Friday
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# HOUSE OF COMMONS
## OFFICIAL REPORT

# PARLIAMENTARY DEBATES

## (HANSARD)

**Friday 10 December 2021**

# House of Commons

*Friday 10 December 2021*

*The House met at half-past Nine o'clock*

## PRAYERS

[Mr Speaker *in the Chair*]

**Katherine Fletcher** (South Ribble) (Con): I beg to move, That the House sit in private.

*Question put forthwith (Standing Order No. 163).*

*The House divided:* Ayes 3, Noes 53.

**Division No. 145] [9.34 am**

**AYES**

Bacon, Gareth
Daly, James
Davies, Mims

**Tellers for the Ayes:**
**Jane Hunt and**
**Elliot Colburn**

**NOES**

Allin-Khan, Dr Rosena
Andrew, rh Stuart
Antoniazzi, Tonia
Blunt, Crispin
Carter, Andy
Charalambous, Bambos
Churchill, Jo
Cleverly, rh James
Davies, Mims
Debbonaire, Thangam
Double, Steve
Eastwood, Colum
Elphicke, Mrs Natalie
Evans, Chris
Everitt, Ben
Fletcher, Mark
Foxcroft, Vicky
Glindon, Mary
Grady, Patrick
Greenwood, Margaret
Hands, rh Greg
Hart, Sally-Ann
Hayes, Helen
Henry, Darren
Hollobone, Mr Philip
Holmes, Paul
Hopkins, Rachel
Huddleston, Nigel
Hudson, Dr Neil
Hughes, Eddie
Jayawardena, Mr Ranil
Johnson, Gareth
Keeley, Barbara
Lucas, Caroline
Malthouse, rh Kit
Mann, Scott
McDonald, Andy
Mullan, Dr Kieran
Nici, Lia
Phillips, Jess
Pincher, rh Christopher
Quince, Will
Randall, Tom
Richards, Nicola
Saxby, Selaine
Shannon, Jim
Smith, Jeff
Sobel, Alex
Spellar, rh John
Stephenson, Andrew
Throup, Maggie
Vickers, Martin
Wakeford, Christian

**Tellers for the Noes:**
**David T. C. Davies and**
**Mrs Heather Wheeler**

*Question accordingly negatived.*

## Medical Cannabis (Access) Bill

*Second Reading*

9.48 am

**Jeff Smith** (Manchester, Withington) (Lab): I beg to move, That the Bill be now read a Second time.

Before I begin, I want to thank briefly a number of people who have advised me and helped bring this Bill forward today. Among others, particular thanks go to Professor Mike Barnes and Professor David Nutt; to Rudi Fortson; to the parents of children with treatment-resistant epilepsy who have talked to me—Hannah Deacon, Matt Hughes and Emma Appleby; to Peter Carroll and the great campaigners at End Our Pain; to the brilliant Adam in the Public Bill Office here in Parliament; and to Alex Worrell in my office in Parliament.

We have a problem that is acknowledged in this House—across this House, I think—and certainly outside this House, and I know that Ministers also appreciate the problem and want to try to find a way around it. That problem is that medical cannabis—cannabis-based medical products—is a very helpful and effective treatment for a number of medical conditions, but significant numbers of people who would benefit from being prescribed medical cannabis on the NHS are not able to get the prescriptions that they need.

When I was drawn in the private Members' Bill ballot, I wanted to try to find a legislative way forward to address this problem. I had hoped to agree an approach with the Government. I had a number of conversations with Ministers. I do believe that Ministers want to find a way forward on this but, unfortunately, that has not been possible, which is why I have put forward the proposals that are before us today. As I say, I do not think there is a lack of will from the Government, but that reflects an inflexibility in the system, which is at the root of the problem. The Bill's modest proposals try to find a way to help overcome the barriers. It is not a magic bullet and it will not resolve all the problems, but in due course it might help some patients to get the medicine that they need.

**Jim Shannon** (Strangford) (DUP): I am very supportive of the hon. Gentleman's Bill. My constituent Sophia Gibson—she is a young girl—and her mummy and daddy Danielle and Darren got medicinal cannabis. Some hon. Members will know the story and about how we went to the previous Minister. I can vouch for medicinal cannabis making the difference for that young girl by stopping her epilepsy. She is better today because of access to medicinal cannabis.

**Jeff Smith:** I thank the hon. Gentleman for his intervention. That is one example of a significant number where lives have been transformed by this medicine. There is frustration that people cannot get it as they should.

When the Government passed the Misuse of Drugs (Amendments) (Cannabis and Licence Fees) (England, Wales and Scotland) Regulations 2018, which moved cannabis from schedule 1 to schedule 2, it became legal for clinicians on the specialist register to prescribe cannabis-based medical products. That legalisation came in the wake of a high-profile campaign by patients who were unable to get the medicine that they needed. The highest-profile cases—many will remember Alfie Dingley and

*[Jeff Smith]*

Billy Caldwell—were of children with severe treatment-resistant epilepsy. Medical cannabis helped their conditions remarkably, as the hon. Gentleman just outlined, but generally they had to get it from abroad—usually from the Netherlands—or on the illegal market.

The 2018 regulations, which legalised cannabis-based medical products, offered a hopeful way forward for those children and others. Hon. Members and the public would be forgiven for thinking that the problem was resolved, but, three years later, only three prescriptions for medical cannabis have been obtained through the NHS—three prescriptions in three years. Cannabis-based medical products are an appropriate treatment for a larger number of people and they have been able to access private prescriptions, but often they pay a fortune. I am told that there are about 10,000 private prescriptions for cannabis-based medicines in the UK for various conditions, including chronic pain, Tourette's, anxiety and epilepsy, but virtually no one can access them on our national health service.

**Alex Sobel** (Leeds North West) (Lab/Co-op): One public perception that is wrong is about how medicinal cannabis is produced. It is produced in secure conditions by highly trained people, creating good-quality jobs in secure premises. It is not done in a back bedroom somewhere. Should we not be bringing those industries forward to give relief to thousands of people across the UK through the NHS?

**Jeff Smith:** My hon. Friend makes a really important point. It is about not just medicines and health, but a life sciences opportunity that we ought to take up. The problem is that, if people cannot get the product, which, as he says, is well manufactured and safe, easily on prescription, the risk is that they will go to the illicit market and get products that perhaps should not be trusted as much as a prescribed product.

Earlier this week, I spoke to a mother who has a daughter with treatment-resistant epilepsy and she pays £2,000 a month for her daughter's medicine on a private prescription. One of my constituents pays nearly £700 a month for his grandson's medicine. Epilepsy prescriptions can cost £1,000 to £1,500 a month—that is not unusual. Families of patients in the most urgent need often have to resort to support from crowdfunding or individual donors to keep their medicine going. It is just not right that patients have to resort to that for a prescribed medicine because they cannot get it on the NHS. As I mentioned, many others are forced to get their medicine through illicit means.

Much of the campaigning on this issue is still focused on children with treatment-resistant epilepsy; they have been the highest-profile cohort of patients and I suspect many of the contributions to the debate will focus on that cohort. However, I want to emphasise that they are not the only patients who would benefit from access to cannabis-based medicines. They are probably the cohort most acutely affected. For many of them, it is an urgent and high-stakes issue—sometimes, it can be literally the difference between life and death—so it is right that we focus some of our discussion on them. I will offer a couple of examples to illustrate the importance and the power of this medicine to that group and others. Those in that cohort are not the only ones who can benefit.

In 2018, the then chief medical officer, Dame Sally Davies, said that there is

"conclusive evidence of the therapeutic benefit of cannabis based medicinal products for certain medical conditions".

That is why she recommended that they should be moved out of schedule 1.

**Patrick Grady** (Glasgow North) (SNP): I congratulate the hon. Gentleman on bringing forward the Bill. Although it applies to England only, many of us would like to see access to medical cannabis more widely across the whole UK, especially when we have heard testimonies from constituents and their children who would benefit. As the campaign continues, does he agree that the devolved Administrations and the Westminster Government should work together on this wherever possible and, if appropriate, ensure that powers are devolved so that the devolved assemblies are able to go further and faster if they want to?

**Jeff Smith:** The hon. Gentleman makes a really important point, and I agree. I do not agree with everything that the devolved Administration in Scotland do, but they do have an approach to these sorts of issues that is more focused on harm reduction and evidence than perhaps we have in England.

Cannabis-based medicines are already approved as a treatment for a small number of medical conditions. Currently, the National Institute for Health and Care Excellence guidelines recommend four licensed cannabis-based medical products that can be prescribed in the UK. I will talk about the terminology in a moment, but there are two THC-based medicines—dronabinol, which is licensed for appetite loss in AIDS patients and as an antiemetic in chemotherapy, and nabilone, which is a synthetic cannabinoid medicine licensed for nausea in individuals receiving chemotherapy. There is also Sativex, a combined THC and CBD medicine, which is licensed for muscle spasticity in multiple sclerosis patients, and Epidiolex, a CBD-based medicine—it is 99.8% CBD with less than 0.1% THC—for the two rare childhood epilepsies, Lennox-Gastaut syndrome and Dravet syndrome.

I am referring to THC and CBD; it might be helpful if I say a few words about terminology, and about the nature of cannabis, ahead of my next remarks about the proposals in the Bill. The cannabis plant is made up of something like 147 cannabinoids. They are the compounds that act on the cannabinoid system in the human body. There are also over 100 terpenes, which are aromatic compounds; flavonoids, which are pigments; and four other minor sets of compounds, so it is quite a complex botanical plant.

The complexity of the plant and its compounds is part of the issue that I will try to explain shortly, but the two main types of compounds that I am referring to are tetrahydrocannabinol, or THC, which is the psychoactive ingredient—very broadly and slightly simplistically, that is the ingredient that produces the high that recreational users experience, but it is also a painkiller—and cannabidiol, or CBD. Broadly, CBD has a more sedative effect—a kind of chill-out effect.

CBD on its own is legal in many countries, including this one; it is the THC content that makes cannabis illegal for recreational use in many countries. Different strains of cannabis plant have different balances of THC and CBD, and cannabis medicines do too. For

example, Epidiolex, which is one of the most used medicines for severe epilepsy, is overwhelmingly CBD and has a very small amount of THC. Sativex has a higher proportion of THC. That is important because different treatments and balances work for different patients, and sometimes people have to adjust and tweak their treatment to find out what is right for them. If I refer to full-spectrum cannabis extract, that is a cannabis compound concentrate that preserves the full cannabinoid and terpene contents of the raw cannabis plant, including CBD, THC and other compounds. That is the plant, which is the basis of the medicine.

I want to provide three case studies of the real-life effect of cannabis-based medicines. Probably the most famous case is Alfie Dingley and his mum Hannah Deacon, whose campaign for access to medical cannabis helped to change the law in 2018. Alfie was perfectly healthy until he was four months old, when he became constantly sick and began having seizures. The seizures continued for months and he lost every skill he had developed. He was diagnosed with auto-immune epilepsy. The amount of time between Alfie's clusters of seizures shortened as he got older. By the time he was five, they were happening every week. Each time, he needed up to five doses of intravenous steroids, which had a really negative effect on his personality and behaviour. Eventually, Alfie was diagnosed with a rare epilepsy syndrome which affects only nine known boys worldwide. There are slightly more girls with the syndrome, but only nine known boys in the world.

Hannah, Alfie's mum, was desperate for a solution. She researched anything that might help and came across medical cannabis, so she learnt about the human cannabinoid system and cannabis medicines. At the time, Alfie's doctors were telling her that regular steroids would eventually kill him, so to Hannah, cannabis medicines seemed like his only chance. She began the campaign for Alfie to have a prescription of cannabis medicines in the UK, where they were illegal at the time.

Once the family had raised enough money, they moved, in September 2017, to the Netherlands, where they could get medical cannabis legally. There they gave Alfie an oil prepared from Bedrolite, which is made by the Dutch company Bedrocan. That is a standardised strain of cannabis plant, with full extract CBD oil. Over the next three months, Alfie's seizures became less frequent. They added THC oil called Bedica, also made by Bedrocan, under the guidance of their paediatric neurologist. Alfie went without seizures for 40 days. When he did have the clusters, they were less intense and were controlled much more easily. His cognitive development improved greatly.

Living abroad, however, was really hard for the family. After five months they ran out of money, so they had to come back home to the UK. In the UK, they had to fight for a prescription that contained both CBD and THC. Eventually, as a result of the campaign led by Hannah and other families, and under immense pressure from those desperate families, the Government agreed to change the law to make medical cannabis legal. Alfie finally received an NHS prescription for the products he had found so beneficial in the Netherlands in November 2018. It is still one of only three prescriptions in the UK, and his family had to go through an unusual process and special approvals to get that medicine.

Three years later, Hannah has recently reported that Alfie has not had a seizure in over 500 days. Before his medical cannabis treatment, he was having 150 fits a week. Although cannabis medicines are not a silver bullet for everyone, they have been absolutely life-transforming for Alfie, Hannah and the rest of the family. Alfie's is a particularly unusual syndrome, but the majority of children in similar situations have not been able to get access to medicines despite their now being legal.

**Andy McDonald** (Middlesbrough) (Lab): My hon. Friend is making a fabulous speech and I am sure people will study it after the event. He mentioned Mike Barnes. Does he agree with me and Mike Barnes that the children who are outside the syndromes he is so expertly describing have nothing to lose by trying to see if cannabis-based products work for them? Is it not a grave injustice that those children are denied that opportunity?

**Jeff Smith:** My hon. Friend makes a really important point. They have nothing to lose. The problem is that we have to balance benefit and risk and, for this cohort of children and lots of medical cannabis patients across the country, the benefit is far greater than the risk. That is the frustration, and the problem with access to medicine is that lots of patients with different conditions would benefit massively and, if we are being honest, I think we all know that the risk is pretty low.

I want to contrast Alfie's case with the story of another mum and her son who does not have a prescription for his epilepsy. This young man is now 18; he started having seizures in 2016 when he was 12—does that add up? I thought I had got my dates wrong, but that is correct. In 2017, after trying treatment on seven different anti-epileptic drugs and 16 different combinations, he was diagnosed with drug-resistant epilepsy. A cocktail of pharmaceuticals left him with impaired cognition, memory loss and an inability to process new information. He was still having regular seizures and was often in and out of hospital, requiring emergency treatment for status epilepticus: a seizure or a series of seizures that last for more than five minutes and can be fatal.

In 2018, desperately looking for anything that might help, the boy's mum took him to the Netherlands, where a hospital agreed to treat him with Bedrolite. The doctors there eventually concluded that conventional anti-epileptic drugs were making his seizures worse and weaned him off them gradually, resulting in his cognition and memory improving. When they tried to wean him off the cannabis-based medicine, Bedrolite, his symptoms rapidly deteriorated and he almost died. He was put back on an increased amount of Bedrolite in combination with two newer anti-epileptics, and he has now been completely seizure-free for more than a year.

That young man's health depends on Bedrolite, which is a fraction of the cost of the emergency hospital treatment that he used to require. His Dutch neurologist said that adults with uncontrolled epilepsy as severe as his would likely have to live in an institution for their whole lives. However, the young man writes:

"I'm now able to think about my future for the first time in years and want to go to art school. We are desperate to come home but I'm really afraid of the seizures starting again if I'm not

*[Jeff Smith]*

allowed a prescription for Bedrolite. My mum and I are so scared of more seizures again and that I won't be allowed to carrying on living a healthy life like I can now."

As a result of the barriers to access in the UK, the mother and son are effectively living in medical cannabis exile in the Netherlands. That is not right.

The third example is not a child with epilepsy. Lucy Stafford has a condition called Ehlers-Danlos syndrome. She had been almost permanently in hospital, having suffered from joint dislocations after her first surgery when she was 10 and another 19 operations throughout her teenage years. Her condition deteriorated. She became bed-bound at 17. She said:

"I was kept alive by intravenous feeding tubes and taking fentanyl to ease the debilitating pain of dislocating multiple joints a day".

As many people know, fentanyl is an opioid that has been responsible for a very large number of overdose deaths in the USA. We do not really want people to take it if there is an alternative. The alternative to lots of opioid treatments is, in my view, medical cannabis.

Lucy faced extreme pain from a permanently dislocated jaw, and when she was in hospital, she faced potential death from sepsis. Lucy's pain specialist suggested medical cannabis as a last resort. The prescription was turned down for NHS funding, with a letter saying that cannabis was unlikely to work and that there was a one in four chance that she would end up with psychosis, so Lucy and her mother went to Amsterdam and sourced medical cannabis. Eventually, her jaw began to unlock. She was able to reduce her opiates and other pharmaceutical medications. She has since become able to walk unaided. She is now back in the UK and she started a degree in neuroscience at the University of Sussex this September.

Lucy's private prescription for cannabis in the UK initially cost £1,450 a month. She is now enrolled in a medical cannabis trial called Project Twenty21 run by an organisation called Drug Science. I draw attention to my entry in the Register of Members' Financial Interests: I am an unpaid trustee of Drug Science, which does fantastic work in its research into drugs. Project Twenty21 facilitates access to medical cannabis effectively at cost price, once patients have been seen and diagnosed by specialists, so Lucy's medicine now costs her about £450 a month. As an example of the potential saving to the NHS, when Lucy was on a feeding tube her medication alone cost more than £250 a day, and the hospital room cost very much more. Overall, the estimated cost to the NHS is probably more than £100,000 a year. Despite the huge savings, her local hospital trust refuses to allow her physician to prescribe medical cannabis for her on the grounds of

"lack of evidence of efficacy".

That is the key problem in the UK: the difficulty of getting through the barriers in the system. Lucy's life has clearly been absolutely transformed by medical cannabis, but because of the systemic barriers, she has not been able to access it through the NHS. That is not logical in any way. It would make much more sense for the hospital trust to support her.

We know that cannabis-based medical products work for many patients. We know that they are legal. We know that they are effective. They are being privately prescribed by some specialists in the UK, but patients cannot get them on the NHS, so ordinary families are sometimes paying a fortune for their treatment. Some are having to go to Holland to get their medication.

One thing really demonstrates the absurdity of the situation. Because of import-export problems since Brexit, it has now become even more difficult to import Bedrocan products, which are the medicines produced in Holland, so the Government have done a deal that has facilitated the imports and licensed production facilities in the UK. Virtually nobody can get medical cannabis on prescription on the NHS, but the Government accept its efficacy enough to have done a deal with the Dutch Government to ensure a supply of Bedrocan for UK families and have even gone to lengths to start having it produced in the UK. It does not make any sense at all—it cannot be right.

Why are we in a situation where patients cannot get these NHS prescriptions? The general consensus is that it stems from a nervousness regarding the evidence and the guidance about these medicines, and a consequent reluctance of many clinicians to prescribe on the NHS. There are a very limited number who will prescribe privately: in the case of childhood epilepsy, there have been only three specialists willing to prescribe. One is now retired, and the others are not able to take on any more patients, so there is another blockage. There is also a reluctance among clinical commissioning groups and trusts to fund prescriptions; Lucy's hospital trust is a good example.

At the moment, only a small number of cannabis-based medicines are licensed by the Medicines and Healthcare Products Regulatory Agency for the small number of specific conditions that I outlined earlier, so the cannabis medicines that are generally prescribed in the UK are unlicensed and prescribed as "specials". Clinicians, even specialists, are sometimes reluctant to prescribe those unlicensed products. In the narrow pool of those who can prescribe, there is often a reluctance to prescribe unlicensed cannabis-based medicines, owing to a lack of knowledge and training; confusion over conflicting guidance from Government bodies such as the National Institute for Health and Care Excellence, and from the NHS and professional bodies such as the British Paediatric Neurology Association; a lack of confidence in the evidence base because of a lack of randomised controlled data; and ultimately a fear of repercussions because of the personal liability when prescribing an unlicensed medicine.

Currently, only specialist doctors on the General Medical Council specialist register are allowed to initiate a prescription, although GPs can carry it on under the guidance of a specialist. The specialists who do want to prescribe usually face barriers from their NHS trust or CCG, which normally declines to fund the prescriptions. If an NHS prescription is to be made, it has to go for approval to what is called a higher authority, usually a CCG or trust, which is usually reluctant to fund because of the problem relating to evidence and contradictory guidance. I should add that that process applies to no medicines other than medical cannabis.

For some time, campaigners have pressed the NHS and the Department of Health and Social Care to explain the process and the pathway that can deliver an NHS prescription in cases in which an NHS specialist wants to prescribe cannabis-based medical products.

Perhaps the Minister could enlighten us, because although the Government committed themselves to doing that in 2019, it has not happened. The only solution suggested so far is an individual funding request, but we know that families who have tried to take that route have been rejected and told that the patient has not demonstrated clinical exceptionality. It is very difficult to obtain funds in that way. If the impact that medical cannabis has on that cohort of epileptic children with extremely rare and severe diseases is not deemed clinically exceptional, I would ask what is.

There are two ways in which we need to make progress. First, we need clinicians to be confident in the specials that they are able to prescribe, and we need NHS bodies to be confident enough to fund them. Secondly, we need more safe, effective cannabis-based medicines to be licensed. That is a key issue, because although there is a wide body of evidence for the efficacy and safety of cannabis medicines, it is largely patient-reported or observational and evaluative. The UK's medical regulatory bodies generally only license medicines on the basis of randomised control trial data. I do not think anyone would deny that double-blind placebo randomised control trial data are the gold standard for medical trials aiming to demonstrate the safety and efficacy of medicines, but they are not the only way of demonstrating those qualities, and they are very difficult to carry out on whole-extract plant cannabis products.

Cannabis-based medicines are not made up of a single compound, and patients often use bespoke mixtures to treat their conditions most effectively. Let me quote Professor Mike Barnes, as my hon. Friend the Member for Middlesbrough (Andy McDonald) did earlier. He has said:

"While there are some RCTs"

—randomised control trials—

"for CBMPs"

—cannabis-based medical products—they are generally for isolates of those products, and

"the cannabis plant doesn't lend itself to being studied this way as it's a botanical product with several different components."

Many experts, including Professor Barnes, would argue that we need to look at a different evidence base to demonstrate the safety and efficacy of whole-plant extract cannabis-based medicines.

Even Sir Michael Rawlins, the previous head of the MHRA and NICE, pointed out in 2008 that RCTs were not the only way of obtaining getting evidence. He said:

"Randomised controlled trials… regarded at the 'gold standard' of evidence, have been put on an undeserved pedestal. Their appearance at the top of 'hierarchies' of evidence is inappropriate; and hierarchies, themselves, are illusory tools for assessing evidence. They should be replaced by a diversity of approaches that involve analysing the totality of the evidence-base."

There are many other sources of evidence that could equally inform medical practice. They could include patient reported outcome measures—PROM—trials, real-world evidence effectiveness trials, pharmacoepidemiology —I can never get that word right—which means looking at real-world evidence among a large group of patients, observational research, and n=1 trials.

**Barbara Keeley** (Worsley and Eccles South) (Lab): I have been working with a constituent whose son is in this position. Does my hon. Friend agree that the side-effects of the synthetic elements of the products being used are a serious issue? It is all very well to say that trials and evidence are needed, but people are using other products that they are getting privately, and my constituent is desperately worried that the side-effects could proliferate over time when a child has been pushed into taking them.

**Jeff Smith:** That is an important point. No one is claiming that every product is absolutely safe, and products often have side-effects, as Alfie's case demonstrated. He had been pumped full of steroids which affected him badly and would eventually have killed him. That was a medication that was recommended until he started taking medical cannabis.

There is lots of evidence from around the world. Cannabis-based medicines have been legal in Canada and some US states for some time, and there are tens of thousands of individual patient reports on the therapeutic value of cannabis-based medicines in the Canadian and, in particular, Minnesotan databases. They do not equate to the so-called gold standard double-blind randomised control trial level of proof, but they are highly suggestive of a pattern of evidence that should be taken seriously. Another issue is that many people would argue that it is not ethical to insist on RCTs for the cohort of children with epilepsy, as they would have to be taken off the medicine that is keeping them well, and keeping them alive in some cases, to put them on a placebo. Some people would question that process.

In 2019 the Health and Social Care Committee looked at the barriers to access for cannabis-based products, and the Government produced a response to its report in which they made reference to the need for observational trials to help the patient cohort of children with severe epilepsy. Even the Government argued that we should be considering other forms of evidence, and I know from my interaction with the MHRA that it is considering other forms of rigorous, well-researched evidence. Unfortunately, the Government's view seems to have changed. I have spoken to Ministers and officials again, and they seem to be wedded to the idea that RCTs are the only way forward.

My Bill would set up a commission to propose a framework for the assessment of cannabis-based medicines and their suitability for prescription in England, to sit alongside the existing MHRA processes for conventional pharmaceutical drugs. The commission would help rigorously to assess all the existing evidence base and to consolidate all the available evidence, which could give those who are eligible to prescribe more confidence in the evidence for prescribing this particular unlicensed medicine.

I hope that the commission's work will result in a more suitable framework for the assessment of the efficacy and safety of cannabis-based medicines, which I hope would result in more cannabis-based medicines, including whole-plant medicines, becoming licensed. That would go a long way towards addressing the problem. It would improve the likelihood of prescription on the NHS for both severe and common conditions. The commission would also be tasked with identifying any other barriers that could be overcome to improve access. That might result in the adoption of short-term solutions that I will touch on shortly.

**James Daly** (Bury North) (Con): The hon. Gentleman is making an excellent speech on this important issue. From my research it seems that the manufacturers and

*[James Daly]*

producers of cannabis-based products are not investing in the clinical trials and evidence that would be necessary, or at least proportionate in comparison with what happens for other medicines. Will he say why that is not the case, or will he point to evidence of such trials being undertaken by the producers of these medicines?

**Jeff Smith:** The hon. Gentleman makes an important point. Trials are happening, but there are two problems. The first is the cost, because RCTs are extremely expensive. As I mentioned earlier, the problem with RCTs is that they are not really suitable for some of these medicines, such as whole-plant cannabis extract medicines, which is the essential problem. We can isolate compounds and put them through the RCT process, but it is much more difficult with whole-plant cannabis extract medicines. Those are the two difficulties, and I will go on to suggest that the Government could commission trials as a possible way forward.

**Tom Randall** (Gedling) (Con): The hon. Gentleman is making an excellent speech, which I am following with great interest. As I understand it, he is proposing the creation of a new body to look into this matter. We often talk about NHS bureaucracy and so on. Before he goes on to the other part of his Bill, could he explain why he thinks the creation of a new body would particularly resolve the ongoing issue that he has outlined very well? Could the matter be addressed within existing NHS structures?

**Jeff Smith:** The matter is not being resolved in the current processes, and that is part of the problem. I emphasise that I am not proposing a new permanent body; this would be a bit like a royal commission, although I would want it to be much shorter and more focused. It would be a commission of experts to look at the problem and propose a new framework for assessment of the evidence. That would, I hope, lead to a better process for licensing. I reassure the hon. Gentleman that I am not proposing any new bureaucracy.

The other part of my Bill proposes a register of GPs trained in cannabis-based medicine, who could prescribe cannabis-based medicines for certain conditions.

**Margaret Greenwood** (Wirral West) (Lab): My hon. Friend is making an excellent speech, and I know both his speech and his Bill are very much welcomed by my constituents, particularly one who suffers from progressive myelopathy. He is in almost constant pain, and I know he would like to thank my hon. Friend for all his work. On the business of creating a register of GPs trained in prescribing medical cannabis, obviously GPs adopt different specialisms according to what they are interested in and so forth, so what mechanisms would we need to deal with a situation where somebody's GP was not registered when they might nevertheless benefit from a prescription, and how that might be addressed?

**Jeff Smith:** My sympathy to my hon. Friend's constituent; chronic pain is one of the conditions for which cannabis can be very beneficial, and I hope he can find a way forward. I will talk briefly about GPs. My hon. Friend is right that they specialise, but part of the problem with GP training and medical training in general is that there is very little training on the cannabinoid system, so I would not expect all GPs to come forward. She anticipates my remarks, so I will move on, but the point is that there is sufficient interest from GPs to enable her constituent to find somebody who could help with his condition.

I should perhaps be clear that I am not expecting GPs to initiate a prescription for some of the very rare and specialist conditions, such as some of the epilepsy conditions we have talked about, although for childhood epilepsy GPs are currently allowed to continue a prescription that has been initiated by a specialist. Many other conditions that can be effectively treated by cannabis-based medicines, however, are what we might call GP conditions, and chronic pain would be one of them. Enabling trained GPs to prescribe medical cannabis should improve access for patients with symptoms commonly dealt with by GPs, such as chronic pain, muscle spasms, nausea and anxiety. Currently, patients would have to go to a private specialist doctor to access the medicine for one of those conditions. Although GPs would not be initiating prescriptions for the rare and severe patients, training more GPs could result in better outcomes for people with those conditions, such as intractable epilepsy, because their initial consultation with a GP could be more informed about cannabis as a useful treatment and could result in more effective referrals to consultants who could prescribe the medicine.

I emphasise that inclusion on the register would be on an opt-in basis for GPs. I would not expect all GPs to be required to take on the prescription of cannabis, but a significant number—the polling suggests 24%—would be willing to do so. Under the current law, a GP is not allowed to initiate prescriptions, but I am told that 73% are open-minded about playing more of a role in the prescription of medical cannabis.

Those are the two proposals in the Bill. I will briefly outline a few suggestions that have been put forward to me as alternative ways to allow patients to get the medicine they need. A number relate to the evidence base and some relate to funding, because one problem, of course, is the cost of prescriptions. One way forward could be a fund to temporarily pay the cost of the private prescriptions for patients with certain conditions, such as treatment-resistant childhood epilepsy. I know a number of hon. Members in the Chamber have called for that. I cannot propose that in a private Member's Bill, because it is a spending commitment, but I hope the Government will consider it as a way forward, particularly for the cohort of patients with childhood epilepsy. It would be a discretionary fund to fund private prescriptions for those who need them in the interim while our collective failure to allow NHS prescribing is sorted out.

I hesitate to say this in an arena where rampant Euroscepticism has been known to raise its head, but another suggestion is to allow cannabis-based medicines that have been authorised for use by a state within the European economic area to be prescribed by a medical practitioner as if the product in question has been granted a marking authorisation for the purposes of the Human Medicines Regulations 2012. I think that would be a good way forward—it is a way partly to get around the problem—although I do not expect everybody in the Chamber to support the idea. As we know, these medicines are safe, effective and licensed in lots of countries, such as Holland, and we need to learn from places that enable patients to get their medicine.

On funding, another way forward might be to allow a slice of the NHS innovative medicines fund to go towards epileptic medical cannabis patients. Campaigners were previously told that that could be a way forward, but have been told more recently that it is not because the fund is supposed to be only for cancer medicines. That appears to be an arbitrary Government decision and there appears to be no reason why some of that funding could not be allocated to epileptic medical cannabis patients.

On evidence, we could set up a Government office for medical cannabis. The hon. Member for Gedling (Tom Randall) might not like another layer of bureaucracy, but other countries, including Australia, acknowledge the need to treat this medicine differently. They think outside the box and look at all the available evidence and evaluate it robustly. We could mandate the Government to commission more trials or mandate the commencement of an observation trial that involves all children with treatment-resistant epilepsy, as a way to make sure that they get immediate access and to ease their prescription-cost burden. The Secretary of State already has the powers to do that and could set up an observational trial that involves all children with treatment-resistant epilepsy to fund their treatment. As I say, we could establish a patient-reported-outcome-measure study, a managed-access programme—as happened with Orkambi, the cystic fibrosis medicine—or a compassionate-access scheme like the one that currently operates in Northern Ireland and is open to a wider cohort than just children with epilepsy.

There are, then, a number of ways in which the Government could help in the short term and in the longer term. The Bill proposes just two modest measures that might make a difference in due course. If the Government are not prepared to accept the proposals in the Bill, what is their solution? People are in pain and unable to access through the NHS the medicines that in some cases are keeping them alive. We cannot allow this situation to go on because we collectively fail to overcome the barriers. It has gone on for too long and we need to address it.

I suspect some colleagues will speak sympathetically but say that this Bill is not the solution; if they do, I hope they will set out what they think is the way forward and the solution. I am happy to support them if they do, because I just want to find a way forward. My Bill proposes two good ways forward, particularly for the families of children with childhood epilepsy—whose lives sometimes depend on getting these medicines—but also for the many people who benefit from cannabis-based medicines and are denied them by a combination of bureaucracy and inertia. If people are not happy with my Bill and are not prepared to support it, the question must be: if not this, what?

10.34 am

**Katherine Fletcher** (South Ribble) (Con): I commend the hon. Member for Manchester, Withington (Jeff Smith) for bringing this really important matter to the attention of the House. He has made a wonderful speech that has stepped through lots of the dynamics in the debate.

This is a genuinely difficult topic. Many people present today want to participate in the debate and demonstrate their care, compassion and concern for the individuals at the heart of it. Indeed, that is one of the themes that I want to cover today. This is a funny place; it can be quite fraught, which might not necessarily be obvious to those observing us from outside this House. Members have to balance our compassion for an individual with the office that we hold and the responsibilities that that brings. Although I want to talk about a number of the points that the hon. Gentleman has made, I also want to highlight how difficult that trade-off can be.

Since I joined the House in 2019, I have sought, where possible, to find a way of speaking English in a normal way, and I shall try to do that on this topic. When I first pitched up here, I did not really understand the nature of the trade-off. Bills on topics such as this land at the heart of the matter, which is that this is not necessarily a particularly easy or comfortable thing to talk about. I will try to stick with what I promised and use some real-world examples.

With the House's permission, I want to highlight the real-life experiences of one of my constituents in South Ribble, a redoubtable lady by the name of Joanne Griffiths. Joanne is a wonderful individual, but this is really about her son, who she calls "boisterous Ben". Ben has great difficulties with his epilepsy and has struggled with treatment over the years, but before I start to highlight the case and understand how it pertains to the subject, let me give a bit of clarity. Joanne does not support the Conservative party. In the past, she has been on a leaflet with the right hon. Member for Islington North (Jeremy Corbyn). I am not trying to make a party political point; when MPs from whatever party are elected, we are here to support all of our constituents, and we take that job incredibly seriously—I want to put that on the record. She will never ever vote for me, but I will speak for her genuinely and honestly and in a way that is in her best interests. In these more febrile times, that is an important point to make, but let us get back to what is really important, which is Joanne and, more importantly, her son, Ben.

I want to put her efforts for Ben on the record, and the easiest way to do that is to quote her in her own words:

> "It has been three years since the law changed, and I have spent four years fighting for access to what is very much the only medication to have any effect on my son's hundreds of life-threatening seizures per day. Medical cannabis has transformed his life and gives him seizure freedom, and we do not wish any other parent or child in the area to go through what we have, and we are still suffering."

When I was elected back in December 2019, as MPs we could get permission from individuals to act for them and we could take on casework from our predecessors. The complexities of the system mean that that often comes in printed paper form. I was given a large pile of handouts and one file, which must have been 1.25 inches thick. When Joanne says that she has been campaigning for four years, I can tell Members that she has been campaigning for four years. I did not so much pick up that file as weigh it. If any given set of paperwork can describe the emotion and the passion that the debate arouses, it is that sense of, "There you go! Congratulations, you've just won an election, you can help this lady and her family."

Within that case file are letters and notes from Joanne's meetings with her local MP, my predecessor. She has met Ministers, pressure groups and policy researchers.

*[Katherine Fletcher]*

She has been a tireless campaigner. She even had members of my predecessor's staff go with her to attend appointments with medical professionals. Reading that and reading all the correspondence, I can state confidently that Ben could not have a better mother. She is not a tiger mum; she is like a proper lioness defending her son. It is really important that I put my genuine admiration on the record today. She has fought tooth and nail for him. The question that I want the House to examine is: should she have to be that lioness of a mum?

Let me give the House the highlights of what Joanne has done over the last four years—this is by no means all of it. She has fought for medical cannabis to be legalised. She has met the Secretary of State for Health—and all Members of this House know that people do not suddenly turn up with that idea on a Tuesday and then it happens on the Friday; it takes a lot of time, effort and engagement. Along with others, she has helped to secure the legalisation of certain types of medicinal cannabis. She has fought her way through a system that is not really understanding of the issue in order to see a medical specialist. In 2019, through a private prescription, she got Ben prescribed the Bedica oral solution of 20 mg/1ml with 2% THC, and the Bedrolite oral solution 100 mg/1 ml with CBD at 10%, and less than 1% THC. Joanne said:

"For years now we have had to fund raise up to £2,500 a month to fund this medicine, use all our savings and borrow money from family and friends. We are on the verge of being broken both financially and emotionally due to the stress and with Covid, our fundraising options have all but been shut down. This is on top of running a local business whilst looking after a child with complex needs".

That speaks for itself.

Let me turn to the efficacy of the treatment. Ben's response to the treatment was recently described by the individual funding request panel, which the hon. Member for Manchester, Withington mentioned, as "exceptional" with

"demonstrable improvements to his condition".

That is an independent third party effectively saying that the treatment works.

Joanne is still going, because she is still getting that private prescription. She has fought through the NHS system to see a specialist and get a clinical decision to agree Ben's prescription, with the implication that it would be funded through the NHS, but that prescription has been rejected by the local CCG and hospital trust policy. The lioness mum that she is, she is now back in my inbox and in lots of other people's inboxes, and is campaigning to understand what has caused the blockage in prescribing and what is happening. She has got the Secretary of State for Health and Social Care to instruct the NHS to review what is causing the issue and the blockages, so the questions are being asked at the highest level of the Department. She has also written to the Health Committee.

**Tonia Antoniazzi** (Gower) (Lab): As co-chair of the all-party parliamentary group for access to medical cannabis under prescription, I know very well the person and child described by the hon. Lady. Joanne deserves better. Ben deserves better. I am so pleased that we are seeing through the party politics and that you have met Joanne, because this is a ridiculous situation. You are describing four years of hurt, pain and fighting of the lioness that is Joanne Griffiths, and yet nothing has been done. It really upset me, and I am glad that the hon. Lady is on side. You—sorry; the hon. Lady is on the Government Benches, and this situation has to change.

**Katherine Fletcher:** I agree with you—*[Interruption.]* Oh crap! I agree with the hon. Lady. *[Laughter.]* Might as well get something decent on the record! You can take the girl out of the north of England, Madam Deputy Speaker; I apologise profusely. I agree with the hon. Lady, but I think that there are some issues that prevent immediate "do something" action, and I want genuinely to examine them.

**Tonia Antoniazzi:** It has been four years.

**Katherine Fletcher:** I will happily take another intervention once I have been through the issues, but I just want to continue to highlight what this lady, Joanne, is having to do. She has got the Secretary of State to ask the NHS what is going on. Along with other parents, she is still talking to the Chair of the Health and Social Care Committee, whom she and Ben previously met in his role as Secretary of State. As per the advice from the local CCG, she applied for an individual funding request for a prescription with a demonstrable improvement in boisterous Ben's condition, but it was rejected. She appealed in July and won, but on 3 November, the appeal process was deferred awaiting clarification and more information.

As the hon. Member for Gower (Tonia Antoniazzi) highlights, that must feel Gordian—how can Joanne unpick that? She is still fighting and, as hon. Members would expect, I am supporting her. To the point that the hon. Member for Manchester, Withington raised, I have also written to the Secretary of State about participating in an observation trial.

The story is distressing. I cannot see any hon. Member who is unmoved and is not thinking about what they would do in a similar position. It is complicated and I find it hard to reconcile my personal distress.

**Tonia Antoniazzi:** The hon. Lady says that it is complicated, which it is, but we are now in a ridiculous situation. There is something or someone in the system blocking medicinal cannabis getting to those children. Three prescriptions are already being supported, so why can the others not be supported too?

**Katherine Fletcher:** The hon. Lady raises an important point, which I will come to. I think that those individuals are caught in a pincer movement between scientific proof and medical ethics. I am mindful of the challenge of the hon. Member for Manchester, Withington who asked if they cannot do it, what can they do. I will make some suggestions on that.

The distress is genuine and clearly felt on both sides of the House, but the specific definition of practical actions that address the situation is a problem. If hon. Members will forgive me, I will set out the events in order. Since November 2018, the law has allowed for prescriptions of medicinal cannabis, which is no small thing. It has been an illegal drug for a long time, and it is a Conservative Government who brought that in.

That prescription is now a legal tool in the armoury of qualified doctors. Prescription medicine is rightly the preserve of highly qualified and trained doctors. No one would want me wandering down the high street saying, "Oh you look a bit poorly today—go and have a bit of that." It takes years of blood, sweat and tears. Ultimately, when doctors have completed that technical qualification, they take the Hippocratic oath. Today's debate hinges on the interaction between the Hippocratic oath that doctors take as individuals on qualification—I am aware that not everybody swears on the same text—and the Government's ability to feel qualified enough to influence, or seek to influence, doctors' decisions. I think that is where the blockage is.

**Tonia Antoniazzi:** Again, the hon. Lady's generosity in giving way is noted. On that point, is she trying to say that the prescriptions that have already been written privately by experienced clinicians are unethical?

**Katherine Fletcher:** The hon. Lady perhaps needs to let me make some of my points. She keeps asking me, but I am genuinely trying to get there.

**Dr Neil Hudson** (Penrith and The Border) (Con): I am grateful to the hon. Member for Manchester, Withington (Jeff Smith) for bringing forward this important debate. He spoke with power and passion about a very important issue. I want to touch on the comments that my hon. Friend the Member for South Ribble (Katherine Fletcher) made about the difficulties in decision making for clinicians on the frontline. I speak as a veterinary surgeon, cognisant of the difficulties in making rational, evidence-based decisions in our profession when we are looking at licensed products for the species we are treating and having to make tough decisions about when we go off-licence. I am very sympathetic to my colleagues in the medical profession wanting a large evidence base to make them feel comfortable about making those decisions. Does my hon. Friend agree that it is welcome that NICE has made some recommendations about some trials that can take place and that there are trials under way? That will try to help us improve and increase the evidence base to help clinicians on the frontline make rational decisions.

**Katherine Fletcher:** My hon. Friend anticipates a couple of points I was about to make. I am talking not just about the individual who is prescribing, but about the medical system. There are rightly in our wonderful NHS medically qualified people engaged in lots of layers—my hon. Friend the Member for Gedling (Tom Randall) talks about bureaucracy—but they are people who have taken the Hippocratic oath. That is not just the person on the one-to-one with patients; it goes all the way through the system, and that is what I am worried about, basically.

**Crispin Blunt** (Reigate) (Con): Where my hon. Friend talks about the challenge that faces us, she is absolutely on point. The medical profession of course wants a reliable pharmacopeia to be able to turn to, with all the supporting evidence and the rest. The problem that our profession has inflicted on our constituents is that we are 50 years behind in the research. Outside the regular pharmaceutical assessment there is all the knowledge that is on the streets. It is unreliable, but it is there, so people believe that the medicine works in all sorts of ways. We have a responsibility in this place. People are obviously turning to the criminal supply chain to get such products. That is our fault, and the hon. Member for Manchester, Withington (Jeff Smith) is trying to find a way through so that we can get the service to patients that they deserve. That is why I think this Bill at the very least deserves a Second Reading, so that these issues can be pursued in Committee.

**Katherine Fletcher:** I am not sure I completely agree with my hon. Friend on the translation between the two. He almost makes my point for me. He talks about the ubiquity of cannabis on the streets, which I recognise, and the normalisation of that being within people's purview.

**Crispin Blunt:** There is a wholesale difference between people using cannabis for recreational purposes, which we have made illegal and is one for debate, and people using medicines—medicines that we have made illegal and stopped the research—for therapeutic purposes. That is a quite different issue.

**Katherine Fletcher:** I thank my hon. Friend for the clarification. I think I might have used slightly clumsy language. What I am trying to get at is that for therapeutic use, there is still a required research standard. While cannabis is ubiquitous and lots of people use it for non-therapeutic and currently not legal uses—to quote Marshall Mathers III:

"Marijuana is everywhere, where was you brought up?"—

that does not translate into something that I feel I am comfortable in asking clinicians to engage with.

I want to develop my argument. If I may, I will mention my hon. Friend the Member for Crewe and Nantwich (Dr Mullan) and the five years of blood, sweat and tears—literally, I imagine—through medical school to achieve his title of doctor and take the Hippocratic oath. For those of us who have not gone through that journey, it is worth listening to the oath. The original version—its language is a bit dated now—is:

"I will use my power to help the sick to the best of my ability and judgement; I will abstain from all intentional wrong doing or harm".

I think that touches on the point my hon. Friend the Member for Penrith and The Border (Dr Hudson) made about how, to avoid doing harm, there needs to be some certainty either way. In its more up-to-date form—this is the oath that doctors from the University of Exeter take—it states:

"I…pledge"—

I am not pledging myself—

"that I will do my best to serve humanity—caring for the sick, promoting good health and alleviating pain and suffering."

Doctors are coming in wanting to do that, and I do not think the "blockage" that was referred to is anything to do with intention or fuddy-duddyness. Another of the lines they say is:

"I will care for all patients equally and not allow prejudice to influence my practice."

Again, any doctor looking at a child as sick as Ben can be when his seizures are bad are not, having taken that oath, going to go, "Oh, well, there's something I could prescribe." Forgive me for continuing to emphasise the point, but the oath goes on:

*[Katherine Fletcher]*

"I will respect the autonomy and dignity of my patients, and will uphold their confidentiality. I…support…teachers, colleagues and all those who sustain the NHS."

Then it gets to these lines:

"I shall never intentionally cause harm to my patients, and will have the utmost respect for human life.

I will practice medicine with integrity, humility, honesty and compassion.

I recognise that the practice of medicine is a privilege with which comes considerable responsibility and I will not abuse my position."

This oath is a signifier of the integrity of individual doctors and medical ethics. It is their loadstone at the core of what they do, and I agree with them that it needs to be protected at all costs. Each doctor needs to weigh their own decisions, but for these complex cases—especially for some of the people who, by anecdote and, as I would put it, a good old case of looking at, have hugely benefited from medical cannabis—there is not one doctor in the system, but a series of them. While Ben has secured one NHS professor's support for prescription and one private doctor's support for prescription—I draw no distinction between the scale of the personal challenge and the qualifications that somebody has regardless of where they work—other medically qualified professionals within the CCG or funding panel are saying that they need more evidence.

**Dr Kieran Mullan** (Crewe and Nantwich) (Con): I think it is very important for Members to remember that, at various stages through medical evidence building, there have been occasions when people have said very strongly that something, anecdotally, was working, yet further down the line we have discovered that that was not the case. There is therefore hesitancy when it comes to that kind of observational medicine as evidence, because I am afraid it is not reliable.

**Katherine Fletcher:** I thank my hon. Friend for his intervention, and if I do not embarrass him too much, may I also thank him for his service in hospital during the covid pandemic? It is the strength of experience and the variety of experience on these Benches that makes sure, when we do put stuff through, that the laws of this country are scrutinised by people from different perspectives, and he is a great example of that.

Joanne position's is that she is coming to me with Ben saying, "This doctor says he can have medical cannabis, and then I have another set of doctors saying, 'Well, we need more evidence before we can prescribe it'."

**Tonia Antoniazzi:** Will the hon. Lady give way?

**Katherine Fletcher:** No. Would the hon. Member let me, honestly, make a bit of progress? I hope she does not mind; I think I have been very fair.

We have a loving family in a state of limbo, we have medical professionals deeply concerned about whether it is the right thing to do and whether it is breaking their Hippocratic oath to prescribe, and we have someone who is not remotely qualified to make this decision being asked, in effect, to engage in a medical ethics debate when I am not qualified to do so.

I want to turn to another aspect, and this may be the point at which I have to declare my biology degree and a distinct possibility that this might get a bit nerdy. I apologise for that, but geeks may take over the world. I think we need an examination of the other side of this issue: how do the scientists, whether or not they are medically qualified doctors, and how does science provide an evidence base that gives the doctors some confidence and cuts out all of the nonsense? Effectively, I am asking for the House's forbearance on the topic of standards of scientific proof.

To recap, the families of the children, including Ben, believe, based on the evidence of their own eyes—a No. 1 eyeball—that medicinal cannabis has an enormously positive effect on the seizures; seizures that are so distressing. I do not want to keep walking away and making this a theoretical concept, because it is not.

The family have secured the support of two medically qualified individuals, but others believe that the scientific literature lacks the evidence base—as has been pointed out, we do not have the evidence base because we made it illegal for 50 years and it became legal only three years ago—to prescribe specific compounds and drugs. There has not been enough research to understand formally, in the gold standard of a double-blind trial, whether these cannabis medicines do work.

The hon. Member for Manchester, Withington talked about the availability of different formulations of this generic thing, with different strains and different levels and ratios of THC and CBD. He mentioned a trial and error process to get these very sick children and adults a stable medicine that works for them. If it was my child, in extremis and in an emergency, I would want to go through that process, but as I scientist I think that trial and error can lead to rally big problems. It is not good enough to say, "We think medical cannabis has worked, so we'll give you 0.5% or we'll give you 10%".

**Tonia Antoniazzi:** The problem is that we have been having this discussion for many years—ad infinitum. The hon. Lady is standing here today painting that picture. Ben has already had every single possible licensed or unlicensed medicine through the NHS. This is the only one that makes his life incredibly better. It is not a miracle cure, but it gives him a quality of life that he deserves. So do those other children. There is more than anecdotal evidence out there. I think she is insulting the families by making that case today.

**Katherine Fletcher:** The hon. Lady is being unfair. Listening to my words, she will understand that I have that level of emotion about a very poor and sick child, but I am trying to find a way of helping him that does not potentially put other children at risk because we are giving something on anecdote. I remind her that thalidomide was thought to be fine. If we step away from—*[Interruption.]* I cannot hear her chuntering at me from behind a mask. If she wants to insult me personally, stand up please.

**Tonia Antoniazzi:** I would not personally insult the hon. Lady because I do not think that this place is the place to do it. I will happily have a conversation with her afterwards. The issue we have here is that the word "anecdotal" has been thrown around. None of the experiences and none of the work that has been done by

many of the people involved is anecdotal. this is not anecdotal. It is not about ethics. It is about getting medicine to the children who need it because the situation is now intolerable.

**Katherine Fletcher:** The term "anecdote" means, within a scientific context, not statistically proven. While the emotion that the hon. Lady shows on behalf of Ben's family and other families is important, it is also important to step back. If nothing else, the pandemic has shown us the power of science to find the right answers to solve problems.

**Dr Mullan:** It is very important that we do not allow our compassion and our concern about individual cases to cloud our judgment about the fact that the NHS, the Department of Health and Social Care and the MHRA have to put systems in place that apply to every medicine across all the many treatments that are used. Questions like this arise repeatedly about many medicines. We should not use one case or one example to change the whole approach, which overall—as my hon. Friend has explained—aims to keep people safe.

**Katherine Fletcher:** If the Bill solved a specific problem, it could enjoy my support.

**Jeff Smith:** The hon. Lady is making a thoughtful and important speech. May I go back to the mention of thalidomide, which I think is an unfair comparison? Thalidomide went through all the randomised controlled trials. People have used cannabis for thousands of years and nobody has ever found any evidence of any resulting foetal abnormalities, although there have not been randomised controlled trials.

The hon. Lady may wish to correct my impression, but she seems to be saying that randomised controlled trials are the only way to get evidence. I just think that we need to look beyond that. There is a whole wealth of evidence out there—a body of evidence. I am no scientific expert, but that is why I am proposing a commission of experts to look at the evidence and recommend a way forward. I just think that the comparison with thalidomide is not one that we should be making.

**Katherine Fletcher:** I made the comparison with thalidomide because it was an inappropriately researched product that had hugely deleterious effects, because people were not looking properly. I am happy to clarify for the record that I am in no way suggesting that medicinal cannabis could have the same side effects as thalidomide. I am talking about the scientific method.

**Jim Shannon:** On that point, will the hon. Lady give way?

**Katherine Fletcher:** This sitting Fridays thing is fascinating. I would absolutely love to give way.

**Jim Shannon:** The hon. Lady refers to evidence. Sophia Gibson, the daughter of my constituents, has had the use of medicinal cannabis for three and a half years. It has greatly improved her quality of life, reduced her epileptic fits and given her the opportunity to transcend from primary school to secondary school this year. Her parents have a very strong evidential base that it works.

**Katherine Fletcher:** I know her parents do, but as a scientist taking a decision on an n of 3—n being the number—it is not possible.

**Several hon. Members** *rose—*

**Katherine Fletcher:** Let me make a little progress. I am trying to defend science, but I am incredibly conscious that others want to speak and have other perspectives on the matter.

August bodies such as the British Paediatric Neurology Association, the General Medical Council, the National Institute for Health and Care Excellence and the Royal College of Physicians have all issued guidance around the original change in the law, which was initially cautious. NICE has recently updated its guidance to state:

"There is no recommendation against the use of cannabis based medical products."

However, it still does not address the issue of a positive evidence base for the safety and effectiveness of these drugs. How do we do that?

**Mark Fletcher** (Bolsover) (Con): In response to some of the passions expressed, I want to say that my hon. Friend is making an incredible speech. Not only is it emotional, but it outlines the difficulties of ethics, decision making, science and research. I have listened for the past 30 minutes, captivated by the way in which she is presenting the matter to the House. On behalf of all hon. Members here today, may I say thank you?

**Katherine Fletcher:** I thank my hon. Friend. I reassure the House that it is not only a surname that we have in common.

I think we are getting somewhere. We need a scientific evidence base that we can prescribe to doctors or the system more broadly that will give them more confidence—or, as the hon. Member for Manchester, Withington suggests, effectively a bypass mechanism that says, "I know we haven't got any evidence, but on this we'll have to look at the very compelling but relatively small numbers." There is an implication that we should just throw out what is working very well.

This is where the hon. Member might welcome what I am trying to get at—well, he might. The gold standard randomised controlled trial requires a very strongly controlled placebo. There are two cohorts of people who absolutely do not know whether they are on the placebo or the real thing, because there are a series of cognitive biases that can kick in if they think they are receiving a medicine and are not. I agree 100% with, and understand why, anybody whose child is currently taking medicinal cannabis and is stable and happy, would never put themselves in a position where they would have a one in x chance of receiving a placebo as opposed to the medicine. I spoke with Joanne Griffiths directly about that and I understand that.

However, during the covid pandemic the scientific establishment has changed trial design and its ways of doing things, so it has to be possible to find a placebo cohort of children with similar conditions who are not taking additional cannabis medicine. There are a number of reasons why people might choose to not use it. The UK is not an island. The other problem is that the numbers are fantastically low, so there is a relatively low pool of people to play with. However, the UK has

*[Katherine Fletcher]*

shown itself to be a leader in global science. I think it would be possible to find, in other countries where they have not taken the progressive steps we have taken in the UK to legalise medicinal cannabis, a group of children with similar medical conditions and use them as the placebo. There is an opportunity for the scientific community to maintain the gold standard of a double-blind trial, but not necessarily put people in the position where they need to come across.

My call to Government would be to speed up the current observation trials and to engage with scientific leadership—remember, it is this Government who are putting extra billions into research and development because we are a science superpower—on a more creative RCT trial, looking for the placebo that proves or disproves it over a series of numbers on a global scale.

I will draw my remarks to a close. It is in the pincer between medical ethics and standards of evidence where, tragically, young men like Ben sit, and we see the distress. There are potential solutions. I see the sense of measures in the Bill, but they come back too much to the idea that by voting for the Bill as an MP and as an unqualified individual, I will be telling a medical professional what to do. That is how I read the Bill.

**Crispin Blunt** *rose—*

**Katherine Fletcher:** I am very conscious that others want to come in, so I am going to crack on.

While I am a nerd and I can understand the science, I think we are on shaky ground if elected individuals get into a position where we are strongly incentivising the system or telling medically qualified people who have taken an oath what to do. I do not think it is possible for us to say, "Okay, I know we do not have peer review evidence that that particular drug x on that percentage formulation can work, but the family says it does and I can see it does, so off you go and prescribe it." Simply put, I do not think we can tell doctors what to do. I say that with a genuinely heavy heart.

I hugely commend the hon. Member for Manchester, Withington for bringing the Bill before the House today. I thank the hon. Member for Gower for her passionate contribution. I know she will continue to stick pins in me to make sure I continue to work behind the scenes. *[Laughter.]* My final message to Joanne is this: "I know you think I don't care. I do. I just cannot support the Bill today."

11.14 am

**Andy McDonald** (Middlesbrough) (Lab): I confess to having been depressed many a time in this Chamber, but after that last contribution I cannot remember feeling as low as I do at this moment. *[Interruption.]* I ask Members please to take this Bill seriously. It is not in any way about telling medical practitioners what to do. I ask them please to read the Bill. The proposition opposite the argument around placebos that we would somehow look to a cohort in some other jurisdiction for available children to participate fills me with absolute and utter horror.

I rise to speak in support of the Bill, and in doing so I congratulate my hon. Friend the Member for Manchester, Withington (Jeff Smith) on his masterclass. If anybody needs to understand what Members have tried to persuade this place to do over many years, they should read that speech in *Hansard*. It was a comprehensive account. But we are here yet again. With respect to the hon. Member for South Ribble (Katherine Fletcher), she has taken us back years in going back to the basics—to the very beginnings of this debate—and I regret that bitterly. My hon. Friend has brought forward a modest, focused and eminently reasonable Bill, which I trust and hope will gain the support of the entire House.

The application of medical cannabis extends to and is of benefit to those with conditions such as intractable nausea, vomiting and chronic pain, but I want to focus my remarks on cases of epilepsy. We have had many a debate in this place about medical cannabis and heard incredibly moving stories from families about its wonderful efficacy in response to severe treatment-resistant epilepsy. Only last month, we had an excellent debate in Westminster Hall, secured by the hon. Member for South Leicestershire (Alberto Costa), who spoke with such eloquence and forensic accuracy about the efficacy of these treatments. We also heard from the right hon. Member for Hemel Hempstead (Sir Mike Penning), who has been a determined advocate in this campaign.

Notwithstanding the welcome change to the law to facilitate NHS prescriptions of medical cannabis, only three such prescriptions have been issued in the three years since 2018. As such, the parents of children with intractable epilepsy, knowing that the medical cannabis treatment they have procured works, with seizures much reduced or eliminated, have been left at breaking point emotionally and financially, having to find up to £2,000 a month to pay privately for this medicine. There can be no question but that those who issued those prescriptions did anything other than obey the Hippocratic oath.

None of us can imagine how on earth those loving parents cope with such massive costs. Up to £2,000 a month—that is the equivalent of an additional and very substantial mortgage; in fact, it would dwarf many people's mortgage payments. Not even we MPs, on over £80,000 a year, could cope with that. How on earth can we expect those families to withstand those huge costs simply trying to keep their children alive and free from the ravages of seizures by accessing a known and proven prescriptive solution? That these families cannot secure NHS prescriptions for their children, when it has been proved beyond doubt that cannabis is efficacious, is a monumental shame. The campaign group End Our Pain rightly said that this saga has dragged on for far too long. Those families have petitioned, marched and campaigned with such dignity. They should not and must not be ignored.

The new Secretary of State for Health and Social Care was pivotal in the change in the law when he was Home Secretary. I urge him, the Minister and the Department to give effect to that change and remove all barriers to getting medical cannabis to those patients. The Bill will make an invaluable contribution to increasing prescription capacity by pointedly freeing up one of the blockages in getting these vital prescriptions to the people who desperately need them and who so evidently benefit from them.

It is a simple Bill with a mere three substantive, but very precise, clauses. The overall effect will be, first, to require the General Medical Council to operate a register of general practitioners who may prescribe cannabis-based

products in England, changing the position from prescription only by consultants. It will also require the GMC to set the criteria to include training and professional development requirements to enable GPs to be on the register. It is up to each GP to decide whether they participate.

The second limb of the Bill will establish a commission to bring forward a framework for the assessment of cannabis-based medicines and their suitability for NHS prescription, and it will task such a commission with recommending measures to overcome barriers to gaining access to cannabis medicines on the NHS. I am sorry that the hon. Member for South Ribble is not in her place.

My hon. Friend the Member for Manchester, Withington has made provision in such a commission for the careful consideration of evidence other than from conventional controlled trials, including from observational studies and other countries where cannabis-based medicines are more readily prescribed. This is not a case of licking a finger and sticking it in the air. It is about proper research on which we can rely. We have heard it explained to us how randomised trials are not the appropriate way to go about business. In any event, that being held up as the gold standard is certainly open to debate.

I am afraid that the mantra of conventional random trials is simply inhumane. We have a situation where patients and their families know that this works, but the current system is trapped in inflexible and flawed processes that badly fail epilepsy sufferers, who have to mortgage all that they have to pay for these prescriptions or continue to suffer the ravages of seizures and often some dreadful side effects of powerful drugs. This Bill is a careful step along the way in addressing one small part of the blockage to sufferers getting the right treatments.

Somewhat belatedly, I must declare an interest, Madam Deputy Speaker, as I have a 26-year-old son with epilepsy and severe developmental delay and special needs as a consequence. I would like to explore further whether medical cannabis might be of assistance to him, but hitherto, the system is as resistant as the condition itself. He had two older brothers, one of whom we lost when he was just 16 years old, 15 years ago—colleagues will have heard me mention him before. I do not know whether medical cannabis would have helped him, had we even known about it then, but I will do everything I can to assist families right now in their determination to get the medication that their children need.

We were confronted with our beloved Rory locked in status. I recall so vividly calling the ambulance and having him whisked off to hospital, where the consultant told us we better call a priest, and then all of us, my wife Sally, my son Paddy and my daughter Rosie, holding Rory as he died. I never want to have any of those families suffer such an outcome. I bitterly regret that I have not shown the courage and determination of people such as Hannah Deacon in securing that medication for her child. How I wish I had been as wise as she. I beg right hon. and hon. Members not to talk this Bill out today, as they have been instructed to do, but to do the right thing and help to take this small step today, to remove one of the barriers placed in the way of people so desperately in need of these treatments and to give them access to this life-changing and indeed life-saving treatment.

11.25 am

**Mrs Natalie Elphicke** (Dover) (Con): I am extremely moved and saddened by the comments of the hon. Member for Middlesbrough (Andy McDonald). My great sympathies and good wishes to him and his family.

This is such an important topic to be discussing today, and I thank the hon. Member for Manchester, Withington (Jeff Smith) for introducing his private Member's Bill. The issue affects many people up and down the country, adults and children alike. I welcome the opportunity to speak in this debate and will focus my remarks on epilepsy in children.

My constituent, Teagan Appleby, who was mentioned earlier, is one of those who cannot access medical cannabis on the NHS. Teagan is reliant on medical cannabis to manage her epilepsy so that she does not suffer hundreds of fitting episodes. I pay tribute to Teagan's mother Emma for her superb care of Teagan. It is simply unfair and unacceptable that, in addition to looking after Teagan, Emma has to raise thousands of pounds each month to get hold of Teagan's medicine. That should not be the case—that is what our NHS is there for. The law was changed by my right hon. Friend the Secretary of State for Health and Social Care when he was Home Secretary, but too many people simply cannot get an NHS prescription in practice even after that change.

Teagan's case was one of the first constituency surgery cases I worked on after being elected in December 2019. As is the case for many hon. Members representing children who have epilepsy and need medicinal cannabis, the issue has gone on for many years—too many years. Many hon. Members have worked hard to secure access to the medicine, and I pay tribute to them for all the work that has been undertaken. I attended the debate on this topic here just over a month ago, on Thursday 4 November, which followed the Westminster Hall debate on 3 November, to which the hon. Member for Middlesbrough referred, where the narrower topic of the situation for epileptic children was explored.

Pursuing the situation for Teagan, I had fully expected that it would be a case of, "Where there's a will there's a way". I am sorry to say that has not been my experience of the NHS in this case. Instead it seems to be, "Where there's no will, no one will pay". I do not mean political will. As has been set out time and again in this place, the political intent is clear and I truly believe it is cross-party.

I was present when the Minister for primary health, my hon. Friend the Member for Lewes (Maria Caulfield), said last month:

> "The Health Secretary and I are committed to doing everything in our power to accelerate this work."

I have spoken to her personally about the sad situation that affects Teagan and I have absolutely no doubt about her resolve or that of the Government resolve on this. She said further:

> "We have changed the law, but that has clearly not been enough. We need to find a resolution, so that we can get these medications licensed if the clinical evidence is there, and we need to work with the regulator."—[*Official Report*, 4 November 2021; Vol. 702, c. 1120-21.]

I agree with her: the law has changed, but that is not enough. It is not enough to ensure that Teagan gets the medicine she needs on the NHS.

*[Mrs Natalie Elphicke]*

In my own experience of pursuing the matter as a constituency MP, I have seen the blocks and barriers to helping Teagan at first hand, as I am sure many others have in many other cases within the NHS. These blocks and barriers are harder to overcome because of the specialty of dealing with those children and with specialised medicines in a shared care environment. This is one aspect that clause 1 seeks to address.

Medical cannabis can be prescribed on the NHS, and changes were made in November 2018 to legalise that position. Although that class of drugs is unlicensed, it is not unlawful. Plenty of unlicensed medicines and treatments can be prescribed on the NHS. Indeed, I once read that exercise might be available for prescription on the NHS, but I am not sure whether that is the case. I have been able to confirm that the National Institute for Health and Care Excellence has approved the funding of the Alexander technique for Parkinson's disease, as well as ginger and acupressure for reducing morning sickness.

This particular drug, cannabis, is illegal, and I support that position and fully oppose a relaxation on or general legalisation of cannabis. The same is true of morphine, which is sold illegally as heroin. I support that position and fully oppose the general legalisation of heroin, but I have needed morphine in hospital and have been utterly and profoundly grateful for the relief it gives—other Members may have had the same experience. I am mindful of that, which is why it is vital that we find a way to support Teagan and those like her who need access to the medicine that works for them.

That support is twofold: money and prescribing. I am afraid it cannot wait for the outcome of years of medical trials or the vague hope that some company will want to invest in developing further research in this area, because this is an issue that affects, in numbers, relatively few children, but its impact on their quality of life and their condition is utterly profound.

Of course, medicines need to meet the highest standards, and there must not be a question of opening Pandora's box and legalising cannabis through the back door—I know some hon. Members are concerned about that aspect of the debate. That will need to be explored further in Committee to ensure that the Bill is entirely robust.

For me, the question is how I can help Teagan and other children like her to get the support they need paid for by the NHS. Subsection (2) of proposed new section 34CA of the Medical Act 1983 sets out that a register may be kept of prescribing GPs. At the present time, there must be concern that the terms and conditions of what is described in the subsection as the "criteria" and "training" elements may not resolve the problem faced by Teagan, and a number of Members have referred to the hesitancy within the medical profession on some of these issues and have recognised the immense specialty of these issues.

Let us suppose that Teagan's GP is willing to prescribe. The money to pay for prescriptions currently needs to come from the area's clinical commissioning group or the main NHS funding for exceptional medicines. I have tried both sources for Teagan without success. I ended up in a perpetual loop: essentially this is not an approved medicine, so it will not be funded, even though it is a legal medicine that can be prescribed. Some specialist consultants do not accept that the medicine works, even though it clearly does work for those families who have children taking it. Teagan's mum knows it works, which is why, month after month and year after year, she tirelessly gets the money through fundraising to help her daughter get the medicine she needs. If Teagan does not get the medicine she needs, she gets more ill; if she gets the medicine she needs, she is better. Sometimes the particular type of medicine she needs has to change in order for it to remain effective. Then it is changed, and she is better again. That seems to me to be unquestionable and reliable evidence. Indeed, it can be found in Teagan's own medical records, including those that are kept when she is hospitalised, which she is on occasion.

I am mindful of what was said by my hon. Friend the Member for Crewe and Nantwich (Dr Mullan), but I would suggest that that is documentary and professional evidence, given that it is in Teagan's medical records. Prescriptions are being given for this medicine. I therefore do not accept that the evidence is simply observational, as was suggested by my hon. Friend the Member for South Ribble (Katherine Fletcher). I realise that she was referring to it in a scientific context, but, as she said herself, we are having a debate that people can understand and connect with. These are not "observations" by Teagan or her family; they are clinical notes in her formal medical records, and I think that some of the evidential base that is needed can be found in those few but very well-observed and well-documented cases in which children are using this particular medicine.

**Dr Mullan:** I think we need to understand that this is not just about whether a treatment works for a particular patient. There are plenty of treatments that work, but with more study and better understanding we come to recognise that there are many side-effects, and that problems that might crop up among a small number of patients could turn out to be devastating. We must be careful about what we mean when we say that a treatment is effective. We have all just experienced the process of approving a vaccine which we know works, but which we also know has severe side-effects. We must look at a bigger picture than what happens in the case of any one individual patient.

**Mrs Elphicke:** My hon. Friend clearly has considerable practical experience in medicine, and, as I have said, the subject of medical cannabis and the treatment of children is very much a specialist area. However, it would be perverse indeed for people to be ordered to have a medicine that they do not want—my hon. Friend has raised the question of research and the covid vaccines—while others are prevented from getting medicines that they do want when they know that they work.

**James Daly:** My hon. Friend is making a powerful speech, and I ask this question with the aim of developing my own knowledge of the subject. According to what the hon. Member for Manchester, Withington (Jeff Smith) said about the two-stage process of being referred for treatment, there is a clinical referral which is then considered by the clinical commissioning group. In Teagan's case, after the clinical referral did the CCG cause the blockage? If so, were clinicians at a CCG level or non-medically qualified people making that decision?

**Mrs Elphicke:** As I said earlier, that is the perpetual loop. This is not an approved medicine, so it cannot be funded despite being a legal medicine that can be prescribed. The prescription element is of particular concern to a number of Members. In view of the hesitancy and the expertise about which we have heard today, the pool of people who might be able to prescribe this medicine on the NHS is not a large one, and I think that that is largely what is driving the proposals in the Bill.

I want to say something about professionalism, a subject that has arisen more than once today. Private prescriptions from qualified GPs are being given by qualified specialists in this area. As with so many areas of medicine—and Members who are doctors will know this better than anyone—some doctors believe that one medicine will work for some patients and another will work for others, and different doctors take different views. It is important to note that these are professionally prescribed private prescriptions. The issue is that the prescriptions are not available where they are needed on the NHS.

I will move on to funding and why the drug might not be funded because of the status of the medicine and the licensing. I have heard the Minister for primary care refer to the licensing tests of quality, safety and efficacy, which all hon. Members would agree are important. The quality and effectiveness of medical cannabis in the few cases relating to epileptic children can be satisfied. It is obtained openly via private prescriptions through recognised channels. As I have said—and I emphasise this for Conservative Members in particular—that is lawful. It is medication lawfully prescribed by doctors. It is NHS prescribing that is the barrier.

On safety, there is always a risk in having any medicine, and there are consequences of not having it. A professional doctor and those involved in medical care will look at what happens when someone has a particular medicine and its potential risks, and what will happen if they do not. In this case, not having the medicine results in worse health outcomes, and a worse quality of life, for Teagan. If the Alexander technique, acupressure and ginger can be funded on the NHS, it should be considered whether the right bar is being set for Teagan's medicine to be funded.

My hon. Friend the Member for South Ribble mentioned the speed with which the covid vaccination got regulatory approval—a pace and speed that we have not seen with medical cannabis. Some of the Acts that we pass in this place have effects that can be measured in centuries, such as the Environment Act 2021; we will move on to discuss climate change more generally later. Some of the decisions that we make in this place, however, have an impact on lives that can be measured in days, months and years. I suggest that this is one of those cases.

The Government have authorised the medicine to be available—that decision was taken. It is about completing the journey, so that there is the intended effect of ensuring that where clinically appropriate and in a child's best interest, that child can be treated with the right medicine for them under the correct supervision and that that medicine can be funded on the NHS.

Teagan Appleby needs medical cannabis to improve her serious health condition. Without it, she suffers from fits. With it, she is so much better. That is why I support the prescription of medical cannabis on the NHS for little Teagan and the other children who clearly need it. I pay tribute Teagan's mum, Emma, who has been a tireless and energetic campaigner on behalf of her daughter to get the medical treatment that she needs. I close by thanking again the hon. Member for Manchester, Withington for bringing forward the bill and the Minister for her attention to Teagan's case and the matter.

11.43 am

**Jim Shannon** (Strangford) (DUP): It is a pleasure to follow the hon. Member for Dover (Mrs Elphicke). I wholeheartedly agree with her point of view, as do other hon. Members. I refer to what she said about "completing the journey", which is what we want to do today, so that we can get to where we want to be. I commend the hon. Member for Manchester, Withington (Jeff Smith) for bringing forward the Bill, which I am pleased to see being debated in the House. I commend the hon. Member for Middlesbrough (Andy McDonald) for his personal story, which served to emphasise to us in this House how important it is for the Bill to pass. I know that it was hard for him to tell us that story, but it was also hard for us to listen to it because we sympathised with him. I thank him for sharing his story and for giving us that force of personal experience, which makes a difference.

I thank you, Madam Deputy Speaker, for allowing me to speak this morning. I will not detain the House for long; I intend to keep my comments fairly concise. I shall give as an example one story, which I will leave with the House. Along with other Members, who are all in their places today, I am well known for advocating medicinal cannabis under specific circumstances. I fought furiously for young Sophia Gibson in Newtownards to get the medication that her parents knew would make a difference to that sweet little darling of a girl. The following note is from her mum and dad who fought night and day for their child. They went to live in Holland, as others have said, and tried to raise funds. They did all of this alone and in desperation, which underlines the battle that is faced by parents throughout the United Kingdom of Great Britain and Northern Ireland and why I am supportive of access to medicinal cannabis in certain circumstances. As the hon. Member for Dover said, I am not talking about a universal application or prescription for medicinal cannabis; it is specifically for those whom it can help from a medicinal point of view. That is what I have always said. Perhaps I put things very simply, but that is what I think this Bill is about, which is why I support it.

I do not want to take too long, but I will quote the parents' story:

> "Three years ago, our lives were changed when Sophia received the great news that she would get her whole plant medicinal cannabis medicine via an NHS prescription. The expert panel was set up to help children like our daughter, but was quickly scrapped. Three years ago, the law surrounding medicinal cannabis was changed, but nothing has changed since. There are still only three whole plant medicinal cannabis NHS prescriptions in the United Kingdom. Why, we asked, when this marvellous medicine has kept our daughter out of hospital for over three years, has improved her life immensely, and kept her seizures the most controlled that they have ever been in all her young life. Some say that this is classed as anecdotal evidence"—

I say that it is not. It is real evidence, as the hon. Members for Dover and for Manchester, Withington have also said—

*[Jim Shannon]*

"but we are with Sophia the most and see the difference. The hospital records speak volumes: Sophia has not needed to avail herself of ambulances, of A&E visits and of hospital ward visits for over three years."

Is that not evidential basis for thinking that change can make a difference? I respect the fact that others have much more understanding of medical and health matters than I, but, I have seen evidence from my constituents. The parents continue:

"These are facts. Why can't other children and adults avail themselves of this medicine via the NHS? Why has it become a two-tier system that, if you have the money, you can avail yourself of it? Why are so many forced into fundraising, selling their personal belongings, or taking loans out just to keep their loved ones safe?"

The hon. Member for Middlesbrough referred to that. The parents said:

"Imagine every month having to add over £1,000 to your essential bills for a medicine, because that is exactly what some families are forced to do, being so scared that if you don't have that money what will happen to your child."

That is the reality for some in the United Kingdom today. Let me read on:

"We know we are blessed and so fortunate to have an NHS script because we know that we couldn't afford that money each month for a private prescription. We thought three years ago that, after the three prescriptions, many more would follow, and what a let-down it has been. Soul destroying for us because you feel bad that you have an NHS script and others don't. Why do our loved ones need to suffer—whether it be physically with seizures or mentally—and have this additional stress when, three years after a standstill, we have some of the best resources, doctors and health service in the world?"

I pay tribute to our NHS and to everyone involved. In this House, we are privileged to have those who make a contribution to it every day. The parents end with these words:

"We could have been leading the way, but instead we are stalling, passing the buck with no answers or resolutions for these families. How many more lives will be taken or be at risk before they can get the medication that they want"—

that is what the hon. Member for Dover said and that is what I endorse as well. They said:

"Families have enough stress and worry without having to do all this. We hope someone, somewhere"—

in this House—

truly listens and can have the answers for us all."

That is a wee summary of Sophia's story.

Sophia has not been in hospital since July 2018, which is three and a half years ago. Her seizures have reduced dramatically and are managed at home, as they are so brief. The change is almost miraculous, yet families throughout the UK are forced into a two-tier system where if they can afford a private script to help their child, they can have it. Sophia's parents have said, "We know we are blessed"—and they are—"and so fortunate". They still to this day do not know why Sophia's consultant had a change of heart, but he did, and my constituents today benefit from that and his courage to stand out from the crowd and take a chance on the only medicine that has helped Sophia.

This year marks the end of Sophia's time in primary school and her transitioning into high school next year. Did Sophia's parents ever think that would happen? There were times they thought they would never see the day, as they thought on many occasions that they would lose her. They and we thank God every day that her neurologist in Belfast prescribes the medicine. Whole-plant medicinal cannabis worked for their precious little girl. We just need other NHS neurologists to listen and take the chance and give all those loved ones a chance at a better quality of life.

I understand that people have a different point of view, and I always respect other points of view, even though I may not agree with them, but I urge those who are not yet convinced—I look to the Minister, for whom I have great respect on a personal basis and as a Minister, and she knows that—that today we have an opportunity to change lives in this House with something that I have seen makes a difference.

To conclude, nothing I could say could explain it better than Sophia's story. That is why I stand today for Sophia Gibson's story, and also for the family of Jorja in Dundonald in the constituency of my hon. Friend the Member for Belfast East (Gavin Robinson), so that they can have the new life they need for their child, like with Sophia. I again commend the hon. Member for Manchester, Withington on bringing forward the Bill. I implore—others have said they would beg, and I would beg if that is what it takes—the Minister to make the change and make it happen today. It will save lives. It will lift quality of life and it will, I believe, be an answer to prayer.

11.52 am

**Crispin Blunt** (Reigate) (Con): What a terrific debate to have the privilege of taking part in. I have spoken on this subject before, so I will try to keep my remarks to a minimum, because many of them are already on the record, and I want to respond to the points raised in the debate.

First, I record an interest—it is not a financial interest—as I chair the Conservative Drug Policy Reform Group Ltd. I am unpaid for it and have no stake in it, but it is a think-tank that I have set up to try to get evidence-based policy delivered and to make the case on drug policy in its widest forms. We are dealing today with the opportunities we have missed due to the absence of drugs from the development of medicine. Given also the awful criminal justice consequences of our wider drugs policy over 60 years, I believe it is vital to get proper evidence into this space to guide our policy. That is why I welcome the Government's drug strategy, published just a few days ago, with its commitment to evidence and data, and it is on evidence and data that we should be formulating policies.

It has been a terrific privilege over the past four years to work with the promoter of the Bill, the hon. Member for Manchester, Withington (Jeff Smith), who has become my friend in this cause. To colleagues, and in particular to my hon. Friend the Member for South Ribble (Katherine Fletcher)—she gave a very brave speech to juxtapose the almost unanswerable case of her constituent with the wider challenge of exercising our duty as Members of Parliament—when she says she wants to oppose the Bill, I say to her, "Not yet." The issues that have been engaged in here, and the debate that is being had, deserves to go to a Committee of this House so that discussion can continue. It would be quite wrong to oppose this Bill on Second Reading. It is fine that, after

all the efforts of the Government, who have been trying to engage with the hon. Member for Manchester, Withington to find a route that they could support, we have not yet been able to get that route, but let us continue that discussion in Committee. The debate will continue anyway; we are trying to find the right construction of our analysis of the evidence in order to arrive at a better answer than we have today.

The raw emotion engaged by the magnificent speech from the hon. Member for Middlesbrough (Andy McDonald), and the emotion surrounding speeches made by other colleagues on behalf of their constituents, is incredibly powerful in its own right, but my hon. Friend the Member for South Ribble quoted the doctors' oath, which says:

"I will…not allow prejudice to influence my practice".

If only our profession had done the same, because the position of cannabis and the psychedelics in schedule 1 to the Misuse of Drugs Regulations 2001 is not supported by any evidence. Why on earth is heroin subject to fewer controls for research purposes than the psychedelics? I am not aware of any cases where the psychedelics have directly caused harm—obviously nothing like the scale of harm caused by drugs that have been made legal, such as alcohol and tobacco, or by the opiates. In response to parliamentary questions, the Home Office has been unable to produce the evidential base.

The rotten truth about cannabis is that its position in the regulatory framework rests on the racist policing of the United States in the 1950s, which is the basis of the world's approach to drugs policy, and that basis is morally bankrupt. When we have now to deal with the consequences, we ought to bear that in mind. We have a duty to try to find a way to make good the damage that we have done. When I say "we", I mean 50 or 60 years of politicians, who have avoided engaging in these difficult questions. We have put ourselves on a moral high mountain, and have not been prepared to engage with the difficult trade-offs that are engaged by this issue. Our objective should be to protect the public good and to have a positive outcome for society through medicines and treatments—the positive things that drugs can do—as well as to minimise the damage that they can do.

I want to draw the attention of the House to the work of the magnificent people who work at Conservative Drug Policy Reform Group Ltd. The organisation is not part of our party, but I fully accept that its principal objective is aimed at our party because the position on the centre right is naturally rather more resistant to change than, perhaps, other parts of the political spectrum. Eighteen months ago, the group produced a terrific review of where we are on medicinal cannabis, called "The UK Review of Medicinal Cannabis", which identifies, as a consequence of our policy, how many people are being driven into criminality in order to get the therapeutic use of a medicine based on cannabis.

It is not right that there are about 50,000 people growing their own cannabis to try to treat their multiple sclerosis. We should be in a better place and serve people better. We should not need Carly Barton to have to produce a pass to say that people have a diagnosis that might suggest that they would need medicinal cannabis in order for them to avoid arrest. All those people are formally at risk of 14 years in prison in order to access a therapeutic product. We are not in the right place on this issue, and it is up to us to try to correct it.

I totally agree with my hon. Friend the Member for South Ribble that we should not impose the answer on medical professionals, scientists and researchers, but I am afraid that that is what we have done, which is why we are held in collective contempt by the body of science and research. Opportunities have gone begging over decades because our drugs policy, in its widest sense, has not been informed by evidence and data.

**Katherine Fletcher:** My hon. Friend paints a picture that I recognise in part, but I am sure that he would welcome recent innovations and changes in the law, such as the Government allowing psilocybin—magic mushrooms—to be used in research on clinical depression. Does he welcome the fact that there is movement in this space despite, I grant you, more than a century of ignorance in the area?

**Crispin Blunt:** I fear that I missed what my hon. Friend refers to, because it still sits in schedule 1. When my team first presented the case for moving psilocybin out of schedule 1 so that we could actually do some research at scale, I thought that the case was so blindingly obvious that it would take about five minutes to speak to a Minister and get it done; indeed, I had a conversation with a Minister that rather implied that. But then we ran into what colleagues might in other circumstances call the blob—the endless circuit on which the family of Teagan Appleby have found themselves, as my hon. Friend the Member for Dover (Mrs Elphicke) explained.

I simply say to colleagues, given the data that I will publish through the Conservative Drug Policy Reform Group next week, that it is a substantial majority position in this House that our drugs policy is not working and we need to do something about it. The worst signal that we could send would be that we are not going to continue the conversation about the proposal in the Bill by sending it into Committee. If we do not give it a Second Reading, that is what we will be doing. Let us get it into Committee and continue to have the conversation. Whether it is fit for Third Reading, or for the Government to support, is a decision we can take later.

12.1 pm

**Tonia Antoniazzi** (Gower) (Lab): I rise to support the Bill. I am very proud of the work that my hon. Friend the Member for Manchester, Withington (Jeff Smith) has done to break the barrier that is there. I commend the hon. Member for Dover (Mrs Elphicke); I know Emma Appleby and Teagan very well, and I listened with joy to the hon. Member's words, which show her great understanding of the situation that Emma finds herself in for her child to survive. She is one of many parents we work with. As co-chair of the all-party parliamentary group for access to medical cannabis under prescription— with the hon. Member for South Leicestershire (Alberto Costa)—I am very proud of our work, particularly with the hon. Member's predecessor, the right hon. Member for Hemel Hempstead (Sir Mike Penning).

This has been a journey. I have been in this House for nearly four and a half years, which is not a long time—I am quite a youngster by many standards—but I remember standing at the doors on a Friday, overhearing the conversations of peers from across the House. Basically, they were laughing at a Bill introduced by my late hon. Friend the Member for Newport West, Paul Flynn. It

*[Tonia Antoniazzi]*

really did break my heart, because Paul worked tirelessly to break that barrier and get medicinal cannabis legalised. Soon after he passed away, we had a breakthrough thanks to the campaigning of the right hon. Member for Hemel Hempstead, the End Our Pain organisation and the tireless work of Hannah Deacon and Peter Carroll. Those people must be remembered in this House, along with the many, many parents and people working alongside them, as well as the hon. Member for Reigate (Crispin Blunt). Many people are fighting for the cause.

We are in a ridiculous situation, and I am very emotional. My hon. Friend the Member for Middlesbrough (Andy McDonald) has spelled out what it is like to be a parent and have that loss. I cannot even bring myself to imagine it. It does not matter whether you are a parent or not; to see these children is heartbreaking. It is four and a half years since I stood here incredulous at the mockery made of the Bill that was being brought forward. The law has changed; we have had three prescriptions on the NHS. We have had no other change.

I thank the Minister and the Secretary of State for our recent conversations about this situation. While there is a lot of empathy in this House, there is little action. I have stood with the parents and we have had many meetings here in the House. Members have gone to meet the parents and sometimes the children—most recently outside of the House because of covid regulations—to hear their story at first hand, and there is an empathy. But those parents and children have had to wait. They had to wait because Brexit was going on and they were on the back burner; they had to wait again because there was an election in 2019 and they were put on the back burner; and then there was covid, albeit nobody saw that coming, and they had to wait. They have been hospitalised, they have not been able to get hold of their prescriptions, there have been problems in fundraising to get their prescriptions and, as has been said, they have been unable to pay for their prescriptions, even having to sell their house. The situation they have been put in is inhumane.

I see that the hon. Member for South Ribble (Katherine Fletcher) is leaving, but I was going to pay tribute to her. I am so glad that she has engaged with this debate with her constituent Joanne and Joanne's son Ben. It is wonderful that she has listened to them and continues to want to fight, even though she knows Joanne will not be voting for her, which is very amusing for us. It is good that there is that engagement. I do not stand here with a geeky knowledge of science, to use the hon. Lady's words, or as a general practitioner, but I stand here with four and a half years' experience—the experience of a mother—to see the passage of the tireless work that has been done across the House, only for nothing to have changed. That is why I pay tribute to the Bill.

**Jim Shannon:** The hon. Lady is right. If the Government are not minded to support the Bill, as it seems they may not be, does she, like me, ask, "Well if you're not going to help, what are you going to do?"

**Tonia Antoniazzi:** Absolutely. I really want to know what they are going to do. This has been collaborative, cross-party work, and I have had good conversations with the Secretary of State this week and with the Minister a week ago. The solution that has been put forward to me is quite interesting. They say, "Oh, well you could find one of these drug companies that you know and work with, and maybe they could put an observational trial together, and we could have the conversations with the necessary bodies, we could work on this and then it could move forward"—this is the point I was coming to—"in another two to three years." After four and a half years, we are already in a situation where some of these children are now adults, so we are going to be looking at another, completely different situation. This situation has to change.

My hon. Friend the Member for Manchester, Withington has worked tirelessly on the Bill, giving the Government an option to move this issue forward, yet yesterday I was told, "Don't worry, Tonia; talk for as long as you like, because they're going to talk it out anyway." We have had debate upon debate upon debate. This is a private Member's Bill. It would address the issues and move everything forward. That is the disappointment of this place. When the parents we work with know there is going to be a debate, they get all excited, and then nothing happens. Unfortunately, because of the way the parliamentary system works, that is how it is. That is why the Bill is so brilliant. It absolutely hits the nail on the head and I want it to pass—but we know that is unlikely.

We know there is a blockage in the system. I will not stand here and call out where I think that blockage is, but it is my personal view and my experience. It is what I have read and what I know. When somebody very high up in the system says, "We do not want this to happen," it usually does not happen. There is a blockage, and that blockage has to be broken down. I am not a GP or a medical expert, but it is wrong that this is not being looked into properly.

In the conversations that the right hon. Member for Hemel Hempstead and I had with the NHS we were promised an observational clinical trial, but that had changed to an RCT by the time of our next conversation with the same people. Why? We had the perfect situation. These children were already on the medicine and were already proving that it makes their lives better.

**Dr Mullan:** I want to make it clear that we said there are approved and allowed uses of this treatment, and I do not doubt that it helps in some circumstances, but today we have ended up having a general debate about types of evidence, with Members almost criticising RCTs and pumping up observational trials as an effective way forward. I caution Members to remember that the MMR scandal, which we now know led to the deaths of children because of how medical practice was changed, was based on an observational study of a small number of people—*[Interruption.]* It is not rubbish; it is true. Those parents were absolutely convinced that the MMR vaccine had caused autism in their children. They were very passionate about it and, when we looked at it properly with a longer lens, we saw that it was wrong. Be cautious about talking down RCTs and talking up observational studies. *[Interruption.]*

**Madam Deputy Speaker (Dame Rosie Winterton):** Order. We must not have conversations across the Chamber. It is very confusing, not least for the *Hansard* writers.

**Tonia Antoniazzi:** I understand what the hon. Member for Crewe and Nantwich (Dr Mullan) is saying, but he is not making a like-for-like comparison. Rachel Rankmore and her partner Craig have looked after Bailey through thick and thin, and she has just sent me this message:

"We were told that Bailey may not wake up the Bailey you know because of brain damage from seizures and the very potent pharma drugs or not wake up at all the last time he was in hospital suffering 100s seizures before cannabis. He now lives an amazing quality of life out of hospital."

She is furious about what has been said in the House today. The improvements they have seen in their child are being cast aside. Bailey would be dead if not for medicinal cannabis, and so would many others.

**Dr Mullan** *rose—*

**Tonia Antoniazzi:** I will not give way because I need to make progress, and I said I would not take up too much time.

We got somewhere with the previous Minister, the hon. Member for Bury St Edmunds (Jo Churchill). She talked about the innovative medicines fund, and innovative medicine is exactly what this is. It has been around for a long time, and we do not have time to wait.

The Government need to set up a compassionate fund now, while the trials are happening, because these children will not go on to an RCT. They will not have the drugs flushed out of their system and take that risk, as happened to Bailey, who nearly died in a hospital bed. That is not going to happen, and we have to realise that this Bill and a compassionate fund for these children is the way forward, so that they do not have to lose their house and so they have the same access to medicines that others have.

We talk about intractable epilepsy, and they have tried everything else. From the risk-benefit analysis and the conversations I have had with clinicians, the benefits outweigh the risks in all these cases, which is why we are so strong and emotional about it. I do not want the Government to take us backwards but, in the recent conversations that I and my APPG co-chair have had with them, we have been told that we will have to wait another two to three years. That is unacceptable. We need to take the next step to move on. We are legislators, and the law has changed, but there have been only three NHS prescriptions—that must change.

I pay tribute once again to my hon. Friend the Member for Manchester, Withington for offering a sensible way forward. The children of the parents with whom we work deserve to live their best life. It is about time that the Government started to listen.

12.15 pm

**Selaine Saxby** (North Devon) (Con): On sitting Fridays, I often find that we have much in common with Opposition Members and that, when we work together, such as through all-party parliamentary groups—the hon. Member for Gower (Tonia Antoniazzi) referenced such work—we are divided only by how, rather than whether, we will get there. I recognise what an emotive topic this is and send my deepest sympathies to the hon. Member for Middlesbrough (Andy McDonald), who shared his story. I am grateful not to have such a case in my inbox, because this is an incredibly emotional issue.

When we hear about individual cases of children and families with drug-resistant epilepsy who have found relief from whole-plant extract medical cannabis, all we want to do as human beings is help. Most of us came here to make people's lives better, and we all want to expedite such things as far as is possible. I am a mathematician by training—I will not draw on medical GCSEs and A-levels—and, as I do not have such a case and therefore an emotional tie, I would like to use logic and talk through what the Government have done to make progress in the area before looking at the specifics of the Bill and how we have, hopefully, started to make some progress.

In November 2018, cannabis-based products for medicinal use, known as CBPMs, were rescheduled under the Misuse of Drugs Regulations 2001 from schedule 1 to schedule 2, as detailed in the excellent opening speech by the hon. Member for Manchester, Withington (Jeff Smith). I thank him for bringing the matter to the House to enable us to speak on it again. The change followed advice in July 2018 from the UK Government's chief medical adviser and the Advisory Council on the Misuse of Drugs, both of whom said that the rescheduling of such products would facilitate the development of clinical evidence.

I have not been in this place that long but, for most of my two years here, we have been in a global pandemic. Again, my heart goes out to the families tied up in this, but the pandemic has slowed down medical trials and treatments for a huge number of people. My hon. Friend the Member for Crewe and Nantwich (Dr Mullan) referenced the need for research in the area. In the last 12 months, 18 trials of cannabis-based products for medicinal use have come forward, and six are now complete. Things are therefore moving, although perhaps not at the pace that we would like.

Since the change in the 2001 regulations, doctors on the General Medical Council's specialist register have been able to prescribe an unlicensed CBPM if clinically appropriate for their patients. As we have heard, the law allows GPs to prescribe these products under the direction of a specialist as part of a shared care arrangement. Currently, all the CBPMs prescribed by specialist doctors are, as we have discussed, unlicensed medicines, which unlike licensed medicines have not undergone rigorous tests for quality, safety and efficacy. As has been said so passionately, such unlicensed medicines are treatments of last resort, and patients at that stage in their treatment pathway will be under the care of a doctor with specialist knowledge in their field and all the treatment options to take responsibility for such prescribing.

As we know, access to medical cannabis has been debated at length in both Houses. However, while it is understandable that these campaigns continue for greater access to unlicensed cannabis-based products for medicinal use funded by the NHS, as detailed so beautifully by my hon. Friend the Member for Dover (Mrs Elphicke), these products have not had their safety, quality or efficacy assessed or assured by the Medicines and Healthcare products Regulatory Agency or their clinical and cost-effectiveness assessed by the National Institute for Health and Care Excellence, otherwise known as NICE, which is the basis for NHS routine funding.

It is critical to progressing public funding decisions that manufacturers of those products invest in those clinical trials and prove that the products are safe and

*[Selaine Saxby]*

effective so that more of our constituents are able to access them. The National Institute for Health Research remains open to receiving good-quality proposals for research in this area. The latest clinical guidelines from NICE demonstrate a clear need for more evidence on the clinical and cost-effectiveness of the unlicensed medicines.

**Sally-Ann Hart** (Hastings and Rye) (Con): On the NICE guidelines and the clinical evidence, does my hon. Friend agree that all medication, whether cannabis-based, heroin-based or cocaine-based medication, must have rigorous testing through clinical trials so that we understand the possible side-effects and everyone—GPs, all doctors and patients—has full knowledge in making the ultimate decision on whether a drug should be prescribed?

**Selaine Saxby:** I agree with my hon. Friend: it is vital that we fully understand the side-effects of these drugs that we know, when used in the wrong way, have clinical downsides.

The Government continue to support the establishment of clinical trials with NHS England and the National Institute for Health Research, but they have been clear that the law enables lawful access where deemed clinically appropriate. The most significant barrier to access on the NHS is the lack of evidence on the quality, safety, and clinical and cost-effectiveness of these products. That sounds uncaring, but I want to revisit the black-and-whiteness behind the terrible emotion tied up with these individual cases.

I understand that the Royal College of General Practitioners is supportive of the Government's position that, until the evidence base has developed further, GPs should not be asked to initiate prescribing these products independently of a specialist. I suspect that trust in doctors in this particular area is well placed, which in my mind makes clauses 1 and 2 hard to support.

There is indeed clear merit in understanding, then overcoming any barriers to accessing unlicensed cannabis-based medicines on the NHS. That is why in March 2019 the then Health Secretary commissioned NHS England and NHS Improvement to review NHS systems and processes and identify and recommend any actions necessary to addressing barriers to clinically appropriate prescribing of unlicensed cannabis-based medicines on the NHS.

The findings of that review were reported in August 2019 and the majority of recommendations have now been implemented. Since this work has been undertaken recently and the recommendations acted on, I find it hard to support clause 3 of the Bill, as so much has already been achieved by non-legislative means. I very much hope that trials will progress to enable more families to access this treatment, and I take this opportunity to thank the hon. Member for Manchester, Withington for introducing his Bill.

12.23 pm

**Dr Rosena Allin-Khan** (Tooting) (Lab): I must begin by paying tribute to my hon. Friend the Member for Manchester, Withington (Jeff Smith), a fantastic campaigner who is working across party lines and with affected families up and down the country to make a real difference, both for those who are unable to obtain the treatment they need and for those who are left paying huge sums of money for private prescriptions. I also pay tribute to my dear and hon. Friend the Member for Middlesbrough (Andy McDonald), whose bravery in speaking today adds powerful testimony to this debate. I know 100% that his story echoes those of the people we are fighting for in this debate.

The objectives of this Bill, for me, are clear and simple, but I fear, listening to some of the contributions today, it has been misunderstood. It would be a huge step forward for patients who need access to medical cannabis, and it creates a register of general practitioners trained in medical cannabis who are allowed to prescribe it, in addition to the specialist doctors who are already able to do so. Inclusion on the register is on an opt-in basis for GPs. The Bill importantly creates a commission to propose a framework for the assessment of cannabis-based medicines and their suitability for prescription in England, to sit alongside existing Medicines and Healthcare Products Regulatory Agency processes for conventional pharmaceutical drugs.

I think it is very clear that what the Bill is asking for is a step forward with an end in sight for the pain, anguish and heartache, not to mention bankruptcy, experienced by many families. No one is saying that there should not be a robust examination of all evidence, but we are saying that there are current mechanisms in place to protect people on the medication and that, while we wait for some extremely timely processes, there are families who cannot wait and who are very clearly benefiting from the medication. It is very important that we recognise that.

The commission is also tasked with recommending any other measures to overcome barriers to access on the NHS, which has been mentioned. Those changes would be welcome, as they would certainly help to reduce many of the barriers patients currently face when attempting to access medicinal cannabis. Progress in making cannabis-based medical products available to those who need them has been extremely slow. As we have heard today, there are people who have transitioned from childhood to adulthood while waiting for further progress on something that is important. The impact of continued seizures means that there is developmental delay for young people—the children we are talking about—and their ability to achieve their full potential in life. We cannot ignore that.

Labour welcomed the fact that the Government accepted the therapeutic use of cannabis in 2018, but it still remains too difficult for suffering patients to obtain the treatment that they need. Despite that change in the law over three years ago, the vast majority of people who would benefit from cannabis-based medical products are still unable to access them through the health service. The campaign group End our Pain believes that only three prescriptions have been granted through the NHS. That is surely nowhere near the levels that this House, patients and the wider medical community would have anticipated.

**Andy McDonald:** My hon. Friend is making a wonderful summary and presentation. Is she as frustrated as I am by some of the contributions that have been made today, which seem to suggest that we need to start again when having this debate? We have been through this

process. The law has been changed to allow the prescription of these products, yet all we have are three. Is it not really frightening that we are now challenging the original decision to change the law? That is what has happened today.

**Dr Allin-Khan:** Absolutely. I thank my hon. Friend for his contribution. To take any further step backwards from the progress we have made in a cross-party collegiate manner would be a travesty. We would be letting down families across the country.

**Lia Nici** (Great Grimsby) (Con): The way the discussion is going at the moment is that we are talking about going backwards. The reason my hon. Friends are having those discussions is that the law has already changed, and I do not believe we need to legislate. We need to say, "We need to get these medicines that are approved already on the NHS."

**Dr Allin-Khan:** I thank the hon. Member for that contribution. That is exactly right. The Bill seeks to move that forward, not frustrate the process. I welcome any intervention that underscores that.

**Lia Nici:** When we talk to members of the public and our constituents about the debates we have, we explain that we learn a lot by having this exchange of views. It is wonderful. Every school and business should have such debates in this collegiate way. It is not that we are against the Bill, but that we believe the law is already in place. We just need action on NHS funding and to get more of these approved, tested medicines on the lists.

**Dr Allin-Khan:** In three years, we have had three prescriptions on the NHS. In three years, we have seen people in fear of not having roofs over their heads because they cannot afford to give life-changing medication to their children.

**James Daly:** Will the hon. Member give way?

**Dr Allin-Khan:** I will make a bit more progress and then I would be absolutely delighted to give way.

The situation that we face, whereby only three prescriptions in three years have been allowed, pushes more and more patients into the hands of private providers, who, as we have heard, are charging extortionate amounts of money each month for treatment. For the vast majority of people, that is simply out of reach.

Let me add something that I was not originally going to say: I, too, am a science geek. I have a biochemistry degree and I worked in medical research before even going to medical school. I understand the importance of robust, evidence-based medicine, but I can also tell hon. Members that people searching in a very desperate way for things that will improve the quality of their life, or even keep their children alive, might also go to places where absolutely no thought is given to the purity of a drug. They may seek alternatives that are increasingly more dangerous for their children. It is important to recognise that.

**Christian Wakeford** (Bury South) (Con): As another science geek with a chemistry degree, in which I specialised in drug design and synthesis, I completely agree with the hon. Member's point. That is part of the concern. It is about having not just the product right now, but the right product, and about making sure that we have efficacy and safety. I completely appreciate all these points. That is why I do not necessarily agree with the perspective on the commission, but I have a lot of sympathy for clauses 1 and 2, which will go some way to help. However, the main stumbling block is the financing. We have already legalised the product. Every time it falls down, is it because it has not been licensed? Maybe, but finance seems to be the stumbling block at every single level.

**Dr Allin-Khan:** I do not need to tell the hon. Member, who has mentioned his CV—as many of us scientists have today—the cost of not investing in these young people. Think of every time a young person who would benefit from this drug goes into intensive care with seizures, every time they have alternative, expensive sedatives keeping them alive on a ventilator or the fact that they do not fulfil their potential, cannot go on and work and cannot give back to the economy. It is a false economy not to invest in this.

**Colum Eastwood** (Foyle) (SDLP): Does the hon. Lady agree that it would be much better if we had less sympathy from Government Members and we got them to stop talking the Bill out and come with us to vote it through?

**Dr Allin-Khan:** I could not agree more; my hon. Friend puts the point across perfectly. If anyone is planning on talking the Bill out today, please will they ask themselves who benefits from that and whether they would feel proud of frustrating a process for many children and families that would mean that they did not have to go through, frankly, the hell that we have heard described?

**James Daly:** The hon. Lady is being extremely generous with her time; she will please forgive me for intervening, but I want to call on her expertise. The specific intent of Parliament was to allow medical professionals to prescribe non-licensed cannabis-based products. It cannot be any clearer than that; that is where the law is now. I agree with the point that was made—the fact that there have been only three prescriptions is ridiculous. However, perhaps she can address this question: the medical professionals who are considering such matters can see the evidence that we have talked about—it has been incredibly well articulated by all hon. Members—so why are they not referring those matters on and saying, "This patient needs this treatment"?

The other question that I want to ask—very inarticulately—is about the two-stage process of the clinical referral and then the money within the CCG. Is the problem that it is getting through the first bit—the clinical referral—but the money in the CCG is stopping it? I wonder if she could address those points in her remarks.

**Dr Allin-Khan:** My understanding and my belief, unless someone has an alternative proposal, is that clinicians are often screaming from the rooftops in the knowledge that their patients need this medicine. We are where we are, however, with only three prescriptions having been granted in three years. This Bill seeks to improve that and move us forward.

*[Dr Allin-Khan]*

Families being forced to pay for treatment from private providers creates an unjust two-tier health system. A founding principle of our health service is that we do not believe that people's access to treatment and services should be based on their ability to pay—it is as simple as that. The barriers in accessing medicinal cannabis are causing exactly that situation. We would not tolerate that for any other medication, so we should not tolerate it here. The Government must speed up and improve the availability of medical cannabis on the NHS and guarantee that patients across the country can access those products where appropriate.

We have all heard the testimonies of children who receive no respite from their seizures and of patients whose chronic pain has become a constant of their lives. Working in hospitals, I regularly meet those people and their families, who beg me and other doctors to help their loved ones. Witnessing their suffering never gets any less upsetting, especially when we know that there are options to alleviate it. Unrelenting pain can be so devastating for all involved. It is imperative that we listen to those who would benefit from access to cannabis-based products and allow them to guide our future thinking.

We have a voice in this place. I commend hon. Members from both sides of the House for using their voice today to speak up for those families who cannot be here to make the case themselves. Hon. Members have been begging, but we should not have to beg to do the right thing for the people who we serve.

**Tonia Antoniazzi:** Some of the voices that we have heard in the House today have talked about an unlicensed drug. The children who we have been talking about have been taking unlicensed drugs. I went to The Hague with two different families—two mothers—to pick up a prescription there before they could get it here. We walked into a pharmacy and picked it up, just as I would pick up my inhaler from Boots. There should be no fear. This is an over-the-counter drug in places such as the Netherlands, not an awful unlicensed drug that it is impossible to get. Does my hon. Friend agree that we need to break down that barrier and move on?

**Dr Allin-Khan:** As usual, I could not agree more with my hon. Friend, who makes a passionate and fair point.

The Bill serves as an opportunity to move forward in a way that even the sceptics could support. I say again that anyone who is planning to talk out the Bill should take a long hard look at themselves in the mirror and ask themselves what they are doing. They need to walk a mile in the shoes of the families who are worrying about whether their child will be alive the next day.

Last month, we had two debates on the issue in a matter of days. I would like to think that that demonstrates the collective will in the House to make progress, but that will and the warm words it brings are not enough for the thousands of people who should have benefited from those prescriptions in 2018 and since. We now need further action, and I wholeheartedly believe that the Bill would go some way towards achieving that. I trust that the Government believe that too.

12.39 pm

**Elliot Colburn** (Carshalton and Wallington) (Con): I join others in congratulating the hon. Member for Manchester, Withington (Jeff Smith) on securing time for us to debate the Bill today. He is clearly very passionate and knowledgeable about this issue, and I learnt a huge amount from his opening speech, for which I am extremely grateful. I also pay tribute to the hon. Member for Middlesbrough (Andy McDonald) for his moving testimony. It is characteristic of sitting Fridays that we tend to work more collegiately across the House. My hon. Friend the Member for North Devon (Selaine Saxby) said that it is not a question of whether we do but of how we do, and I entirely agree with her.

I am really here today at the behest of a constituent who asked me to come to the House and share his experiences, but before I delve into those, it may be helpful for me to give some of my own perspective. Before coming to this place, I too was employed in the NHS, although not as a frontline practitioner; I was not a doctor or a nurse. I worked for the sustainability and transformation partnership, the footprint of the new integrated care systems in south-west London. Along with commissioners across six south-west London boroughs, I looked at all the services that those boroughs provided, and this was a topic that arose during that time. It was obvious to me, when I spoke to colleagues, that there was almost a nervousness, almost a—confusion, I suppose, is the word I am looking for; it is a bit hard to describe—about commissioning medicines of this type.

I thought it might be helpful for the Front-Bench team to hear a bit about the experience of frontline commissioning, but, as I said earlier, I am really here at the behest of one of my constituents to share his story. I hope the House will indulge me if I go into a bit of detail, because I did find this very profound, and I hope that other Members will agree with me. My constituent sent me an email, in which he wrote:

"I would like to explain to you a little of my life which unfortunately has been plagued with intractable chronic migraines and the fallout from such.

Although suffering all my life with Migraine attacks, 5 years ago I was diagnosed with severe chronic migraine which after a long wait I was prescribed 9 different medications to try and bring the migraines under control, none of which worked only causing nasty side effects.

Having…sickness constantly with added migraine pain—I was left diagnosed with intractable chronic migraine with attacks 6 days out of 7, putting me out of work and putting me in a state of deep depression.

I was fortunate to meet a Dr. who was testing the benefits of Cannabis in neurological cases and after a discussion I decided to follow her strict advice and started self-medicating Cannabis which unfortunately meant sourcing off the black market, something that I'm not in any way proud of but the impact of using cannabis for my ailment was profound.

Within three days of my first use, my migraine frequency dropped significantly as did…the usual nausea which accompanies my attacks. Within a week, I felt for the first time somewhat normal, depression had lifted, I was able to start work again almost immediately (I was open and honest with my employer who welcomed me back into the workplace and to this day has been extremely supportive).

Summarising my experience, I went from someone who saw no hope in any way with modern medicine to someone who almost overnight got their life back.

I have one son—aged 12 who has got his father back, and my wife although extremely anti-drugs (a doctor who works in the dental profession) has seen the relief I experience, especially after seeing me for many years hiding in a dark room, in pain, hiding from the world most days to someone who now is relishing in family life."

My constituent went on to say:

"The stigma of the word Cannabis is something that I have had to deal with".

This, he said, included

"seeking out black market providers which in its self I would not want anyone to go through",

and I think all Members would agree with that.

**Lia Nici:** On that point, which I was going to raise later, quite often the issue is semantics. There is a fear about the word "cannabis", be it medical or not, and we need to get over that. One of my concerns about the Bill is the use of the broad term "cannabis". I think that my hon. Friend's constituent has been fighting with that issue.

**Elliot Colburn:** My hon. Friend has taken the words right out of my mouth. When talking to Carshalton and Wallington residents, I have found that there is a sense of stigma, and a stereotype, associated with the word "cannabis".

**Christian Wakeford:** Earlier this week, we started talking again about drugs from a public health perspective. We need to tackle the stigma of not only drugs, but alcohol addiction. No one chooses addiction. There are many things that we can do, including removing the exclusion of addiction from the Equality Act 2010, and properly funding addiction and rehabilitation services, but, again, this comes down to the financing.

**Elliot Colburn:** My hon. Friend is absolutely right.

**Ben Everitt** (Milton Keynes North) (Con): My hon. Friend is being very generous with his time. A point that occurred to me earlier is that one of the problems that we have when we debate this issue in Parliament and elsewhere is the conflation of national drugs policy and policy relating specifically to medicinal drugs—in this case, specifically medicinal cannabis. In many ways, it is deeply unhelpful when those two matters are conflated, because people come at them with strong opinions. However, the case study that my hon. Friend is outlining today shows the relationship between the two, and I am grateful to him for bringing that to the attention of the House. May I make a plea to everybody here—I hope that he agrees—not to fall into the trap of conflating the two issues, because although they are very important and we should have a discussion about both, they are vastly different?

**Elliot Colburn:** I totally agree. Indeed, I had no intention of opening the can of worms around recreational use, decriminalisation, legalisation, or whatever term we might want to use. I hope that my hon. Friend can rest easy in the knowledge that I will not go there, as they say.

My constituent said that he would not want to put anyone else through having to seek out black market providers, and that somewhere in the back of his mind was always the worry of being prosecuted, but to him the benefit outweighed the risk tenfold.

**Lia Nici:** The case that my hon. Friend is outlining highlights real concerns about the side effects of smoking recreational drugs, including potential mouth cancer, potential throat cancer and potential psychosis, as well as the unpleasant social activities. I have had constituents who have had to live next door to people who take recreational cannabis, and it really is not a pleasant situation to be in—and then we get into the issue of potential secondary smoking and all those kinds of things. That is why constituents such as my hon. Friend's should not have to go through that route.

**Elliot Colburn:** I totally agree. It might be of some use to the House if I read a little more of my constituent's reflections, as he went on to say:

"Then came along the introduction of Drug Science and their Project Twenty 21, this gave me the ability to seek professional help, to be able to get a prescription to legal Cannabis flower to which I vape as a preventative and when needed as a pain killer. I still get migraines but luckily now I have a medicinal way to cope and quell most of the side effects, literally giving me my life back.

Although this does sound like a fairy tale, with a happy ending, there is a darker side to this.

Currently the expense and experience of being with a private clinic and private dispensary/pharmacy is quite strained, adding anxiety and stress into the situation. We rely on the ability of both the clinic's and Dispensary's to keep us in prescription which does not happen and is quite literally floored. Medication is imported into the UK, its very often caught up in customs and the added issues with Covid has broken supply chains.

Dispensary's are often out of product and the clinics are not kept abreast of this so many re-writes of prescriptions have to happen and thus costing time to get the needed medication and cost for re-writes. This all breaks down to us the patients being without medication, sometimes up to a month, putting us back at square one (prescriptions have to be written monthly).

On top of the supply and demand issues, quality is also something that has been with issue, many reporting to Yellow Card unusable medication due to sub-standard product and often mould that cannot be used – with no way of a refund or quick turnaround of a re-stock.

Without a shadow of a doubt this would never happen under the NHS but as we have no other choice in the matter its either suffering under private clinics or unfortunately breaking the law and turning back to the black market.

There are many thousands like me in this position, I'm but a single drop in a large ocean of people with similar experiences, I would like to draw your attention to this so you may air this as unfortunately the situation is not getting better. I understand that the primary concern is for children with epilepsy though there is a much larger footprint of people benefiting from medical cannabis and this should whole heartedly be pulled into the NHS to better control and support patients.

I would be grateful if you could keep this all"—

he refers to all of us in this place—

"in the back of your mind so you have some real world information from one of your local constituents of the big picture surrounding medical cannabis, it's time for this to be pushed forward as it was supposed to have been back in 2019…

Luckily medical cannabis has given me my life back, I hope others can benefit in the future but it needs to be under the protective umbrella of the NHS."

I thank that constituent for sharing what was obviously a harrowing story, and for permitting me to raise it on the Floor of the House this afternoon. I am sure colleagues will agree that that was incredibly brave, so I am very grateful to that person for allowing me to do so.

We have heard many constituents' stories during the debate, although we have explored just two elements of them—childhood epilepsy and the migraines that my

*[Elliot Colburn]*

constituent has suffered. I would like quickly to bring in one more, which is the exploratory research being conducted on the use of CBD for fibromyalgia and other treatment-resistant neuropathic pain.

I know the suffering that those conditions can cause, especially when there is so little known or understood about them; I have many family members who have been diagnosed with fibromyalgia or similar conditions. Again, I have seen the benefits that CBD can bring, but I agree with colleagues about the need for robust research. I do not think it is a question of whether we will get there, but a question of how. I hope that the Minister has been able to take on board the experience—

**James Daly:** Does my hon. Friend agree that the law is very clear that medical professionals can prescribe non-licensed cannabis products, but the question is why clinical commissioning groups are not funding that? That is what we have to address, to force them to fund it.

**Elliot Colburn:** I totally agree with my hon. Friend. I have experience of working in what we might call a super CCG, which is now an integrated care system, looking at commissioning at a strategic level across six London boroughs, which is by no means a small footprint—we commissioned services for more than 1 million people when I was there, including for four of London's biggest hospitals. I agree with the shadow Minister, the hon. Member for Tooting (Dr Allin-Khan), that practitioners were screaming from the rooftops that they wanted to be able to give such prescriptions and, indeed, felt confident about that. I will not say that they all were—a lot of the colleagues I used to work with in the NHS were not—but a significant amount were confident. From a commissioning perspective, when we were sat in our offices in Wimbledon, talking about commissioning services and looking at the health of the six south-west London boroughs we were tasked with dealing with, there was a clear sense of nervousness and even confusion among commissioners. That obviously needs to change and there needs to be some way to support commissioners to make the positive decisions to deliver the funding. I hope that when the Minister responds we will hear a little bit about what the Government can do about that.

In bringing my remarks to a close, I emphasise that the constituent experiences we have heard about in this debate, including from the constituent who was kind enough to allow me to read out their story, have been profound. That should be in the back of all our minds when we discuss this issue, because there are real-life implications that we do not always see when we pore over the details of text. I look forward to hearing from the Minister what we can do to unlock some of the issues we have explored in this debate.

12.56 pm

**Barbara Keeley** (Worsley and Eccles South) (Lab): I thank my hon. Friend the Member for Manchester, Withington (Jeff Smith) for introducing this important Bill that could improve the lives of so many people. As we have heard, it could particularly help families with children affected by serve treatment-resistant epilepsy, for whom cannabis-based products may be the only treatment that works. I pay tribute to my hon. Friend the Member for Middlesbrough (Andy McDonald) for his powerful appeal on behalf of the Bill.

My constituent Zoe Kirkman contacted me several years ago when she was seeking treatment for her son Riley, who experienced severe seizures up to 30 times a day that were very distressing for both him and the rest of his family. Ms Kirkman told me she was worried that he could die at any moment as a result of a seizure. These are the fears of parents and that is what drives them.

Riley's condition has led to his missing a lot of education and being out of school a lot. As she could not access cannabis-based treatment for Riley on the NHS, Zoe Kirkman was forced to purchase THC and CBD products privately. As we have heard, many families are in a similar position, left with no choice but to pay hundreds of pounds a month—in some cases thousands—for private prescriptions. THC products work better for Riley, but Zoe Kirkman told me that there was little support alongside the prescriptions when they were purchased privately. The fact that parents are pushed into private prescriptions with little support must have some weight with us.

Thankfully, the cannabis-based treatments that his mother bought have reduced Riley's seizures significantly and allowed him to stop taking a lot of his medications. However, he is still out of school because his school cannot include the cannabis-based treatment in his rescue package, as it is not prescribed on the NHS. For the same reason, Riley cannot access respite care, which would help him, at St Francis children's hospice. Will the Minister say why schools and respite-care facilities such as hospices cannot be allowed to administer the oils that make such a difference to children such as Riley? Zoe Kirkman tells me that if Riley has a seizure because of a gap in the treatment, it can take weeks for his condition to settle down again.

In July 2018, I wrote to the then Home Secretary to raise Riley's case. I received a belated response from a Home Office Minister in January 2019—more than six months after my initial letter—saying that following the changes to the law in November 2018, he hoped Riley would be receiving the treatment he needed. Of course, he is not receiving that treatment. The campaign group End Our Pain estimated that, a full three years on from the rescheduling of cannabis-based products to schedule 2 to the Misuse of Drugs Regulations 2001, just three children living with severe epilepsy have received an NHS prescription. As we know, two of them were at the centre of the 2018 campaigns. We have heard that a number of times in this debate and it is right that we focus on the fact that there have been just three prescriptions, and ask why.

When the Health Committee ran its inquiry on medical cannabis in March 2019, it heard from Peter Carroll, the campaign director at End Our Pain—we heard about him in earlier speeches—who said:

> "What has happened is that hopes have been correctly raised, because this offers a lot of hope and benefit to a lot of people, but we have now moved across to implementation and the honest reality is that it is a disaster…The families…should be getting prescriptions…and watching their children…hopefully…improving day after day."

After the Government raised hopes with the change in the law, it is a great pity that they have not increased access to medical cannabis for those who need it in line with the findings of the review that they commissioned in 2018. I hope that the Minister will explain why.

While I accept that we still need more research and studies into the effectiveness of cannabis-based products for treatment-resistant epilepsy in children, the Bill would offer important measures to increase the number of doctors who could prescribe such products and widen access to them through its proposed commission.

I asked Zoe Kirkman what she hoped for. She told me it was a purer form of the medication, because the products available to purchase contain a lot of synthetic ingredients and she worries that they could have long-term side effects for Riley. I hope that, through the Bill, Zoe Kirkman and Riley, and many families like them, will finally be able to access the treatment they need through the national health service.

The Bill contains a proportionate set of measures, with a commission to propose an assessment framework for cannabis-based medicines and their suitability for prescription and to make recommendations of measures to overcome the barriers that we have heard about in CCGs and other NHS structures to accessing cannabis from the NHS for medical reasons.

We have had a lengthy debate about different forms of trials. The commission could consider evidence from observational studies and from other countries as well as conventional control trials. My hon. Friend the Member for Manchester, Withington made an important point about evidence that could be weighed from EU countries—it is time that we started to think about that. It could also consider the important register of GPs who may prescribe cannabis-based medicines and permit them to do so. That would help to avoid the side effects of the cannabis-based products that Zoe Kirkman is currently forced to buy as the only option available. Most importantly, Riley would be able to attend school and have respite care when he needs it.

Let us end the years of pain. As my hon. Friend said at the end of his excellent speech, if not this Bill, what else?

1.2 pm

**Sally-Ann Hart** (Hastings and Rye) (Con): I welcome this important debate brought by the hon. Member for Manchester, Withington (Jeff Smith). Since 1 November 2018, cannabis-based products for medicinal use have been listed in schedule 2 to the Misuse of Drugs Regulations 2001. The change in law was based on expert advice from the chief medical adviser to the UK Government and the Advisory Council on the Misuse of Drugs, both of whom said that the rescheduling of such products would facilitate the development of clinical evidence.

All of us in this House have enormous sympathy with individual cases. I pay tribute to the hon. Member for Middlesbrough (Andy McDonald) for telling his family story, which I heard with great sadness and compassion. We also have a wider duty to safeguard through clinical evidence. I feel strongly about safeguarding.

A change has also occurred in that specialist doctors included on the General Medical Council's specialist register can now prescribe cannabis-based products for medicinal use where clinically appropriate and in the best interests of patients. GPs may prescribe licensed cannabis-based medicines subject to any restrictions under the product's marketing authorisation, but the law prevents GPs from prescribing unlicensed cannabis-based products for medicinal use unless it is done under the direction of a specialist doctor. That, at the moment, until we have more licensed cannabis-based products, is there for safeguarding purposes.

There are licensed cannabis-based products—not very many, but I think there are two or three—already routinely available on the NHS, and access to those licensed products has been promoted. For example, the chief pharmaceutical officer recently issued a reminder to clinical commissioning groups and the NHS trusts in England, highlighting that Sativex, for example, is recommended by NICE and available on prescription. There is also cannabis-based epilepsy medication available.

On Sativex, I wonder whether that sort of cannabis-based medication would have helped my aunt, who died aged 38 from multiple sclerosis. By the time she died at 38, she was practically blind and wheelchair-bound, so I feel very strongly that the right medication must be clinically looked at and evidenced in order for the right prescriptions to be made.

**Mark Fletcher:** We have heard a number of incredibly personal stories of family members or constituents today, but my hon. Friend's point is that we should not only let the personal impacts influence us, but ensure that the evidence comes forward as well. Does she agree that it is vital we have both in this debate?

**Sally-Ann Hart:** I thank my hon. Friend for that comment. Very often in political debate we are driven by emotion, and that is right, because we have that emotion driving us forward to make change. However, that emotion must be tempered sometimes by evidence. When we are trying to get legislation through Parliament, we all know that there must be a good evidence base for us to work with to drive that legislation through.

In addition to the licensed cannabis-based products, since the change in regulations, doctors on the GMC's specialist register have been able to prescribe unlicensed cannabis-based products for medicinal use if clinically appropriate for their patients. The law allows GPs to prescribe those products under the direction of a specialist, as part of a shared care arrangement.

If a GP decides to accept ongoing shared care responsibilities and prescribing, they must be competent to exercise their share of clinical responsibility and confident and happy to accept the associated legal and professional responsibilities of doing so. It is right that we put those decisions in the hands of specialist clinicians, those with the best knowledge of all the treatments available for the conditions they are specialist in.

However, the law did not relate to funding those products within the NHS, which is governed by a range of processes and procedures to ensure equitable distribution of funding, prioritising funding for those medicines that have proved their safety, quality, whether they work and their cost-effectiveness. This is where the evidence base is vital.

Currently, almost all cannabis-based products for medicinal use prescribed by specialist doctors are unlicensed medicines, which, unlike licensed medicines, have not

*[Sally-Ann Hart]*

undergone rigorous tests for quality, safety and efficacy. They are treatments of last resort, and patients will be at a stage in their treatment pathway where they will be under the care of a specialist doctor who has expert knowledge of their field and of all treatment options and will take responsibility for prescribing. Prescribing is limited to specialist doctors because it is important that that restriction forms part of the checks and balances that the Advisory Council on the Misuse of Drugs asked the Government to put in place when rescheduling cannabis-based products for medicinal use to minimise the risk of misuse and diversion. No matter how much we all want to see a change made, we are all aware that unfortunately there are people out there who would use medical cannabis as an excuse for recreational drug use. We have to avoid that at all costs.

**Ben Everitt:** On specialist prescribers, perhaps the barrier is not just the fact that prescription is limited, but the stigma around it. GPs are reluctant to engage with anything to do with cannabis because they almost feel that they might get professional blowback as a result of prescribing it.

**Sally-Ann Hart:** My hon. Friend raises a very good point. I would add that perhaps the reason why GPs are not forthcoming when it comes to working with specialist doctors is that they want to prescribe medicines that they know have been rigorously tested and to be aware of the possible side effects. We have to be aware that GPs take an oath, as my hon. Friend the Member for South Ribble (Katherine Fletcher) said, and part of that oath is that they will not do anything that will damage a patient. If a GP cannot be sure of the side effects or sure that drugs have not been rigorously tested with clinical evidence, they will be less inclined to offer those drugs.

**Dr Hudson:** There has been a lot of commonality today in the quest for increased knowledge about what is going on and for improving the evidence base, but also for the confidence of practitioners in being able to prescribe. Does my hon. Friend agree that it would unite us across the House if there were a renewed impetus from the Government to increase the information for medical practitioners about what can be done, so more of them can be confident in doing it, as well as a renewed impetus for the funding for research trials? That would give us a common momentum towards what we are all hoping to achieve.

**Sally-Ann Hart:** I thank my hon. Friend for his points. I have now forgotten his first point—I apologise for that—but I will come on later to clinical trials and the funding for them. Could he repeat his first point?

**Dr Hudson:** It was about renewed impetus from the Government to improve the outreach of information to medical practitioners so that more of them are aware of the licensed products, their capabilities and the clinical indications. As a veterinary surgeon, I feel very sympathetic to my colleagues in the medical profession, who want to be able to treat their patients with the best evidence base and the best information possible. Ministers could renew the impetus for more information for practitioners, as well as more funding for research. Those were my first and second points.

**Sally-Ann Hart:** I thank my hon. Friend so much. I just want to reiterate that the chief pharmaceutical officer recently issued a reminder to clinical commissioning groups and NHS trusts in England, highlighting the fact that cannabis-based drugs are available. What my hon. Friend is suggesting is that GPs need to be given even more regular information.

**Jeff Smith:** Immediately before the last few interventions, the hon. Lady said that we all know that people would try to use medical cannabis as recreational cannabis. I have to ask her where the evidence is for that. The fact is that these medicines are not the same as recreational cannabis. Look at Epidiolex or Bedrolite: people do not use them to get high. We are talking about completely different things. I really think that that is a red herring that the hon. Lady should not have thrown in.

**Sally-Ann Hart:** I thank the hon. Gentleman for his comments. I retract the statement that "we all know", but there is a risk that some people may use medicinal cannabis as an excuse for growing cannabis for recreational use.

**James Daly:** My hon. Friend is making a very good speech. I fully accept the points that other hon. Members are making, but when the law was changed in 2018, it was not changed with a proviso that there had to be a certain amount of medical evidence to support the use of non-licensed cannabis treatments. It gave specialist practitioners the right to suggest that those products should be used. The problem a lot of the time, as my hon. Friend the Member for Carshalton and Wallington (Elliot Colburn) said, is that the clinical commissioning group—the people with the money—will not financially support such a recommendation. There are two sides to this, but a lot of practitioners do want to make sure that these medications come in and are used to support treatments at the earliest opportunity.

**Sally-Ann Hart:** I am sure the Minister has heard my hon. Friend's comments and will take them on board.

**Mark Fletcher:** Will my hon. Friend give way?

**Sally-Ann Hart:** I will give way, but can I then make some progress? Is it on this point?

**Mark Fletcher:** It is slightly separate, as I am going back in my hon. Friend's speech, but I thank her for giving way. She has taken many interventions, and I think she is doing a marvellous job. I want to go back to her point about specialists being able to prescribe versus GPs. I have a particular concern about the pressures on GPs at the moment, particularly coming out of the pandemic and the fact that there is such demand and such a backlog in the system. My concern is that this is a further complication that GPs would have to work through. Although I am not necessarily against the thrust of where we are going with today's Bill, does she share the concern that GPs have a lot on already?

**Sally-Ann Hart:** I would agree with my hon. Friend on the basis that GPs have a lot on at the moment. I know that they are having to get involved in the roll-out

of boosters and more vaccinations for covid. Therefore, when doctors in general practice are actually looking after patients, whether face to face or in a telephone conversation, they need to have the certainty, surety and confidence that whatever they are prescribing for their patients has been approved by NICE or whichever organisations are required to approve our medicine prescriptions.

**Ben Everitt:** I am very grateful for my hon. Friend's generosity, and perhaps this intervention may allow her to pivot to the rest of her speech. We are almost in a chicken and egg situation now, with only three treatments available through the licensing system, but needing to get so many more through. With GPs or prescribers having only those three to choose from and really not trusting all the evidence before them, we need more evidence. This goes back to what my hon. Friend the Member for Crewe and Nantwich (Dr Mullan) said about needing more hard evidence to give the licensing authorities the confidence to push these things through and, crucially, GPs and prescribers the confidence to be able to make the call about whether these things are the right medicines for the right people. Again, as he pointed out, not every treatment is suitable for everybody, and we need to be absolutely clear that we have the evidence to show that the side-effects are minimal for all groups before prescribers make such calls.

**Sally-Ann Hart:** Yes, I absolutely agree with what my hon. Friend says, and I will be coming to the call for evidence a little bit later in my speech—

**Barbara Keeley:** Will the hon. Lady give way?

**Sally-Ann Hart:** Can I just finish one sentence?

I will be coming back to the need for more evidence and for manufacturing businesses to come forward, because there is huge potential. There is huge potential for manufacturing businesses and pharmaceutical companies to come forward with evidence to expand the amount of cannabis-based products that will and should be available on prescription from the NHS, so that the mothers who are trying their best for their young people and children are not having to pay a fortune to get this medicine privately.

**Barbara Keeley:** It is obvious to see what is going on here—Government Members are trying to talk out the Bill—but an argument was made in the previous intervention that we needed more evidence. This Bill would provide that, because it would bring forward a commission that would consolidate evidence and give a suitable framework for assessing cannabis products. That is what it is all about. Government Members worried about evidence should vote for the Bill.

**Sally-Ann Hart:** I just want—

**Dr Mullan:** Will my hon. Friend give way?

**Sally-Ann Hart:** Is it in relation to this point?

**Dr Mullan:** Yes. I gently ask Opposition Members to consider whether they can think of any example where we have used primary legislation to further the advance of research for a particular series of treatments. It is not how we do it. There is a whole series of programmes and ways in which we do that in our NHS, and primary legislation is not it.

**Sally-Ann Hart:** I agree with my hon. Friend, because we have a regulatory pathway in place—I will come back to this a little later, when I can move on with my speech—under the Misuse of Drugs Act 1971 regulations and medicines regulation, through which cannabis-based medicines have already been approved for use in the NHS.

To go back to prescribing, the prescriptions are limited to specialist doctors and GPs working with those specialist doctors. They are not the first-line treatments, and patients will always be at a stage in their treatment pathway where they are in the care of a specialist doctor. While the evidence base remains limited—we have all spoken about how important it is to ramp up that evidence base—it is right that the decision to prescribe unlicensed products lies essentially with specialist doctors, because they have that expert knowledge in their field, and they take the responsibility for prescribing.

I completely understand why some groups have campaigned for greater access to unlicensed cannabis-based products for medicinal use funded by the NHS. However, I feel very strongly that these products—we are looking at a drug that has multiple chemicals in it, and I will come back to that later—have not had their safety and quality, and whether they work and are efficacious, assessed or assured by the Medicines and Healthcare Products Regulatory Agency or their clinical or cost-effectiveness assessed by NICE, and that has to be the basis for all NHS routine funding. The NHS has a duty of care. People trust it. We trust the NHS. We trust our doctors to ensure they are giving us the best possible advice and prescribing the best possible medicine that has been rigorously tested and has a clinical evidence base.

When GPs are looking at medicines and whether something is approved, they are looking at a cost-benefit analysis. Throughout covid, we have been looking at what age to give people vaccines. At the beginning, a cost-benefit analysis was made about whether the benefit of giving an over-18 a vaccine outweighed the cost or risks involved. We have to be very careful about that when taking any medication forward.

It is critical to progressing public funding decisions that manufacturers of these products invest in clinical trials and prove that their products are safe, effective and work. The National Institute for Health Research remains open to receiving good-quality proposals for research in this area as a priority, and it is clear, as I said earlier, that there is huge potential in cannabis-based medicines. Manufacturers need to ramp up putting quality proposals forward for research, so that more cannabis-based medicines can be approved for NHS use. That is not for us in this House to dictate, but for those businesses to put forward their proposals to get clinical trials going, so we have a much wider selection of drugs available for NHS prescriptions.

**Lia Nici:** Does my hon. Friend agree that it is not just about drug companies missing out on a huge business opportunity, as well as the health benefits? It is for the NHS and clinical commissioning groups to ask for, and to promote the fact that they are looking for good-quality research and good-quality products to put in their systems.

**Sally-Ann Hart:** I agree with my hon. Friend. That reminds me of a request I made to our local CCG. It is up to MPs to lobby local CCGs and for constituents to lobby their MPs. I lobbied our local CCG recently with regard to—*[Interruption.]*

**Katherine Fletcher:** I apologise for the heckling of nerdery. Neurofibromatosis.

**Sally-Ann Hart:** I thank my hon. Friend for prompting me to remember it. Neurofibromatosis is a terribly rare disease. It would be great if we could have the café au lait marks put in children's red books, but of course we need the evidence base to do that. I lobbied our local CCG to see if it could do that and I know it has been taken higher up the chain to see what evidence base we need. I quite agree with my hon. Friend the Member for Great Grimsby (Lia Nici), because we can lobby and the CCG can do the same.

**Mark Fletcher:** On both sides of the House, there is a clear demand to see that evidence base come forward. We are sending a very powerful message to companies and manufacturers by saying, "Please provide us with this evidence, because we want to go in the same of direction". My hon. Friend is doing a very good job on that front.

**Sally-Ann Hart:** I thank my hon. Friend for his comments. I agree that there is huge scope for the pharmaceutical industry in this area.

The latest clinical guidelines from NICE demonstrate a clear need for more evidence on the clinical and cost-effectiveness of unlicensed medicines to support routine prescribing and funding decisions on the NHS. That is why access on the NHS remains limited and prescribing is almost entirely within the private sector. We have to ask why there are so few licensed products. As we have all highlighted today, that is up to manufacturers and we cannot force manufacturers to apply for marketing authorisation. It has to come from them. While we can encourage, as my hon. Friend the Member for Great Grimsby pointed out, we are dependent on manufacturers being prepared to subject their products to rigorous clinical trials to demonstrate their benefits; and to demonstrate that those benefits outweigh any significant risk, as well as the cost-benefit analysis and the fact that they provide a material benefit over and above more established treatment options.

The MHRA is well equipped to provide independent advice to researchers and companies wishing to conduct clinical trials in the UK. We need to get the message out that they are there waiting for manufacturing businesses to come forward with their clinical trials. The MHRA, which is rightly recognised internationally for requiring the highest standards of quality, safety and efficacy, will assess any information submitted in support of applications for marketing authorisations.

I shall move on briefly to clause 3, which proposes that a commission be established to

"propose a framework for the assessment of cannabis-based medicines and their suitability for prescription in England".

As I have discussed, there is already a regulatory pathway in place under the Misuse of Drug Regulations 2001 and other medicines legislation through which cannabis-based medicines have been approved for use on the NHS.

**Jane Hunt:** Is this more about trust? If the regulations are in place, that would give GPs and other medical professionals the chance to be bold. This is a bit like what I said to the Secretary of State for Education about the dreadful case of poor Arthur, which was about social workers having the opportunity to be bold. We should recognise that these people have years of professionalism behind them, so why not give them the opportunity to be bold? The Bill proposed by the hon. Member for Manchester, Withington (Jeff Smith) has given us an opportunity to say, "We support you to make those decisions. Please make them and let us have that evidence as well."

**Sally-Ann Hart:** I agree with my hon. Friend. We all have huge sympathy with the Bill. I hope that, with the debate and the discussions going on today, we all—the manufacturers, the Ministers and us—are emboldened to look at how we can promote the matter and engage with manufacturing industries so that we have a better choice of cannabis-based medicines for prescription purposes on the NHS. It is important to note that.

Obviously, as has been discussed today, we are all aiming for the same thing. We sit as Members of different parties in this House, but we very often want the same thing. We want to create a better healthcare system. We want to create a better medicine prescribing system. We want to reduce poverty and disadvantage. We want to create better education systems and so on. Sometimes, though, we have a different way of doing it. That is what the debate entails; it is about the way that we do things.

**Tom Randall:** I have been listening intently to my hon. Friend. During the course of the debate, we have heard from many self-professed science geeks, talking about the nature of cannabis and other issues. Given that we are talking about primary legislation here, and given my hon. Friend's background as a solicitor, I wondered whether she had given any thought to the usefulness or the appropriateness of using primary legislation to achieve the goals that the hon. Member for Manchester, Withington (Jeff Smith) seeks to achieve by bringing this Bill before the House this afternoon.

**Sally-Ann Hart:** I am not a science geek. I would not even say that I was a legal eagle geek, but I do understand that primary legislation is very important in certain circumstances, but perhaps in this sort of situation it is not the right route to go down, because there are so many other methods that are perhaps better—methods where you involve the manufacturers, the doctors and clinical staff—

**Tonia Antoniazzi:** What has been put to the House today is a solution and a way forward following almost four and a half years' work. Every single option has been explored, and it really disappoints me to see hon. Members from the 2019 intake talking out the Bill because they have been told to do so. All the Government want to do is kick the can down the road. That is not acceptable, and it is not a way forward. We all have empathy and sympathy for these families, so let us get something done and let us use this Bill to move forward.

**Sally-Ann Hart:** I thank the hon. Lady for her passion. The whole point of debates in this Chamber is to properly scrutinise proposed legislation so that we make the right decisions.

**Barbara Keeley:** Will the hon. Lady give way?

**Sally-Ann Hart:** I will give way in a minute.

We already have legislation and pathways in place. The Government have made big inroads on facilitating cannabis-based products for NHS prescription. We are on the path. Do you think primary legislation will force the hand of pharmaceutical companies or manufacturing businesses to bring forward products for clinical trials?

**Tonia Antoniazzi:** That is quite incredible. I invite every Conservative Member to join the APPG on access to medical cannabis under prescription, to understand better where we are. We are not in a good place. We have explored all the options, and this is not a request for big pharma to come in. I used to play rugby, and I have a friend who followed me in playing for Wales. She is a wonderful woman, and her child is now going on to Epidiolex because the family cannot afford to go on to Bedrocan. She knows she has to give Epidiolex a chance, but she knows it will not work and she is not being given the option because of the two-tier system this Government created.

**Sally-Ann Hart** *rose—*

**Madam Deputy Speaker (Dame Eleanor Laing):** Before the hon. Lady answers the intervention, I must ask her not to use the word "you." When one says "you," one means the Chair. I have not interrupted the flow of her speech, but she has said "you" a few times, and I would be grateful if she would say "the hon. Lady" rather than "you" because "you" means the Chair.

**Sally-Ann Hart:** Thank you for your advice, Madam Deputy Speaker. I take it on board, and I apologise for using that term in the House. I know I should not be saying it. When you are—*[Laughter.]* When one is going with the flow, it just comes out.

**Madam Deputy Speaker:** For the sake of clarity, it is okay if the hon. Lady says "when you are" when she means "when one is" because it is vernacular. I would not be so pernickety as to pick her up on that, and it is absolutely fine.

It is not often that I have the chance in a quiet House to clarify the rules that a lot of people do not understand, and that the hon. Lady clearly understands very well indeed. There are good reasons for the rules. It is not some old-fashioned tradition that we are sticking to because it is a tradition; it is because it changes the tenor of the debate. She is proceeding perfectly properly.

**Sally-Ann Hart:** Thank you, Madam Deputy Speaker. I understand that we have to use the right terminology because it depersonalises the debate, which is most important.

I am not sure whether I answered the intervention by the hon. Member for Gower (Tonia Antoniazzi), but I had better move on.

**Barbara Keeley:** The hon. Lady is talking about needing a debate on the Bill, but that debate could happen in Committee. All the points that Conservative Members are making—excruciatingly slowly to spin out the time and talk out the Bill—could happen there. The way that the legislative process works is that we get to Second Reading and vote for the Bill, then the details that Conservative Members are so keen to bring up now can be thrashed out in Committee. Let us make some progress.

**Sally-Ann Hart:** I thank the hon. Lady for her intervention, but if we only had debate in Committee, many hon. Members would not get to put forward their view, because they might not be on that Committee.

**Jane Hunt:** My hon. Friend has dealt with some of what I was going to say. I would say that today has been an amazing achievement for hon. Members, particularly Opposition Members. You have done well—

**Madam Deputy Speaker:** Order. Please, it is "hon. Members" not "you". I have not achieved anything at all today.

**Jane Hunt:** I apologise unreservedly. Hon. Members have achieved a great deal today and should not be disheartened. The people watching and listening should also not be disheartened because they have done a great thing today.

**Sally-Ann Hart:** Hon. Members have made great strides today.

To go back to clause (3)(1)(a), which proposes that a commission should be established to,

"propose a framework for the assessment of cannabis-based medicines and their suitability for prescription in England",

I have already said that there is a regulatory pathway in place under the Misuse of Drugs Regulations 2001 and medicines legislation. It would be inappropriate to establish a commission or any other body that aimed to circumvent existing regulatory controls or to subject medicinal cannabis to any less stringent assessment than is the case for other medicines used for serious or chronic conditions.

**Mark Fletcher:** One of my difficulties with the Bill is with clause 3 and the precedent it would set that the House effectively gets to decide which medicines we should prioritise and for which conditions. Does my hon. Friend share my concern that, if we go down that route, we undermine our independent regulatory system that is based on science and evidence?

**Sally-Ann Hart:** I wholeheartedly agree with my hon. Friend.

**Ben Everitt:** On that point, broadly, not many of the tricky problems that we deal with in this place are solved by the addition of more Government. Certainly, the danger of undermining NICE and the role of CCGs should not be underestimated. We need to take action to speed up the licensing of drugs as they come through, but I do not think that more Government is the way to do it.

**Sally-Ann Hart:** I agree on that point, and I wholeheartedly agree that we need to take more action to speed up the registering of prescription drugs, particularly if they are cannabis-based and there is an evidential base that they help many people who are in desperate need of that sort of medication.

The legislative changes presented in the Bill will not improve or expedite the development of the evidence required to support routine prescribing and funding on

*[Sally-Ann Hart]*

the NHS. I have raised the issue that manufacturing businesses and pharmaceutical companies need to come forward with their products for clinical trial. That is the most important thing.

I welcome the fact that the Government continue to support the establishment of clinical trials with NHS England and the National Institute for Health Research. From 1 April, a national patient registry was introduced to record patient outcomes. We talk about the amount of funding to do this or to do that, but we need closely to examine outcomes, because we need to know whether whatever goes in has a beneficial effect at the other end; that is vital, and we all have to take responsibility to ensure that it happens.

In recent years, there has been a lot of research into how medicinal cannabis can help epilepsy, mainly involving children with rare and serious epilepsy syndrome. Most studies have focused on CBD. The studies suggest that CBD may be an effective treatment for some rare types and hard-to-treat forms of epilepsy. There have been reports of side effects in about one in three people taking CBD, including drowsiness, reduced appetite and fatigue.

Most studies look at cannabis as an additional treatment for those who already take a number of prescribed epilepsy medicines, so it is difficult to tell whether cannabis works when taken on its own, and we have to be honest with ourselves about that. In addition, there do not appear to be any studies comparing medical cannabis with other medicines already licensed for treating epilepsy, so there seems to be no evidence—or not enough evidence—on whether medical cannabis is more or less safe, or more or less effective, than other epilepsy treatments.

**Tonia Antoniazzi:** I thank the hon. Lady for her generosity, but it is very frustrating to be sitting on these Benches and listening to what she is saying, because it is not true. The problem is that children have been dying, and these families have tried absolutely everything. The unlicensed drugs that children have had to take before they even had access to medicinal cannabis put them practically into a coma just to be alive; that is not acceptable. Please—I beg her to come and join the all-party parliamentary group, and to educate herself and her colleagues better.

**Sally-Ann Hart:** I thank the hon. Member for her intervention, but more clinical evidence is required on cannabis-based drugs. It is really important that that clinical evidence is there for everybody to see.

**Ben Everitt:** My point relates to the evidence available for the CBD-related products and therapies to which my hon. Friend has been referring. There is a lack of evidence on the THC end of things. THC is the chemical in cannabis that gets people high, and there has therefore been a reluctance for researchers and so on to look into the evidence base. We need more structured and reliable evidence on medicinal cannabis across the board. As my hon. Friend the Member for Crewe and Nantwich has said in interventions, the evidence needs to be something on which we can rely, so that we can make better policy and push these treatments through the licensing paths quicker.

**Sally-Ann Hart:** I completely agree.

It is a really positive step that the NHS refractory epilepsy specialist clinical advisory service has been established to support clinicians working with patients to optimise the treatment of refractory epilepsy, and that an e-learning model has been developed by Health Education England. This shows what can be done as we move forward.

I have to highlight my concern with some of the arguments surrounding the legalisation of cannabis for medicinal use in the UK, especially those that call for sick people to be permitted to grow their own cannabis under licence. I recognise that the hon. Member for Manchester, Withington mentioned my concern that, if we give permission, we have to be careful that people do not abuse it for recreational purposes. We have to be aware of that. The argument that the continued ban on cannabis is irrational because cannabis works as a medicine for a number of medical conditions indicates that there may well be a push for cannabis to be legalised without any real proof required of safety and effectiveness.

**Katherine Fletcher:** My hon. Friend is making a really interesting point. It is very important that we are careful not to conflate the legalisation of cannabis for recreational use and what is already legal. I know she is not, but does she accept that clarification?

**Sally-Ann Hart:** I do not want to conflate them, but we have to be aware of that. We must also be aware that using cannabis, medicinally or otherwise, carries risk. There is really not enough data on the effects of cannabis on a child's brain development, for example. Cannabis carries significant mental health risks for some individuals, and using it increases the risk of developing psychosis, depression and anxiety, as highlighted by Professor Colin Drummond, chair of the addictions faculty at the Royal College of Psychiatrists.

**Dr Allin-Khan:** What effect does the hon. Member think it has on a child's brain to have upwards of 30 seizures a day?

**Sally-Ann Hart:** I absolutely welcome that intervention from the hon. Lady. Thirty brain seizures a day would have a devastating impact on a child, but we also have to look at the cost-benefit analysis of the drugs that are being administered.

**Tonia Antoniazzi:** On that point, the cost of having a child at home on medicinal cannabis is a lot less than the cost of having that child in hospital. We have 20 children who are living proof of that. We have been asking for over four years for an observational trial of those children. That was agreed to by the NHS and then it was reneged on. There is RESCAS—the Refractory Epilepsy Specialist Clinical Advisory Service—but RESCAS does not work. I am afraid that the hon. Lady is not speaking with a clear and informed view. Unfortunately, that is stopping these children getting what they need today with this Bill.

**Sally-Ann Hart:** The hon. Lady is clearly very passionate about this, but I feel very strongly that we have to make sure that all the right safeguards are in place. Many of these patients are children, and we have to make sure that they are not damaged when it comes to drug prescriptions.

In summary, it is vital that access to unlicensed medical cannabis must have safeguards and that cannabis-based medicinal products are rigorously tested in clinical trials to ensure safety, quality and efficacy. The social let alone economic costs are otherwise too high. The Government have been clear that the law enables lawful access where it is deemed clinically appropriate. The most significant barrier to access on the NHS is the lack of evidence of the quality, safety and clinical and cost-effectiveness of these products. In the absence of that evidence, clinicians are reticent to prescribe, as has been highlighted, and there are no legislative levers that the Government could support that would change that. Producers of unlicensed cannabis-based medicinal products, like those of any other medicine, need to invest in clinical trials to support the use of their products and be prepared to submit their products for scrutiny by the medicines regulator and NICE.

1.54 pm

**Dr Kieran Mullan** (Crewe and Nantwich) (Con): I welcome the opportunity to speak in this debate. I congratulate the hon. Member for Manchester, Withington (Jeff Smith) on introducing the Bill and highlighting the issue. I understand that he is trying to improve the situation for patients who are struggling, and I accept that he has the best intentions in that regard.

At the outset, I think we have to unpick some of the debate so far. We are talking about two different things, potentially: unlicensed and licensed treatments. Some of the criticisms that have been raised about lack of evidence are very valid in relation to unlicensed treatments, but not so valid in relation to licensed treatments; that is an issue about how we spread best practice. What we are talking about today affects a lot of the NHS and a lot of treatments in many different ways: how we test and evaluate treatments, the accountability of our doctors and other healthcare professionals, and how we spread learning and best practice in the NHS.

We have come an incredibly long way with testing and evaluating treatments in the NHS. I will try to give some of the history and the context of the challenge of knowing what good treatment is, because it is an enormous challenge. If people understood the history and how badly we have got it wrong on so many occasions, they might better understand why healthcare professionals can often be reluctant when it comes to unlicensed treatments.

The starting point is the time when medicine was practised almost entirely without evidence. It was practised for a very long time without what we would now consider evidence. Clinical medicine has evolved organically over hundreds of years, if not thousands, from a starting point at which even the concept of evidence-based medicine was alien. In fact, there were occasions when individuals who sought to advance the cause of understanding the body and disease were castigated for challenging established understanding, even in relation to the most basic things.

An old example that illustrates how fundamental the challenge of understanding good practice can be relates to handwashing. We all now take handwashing for granted as something that we should all do and that helps to keep us safe, particularly in relation to a pandemic, but that is largely down to the efforts of one man: Ignaz Semmelweis, a German-Hungarian physician and scientist born in Hungary in 1818. He died in an asylum in 1865 having suffered a nervous breakdown, ostracised by the medical establishment that rejected his theories, which we now know to be true.

Semmelweis looked after women giving birth at a Viennese hospital. He worked in two different clinics; one had a maternal mortality rate of about 10% because of the infections that women would get after giving birth, while the other had a maternal mortality rate of about 4%. The difference was so stark that women begged to be admitted to the second clinic because it was common knowledge that they were much more likely to die in the first.

Semmelweis noticed that difference and set out to understand it. He studied every detail of what was happening in each clinic, eliminating all possible differences, and discovered that the only major difference was the people working there. The first clinic taught medical students; the second did not. He combined that knowledge with the incidental finding that a friend of his who had pricked himself with a scalpel when performing an autopsy had become sick and died, in the same way as the ladies in the first clinic, of a general unwellness—germs were not even understood at that point.

Semmelweis theorised that the connection must be something to do with contact with bodies among people at the clinic who were looking after the women giving birth. He instigated what we now take as common sense: handwashing with a chemical for anybody who had had any contact with those bodies and who went on to look after the women. When he instituted that policy, the maternal mortality rate in the clinic fell to exactly the same rate as the other's.

That theory is a landmark in our understanding of clinical medicine, but at the time it was considered extreme and Semmelweis was widely mocked. He was eventually dismissed from the hospital for political reasons, harassed by the local medical community and forced into an asylum; he ended up dying in terrible circumstances. That just goes to show how fundamental it is to doctors that we recognise that at various times medicine has got it very badly wrong in all directions. That guides a lot of what we do when we decide what treatments to give.

Sometimes our beliefs about treatment are based on an incorrect understanding of the nature of disease, false assumptions about how the body works or misconceptions about cause and effect. If people get better after treatment, we very often assume that the treatment helped, when often it was just incidental. We now know about the placebo effect, an incredibly powerful effect that generates improvements in patients without the benefit of any evidence whatever. From 1898 to 1913, a heroin-laced aspirin was available for the treatment of sore throats, coughs and colds, with a particular focus on it as a treatment for children; it was only in 1924 that heroin was banned completely as a treatment.

We still have a long way to go. Some research suggests that up to half the treatments we use even now lack what we might consider a full and reliable evidence base. Importantly for this debate, we can be badly

*[Dr Kieran Mullan]*

wrong not just in identifying an effective treatment, but in understanding its side effects in the longer term. I have listened carefully to the descriptions of benefits for individual patients and I do not deny in any way, shape or form that they are benefiting, but when we aggregate that across the whole population, we can discover side effects, particularly in the long term, that we are simply not aware of when considering the benefit for an individual patient.

There was some criticism of my hon. Friend the Member for South Ribble (Katherine Fletcher) for raising this example, but I had planned to raise it, too. People will have heard about the thalidomide scandal. That is important not as a comparison with a particular side effect, but in understanding how we get things wrong with medicine. Thalidomide was licensed in July 1956 for over-the-counter sale. No doctor's prescription was even required in Germany. By the mid-1950s, 14 pharmaceutical companies were marketing thalidomide in 46 countries and, by 1958, that included the UK. A UK Government warning was not issued until May 1962 and, in the intervening period, the drug was responsible for a wide range of birth defects in children who would otherwise have been born healthy.

Fen-Phen was a weight-loss drug used in the 1990s. It is estimated that as many as 6.5 million people took it. People taking it experienced heart disease, lung and pulmonary problems, and millions of pounds in compensation was paid out to people who took it after it was withdrawn.

Vioxx was taken off the market in 2004 after having been available for five years. That is considered to be one of the largest drug recalls in history. Vioxx was given to more than 20 million people as a painkiller for arthritis, but was later found to be responsible for an increased risk of heart attack and stroke. *The Lancet* reported that as many as 140,000 people could have suffered from serious coronary heart disease from taking this drug in the US alone. One study that I reviewed in anticipation of this debate found that 462 medicinal products were withdrawn from the market between 1953 and 2013 alone. This provides an important context for our discussion in terms of medicinal safety.

Modern clinical training teaches us how easily we can get our understanding wrong, how it can change and how difficult it can be to really understand the short and long-term benefits and harms of a medicinal treatment. We have a much more sceptical, vigilant workforce in healthcare as a result, and we must not be quick to rush to judgment when there is uncertainty about a particular treatment. We have come a long way with bodies such as the MHRA, NICE and others that attempt to support clinicians in making evidence-based decisions, because we realise that leaving it to the individual clinician is not necessarily helpful.

**Tonia Antoniazzi:** Do I understand the hon. Member well in thinking that he is saying that medical scientists do not know anything? We have allowed these children to have the medicinal cannabis. Is he saying that the scientists are wrong?

**Dr Mullan:** I encourage the hon. Lady to listen carefully to what I am saying. I said at the start of the debate that, absolutely, there are very good reasons for individual patients to receive this treatment. I have acknowledged that there are licensed treatments based on evidence, so I think she is kind of misrepresenting what I said. I said clearly that I am giving context to the—

**Madam Deputy Speaker (Dame Eleanor Laing):** Order. I am sure that the hon. Member for Gower (Tonia Antoniazzi) was not misrepresenting what the hon. Member for Crewe and Nantwich (Dr Mullan) said. She is doing whatever he is suggesting that she is doing, but it will not be misrepresenting, because that would not be honourable.

**Dr Mullan:** Perhaps the hon. Lady is inadvertently giving an incorrect impression of what I said. I made it very clear that this is the context for how clinicians behave in our NHS.

**Mark Fletcher:** Far from doing what has just been accused of you, I felt as though you are giving a—*[Interruption.]* The hon. Gentleman is giving a cautionary tale and providing context for this debate, and that is very important for this discussion.

**Dr Mullan:** I thank my hon. Friend.

**Tonia Antoniazzi:** I thank the hon. Gentleman for his generosity in giving way again. This debate has been had in the House for many years. We have spoken about it a lot. I would like to extend an offer to him and other hon. Members to join the all-party group on access to medical cannabis under prescription and to educate themselves.

**Dr Mullan:** With the greatest possible respect, I do feel that I understand the challenges that the hon. Lady is talking about. I will go on to answer her question about the fact that we have talked about it for a long time, so how do we move it forward? As I will explain, unfortunately, that applies to a very wide range of treatments and clinical practices in the NHS and across the world. This is about the appropriateness of picking out one specific area of clinical practice and using primary legislation as a way to overcome one particular problem. That is my concern.

**Andy McDonald:** The hon. Gentleman is failing to grasp that we have done it. The change has been made. What I am hearing time and again from Government Members is them rewinding and revisiting the process. The medications we are talking about are authorised and have been prescribed. We do not need to go through this exercise again—we have done that, and we want to move on.

**Dr Mullan:** I have explained that there are two challenges here. There are licensed, accepted treatments that are not being used, and there are very many examples across the NHS and healthcare globally of accepted, best practice, effective treatments that are not necessarily used as widely as they should be. We should not be picking out a particular treatment and using primary legislation as a mechanism to overcome that in one example; we should be working across the system and doing the hard work that has to be done to change clinical practices, as I will go on to explain.

In terms of reopening the debate, as I have explained, there is still a debate to be had about unlicensed treatments where there is not an evidence base for their use. We are talking about two things today, and I wish hon. Members

would be more careful in understanding the distinction between the two and not—*[Interruption.]* That is the argument I have made. I will carry on and make progress on the other issues I wish to discuss.

**Mark Fletcher:** I think there has been an accusation from the Opposition Benches that my hon. Friend does not seem to be educated in this particular area. Can he outline for the benefit of the House how much he understands medicine?

**Dr Mullan:** I thank my hon. Friend. When it comes to the issues I want to come on to talk about, it is not so much my practice as a doctor, but the fact that several years before becoming an MP I worked for the national clinical audit commission. The whole task of that organisation and very many other organisations in the NHS is to attempt to get clinical practice to change. There can be evidence and acceptance of what is best, and it does not happen, for very many reasons. That is the point I am trying to get across today.

I understand the focus on this particular treatment and I do not in any way underestimate the impact on patients but, as a constituency MP, I have several other examples of other treatments and other things people want to have on the NHS that they are not able to access. We have to think about how we tackle that in the broader sense, and I do not believe that picking out a particular treatment and putting it into primary legislation is the way to do that.

**Ben Everitt:** In an effort to draw some unanimity across this House, we are all keen to move things forward. We do not want to wind the clock back; we want more treatments through the licensing process. Does my hon. Friend agree that what he is calling for is a cautious, evidence-based way of doing that? We are not winding the clock back—*[Interruption.]* The shadow Minister intervenes from a sedentary position, but it was she who pointed out that the legislation is already there and that this private Member's Bill does not seek to frustrate that. I think we are all pushing in the same direction and I would like to draw us to push further.

**Dr Mullan:** The point to draw from my hon. Friend's intervention is that I have been working in this field for some time and I cannot think of any other example where we have decided to set aside all the ordinary processes that have been developed over many years, with great thought and attention to ensuring they are equitable in terms of resources, the NHS's time and NHS researchers' time, and come up with a whole separate process for determining the evidence on a particular treatment. That has never happened before that I am aware of.

I am happy to take an intervention from anyone on the Opposition side who can give me an example of when we have ever done that before, putting in place and encouraging the use of a particular treatment. I notice they do not—

**Jeff Smith** *rose—*

**Dr Mullan:** Do, do intervene.

**Jeff Smith:** The hon. Gentleman is right, and I respect his view. He is very knowledgeable in these areas. The point, as I tried to outline earlier, is that there are very many experts who think the process we have at the moment is not appropriate for the cannabis plant and the full plant cannabis extract. All I am asking is for the wider evidence base to be looked at. That is also what the NHS asked for in 2019 and what Sir Michael Rawlins said we should be looking at. There are a lot of people who think that randomised controlled trials are not necessarily the right way forward in this particular instance. All I am asking is for the evidence to be looked at.

**Dr Mullan:** All I would say is that those discussions need to be had with NICE, the NIHR and the Department of Health and Social Care and many other people, but to use primary legislation is not the appropriate way to do it, I am afraid.

**Dr Allin-Khan:** Without doubt, no one in the House wants anyone to suffer unnecessarily. However, most of us understand, as I am sure the hon. Member does, that in this case a randomised control trial would be immoral. The recipients of these medications are in such dire need that to find a group of children in as dire need and deliberately withhold treatment from them would be immoral. I respect him for his clinical and professional practice and as a Member of Parliament, but what is his alternative? The Bill, which has already gone through several stages with cross-party agreement and understanding, seeks to take this forward in unusual circumstances, where an RCT would be immoral.

**Dr Mullan:** As you know, I respect your experience—

**Madam Deputy Speaker (Dame Eleanor Laing):** No—hers.

**Dr Mullan:** I respect the experience that the hon. Member brings to her role. At no point have I said that the only way in which we can proceed is through RCTs. Earlier in the debate, when Opposition Members started talking in broad terms about observational studies and, to my mind, they were unfortunately disparaging RCTs, my comments were about being cautious. RCTs are incredibly important—they are fundamental to the vast majority of clinical medicine. I agree that other types of studies will be needed in some circumstances, but people need to make those arguments to the National Institute of Health Research. It is not for us as parliamentarians to override well-established processes designed to ensure that things are done in an appropriate, fair, thought-through and well-funded way.

**Andy McDonald:** The hon. Member is eloquent, but he is making a case for the commission. As the explanatory note says, the commission would be

"required to consider the role of evidence other than from conventional controlled trials, including from observational studies and other countries in which cannabis-based medicines are more widely available."

So the net is wide. We are not pre-determining the evidence that would be considered. Opposition Members are saying that randomised control trials are not appropriate—we agreed on that; he has said that that is problematic—and there are other ways to look at this. We are not pre-determining it. We are saying that a commission of experts should do exactly that. Can he not see that he is speaking in favour of the Bill?

**Dr Mullan:** No. The point I am making is that nothing in the NIHR's work says that it will only consider research and applications that are RCTs, and nothing prevents NICE from looking at any number of other methods of research. Opposition Members are saying that the Bill is the only way to get people to look at the evidence more broadly, but that is simply not true.

**Katherine Fletcher:** Briefly, I think I heard the hon. Member for Tooting (Dr Allin-Khan) talk about an RCT being immoral, implying that there is only one specific type of study design. She is talking about an RCT that would include forcing a placebo on children who are receiving medicine at the moment, but does my hon. Friend agree that RCTs can be designed in other ways and that we should not tar them all with one brush?

**Dr Mullan:** I agree. We have talked about observational studies and RCTs, and there are a number of different ways in which the evidence base can be developed.

**Dr Allin-Khan:** Having a number of research degrees, I am very aware that there are many different types of trials and that a randomised control trial is not the panacea in all cases. That exactly speaks to the importance of the Bill, which considers a number of other options. It talks about looking at evidence from a widely cast net—it is in agreement with the hon. Member. If he does not agree with the Bill's suggestions, which he is speaking to, what is his alternative?

**Dr Mullan:** I will go on to talk about what I think you need to do—when I say "you", of course, I mean the clinical community rather than the hon. Member—to advance these issues. I am afraid that very difficult work needs to be done across many parts of the clinical community, involving engagement with individual clinicians. The last thing we should be doing is creating a new mechanism for the appraisal of a clinical treatment in the NHS. I cannot support that when there are already well-established, well-developed mechanisms for the purpose which do not rely on any particular randomised control trial, for example. We know that, because several treatments have been approved, although it has been argued that cannabis-based treatments cannot be approved in the existing frameworks.

**Barbara Keeley:** Both the hon. Gentleman and one of his hon. Friends have questioned the use of primary legislation such as this wonderful Bill to advance this cause and remove these barriers. His hon. Friends have done the same on a number of occasions when private Members' Bills have come before the House. What about the Autism Act 2009? What about the Down Syndrome Bill, which we discussed last week? When an issue—such as a medical condition—is not receiving the attention, or the appropriate treatment, that it should be receiving from the NHS, Members present Bills to deal with that. Such Bills are generally applauded here, but somehow this particular instance of using primary legislation to remove these barriers for this group of people—

**Dr Mullan** *indicated dissent.*

**Barbara Keeley:** The hon. Gentleman sits there shaking his head, which he has been doing for about an hour, but it is not reasonable to pick this out as a separate issue.

**Dr Mullan:** There is a difference between presenting a Bill that seeks to establish frameworks and approaches that have had a wider application and seeking to use a Bill to advance a particular medical treatment. There is not another example of that in the House. The examples that the hon. Member has given did not seek to advance a particular medical treatment through primary legislation. I do not consider that acceptable.

**Tom Randall:** This is a point that I hope to address in my own speech, should I have time to make it this afternoon. I know that many Members wish to contribute.

I spoke in the debate on the Down Syndrome Bill last week. Does my hon. Friend agree that the difference between that Bill—and the Autism Act—and this legislation is that whereas the Down Syndrome Bill was seeking to fill a gap, trying to bring different agencies together to create a common framework because there was obviously a deficiency and they were not working together, this Bill, as I understand it, seeks to duplicate the work of a body that already exists and is already functioning? In that sense, the two Bills are very different and cannot be compared.

**Dr Mullan:** I entirely agree. For example, if this legislation were seeking to reform or amend the general approach that we take to the appraisal of healthcare technology treatments in the NHS, I might have more sympathy with it, but it is not seeking to do that. Its promoter has picked out a particular line of medical treatment and sought to use primary legislation to drive it forward, and for the reasons I gave earlier relating to the history of deciding what treatments doctors should or should not be using, that is something about which I am extremely uncomfortable, although I am very sympathetic to the individual cases that Members have been raising.

**James Daly:** In November 2019, NICE conducted a review of the international evidence available in respect of this important issue. The report that followed was essentially inconclusive, but it did consult widely and obtained a wide range of information on some of the issues that Members have rightly identified. If the commissioning proposal in the Bill went ahead, how would the relationship with NICE and its statutory responsibilities work in this situation?

**Dr Mullan:** As my hon. Friend says, this is creating complexities and competing relationships that need to be given considerably more thought, rather than our aiming to promote a particular treatment.

We have talked about the risks. I now want to describe some of the many ways in which healthcare practitioners are held to account for their decisions. This is particularly important in relation to the unlicensed use of a medicine. First there is the sense of personal, moral or social responsibility that we would hope anyone involved in healthcare feels. Even if we do not necessarily take the Hippocratic oath any more, we are signed up on the basis of the fundamental principle, "First, do no harm". Understanding that can be complicated, as I have tried to explain in relation to side-effects, for example.

Secondly, we are accountable to our employer. For example, a person working in a hospital is not free to practise as they wish. Their employer will have reasonable

expectations that they ensure that their practice is safe, evidence based and works in the best interests of their patients. Increasingly, employers will place a big emphasis on following best practice guidelines from royal colleges, the National Institute for Health and Care Excellence and others that restrict their practice in some regard.

**Andy McDonald:** There is nothing in this Bill that will substitute our view and our professional assessment for that home medical practitioner. I want to congratulate the Members on the Conservative Benches: the clock is running down to 2.30 and they have successfully talked out this Bill. May I just ask anybody on those Benches to volunteer some explanation that I can take back to my constituents who wanted to see us make progress today, and we have not. By the way, can they also think of something that I may be able to say to my wife?

**Dr Mullan:** I think the hon. Member will understand that legislative progress is not an exercise purely in discussion. We should not be putting forward legislation if Members on one side of the House do not feel that that legislation should be passing into law. I am very happy to say that, for the reasons that I have outlined and will continue to outline, I do not feel that this legislation is appropriate, and I do that and will still sleep soundly tonight. It does not mean that I do not understand the deep concern, the hurt, and the anguish that individual parents are feeling. As I have said, I have worked in this field for a long time. There are very many people who suffer hurt and anguish in relation to treatments. I can talk about my own personal experience. My mother was diagnosed and treated for cancer. There was a period of a couple of years where I had seen a treatment that I wanted her to be on because I felt that it would be effective. There was some evidence to suggest that it was effective. We had to wait a couple of years for the further studies to come out, recommending that particular treatment. I have a young boy in my constituency, or a neighbouring constituency, whose family has raised an enormous amount of money to go to another part of the world to try a treatment that we do not consider to be sufficiently evidence-based—

**Andy McDonald:** That is not this—

**Dr Mullan:** The Member shouts from a sedentary position, but I am afraid that we are talking about a relevant issue. Labour Members want unlicensed treatments to be brought forward. There is a mixture of unlicensed treatments and licensed treatments.

**Hon. Members:** Absolutely wrong.

**Dr Mullan:** Members say that they do not want to achieve that, so why are they bringing forward this legislation? If they do not think that it will make a difference to the use of a treatment, why are they bringing this Bill before the House? They must think that it will have an impact.

**Jeff Smith:** I think the hon. Gentleman might have inadvertently misrepresented things. I have not proposed the Bill to try to have unlicensed medicines—as I think he said—put forward. What I am trying to do is to introduce a Bill that will enable clinicians to look at a wider evidence base in order to get those medicines licensed. That is what I am trying to do. I want to listen to the hon. Gentleman because he is very knowledgeable and I respect what he is saying. I think he is making an important speech. It is disappointing, however, that Members have spoken for so long that the Minister will not be able to speak. That is a bit of a poor show from the Government.

**Dr Mullan:** As I said, my view is that there is nothing at the moment in any of the legislation or roles of the bodies that we already have in place that restrict them from looking at any particular type of evidence. That is simply not true. They are allowed to look at whatever evidence they choose to look at. It is whether that evidence is there, is available to them and is sufficient.

**Tom Randall:** I know that there has been a lot of talk in this debate about a campaign that has been going on for four years. My hon. Friend speaks with his medical experience, and many of us on these Benches do not. Does he agree that there has been a churn in the representation of this House over the past four years and there are new MPs who are coming to this debate afresh? This debate has been very useful in illuminating and educating those Members who are newer to the debate and that has been a very productive exercise. Does he further agree that, in spite of the understandable emotions that exist within this debate, the primary duty of Members of this House is to pass good legislation?

**Dr Mullan:** I completely agree. I would just add that processes are in place because we are at the greatest risk of making mistakes when we are faced with people in very desperate circumstances. The risk is greatest when a parent is extremely concerned for the welfare of their child, or when someone has a terminal illness. Those are the types of scenarios where people are most at risk of having the wrong treatment. I gave the example, which is incredibly important to remember in the wider discussion, of the MMR cases. Parents were advocating very, very strongly that that treatment had caused damage and distress to their children. Doctors were involved in amplifying and giving credibility to that circumstance. As a result, fewer people took their vaccines. I say this with all compassion to individual parents, but we have to retain a degree of objectivity, and I am afraid that parental passion is not a substitute for the systems we put in place.

**Lia Nici:** We all know there are a huge amount of emotions around this argument. All of us, I think, across the House would like to see the situation move forward. The issue is that the proposed legislation will not move things forward. In fact, it has the potential to slow the whole process down. If I understand it correctly, a private Member's Bill cannot bring forward any money resolutions. What we need here is money, and for CCG and NHS processes to be working properly. We do not need primary legislation to do exactly what hon. Members across the House want. We just need to get on with it via the NHS and CCGs.

**Dr Mullan:** My hon. Friend is correct to say that in other circumstances funding and pots of money are sometimes set aside to deliver improvement in a particular area. However, as she says, the Bill is incapable of bringing forward funding in that regard.

**Tonia Antoniazzi:** I thank the hon. Gentleman for giving way. The hon. Member for Great Grimsby (Lia Nici) makes a valid point. We have asked for a pot of money. We went to the Department of Health and Social Care. The hon. Member for Bury St Edmunds (Jo Churchill) was on the verge of organising it and getting it sorted so that we could have that pot of money. The Bill was the next option, because that option was no longer available when she was replaced as Minister. What next? There are 20 families, and hundreds more, who need something to happen. Inertia is not what we want. We have to move on. What is being done by the Government?

**Dr Mullan:** I am not familiar with the discussions the hon. Member may or may not have had—I am sure the hon. Member did have them—with the Government in relation to pots of money. Again, I will gently say that there are enormous pressures on NHS budgets. That is why we have NICE, for example, to take out some of the emotion and personal feelings people have in relation to clinical care, and to try to look objectively at what secures value for money. I am not aware of what work the Department may have done on whether this represented an equitable use of resources for this particular area of clinical care. I will be happy to write to the Minister and make inquiries, as I am sure Opposition Members and the all-party group have done.

**Andy McDonald:** On cost-efficiency, does the hon. Member not agree that, considering the cost of emergency admissions to hospital and the use of intensive care and expensive medicines that do not work as effectively, this system would be a much better use of national health resources and would actually be a financial economic benefit to our nation, not a detriment?

**Dr Mullan:** I agree. I am sure that that is part of the reason why some treatments secured a licence and NICE approval. Again, we must not give the impression to people listening to the debate that the NHS's systems are not engaging with this issue. I am sure that some treatments were approved. I am sure—or would hope, if the evidence is there—that future treatments might also secure approval as we go forward, particularly if the evidence is there to demonstrate that they are of use. I just reiterate that the things that Members on the Opposition Benches have been asking for have been happening. It may be at a rate that frustrates them, but I share that frustration, as do many others, and it goes across lots of different clinical treatments. I have direct experience of it, and it is not just an issue for the NHS; it is a global issue for modern healthcare systems when a vast amount of money is going into medical research with new treatments all the time. Governments need systems to decide which treatments they approve and so that they can look at the evidence properly. That is why we have the MHRA, NICE, the royal college guidelines and NHS best practice guidelines. All those things are in place.

2.30 pm

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

*Ordered,* That the debate be resumed on Friday 14 January.

## Business without Debate

### CLIMATE CHANGE BILL

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

### BRITISH GOODS (PUBLIC SECTOR PURCHASING DUTY) BILL

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

### CLEAN AIR TARGETS (WORLD HEALTH ORGANIZATION GUIDELINES) BILL

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 18 March 2022.*

### CONSUMER PRICING BILL

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

### BROADCASTING (LISTED SPORTING EVENTS) BILL

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

### PUPPY IMPORT (PROHIBITION) BILL

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**Madam Deputy Speaker (Dame Eleanor Laing):** It is lucky there are no rules about repetition in this place.

### EMPLOYMENT (APPLICATION REQUIREMENTS) BILL

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**PUBLIC SECTOR WEBSITE IMPERSONATION BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**HUNTING TROPHY IMPORT (PROHIBITION) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**John Spellar** (Warley) (Lab): On a point of order, Madam Deputy Speaker, is there any way of putting on the record that this immensely popular Bill, both in this House and with the public, has been blocked by a Government Whip when the Government have still not produced their own Bill?

**Madam Deputy Speaker (Dame Eleanor Laing):** There is no way of putting that point on record. We have now had repetition, deviation and opportunism.

**ARMENIAN GENOCIDE (RECOGNITION) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**HOUSE OF LORDS (HEREDITARY PEERS) (ABOLITION OF BY-ELECTIONS) (NO. 2) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**EMPLOYMENT AND TRADE UNION RIGHTS (DISMISSAL AND RE-ENGAGEMENT) BILL**

*Resumption of adjourned debate on Question (22 October),* That the Bill be now read a Second time.

**Hon. Members:** Object.

*Debate to be resumed on Friday 18 March 2022.*

**CLIMATE AND ECOLOGY BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 18 March 2022.*

**PUBLIC ADVOCATE BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**LOCAL GOVERNMENT (DISQUALIFICATION) BILL**

*Consideration of Bill, not amended in the Public Bill Committee*

**Hon. Members:** Object.

*Bill to be considered on Friday 14 January 2022.*

**AMBULANCE WAITING TIMES (LOCAL REPORTING) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 18 March 2022.*

**COPYRIGHT (RIGHTS AND REMUNERATION OF MUSICIANS, ETC.) BILL**

*Resumption of adjourned debate on Question (3 December),* That the Bill be now read a Second time.

**Hon. Members:** Object.

*Debate to be resumed on Friday 14 January 2022.*

**ILLEGAL IMMIGRATION (OFFENCES) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**PLASTICS (WET WIPES) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 4 February 2022.*

**NHS ENGLAND (ALTERNATIVE TREATMENT) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 21 January 2022.*

**PUBLIC HEALTH (CONTROL OF DISEASE) ACT 1984 (AMENDMENT) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 21 January 2022.*

**BBC LICENCE FEE NON-PAYMENT (DECRIMINALISATION FOR OVER-75S) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**CARAVAN SITES BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 21 January 2022.*

**GREEN BELT (PROTECTION) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**PUBLIC SECTOR EXIT PAYMENTS (LIMITATION) BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 21 January 2022.*

**COVID-19 VACCINE DAMAGE BILL**

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

**Hon. Members:** Object.

*Bill to be read a Second time on Friday 14 January 2022.*

**Colum Eastwood** (Foyle) (SDLP): On a point of order, Madam Deputy Speaker. Could you offer me some advice? We have had to endure very lengthy speeches today, which has had the effect of ensuring that we did not get to vote on the very important Medical Cannabis (Access) Bill before the House. We did not even get to discuss the Climate Change Bill in my name, which thousands of people support because of the massive damage that is being done to this planet through Government inaction. Can you please advise me when and how I can get some parliamentary time to discuss and debate a Bill that has lots of support out there among the public?

**Madam Deputy Speaker (Dame Eleanor Laing):** The hon. Gentleman makes a perfectly reasonable point, and I can understand his disappointment that his Bill has not been aired today. I think that when we came to his Bill I asked him to name a day for Second Reading, and he named the day. I cannot now recall, having done 27 others, exactly which day he named, but whichever day it was, I hope that on that day we will have a chance to hear what he has to say about his Bill and to discover how much support it has. I hope that is helpful to the hon. Gentleman.

## Children and Young People with Complex Needs

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

2.39 pm

**Sir Charles Walker** (Broxbourne) (Con): Sadly, some children and young people are not able to live safely with their families. The significant majority of these children have experienced trauma at a point during their developmental years, resulting in a range of behaviours, many of which cause distress to them or others. Those behaviours include self-harm and an increased vulnerability to criminal exploitation.

If a young person is unable to live safely at home, he or she may come into the care of the local authority or require hospital care. There is currently an insufficient supply of specialist care to meet the needs of such young people. As a result of the challenges posed by covid-19, health and social care professionals describe an unprecedented level of complexity and acuity of need, making an already difficult situation worse.

When a young person comes into care they will require either a children's home, with staff skilled and experienced in meeting complex needs, or in some instances a court-directed placement into a secure unit, to keep them safe. Over the past 18 months, Hertfordshire children's service has made three applications to the national secure bed bank. Despite repeated referrals, a secure placement was achieved for only one child. The most recent referral was made approximately six weeks ago, and on that occasion the local authority was advised that there were 50 referrals for only four available beds. That means that a secure bed was not available for 46 young people who had been assessed as requiring such accommodation to keep them safe. In each of those cases, the relevant authorities, including Hertfordshire, were required to make their own arrangements while the secure referral remained active.

Increasingly, local authorities turn to the courts for a deprivation of liberty order in the absence of more appropriate secure placements. Such orders are sought as a last resort, even though when granted they can place local authorities in the invidious position of having knowingly to place children in environments that are not best suited or equipped to meet their complex needs. Similarly, young people who require psychiatric hospital care find such care unavailable because of a shortage of appropriate hospital beds. In Hertfordshire, a number of young people have been assessed as detainable under the Mental Health Act 1983 and are waiting for appropriate hospital beds. The number waiting for a placement often rests at around 10 children, which means that in each of their cases their needs are not being met.

Despite people's best efforts, the whole system is creaking because it is unable to cope with the demand. Problems with recruitment and the increasing complexity of some children's needs mean that Ofsted and the Care Quality Commission too often find themselves in the position of having to close providers down, or reduce their bed capacity. It is important to note that there is a difference between physical beds and usable beds. Many beds are not in service because, in meeting the increasingly complex needs of children in care, there is not the staff capacity safely to service all the available beds in a home.

Not only is the current situation having a detrimental impact on young people, but its impact on the public purse is significant. Delivering bespoke care to a young person, often through a commissioned provider, is very expensive, particularly because these young people, due to the risks they present, will require high staffing levels. Placements are expensive: they can cost from £4,500 a week to upwards of £30,000 a week. Often, a child who has difficulty accessing support further down the needs scale quickly ends up requiring a far most costly set of interventions and specialist care.

It is of course important to intervene early to work with young people in the community to prevent family breakdown and the escalation of needs, but the current placement situation must be addressed, so in this debate I wish to ask regulators to work with the care sector to reopen closed beds through the development of a specialist taskforce that supports providers—be they mental health providers, social care providers or specialist schools—that struggle to deliver good-quality care. Alongside such efforts, we should make a national intervention to reassure providers that their Ofsted rating will not be negatively impacted if they admit children with the most challenging of needs. Too often, specialist care providers will refuse these children because they are concerned that if a child absconds or creates a high level of service demand, that will negatively affect their Ofsted rating.

We also need a national campaign both to challenge the stereotypes about children in care and to recruit residential childcare officers. Such schemes are already in place for fostering and adoption, and we have Teach First and Think Ahead. A similar programme now needs to be introduced to attract people into child social care and, in particular, the care of children with high levels of need.

Backing up this recruitment drive, we need a programme of support to design children's homes that can accommodate children with the most complex needs but, as I have already said, without extra specialist staff the Government programme to match fund local authorities to develop new children's homes will face significant challenges. New homes require skilled staff if they are to be viable. Also, in wanting to build new specialist homes, we need to appeal to the better part of people's human nature, as too many of these specialist homes, when they come up for planning approval, are opposed by local communities.

When it comes to registering specialist residential care homes and facilities, we need to find a way of expediting the Ofsted registration process, which can take upwards of three months. In an emergency, a local authority will sometimes use one of its bedroomed properties as a care setting for a vulnerable child or adolescent, with a rota of specialist social care staff in attendance. Without Ofsted registration, such facilities will be operating outside the regulatory framework.

**Darren Henry** (Broxtowe) (Con): I hear my hon. Friend's point about care in the community, which is essential and something we need to focus on. Children and young people with complex needs too often end up in hospital, which is not the right place for them, as they end up being affected by people in hospital with other

*[Darren Henry]*

issues. Care in the community is essential. How can we give local authorities the onus and the investment to make this happen?

**Sir Charles Walker:** I thank my hon. Friend for his intervention, and I will come on to that. We need to have the right setting delivering the right care—the care that the child needs. The child needs to be at the centre of that care.

How does a care emergency arise? That question is often put to me. Beyond the national shortage of beds, a provider can notify a local authority, with only a few hours' notice, that it will be terminating a young person's placement in its facility. They can say, "In just a few hours, you will have this child back. This child is now your problem again." This practice needs to be eliminated, but eliminating it will only alleviate the need for the provision of emergency accommodation and care; it will not end it. That will be done only through the provision of more beds, in both the social care sector and the psychiatric care sector. In the psychiatric care sector, it is not just the overall quantum of beds that counts; it is also the type of bed. These will cover general adolescent units, eating disorders, low-secure units and psychiatric intensive care units.

Almost all the concerns I have highlighted and will highlight this afternoon were identified in Sir Martin Narey's independent review of residential care and in the Government's response of 2016. We need to implement the findings of this report and tie them into a review of the Care Standards Act 2000 and the children's homes regulations.

If anyone watching or listening to this debate wants to learn more about what is happening in this sector, I refer them to an excellent report by the BBC correspondent Sanchia Berg that can be found on the BBC website, dated 12 November, "The court orders depriving vulnerable children of their 'liberty'". The report contains harrowing accounts of what is happening, and they are framed throughout by the concerns of the High Court judge Sir Alistair MacDonald, who is deeply concerned about what he is witnessing in the courts and family courts.

Let me return to Sir Martin Narey's independent review. Beyond its implementation, we need better joined-up care between the NHS and local authorities. The continuing healthcare framework has much to recommend it in relation to children and adolescents, but it is still heavily slanted towards their physical health. A robust commitment to parity of esteem would see the framework cover clinically diagnosed mental illness, as well as the challenges caused by trauma, attachment difficulties and, increasingly, autism. Let me say, as an aside, that all Department of Health legislation should make it perfectly clear that health means mental health and physical health; we cannot have one without the other.

Why is mental health so important? There are still far too many lengthy debates between local authorities and the NHS as to whether a child is suffering from a mental illness or a behavioural difficulty. To many, this seems like dancing on the head of a pin, as the debate does not change the fact that at the heart of the discussion is a child in crisis, as referred to by my hon. Friend the Member for Broxtowe (Darren Henry). A good solution has to be more joint commissioning between health, education and care providers, thereby removing barriers to joint funding. An example of best practice can be found in my own county of Hertfordshire, where we are opening up a three-bed unit that will be jointly staffed by social care professionals and mental health professionals. Perhaps this initiative could pave the way for a national programme of hybrid mental health children's homes, with a hybrid model of worker.

I must conclude by returning to staffing and recruitment. There really is a need for an enhanced programme of training for residential workers that recognises the unique challenges of the role and the high level of skill required to deliver an effective service. Residential work currently requires a lesser qualification than social work, yet those working in residential settings have significantly more direct contact with the most vulnerable children with the most complex needs. Better training would lead to better pay and an enhanced profile, thereby making the role a career of choice and one which is attractive to graduates.

I have made these recommendations and observations today on behalf of the excellent Hertfordshire County Council, which does a fabulous job across my county, and, of course, on behalf of the children for which it cares. Both Hertfordshire County Council and I want to support the Government's programme to develop more beds in the secure estate, but we want an estate that is compassionate and able to provide the high levels of care and support that I know, the Minister knows and Madam Deputy Speaker knows, it wants to provide.

2.53 pm

**The Parliamentary Under-Secretary of State for Health and Social Care (Maggie Throup):** I thank my hon. Friend the Member for Broxbourne (Sir Charles Walker) for securing this important debate on care for children and young people with complex needs, and thank him for highlighting good practice in his constituency and across his local authority.

The Government are committed to ensuring that all children and young people who need care—be that health or social care—receive the safe and compassionate care that we should all expect. We are taking action to support all children and young people's mental health, and to support those with complex needs to stay well in the community. This support starts at birth.

The Chancellor recently announced £300 million for family and early years support in half of upper-tier local authorities over the next spending review period. This includes: £100 million to roll out bespoke parent-infant mental health support to nurture parent-infant relationships, and improve access to perinatal mental health support; £50 million to fund evidence-based parenting programmes; and £82 million to create a network of family hubs. In addition, the Chancellor confirmed £200 million for the supporting families programme, increasing the number of families supported by the programme from 70,000 in 2021-22 to more than 100,000 in 2024-25.

For school-age children, we continue to implement the proposals of the children and young people's mental health Green Paper. In March, we announced £79 million to boost mental health support for children and young people in England. Part of that will accelerate the roll-out of mental health support teams in schools and colleges to cover around 3 million children and young people by 2023. In May, the Department for Education

announced funding worth £9.5 million, which will allow up to 7,800 education settings in England to train a senior mental health lead from their staff in the next academic year.

We are also taking steps to support children and young people with learning disabilities and autism through our newly published national autism strategy, the first autism strategy to be extended to children and young people as well as adults. The strategy is backed by over £74 million for the first year. That includes £3.5 million to help local systems identify children and young people on waiting lists who might be at risk of crisis, and £3 million for respite and short breaks to help families and autistic children and young people with and without learning disability who have struggled during the pandemic.

The independent review of children's social care, which commenced in March 2021, will look at the needs, experiences and outcomes for the children supported by children's social care. We know, sadly, that there are some children and young people who will need in-patient care or a place in a secure setting. NHS England is accountable for the provision of in-patient mental health services for children and young people. In line with the NHS long-term plan, some of the commissioning tasks and relevant budget have been delegated to NHS-led provider collaboratives.

**Darren Henry:** My understanding of the point that my hon. Friend the Member for Broxbourne was making is that we should make sure that the investment goes into residential care. The Minister is talking about the money and the investment being put into in-patient care, but that should really be put into residential care. Will she please comment on that? In addition, taking that a step further, should areas with residential care and the staff equipped to deal with children with complex needs not eventually get people into supported living so that we can ultimately get them into independent living?

**Maggie Throup:** My hon. Friend makes a very good point, and I will come to that later in my speech.

The lead provider works collaboratively with other providers to ensure the appropriate level of in-patient provision in their area; it is important that we have the right mix of provision, whether it is in-patient or community support. They also ensure that the right community services are available to support children and young people when they are discharged to prevent further crises.

Wherever possible, collaboratives will aim to provide high-quality alternatives to admission. However, where stays are required, they should be short and close to home in a high-quality, safe and therapeutic service. We must of course ensure that the rights of children and young people who are placed under the Mental Health Act 1983 are respected.

We published our White Paper on reforming the Mental Health Act in January 2021, setting out proposals to make the Act work better for people. We are committed to ensuring that the reforms we want to make to the Act also benefit children and young people. We will work to ensure that the rights we plan to introduce for patients are also available to children and young people detained under the Act. Reforms to the Act will limit the scope to detain people with a learning disability or autistic people, helping to reduce unnecessary detentions. To ensure that in-patient settings are therapeutic for autistic people, we are providing £4 million to enable in-patient settings to become more autism friendly.

In children's social care, we are committed to doing everything we can to support local authorities in ensuring that the most vulnerable children are protected and that there are sufficient places for children in their care. The Government have given more than £6 billion in un-ringfenced funding directly to councils to support them with the impact of covid-19 spending pressures, including in children's social services.

I take the opportunity to refer briefly to the a point made by the Secretary of State for Health and Social Care in the House a few days ago. He set out that we will be taking further measures to support and protect social care against the threat posed by the omicron variant. We will set out a package of measures at the earliest opportunity. I reassure hon. Members that the timing of the announcement will not have an impact on our ability to implement those protections on the intended date.

The Government are also taking additional steps to support local authorities to fulfil their statutory duties. The spending review 2021 announced £259 million over the spending review period to maintain capacity and expand provision in secure and open residential children's homes. That will provide high-quality safe homes for some of our most vulnerable children and young people.

We recognise that those in the secure estate are some of the most vulnerable in our society. Children and young people in secure settings are more likely than other young people their age to have additional healthcare needs. The integrated care framework aims to support trauma-informed care, and formulation-driven evidence-based whole-system approaches to creating change for children and young people within the children and young people secure estate.

My hon. Friend the Member for Broxbourne talked about beds. In the NHS long-term plan, we committed to investing at least an additional £2.3 billion in mental health services by 2023-24. That will see 345,000 children and young people a year accessing NHS-funded specialist mental health support if they need it. On 5 March, we announced an additional £79 million of funding that will be used to expand children's mental health services significantly in this financial year. It will also help to improve access and reduce waiting times for NHS community mental health support.

There is much to be said about how we are supporting and should further support children and young people, not least those who, because of mental illness, learning disabilities, being autistic or complex trauma, are some of the most vulnerable in our society.

**Sir Charles Walker:** On a point of order, Madam Deputy Speaker. The Minister's Department asked for my speaking notes, which I provided earlier in the week, but barely a question I raised was answered by her. It is not her fault, but I have just had generalities; we got on to social care when I was talking specifically about care for children with a high amount of need. I am confused: what is the point of providing notes to officials in advance of an Adjournment debate if the Minister is not equipped—it is not her fault—with the speech to respond?

**Madam Deputy Speaker (Dame Eleanor Laing):** I took the hon. Gentleman's raised eyebrows as an indication that he wished to raise a point of order before I adjourn the House. We could have had more time on the debate, so I gave him the opportunity to make the point. The Minister is at liberty to say whatever she wishes at the Dispatch Box—that is not a matter for me—but she may wish to respond to his point.

**Maggie Throup:** Further to that point of order, Madam Deputy Speaker. I promise to write to my hon. Friend on the specific issues that he raised and I will look into them very seriously.

**Sir Charles Walker:** Further to that point of order, Madam Deputy Speaker. I thank the Minister for that kind offer. It was not an attack on her—I think she is as disappointed as I am.

**Madam Deputy Speaker:** I appreciate the points that the hon. Gentleman and the Minister have made.

*Question put and agreed to.*

3.4 pm

*House adjourned.*

# Written Statements

*Friday 10 December 2021*

## DIGITAL, CULTURE, MEDIA AND SPORT

### Concussion in Sport: Government Response

**The Parliamentary Under-Secretary of State for Digital, Culture, Media and Sport (Nigel Huddleston):** I wish to inform the House that the Government have today published their response to the report by the House of Commons Digital, Culture, Media and Sport Select Committee into concussion in sport.

Sport is a central part of our national identity and culture. The welfare and safety of everybody taking part in sport is of paramount importance, and the Government are committed to taking action to reduce the risks involved. The actions set out in this report do not represent the final word on the subject and we recognise there is more work to do to continue to make sport as safe as possible for all those who participate in it.

The Government are grateful to the DCMS Select Committee for undertaking its extensive inquiry into concussion in sport. The Committee's report has reinforced the importance of the topic and provided valuable insights that have helped inform the Government's thinking.

Our response outlines the Government's approach to reducing the risks associated with concussion and head injuries in sport. This will involve working with partners from across the sport, health, education, academic and technology sectors.

A full response to each of the Committee's recommendations is also provided in a separate annex to the report.

Within the report, the Government have committed to:

Commission a set of shared high-level protocols around concussion in sport across the UK.

Write to UK Sport and Sport England to explore ensuring funded bodies make use of these shared protocols.

Work across Departments to improve the protocols and pathways for use in treating concussion in sport injuries in NHS A&E settings.

Direct sports to work with Player Associations on training protocols for players' long-term welfare.

Convene a sports concussion research forum of experts to identify the priority research questions and improve the coordination with research funding bodies.

Write to National Governing Bodies to emphasise the importance of player welfare (including concussion) when formulating their governance procedures.

A copy of the Government response to the DCMS Select Committee report will be placed in the Libraries of both Houses.

[HCWS465]

## ENVIRONMENT, FOOD AND RURAL AFFAIRS

### Fisheries: Annual Negotiations

**The Minister for Farming, Fisheries and Food (Victoria Prentis):** At the time of writing, annual negotiations on fisheries are ongoing between: the UK, EU and Norway (the Trilateral); the UK and the EU; the UK and Norway; and the UK and the Faroes Islands.

As regards the Trilateral, which will determine catch limits for six jointly managed stocks in the North Sea (cod, haddock, saithe, whiting, plaice, herring), discussions have been fruitful and we expect agreement between the three parties to be reached later this afternoon (Friday 10 December).

Bilateral negotiations between the UK and the EU on 2022 fishing opportunities on jointly managed stocks are ongoing. Discussions have been constructive so far and there is opportunity to intensify talks before 20 December if necessary.

We are continuing to discuss possible exchanges of fishing opportunities with Norway and the Faroes. If there are agreements to be reached, of which we remain optimistic, we hope to conclude them in the next few weeks.

We have also concluded a number of other negotiations this year, including in Regional Fisheries Management Organisations (RFMOs) and on catch limits for three straddling species (mackerel, Atlanto-scandian herring, and blue whiting) with coastal State partners in the North East Atlantic.

[HCWS466]

## HOUSING, COMMUNITIES AND LOCAL GOVERNMENT

### Delivery Supply Chain: Planning Controls

**The Minister for Housing (Christopher Pincher):** I wish to update the House on the measures the Government are taking to facilitate flexibility within the delivery supply chain and mitigate challenges faced by construction sites.

Due to the covid pandemic, the logistics sector is facing an exceptional challenge resulting from the acute shortage of HGV drivers across the distribution network. This has resulted in missed deliveries which have the potential to lead to significant shortages and hinder economic growth.

Through a previous written ministerial statement made by the former Secretary of State, dated 15 July 2021, the Government responded to these pressures proactively by ensuring the industry had the tools available to adapt effectively and minimise any disruption to the public. The statement made it clear that local planning authorities should take a positive approach to their engagement with food retailers and distributors, as well as the freight industry, to ensure planning controls are not a barrier to deliveries of food, sanitary and other essential goods.

I am now expanding the scope of these measures. The purpose of this written ministerial statement, which comes into effect immediately, is to make it clear that local planning authorities should take a positive approach to their engagement with all supply chain stakeholders to ensure planning controls are not a barrier to the supply of all goods and services.

Many commercial activities in England are subject to controls which restrict the time and number of deliveries from lorries and other delivery vehicles, particularly during evenings and at night. These restrictions may be imposed by planning conditions, which are necessary to make the development acceptable to local residents who might otherwise suffer from traffic, noise and other local amenity issues. However, this needs to be balanced with the public interest, for all residents, to have access to shops which are well stocked.

The National Planning Policy Framework already emphasises that planning enforcement is a discretionary activity, and local planning authorities should act proportionately in responding to suspected breaches of planning control.

Local planning authorities should not seek to undertake planning enforcement action which would result in unnecessarily restricting deliveries, having regard to their legal obligations.

Construction output has also been inconsistent in recent months and not returned to pre-February 2020 levels. Construction sites in England may also be subject to controls which restrict the hours within which they can operate. Wherever possible, local planning authorities should respond positively to requests for flexibility for operation of construction sites to support the sector's recovery.

The Government recognise that it may be necessary for action to be taken in relation to the impacts on neighbours of sustained disturbance due to deliveries and construction outside of conditioned hours, particularly where this affects sleep. In this case a local planning authority should consider any efforts made to manage and mitigate such disturbance, taking into account the degree and longevity of amenity impacts.

This statement will replace all the previous statements on these matters.

This written ministerial statement only covers England and will expire on 30 September 2022, giving direction to the industry and local planning authorities over the next 10 months. We will keep the need for this statement under review.

[HCWS467]

## PRIME MINISTER

### Intelligence and Security Committee: Annual Report 2019-21

**The Prime Minister (Boris Johnson):** The Intelligence and Security Committee of Parliament has today laid before Parliament a report covering the work of the Committee between July 2019 to July 2021. The Government welcome the independent and robust oversight of the security and intelligence agencies and the wider intelligence community that the Committee provides. As this report demonstrates, the work of the Committee is wide-ranging, on topics vital to ensuring the public can have confidence that our world-class intelligence agencies continue to operate effectively and proportionately in light of the threats we face.

The period covered in this report has been a particularly challenging one, and it is a testament to the Committee that it has been able to provide oversight despite disruption to its work plan from the pandemic. The Government look forward to seeing the conclusions of a number of ongoing Committee inquiries.

The agencies and wider intelligence community value the oversight the Committee provides and have ensured Committee requests in this period have been given high importance. However, it is proper and right that agency and intelligence community resources continue to be appropriately prioritised to ensure the safety and security of our nation; the agencies have shown both resilience and ingenuity in continuing to deliver despite the challenges this period has brought. the intelligence community and Government were in touch with the Committee during the drafting of this report, and would remind the Committee of the importance of mutually agreeing timelines for returns to ensure these are reasonable and achievable.

During the period covered by the Committee's report, the Government have published three formal responses to ISC reports, which address the recommendations and conclusions the Committee have made: Russia, published on 21 July 2020; Northern Ireland-related Terrorism, published 11 February 2021; and GCHQ Procurement: A Case Study, published 22 July 2021.

The Government remain confident that the current memorandum of understanding with the Committee is sufficient to allow for robust oversight of the agencies and wider intelligence community. The National Security Adviser has written to the ISC Chair to restate this position.

I would like to again thank the Committee for its work, and I look forward to working with it as it continues its vital oversight duties.

[HCWS464]

# WRITTEN STATEMENTS

**Friday 10 December 2021**

No proofs can be supplied. Corrections that Members suggest for the Bound Volume should be clearly marked on a copy of the daily Hansard - not telephoned - and *must be received in the Editor's Room, House of Commons,*

**not later than**
**Friday 17 December 2021**

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