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Public Bill Committee

HEALTH AND CARE BILL

Twenty First Sitting

Thursday 28 October 2021

(Afternoon)

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Monday 1 November 2021

The Committee consisted of the following Members:

Chairs: Mr Peter Bone, † Julie Elliott, Steve McCabe, Mrs Sheryll Murray

† Argar, Edward *(Minister for Health)*
† Crosbie, Virginia *(Ynys Môn)* (Con)
† Davies, Gareth *(Grantham and Stamford)* (Con)
† Davies, Dr James *(Vale of Clwyd)* (Con)
† Double, Steve *(St Austell and Newquay)* (Con)
† Foy, Mary Kelly *(City of Durham)* (Lab)
† Gideon, Jo *(Stoke-on-Trent Central)* (Con)
† Higginbotham, Antony *(Burnley)* (Con)
† Madders, Justin *(Ellesmere Port and Neston)* (Lab)
† Norris, Alex *(Nottingham North)* (Lab/Co-op)
† Owen, Sarah *(Luton North)* (Lab)
† Robinson, Mary *(Cheadle)* (Con)
Skidmore, Chris *(Kingswood)* (Con)
† Smyth, Karin *(Bristol South)* (Lab)
Timpson, Edward *(Eddisbury)* (Con)
† Whitford, Dr Philippa *(Central Ayrshire)* (SNP)
Williams, Hywel *(Arfon)* (PC)

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Public Bill Committee

Thursday 28 October 2021

(Afternoon)

[Julie Elliott *in the Chair*]

Health and Care Bill

New Clause 44

Directors of public health

"(1) The National Health Service Act 2006 is amended as follows.

(2) After section 73A, insert the following section—

'73AA Powers and duties of directors of public health

A director of public health appointed under section 73A—

(a) is an officer of the local authority and has responsibility for its public health functions;

(b) must be an NHS consultant in public health responsible for giving independent professional public health advice and for promoting public debate on health matters;

(c) is a corporation sole and NHS body for working with others to initiate measures to improve the health of the people;

(d) is an officer of the Crown responsible for such functions as the Secretary of State may specify;

(e) as an officer of the Crown has power to draw the attention of the Chief Medical Officer and the Attorney General to events within the area of the local authority creating circumstances in which it might be appropriate to bring proceedings in the name of the Crown for public health purposes;

(f) is an officer of the National Health Service responsible for promoting the provision of services which are outcome-focused, are provided following a proper needs assessment and pay attention to the promotion of health and the prevention of illness;

(g) as an officer of the NHS, has power either personally (in the case of a body which primarily serves the population of the local authority which appointed the DPH) or through joint arrangements with other Directors of Public Health (in the case of a body which primarily serves the population of several local authorities) or through a collective arrangement established by the Chief Medical Officer (in the case of a body with a national remit) to appoint, or approve arrangements for the body to appoint, a consultant in public health to serve on the governing body of any NHS body, any NHS Foundation Trust, any of the bodies established under this Act or any of the bodies established under the Health & Social Care Act 2012. For the avoidance of doubt the consultant so appointed may be, but need not be, the Director of Public Health personally;

(h) must be contractually required, subject to law, to carry out the functions in paragraphs (b), (c), (e), (f), and (g) as an independent health professional treating a population as a patient and pursuing the improvement of its health and must be contractually entitled not to be subject to any detriment by the local authority or by the Crown for so doing.'"—*(Alex Norris.)*

This new clause would clarify the roles, powers and duties of directors of public health and put them on a statutory footing.

2 pm

Brought up, and read the First time.

Alex Norris (Nottingham North) (Lab/Co-op): I beg to move, That the clause be read a Second time.

It is a pleasure to resume our consideration with you in the Chair, Ms Elliott. The new clause is in my name and those of my colleagues. If we think about the pandemic and the last 18 months, we will have various views on all sorts of things that have gone on during that period, but I think that one thing that we would be of one mind on is how well our nation's directors of public health have performed in this crisis. They have been incredible, pulling together the local response and bringing to bear their unique combination of training, relationships and local soft power in order to ensure that the local approaches to dealing with the pandemic in aid of the community have been strong ones. I think we would all say that they have done absolutely superbly.

The new clause seeks to codify a little more formally the place of directors of public health in the system. As we are authoring a new system in the Bill, this is no bad time to do that. The purpose of the new clause is to clarify the roles, powers and duties of directors of public health and to put them on a statutory footing. Whatever structures DPHs sit within, their major role—the reason why as a country we need them and why we invest in them as we do—is that they act as an independent advocate for the health of the population, for system leadership and for the improvement of the system for the population. They are already responsible within their area for a broad range of things, such as measurable health improvement, health protection, public health input, planning, commissioning, reducing inequalities and more. There is a strong reason to put them on a statutory footing. They of course provide an independent advisory function for a wide range of organisations, including the NHS. My local DPH is very good indeed. She often reminds colleagues that she is the system's DPH rather than just the local authority's. She may well be hosted by the local authority, but her remit goes much broader, and that is a very good thing. Putting DPHs on a statutory footing would recognise the system leadership role that they have.

The new clause would use a corporation sole model to ensure that directors of public health have scope for independent action; it would ensure that special arrangements are made for them, as officers of the Crown, to bring certain things to the attention of the Attorney General and the chief medical officer, and to ensure public health representation on NHS managing, regulating or commissioning bodies where necessary; and it would guarantee their professional independence in these wider functions. In the vast majority of cases across the country, most of these functions and roles are operating very well indeed, but the new clause would give statutory underpinning to that.

Together, these changes would allow DPHs to have influence across the entire place that they work for and across all policy areas, including budgetary and allocative decisions, and ensure that they have a chance to play their part across all decisions being made in the local community that impact on public health. This proposal would hardwire links between DPHs and the NHS public health workforce who enact public health policy. For place-based officials, having strong links with local and regional NHS employees is not only a benefit but a

necessity. It would help to strengthen our response to health inequalities and hence the prevention of ill health—we have spoken at length about that during these proceedings—as well as enhancing relationships for emergencies, which we have seen in recent months.

Where this is done best, it is a strong model. I know that some directors of public health have consultants within their local NHS trust. That is something that the Association of Directors of Public Health is very keen on. If the Bill and the direction of travel are about an integrated system, those kinds of integrators are a very good model of doing that.

These are critical roles. We have seen that in challenging times, but in more general times, as we push on in order to have a healthcare system that is more preventive, that closes inequality gaps and which delivers excellent services to our population, directors of public health will be really key players in it, so I hope that this attempt to put them on a slightly stronger and more consistent footing will be welcome.

The Minister for Health (Edward Argar): It is a pleasure to see you in the Chair once again, Ms Elliott.

My understanding, in the light of what the shadow Minister has said, is that one of the underlying aims of the new clause is to ensure that the public's health is at the fore as we reform the health and care system. I have the utmost sympathy with that an aim

The Government recognise the importance of a robust public health system that works to improve the health and wellbeing of the nation and to prevent disease. That is why we have taken decisive steps to reshape our national public health bodies so that we are well equipped to face future challenges. Furthermore, we agree that directors of public health and their teams should have a crucial role at the heart of the new system.

The shadow Minister is absolutely right to say that although directors of public health are hosted by local authorities, they represent the whole system, and we owe them a debt of gratitude. In our past lives, he and I would have worked with DPHs in our local authority contexts, and of course, as Members of Parliament, we have all seen what our local DPHs have had to do over the past year and a half. I suspect that Members who did not know their local DPH have probably got to know them and their work in the community a lot better, which is no bad thing.

This fits naturally with the strategic emphasis on population health that we expect of integrated care systems. Both the Department of Health and Social Care and NHS England have set out in published policy and guidance documents our expectation of directors of public health having an "official role" in integrated care systems. Officials in the Department are working closely with the Association of Directors of Public Health and others to help describe further the place of these roles, the outcomes that we hope collectively to achieve, and the ways in which they can best add value to the system's impact on health overall.

Although we entirely understand the motivation behind the new clause, I am not sure that it is strictly necessary. It seeks to clarify the roles, powers and duties of DPHs, but their roles and responsibilities are already clearly and accurately set out in legislation and current guidance. The requirement for the recruitment to the role of director of public health, for example, is already clear on professional qualifications, and the registration and regulation requirements are clearly laid out. The new clause may have the effect of reducing the flexibility of the post, although I am sure that the shadow Minister would say that that concern is unfounded.

Furthermore, the current system already provides independence and influence for directors of public health, and that is strengthened by several provisions in the Bill, which includes, for instance, a duty on ICBs to seek advice from persons with the appropriate expertise on prevention and public health, including directors of public health, complementing the existing duty, in the section 6C regulations of the National Health Service Act 2006, for local authorities to provide the NHS with public health advice.

Additionally, we do not believe it necessary to make directors of public health officers of the NHS, as the Bill already provides opportunities for DPHs to link into and influence NHS bodies in their current guise. Integrated care partnerships, for instance, must develop an integrated care strategy to which integrated care boards must have regard in drawing up their commissioning plans. The intended result is to create a plan to meet the health—including public health—and social care needs of the population within their defined geography. That will provide directors of public health with the opportunity to influence NHS commissioning plans to meet wider public health aims.

It is also possible that the new clause would create a number of undesirable consequences—I suspect that the shadow Minister will allay some of those fears in his response. Rather than bringing clarity, the new clause could create confusion and complexity in a system that is already functioning effectively with a clear understanding of the role and how it operates.

The new clause would put a host of prescriptive new requirements on DPHs, including a requirement for them to be officers of the NHS, NHS consultants in public health, and officers of the Crown, while retaining independence of thought and action.

While we certainly understand the motivation of wanting to knit together the system through an individual post, that approach would add a layer of complexity. I believe that it would be challenging for an individual holding that office to seek to balance those complex responsibilities, accountabilities and potentially competing priorities within various organisations. That would also complicate the lines of accountability

My concern is that the new clause is overly prescriptive about the status and nature of the role, which would go against the overall aims of the Bill in terms of permissiveness. Although we hope and expect that directors of public health will act as a nexus for bringing coherence to the local system's focus on population health, we are not convinced that this level of prescription over permissiveness is appropriate. That reflects a thread of the debate throughout the passage of the legislation on where the appropriate balance should be struck.

Proposed new paragraphs (e) and (h) would weaken the ties that directors of public health have with local authorities. Since the 2012 reforms, there has been widespread consensus that local authorities are best equipped to deal with a wider range of public health matters for their population's needs. In that context, I

[Edward Argar]

pay tribute to local authorities for their role in tackling the pandemic, including those in elected roles. If I recall correctly, the wife and partner of the shadow Minister, the hon. Member for Ellesmere Port and Neston, is active as an elected councillor in a local authority. Many Members of this House will have served in that role, too, and will recognise what local authority councillors and officers do in that space.

From their home in local government, DPHs have been able to maintain an independent mindset while playing a critical role in improving and protecting the public's health. Although it may well evolve in future, that system is working, and we have a strong and solid base that is understood by all system players. I therefore encourage the shadow Minister to continue to work with me and others to make that system work, rather than seeking to press the new clause to a Division.

Alex Norris: I certainly did not intend to add complexity; I was hoping for clarity and consistency. Nevertheless, as the Minister says, those roles are currently functioning effectively, so I will not divide the Committee.

I would say to the Minister and his colleagues, however, that we need a real watching brief on this matter, because assuming that the Bill continues its onward journey and establishes those ICS footprints, there will be a range of different outcomes and organisational cultures. The stronger systems will be those in which the DPHs are at the heart of insight and decision making, and the reverse will be a defining characteristic in systems that are not as good. I certainly hope that we consider the Care Quality Commission reviews that were included in an earlier new clause, and any sector-led improvement, as well as the work those systems do to reflect on what they do and do not do well.

One of the criteria for both streams of improvement ought to be what the DPH does, how central they are, and how sighted they are on decision making. As I have said, in good systems that will be good, and in weak systems it will be weak. Those criteria would be a bellwether of how good the local ICS footprint is. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 45

Duty on integrated care boards to have regard to net zero commitment

"(1) The National Health Service Act 2006 is amended as follows.

(2) After section 14Z43 (inserted by section 19 of this Act) insert—

"14Z43 Duty to have regard to net zero commitment

When procuring or commissioning goods and services on behalf of the NHS, integrated care boards must have regard to NHS England's commitment to reach net zero by 2040.""—*(Justin Madders.)*

This new clause would place a duty on integrated care boards to have regard to NHS England's commitment to reach net zero by 2040.

Brought up, and read the First time.

Justin Madders (Ellesmere Port and Neston) (Lab): I beg to move, That the clause be read a Second time.

It is a pleasure to see you in the Chair, Ms Elliott. I will be brief in speaking to the new clause. What we are seeking to achieve is pretty clear: for integrated care boards procuring or commissioning goods and services on behalf of the NHS to have regard to NHS England's commitment to reaching net zero by 2040.

We can assume that the Government fully support the commitment made by NHS England. We were all transfixed by the goings-on in Committee yesterday, so we may have missed the part in the Chancellor's statement about investment in net zero and in the NHS, but perhaps the Minister will say a little more on that. I suspect that although he will accept that ICBs should have regard to the overall commitment, he will say that the new clause is unnecessary as NHS England already has a commitment that will percolate down to ICBs. We would say that NHS England can achieve that target only by working through ICBs, which will, of course, have the ability to commission more than £100 billion-worth of services.

We may end up yet again in the realms of the permissive versus prescriptive debate, but the power of public sector procurement is a massive issue, and there is no bigger part of the public sector than the NHS, which is the responsibility of the Minister's Department. We should be very much on the front foot in using that to deliver the commitment to net zero.

Of course, we have yet to see what will replace the public contracts regulations in Government procurement as a whole. It is hoped that the same commitment to green issues will be in the mix somewhere, but until we know what that looks like, the new clause presents an opportunity to enshrine in law a commitment that I think most if not all Members want to see delivered.

2.15 pm

Edward Argar: There is no doubt that the climate emergency is also a health emergency. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS.

The NHS accounts for around 4% to 5% of UK emissions, and the hon. Member for Ellesmere Port and Neston is right to highlight the critical role the NHS has to play in achieving net zero. Although I have some sympathy with the intention of the new clause, I remind the Committee of the commitment. The commitment to be net zero by 2040 applies only to NHS direct emissions, such as those from building energy and does not apply to supply chain emissions that are the target of the new clause. While ICBs should and will consider the environmental impact of their procurement, that consideration must go wider than the commitment made by NHS England to net zero direct NHS emissions.

To support that work, NHS England is already leading the way on the agenda through a dedicated programme of work, which includes ambitious targets for achieving net zero for the NHS carbon footprint plus by 2045 and for its direct emissions by 2040. We fully welcome and endorse those ambitions. As part of that programme of work, under the 2021-22 NHS standard contract, every trust is expected to have a green plan. As NHS England has made clear in its guidance on green plans, published in June 2021:

"Every trust and every ICS is expected to have a Green Plan approved by that organisation's board or governing body. For trusts, these should be finalised and submitted to ICSs by 14 January 2022. Each ICS is then asked to develop a consolidated system-wide Green Plan by 31 March 2022, to be peer reviewed regionally and subsequently published."

On the question of procurement, the NHS is already publicly committed to purchasing only from suppliers who are aligned with its net zero ambitions by 2030. Earlier this year, NHS England set its road map giving further details on the expectations of suppliers to 2030. That work is supported by a broad range of additional action on NHS net zero. NHS England will publish the world's first net zero health building standard; it will apply to all projects being taken forward through the Government's new hospital programme, which will see 48 new hospitals built across England by 2030—I can almost see the slightly cynical smile through the hon. Gentleman's mask.

I know the shadow Minister will argue that the new clause would give impetus to the NHS to move towards net zero in the work it is already doing. I am afraid I am not convinced that it is necessary, given the substantial work already under way. The NHS is already showing its commitment, backed up by clear plans.

Justin Madders: I wonder whether the Minister's nickname in the Department is Steady Eddie, given his consistent responses to many of my new clauses and amendments—consistent, but not always correct. It is very important that the commitment is delivered. We are clearly going to have a disagreement about the best legislative framework in which to do that, but I am not going to push this to a vote. It is clearly an issue that all Members are very keen to see delivered.

I am sure that we will debate the new build programme on a number of other occasions—we may get beyond how many new hospitals it is and on to some of the wider issues. It is a matter we will come back to on a number of occasions.

I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 46

EXCLUSION OF NHS BODIES FROM ABILITY TO WITHHOLD INFORMATION REQUESTED UNDER THE FREEDOM OF INFORMATION ACT 2000 ON COMMERCIAL GROUNDS

"(1) Section 43 of the Freedom of Information Act 2000 is amended as follows.

(2) After subsection (3), insert—

'(4) Subsection (2) does not apply to information held by NHS England, integrated care boards, NHS Trusts and NHS Foundation Trusts except to the extent that subsection (5) applies.

(5) Subsection (2) applies to information held by NHS England, integrated care trusts, NHS Trusts and NHS Foundation Trusts relating to another organisation if disclosure of the information would in the opinion of the organisation pose a real and significant risk to the commercial interests of that organisation.'" *—(Justin Madders.)*

This new clause would prevent NHS bodies from withholding information on commercial grounds unless the information related to another organisation and that organisation considered that its disclosure would pose a real and significant risk to the commercial interests of that organisation.

Brought up, and read the First time.

Justin Madders: I beg to move, That the clause be read a Second time.

New clause 46 would amend the Freedom of Information Act 2000. It is a recognition that, as a result of the move to integrated care systems, the whole concept of the NHS being run as individual businesses really ought to go. We have already pointed out in our discussions the apparently contradictory duties placed on NHS bodies in this regard. Some consider themselves as quasi businesses and refuse to disclose their business plans or provide information about their business dealings under the Freedom of Information Act. That makes it difficult for staff to understand the precise nature of proposals. I will come to some examples of that later. I have to say that they take their lead from the Government a bit in that respect. As we are no longer in the era of markets and competition, and NHS bodies no longer have to compete with one another, commissioners really do not need to enter into complicated contractual arrangements. So there is not really the need for them to cite commercial confidentiality as a reason not to comply with FOI inquiries. The interests of trusts, the public and patients should be aligned. They should not be subservient to wider commercial interests.

The Minister may say that this is not an issue, that the NHS is already open and transparent and that everything is sweetness and light in the garden. It certainly should be, but we think there are occasions when that has proven not to be the case. It might also be argued that NHS trusts and foundation trusts have to have some protection from FOI requests so that they can conduct their affairs properly when they are properly engaged in commercial activities such as procurement. That might well be the case, but we can illustrate from the experience of trade union colleagues, especially in the case of contracts for clinical services placed with private providers in the outsourcing of facilities to subcos, that the reality is somewhat different. We often hear that the staff representatives hear that the trust they work for is considering outsourcing some service. Of course, these are the staff who carry out that particular work. Rumours and leaks slip out before there have been any discussions with trade unions, but the trust has already made the decision to outsource and starts talks on TUPE transfers before any real dialogue has taken place.

There is a great deal wrong with that approach, given the requirements that we have talked about previously with regard to the NHS constitution. The point here is that, where management have refused to discuss anything other than the results of a decision that they have already made, staff and trade unions often have to resort to FOI to get answers to the questions they are asking. They put in their FOI request relating to how the trust has made its decision to outsource the service. Then they get the reply, "We're not going to tell you, because it is commercially confidential." I think the fear of trusts is not that a commercial interest is endangered but that its reputation is going to be damaged. They are not confident about negotiations with staff representatives and know that the cases that they have built are painfully weak and will not stand up to rigorous external examination.

Staff, understandably, are anxious and curious because they know that their terms and conditions are often tucked away in the business case under the heading "Savings", which is where the debate really ought to be.

[Justin Madders]

That is why we never get to the truth of these things. So it is not really an issue of commercial confidentiality. It is about refusing to be open and transparent about the true intentions. This has been well documented with the subco sagas. In around 20 cases, trusts had decided to form subcos to deliver facilities management services. We could look at all the tax implications of that and the ducking and diving that follows, but we are not going to do that. We need to point out that in those cases the subcos are fully owned by the parent trust. There is no intention for them to procure anything, because that is what forming the subco delivers. There is no information or collection of details on bids from other organisations. There is no commercial competition aspect to this at all. In many cases, trusts are asked by the staff to provide the business case for going down the subco road and the answer they get back is, "Well, we are not giving you that because it is commercially confidential." The trusts may have at least pretended to look at options, and even scored them, to arrive at the decision they have already made, but why is that process secret? Who would receive a commercial advantage from seeing that information? The trusts might argue that disclosure of the financial case might give the bidders information that they could exploit, but if there is a proper competitive tendering process, that should not be an issue at all. Even if it were, the recourse is to redact the numbers in the one or two places where they are most sensitive. The rest of the business case ought to be disclosed, but that is not what happens.

Let us assume for a moment that the trust has made a strong case, as it will have to do under the new provider selection regime. Will the new regime set out disclosure requirements in respect of business cases and so on? Looking at what NHS trusts do, are they actually put at a disadvantage by having to disclose their business case? We know what will be in those business cases, as the Treasury sets out guidance as to what is required, and most of the cases are about a rationale for change. That should not be a secret, and the old Office for Government Commerce set out guidance that covered how FOI requests were to be dealt with during the various stages of a public procurement. That guidance said clearly that business cases can and should be disclosed.

I will briefly address the wider issue of FOI requests. As the Minister may or may not be aware, I am a regular submitter of FOIs to his Department—indeed, all Government Departments and the wider NHS—and I have to say that over the past few years I have been more disappointed than delighted by the responses I have received. Many are rejected for a variety of reasons. It seems I am not alone in that respect: only this week, openDemocracy issued a new report on FOIs, called "Access Denied", so I think we can all guess what they found. I will run through a few highlights from that report anyway: it said that 2020 was the "worst year on record" for FOI transparency. The Government exploit legal loopholes to deny access to information and, most controversially, the clearing house that openDemocracy reported on last year does not simply advise Departments on their responses, but plays a much more hands-on role, which includes drafting responses to FOI requests. I do not think that is because they want to help Departments to be as transparent as possible, but because they want to help them to avoid revealing the truth. Transparency and a commitment to the principles of freedom of information start at the top with the Department, and it should be leading on this subject.

On a slightly more positive note, there are better examples. There are trusts that work with their staff and even with the wider public and patients. They have open discussions. They do not hide their case; they make their case. If they have to engage in a tender process, they involve staff in specifications, options appraisals and questions to bidders at every stage of the process. If they can do it, why can't every trust do it? The answer is that trusts can wriggle out of their obligations by using these loopholes in the Freedom of Information Act request procedure, and nobody is able to challenge that. It is time that changed, which is why I ask the Minister to support this new clause.

Karin Smyth (Bristol South) (Lab): It is a pleasure to see you in the Chair, Ms Elliott. I rise briefly to support my hon. Friend and echo everything he has said. I have spent a great deal of my time in this place looking at the issue of wholly owned companies, trying to stop them from happening and questioning why they are happening. I think I remember sitting opposite the Minister in an Adjournment debate talking about the excitement of VAT rules and tax exemptions, a subject that is beyond the individual ken of most of us, but once we dig into it we find that the mixed messages the Government gave were not very helpful, and that underlying this problem is the culture of secrecy.

We have alluded to why this is so important: we need the openness provided by agenda meetings and locally accountable people—people we can actually talk to about our health services—and setting that culture from the top is really important. Ultimately, this is about patient safety, because once we have a culture in which there is a presumption of denying information and having to jump through hoops to get it, that permeates the entire organisation. That, sadly, is why we continue to revisit problems with patient safety. This issue is therefore really important, and I hope the Minister will look favourably on the new clause.

2.30 pm

Edward Argar: I can reassure the shadow Minister, the hon. Member for Ellesmere Port and Neston, that I am not aware of how many FOIs he tables, which is possibly as it should be; it suggests that they are handled in the appropriate way by officials, and not by me. I am sure he keeps officials busy with those requests.

I think we can all agree that transparency and openness are of key importance but—this is where the hon. Gentleman and I may diverge slightly in our views—it is also vital that genuinely commercially sensitive information is adequately protected. Section 43 of the Freedom of Information Act recognises the balance that needs to be struck. It exempts from disclosure any information that would, or would be likely to, prejudice the commercial interests of any person, including the public authority holding the information. It is, however, as he will be aware, a qualified exemption. Merely identifying that the information is commercially sensitive is not enough. The public authority holding the information must weigh up the "genuine public interest" arguments in favour of and against disclosure.

I remind the Committee that there is a robust system in place for testing such decisions. We have an independent commissioner who can scrutinise the decisions, who has the right to see the information in question and who is more than capable of challenging public authorities where he believes that disclosure is in the public interest. Beyond that, of course, those requesting the information have a right of appeal to the tribunal.

There genuinely needs to be a level playing field between public and private contractors, but the new clause would, I fear, place NHS bodies at a disadvantage in some commercial negotiations. It could mean that the NHS was not able to protect its commercially sensitive information, whereas other parties could. I struggle to see how an uneven playing field would benefit the general public and protect taxpayers' money. I fear that the new clause would also place a significant additional burden on NHS bodies at a time of real strain and, as I have highlighted, there are already remedies in place that meet its stated aim.

I am also concerned about the power the new clause could place in the hands of those conducting commercial negotiations with the NHS. It would be for them, not the public authority, to decide if and when the release of information would pose a real and significant threat. It is difficult to see how the opinion of the organisation could be tested or challenged through the usual route of appeal, as they would not be a public authority within the scope of the Act. The Information Commissioner's Office would be assessing an NHS body on the basis of judgments reached by a third party. I also point out that

"pose a real and significant risk"

is not a test used elsewhere in the Freedom of Information Act, and so could be open to novel interpretation by the originator of the material. For those reasons, I do not think that the new clause would achieve in a fair way what the hon. Gentleman seeks.

Justin Madders: I am relieved to hear that the Minister is not personally dealing with my FOI requests. I know he is very busy dealing with all the foundation trust applications in his in-tray. He made some fair points about ways in which the new clause might cause unintended consequences, but we wanted to put on record our concern about the way the Freedom of Information Act has been used by some trusts to avoid proper scrutiny. As my hon. Friend the Member for Bristol South said, this is unfortunately part of a pattern in patient safety issues, and that is obviously something we have discussed in this Committee. I will not put the new clause to a vote, and I beg to ask leave to withdraw it.

Clause, by leave, withdrawn.

New Clause 49

PROTECTION OF THE TITLE OF "NURSE"

"(1) A person may not practise or carry on business under any name, style or title containing the word "nurse" unless that person is registered with the Nursing and Midwifery Council and entered in sub part 1 or 2 of the register as a Registered Nurse or in the specialist community public health nursing part of the register.

(2) Subsection (1) does not prevent any use of the designation 'veterinary nurse', 'dental nurse' (for which see section 36K of the Dentists Act 1984) or 'nursery nurse'.

(3) A person who contravenes subsection (1) is guilty of an offence and liable on summary conviction to a fine not exceeding level four on the standard scale."—*(Justin Madders.)*

Brought up, and read the First time.

Justin Madders: I beg to move, That the clause be read a Second time.

This is another Ronseal new clause: it does exactly what it says on the tin—it seeks to create legal protection for the use of the title "nurse". The title "registered nurse" is protected, but "nurse" is not, meaning that, legally, anyone can call themselves a nurse. Under current legislation, people could operate under that title even if they had no nursing qualifications or experience, or had been struck off. To protect the public, the title should be limited to those, such as registered nurses and dental nurses, who are registered with professional regulators. That would put it on a level with other titles, such as paramedic and physiotherapist, which are limited to those on professional registers.

The issue of the title of nurse not being protected in law has long caused concern to the profession. There are many examples where the title has been abused. We have seen people campaigning for election calling themselves nurses when they were not—I appreciate that that is outside the Minister's responsibility, but it shows the power of the title, its significance and the risk we are trying to deal with through this new clause.

Earlier this month, an anti-vaccination campaigner who denies the existence of covid-19 told *Nursing Times* that she planned to continue to call herself a nurse despite having been struck off by the Nursing and Midwifery Council for putting the public at risk of harm. Professor Judith Ellis, chair of the Tropical Health and Education Trust and former interim chair of the NMC, has campaigned for years for protection of the nurse title, and we commend her for her work. She said:

"It is totally unacceptable that when someone in the UK describes themselves as a 'nurse', the patient or their relatives have no way of knowing, or indeed checking, if that individual has the knowledge or skills to safely care for them or their loved ones. The title 'nurse' needs to be protected."

Nursing is the most trusted profession in the UK, yet someone ill or vulnerable could trust a person calling themselves a nurse and that person might be nothing of the sort. NHS England's chief nursing officer, Ruth May, has committed her support to protect the title of nurse in UK law. She said:

"The protection of a professional title provides assurance that someone using that title is competent and safe to practise",

adding that she is

"committed to doing all we can to strengthen protection of the public."

I welcome anything the Minister can say about this issue; I do not know whether the Department is considering it, but I have heard rumours that it might be. We have talked on a number of occasions about patient safety, transparency and openness, and this measure would be entirely consistent with those aims. Can the Minister give us some comfort or confidence that we might be able to make some progress on this important issue?

Dr Philippa Whitford (Central Ayrshire) (SNP): I rise to support what the shadow Minister said. It has indeed been an area of contention for many years not only that

[Dr Philippa Whitford]

nurses who have been struck off can use the title but that the title is used loosely. We touched on the same issue when we talked about regulation and about aesthetic procedures: when these titles of doctor, and particularly nurse, are used the public have a perception of what that means. They assume it means a registered and regulated practitioner, and therefore the patient is given far too high a degree of trust in the person simply from the use of that title. It should be a protected title.

Edward Argar: As has been set out, the new clause would protect the title of nurse by making it an offence for a person to use that title unless they were registered with the Nursing and Midwifery Council. I entirely understand the intention behind that; as the shadow Minister and the SNP spokesperson have set out, a title such as that comes at any time, but particularly after the past year and a half, with an expectation of the qualifications and duty of care that sit behind it, and brings with it trust. Therefore, it is extremely important that that trust is not in any way abused. I am sympathetic to the intent behind the new clause; I know it is something my constituency neighbour the shadow Secretary of State, the right hon. Member for Leicester South (Jonathan Ashworth), has also spoken about in recent weeks.

The title of registered nurse is protected in law but, as the hon. Member for Ellesmere Port and Neston rightly says, the title of nurse itself is not, given its use across multiple professions, including dental nurses, school nurses, veterinary nurses and so on. As the interim chief nursing officer for Scotland has pointed out, the impact of any change on other groups currently using the title of nurse outside healthcare settings would need to be carefully considered. Quite rightly, the interim CNO said that there is an issue, but it needs to be carefully considered and calibrated.

I am sympathetic to the principle that protection of the title of nurse would be seen as a positive step by the profession, stakeholders and the public. I am also aware of concerns about the potential for confusion in this regard, as highlighted by the petition brought forward by Alison Leary, and I can see the benefit in providing reassurance and clarity to patients and professionals. Given the complexities inherent in making "nurse" a protected title, we need to do further work and gather further evidence to better understand the case for change and the potential impact on some of those other perfectly legitimate professions that use the title.

Dr Whitford: I recognise that the term is also used as highlighted—for example, "nursery nurse". However, veterinary nurses and dental nurses are registered professionals, and therefore that is outwith the group we are talking about. I can see that there needs to be discussion around the more social "nursery nurse". School nurses are also nurses.

Edward Argar: They are, but my point was the difference between registered nurses and just using the title "nurse". The question is how, in legal terms, we catch that. I accept the hon. Lady's point that they are all registered nurses. However, we have to make sure that, in drafting, the legislation would not inadvertently catch people who may well be perfectly legitimately registered, as she says, but could potentially be caught if we did not draft or consider the measure carefully.

Dr Whitford: I recognise the importance of drafting, but obviously the new clause is seeking to establish that the title "nurse" could be used only by nurses registered with the NMC, dental nurses and veterinary nurses—so that it could not just be used as a title by someone who is not on the register.

Edward Argar: I go back to the point I made: there are some perfectly legitimate professions—where there is an expectation and understanding of what they do and a respect for what they do—who use that title, as she alluded to. That is why we have to think a little more carefully about how we might do that, and whether it is the most effective way of assuring and enhancing patient safety.

Protection of title is only one part of the protection regime; it is important, of course, but there are other parts. We should also look at prosecutions of protection of title offences, which are extremely rare; we need to look at that in the context of how that might be enforced. Part of the reason for that is the availability of offences such as fraud by false representation that carry more substantial penalties including custodial sentences, which, I suspect, are sometimes the mechanism used to prosecute in such cases. Depending on the context in which the title is used, other legal action could be taken against a person, including criminal proceedings, civil proceedings and employment disciplinary proceedings, particularly where the person used the title to gain work or employment. There is also the opportunity to prosecute employers who hold their staff out to be regulated healthcare professionals when they are not.

To give some succour to the hon. Member for Ellesmere Port and Neston, we are committed to reviewing the protection of titles as part of the ongoing Government review of the regulation of healthcare professionals.

Justin Madders *rose—*

Edward Argar: Just one more sentence, then I will give way to the hon. Gentleman before I sit down.

We need to gather further evidence to better understand the case for change and whether it represents the most effective and enforceable way to promote patient safety. However, I will certainly carefully consider the proposals he has put forward, in that context, as will my colleagues. I have a few sentences left, so I will give way while I can.

Justin Madders: The Minister is sympathetic and has highlighted why the issue needs careful consideration throughout the debate. Are we able to get a formal commitment to public consultation on the issue from the Minister today?

Edward Argar: The shadow Minister pushes me a little further than I can go today. However, what I can say is that I have considerable sympathy with what he has said. I will undertake to look at what he and the right hon. Member for Leicester South have said in the context of that review.

Any subsequent change from that review and from consideration thereof probably sits most effectively, in terms of legislative reform, as part of the reform programme for the Nursing and Midwifery Council, which is most effectively taken forward via secondary legislation under

section 60 of the Health Act 1999. In the context of that review, and any secondary legislation flowing from it under section 60, we will look at what he set out in his new clause.

Justin Madders: I am grateful to the Minister for his positive comments. We were probably pushing our luck with getting a formal commitment from him, but it sounds like we are probably as close as we are going to get to progress on the matter without pushing the new clause formally to a vote. We will keep a close eye on the issue and will, no doubt, come back to it if progress is not made in orderly time. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 50

ACCESS TO INNOVATIVE MEDICINES AND MEDICINAL PRODUCTS REVIEW

"(1) The Secretary of State must undertake and publish a review of the use by the NHS of innovative medicines and medicinal products.

(2) The review must—

(a) conclude before 31 December 2022;

(b) consider ways to improve the use of innovative medicines and medicinal products within the NHS in England.

(3) The review may consider—

(a) the creation of a specific pathway to assess medicines and medicinal products for rare and less common conditions;

(b) improvements to the way in which patient and clinical experience is accommodated when considering the adoption of new medicines and medicinal products."—*(Alex Norris.)*

This new clause would require the Secretary of State to carry out a review of the assessment and use of innovative medicines and medicinal products, and to consider how to improve access to medicines and medicinal products for people with rare and less common conditions in particular.

Brought up, and read the First time.

Alex Norris: I beg to move, That the clause be read a Second time.

The new clause would put a helpful requirement on the Secretary of State to undertake a review of the assessment and use of innovative medicines and medicinal products, which I believe would be a positive step forward. Medical innovation, including new drugs and cutting-edge treatments, produces life-saving and life-changing results, and those benefits are particularly felt by those with rare and genetic diseases.

2.45 pm

We spoke yesterday about a common desire for the UK to be at the vanguard of the development of new treatments, medicines and medical devices. With our world-leading life sciences industry and academia, if we wire that up and back it, we will be world leading in the production of such treatments. We want to be at the forefront of clinical research and medical trials, and the new clause would give the Secretary of State a chance to review and outline how we are doing and what we can do better. It would help the Government because they have a manifesto commitment to allow doctors to

"use the most advanced, life-saving treatments",

so the new clause would be a good way of demonstrating that they are keeping to their commitment.

To help the Minister further because I know he has a lot on, I have a few thoughts on what the review might contain—if I see them tomorrow in a written ministerial statement in this exact form, I will not take that as plagiarism, but will say, "That is a wonderful thing, indeed." There are three principles. First, the review should give patients a greater role in decisions about their care and it should protect clinical decision making in the NHS. Part of that is the opportunity to reduce variation in prescribing across the country. It is critical that patients are empowered to take greater control over their own care. It is about patients knowing what their options are so that they can help make decisions about the medicines they use. Evaluating the use of shared decision making across the NHS should therefore be part of any review of medicines. I am interested in the Minister's reflections on that.

Second, the review could assess whether patients' rights to access NICE-approved medicines were being upheld across the country, and ensure that clinical independence in prescribing decisions was taking place without additional barriers or restrictions being placed on them, particularly around geography. My hon. Friend the Member for City of Durham spoke earlier about the postcode lottery in care. This is another area where we would be keen to know, whether a patient is in the east midlands, the north-east or wherever they are, that they have equitable access to the treatments they need.

Thirdly, and this is what makes it pertinent to what we are considering in the Bill, a review of medicines should also look at the ways in which we can incentivise integrated care systems to drive the uptake of NICE-approved medicines. I am not sure the Minister will be quite as keen on this idea, but we could creatively use annual rebates that come through as part of the voluntary scheme to incentivise and level out regional vacancies. At the bare minimum, it would be helpful and quite illustrative to understand, ICS by ICS, what the uptake is of certain medicines, where the variations are and why those variations occur. If we assume that they would be statistically significant population sizes, it would be very interesting, and we would expect to see certain conditions repeating at a certain proportion of those populations. I think they would tell us some interesting things about who is using what treatments and who is not.

Turning to subsection 3 (a) of the new clause, which relates to rare diseases, I do not know whether the Minister is taking these debates as often as the hon. Member for Bury St Edmunds (Jo Churchill), and presumably now the hon. Member for Erewash (Maggie Throup) in her new role, but one of the great things about Westminster Hall debates is that rare conditions come up a lot. They come up more than they would on a per capita basis, which is a good thing because it shows that hon. Members recognise the profound impact they have on our constituents.

Colleagues always make the point in these debates that by definition, those with any given rare disease are few in numbers, but when we add up all the people with rare diseases, that is quite a big group of people, and I wonder whether we are serving them as well as we could. The definition of a rare disease is a disease that affects fewer than 2,000 people. However, there are 8,000 rare diseases.

Dr Whitford: I wonder whether the hon. Gentleman shares my concerns after leaving the European Union about access for clinicians, and indeed their patients, to the European reference network, which helps to provide advice and treatment and has co-ordinated research, through the European Medicines Agency, into these rare, often childhood, diseases? They can be studied much more easily in a population of 500 million than one of 60 million.

Alex Norris: I am grateful for that contribution. It is axiomatic that, if we are talking about diseases that affect small populations in this country, growing the field of people who are affected so that we can undertake better research, trials and treatment can only be a good thing. I hope that the Minister might touch on how he is ensuring that we are not disadvantaged in that way. When we add up the nearly 8,000 diseases, we are talking about 3.5 million people—one in 17, so one person on the Committee, basically—who will in their lifetime be affected by a rare disease. So actually they are not so rare at all. It is really important that we are meeting that group of people's needs, but access to medicines and medical devices remains a problem, which is why such reporting for rare conditions is so important.

At the moment, approved medicines are available for only 5% of rare diseases and, even where licensed treatments exist, patients can face an uphill battle in accessing them on the NHS. I am sure that most of us will have at least one case of a young constituent who desperately needs medicinal cannabis to treat epilepsy. There is a political consensus that this is the right thing to do, and we ought to do it. That has been a settled matter for at least three years now, but frustratingly it is still not getting through, and that is a pattern across rare diseases. Perhaps that points us to the conclusion that the current assessment process is not quite accounting for the unique challenges presented by rare and ultra-rare diseases.

I do not think that the Minister will want to be drawn on the National Institute for Health and Care Excellence methods review, because we are in that process. I have spoken in multiple debates about my enthusiasm for NICE, and its processes and expertise, but clearly something is missing. My working theory is around evaluation. Again, if we have a small patient population, the data is noisy and there are higher degrees of uncertainty due to the small sample sizes. That leads us nicely to the point that the hon. Member for Central Ayrshire made about trying to grow those pools. At the moment, we are unable to get first-in-class treatments in many cases, which we should want to do something about.

Herein lies the squeeze, as the medicines for rare and ultra-rare diseases are often assessed by processes that were designed for drugs with larger target populations. The statistics are a bit of an apples-to-oranges comparison, which creates a severe disadvantage. The purpose of the new clause is to get the Secretary of State to report generally on how we are ensuring that we are world leading and meeting population need, and then to drill down within that on how we are ensuring that the system for rarer conditions is fit for purpose. As I say, I am conscious that the methods review is ongoing, but I hope that the Minister might at least give us a sense of the general policy direction in this area, and what we might look to do differently in the future.

Edward Argar: I am grateful to the shadow Minister for this discussion. I reassure members of the Committee that the Government remain absolutely committed to ensuring that UK patients, including those with rare diseases and less common conditions, have access to the most promising medicines and medicinal products. Hon. Members raised some important points, which I will seek to address in my broader response to the new clause.

The first part of the new clause asks the Secretary of State to undertake and publish a review of the use by the NHS of innovative medicines and medicinal products. We have existing reporting tools at our disposal to monitor that. Indeed, NHS Digital publishes a bi-annual report on the use of innovative medicines by the NHS in England, known as the innovation scorecard. The latest publication from June 2021 shows that uptake of over 70% of the NICE-approved medicines reported in the scorecard has increased over the past 12 months. I can assure the Committee that we are committed to further strengthening these innovation metrics and to improving our understanding of the use of innovative medicines and medicinal products in the NHS.

The accelerated access collaborative—the umbrella organisation overseeing the health ecosystem—is also continuing to develop the AAC scorecard that monitors the impact of the programmes, and is scoping the development of an overarching innovation metric.

In the second part of the proposed new clause we seek a review to consider ways to improve the use of innovative medicines and medicinal products in the NHS in England. As I am sure right hon. and hon. Members will be aware, the accelerated access review, an independent review published in 2016, set out detailed recommendations to increase the uptake of proven and cost-effective new treatments and technologies in the NHS. The report identified several strategic barriers to UK health innovation, including fragmentation across the system, alongside a lack of horizon scanning and insufficient commercial flexibility in NHS England.

Following publication of the AAR, the Government, the NHS and partner organisations have worked closely together to increase the use of proven and cost-effective medicines. The Government established the accelerated access collaborative to bring together leaders from across the life sciences sector to tackle the barriers to the adoption of innovations in the NHS. It is delivering real success. Last year alone it helped over 300,000 patients to access proven innovations, resulting in 17,000 fewer hospital admissions and 140,000 fewer days spent in hospital, delivering more than £100 million of savings for the NHS. That is thanks to AAC programmes, such as the rapid uptake products programme, which offers bespoke support to NICE-approved innovations to address the systemic barriers that inhibit their widespread use across the NHS, and the early-stage support programme, which supports categories of new, potentially highly effective products that need support through the regulatory and approvals process.

However, the Government acknowledge that there is more we need to do to tackle unwarranted variation in the uptake of clinically proven and cost-effective treatments. This is why we recently published our ambitious life sciences vision, which was co-developed with industry following extensive engagement with stakeholders from charities, patient interest groups, the NHS and the

devolved Administrations. The vision lays out our priorities to improve the use of cost-effective innovation, including new medicines and medicinal products within the NHS, with a particular focus on identifying and addressing any unwarranted variation in uptake. The AAC will continue to be at the forefront of that agenda, and work is under way to consider how to best utilise regional, local and frontline delivery partners to support the adoption and spread of proven innovations.

It is important to note that there are already mechanisms in place to assess and support medicinal products for rare and less common conditions. The innovative licensing and access pathway—ILAP—brings together the Medicines and Healthcare products Regulatory Agency, the National Institute for Health and Care Excellence, the NHS and the devolved Administrations to provide tailored, joined-up regulatory and access guidance to businesses. The scheme began operating in 2021, and over 50 applications for innovative medicines have been received so far.

NICE also plays an important role in ensuring that patients have access to promising new innovations, including for patients with rare diseases. Through its technology appraisal and highly specialised technologies programmes, NICE makes recommendations for the NHS on whether new medicines represent a clinically effective and cost-effective use of NHS resources. Where NICE makes a positive recommendation, NHS England and Improvement and clinical commissioning groups are under statutory obligations to fund the technology. It is our intention to extend that obligation to integrated care boards.

Patients with rare diseases are already accessing effective innovations through the NICE programmes. For the drugs for rare diseases—known colloquially as orphan drugs—appraised since 2013, 87% of NICE's technology appraisal recommendations and 100% of its highly specialised technologies programmes recommendations were positive. That is a significant and positive outcome for patients. However, I am aware of the long-standing challenges, which were alluded to by the hon. Member for Nottingham North, where evidence relating to a medical technology is uncertain. That is a particular challenge regarding rare diseases where, as he said, the population is small.

3 pm

To address this, NICE and NHSEI have developed managed access agreements to enable earlier access to these promising treatments while further evidence is collected to address the clinical uncertainty. That has included a deal for Zolgensma, a new and potentially curative one-off gene therapy for babies with the rare genetic disorder spinal muscular atrophy. NHSEI continues to utilise its sophisticated commercial capabilities to negotiate deals with industry that give patients access to the most innovative new medicines and ensure the NHS gets the best value.

Hon. Members will also be aware of the Government's manifesto commitment to extend the successful cancer drugs fund into an innovative medicines fund, which will ensure equal potential for cancer and non-cancer patients, including those with rare diseases and less common conditions, to benefit from early access to the most promising new medicines.

NHS England has been working in partnership with NICE to develop proposals for the innovative medicines fund and expects to lead a public consultation in the coming weeks on detailed proposals for the operation of the fund. NICE is undertaking a comprehensive review of its methods and processes and is considering its approach to managing uncertainty as part of this. NICE is also considering the role of patient and clinical expertise in its health technology assessments as part of the review, and it recently consulted on a range of proposed changes. It is too soon to comment on the final changes that NICE will implement, but I would reassure the Committee that NICE will carefully consider stakeholder responses in developing its final methods and processes manual.

The Government published the new United Kingdom rare disease framework in January 2021, outlining the key priorities for rare diseases in the UK over the next five years. One priority area, identified through the national conversation on rare diseases, is to improve access to specialist care, treatments and drugs. Development of nation-specific implementation plans for this priority are under way across the four UK nations and will involve further engagement with the rare disease community. I believe these are the right steps to take, and I therefore encourage the hon. Gentleman not to press his new clause to a Division.

Alex Norris: I am grateful to the Minister for his full answer. He mentioned reviews around the innovative medicines fund and NICE methods, and it is probably wise for us to let those processes play out before looking at anything else, so I do not intend to press the new clause to a Division. However, I will leave the Minister with some final thoughts on NICE methods.

First, I hope there will be a parliamentary moment for us to engage with that and have those conversations. The process has independence for a very good reason, but we should still have views on its overall direction. I want to flag ahead of that—with a focus on combination therapies, particularly in the cancer space—that we are understanding better every day how different therapies used together can have an incredible aggregate impact on the individual.

I do not think it is breaking any great state secrets to say that the problem is that the way we pay for drugs in this country is an imperfect market. Do not get me wrong; it has found a balance, but one problem is that the treatments are—funnily enough—often priced to what we can afford to pay for. That is fine until we need to combine two different treatments from different providers, when it becomes really challenging to work out how to apportion that. If we are to achieve the innovations that we need, particularly in cancer, we will need a good answer to come out of that review.

I hope that the Minister has a watching brief on that review, and that when NICE has finished, we can have a good conversation about the outcome to ensure that it supports the goals that I think we all have. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 51

DUTY ON INTEGRATED CARE PARTNERSHIPS TO PREPARE AND DELIVER A BEST START FOR LIFE STRATEGY

"(1) The Local Government and Public Involvement in Health Act 2007 is amended in accordance with subsection (2).

(2) After section 116B (substituted by section 20 of this Act) insert—

'116C Duty on integrated care partnerships to prepare and deliver a Best Start for Life strategy

(1) Each integrated care partnership must—

(a) assess the needs of expectant parents, infants and young children in its area;

(b) prepare and publish a strategy to improve outcomes and reduce inequalities among expectant parents, infants and young children;

(c) consult parents and carers in the area when developing the strategy;

(d) monitor and evaluate the effectiveness of the strategy.

(2) Local authorities, NHS bodies and other relevant partners must—

(a) cooperate on delivering the strategy;

(b) have regard to the strategy when exercising their functions.'"—*(Alex Norris.)*

This new clause would require each Integrated Care Partnership to prepare and deliver a "Best Start for Life" strategy, in cooperation with relevant bodies.

Brought up, and read the First time.

Alex Norris: I beg to move, That the clause be read a Second time.

I cannot quite remember on what day this new clause was submitted; it is towards the end of the new clauses but not at the very end, so that probably carbon dates it by 10 days or so. Nevertheless, we had some news in this space from yesterday's Budget. We are in the strange situation of having seen effective early intervention services, such as Sure Start, take a clobbering for a decade, and then getting paid back pennies on the pound and being supposed to feel grateful for it. We are not. Nevertheless, there needs to be a commitment at all levels of Government and local government—and, in this case, integrated care boards—to have a real focus on early years.

The first 1,001 days of a child's life, from conception to age two, are crucial. Getting things right in this period can determine what kind of life a child has and their health, wellbeing, cognitive function and psychological make-up. During those early years, a baby's brain grows rapidly, and it doubles in size within the first year of life. As is so well established, child development is influenced by early experiences and environment, which means that it is so important to ensure that little ones in our communities get what they need—care, nurture and support—while ensuring that they are protected from neglect, harm and stress.

As the Government's strategy in this space recognises, getting things right impacts not just on the lives of our children, but on our entire society. By ensuring that children get what they need at an early age, we can target some of the big issues that we have talked about for the last two months in this Committee: physical and mental health issues, pressures on the NHS, crime and antisocial behaviour, and drug and substance abuse. So much of that leads back to the early stages in life, and this is a matter of established science. There is no doubt that in this country, we are not very good at doing something about that. Six months or maybe even a year ago—time flies—we had a fantastic Westminster Hall debate, led by the right hon. Member for South Northamptonshire (Dame Andrea Leadsom), who chaired a very good review in this space.

There is barely a leaf's width of disagreement on this issue between right hon. and hon. Members of all political persuasions. The common diagnosis for why we have not made more progress is that we know that such things save public services money in a generation's time, but we cannot demonstrate that in a cashable savings way that passes Treasury processes. I am afraid that I did not see anything yesterday to suggest that that fight is yet being won, and I hope the Minister and his colleagues are doing everything in their power to argue for early interventions. Frankly, I would argue that for pretty much all Members present, the bulk of the returns will come when someone else is sitting in our seats and our roles are somebody else's dreams, but that should not stop us acting, because it is so significantly in the national interest and in the interests of our communities.

There are huge inequalities. The most basic health statistic is that a child born in my city will live for seven fewer years than one born in the City of Westminster—never mind the yawning chasm of almost twice that in healthy life expectancy. That is the result of smaller inequalities that all add up to different life paths: family income, financial stress, smoking and alcohol use, and access to care and services. We know that the 1,001 critical days from conception are the moment to offer really good-quality support. Families receive support from a wide range of services, including maternity, health visiting and early years, and perhaps children's social care, mental health and paediatrics.

As well as the inequalities, there is complexity. I have mentioned five different organisations with five different uniforms, five different organisational plans and five different organisational cultures. Someone has to pull that together. We have been told throughout proceedings on the Bill that that is exactly what integrated care partnerships are here to do, so let us put a responsibility on them to do so, and to have a plan. I dare say—the Minister might say this himself—that they are more than likely to want to do that themselves, and that would be a very good thing, but I do not think we can allow variance. This should be important for everybody and all footprints should be doing it, so that the first 1,001 days are given priority in new health systems. That would have a significant impact on the long-term health and wellbeing of our country.

Dr Whitford: I rise in support of the new clause. It is important to shift the narrative from what is often a structural focus on the NHS, and catching people when they fall, to looking at wellbeing and population to allow people to be healthier and live higher-quality lives for longer.

The hon. Member for Nottingham North mentioned the slowing down of improvement in life expectancy and the variation in life expectancy, but the bigger issue is the failure to improve healthy life expectancy. The 20 years of unhealthy life expectancy faced by many across the UK, particularly in more deprived areas, put pressure on the NHS, and we have seen that come home to roost over the last decade.

A lot of those health issues, or unhealth issues, are laid down in childhood. I am vice-chair of the all-party parliamentary group for health in all policies, which conducted an inquiry into the impact of child poverty. A figure from the Faculty of Public Health that has

stayed with me is that the UK loses 1,400 children a year as a direct result of poverty, including by immature birth, small birth weight, foetal alcohol syndrome, fires, road traffic accidents, alcohol and drugs, violence and suicide. That is the number of students in a large secondary school, and if the roof of a large secondary school were collapsing every single year, we would do something about it.

Often, the time to do something about that is in the 1,001 days from conception forward, as the hon. Gentleman said. That means looking at maternal health and nutrition, which is why the early years collaborative in Scotland led to the Best Start grants to mothers and children at birth, on entering nursery and on entering school.

One internationally used measure on the health of our youngest children is infant mortality—death perinatally or in the first year. In 2014, England and Scotland had the same rate of 3.6 per 1,000 live births. In Scotland, we have managed to drive the rate down to 3.2, but in England, it is currently at 3.8. In some poorer areas of the UK, the rate is worse than in parts of the global south and the developing world. That is a brutal statistic.

We talked yesterday about maternal and infant deaths, but this also relates to the attainment gap and other issues faced throughout life by those who struggle in childhood. Investing in early years saves money in the long term. That might be the pitch to the Treasury: if we gave more children a decent start in life, fewer would struggle in the education system, fewer would struggle to get jobs, and fewer would be trapped by addiction or caught in the criminal services system. Instead of picking up the pieces later through the NHS or other public services, surely we should be investing in the best start in life for all our children.

Edward Argar: We believe that the creation of integrated care boards and integrated care partnerships represents a huge opportunity to support and improve the planning and provision of services to ensure that they are more joined up and better meet the needs of expectant parents, parents, infants and young children.

We acknowledge that new clause 51 is intended to ensure that the needs of expectant parents, infants and young children are expressly considered by ICBs and ICPs through the development of a tailored strategy. We are working on bespoke guidance, which will set out the measures ICBs and ICPs should take to ensure that they will deliver for babies, children and young people. That will cover the importance of the ICP integrated care strategies having measurable objectives for babies, children and young people.

The strategy must also set out how assessed needs for the area are to be met. The Department is working with NHS England and NHS Improvement and the Department for Education on the drafting of this bespoke guidance, and we will work with stakeholders in the upcoming months on refining the guidance prior to publication.

As per our general approach to the Bill, although we are clear about the statutory functions that will be conferred on ICBs—as they are currently on clinical commissioning groups—including on children's safeguarding and special educational needs and disabilities, when it comes to implementation, we want to provide local areas with the flexibility to determine what will work best for their systems. We fear that over-prescribing system approaches in the Bill will make it harder for systems to design the approaches that will work best in their areas. That is why we believe the wording, as currently drafted, is appropriate.

3.15 pm

Alex Norris: The point that the hon. Member for Central Ayrshire made about the UK losing 1,400 children a year is sobering. Whatever comes out of the process that the Minister mentioned must to be different from what we have today, or we will keep repeating that mistake. I shared the hon. Lady's view about the pitch to the Treasury, but we will have to demonstrate that planning cycles in this country are mature and flexible enough to reflect the fact that not everything can be delivered, and show immediate returns, before the next general election. It is a challenge, and we will have to do better in that space. I am grateful for the Minister's response, and he addressed my concerns very well. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 52

PLAN FOR IMPLEMENTING RECOMMENDATIONS OF THE INDEPENDENT MEDICINES AND MEDICAL DEVICES REVIEW

"The Secretary of State must, within six months, publish a report containing a plan for the implementation in full of the recommendations of the Independent Medicines and Medical Devices review that have hitherto not been implemented." *—(Alex Norris.)*

This new clause would require the implementation of any remaining recommendations from the IMMDS report.

Brought up, and read the First time.

Alex Norris: I beg to move, That the clause be read a Second time.

In February 2018, the noble Baroness Cumberlege was asked to carry out the independent medicines and medical devices review into the experiences of people—generally women—who had been treated with Primodos, sodium valproate or pelvic mesh implants. In very many cases, they had to battle for decades to be heard. They were gaslit, belittled and ignored at every turn. Some of the ways in which they were treated were just astonishing, and so upsetting. However, through that report they got their deliverance. They were vindicated: what they said had happened to them had happened to them—even though they had not been believed—and it should not have done. Acknowledging the pain that had been caused to these families was a big start in helping them come to terms with what they had experienced.

The excellent review team set out nine ways in which things would be made better, or at least a little bit easier, for those people now, and to try to prevent future incidents. Those nine recommendations should have been accepted in full. Instead, we have seen from the Government a pattern of accepting things that I suspect they were already keen to do, but otherwise taking the families for a long walk when it comes to the harder and more significant things that the Government clearly do not want to do. In aggregate, it has become a refusal to do right by these families, and that is a really poor decision.

[Alex Norris]

This new clause seeks to attend to that by saying that within six months, the Secretary of State must publish a report containing a plan for the implementation of the recommendations in full. Of the nine, only four are being implemented in full and, frankly, that is not good enough. I am pleased that there has been an apology, and the families were too. I was also pleased to see legislation for a patient safety commissioner. We were lucky that the Medicines and Medical Devices Act 2021 was in front of us at that time, because it gave us a moment to introduce that and a devices database, which the hon. Member for Central Ayrshire and I pursued during proceedings on that Bill. Those things have a bit further to go, but they were significant, as were the promises of cultural reforms at the Medicines and Healthcare products Regulatory Agency. We will wait to see meaningful change there. With the remaining five recommendations, there has been a mixture of in-principle acceptance, partial acceptance and, in some cases, outright denial. I do not think that is good enough, and the new clause seeks to change that.

These are the bits that we are still missing. Recommendation 3 calls for:

"A new independent Redress Agency for those harmed by medicines and medical devices".

The Government responded that they did not accept that. The problem is that families are therefore left to rely on conventional civil and legal routes. Those are expensive and long, and who do the families sit against in the courtroom? Very big companies with very big legal teams, so there is a significant imbalance. The whole point is that, as recommendation 3 goes on to state:

"The Redress Agency will administer decisions using a non-adversarial process with determinations based on avoidable harm looking at systemic failings, rather than blaming individuals."

That would have been really significant, but we do not have that. Instead, families are left stuck in the court system for as long as they can stick at it.

Recommendation 4 states:

"Separate schemes should be set up for each intervention—HPTs, valproate and pelvic mesh—to meet the cost of providing additional care and support to those who have experienced avoidable harm and are eligible to claim."

Again, the Government do not accept that. These families meet exceptionally challenging needs day after day. Some have lost their house; some have had failed relationships; and all struggle with mental health, or certainly distress, as a result of what has happened, and we are not doing enough to help them. This should have been done, if not on day one, at the very first possible moment for support, rather than us expecting them to fall back on the conventional system, as they did. What have they gained by their vindication?

Recommendation 5 states:

"Networks of specialist centres should be set up to provide comprehensive treatment, care and advice for those affected by implanted mesh; and separately for those adversely affected by medications taken during pregnancy."

The Government accept that only in part; it is particularly with regard to valproate that those affected will not get those centres. I will listen carefully to the Minister's justification for that. I understand that valproate is different, in the sense that its use is ongoing in certain situations where that remains medically appropriate. However, the lack of specialised knowledge is a real issue. If there is not specialisation, we need a real sense that there is a universal step change in knowledge and experience in this area to give us greater comfort.

Recommendation 8 states:

"Transparency of payments made to clinicians needs to improve. The register of the General Medical Council (GMC) should be expanded to include a list of financial and non-pecuniary interests for all doctors".

That is very basic. There were relationships between clinicians and big drug companies that were unknown to the families when certain treatments were suggested. The Government accept the recommendation in principle, but will not use the General Medical Council model, preferring to go practice by practice. That is big mistake. Our constituents can go to one easy, obvious place—our website—to find out our exact financial interests if they have concerns or just want to know them. We ought to be able to do the same, through the GMC, when it comes to doctors. Again, there is an unwillingness to move quickly enough to resolve these issues.

Finally, it remains surprising that the Government have not availed themselves of recommendation 9. I will listen carefully to the Minister's response on this point. It states:

"The Government should immediately set up a task force to implement this Review's recommendations. Its first task should be to set out a timeline for their implementation."

Of course there should be a taskforce, including families and the broader aspects of the state, to do that. Again, the Government say they accept the recommendation in part, but the reality is that they have no plans to establish an independent taskforce. There is a patient reference group, and we of course support its work, but it is not in control; it is not at the table. The problem is that these things were done to families; they had no agency and no say. The solutions that come out of this cannot follow that same model. Once again, families are having things done to them, rather than being worked with.

I meet representatives of these groups frequently, as I know colleagues do. I like meeting them. These are good people who have been through incredible things and have extraordinary dignity and courage, not to mention that they are brilliant campaigners. They are probably sick of seeing me, and I would rather see them in happier circumstances. When I ask them what is next, they say that they are campaigning again. They campaigned over many years to be listened to, and were proven right in the most absolute terms, but they feel they have to campaign again to get the justice that should flow from that report and from their vindication. What an extraordinary demonstration of how we have let them down. They fought for too long. It is time that we stood up for them and did right by them by implementing the recommendations in full; otherwise we fail them again. I hope to hear of significant progress from the Minister.

Dr Whitford: I support the new clause. For a surgeon, knowing that an operation that they were trained to carry out, and performed in good faith, has caused harm is one of the worst things that can happen. I remember how I felt in the mid-1980s when we began to realise the impact of contaminated blood. It had a huge impact on how I operated. I used special diathermy

techniques to avoid blood transfusion in all elective circumstances, and that is something I carried on throughout my time doing breast cancer surgery.

In this case, there may well have been doctors who were dealing with device companies and so on—that regulatory declaration is absolutely needed—but there will be a much greater number of surgeons who were using a device that was licensed and was given to them as the correct, safe device to use.

I find it shocking that although the report was commissioned by the Government, they have accepted fewer than half of its recommendations. The others directly relate to patients who have suffered harm, whether that is the women who had vaginal meshes inserted, or the mothers of children who were harmed by the use of Primodos or sodium valproate.

Sodium valproate is still an excellent anti-epileptic and will not disappear, but it is not a matter for specialist centres. It is so widely used that it is critical that within primary care and on product boxes it is made clear that women who are looking to conceive or who are of child-bearing age should not be left on Epilim; that should be discussed with them right from when they are young teenagers, so they can think about the impact later on.

The recommendations that have not been accepted are not to do with reorganising licensing, or a yellow card system; they are all recommendations that relate to women. That is really disappointing. The redress for them—the setting up of specialist centres to try to repair the damage as far as possible—is what is not being provided. The Government should look at the fact that those are the recommendations they have skirted around and not accepted. These women and the children affected have gone through enough.

Edward Argar: It is quite right that we articulate once again the suffering that was the genesis of the review. The hon. Members for Nottingham North and for Central Ayrshire spoke with passion on the issue. We are talking about procedures that had a dreadful impact on individuals and their families.

The Government recognise the effect that the independent medicines and medical devices safety review, and the lived experiences behind it, has had on all the women and children impacted, and their families. That is why, on the day after the review was published, the Government issued a full and unreserved apology on behalf of the health and care sector for the time it took to listen and respond.

I am grateful to Baroness Cumberlege for all the time and effort she put into her report. As hon. Members will be aware, that sentiment was expressed at the time by the Minister responsible for responding to the report, who is now of course the Secretary of State for Digital, Culture, Media and Sport.

The Government published our response to the review on 21 July this year, after carefully considering each of the review's nine strategic recommendations and the 50 actions for improvement in greater depth. Our response set out an ambitious programme for change that, at its core, is focused on improving patient safety.

The Government accepted the vast majority of the strategic recommendations and actions for improvement. I reassure the Committee that we are committed to making progress on all accepted recommendations at pace. That is why, in our response to the review, we committed to publishing an update on our progress in implementing the accepted recommendations 12 months after the initial response. I know that hon. and right hon. Members from across the House will rightly vigorously continue to hold the Government to account on that. I reassure them that the Government take very seriously our responsibility to implement the accepted recommendations at pace.

Many of the recommendations will introduce large-scale changes to patient safety, and we have a duty to get their implementation right. I hope it will encourage hon. Members to hear that the Government have already made strong progress on implementing many of the accepted recommendations of the review. I will turn to those in more detail, because I think it is important that we update the Committee and the House.

3.30 pm

Recommendation 2 called for the appointment of a patient safety commissioner. I am pleased to say that, through the Medicines and Medical Devices Act 2021, we have legislated for the establishment of that commissioner. A consultation on the proposed legislative details of the appointment and operation closed in August 2021. The responses from this consultation will feed into the drafting of the detailed regulations on the appointment and operation of the commissioner. A campaign to fill the position is due to be launched later this year. It will be in line with the public appointments process, and we expect to appoint the Commissioner in the first half of 2022.

Recommendation 5 called for the establishment of specialist centres for those adversely affected by implanted mesh. Rapid progress has been made, and as of April 2021 there were eight specialist centres in operation across England to provide comprehensive treatment, care and advice for women affected by implanted mesh. Good progress is being made towards the establishment of a regional service with a south-west provider to ensure patients across the country can access these vital services.

Recommendation 6 highlighted the need for the Medicines and Healthcare products Regulatory Agency to undergo substantial revision, particularly in relation to adverse event reporting, medical device regulation and patient engagement. The MHRA has initiated a substantial programme of work to improve how it listens and responds to patients and the public, to develop a more responsive system for reporting adverse incidents, and to strengthen the evidence to support timely and robust decisions that better protect patient safety.

Recommendation 7 called for the establishment of a central patient-identifiable database that would collect details of the implantation of all devices at the time of the operation. The Government welcomed this recommendation and have legislated for a patient-identifiable database in the Medicines and Medical Devices Act 2021, which creates a power for the Secretary of State to regulate for the establishment of a UK-wide medical device information system, known as MDIS. As required by the 2021 Act, the Government are planning to hold a public consultation on the MDIS regulations, and aim to lay the regulations before Parliament

in due course; that will be subject to availability of parliamentary time and the agreement of the usual channels.

The first part of recommendation 8 highlighted the need for greater transparency on payments made to clinicians. The recommendation called for a register of doctors' interests, including financial, non-pecuniary and clinical interests, and recognised and accredited specialisms, to be held by the General Medical Council. Our response goes further than the review's recommendation by ensuring that this regulatory requirement applies to all registered healthcare professionals, not just doctors. The Government believe that publications of interests should be held by healthcare providers at the local level, not the General Medical Council. The shadow Minister has set out eloquently, as always, why he does not agree with that. While we do not agree, I respect his integrity. He knows his mind and has studied these issues very carefully, particularly through his work on this report. Our view is that our approach is more appropriate because patients know where healthcare professionals work and are more likely to seek information from the organisation that provides their treatment and care.

Over the coming year, as we approach that update, we will continue to work with professional regulators, NHS England, NHS Improvement and independent providers to monitor implementation.

The latter part of recommendation 8 calls for mandatory reporting for the pharmaceutical and medical device industries of payments made to teaching hospitals, research institutions and individual clinicians. We agree with the need for greater transparency. As in the case of doctors' interests, it is important that information be published and easily accessible for patients. We are therefore exploring options to expand and reinforce current industry schemes, including making reporting mandatory through legislation.

I appreciate that the objective of the amendment is to hold the Government to account for implementation of their response. The Government have already committed to publishing an update on implementation; we intend to do that by summer 2022. I believe that significant progress on the recommendations has been made, but I am conscious that the shadow Minister, with his depth of knowledge in this area, may wish to press further in the coming months. I suspect that he will rightly continue to hold the Government to account.

Alex Norris: I am grateful for colleagues' contributions. The comments of the hon. Member for Central Ayrshire presaged what the Minister said: yes, the Government have been able to do the more strategic aspects of this, but they have done half a job. The half they left out relates to people who have fought for so long just to get a little support, and recognition that they have been badly wronged in a way that significantly changed their life. They really do not ask for much—just a bit of support. It is not a nebulous or open-ended ask; it is just for what was in the report, and that does not seem too much to me.

The Government have been in defensive mode for a long period on this issue, but I desperately hope that they do not think they have done the job, because they really have not. I also hope that they do not think these women will go away, because they absolutely will not, and a lot of right hon. and hon. Members in this place want to help them and give them a platform from which their voices will be heard. A good way to act would have been through the new clause. With that in mind, I intend to press it to a Division.

Question put, That the clause be read a Second time.

The Committee divided: Ayes 6, Noes 7.

Division No. 44]

AYES

Foy, Mary Kelly	Owen, Sarah
Madders, Justin	Smyth, Karin
Norris, Alex	Whitford, Dr Philippa

NOES

Argar, Edward	Double, Steve
Crosbie, Virginia	Gideon, Jo
Davies, Gareth	
Davies, Dr James	Higginbotham, Antony

Question accordingly negatived.

New Clause 53

WOMEN'S REPRESENTATION IN REPRODUCTIVE HEALTHCARE PLANNING

"(1) The National Health Service Act 2006 is amended as follows.

(2) After section 14Z42 (inserted by section 19 of this Act) insert—

'14Z24A Duties regarding reproductive healthcare planning

Integrated care boards, when making policy decisions regarding the delivery of reproductive healthcare, must—

(a) conduct regular and ongoing consultation to ensure that women are meaningfully involved in, and inform these decisions; and

(b) work in partnership with non-profit sector partners and local community groups with existing expertise in this area.'"—*(Alex Norris.)*

This new clause ensures that women, and partners with relevant expertise, are involved in ICB decision-making related to reproductive healthcare.

Brought up, and read the First time.

Alex Norris: I beg to move, That the clause be read a Second time.

The new clause is a fitting follow-up to new clause 52, in the sense that the theme of the report was that, yes, dreadful things happened, but—as the hon. Member for Central Ayrshire said—largely with a complete lack of knowledge among clinicians, who were just following the guidelines, as they were supposed to and had been trained to. A common theme beyond that is that this happened to women, and when women tried to express their concerns, the system was not geared up to listen. Instead, the response of the system was to write them off—some of the name calling will probably not amaze us, but it should.

The new clause seeks to ensure explicitly that local care boards take into account the views of women on reproductive health. High-quality reproductive healthcare should be accessible and individualised at each stage of a woman's life, from puberty and through the years of menstruation to the menopause and beyond. This is

something that we will discuss tomorrow through the private Member's Bill of my hon. Friend the Member for Swansea East (Carolyn Harris). She will put the case well, I have no doubt.

The system should enable women to decide whether, when and how often to have children by informing them about, and providing easy and timely access to, the full range of contraceptive methods. Maintaining good reproductive health and wellbeing has profound and positive long-term effects for women and wider society. However, at the moment, inherent system fractures in the commissioning and delivery of reproductive healthcare services mean that many women are left struggling to access basic reproductive care, including contraception and gynaecological cancer screening.

The impact of the current situation is stark. Almost half of British women have experienced poor sexual and reproductive health, and that figure should give us pause. We know that since the Health and Social Care Act 2012—again, this is something in that Act that we should want to change—reproductive healthcare has been compromised by a lack of strategic prioritisation and prevention, a deeply fragmented commissioning landscape, and of course that ongoing theme of significant cuts to public health, which in this case include a 14% real-terms reduction for sexual and reproductive health services. Again, that has been felt more by poorer communities, and all those factors have resulted in gaps in the reproductive care pathway, creating disconnected and disjointed care for women. For example, in many areas of the country, women are not able to access a fitting for an intrauterine device—one of the most effective contraceptive methods—or cervical smear tests in a similar healthcare setting, meaning that they have to go through multiple invasive exams in different settings. Of course, it is important that those tests take place, but we should seek to make it the easiest process that it can possibly be.

Women approaching the menopause are not able to access treatment for heavy menstrual bleeding at community clinics or GP practices, because many are not commissioned to provide that service or lack the funding or trained staff, resulting in those women being bounced around the system while living with obviously debilitating conditions. This Bill is an important moment to tackle long-standing structural challenges in reproductive healthcare. If we are truly moving towards greater integration and collaboration within the healthcare system, this is a really good chance to implement holistic women's reproductive healthcare services at a regional and local level. Through listening to women and integrating care around the needs of the individual, rather than the institutions, we can deliver holistic care across the breadth of reproductive healthcare.

I know that there is a broader duty in this Bill for integrated care boards to promote the involvement of their patients and carers in decisions about the provision of health and care services, as well as having regard for inequalities. This new clause builds on that by wiring in engagement with women, because it is not happening. Again, if we just keep doing things in the same way, we will get the same outcome, so this is an opportunity to design a healthcare system for women that listens to women and builds in accountability. That will help ensure that reproductive healthcare pathways fully meet the needs of those who they are meant to serve, which would be a very positive outcome.

Karin Smyth: I rise to support the comments made by my hon. Friend the Member for Nottingham North. He is absolutely right that this new clause follows neatly from the previous one, because I am in no doubt that if women were more involved and more listened to and had more power within the healthcare system, the debacle around vaginal mesh would not have got so far, and we would not sadly still be in a state where the recommendations have not been implemented. This is about power, listening, and having a voice in the system with regards to reproductive healthcare planning.

In the Chamber last week, I said regarding my hon. Friend the Member for Swansea East's menopause revolution that when we worked on a women's health strategy in the late 1980s, we barely mentioned the menopause. We were looking at reproductive rights even then, and for those of us who have followed this issue over a period of 30-odd years, it is deeply worrying to see where we still are. Again, this comes back to very basic patient care. I will certainly be supporting my hon. Friend the Member for Swansea East tomorrow to start the menopause revolution, which is going terribly well. We are hoping for serious improvements in healthcare over the coming years, and this new clause highlighting reproductive healthcare planning is really significant for the voice it should give to women at this important stage in their lives.

Edward Argar: It is possibly lucky for the Government that the hon. Member for Swansea East is not on this Committee, because she can be extremely persuasive. In my role at the Ministry of Justice, she managed to get a number of things out of me by persistent campaigning.

I am grateful for the opportunity to have this debate today. Women's reproductive health remains a priority, and it is vital that women's voices are listened to, particularly when it comes to their own healthcare. That is why we are developing a new section of the reproductive health strategy, which will of course sit alongside the developing women's health strategy. They will both seek to address issues relating to women's reproductive health.

3.45 pm

We recognise the importance of effective public involvement when it comes to addressing equalities considerations and taking action to reduce health inequalities. There are already duties, in both existing and proposed legislation, on ICBs and NHS England to involve patients and the public in healthcare planning. We are producing new statutory guidance to support ICBs and NHS England in involving people, including those with relevant lived experience, throughout policy planning and delivery.

Dr Whitford *rose—*

Edward Argar: The hon. Lady may be about to agree with me; she is welcome to do so.

Dr Whitford: When we debated vaginal mesh, Primodos and valproate in the Chamber, one of the big issues that came up—I certainly spoke about it—was the issue within medicine, with doctors. What work will be done with Health Education England and medical schools to

[Dr Whitford]

ensure that young student doctors, and doctors in early training, recognise this terrible dismissal of women's concerns about all aspects of their health? The menopause is a classic, but there are many others.

Edward Argar: The hon. Lady is absolutely right to raise that. We need to get across, loud and clear, to our future clinicians almost right from the start—from their training and early education—the message that everyone's health concerns matter equally, subject, obviously, to clinical decision making. I hope and believe that HEE and others will engage with that process in the context of the women's health strategy. We do not want it to be a document that just sits on a shelf, or want it to look at issues in a siloed way; it should look at them across the piece. Over many years, there have been strategies on particular aspects of health. In the strategy, we seek to bring together a whole range of factors, so that we can look at how women interact with the healthcare system, and how to meet their needs holistically.

We want to maximise the independence of ICBs, so that they function in the way that best suits the needs of their patients and their organisations. We are therefore keeping their legislative obligations proportionate; that brings us back to a debate that the Committee has had multiple times about the permissive nature of the legislation. I agree that appropriate representation is essential in healthcare planning. I fear that the new clause is overly specific and not necessarily in keeping with the obligations on ICBs set out in clause 19 on general functions.

The Bill already puts obligations on ICBs that will help to ensure that relevant groups are fully represented and consulted in decision making. In particular, ICBs will need to ensure that they have taken appropriate advice from a broad range of those with professional expertise. As the work of ICBs will inevitably cover reproductive health, that requirement ensures that relevant groups are included in this work. Furthermore, as we discussed in the opening sittings of the Committee, local areas will have the flexibility to determine any further membership of the ICB beyond the minimum for which we have legislated. That discretion will allow local areas to ensure appropriate representation.

On working in partnership with the non-profit sector and local community groups, I recognise the essential role that those organisations and groups play, and agree that they should be involved in strategic decision making where appropriate. Each ICB and their partner local authorities will be required to establish an integrated care partnership. We expect the ICP to bring together organisations from across health, social care and public health, and representatives from wider areas where appropriate. That could include organisations from the voluntary and community sector. The ICP will be tasked with promoting partnership arrangements and developing a plan to address the health, social care and public health needs in its area. As that will include reproductive healthcare needs, we would expect relevant local groups to be represented. The ICB and local authorities will have to have regard to that plan when making decisions. That will enable more joined-up planning and provision, both in the NHS and by local authorities, which will enhance the services that people receive.

Existing and proposed duties already address the concerns underlying the new clause and ensure effective public involvement. We have concerns about imposing additional duties on individual services. Our approach enables local NHS bodies, supported by national guidance, to decide how best to involve patients and the public in the planning of commissioning arrangements, and in developing and considering proposals to change them, so we are not convinced that the additions in the new clause in respect of reproductive healthcare are necessary.

Alex Norris: I am grateful for the contribution from my hon. Friend the Member for Bristol South. Many people will be looking with great interest at what happens tomorrow. She spoke about the menopause not having been on the political agenda for such a long time. I think that that has changed, and not before time, so we are all very much looking forward to what will happen.

We have tested the Minister on the permissiveness point quite a lot, so by this, the 22nd sitting of the Committee, I think it is possibly an established fact, and I do not intend to divide the Committee, but I do want to come back on what he said about the sufficiency of the duties as drawn. When we have pushed for individual plans for each ICB—say, on inequalities, on the first 1,001 days and on drugs and health—there has almost been a sense of, "Well, of course these bodies will want to do that. It will be their local decision, but of course the evidence will drive them to do that." I do not think we can say, on women's health, that that is an "of course", because we know that actually, historically, it can be very much an afterthought.

The thought that I might leave colleagues with on this issue is that we are having a growing conversation in this country about misogyny, and one of the things that you will hear men say a lot—I have said this myself, because I mean it—is, "We have to hold one another to account for the things we say and the way we act." I completely agree with that. In that spirit, we have to understand that if a lot of the basic reproductive healthcare things that we are talking about today happened to men, we would be doing them in McDonald's drive-thrus. It is as simple as that. Therefore, if we are to have an honest conversation with one another about misogyny in this country, it is that sort of thing that we mean. It is not always about pointing fingers and blaming, or policing jokes, which I think is important; it is actually about saying that services are different because these things do not happen to us and we should be more mindful of that and should want to change. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 54

ENHANCED DATA COLLECTION

"(1) The National Health Service Act 2006 is amended as follows.

(2) After section 14Z43 (inserted by section 19 of this Act) insert—

"14Z43A Duty to develop data collection systems

Integrated care boards must—

(a) develop single whole-system IT systems across the whole of their integrated care system with the explicit purpose of supporting data collection and sharing;

(b) prioritise the use of those data systems for streamlining patient pathways;

(c) establish mandatory standards for patient-initiated follow ups; and

(d) use the data systems developed under paragraph (a) to report on a regular basis performance against improving patient outcomes in line with the standards established under paragraph (c).""—*(Alex Norris.)*

This new clause requires ICSs to develop digital data collection and sharing systems, and use them to track performance against mandatory standards, with specific regard to patient-initiated follow ups.

Brought up, and read the First time.

Alex Norris: I beg to move, that the clause be read a Second time.

I keep going, Ms Elliott. Again, you can perhaps file this under gluttony for punishment. I do not intend to talk for very long about this new clause. I am sure that the Minister will be able to give us comfort easily on the point of new clause 54. It is just to develop the point about data one last time before our carriages turn into pumpkins.

A specific part of the Bill deals with data, and we had some very good conversations at that point. I will not repeat any of that. I will explain what I am chancing my arm at in new clause 54. I talked previously about systems and the problems with systems talking to one another. Here, we are asking integrated care boards to develop

"single whole-system IT systems".

That is perhaps at the top end in terms of what should be aspirational and what is in fact achievable, but I do want to pursue the point a little.

Data is critical, as we have said before, in driving improvements. NHS England's own website talks about the need to use it to improve services and decision making, to identify trends and patterns, to draw comparisons, to predict future events and outcomes and to evaluate services. But to do that, we have to have some sense of consistency. I will not repeat the arguments around the General Data Protection Regulation—we had those at length—but that shows the challenges if we do not get it right.

Going down to ICS level, if we are going to have a system that really does harness all the information, we need systems that talk to one another. Therefore, the prescription in proposed new subsection (a) is that it is a single system. As I have said, that is the stretch target. What I am hoping to get from the Minister is a sense of where he thinks this will land. Is it the same organisations using the same systems but trying to find a new way to do them, or will there be some new, novel approach to how we support footprints to do that? It is an established fact that data is going to be really important to local systems, so we want to give them the fairest wind to make the best use of it that they can.

Dr Whitford: On new clause 54, I just want to speak to proposed new subsection (d)—the use of data to assess performance against outcomes. Between 2009 and 2019, there was really no significant national audit of quality of breast cancer services in England, even though some of that audit had been carried out in previous years. Part of that was due to the fracturing of the system from the social care Act. There might be only one breast unit within an area, and quality was left to commissioners. How can commissioners measure whether a local breast unit is treating people properly or achieving the aspired-to targets?

In Scotland, 19 of the commonest cancers are audited; I was involved in developing the breast cancer standards in 2000, and they have been updated many times since. They are assessed annually with an annual peer review conference, where clinicians will openly discuss the challenges they face and therefore will share the solutions many of them have come up with. The clinical things that we know will affect the survival and outcomes of our women in the future are all set as national benchmarks. It is important that, while data would be collected locally, it is benchmarked against national standards.

The Getting It Right First Time project was restarted in England a few years ago but, to my knowledge, although the Getting It Right First Time for breast cancer report was completed at the end of 2019, I have not seen it published. That appeared to be due to the election in December 2019; perhaps the Minister can clarify whether the breast cancer GIRFT report has now been published, when it might be published and what other GIRFT reports have come out.

The problem is that, even if that report were published now, two years after its completion, it would largely be based on data from 2018, and therefore clinicians would shrug their shoulders and say, "Out of date." It is important that data is used in a timeous manner to audit as quickly as possible, so that the audit loop can be closed and services improved. Having led on this process in Scotland, I saw the change in standards between 2001, when we began the first assessment, and 2005, and it is an incredibly satisfying, not frightening, thing for clinicians to see year on year the quality of care delivered by their unit driven up. There must be national standards, but local audit.

Edward Argar: This new clause would create an obligation on ICBs to develop system-wide data-sharing IT systems. It would also require them to set and report on targets linked to outputs from this system. I recognise the importance of effective IT systems for the efficient delivery of services and for holding systems to account. However, we must set that against seeking to maximise the independence of ICBs to function in a manner that best suits the needs of their patients and organisations.

The obligations set out in the Bill are designed to establish a framework which ensures that ICBs fulfil their functions properly, while granting them as much discretion as possible in how they do so. The provisions in the Bill strike the balance between conferring the necessary duties and functions on ICBs to operate safely and effectively, and avoiding being overly prescriptive in any specific area. By placing too many statutory duties on ICBs, the risk is that innovation and locally led solutions may be stymied and focus may be taken away from their primary function of arranging for the provision of health services.

Of course, ICBs should be committed to improving patient pathways. However, we believe the duties already set out in the Bill are sufficient to ensure this happens. Further to the requirements set out in the Bill, there are already specific relevant provisions elsewhere in legislation.

[Edward Argar]

Section 251B of the Health and Social Care Act 2012 places a duty on certain health or social care organisations, which would include ICBs, to share information about an individual with certain persons where this will facilitate the provision of health services or care to the individual and is in the individual's best interests.

In addition, there is significant work already under way on data strategy, which will have a direct impact on ICBs. The data strategy "Data Saves Lives: Reshaping health and social care with data" sets out commitments to transform the way that data is used across the health and care system, giving patients control of their health data and enabling staff to save more lives through improved care and treatment. It recognises that ICBs will help the NHS to join up data and delivery more seamlessly, working side by side with local government, third sector partners, and the wider health and care system to address long-term challenges, and sets out that each ICB will be expected to use digital and data to drive systems working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

The data strategy was published in draft for engagement in June and a final version will be published by the end of the year. It sets out a range of commitments to ensure that health and care professionals have the data they need to provide the best possible care, that local and national decision makers are supported with data, and that data for adult social care are improved. It also includes commitments on every ICB having shared care records in place, and commitments in relation to data sharing between NHS organisations and supporting the underpinning infrastructure in order to ease data sharing.

4 pm

The hon. Member for Central Ayrshire raised a specific question about publication of the GIRFT data. I do not have that to hand, but I hope she will permit me to write to her outside the Committee in order to give her that information, if I am able to do so.

As a result of the above, I do not believe that adding an additional duty to ICBs would be necessary, as the work is already under way.

Alex Norris: This is not something that we will be able to resolve with top-down prescription, but I have made the point that I hope we will do everything we can at a national level to model best practice, to demonstrate best practice and to give our local systems access to best-practice systems, because that will be very important. On that basis, I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 56

DOMESTIC VIOLENCE TRAINING FOR GPS

"(1) The National Health Service Act 2006 is amended as follows.

(2) After section 83B (inserted by paragraph 3 of Schedule 3 of this Act) insert—

"83C Duty concerning domestic violence and abuse

(none) Integrated care boards must ensure that specialist domestic violence and abuse training, support and referral programmes are universally available to all general practitioners.""—*(Alex Norris.)*

This new clause adds a requirement for specialist domestic violence and abuse programmes to be available universally throughout general practice.

Brought up, and read the First time.

Alex Norris: I beg to move, That the clause be read a Second time.

Domestic abuse is an issue of significant interest across this place. We know that two women a week are killed by a current or former partner in England and Wales alone. As we mentioned the other day, a quarter of women will experience domestic abuse in the course of their lifetime, which has devastating effects. It impacts on both the physical and mental health of survivors and their children, and it has a terrible cost in general to everybody, including a financial cost.

New clause 56 would impose a duty at a local level to ensure that GPs have access to specialist domestic violence and abuse training. It is something that would be very welcome, and we are proposing a duty for integrated care boards to provide that. GPs are a credible point of contact for people in violent relationships. Some 80% of women in a violent relationship seek help from health services first. In some cases, that is their only contact. Training for GPs is vital to ensure that such contact is of the best possible quality. A study of women in violent relationships in the Netherlands found that 50% of women who did not speak to their GP about the matter would have done so if the GP had been in a position to approach it. Moreover, 50% of the women who did talk to their GP did so because they hoped to be referred on, so they wanted to have a high-quality conversation with someone who knew the system.

From my time prior to this place and my experience in Nottingham, I have a lot of enthusiasm for the IRIS programme—the identification and referral to improve safety programme. A trial carried out by Bristol University found that the training programme led to up to six times more women receiving the help they needed, and that it boosted the number of referrals to specialist domestic violence agencies. After IRIS training, GPs reported being better able to assess domestic violence risks and a greater awareness of services, while 99% of service users felt listened to and 87% felt safer.

The evidence is that such training works. This is of course not the way in which we should write a new clause, but I am saying that IRIS should be universal or something like it. I would leave the "something like it" to the provider market and to commissioners but, in general, the principle is that all GPs should have training so that they can understand and act on domestic abuse and have the right resources to provide support and make skilful onward referrals, so that the system can wrap its arms around an individual who is trying to get out of an abusive situation. That would be exceptionally important for such women, and I hope the Minister will have some thoughts about how we can get to a universal, IRIS-like level of engagement with our GPs.

Edward Argar: The new clause would require ICBs to provide specialist domestic violence and abuse training, support and referral programmes to all GPs, with the aim of strengthening the health response to domestic abuse and improving links between the NHS and voluntary sector support for victims. We have concerns about the new clause, which is why we cannot accept it, but I hope that I can set out to the shadow Minister my reasoning.

Domestic abuse, as we discussed yesterday when considering another proposed new clause, is a terrible crime, and it can have a devastating impact on victims and survivors. It is also important that we remember that children are often just as much victims as the victims themselves, through the experiences that they have of domestic abuse and domestic violence. The Government are clear that there is absolutely no excuse for abuse. Tackling domestic abuse and supporting victims, survivors and their children is a key priority for Government, now more than ever.

The Domestic Abuse Act 2021 and the forthcoming domestic abuse strategy will help to provide a whole-system approach to protect and support victims and their children. The measures in the 2021 Act seek to promote awareness by introducing a statutory definition of domestic abuse, and to recognise children, as I alluded to, as victims in their own right, in order to protect and support both, tackle perpetrators, transform the justice response, and drive consistency and better performance in the response to domestic abuse.

The 2021 Act also sets out the convening of local domestic abuse partnership boards, with healthcare representation. We recognise the key role that healthcare services play within a whole-system approach to tackling domestic violence. Healthcare services must identify signs of risk and harm, enable victims and survivors to come forward, and provide timely integrated care and support. We know how important it is that statutory agencies and professionals properly understand and react to domestic abuse. However, I hope that I can reassure the Committee that placing in the Bill a formal duty on ICBs to ensure that specialist domestic violence and abuse training, support and referral programmes are universally available to all GPs is not necessary.

General practice is delivered by multidisciplinary teams, rather than just GPs, and existing Care Quality Commission registration requirements include a review of practices' safeguarding processes. In addition, NHSEI's ICS people guidance sets an expectation that ICBs will foster learning and continuing professional development. Going further, the Bill, in proposed new section 14Z41 of the National Health Service Act 2006, imposes a duty that each ICB

"must, in exercising its functions, have regard to the need to promote education and training for the persons mentioned in section 1F(1)"

of the 2006 Act.

Sarah Owen (Luton North) (Lab): Again, I break the convention that Whips do not speak, because this issue is close to my heart. I listened carefully to the discussions yesterday, and to what the shadow Minister, my hon. Friend the Member for Nottingham North, and the Minister have said on the new clause, but if we looked at domestic abuse as a disease or virus, given the fact that it kills women, it kills people in their homes, and has mental and economic impacts that affect people's overall health, we would certainly ensure that GPs were trained on it. Why can we not do the same thing with domestic abuse?

Edward Argar: I am grateful to the hon. Lady. In part, the reason is because this is sadly not a well drafted new clause. It is very narrowly drafted to GPs, not recognising the multidisciplinary nature of how healthcare is delivered in GP practices. I suspect that we all have correspondence from constituents—whether happy or unhappy—going to doctor associates, practice nurses and others. That is one of my key concerns, but let me articulate a little more what is already being done. I see where she is coming from. As I mentioned yesterday, I was the Minister with responsibility for victims of domestic violence, and of crime in general, when I was in the Ministry of Justice, so it is something that I am very familiar with. It is about raising awareness not just with GPs, but within the police and a range of agencies. My challenge, just before she intervened, was partly about the way the new clause is drawn, but let me articulate a little further our views on it. I am keen to do so before the business possibly collapses early in the House, and we have to adjourn in order that I can respond to the Adjournment debate.

Section 1F of the 2006 Act defines a wide group of people, covering persons who are employed, or who are considering becoming employed, in an activity that involves or is connected with the provision of services as part of the health service in England. That duty on ICBs would already cover general practitioners, but it goes wider. I appreciate that the new clause goes beyond training, so I will also discuss the support and referral elements that the hon. Member for Nottingham North talked about.

The NHS provides care and support to victims of domestic abuse through a range of healthcare services. This response is centred around ensuring that healthcare professionals are trained to spot the signs of domestic abuse and those at risk; to make safe and sensitive enquiry of the issue; to know where to refer people to get further support, and to know when and how to share information appropriately with colleagues and other organisations.

All NHS staff must undertake annual mandatory safeguarding training, which includes focus on domestic abuse. NHS England, NHS Improvement and Health Education England are reviewing mandatory safeguarding training for all health professionals to ensure that they are fully equipped with the key skills, knowledge and principles to protect all citizens. The Government published an online domestic abuse resource for health professionals and have developed a number of training modules with the Institute of Health Professionals, the Royal College of Nursing and the Royal College of General Practitioners.

From 2018 to 2020, the Department managed £2 million of funding for the domestic abuse pathfinder programme, which created a model health response for survivors of domestic violence and abuse in acute, community and mental health services. The pathfinder toolkit was published in 2020 as the result of emerging promising practice at our pilot sites, coupled with the expertise of the pathfinder consortium of specialist domestic abuse organisations, to encourage best practice across the health system. Pathfinder has given us a model for our response to domestic abuse in healthcare. It is a model for integrated, joined-up and trauma-informed care and support, with healthcare settings and the voluntary sector working together.

As the shadow Minister mentioned, the Department of Health and Social Care has also funded the IRIS programme, to which I pay tribute. IRIS is a training, referral and advocacy model to support clinicians in better supporting patients who are affected by domestic violence and abuse, and to increase the awareness of

[Edward Argar]

domestic violence and abuse within general practice. IRIS is recognised by the DHSC as good practice, and via the National Institute for Health Research we funded a study that demonstrated the effectiveness of the IRIS programme at scale. I am delighted to note that the study won the 2020 Royal College of General Practitioners research paper of the year award.

I am proud that the Government have championed the building of that evidence base. I believe that it would not be best or appropriate, however, for the legislation to require local health and care systems to adopt specific programmes. Indeed, such detailed requirements would reduce local health and care partners' flexibility to meet the needs of their local populations or to engage with particular local organisations and expertise in delivering their programmes.

Beyond ICBs, I see a huge opportunity for integrated care partnerships to support improved services for victims of domestic abuse, sexual violence and other forms of harm, through better partnership working and joint planning of services. The Government have also developed a cross-Government strategy for tackling violence against women and girls, and will develop a cross-Government domestic abuse strategy.

As committed to in the tackling violence against women and girls strategy, the DHSC will continue to work closely with NHS England and NHS Improvement to promote evidence-based approaches to tackling violence and abuse through guidance and engagement with the new system.

Alex Norris: I am grateful to the Minister for his response. I am more than happy to wait for the domestic abuse strategy, but I really hope that such measures will feature in it, and that when the strategy goes around various Departments for their comments, the Minister will make a commitment—

Edward Argar: May I make the offer to the hon. Gentleman that I or the relevant Minister leading on this—whoever is more appropriate—will engage directly with him?

Alex Norris: That is very welcome, and in that spirit, I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 57

CANCER STRATEGY

"Within 12 months the Secretary of State must—

(a) publish a new cancer strategy; and

(b) either designate a minister or appoint a national lead with responsibility for enacting its implementation."

—(Alex Norris.)

This new clause requires the publication of a new cancer strategy, with a minister or other person made responsible for its delivery.

Brought up, and read the First time.

Alex Norris: I beg to move, That the clause be read a Second time.

The Chair: With this it will be convenient to discuss new clause 64—*Cancer treatment data reporting*—

"(1) Beginning within 6 months of the passage of this Act, the Secretary of State must publish each month data on—

(a) the number of patients awaiting treatment for cancer,

(b) the number of patients with a cancer diagnosis, and

(c) what NHS's previous estimate was of the number of patients who would have a cancer diagnosis at that point in time.

(2) Six months after the publication of the first report under subsection (1), and every six months thereafter, the Secretary of State must publish a report on the action being taken to reduce the number of patients awaiting treatment for cancer."

Alex Norris: I am conscious of other business, so if I am interrupted, I will not take it as rudeness.

Edward Argar: We may be okay.

Alex Norris: New clauses 57 and 64 both relate to cancer. It is not quite possible to quantify the damage done by cancer in this country because we end up just throwing big numbers around. In the UK, there are 375,000 new cases and 166,000 cancer deaths each year. Each of those numbers represents a person with a devastated family. I lost my father to cancer in my infancy—35 years ago in January—and that loss is something that lives with a family for the rest of their lives.

We know that one in two people born after 1960 will be diagnosed with cancer. Our investment in cancer services is £5 billion a year, but the cost dwarfs that, at over £18 billion. Nearly 40% of cancers are preventable. Happily—this is something we should be proud of in this country—the developments that we are making in medical and technological areas mean that cancers are increasingly survivable, with the survival rate doubling in the last four decades. Better diagnosis and treatments mean that nearly 50% of those diagnosed with cancer in England and Wales now survive for 10 or more years, and there is no reason for that to stop increasing.

4.15 pm

The reason for new clause 57 is that we need a proper national-level cancer strategy. During the pandemic we talked about dealing with the backlog, which I will address shortly. We got to the point where there was a recovery strategy for about three months at about this time last year, and then it was suggested that local communities had to respond, but I do not think that quite does it. We need a national-level strategy with a national-level lead to make sure it gets the necessary attention. Again, we must improve our access to data, but I will not labour the points I made earlier.

With regard to the backlog now, last month there was a very worrying report from the Institute for Public Policy Research on building back cancer services in England, with missing patient backlogs a particular concern. The pandemic led to 37% fewer endoscopies, 25% fewer MRIs and 10% fewer CT scans between March 2020 and February 2021. Every four-week delay in diagnosis and treatment leads to a 10% loss in survival rate. With nearly 370,000 fewer people than expected referred to a specialist, it is estimated that we are close to 20,000 missing diagnoses, and are therefore

starting to see a fall again in the number of cancers diagnosed while still highly curable, so lives are at stake here. A national strategy where all the partners have very clear roles would be very good.

New clause 64 is about data; the two new clauses are well read together. This is about being honest about the data and the impact of the pandemic, and also the impact of an underserved NHS in the run-up to the pandemic, which meant that cancer targets had not been met for a very long time. We need to pull that together in one honest appraisal of the situation so that we can start to plan to tackle it. It is absolutely fundamental for families.

Edward Argar: New clause 57 seeks to commission, as the shadow Minister has said, a new cancer strategy and to designate a Minister or appoint a national lead with responsibility for enacting its implementation. The Government's current cancer strategy is incorporated in the NHS long-term plan, published in 2019. That plan sets out ambitions that by 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 54% to 75% of cancer patients, and 55,000 more people each year will survive their cancer for at least five years after diagnosis. The shadow Minister is right to highlight the importance of the issue as something that touches everyone in some way, directly or indirectly. In the midst of the pandemic last year, I lost my uncle to cancer, and I suspect families all over the country are experiencing something similar among their family and friends. That is in the nature of the disease that we are talking about.

The NHS long-term plan contains a series of commitments to support the ambition. It focuses primarily on fast and early diagnosis, raising greater awareness of the symptoms of cancer, lowering the threshold for referral by GPs, accelerating access to diagnosis and treatment, and maximising the number of cancers that we can identify through screening. That ambition was intentionally set at a stretching level. Achieving it requires material progress in all of the long-term plan's activities as well as successful innovation. The covid-19 pandemic has made the ambition even more challenging because of the additional pressure it has put on the NHS. It is still too early to assess the extent of the pandemic's effect on that ambition in the long term. We remain absolutely committed to the need to prioritise earlier diagnosis to improve cancer outcomes. This ambition was strongly supported by the many cancer charities that worked with us to agree the priorities for the NHS cancer programme, and I pay tribute to them all.

I understand the intention behind the new clause. The covid-19 pandemic affected all NHS services in creating an environment unforeseen at the time by the long-term plan. In response to the pandemic, NHS England and NHS Improvement set up the cancer recovery taskforce, which provided advice and guidance on the national strategy for the recovery of cancer services. It monitored progress against the aims of restoring demand, reducing waiting times and ensuring sufficient capacity for cancer diagnosis and treatment. The taskforce published the cancer recovery plan in December last year, which fed into NHS operational and planning guidance outlining how the NHS would return to its pre-pandemic cancer performance within the long-term plan. It is thanks to the taskforce and forward planning that the CQC's "State of Care 2020/21" report says that cancer services have achieved the best response and recovery, generally closing the gap in access on pre-pandemic levels more than any other area, although it notes that this still leaves a large backlog, which the recovery plan is focused on tackling.

The long-term plan commits NHS England and NHS Improvement to speed up the path from innovation to business as usual, spreading proven new techniques and technologies and reducing variations. I therefore consider the new clause, while it covers an important issue and quite rightly draws it to the attention of the Committee, not strictly necessary, because an ambitious cancer plan is already embedded in the long-term plan, with clear plans in place to support the recovery of cancer services from the pandemic specifically. We are fully committed to the actions within these plans and to seeing the long-term plan to its conclusion.

Dr Whitford: The Minister has not mentioned the workforce, specifically in radiology, which is very much the central specialty in diagnosing cancer. The data show that, once someone has been recognised as a cancer patient, they are still being treated relatively quickly—as he highlights, there is a shorter gap—but the problem is actually diagnosing someone, and the radiology workforce has a drastic shortage.

Edward Argar: I am grateful to the hon. Lady, who is distinguished in this field herself, from her previous career. She quite rightly highlights the importance of the workforce. Since 2010, in both radiology and radiography, there have been significant percentage increases in the workforce of those specialist professions. However, she is right to highlight that, while we have seen a significant percentage increase, in absolute terms we still need to do more to grow those professions. We have plans in place to do that, but that is a slow task; it can, in some cases, take up to 10 or 12 years to become an experienced specialist in that field.

On those increases since 2010, the Government would argue that we put measures in place, but it is also important to recognise that the previous Labour Government were working on this as well, hence the pull-through; those radiologists and radiographers did not magically appear immediately after 2010. There were programmes in place before and after that, so it is right that we recognise the contribution of the Opposition when they were in Government.

Finally, the new clause also seeks to place a Minister or national leader in charge of that new cancer plan. My ministerial role includes responsibility for elective recovery and recovery from the pandemic—our plan to tackle those waiting lists. As the shadow Minister knows, my hon. Friend the Member for Bury St Edmunds (Jo Churchill), the former Under-Secretary of State for Health, who briefly sat on this Committee, had responsibility for cancer services specifically, as does the new Under-Secretary. Dame Cally Palmer is the national lead as the national cancer director at NHS England and NHS Improvement. She has a distinguished career as chief executive of the Royal Marsden Hospital in parallel. We are jointly responsible for the current cancer plan. It is therefore unnecessary to include that new duty when we already have those accountabilities.

[Edward Argar]

I will move on briefly to new clause 64, which we are considering with new clause 57. It seeks to legislate for an additional duty on the Secretary of State to publish data on cancer waiting lists, cancer diagnoses and action being taken to reduce the number of patients waiting for cancer treatment in England. Again, I understand the intention behind the new clause. Cancer is one of the greatest challenges to people's health, as we set out. I would like to highlight first the fact that the Government are already delivering on the request for monthly publication of cancer performance data. Ensuring transparency of data is a priority. Each month, we publish official statistics on waiting list data, including the number of patients who began cancer treatment and waited longer than 62 days for treatment. NHS England also publishes monthly management data on the number of people currently waiting longer than 62 days for diagnosis or treatment. The new clause calls for data that is very similar to what is already published, and we therefore consider that it would be duplicative.

Secondly, on the request to publish predictions—that is not something that is currently done. Doing so would likely result in unhelpful poor-quality assumptions or modelling that could lead to expectations or an understanding that is not reflected in the reality of the data that comes through. While we look at all data sources internally, it would not be in the best interests of scrutiny and, potentially, patients to publish poor-quality predictions with a limited confidence factor.

Thirdly, there is no evidence of need. Following the success of campaigns such as Help Us, Help You, we have seen the public seek medical attention for symptoms that might be cancer, while cancer referrals from GPs have been at record levels since March. At the same time, the NHS has been delivering high-quality and innovative solutions to improve cancer care and treatment. We have announced funding for elective recovery, including cancer services, of £2 billion this year and £8 billion over the next three years, which will increase activity and deliver millions more checks, scans, procedures and treatments. We will continue to publish and review the monthly official statistics to monitor progress.

Finally, on the request for the Secretary of State to publish a report every six months on the actions taken to reduce the number of patients awaiting cancer treatment, I should state that the NHS has already undertaken extensive work to reduce the number of patients waiting for treatment and to continue progress in delivering the long-term plan ambitions for cancer. We will publish the elective recovery delivery plan later this year, which will set out how the NHS will deliver increased elective capacity and how cancer patients will be prioritised for access.

Furthermore, the NHS cancer programme already regularly reports on progress through both NHSEI and DHSC governance structures, through publication of monthly data on cancer waiting times and through regular communications products. We would therefore argue that the new clause is duplicative. While I assure the Committee that we are taking urgent action to reduce cancer waiting lists, we consider the new clause to be unnecessary.

Alex Norris: I am grateful for that answer, which reflects the current difference in public policy between the Government and the Opposition. At oral questions to the Health Secretary, I always ask and will continue to ask whether the Government's position is that the current plans and status will be sufficient to meet the challenges and the backlog—we think they are not. While the system was overheated before the pandemic, it has been distressed by the last 18 months. We do not think that asking that system to meet both emergent and old problems will work. However, that is probably a point for oral questions and future debates, rather than this Public Bill Committee. On that basis, I will withdraw the clause.

As we are coming to the end of the debate, I might gently say to the Minister, on his point that the Government do not make predictions because they might be unhelpful in the future, that it feels as if, every time he goes on the news, the Health Secretary puts waiting lists up by another million in an extraordinary attempt to manage expectations. Was it 13 million last time? It just goes up and up. I do not think it is quite fair to say that Ministers do not do that—the Health Secretary, at least, certainly does. Nevertheless, that is no reason not to withdraw the clause, and I therefore beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

Ordered, That further consideration be now adjourned. *—(Steve Double.)*

4.29 pm

Adjourned till Tuesday 2 November at twenty-five minutes past Nine o'clock.