currently practising. My wife is a criminal duty solicitor with Williamsons Solicitors in Hull, and she is also a part-time judge. I thank the Criminal Law Solicitors Association, the London Criminal Courts Solicitors Association, the Bar Council and the Law Society for contacting me regarding this debate, and for very helpfully providing me with information, which I think will benefit this House.

Expenditure on the Crown Prosecution Service has been reduced significantly from £672 million per annum in 2009-10 to £487 million in 2015. That is a reduction of a massive £185 million per year. At the same time, the number of cases brought to magistrates courts is down from approximately 641,000 to 539,000. On the finances of the CPS, I understand that since 2010, some £83 million has been spent on redundancies, with £20 million of that spent on only 153 staff, or upwards of £131,000 per—senior, I suspect—member of staff.

What has been the effect on cases? The effect has been significant: there is a staggering 23% increase in vacated trials—cases that are due to go to trial but, probably on the day of trial at Crown court, are vacated for whatever reason. In my submission, the reason is often that the CPS is not prepared or ready. In my area of Humberside, 55% of cases are vacated, according to the Public Accounts Committee inquiry of May 2016; the lowest proportion of vacated trials was 11%, in Cleveland.

Alex Chalk (Cheltenham) (Con): The hon. Gentleman is making a powerful speech. I refer the House to my declaration in the Register of Members' Financial Interests. Is it not right that whether the CPS is ready at trial is down to several factors, and not only funding? In fact, the CPS's ability to be ready at trial and to perform well has improved over recent years, in spite of funding not having gone up, as he rightly pointed out.

Karl Turner: I will read out a whole load of stats and talk about what is happening in the profession in the real world—about what lawyers and solicitors from the defence, and barristers who prosecute and defend, are saying is really happening. The hon. Gentleman wants to pretend that everything in the garden is rosy. Good luck to him, but I have to disagree. I know what is happening, not least because my wife is a defence solicitor in Hull and experiences the pressure on CPS lawyers day in, day out—although at the moment she is on maternity leave. Only today I was contacted by members of the profession, and they described a scenario in which a caseworker burst into tears when sitting in the Crown court behind counsel. If the hon. Gentleman thinks that things are rosy, he is mistaken.

Mr David Burrowes (Enfield, Southgate) (Con): Similarly, I declare an interest: I am still a defence solicitor, and if I catch your eye later, Mr Hanson, I will speak about my experiences. I will probably share similar experiences to those of the hon. Gentleman. He does angry well and quickly, but he was actually asked a genuine question on clarifying the stats. There are lots of reasons to vacate trials, and they can involve issues beyond funding-related prosecution preparedness; that was what the question was about.

Karl Turner: The hon. Gentleman is of course right, but I was less than two minutes into my remarks when the hon. Member for Cheltenham (Alex Chalk) intervened. If I am allowed to, I will come on to clarify the points being made by the Government Back Benchers.

Nick Thomas-Symonds (Torfaen) (Lab): I refer the Chamber to my entry in the register. The statistic is this: in 2014-15, the Crown Prosecution Service spent £21.5 million preparing cases not heard in court; of that, only £5.5 million can be attributed to factors not within CPS control.

Karl Turner: My hon. Friend is absolutely right. I will make that point myself. Excluding guilty pleas, conviction rates in magistrates courts and Crown courts are significantly down, despite the headline figure of an 80% conviction rate. I think the conviction rate in magistrates courts is about 50%, and in Crown courts it is about 25%, excluding guilty pleas. Since 2010, CPS staff numbers have fallen by a whopping 2,400. The CPS is suffering a brain drain and haemorrhaging experienced in-house lawyers, who leave for independent practice, or simply take the money and run.

On a serious note, I mentioned a caseworker bursting into tears in open court, clearly because of the pressure. I am told that the stress levels at the CPS are seriously high. Interestingly, a 2012 LawCare survey of the law profession revealed that more than 50% of the legal profession generally felt stressed, and that 19% were suffering from clinical depression, with more than one fifth of the profession suffering from mostly avoidable and preventable mental ill health. Stress at the CPS must be off the scale, particularly considering a recent Law Society survey in which 95% of respondents said that they were stressed at work.

Furthermore, in May 2016 the Public Accounts Committee inquiry found that

“The criminal justice system is close to breaking point.”

According to the National Audit Office report of March 2016, “Efficiency in the criminal justice system”, the number of cases outstanding in Crown courts had increased by 34% since 2013, and the waiting time for a Crown court case to be heard had increased from an average of 99 days to 134 days—an increase of about 35%.

In 2014-15, the Crown Prosecution Service spent £21.5 million preparing cases that were not heard, as the shadow Solicitor General, my hon. Friend the Member for Torfaen (Nick Thomas-Symonds), helpfully said. What has happened to those cases and the £21.5 million? If memory serves, it costs just shy of £1,000 to prepare a case for Crown court—the CPS says that being trial-ready costs it about £1,000—and £21.5 million has been spent on preparing cases that got nowhere. One must assume that the evidential test had been passed, and that the CPS reviewing lawyer had determined that there was

enough evidence—that is, on balance, more evidence than not, and a more than 50% chance of a successful prosecution—and that it was in the public interest to prosecute that case. Twenty-five million quid was spent on preparing cases that went nowhere. The Solicitor General might be able to correct me and clear the matter up, but I assume that that is down to cases coming to nothing. In the magistrates court or, worse still, the Crown court, perhaps the CPS lawyer just gives in for whatever reason. I do not know; I am guessing. I have no idea.

The Solicitor General (Robert Buckland): I am anxious to answer as many questions as possible. In the Crown court, cracked and ineffective trials that have not gone ahead for prosecution reasons have, as a proportion, fallen to only 13.5%. That proportion of the total is falling; it is important to bear that in mind when looking at the overall context. I hope that helps the hon. Gentleman.

Karl Turner: That is a fair point, but nevertheless £21.5 million is a staggering amount of money to be spent by the CPS on preparing cases for trial only for them not to come to anything. It is easy to mention such figures, but we must have some thought and regard for the victims in the cases, who will be anxious for the case to make progress and to have their opportunity to give evidence for the prosecution, and desperate to find out what happens in the trial. In my submission, the victims suffer the most from all that. *[Interruption.]* I will not give way, because I have been notified by the Attorney General's office that some Government Back Benchers have indicated a wish to make a speech in the debate.

Interestingly, Her Majesty's Crown Prosecution Service inspectorate found that charging decisions were not correct in 18.2% of cases. There is clearly a problem between the police, who are either, in cases where they are authorised to charge a case without referring it to the CPS, authorising charges that they perhaps ought not to and probably not getting advice from a CPS lawyer, or—I say this carefully—perhaps not giving the full information to the CPS reviewing lawyer.

It would not be fair if I did not say that I have the highest possible regard for CPS lawyers individually. Prior to my election to the House, I prosecuted for a fair while from chambers, and I found that CPS caseworkers and lawyers had the highest professionalism. They were committed and extremely capable individuals who cared a great deal about the job they did. I pay tribute to each and every one of those CPS lawyers, who are under incredible pressure. I also pay tribute to the Director of Public Prosecutions, Alison Saunders, whom I know personally. When I was shadow Solicitor General and shadow Attorney General, I met her on a good number of occasions, and I know that the Solicitor General meets her regularly, too. I find the DPP very professional, extremely impressive and extremely committed to the task in hand. Unfortunately, she is under considerable pressure, but she does the very best in difficult circumstances.

The decisions that I referred to should have been reviewed by a Crown prosecutor prior to the charge being authorised, but—this is a staggering figure—in 38.4% of cases, decisions were not reviewed before the case was first heard at a magistrates court. Prior to being elected to this place, I practised as a junior. I was

the one who prosecuted for the CPS. Before my next day in the magistrates court, if I was lucky—sometimes it was on the morning—my clerk would give me a big, black CPS bag containing files for the next morning. I would go home and prepare 10, 12 or 15 files for trial. It would often take me through the night. All night long, I would drink large quantities—*[Interruption]*—of coffee, the Solicitor General will be rather relieved to know.

I would go into the courtroom the following morning to find that witnesses were not there, police officers were not available, shift patterns had changed all of a sudden, reviewing lawyers were unavailable, and the caseworkers who were available on the end of the telephone were not in a position to make any decisions. The defence, who were keen to crack the case and put it to bed, might offer me a section 5 public order offence, rather than the section 4 offence that had been charged. I would read the file and think that whoever had authorised the section 4 charge had been optimistic, to say the least, and would want to drop it in preference for a section 5 charge, which would be easy enough to get home and get a conviction for, but no lawyer would be available for me to speak to.

That was then. I have not been in a magistrates court to prosecute—I have recently been in one in a pro bono matter—since 2010. Things were bad enough then, but they are getting worse. Things are much worse now than when I was on my feet in magistrates courts before I left Wilberforce chambers in April 2010.

Some 38.4% of cases are not reviewed before they first come before the magistrates court. In reality, that means that if the prosecuting lawyer has been really lucky, they open their file and they have their witnesses ready, they have interviewed them individually, they have checked that what the police say in their statement is what they are about to give as evidence and is correct, and they are ready to crack on. But then they find that things are not quite right. The charge is probably not correct, in truth. Whoever has reviewed it probably has not done so very well, or things have been kept from the reviewing lawyer that are particularly important to their charging decision. The fact that 38% of cases are not reviewed means that when a prosecuting lawyer goes in to prepare cases for trial, nearly half of them will not even have been reviewed by a CPS lawyer. They have one arm very definitely tied behind their back.

I have kept Members long enough, but given that Government Members will say that everything is great, I want to talk about what the profession says—what individuals at the Bar say about their experience in the CPS. It would not be right for me to name people, but this is from an experienced CPS prosecutor of 30 years' call:

“CPS hesitate to instruct QCs to prosecute even murders. Very serious, high publicity, or multiple murders will get a Silk prosecuting; otherwise not. The decision tree is on the CPS website”,

which I helpfully have in front of me. He continues:

“As a fairly senior junior barrister... I have over the last 5 years prosecuted some 12 murder cases. I have done this as single counsel. About 8 of those have been prosecuting against QC and a junior. One was of two defendants both with QC”

and their respective juniors. The CPS provided him with a CPS lawyer—a higher court advocate—in that case. He was against two silks, effectively—two Queen's counsel—with their own juniors. I am talking about a junior not of the level I was at prior to coming into this place

[Karl Turner]

but of probably 20 years' call, who has prosecuted and defended for an awfully long time and has a great deal of experience of being junior to leading counsel, and of prosecuting a murder on his own without leading counsel.

That CPS prosecutor says that, in contrast, judges "have some influence on Defence getting a QC, and will say in open court 'This being a murder case the Defendant should'—the judge of course is right—

"have leading counsel" and the legal aid is then likely to be extended to cover that."

In that scenario of a double-handed case with two defendants, why should the victim, whose loved one has allegedly been murdered, have counsel bringing the case for the prosecution against two leading counsel and two junior counsel? How does the victim feel in that scenario?

I hope it will not annoy you too much, Mr Hanson, if I talk briefly about some other cases that have been mentioned to me.

Mr David Hanson (in the Chair): Order. Before the hon. Gentleman continues, I remind the House that the debate will finish at 5.30 pm. The hon. Gentleman has the floor, but other Members have indicated that they wish to speak.

Karl Turner: I will be as quick as I possibly can be, but it is crucial that I mention what the junior members are saying. This person says:

"I often work in the magistrates court, where matters are unfortunately often in chaos so far as prosecutions are concerned. The CPS are dealing with hundreds of cases, often of a domestic violence nature and many of which are doomed from the start because Complainants had told the police in terms either that they won't be coming or for which no statement has even been taken."

He or she goes on to say:

"They do not appear to have such resources, either for these sorts of cases or indeed others."

It is chaotic in the magistrates court. Another lawyer emailed me to say:

"The problem is not just money"—the point made by the hon. Member for Cheltenham—"it is doctrine, dogma and management double speak. I get six cases to prosecute in the magistrates at 4pm the afternoon before" the case is due to be aired in court. He or she continues:

"Each of those cases will be defended by a separate lawyer who only has that one case to deal with. The hearing record sheets" are not there, and all sorts of things are missing from the files. It is utterly chaotic.

I have got a huge number of cases that I could read out, Mr Hanson, but I will not annoy you by doing that. I want to give other Members an opportunity to tell us, if indeed they want to, that everything is rosy in the garden, despite the fact that £185 million per annum has been cut from the CPS budget.

Mr David Hanson (in the Chair): The hon. Member for Kingston upon Hull East (Karl Turner) was entitled to speak for as long as he wished, but we now have a limited time before I have to call the Front-Bench Members. I hope that Members can self-regulate on these matters.

4.52 pm

Mr David Burrowes (Enfield, Southgate) (Con): It is a pleasure to take part in the debate. I declare an interest as a criminal defence solicitor. I have an interest in defence, but primarily an interest in the criminal justice system, which we all share. We need a good, efficient and effective CPS as part of the criminal justice system. That is good for all: for defendants, for witnesses, for victims and for public confidence. It is a collaborative effort, so in many ways it is important not to see this issue in isolation.

There are funding challenges—we could have another debate about the funding challenges for the criminal defence service and the challenges for the police and others—but there is a collaborative effort, which is why I welcomed the inspection by the Crown Prosecution Service inspectorate and Her Majesty's inspectorate of constabulary in 2015, which helped us to home in on some of the issues. Yes, one can look at the statistics on cracked trials, but when one looks deeper one sees, as the hon. Member for Kingston upon Hull East (Karl Turner) said, the issue of the police's charging decisions and the impact that has down the line. Getting it right first time was very much the NAO's mantra in relation to getting value for money for taxpayers.

I will try not to take up too much time but I want to draw attention to the statistics. First, it is important to recognise that there has been criticism for some time. There is also the challenge of cuts. Back in 2014, the independent inspectorate's report on the CPS looking at the period 2013-14 said:

"The background of continuing resource reductions is now having an impact on the ability of the service to deliver effectively across the whole range of its activity."

That was then; now, we are looking at what the challenges have been to that. If one brings in the NAO report and other inspectorate reports, one sees that there is a serious challenge from cuts, but if one delves deeper, one sees other issues, including a large variation in performance across the country in the service provided to victims and witnesses. One cannot therefore look just at the money; one has to ask, "Why are there variations? How can we have a more uniform approach that provides a good service to all?"

There has been some progress. I will not seek in any way to cover over the cracks—there are serious challenges and serious problems. I go to courts and I see and hear them and the way they affect morale and confidence in the system. That is a collective challenge that is affecting the criminal justice system. Nevertheless, given some of the statistics, it is worth saying for balance that the proportion of effective trials in magistrates courts has increased from 34% in the year ending September 2011 to 39%. There has been an increase, although it is not enough.

On the issue that the NAO and inspectors have looked at time and again, yes, mistakes are happening, but they are happening through the currency of cases. Early decisions should have been made and what had gone wrong identified. No doubt, the anecdotal evidence provided by the hon. Gentleman can be repeated by the prosecutors. The fact that two thirds of cases still do not progress as planned shows that that needs urgent attention.

The reality, and what I have experienced myself, is that the most frustrating thing about funding challenges and staffing is that, when it comes to the need for an early decision, at court—or preferably beforehand—there needs to be an appropriate review. A review can take place before the door of court so that appropriate decisions can be made for the benefit of the whole criminal justice system. That is something that I think is not happening enough, and down the line, whether in the magistrates court or the Crown court, it leads to vacated trials.

More needs to be done, but during my 20 or so years of practising, there has been a sea change, not least in terms of the recognition of the need for reforms—that the present situation cannot continue. The only way we will get better value for money and better public confidence is by grasping the fact that, in particular, the legal system has been one of the last to come up to date regarding paper and the need for a digitised criminal justice service. That is not the only answer, but we know that when we are struggling to find where that advance information or that disclosure is, we ring up and try to find the duty officer, who then tries to get someone. Thankfully, those things are now part of the past. The future is proper digitisation, which can help in getting prompt disclosure and appropriate decisions made and should lead to early decisions. We are still not getting those appropriate early decisions. The report of the last joint inspection in 2015 made the point that too many police charging decisions were incorrect and picked up too late by the CPS in court. The fact that 38.4% of cases were not reviewed before court must be seriously challenged for the sake of the system and for the benefit of all.

I want to make some brief points on what could be done. I remain concerned about transparency and accountability in the criminal justice system. The decisions made, such as those made by magistrates on the mode of trial—whether the case goes to Crown court—are still not clear enough for everyone

There is variation between areas. There have now been improvements to crime mapping for victims, but we should look much better at justice mapping and the accessibility of justice in a given area. The challenge of less localised magistrates courts and less reporting and less public awareness of what is happening in local courts means that we need the digital service to map better what is happening in our areas to see the impact of decisions, going back to charging decisions and particularly to decisions made in court and their impact. That will help to build confidence and public perception that is not based just on anecdote or the latest scandalous headline in a tabloid.

Transparency is needed, but we also need accountability. One of the frustrations I feel on behalf of the defence service is that I am directly accountable if I make a bad decision—if I have not got my act together and got my witnesses together, or if I have mucked up in court, I will get it in the neck from a senior partner or others, and not least from the client—but I do not see that same accountability for the Crown prosecutor. There is accountability for the police officer handling his case and there is much more in the Crown court, but at the magistrates court, with a pile of cases, when something goes wrong and a decision needs to be made quickly that perhaps goes against the victim and against the

interests of justice in the long run, the Crown prosecutor—strained and challenged though they and the system are—is not challenged and accountable. We do not allow wasted costs orders now because of decisions about publicly funded cases, so the Crown prosecutor does not get it in the neck about wasted costs and lessons are not learnt—it is not so much about berating that individual prosecutor but about the system learning the lessons. Is there a way to provide greater accountability for the CPS, particularly when decisions are made?

Can we recover more costs for the system through costs orders? Can we have more full costs orders in CPS cases, not just contributions to costs? Yes, there are those who cannot afford those, but there are others who certainly can afford to pay prosecution costs. Other agencies will apply for the full costs of a case, including the police enforcement costs; can the CPS introduce full costs orders? Can the CPS also benefit from successful proceeds of crime applications, and can that funding go to the CPS and those prosecuting agencies, rather than to the coffers of the Treasury and the Home Office?

5 pm

Alex Chalk (Cheltenham) (Con): I was not planning on speaking, but having heard some of the remarks that have been made, I thought I would briefly volunteer a few thoughts of my own.

Karl Turner: I am surprised to hear that the hon. Gentleman did not intend to speak. I received an email that said he intended to do so.

Alex Chalk: First, by way of background, like the hon. Gentleman, I worked through the night to prepare long lists for the CPS, from 2002 to 2005. I went around the courts in Hertfordshire—going to the magistrates court and the Crown court, prosecuting and defending cases involving everything from rape to murder to terrorism offences.

I take this opportunity to agree with the hon. Gentleman that the calibre of some of the prosecutors and caseworkers in our Crown Prosecution Service is very high and stands up to comparison with any other prosecuting authority anywhere in the world. One thing I found disappointing was that prosecutors or caseworkers who were exceptionally conscientious or hardworking did not seem to get advancement any faster than people who were not quite as attentive. I thought that was a little unfair.

I agree with the hon. Gentleman on equality of arms. It is vital, particularly when dealing with a serious case, that the prosecution is able to show that there is equality of arms. It is therefore absolutely right, in a serious case, that silk should be instructed if they are up against silk. Where I begin to part company with the hon. Gentleman is on his bald assertion—made with the best of intentions, I accept—that everything can be attributable to funding.

Karl Turner: I did not say it is.

Alex Chalk: Well, one might be forgiven for thinking that that was part of the assertion. If one looks at the figures from 2010, although the hon. Gentleman is absolutely right that there has been a decline, I am afraid it is wrong to suggest somehow that there were no problems previously but there are now.

[Alex Chalk]

From my experience when I was in court, all too often the reason cases cracked, if there was a problem with the prosecution, was system failure. For example, if witnesses had not been warned, if dates to avoid had not been provided or if disclosure had not been served. Those were systematic failings. My hon. Friend the Member for Enfield, Southgate (Mr Burrowes) correctly made the point that systematic change can sometimes be as significant as financial change. The changes we are seeing to the digital case system are causing such an important step change in the quality of the prosecuting service that, for example, when one turns up at the Crown court, one can immediately see on the system that a disclosure has taken place. It provides for that in a far more efficient way.

Karl Turner: Does the hon. Gentleman think that those “systematic failings”, as he puts it, are getting better because the CPS is experiencing a £185 million a year cut to its funds?

Alex Chalk: Let me make it crystal clear: of course I would like to see more funding for the CPS. There is no question about that. However, I take slight issue with the blandishment that if we simply put in the money that has been taken out, everything would be improved. The reality is that, unless we reform the system to make it more efficient, we will be throwing money at the situation and not taking a sensible, radical and reform-minded approach. The simple point I make is that, where we are making real progress as a country, and where the CPS, through its diligent prosecutors and caseworkers, is able to make a difference, is through systematic changes such as those to the digital case system, which are achieving a step change and improvement in quality. That point is worth making.

The hon. Gentleman also rightly praised that excellent public servant, Alison Saunders. In that vein, is it not worth listening very carefully to what she herself said? She came before the Justice Committee, and I think it was I who asked—by the way, I have no difficulties with asking an open question to get an answer that might be unhelpful to the Government—if the CPS has enough money. I would have been perfectly prepared for her to say, “No, it’s hopeless; we’re going to hell in a handbasket and something has to be sorted out”, but her response was:

“Yes, we think we do, particularly now that we have the CSR settlement. I am not saying that it is easy; let me say that first. Over the last five years, our budget has reduced by 23% or so.”

She went on to talk about the sensible and pragmatic steps that have been taken, but she answered that question in the affirmative. On a subsequent occasion, she indicated she fully agreed with this CPS comment:

“This settlement will allow the CPS to respond to a changing caseload and the significant increase in complex and sensitive cases, such as terrorism, rape and serious sexual assaults and child sex abuse.”

One cannot have it both ways by saying she is a fantastic public servant—which she is, by the way—and ignoring what she says.

I respectfully and completely agree with the hon. Gentleman’s intentions. He wants an excellent Crown Prosecution Service. I do, too. He values excellent Crown prosecutors. I do, too. Equally, however, we have to look

at this in a sophisticated way, not simply through the blunt instrument of funding. I believe, broadly speaking, that we are on the right track. We have excellent public servants; we should allow them to get on with their job.

5.6 pm

Mr Ranil Jayawardena (North East Hampshire) (Con): First, I should say that my wife is a non-practising solicitor. For the avoidance of doubt, that is my declaration of interest.

I recently met the chief Crown prosecutor for Wessex, Kate Brown, who is based in Hampshire. She and I discussed the “CPS 2020” plan. It seems to me that it is a clear plan to continuously improve the way the CPS works—those are its own words. I must say to the hon. Member for Kingston upon Hull East (Karl Turner) that the picture he paints is certainly not the whole story. It may be one side of the story; it is more likely part of the story from a particular perspective. While I respect his views and experience, in the interest of fairness, it is important that some of the successes of the CPS are also placed on the record in the short time available.

For instance—I have different statistics from the hon. Gentleman—net annual expenditure since 2011-12 is down £101 million. Yes, a reduction in expenditure has led to a 27% reduction in headcount from that date, but convictions remain steady at around 83%. Some £84 million has been put back into public funds through the proceeds of crime being recovered, even though, owing to the way the criminal justice system has evolved, there is a shifting case load.

There are now 28% more sexual offence cases and 23% more fraud and forgery cases than five years ago. How? Because the CPS has changed the way it works. It is building stronger cases from the start and encouraging more early and appropriate guilty pleas. Some 76% of pleas are now guilty, up from 69% in 2011-12. While Crown court cases remain steady at around 100,000 cases per annum, there has been a 36% reduction in magistrates court cases. The way the CPS works is changing to deliver the right outcomes for citizens across the country.

Karl Turner: Will the hon. Gentleman give way?

Mr Jayawardena: I am afraid, in the interest of time, I cannot. As the CPS put it, it will deliver an efficient operating model through

“digitisation”—

which has been referred to—

“Better Case Management and Transforming Summary Justice.”

Digitisation alone will potentially save more than 5% of the £3.3 million cost of paper and couriers. That is one small element of the savings that can be made in the CPS budget.

The CPS budget is constantly reviewed, which is important. When the Attorney General was asked about that, he made it clear that he has regular discussions with the Director of Public Prosecutions, but that she and he

“both believe that the spending review settlement enables the CPS to respond effectively”.—[*Official Report*, 14 January 2016; Vol. 604, c. 978.]

I think that sums it up. It is clear, if we look at those statistics and at the “CPS 2020” plan—which is the CPS’s document, not this Government’s—that the CPS’s

funding should be reviewed, as it always is, but that more importantly, it is delivering for the needs of decent people across this country who want to see justice done.

5.9 pm

Nick Thomas-Symonds (Torfaen) (Lab): It is a pleasure to serve under your chairmanship, Mr Hanson. I have already referred to my entry in the Register of Members' Financial Interests.

I congratulate my hon. Friend the Member for Kingston upon Hull East (Karl Turner) on securing this debate and pay tribute to the work he did as a shadow Law Officer. When I came into this House, I watched him carry out the role of shadow Solicitor General and, subsequently, shadow Attorney General, and his was a model to follow. His passionate speech at the start of the debate sums up his depth of feeling about the issues before us.

It was great to hear the speech of the hon. Member for Cheltenham (Alex Chalk). His praise of the work done by Crown Prosecution Service staff was very well put, and I think we all agree across the House that tremendous work is done in the circumstances in which those staff find themselves. The hon. Members for North East Hampshire (Mr Jayawardena) and for Enfield, Southgate (Mr Burrowes) both spoke powerfully and talked about digitisation, which clearly will be an issue.

I think all Opposition Members agree with the hon. Member for Cheltenham that this is not purely about money. Obviously it is not. However, it is now 2017, and the Conservative party, either in coalition or on its own, has been in power and responsible for our criminal justice system for nearly seven years. It has to bear responsibility for the system as it is today.

We have heard eye-watering figures about the cuts in the budget. My hon. Friend the Member for Kingston upon Hull East talked about the overall cut in expenditure. Indeed, the resource budget has seen a real-terms cut of 24% since 2010-11. I am grateful to the Solicitor General for answering my written questions about the staffing budget. The figures given show that the staffing budget in 2015-16 is 40% of what it was in 2010-11.

I will make two broad points about the Crown Prosecution Service. The first is about where our criminal justice system is in 2017. No doubt the Solicitor General will have read the Public Accounts Committee report last May, which said:

“The criminal justice system is close to breaking point.”

We also have to look at how the system is performing today. Let us take the Crown court, for example. From March 2013 to 1 March 2016, there was a 34% increase in the backlog of cases. We can also take average waiting times. I have the quarterly criminal court statistics published in September, which look at the previous six months. Whether this is purely about money or not, the performance of the system is as follows. What is the average waiting time in weeks at the Crown court? For both triable-either-way offences and indictable-only offences, it is now above 20 weeks. There has been a steady increase, going back to 2013. There may be slight variations quarter to quarter, but that is the trend from 2013, when the one figure was below 18 weeks and the other was below 15 weeks. That is the performance of the system.

Alex Chalk: The hon. Gentleman draws attention, quite properly, to a very salient figure, but how can one be absolutely clear that that is to do with the Crown Prosecution Service as against the list office, the offence or the actions of the court? Why focus specifically on the CPS?

Nick Thomas-Symonds: I hoped I had made it clear that this is about the performance of the system. The Conservative party, in one way or another, has been responsible for that system for seven years. Wherever in the system we isolate the cause, the Conservative party cannot escape blame for the performance of the system. That is the point I have been seeking to make.

When we talk about money, we have to be extremely careful about false economies, because things can seem as if they will save money. Let me give an example. I drew attention to the staffing budget, which I asked a specific written question about, and the Solicitor General was kind enough to answer very directly. It has been substantially reduced, but at the same time the Crown Prosecution Service is spending substantial amounts of money on agency staff. The response to my written question showed that in 2015-16, more than £7.8 million was spent on agency staff.

When we look at this in the round, we have to do so in two senses. First, of course this is not purely about money, but when money is cut from certain budgets, we have to be conscious of the effect on the system and whether false economies are causing problems further down the line or mean that we have to hire agency staff instead. The second point is about the whole system of which the Crown Prosecution Service is a part. I hope that all of us across this House want to see these measures improve. The responsibility is on the Government for these measures to improve. I am sure they accept that responsibility, but they have to act, and act quickly, because the performance of the system clearly needs to improve rapidly.

5.16 pm

The Solicitor General (Robert Buckland): It is a great pleasure to serve under your chairmanship, Mr Hanson. I know, on a personal level, that you have had a long interest in these matters. I hope the debate has been of particular salience to you.

I thank the hon. Member for Kingston upon Hull East (Karl Turner), my former shadow. It has been nice to be together again in that sense. I have often thought that it would have been great if he and I had done a case against each other, but I was in another part of the country from him. When he was reminiscing—not quite eulogising—about his days carrying large amounts of files to the magistrates court, it took me back to my time back in the '90s when I did precisely the same thing.

Here is the rub: times have changed. The hon. Gentleman will be glad to know that he does not now have to carry all those files. He can have it all on an iPad or a laptop, because of the Transforming Summary Justice initiative in the magistrates court. That means there is far more efficiency now in the use of digital technology in the court. If he came with me to CPS offices, he would be amazed that in magistrates court divisions now, paper is the exception, rather than the rule.

Karl Turner: It is all very good when it works, but people are reporting to me that, sadly, it does not work and often goes wrong—very badly wrong. Cases are vacated as a result of the very thing the Solicitor General mentions.

The Solicitor General: I am grateful to the hon. Gentleman for sharing some powerful anecdotes. I do not underplay anecdote; it certainly helped to inform me in my long career at the criminal Bar. However, the overall statistics tell the full story about what is happening across the system. There is no doubt that in the magistrates court, we are seeing an increase in efficiency. For example, guilty pleas at the first hearing in the magistrates court have increased as a proportion of total cases from just over 62% back in 2010 to over 70% in the past year. That is indicative—

Karl Turner: Of self-represented clients—litigants in person.

The Solicitor General: No, it is not. It is indicative of much better preparation by the prosecution of the cases, so that when defendants appear, they face a case that has been properly put together. That is also reflected by the increase in the overall guilty plea rate, which has gone up from just under 68% to 76.3%.

The hon. Member for Kingston upon Hull East talked about inefficiency. I am pleased to tell him that average hearings per case for both guilty pleas and trials have reduced. For trials heard in the magistrates court, we are now looking at just under three days, as opposed to three and a half days or more. Compliance with judges' orders was always an issue when it came to the Crown Prosecution Service. Hon. Members will remember "mentions"—my hon. Friend the Member for Cheltenham (Alex Chalk) will know exactly what I am talking about. I am glad to say that we have seen an increase in timely compliance with judges' orders in the Crown court in recent years. The rate has increased to more than 80% in the last two years.

Amanda Solloway (Derby North) (Con): Does my hon. and learned Friend agree that we need an ongoing discussion about how the CPS can be more efficient and effective in its work and that that should continue?

The Solicitor General: My hon. Friend represents a city that has a Crown court and a magistrates court. It is an important court centre in the east midlands. I know from my visits to many regions across England and Wales that those conversations continue. There is local liaison and local discussion.

To respond to the point my hon. Friend the Member for Enfield, Southgate (Mr Burrowes) made about accountability, joint performance management, which is what we are talking about, takes place in most areas and enables local agencies, whether the courts themselves or the defence community, to challenge the CPS when performance is not acceptable. Line managers individually assess prosecutors in the CPS, so accountability is an important part of this.

Nick Thomas-Symonds: The Solicitor General read out some of the statistics about magistrates courts. Of course we all want to see and welcome improvement, but is he as concerned as I am that the average number

of days from an offence to completion in a magistrates court has increased from 155 days in the second quarter to 2015 to 162 in the second quarter of 2016?

The Solicitor General: The hon. Gentleman is right to make that point, but the point made by my hon. Friend the Member for Cheltenham is the right one. Here we are debating funding for the CPS and we are eliding two issues: the overall performance of the criminal justice system with the performance of one part of it. What is happening with the caseload, particularly in the Crown court, is that complexity is increasing. There has been a marked shift—the hon. Member for Torfaen (Nick Thomas-Symonds) will agree—away from the sort of volume cases that might take a day or two to quite complex and often difficult cases involving sexual allegations. I am told by many resident judges in the Crown court centres I visit that they now form the lion's share of court work in the lists. That complexity is definitely resulting in more challenges for the Crown court.

I was glad to note that in recent years the Ministry of Justice has increased sitting days. That has certainly helped to reduce any backlog, but with respect to the hon. Gentleman, it would be a little unfair to lay the problems of delay completely at the door of the Crown Prosecution Service. Let us focus on the debate called by the hon. Member for Kingston upon Hull East on funding.

I accept, of course, that as a result of the tough decisions we had to make in 2010, expenditure was reduced. I pay tribute to the hon. and learned Member for Holborn and St Pancras (Keir Starmer), who stewarded the CPS through that period. He did a remarkable job of delivering efficiency and providing leadership, which was then taken up by Alison Saunders, the Director of Public Prosecutions, who has rightly been praised here today. The hon. and learned Gentleman proved that the job could be done with a declining share of expenditure. When we look at the figures—my hon. Friend the Member for North East Hampshire (Mr Jayawardena) mentioned this—we see that performance and conviction rates have stayed remarkably steady through the years.

I am delighted to see on my visits to regional offices that there is smarter use of personnel within the CPS. I will give an example. North-east prosecutors will be able to work remotely—and do so—on south-east cases. That is a good emblematic example of how the CPS is making sure it uses all the resources available to it from whatever part of the country they come. That is certainly a boon to the south-east. I know it happens with prosecutors in Wales who are helping out in cases in London. That is another example of how we must not let regional boundaries become barriers to better working.

Digital case management has now made its way into the Crown court and is making a real difference. With my long years at the coalface of the criminal Bar, I was the first to be sceptical about digital and the use of IT. I have seen it before, but, believe you me, when I saw the pilots in Southwark, for example, I was delighted to see judges embracing that and telling me that the system was user friendly and starting to make a difference. Now that it has been rolled out across the country, it is starting to bear fruit.

Hon. Members talked about the challenges of the CPS and about charging decisions. It is right to say that the police have a role with regard to some charging decisions.

There was a sea change, in that motoring offences were largely transferred to the police for decision making. That of course added to the reality that, with the increase in sexual offences, the CPS was now dealing with an entirely different caseload. There was not a like-for-like transition, and that complexity means extra challenges for CPS lawyers.

The hon. Member for Torfaen referred to the use of agency workers. I make no apology for that, because I think that using the independent Bar—whether to do agency work in the magistrates court or, vitally, to prosecute serious cases in the Crown court—is exactly what the Crown Prosecution Service should be doing. I am glad to say, having spoken with chief Crown prosecutors across the country, that it is increasingly using the experience and expertise of prosecutors to manage cases effectively within the system, so that we have the excellence in advocacy that we get from the independent Bar and the excellence in case management that we get from experienced CPS employees.

Nick Thomas-Symonds: I do not think that there would be any disagreement about the excellence of the advocacy of the independent Bar. I was simply making the point that when we see apparent cuts in the staffing budget, we have to look at the overall picture. We have to look at the temporary staff as well in adding things up to a single figure.

The Solicitor General: Again, I have spoken directly to many CPS staff, particularly in Wales; indeed, a lot of them used to instruct me. Some of the staff have been there for 30 years—the CPS's retention rate is extraordinary. I think I get a bit of frankness from them, and they tell me that, in many respects, working practices have improved. The reduction in offices has helped them to work more smartly. They are now physically co-located in buildings with the police. They are working in ways that they did not dream were possible before.

Alex Chalk: Does my hon. and learned Friend the Solicitor General agree with me, and indeed the hon. Member for Kingston upon Hull East (Karl Turner), that if one is to use the independent Bar, it is also important to ensure that equality of arms is observed? There comes a point at which victims' groups and victims' families can rightly note the disparity that

apparently exists between the seniority of counsel for the defence and the relatively junior status of counsel for the Crown.

The Solicitor General: My hon. Friend makes an important general point. Equality of arms is, of course, enshrined in article 6 of the European convention on human rights. It is something that we all understand as practitioners. It would be wrong of me to comment on individual cases, but I will say that where the Crown Prosecution Service is having to deal with complicated and complex issues relating to homicide, resource is never a bar to using the most experienced and senior counsel available, and that of course includes leading counsel.

Time is extremely short, and I want to give the hon. Member for Kingston upon Hull East a minute to respond, but let me say this. With regard to engagement, the most recent survey of employees of the CPS, of which two thirds took part, showed a welcome increase this year of 5%, right up to a figure of just over 59% telling us that morale in the CPS is good. They face significant challenges, but with increased numbers, particularly in the rape and serious sexual offences units, and an emphasis on the prosecution not just of volume cases but of serious sexual offences, conviction rates continue to stay steady and the numbers of people being brought to justice continue to rise, particularly in the important area of violence against women and girls. I could say much more, but I am mindful of the time.

5.29 pm

Karl Turner: I am grateful to the Solicitor General for what he has said, but I am disappointed that he has not been prepared to admit that everything is not entirely rosy in the garden at the CPS. He describes a scenario in which senior people in the CPS in his own area, who indeed instructed him—

Mr David Hanson (in the Chair): Order. I am loth to stop the hon. Gentleman in full flow, but the sitting stands adjourned.

5.30 pm

Motion lapsed, and sitting adjourned without Question put (Standing Order No. 10(14)).

Written Statements

Wednesday 11 January 2017

CULTURE, MEDIA AND SPORT

Leveson Inquiry and its Implementation

The Secretary of State for Culture, Media and Sport (Karen Bradley): The consultation “The Leveson Inquiry and its implementation” closed on 10 January after running for 10 weeks. We know there is a significant level of interest in the consultation and we are grateful for all the responses submitted. The total number of individual responses to the consultation received is estimated to be over 140,000 and a petition estimated to have over 130,000 signatures has also been received.

[HCWS401]

HOME DEPARTMENT

Office of the Immigration Services Commissioner

The Secretary of State for the Home Department (Amber Rudd): On 16 October 2014 the then Home Secretary announced in Parliament, via a written statement,

the commencement of the triennial review of the Office of the Immigration Services Commissioner (OISC). I am now pleased to announce the completion of the review.

The OISC is an independent body that regulates immigration advisers throughout the United Kingdom, ensuring they are fit, competent and act in the best interests of their clients.

The review concludes that the functions performed by the OISC are still required and that it should be retained as a non-departmental public body. The review looked at the governance arrangements for the body in line with guidance on good corporate governance set out by the Cabinet Office. The review also examined value for money, performance, engagement with the regulated sector and efficiency. The report makes 19 recommendations; 10 for the OISC and nine that will be the responsibility of the Home Office to take forward.

The full report of the review of the OISC can be found on the gov.uk website and a copy will be placed in the Library of the House.

[HCWS402]

Petition

Wednesday 11 January 2017

OBSERVATIONS

TRANSPORT

A509 Development Ashton Grove

The Humble Petition of Ashton Grove, Northamptonshire and the surrounding area,

Sheweth,

That the petitioners believe that the development of the A509 as currently proposed should not go ahead due to reduction in safety, the increase to noise and air pollution, and the privacy concerns that raising the road and removing the trees would cause to residents of Ashton Grove.

Wherefore your petitioners pray that your Honourable House urges the Department for Transport to encourage Northamptonshire County Council to reassess their plans for the A509 and amend them in consultation with local residents.

And your petitioners, as in duty bound, will ever pray, &c.—[*Presented by Mr Peter Bone, Official Report, 12 December 2016; Vol. 618, c. 588.*]

[P001992]

Observations from the Secretary of State for Transport (Chris Grayling):

The Government note the concerns expressed by your petitioners regarding consultation associated with the Wellingborough North development also known as Upper Redhill. As you will be aware, responsibility for

consultations associated with planning applications rests with the local planning authorities; in this case the Borough Council of Wellingborough. I understand that the Borough Council consulted interested parties on the planned development at the time.

In view of this the Government have no powers to intervene in this matter, but we have made Northamptonshire County Council aware of the petition and the Parliamentary concern.

In this particular case the development was originally refused by the Borough Council but then considered and permitted by the Secretary of State for Communities and Local Government via a Public Inquiry in 2009. While the plans have been modified, there has been no change to the proposed access arrangements at Gleneagles by way of a traffic signal controlled junction.

The junction was proposed and designed by the developer and found to work appropriately based on the transport assessments associated with the planning applications. The junction design also provides greater connectivity for pedestrian and cycle movements from the development into the existing network.

The Department for Transport has been advised by Northamptonshire County Council that the design complies with national standards and has been subject to an independent road safety audit. Once complete a further road safety audit will be carried out and any further works or alterations arising from that will be undertaken.

Environmental and noise issues arising from the development are matters for the Borough Council as local planning authority to consider. I understand that the Borough Council and Northamptonshire County Council have been in touch with your constituents to discuss their concerns and I would encourage your constituents to raise any remaining concerns with those organisations.

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