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Public Bill Committee

HEALTH AND CARE BILL

Seventeenth Sitting

Tuesday 26 October 2021

(Afternoon)

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not later than

Saturday 30 October 2021

The Committee consisted of the following Members:

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

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

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Public Bill Committee

Tuesday 26 October 2021

(Afternoon)

[Steve McCabe *in the Chair*]

Health and Care Bill

2 pm

The Chair: Good afternoon. It is lovely to see everyone again. I must remind you of various things before we start. Please switch electronic devices to silent. No food or drink apart from water is permitted. Please wear masks when not speaking, as per the Government and House of Commons Commission guidance, unless there is some obvious reason not to do so. It would be helpful if any speaking notes could be e-mailed to hansardnotes @parliament.uk. I am also asked to remind people that they can have lateral flow tests twice a week if they are coming on to the estate.

Clause 120

International healthcare arrangements

Dr Philippa Whitford (Central Ayrshire) (SNP): I beg to move amendment 110, in clause 120, page 101, line 15, at end insert

"but does not include a Scottish Minister, a Welsh Minister or a Northern Ireland Minister".

This amendment removes devolved Ministers from the definition of a "public authority" on which the Secretary of State could confer functions, or to which the Secretary of State could delegate functions, under this section.

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

Amendment 111, in clause 120, page 101, line 22, at end insert—

"(5A) In section 5 (Requirement for consultation with devolved authorities) in subsection (1), for 'consult' substitute 'gain the consent of'."

This amendment would require the Secretary of State for Health and Social Care to obtain the consent of devolved governments before regulations under section 2 of the renamed Healthcare (International Arrangements) Act 2019 could be made.

Amendment 146, in clause 120, page 101, line 22, at end insert—

"(5A) In section 7 (Regulations and directions)—

(a) in subsection (4), after 'under', insert 'section 2 or';

(b) after subsection (4), insert—

'(4A) A draft instrument which contains regulations under section 2 may not be laid before Parliament under subsection (4) unless a document containing a proposal for such regulations and an impact assessment of the costs and the demand placed on the NHS have been laid before Parliament.'"

This amendment would make regulations giving effect to a healthcare agreement subject to the affirmative resolution procedure, and would require a proposal for such regulations and an impact assessment to be laid before Parliament before any such regulations could be brought forward.

Clause stand part.

Dr Whitford: It is a pleasure to serve under your chairmanship, Mr McCabe.

The amendment brings us back to a knotty problem I have raised previously: although the Bill was brought forward as predominantly a Bill for England, it does have an impact on the devolved Governments, who saw it the day before it was launched. There is absolute support in Scotland, and I am sure across all the devolved nations, for strong healthcare agreements with other nations outwith the EU, particularly Switzerland and the European Free Trade Association countries, which are not currently covered, but it has to be remembered that the delivery of healthcare is a devolved issue. We are trying to ensure that that is recognised in the Bill, so that the UK Government, who absolutely have the right to negotiate international agreements, work much more closely than we have seen them do so far on how the technicalities should work in the devolved health services.

Amendments 110 and 111 relate to the same issue: the fact that the devolved nations, and certainly the Ministers concerned, were not involved in the development of these clauses. There is no mention of them, and no mention of how they will be involved in shaping any healthcare agreements or health insurance card. That is what we are now calling for.

Justin Madders (Ellesmere Port and Neston) (Lab): It is a pleasure to see you in the Chair, Mr McCabe. I shall speak in support of amendment 146, which stands in my name and the name of other Opposition Members. There is a temptation to get teary-eyed and reminisce about the 2017-19 Parliament; it is almost overwhelming, but I will resist and battle on.

What we are discussing in this clause amounts to a significant amendment to the Healthcare (European Economic Area and Switzerland Arrangements) Act 2019, on which I had the pleasure of leading for my party, opposite not one but two of the Minister's predecessors. I hope that the same fate will not befall this Minister as befell his predecessors who dealt with this legislation—although one of them actually got a promotion. Clause 120 renames that Act the perhaps more snappily titled Healthcare (International Arrangements) Act 2019, which is what the original Bill was called until Parliament, in its wisdom, decided that as this was a Brexit Bill, it was better to have it deal with matters associated purely with Brexit, and not to slip in wider powers almost wholly unrelated to our decision to leave the EU.

The clause gives the Secretary of State power to make regulations to pay for healthcare provided outside the United Kingdom where the payments give effect to a healthcare agreement. In the context of what has come before, that is no surprise, and it is certainly something we would expect to be pursued. It also means that the Secretary of State will be able to make regulations on the payment of healthcare provided in another country where the healthcare is outside the scope of healthcare agreements if he thinks that payment is justified by exceptional circumstances and the healthcare is provided in a country with which the UK already has a healthcare agreement. This discretionary power could, for example, be exercised to pay for a specific treatment that falls outside the scope of an existing healthcare agreement.

Not content with giving himself the power to enter into further healthcare agreements outside the EU, by doing this, the Secretary of State effectively gives himself another power to make further payments if he later discovers that there was another matter that he thinks

we should have been paying for that had not been covered by those agreements. It may be that that situation would only arise in exceptional circumstances, but the whole genesis of the original Bill was that it was considered sensible to retain reciprocal healthcare arrangements with countries in the EEA, whereas the clause implies that things may not be quite so reciprocal in future. I wonder what the dynamic will be in negotiations with third countries if, on our side at least, we can just authorise further payments outside any agreement anyway.

These are potentially extraordinarily wide powers, and the regulations would be subject only to the negative procedure. Our amendment is not only consistent with the importance of parliamentary scrutiny, but would ensure value for money. The original Bill contained a similar power to that in the clause and was considered by the Delegated Powers and Regulatory Reform Committee in the other place. It set out clearly the power's potential impact:

"If, without such amendment, the Secretary of State wished to fund wholly or entirely the cost of all mental health provision in the state of Arizona, or the cost of all hip replacements in Australia, the regulations would only be subject to the negative procedure."

[Interruption.] The Minister is chuckling. He may well know that I have used that quote before, because it highlights the extreme examples that are possible under the Bill. The Committee continued:

"Of course, these examples will not be priorities for any Secretary of State in this country."

We should hope not. While the Minister may be able to rule out those two specific examples today, we have to consider how the powers could be used, and not just how they might be expected to be used.

The concern that this is a very broad power has been further strengthened by the inclusion of the power to make payments outside healthcare arrangements. We have to ask what the Secretary of State is trying to solve by giving himself these additional powers. Let us look at what the powers do. There is no limit to the amount of payments he can make. There is no limit on who can be funded worldwide. There is no limit to the type of healthcare being funded. Such powers without qualification or any criteria being applied in the Bill are simply unacceptable, so a resolution of both Houses should be required, alongside an impact assessment of the costs and demands any regulations might place on the NHS.

On the costs, there is no limit on what the Secretary of State might pay. If we are to assume that this will come out of existing departmental budgets, who will receive less? I mention this not just in the context of extra payments that the Secretary of State may make for things not covered by agreements, but in terms of the burden on the NHS of delivering any new obligations, because, to be blunt, cost recovery has been suboptimal. As the Law Society of Scotland said:

"As the NHS has never been very effective in reclaiming the fees owed to it by overseas visitors to the UK, the UK may find itself substantially worse off financially when new arrangements for funding cross-national use of health services are put in place."

The Government need to raise their game on cost recovery, and if there is an additional administrative burden on the NHS in setting up new systems of cost recovery because of new agreements reached, we need a commitment from the Minister to adequate resources to ensure that those services are delivered and the cost recovered.

We support the concept of reciprocal healthcare arrangements. They are a very good thing for our citizens and for visitors to the country, but it cannot be right to give the Secretary of State such a blank cheque. Amendment 146 will ensure transparency, accountability and a proper assessment of the obligations entered into by virtue of regulations under the clause.

The Minister for Health (Edward Argar): The hon. Gentleman alluded to being shadow Minister during the passage of the previous piece of legislation, and that reflects once again his longevity in his post. I am grateful to the hon. Member for Central Ayrshire for amendment 110, and for bringing the issue before the Committee. It is right that we debate and air it in this forum. I am aware of the concerns, which she expressed extremely clearly, about the Secretary of State's ability potentially to confer functions on, or delegate functions under the 2019 Act to, Ministers from the devolved Administrations. She highlighted the perfect example: the challenge that we inevitably face with elements of the devolution settlement. Delivery may rest with the devolved Administration, and is therefore a devolved power; concluding international agreements is a reserved matter and therefore one for the UK Government.

Understandably, the point of principle on both sides is not to concede consent but, from our perspective, to consult. I will come on to that in a minute. I appreciate the perspective brought by the hon. Lady and her colleagues in the Scottish Government. Let me reiterate the UK Government's strong commitment to meaningful and ongoing engagement with the DAs on reciprocal healthcare. There is already a statutory obligation under section 5 of the 2019 Act to consult the devolved Administrations before making any regulations under the Act in areas within the competence of the devolved legislatures.

We are working with officials in the devolved Administrations on the development of a memorandum of understanding setting out how we will fulfil that duty in practice. Indeed, the memorandum goes further in undertaking to engage and consult the devolved Administrations, not just at the end of the implementation stage but from a much earlier stage. I appreciate that the hon. Lady may say that, although that is progress, it does not go far enough. I believe that good progress is being made, but I suspect that on Report, I will have to report back on where we have got to, and whether we have managed to find a way forward. The work continues to be done.

Turning to amendment 110, the regulation-making powers in HEEASAA—I was going to say that was a shortened version of the Act's title; I might just refer to "the aforementioned Act", which may save us a little time—are important as they provide the UK Government with the ability to implement international reciprocal healthcare agreements. The Government fully support the devolution settlement and, as I say, we would not normally confer functions on the devolved Administrations under the Act without their agreement and consent.

To date, we have used the power only to ensure that Ministers in the devolved Administrations can have a role in authorising planned treatment applications if they wish, but we need to ensure that when negotiating agreements and committing to international obligations we can be confident that we can implement them.

[Edward Argar]

Further, we are keen to ensure that Ministers in the devolved Administrations can continue to have a role in devolved planned treatment applications. I reassure the hon. Lady that we continue to explore the issue with the DAs. I do not want to pre-empt what may emerge from that. For that reason, I encourage her not to press the amendment to a Division at this stage. She may reserve her right to do so at a subsequent stage in the passage of the legislation.

Amendment 111 would introduce a duty to seek the consent of the DAs before making regulations relating to international reciprocal healthcare agreements that contain a provision within a devolved competence. Reciprocal healthcare agreements benefit all our residents across the UK, providing safeguards and support for our most vulnerable, as well as greater opportunities to travel, for work or leisure. Where an agreement is in place, those living in the UK can access affordable healthcare when they need it when travelling abroad.

As I have said on multiple occasions, we recognise the need to work with our friends in the devolved Administrations, but we cannot include a statutory consent requirement. That would risk the UK Government not being able to comply with our international obligations, and it would, in a sense, give the devolved Administrations a veto over a reserved matter. I do not understate the complexity of the way the constitutional settlement works in this context.

2.15 pm

Section 5 of the Healthcare—the aforementioned Act —*[Laughter.]* I have to do it that way. Section 5 of the 2019 Act already obliges the Secretary of State to consult the devolved Administrations before making regulations that contain a provision in devolved areas. We are committed to our consultation obligations under the devolution settlements. Again, the memorandum of understanding we are working on, if we can agree it, will I hope clarify and underpin that consultation duty.

Our strong preference is to ensure that a clear engagement and consultation process is in place that will enable the DAs to influence policy formulation on areas of devolved competence, where there is a crossover into resolved areas, in a proactive way. We also recognise the concerns—this is the counterpoint—about the impact that reciprocal healthcare agreements can have on the individual DA's healthcare systems, for example, in relation to non-maternity planned treatment and overseas visitor charging.

Again, I assure Members that before entering into negotiations of these reciprocal healthcare agreements, comprehensive impact assessments will be undertaken in collaboration with the DAs to support the transparency we all wish to see on cost and benefits, and to inform evaluations and produce the conditions for an informed debate. Further, we believe the risks associated with negative impacts on the DAs' healthcare systems will be mitigated through the engagement process, again set out in the MOU. I believe that this legislation provides an excellent opportunity to implement comprehensive reciprocal healthcare agreements that will benefit the whole of the UK, and as I say, we recognise the importance of consultation with the DAs.

As has been set out, amendment 146 would ensure that regulations that implement reciprocal healthcare agreements were subject to the affirmative procedure, as opposed to the negative procedure, in this place. In addition, the amendment would place a duty on the Secretary of State to lay an impact assessment before Parliament before draft regulations could be laid before it.

It is important to say that this Government take parliamentary scrutiny of international agreements very seriously. I know the high degree of scrutiny that the hon. Members for Ellesmere Port and Neston, and for Nottingham North, gave to multiple pieces of legislation and secondary legislation relating to our exit from the European Union. It is right that the Government be held to account on commitments we agree with other countries in any new reciprocal healthcare agreements.

This Government are strongly committed to the principles of transparency and accountability, and I want to reassure Members that, before entering into any reciprocal healthcare agreements, the Government will undertake a comprehensive impact assessment and analysis, working with the DAs. This will, I hope, ensure that we understand, right across our United Kingdom, the strengths and weaknesses, and the benefits and costs.

In addition, under the aforementioned Act, the Secretary of State is obliged to lay an annual report before Parliament providing details of payments made under the Act. This will allow Parliament to scrutinise payments made under any reciprocal healthcare agreements. However, as with the current regulation-making power in the Act, the amended power we are putting forward in this Bill only enables the Secretary of State to make technical and operational arrangements for implementing agreements. For example, the regulations will set out which public body would administer global health insurance cards or similar.

As we set out in our memorandum to the Delegated Powers and Regulatory Reform Committee, we believe that the regulations are unlikely to contain policy issues that require in-depth parliamentary debate and discussion. Therefore, the Government conclude that the negative procedure affords the appropriate level of scrutiny, and this is consistent with the section 2 power we are actually amending.

I would like to take this opportunity to address any concerns about the impact future reciprocal healthcare agreements could have on the NHS—a point that the shadow Minister of State, the hon. Member for Ellesmere Port and Neston, mentioned. Reciprocal healthcare agreements primarily allow individuals to access medically necessary care when travelling abroad. Those travelling to the UK can already access emergency NHS care, so there is very little risk of an additional influx of patients creating additional pressures on the NHS. Instead, the arrangements offer a better way of recouping the cost of emergency treatment, and can actually reduce the debt owed to the NHS. In addition, they also benefit our UK nationals who are travelling abroad and may need to access necessary healthcare, most notably those who may have long-term or complex health conditions.

Reciprocal healthcare arrangements are, and will continue to be, managed centrally on behalf of all parts of the UK by the Department of Health and Social Care. The UK Government are responsible for all financial costs where they relate to the provision of access to healthcare abroad. Given the existing opportunities Parliament has to scrutinise reciprocal healthcare agreements, again, we do not believe that any additional benefits would accrue from subjecting the administrative regulations

made under this provision to the affirmative procedure. For those reasons, I gently encourage the hon. Gentleman not to press his amendment to a Division, although he is giving nothing away at this moment.

Clause 120 amends the—I will say it one more time—Healthcare (European Economic Area and Switzerland Arrangements) Act 2019. The amendments made by this clause will enable the Government to implement comprehensive reciprocal healthcare agreements with countries outside the European economic area and Switzerland. The last time reciprocal healthcare legislation was brought forward in the House, as the hon. Gentleman mentioned, the Government were in negotiations with the European Commission over the terms of the UK's exit from the EU, and therefore this legislation was very much viewed through that prism and focused on that issue. We are now in a different context, in which the uncertainties of those negotiations are behind us and we have entered into a new relationship with the EU. Under the trade and co-operation agreement, people in the UK continue to be able to access affordable, comprehensive healthcare when they travel, work or retire in the EU, and vice versa. I am sure that hon. Members recognise that as a positive and welcome outcome.

Karin Smyth (Bristol South) (Lab): I would like to live in the Minister's world sometimes. What I am struggling to understand from him before he finishes—

Edward Argar: I have a long way to go yet, I am afraid.

Karin Smyth: It looked like he was finishing. My hon. Friend the Member for Ellesmere Port and Neston referred to the suboptimal collection of payments in the health service where they are due. When I was a member of the Public Accounts Committee, it reported on this issue, generally in the context of treatment for overseas patients. I am struggling to understand how the Government expect the NHS to manage this operationally, given how suboptimal overseas payments have been—prescription charge recuperation, for example. This strikes me as an incredibly complicated issue. When we talk about impact assessments, perhaps the Minister could tell us what work has been done in the Department to understand the impact on the service, and how people who are providing treatment are to understand where we have reciprocal arrangements and where we do not, and who is entitled to that treatment.

Edward Argar: I am grateful to the hon. Lady. We have made significant strides forward in making this easier and clearer for the NHS in recent years, recouping money where appropriate to help fund our NHS. We regularly update the guidance to trusts, which—as the hon. Lady will appreciate—are responsible for recouping funds where a patient is chargeable. They are increasingly consistent in how they apply those rules.

I concede to the hon. Lady, quite reasonably, that there are occasions when trusts do not apply the rules in a fully consistent manner. That is why we have taken steps centrally with NHS England to ensure that we pass very clear guidance to them; we do not believe that this will impose any heavier burden on them than is currently the case. Similarly, in the implementation of the agreement with the EU—again, it would be churlish not to admit it—we have faced some challenges in making sure that other countries understand their obligations to British citizens abroad under that agreement. That is in the nature of the early days of a new agreement.

Anecdotally, I receive correspondence on this issue from right hon. and hon. Members, and there was an increase in that correspondence at the very start of the year: Members were either saying that they had constituents who went abroad and did not receive the free healthcare they should have received, or were taking up the cases of people who visited this country who were charged and did not think they should have been, or vice versa. That correspondence has significantly dropped off in recent months, so with that caveat about it being anecdotal, I suggest that the new agreement has bedded in fairly efficiently. I have not had any responses from trusts saying that the way in which the agreement works has imposed any additional burdens on them that they cannot cope with.

Of course, there are other countries with which we already have different bilateral agreements, so I am confident at the moment that the administrative processes will be an effective extension of current processes but, as with all these things, I keep the issue under review. The hon. Member for Bristol South will know from her time in the NHS that if a trust found that the burden was significant or increasing, it would not hesitate to tell me. Equally, we are looking at reciprocal healthcare agreements here—we are not looking at a whole load of agreements, but dealing with them bit by bit, as we negotiate them, and we are allowing them to bed in. That was a long answer, but she made an important point.

It is time for the Government to build on our significant success in negotiating the agreement with the European Union and our new relationship, and to turn our attention to the UK's relationship with countries outside the EU, as another strand of our global Britain strategy. That is why we are extending the geographical scope of the 2019 Act beyond the EEA and Switzerland and renaming it, as the hon. Member for Ellesmere Port and Neston said, the Healthcare (International Arrangements) Act 2019.

Outside Europe, we have limited healthcare agreements with a number of countries, which support people from the UK in accessing medically necessary healthcare. These agreements do not always provide comprehensive cover to those who need it; for example, a person suffering from kidney failure may be able to access emergency treatment if something happens to them while abroad, but they would likely have to pay for their ongoing dialysis needs privately.

The clause will enable the Government to implement comprehensive reciprocal healthcare agreements with other countries around the world by allowing for the reimbursement of healthcare costs and the exchange of data to facilitate this reimbursement. By implementing such agreements, we can better support people when they are abroad. Comprehensive reciprocal healthcare agreements can help people to access necessary healthcare services when they are travelling for leisure or business. Importantly, they can particularly benefit those with chronic health conditions, for whom travel insurance is very costly—or in some cases, sadly, completely unaffordable. Furthermore, agreements usually reduce the burden on NHS trusts, which would otherwise have to pursue individuals to recover overseas charges, as there is normally state-to-state reimbursement built into the agreement.

[Edward Argar]

Hopefully, the provisions will mean that we can reduce the debt owed to the NHS in an administratively unburdensome way.

Finally, reciprocal healthcare agreements can strengthen our relationships with countries around the world and foster greater healthcare co-operation, including on health security and research, the importance of which hon. Members on both sides of the House would acknowledge has been illustrated by the recent pandemic and the research around that.

The clause will enable the Government to implement more comprehensive agreements where that is to the benefit of the whole UK. We will also be able to improve arrangements to make them more effective. Our ambition is for new and improved agreements to be brought under the umbrella of the new UK global health insurance card, which will bring our EU and rest-of-the-world agreements together into a cohesive and visible service for UK citizens, and ensure that people can take advantage of their rights under these agreements.

During the 2019 Bill debates, which I confess to having read, the Government were asked to review the breadth of powers in that Bill after the conclusion of the EU exit negotiations. We have listened to the concerns expressed by the House, and our amendments to this Bill remove section 1 of the 2019 Act, which provided for a free-standing payment power and enabled the Secretary of State to make unilateral payments for healthcare in the EEA and Switzerland—a point to which the hon. Member for Ellesmere Port and Neston alluded. This power is no longer needed now that the withdrawal agreement and the trade and co-operation agreement are in place to protect the healthcare rights of UK nationals living in EU member states.

We are replacing that broad payment power with regulation-making powers. These can provide for payments to be made in two circumstances: first, to implement healthcare agreements, and secondly in countries where there is a healthcare agreement in place but the healthcare falls outside the scope of the agreement, and the Secretary of State determines that there are exceptional circumstances that justify payment. This latter element prevents a cliff-edge loss of rights in marginal cases.

As demonstrated in recent months, healthcare co-operation between countries is vital in our globalised world. Reciprocal healthcare provides safeguards and support for those who might find themselves in a vulnerable position, and supports greater opportunity for travel for those with healthcare conditions. As we move into the post-EU-exit world, we are excited to seize these new opportunities for global Britain. I therefore commend the clause to the Committee.

Dr Whitford: I welcome the drive to set up these reciprocal arrangements. One of the big losses of Brexit threatened to be the loss of the European health insurance card, and I am glad that arrangements have been reached with most European countries, although obviously not in some of the EFTA countries; that is still to be dealt with. I appreciate that the Minister recognises the particular importance of that for people on dialysis, who were unable travel under that scheme, as they require dialysis three times a week. The majority simply could not pay for it themselves, nor would insurance ever be likely to cover it, so I welcome the aim on that. It simply comes back to the need for genuine consultation with the devolved authorities, which would be delivering healthcare for those from the reciprocal countries arriving in the UK.

2.30 pm

I welcome the Minister's mention of a memorandum of understanding, because this is about how the nuts and bolts will work. Even if there is state-to-state reimbursement, how does that go to the devolved nations or within England? How does that go to a trust that has delivered the healthcare? I also appreciate his comments about a genuine impact assessment. Unfortunately, over the last number of years, the phrase "consultation" has lost a lot of its meaning, so there is the drive for consent, particularly in some of the devolved competences. From his comments on an impact assessment and a memorandum of understanding, I look forward to seeing genuine involvement and consultation, because that has not always been the case, and for Ministers to see this Bill the day before it was launched certainly did not represent either respect or consultation. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

The Chair: Does the hon. Member for Ellesmere Port and Neston wish to press amendment 146?

Justin Madders: I thought at one point that the Minister was going to accept the amendment, given the way he was talking about the importance of parliamentary scrutiny and impact assessments. He will not need to be reminded that on a number of occasions in the past 18 months the Department has not produced those impact assessments when regulations have been produced. As he has clearly become a full-blooded Brexiteer, given his comments today, I am minded to press the amendment to a vote because it is about Parliament taking back control.

Question put, That the amendment be made.

The Committee divided: Ayes 6, Noes 10.

Division No. 33]

AYES

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

NOES

Argar, Edward	Gideon, Jo
Crosbie, Virginia	Higginbotham, Antony
Davies, Gareth	Robinson, Mary
Davies, Dr James	Skidmore, rh Chris
Double, Steve	Timpson, Edward

Question accordingly negatived.

Clause 120 ordered to stand part of the Bill.

Clause 121

REGULATION OF LOCAL AUTHORITY FUNCTIONS RELATING TO ADULT SOCIAL CARE

Alex Norris (Nottingham North) (Lab/Co-op): I beg to move amendment 145, in clause 121, page 102, line 40, at end insert—

"(11A) When conducting a review under subsection (1), the Commission must ensure the direct involvement of both users and providers of services."

This amendment creates an explicit requirement for service users' and providers' involvement in the reviews and assessments that the new Part 46A creates.

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

Government new clause 60—*Default powers of Secretary of State in relation to adult social care.*

Government new clause 61—*Care Quality Commission's powers in relation to local authority failings.*

Clause stand part.

Alex Norris: We have been at this now for the best part of a couple of months. This is our 16th session. Some of the faces have changed but largely it is the same group of people. We have reached clause 121 of the Health and Care Bill and we have finally found the bit that is about care. It is amazing—you had to not blink or you might have missed it. But I would not get too excited; it is only two clauses, and neither comes anywhere near addressing the problems we face in our nation's social care.

The national Government's cuts to local authorities over the past decade have had a devastating impact, particularly around social care. They have led to rationed care and poor quality care. They have led to care being devalued as a profession and to providers being unable to retain their staff. As a result, we see short visits and a constant changing cast of carers, and we know that is bad for all those individuals receiving support. That is the story across all our communities, and it is worsening as we go.

Clause 121 proposes that the Care Quality Commission will now make a general assessment of the quality of a local authority's offering for those needing care. Once those reports start coming back, I have no doubt they will make very difficult reading for many parts of the country, if not all, because they will lay bare the issues that I talk about. I do not have any problem with inspection and public assessment of the quality of care services. I do not have any problem understanding this at a local authority level rather than provider by provider. My constituents, and people across the country, deserve excellent services, and I can see how these things work in support of that goal. What I do worry about is that this will be just another way for the Government to passport blame to hard-pressed local authorities that are doing their best but are simply not adequately funded to do their job. That is the reality in this country today.

Amendment 145 seeks to improve clause 121 a little, in line with our broader efforts throughout the Bill, because we want to see service users at the heart of the health and care system as genuine shapers of what happens to them in their lives and their community. We want to make sure that those with the greatest stake and the greatest expertise by experience have the chance to be part of the process, as set out in clause 121, and to talk about their experiences in their community and about how things might be done better, because they hold so many of the answers to the challenges we face. That is a moderate but important ask and I hope the Minister will support it in the Bill or make a commitment that it will follow in the guidance that will be issued to the Care Quality Commission.

Similarly, we should seek the voice of providers, for a couple of reasons. First, they know what the successes and challenges are in their local system, and they know about the hard conversations they have with commissioners, which ought to be conversations about an individual's needs but are, inevitably, rationing decisions. Secondly, and this them gives a special insight, many if not most—probably the vast majority—of these providers work across multiple local authorities, giving them a rich picture of the differences in approach, availability of care and similar. That is a rich contribution. We strongly think that those two voices should be heard, and the amendment is a good way of doing that.

Turning to Government new clauses 60 and 61, I express my gratitude to the Minister for his correspondence on them to give the Committee a sense of where the Government seek to go, but he was not quite able to provide comfort. New clause 60 is a mess constitutionally. It allows the Secretary of State for Health and Social Care greater powers over local authority social care functions, including giving him powers to talk about failures and directions. First, local authority accountability is to its public. We know that, every four years, we have elections. Beyond that, exceptionally and rarely, the Secretary of State who leads for local government—I know they have taken "local government" out of the name, but there is still one in whatever the Department is calling itself now—can take action in instances where the local authority is deemed to be failing in its duties to its population. The Secretary of State can put in directions, support and, as we have seen, even commissioners. That is a well-established process, but the clause inserts the Secretary of State for Health and Social and Care into this arrangement, which is a considerable overreach. It gives the Secretary of State a power to impose themselves on local authorities in a way that I do not think is welcome. At the bare minimum, it ought to be something that is exercised by the colleague of the Secretary of State who leads on local government in ways that are already well established, rather than creating another actor in the piece.

That leads us to the continued pattern that we have seen throughout the Bill. I am afraid that integration is a bit of a myth, but where there is any, it is largely that the health service ought to have more power and, more importantly, that the Secretary of State ought to have more power over telling local government what to do. There is no equivalent or supporting ability for local authorities to impact on the decisions taken by the Secretary of State. That creates a mismatch, which is really undesirable. I am keen to hear from the Minister why it was decided that the Secretary of State needed direct access to do that, when they could perhaps have worked better through their colleague, who does it more conventionally on a day-by-day basis.

New clause 61 dispenses with the Care Quality Commission's ability to issue a notice of failure to a local authority in England. Again, when taken with new clause 60, my suspicion is that that is because the Secretary of State is in charge now. The commissioners and inspectors may be there to give some helpful evidence but, in reality, it is the Secretary of State who will command and control the system. That might be deemed adequate by the Government with regards to the health service, but I do not think it is adequate in local government, given the mandate that our councillors get from their population.

[Alex Norris]

We cannot support the new clauses. We will not oppose clause 121, because there needs to be some oversight in the new environment that the Government are seeking to create, but I have no doubt that we will have to find a better way to do that in years to come. In the meantime, I hope that we can at least enhance that with amendment 145.

Dr Whitford: I rise to support amendment 145 but also to echo the comments of the Labour Front Bench about how far we have to go into the Bill, which is called a Health and Care Bill, before we hear anything about care. I think that all of us with any interest in social care have recognised the challenges within the sector over the past 18 months, which have been laid bare by the pandemic. What needs to come out is a much more radical approach to social care, including closing what is thought to be between a £6 billion and £8 billion funding gap in England every year.

In Scotland, we spend over 43% more per head on social care than in England, and that provides free personal care to people who are resident in Scotland. We fund the real living wage, which helps to begin to tackle the workforce issues, but the deeper issue facing all four nations is that we need a different approach to social care. The Feeley review, which the Scottish Government commissioned last autumn, highlighted the fact that we constantly talk about social care as a burden, and about how much it costs, instead of realising that almost half of those receiving care are people of working age. We must recognise the importance of social care for both younger and older people, recognise it as a human rights issue, and recognise it as funding to allow people to participate in the society in which they live. We need to turn that around, which means that we need to change the approach to the staff who deliver it.

Workforce is the biggest single problem. It is unfortunately much worse since we left the EU—certainly in parts of rural Scotland, where up to 30% of care workers were European citizens. We need to develop care as a profession. It is a registered profession in Scotland, but the staff need to be treated as professionals with career development, so that people come into social care for a lifetime, not just until they get a job on the checkout in Tesco. I appreciate clause 121, but it is not remotely radical enough. In something called the Health and Care Bill it is very small considering the mountain that has to be climbed.

2.45 pm

Edward Argar: I do not think it is an entirely fair reflection to ask why it is taking so long to get to social care reform. We have already had debates about integrated care systems, integrate care partnerships and the integrated care board; a key element of that was about local government working with the NHS in the social care space, so that is a slightly unfair characterisation. Members will have heard the Prime Minister set out his ambitious plan to fix social care and waiting lists, with more to follow.

Clause 121 inserts proposed new section 46A into the Health and Social Care Act 2008, introducing a new legal duty for the CQC to review and make an assessment of the performance of local authorities in exercising certain regulated care functions related to adult social care. As part of the new legal duty, the commission will be required to publish a report of its assessment. The specific regulated care functions that local authorities will be assessed against will be set out in secondary legislation. These reviews will be informed by objectives and priorities set by the Secretary of State and will reflect indicators of quality and methodology devised by the commission and approved by the Secretary of State.

The commission may choose to revise the quality indicators and the statement describing the methodology periodically, or do so under the Secretary of State's direction. In order to provide transparency, the commission must publish the objectives and priorities, the quality indicators that will inform assessments, and the statement describing the methodology. This new duty is crucial in increasing assurance and transparency about how local authorities are delivering critical adult social care responsibilities, on which so many people rely.

Amendment 145 would alter the proposed duty under proposed new section 46A of the Health and Social Care Act 2008, to require the Care Quality Commission directly to involve service users and providers when undertaking reviews of local authorities' regulated care functions. I understand the spirit behind this amendment and sympathise with its aims. It is our intention that reviews by the CQC should draw upon a wide range of information and perspectives from the sector, including from providers and service users.

However, I do not feel this cause is best advanced through acceptance of this amendment. The views of people who use services, and the providers of those services, are already central to the way in which the CQC regulates. The CQC has a proven record of hearing a wide range of views since its creation over 10 years ago, both when it develops its methodology and when it assesses quality and safety in services. That is supported by section 4 of the Health and Social Care Act 2008, which places a duty on the CQC when performing its functions to have regard to views expressed by or on behalf of members of the public about health and social care services, and to the experiences of people who use health and social care services, and their families and friends.

Reviews under proposed new section 46A are not due to commence until 2023-24. As the CQC designs its approach to reviewing local authority performance before then, it will work closely with people who use health and social care services, their families, health and social care providers and the organisations that represent them, as well as other key stakeholders to ensure that its regulation is properly informed by a diverse range of views.

More detailed information on how local authorities' reviews will be undertaken will be provided in a method statement, which the CQC must develop and the Secretary of State will approve. Section 46A(8) requires the CQC to produce a method statement outlining the method that it proposes to use in reviewing local authorities. This statement is a more appropriate place to set out operational details such as when and how providers and service users will be involved—the shadow Minister made a point about whether it would be guidance and whether it should be in the legislation.

I would like to further reassure right hon. and hon. Members, given the CQC's publication of its new strategy, "The world of health and social care is changing. So are we" and "A new strategy for the changing world of health and social care" in May this year. That sets out a bold new approach to regulation, underpinned by a focus on what good and outstanding person-centred care looks like, and smarter use of data and intelligence. The CQC consulted on the strategy earlier this year, receiving more than 790 responses from people who use services, the public and voluntary groups and almost 400 from commissioning bodies and service providers. For the reasons that I have given, I would encourage the shadow Minister to consider withdrawing his amendment.

Let me turn to the relevant clause. Demographic change has resulted in more people having care and support needs, and we expect that trend to continue for the foreseeable future. As social care affects a greater number of people at some point during their lives, it is important that there is a transparent system through which local authorities can be held to account by their populations for delivering the right kind of care—I take the point, which I think the hon. Member for Nottingham North was making, about democratic elections, essentially, forming a key part of that; I do not disagree, but I believe it is important that there is a mechanism to assess quality of care in this context, and the best outcomes within the resources available. The measure delivers on that aim by requiring that assessment of how local authorities are delivering critical adult social care functions.

I believe that this new level of insight will support local authorities to understand what they are doing well and what they could do better. It will also help the Department to understand what is happening, forming an overarching national picture alongside the local-level assessments. I do not believe it challenges the parallel strands, which we have talked about before—the different approaches in a national health service versus local authority social care provision. I do not believe it threatens democratic oversight, either.

Turning to Government new clauses 60 and 61, new clause 60 provides the Secretary of State with powers to intervene where local authorities are failing to discharge their functions under part 1 of the Care Act 2014 to an acceptable standard. This will form one part of a new approach to assurance and support for local authorities, which will underpin our efforts to improve outcomes for people receiving care and support. Our new power of intervention will sit alongside this statutory CQC assurance framework. Where issues are identified, our priority will be to support local authorities to lead their own improvement. However, where CQC assessment identifies a persistent and serious risk to people's wellbeing and local authorities are unable to lead their own improvement, it is right that the Government have powers to step in and help secure that improvement.

We will intervene using the most proportionate and appropriate tools available. That might include requiring local authorities to report to an improvement panel or co-operate with improvement advisers nominated by the Department of Health and Social Care. We have ruled out the use of independent trusts, whereby services are removed from local authority control and transferred to an independent charity or a commercial organisation. We will of course engage partners in the sector to finalise our approach, with additional detail to be set out in the forthcoming White Paper. Where necessary, the new clause gives the Secretary of State, or an individual nominated by the Secretary of State, power to take over the exercise of specified adult social care functions of a local authority.

In the light of our new approach to assurance and support, we are making changes to section 50 of the Health and Social Care Act 2008 through new clause 61. Where the CQC identifies failure, it may make recommendations to local authorities. It must also notify the Secretary of State of the failure and advise him on possible next steps to secure improvement. Because we are creating bespoke powers relating to adult social care services, we are taking adult social care functions under part 1 of the Care Act out of the scope of the existing powers of intervention under section 7D of the Local Authority Social Services Act 1970.

Our intervention amendments are key to ensuring that people can expect high-quality care, regardless of where they live; without clause 121, we would continue to lack a strong understanding of local authority performance, good practice and pioneering approaches that can support local authorities to meet the needs of those who rely on them for social care. I therefore commend the clause and the Government new clauses to the Committee.

Alex Norris: I am grateful for the contribution from the hon. Member for Central Ayrshire. I completely agreed with her point that, fundamentally, the No. 1 basic issue is a complete lack of investment, as we have seen over the last decade. Everything else after that becomes just tinkering around the edges, and there has been too much of that in this legislation. I share the hon. Member's enthusiasm for taking a different approach—to stop treating social care as a burden and to understand our responsibility to working-age adults, but also to older people, and the investment and the national good of investing to ensure that those people can live independent lives and can reach their potential and do what they want to do. That we do not prioritise that in this country is a profound sadness.

Perhaps I was a little glib in the point that I made about the two clauses, and I am conscious that the Minister thinks that was unfair. He talked about other examples in which carers feature in the Bill. The reality is that each time it is about how care affects and reflects on the national health service. It is never about social care; it is about what the health service needs with regard to social care. Those two things are not the same. The point is that the Bill, for better or worse—we are not very enthusiastic about it—has 120-odd clauses about reforming the national health service and two clauses about reforming social care.

The problem is that for 11 years, or certainly for my entire four and a half years in Parliament, the Government have been promising a social care Green Paper that never comes. It is in a desk. It has supposedly been written for many years, but it never sees the light of day. Our failure adequately to grasp social care is really bad for society and terrible for the health service. That is why I made that point. How many more health service Acts do we have to see before someone finally tries to grab hold of social care? The reality is that we will have to see a change of Government for that to happen meaningfully.

[Alex Norris]

The Minister's comments on amendment 145 provided great comfort, so I will not press it to a Division. On the point that he made about needing a mechanism in cases where a local authority fails, in the most exceptional cases I agree with that, but what do we do when national Government fails? National Government have failed on that point for 11 years. The answer is that we wait until the next general election and try to persuade people. We have failed to do that three times in that period. That is right, but it also applies to local government, so I would not want to see that overused. I think I have made my point on Government new clauses 60 and 61, so I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Edward Argar: I beg to move amendment 147, in clause 121, page 102, line 46, leave out "or".

This amendment is consequential on NC59.

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

Government amendment 148.

Government new clause 59—*Care Quality Commission reviews etc of integrated care system.*

Edward Argar: We tabled the amendments following the publication of recommendations by the Health and Social Care Committee on the Bill. The Committee recommended that the Care Quality Commission be given a role in assessing integrated care systems—the umbrella term, of course, for integrated care boards, local authorities and their system partners working collectively. We agree entirely; indeed, I thank the Committee for championing that agenda. The intention is for those reviews to provide the public and the system with independent assurance of how their ICS area is performing, and in particular the effectiveness of joined-up working and integration. Those reviews will be a valuable way to improve the services provided and encourage the effective joint working that the Bill enables.

Edward Timpson (Eddisbury) (Con): I welcome the involvement of the CQC in reviewing the work and impact of the new integrated care systems, but other parts of public service provision, particularly children's services, are regulated by other bodies—Ofsted, in the case of children's social care. Can the Minister reassure me, either now or at a later stage, that those bodies will be involved in the initial discussions about what the reviews will look like, and how Ofsted may be able to provide input to ensure that the review encompasses all aspects of regulation and inspection that will touch on the ICSs.

Edward Argar: I am grateful to my hon. Friend for his comments. He is right that we must not at any point forget the interest of children and families in the context of the services being provided. I hope that I can give him the reassurance that he seeks. I certainly envisage that, as we draw up the system, and as what we are proposing becomes designed and operationalised, the process would encompass close co-operation with Ofsted and other relevant bodies to ensure that it does the job that it is intended to, and that no one falls through the cracks—for want of a better way of putting it—in that regime.

Our approach builds on the existing role of the CQC as the independent regulator of health and adult social care in England. Under the Health and Social Care Act 2008, it already reviews individual providers of health and social care. This Bill expands its role, as under clause 121 it will also have a duty to review and assess the performance of local authorities in delivering their adult social care functions under part 1 of the Care Act 2014.

3 pm

Amendment 147 takes the logical next step by giving the CQC a duty to review integrated care systems. It will allow the CQC to look broadly across the system to review how integrated care boards, local authorities and providers of health, public health and adult social care services are working together to deliver safe, high-quality and integrated care to the public. That will include the role of the integrated care partnership. The experience of, and outcomes for, people who use health and care services will be central to the reviews, especially when people experience gaps between services that impact on their health and care outcomes. The work will provide valuable information to the public on the quality of health and care in their area and will review progress against our aspirations for delivering better, more joined-up care across the system.

The proposed reviews differ from those focusing on a single provider or local authority as they will look at how the entire health and care system is working together. However, we expect that much of the required information will be gathered from the CQC's wider work. Further, we expect the CQC to work closely with NHS England, which will be conducting its own assessments of ICBs. That should avoid unnecessary duplication and, while the CQC may need to gather some additional targeted information, avoid a significant increase in regulatory burden.

The reviews will focus on how well integrated care boards, local authorities, NHS providers and other system partners, such as those in voluntary, community and social enterprise sectors, are working together to arrange and deliver integrated services, including the role of the integrated care partnership. We expect the initial focus of the reviews to be on leadership, integration, and quality and safety, with flexibility for the Secretary of State to set the strategic direction of these reviews by setting the objectives and priorities.

The CQC will be required to publish a report on each ICS area, ensuring that the public have access to information about the provision of care in their area. We expect that system partners will want to develop actions to respond to the reports, and NHS England will want to consider them in relation to their oversight of ICBs and NHS providers.

Over the coming year, the CQC will use its significant experience as an independent regulator to develop and pilot a methodology for reviewing ICSs, in line with its strategy to provide independent assurance to the public of the quality of care in their area. We expect that that will build and expand on the thematic reviews of health and care that the CQC has already undertaken, such as its local system reviews in 2018 of how health and social care services are working together within a system to support older people. We expect the CQC to develop that methodology in collaboration with NHS England and other relevant system partners, which goes back to

the point made by my hon. Friend the Member for Eddisbury. That should ensure that the methodology does not duplicate or conflict with existing system oversight roles. The Secretary of State will also be required to approve CQC's methodology before the reviews can commence. Once again, I thank the Health and Social Care Committee for its work on this matter and for its recommendation, which we are happy to take forward with this amendment.

Alex Norris: I am glad to see this change added to the Bill. Since the publication of the White Paper, we have called for greater oversight of integrated care systems. We offered options in previous sittings around democratic accountability, which would be our preference, but we may have to settle for this change, which does represent progress. Integrated care systems—in particular integrated care boards, which will be the system in reality—will be powerful. They will hold billions of pounds in funds, and will author and manage care for the entire population—a lot of people. The quality of their work will go a long way to deciding the quality of local healthcare provision and, indeed, health outcomes in their communities.

It is right to have oversight of that work, to have a way to hold systems up against each other and understand where there is success and where there are greater challenges, and to use an established overseer with reputation, experience and a degree of independence—one that the public know how to engage with and contact. It represents the first bulwark against the system working in its own interests, rather than in the interest of population health, which is good news.

I have a couple of specific questions, but before asking them I want to make a general point to the Minister. I hope we do not lose one of the best things that local government does, and does much better than the health service, which is sector-led improvement. The idea is that as we have however many—150—local authority areas in England, they will develop an awful lot of great experience over time and can share it among them. I do not mean, "Here, read our manifesto—we're wonderful," but in a day-to-day supportive and developing way, which is better than just waiting for an inspection every four years.

Before I was elected to this place, I was a member peer, and I helped those in other health footprints on the exact point of integration, so I know that established people are already working in this field. I recall that it was at one of these sector-led, improvement-type activities that I first met my hon. Friend the Member for Ellesmere Port and Neston. That was eight or nine years ago, when we were the future once in local government, or perhaps in politics in general—and look at us now! Nevertheless, the point is that there is loads of really good work going on in the LGA, and I really hope to hear from the Minister that that will be seen as an asset, and could now be developed for all these systems as something that would really complement an inspection regime.

I will make two quick points about the inspection regime itself. Proposed new section 46B(3)(a) in new clause 59 says that the CQC will have to establish indicators. Will the Minister clarify what he means by that? Is it about things we would conventionally understand —outstanding, good, requires improvement, adequate—or similar? Again, this needs to be something the public can easily understand, and we need to be able to understand what it is trying to tell us.

Under proposed new section 46B(6)(a)(i), it would be left to the CQC to determine the frequency of inspection. I feel that that is rather a function for the Department, as it commissions the inspector, than for the inspector itself. I seek at least a sense from the Minister of the frequency we are talking about. I understand that it might be different for different footprints—I think it was the hon. Member for Eddisbury who mentioned Ofsted—depending on how their ICSs are doing at a certain point, but what at least is the broad frequency we are talking about?

Those are important details, and I hope to hear greater clarity on them, but the basic principle that there is oversight is one we are supporting.

Edward Argar: I will be relatively brief. I am grateful to the shadow Minister, and I think that on this we are in broad agreement. He raised a few specific points, about which I hope I can reassure him. On local authority sector-led improvement, I entirely share his view; I think it is an asset. We are in the business not of excluding ways to improve, but of creating new ways to improve. If we have something that—he is absolutely right—does add value, I would hope it is looked to as an asset to draw on, rather than pushed to one side.

Let me discuss the hon. Gentleman's other points. On indicators, yes, I entirely agree with him. While we must wait for subsequent developments to assess exactly how we characterise those—we will be doing a system assessment rather than an individual provider assessment, with complex moving parts—I entirely agree with his underlying point, which is that the indicators ideally need to be consistent with extant ones, to be easily understandable and to convey a clear message on performance—be it outstanding, good or whatever—as something that is meaningful to all our voters and to those using the systems.

On the hon. Gentleman's final point about frequency, I may disappoint him a little in not being able to give quite such a clear answer. I am being cautious because I think it is right that the CQC—when it is given this power, subject to the passage of the legislation through Parliament—can take a step back and consider what it thinks. The ICSs will be at different stages of development in different parts of the country; some will be very much advanced because of where they are now, and some will not be.

It would wrong at this stage to be prescriptive about that frequency. I suppose I would say—we have seen this with Ofsted—that some are inspected very regularly because there is clearly a problem that needs to be addressed, but others that are doing quite well will be assessed at regular, but less frequent, intervals. That does not give the hon. Gentleman a clear statistical answer, but I would expect regular routine assessments, obviously with the facility for the CQC to do more frequent assessments where it thinks something needs bottoming out or where it needs to support such improvement. I hope that that, to a degree, answers the points he made, all of which are valid and important.

Amendment 147 agreed to.

Amendment made: 148, in clause 121, page 103, line 3, leave out "or".—*(Edward Argar.)*

This amendment is consequential on NC59.

Clause 121, as amended, ordered to stand part of the Bill.

Clause 122

PROVISION OF SOCIAL CARE SERVICES: FINANCIAL ASSISTANCE

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

Edward Argar: I will be relatively brief. The clause will expand the Secretary of State's powers under the Health and Social Care Act 2008 so that payments can be made to all providers delivering social care services. It will also allow the Secretary of State to delegate the new power to special health authorities via directions.

The power in the 2008 Act excludes providers that operate for profit. Given that social care in England is largely delivered by private providers operating on a profit-making basis, the Secretary of State is unable to make direct payments to much of the sector under the existing power. Crucially, the power can be used only by financial assistance bodies engaged in providing social care services or services connected with social care services.

The coronavirus pandemic has demonstrated the need for speed and flexibility in providing support to the care sector. Without the clause, our only means to deliver financial assistance to social care providers is via local authorities. We are clear that the power will not be used to amend or replace the existing system of funding for adult social care, whereby funding for state provision is funded via local authorities, largely through local income and supplemented by Government grant.

The new power will allow the Secretary of State to react to unforeseen and changing circumstances by directing financial assistance social care providers with greater speed and in a more targeted manner. That is one of the learnings that we are seeking to implement as a result of what has happened during the recent pandemic. I therefore commend the clause to the Committee.

Alex Norris: I will be very brief, not least because we will not divide the Committee. However, I could not let us go past the clause without mentioning the heading. I must read it from the Bill because it gives me so much pleasure: "Provision of social care services: financial assistance". Wouldn't that be something in this country?

It is quite something to see the Government seeking to establish a mechanism to fund social care because we have been waiting 11 years for them to do so. During tomorrow's Budget, we will listen with interest for news of support for social care. Given that most of the Budget has been leaked already, I dare say we will be disappointed. I feel a little as though the clause is the parliamentary equivalent of being threatened with a good time.

We do not have any issue with the establishment of such a mechanism, although our preference would be for that to be done by the Department that leads on local government, rather than by the Secretary of State for Health and Social Care, because we think that that is confusing. However, we do not oppose the principle behind the clause.

I can foresee the scenario in which this power would be desirable, but I would like the Minister to reiterate on the record that it will not lead to the routine commissioning of private providers outside the commissioning plans of the local authority. Each local authority puts incredible efforts into commissioning services in its community. The last thing local authorities want is someone doing a sideline arrangement on a different matter. To be clear, this is an exceptional power—almost an emergency power—and not one that we would expect to be used frequently.

Edward Argar: I think I can give the shadow Minister that reassurance. The clause is intended to reflect some of the learning from the pandemic. There are occasions when such intervention is necessary, but there is no intention, as I said in my remarks, to in any way go round or replace the current commissioning functions of the local authority. I have had discussions with the Local Government Association on exactly that point, so I hope I can give him the reassurance he seeks.

Question put and agreed to.

Clause 122 accordingly ordered to stand part of the Bill.

Clause 123

REGULATION OF HEALTH CARE AND ASSOCIATED PROFESSIONS

3.15 pm

Dr Whitford: I beg to move amendment 112, in clause 123, page 105, line 13, at end insert—

"(f) after subsection (3) insert—

"(3A) An Order in Council under this section—

(a) which affects Scotland may only be made with the consent of the Scottish Ministers;

(b) which affects Wales may only be made with the consent of the Welsh Ministers;

(c) which affects Northern Ireland may only be made with the consent of the Northern Ireland Ministers.""

This amendment would require the appropriate authority to obtain the consent of devolved governments before orders under section 60 of the Health Act 1999 affecting the relevant territory could be made.

Obviously, we are discussing the regulation of healthcare and associated professions. I am concerned that what we see written is that the Secretary of State will have the power to abolish certain regulatory bodies, deregulate certain professions and specifically deregulate social care workers. Most registration and regulatory bodies for healthcare are UK-wide, but it must be recognised that people work and move between the four nations, so anything that happens at that level will have an impact on the devolved health services.

During the debate on the United Kingdom Internal Market Bill, Members raised the issue that professional qualifications gained in any of the four nations must be recognised across all four. That makes absolute sense, but the debate was about teachers, and in England Teach First allows a degree holder to become a teacher within a matter of a couple of months whereas in Scotland and Wales, a postgraduate teaching qualification is required. That did not go ahead, but it highlights the issue.

We see new health professions developing—new grades, physicians and associates—and the devolved nations will have their own view on whether they would use such staff, how they think those staff should be regulated

and registered, and where they would fit in their health services. We face the potential of new grades or qualifications being created that the devolved health services would have no option other than to recognise and accept, yet they would have minimal input, so we are back to the issue of genuine consultation with and consent from Health Ministers.

Earlier, when we were talking about the need to professionalise social care, I was surprised to hear the deregulation of social care workers mentioned. In Scotland, we are moving forward with the registration of care staff as the first step in that professionalisation, and we would not want to see it undermined. That is the same theme, unfortunately, that I have repeatedly put before the Committee. However, it is important to recognise that while the delivery of health and social care is devolved, some of the issues that we are debating would have a significant impact on the three devolved services, and it would be wrong for their Ministers to have these decisions forced on them by the Secretary of State with no significant input or consent as to how to take things forward.

Hywel Williams (Arfon) (PC): I shall be brief. I support my hon. Friend on this matter. Clearly, systems vary from one country to another. Indeed, a long time ago, I was involved in teaching social care staff, and we were ambitious to register all staff whereas, as I remember it, 10% of staff in England were going to be registered at that time. Across the UK, there are different approaches to health provision. As I have said before in the Committee, the Labour Government in Wales have adopted a wellbeing approach for many years, and I think the requirements of implementing such a wellbeing approach might vary from one country to another.

I restate my support for my hon. Friend on this matter and look forward to hearing what the Minister has to say about it.

Edward Argar: Amendment 112 would place on the Secretary of State a duty to obtain consent from the devolved Administrations prior to legislating using section 60 of the Health Act 1999, where such legislation would affect the devolved Administrations. Before I turn to the substance of the amendment, I will set out the benefits of regulating health and care professionals on a UK-wide basis. It is important that we have UK-wide standards to ensure the same level of public protection across the UK and to allow healthcare professionals the flexibility to work across the whole of the UK. We value and will continue to work collaboratively with our devolved Administration partners on the regulation of health and care professionals.

Each devolved legislature, as has been alluded to, has its own devolved arrangements in respect of professional regulation, which are a mix of reserved and devolved or transferred powers. In practice, any use of section 60 affecting professionals in Northern Ireland is exercised only with the agreement of the Northern Ireland Executive. In Scotland, consent is required in relation to legislation concerning healthcare professionals brought into regulation post the Scotland Act 1998. In the case of Wales, the regulation of healthcare professionals is a reserved matter, so consent is not sought.

In practice, the UK Government always seek the agreement of the NI Executive when making changes to the regulation of healthcare professionals, and the Scottish Parliament's consent is required in the circumstances that I set out previously. The amendment would add to that by requiring consent in relation to any changes to the regulation of healthcare professionals affecting the devolved Administrations. In addition, legislation requires that section 60 can be used only following public consultation and the affirmative parliamentary procedure.

The purpose of the professional regulation system is to protect the public. Regulating health and care professionals on a UK-wide basis helps to provide consistency across the four nations and ensures that we continue to work together with the devolved legislatures to align workforce policy. For those reasons, although I appreciate the point underlying the amendment, I ask the hon. Member for Central Ayrshire to withdraw it.

Dr Whitford: We have had a lot of debate over recent years about whether we are aiming for lowest common denominator or to achieve the highest standard. The concern is about delegating or creating new grades of staff who are not expected to have the same level of qualification or training as the people they may be replacing within the health service. That is not always to the benefit of patient safety. We are really calling for meaningful engagement, which is not what we have seen before. It is important to recognise the impact that it would have on the devolved nations.

I totally recognise that professionals need to be able to work across the UK, but it should be about aiming for people to have the training, professionalisation, standards and regulation that they require and which is comparative to the job that they are doing and the service they are delivering for patients. We spent the whole morning on patient safety. The standard of the staff who deliver the care is the most important thing for patient safety. However, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Justin Madders: I beg to move amendment 142, in clause 123, page 105, line 13, at end insert—

"(f) After subsection (2B) insert—

(2C) The regulation of health professions and social care workers must be used where possible to raise professional awareness of rare and less common conditions."

This amendment would require professional regulators to support improved awareness of rare and less common conditions amongst health and care professionals.

May I clarify that there will be a debate on the substantive clause afterwards?

The Chair: There will be, if you so wish.

Justin Madders: I do so wish. I will not detain the Committee long on amendment 142. We are seeking to find ways of increasing awareness of rare and less common conditions among healthcare professionals. I readily accept that the amendment may not be a perfect vehicle for doing that, but the recent UK rare diseases framework included increasing awareness of rare and less common conditions among healthcare professionals as one of its four priority areas, partly due to the challenges that people within the community face in receiving accurate and timely diagnoses in primary care.

[Justin Madders]

What mechanisms can be introduced to help to raise awareness of rare and less common conditions among healthcare professionals? Will the Minister consider introducing reforms to workforce training and resourcing to facilitate that because among the raft of the entire professional regulation process and a range of development issues, continuing development about and awareness of rare conditions is at the heart of proper and effective regulation?

Edward Argar: Amendment 142 would introduce a legislative requirement in section 60 of the Health Act 1999 for health and care professional regulators to raise professional awareness of rare and less common conditions where possible.

The purpose of regulating healthcare professionals is to protect the public. Regulators set the standards that registered professionals must meet; they also set standards relating to education and training. By ensuring that the standards are met, the regulators ensure that on an ongoing basis professionals have the right behaviours, skills, knowledge and experience to provide safe and effective care.

Section 60 of the Health Act 1999 provides powers to make changes to the professional regulatory landscape through secondary legislation. Each professional regulator has its own legislation that can be amended under the powers in section 60, which provides the framework for its establishment and remit. Although I have sympathy with the amendment's aim and the points made by the hon. Member for Ellesmore Port and Neston about the need to ensure that health and care professionals are aware of rare conditions, I do not believe that writing such a requirement into section 60 of the 1999 Act is quite the right approach to achieve that.

All the healthcare professional regulators have the same set of objectives, which were placed on a consistent footing by the Health and Social Care (Safety and Quality) Act 2015. Those objectives are to protect, promote and maintain the health, safety and wellbeing of the public; to promote and maintain public confidence in the professions regulated under the Act; and to promote and maintain proper professional standards and conduct for members of those professions.

A key part of delivering those objectives is setting standards that require professionals to have the necessary skills and knowledge to practise safely. That includes knowledge and awareness of rare conditions where that is necessary for an individual's practice. Regulators set the standards that healthcare professionals are required to meet in order to practise. Professionals have a duty to ensure that they provide a good standard of practice and care, which includes keeping their professional knowledge and skills up to date. That is set out in the guidance issued by the regulators.

For example, the General Medical Council's "Good medical practice" sets out the standards required of a registered doctor. It specifies that a doctor must keep their professional knowledge and skills up to date, must be familiar with guidelines and developments that affect their work, and must recognise and work within the limits of their competence. That provides a clear framework that requires doctors to have knowledge of rare conditions where that is necessary for their practice.

The exact knowledge and skills required for each healthcare professional cannot be known or set by the regulator, but the current legislative requirements put in a place a framework that requires each professional to maintain the skills and knowledge needed to practise safely, including knowledge of rare conditions.

As experts in regulation, it is the responsibility of the regulators to determine what role they need to play in raising issues such as awareness of rare and less common conditions among their professionals. For those reasons, I encourage the hon. Member for Ellesmere Port and Neston to consider withdrawing his amendment.

Justin Madders: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

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

Edward Argar: The clause provides additional powers that will widen the scope of section 60 of the Health Act 1999 and enable the Privy Council to make additional changes through secondary legislation.

The powers will enable the abolition of an individual health and care professional regulatory body where the professions concerned have been deregulated or are being regulated by another body; the removal of a healthcare profession from regulation where that is no longer for the protection of the public; or the delegation of certain functions to other regulatory bodies through legislation which previously had not been allowed. The powers will enable the regulation of group of workers concerned with physical and mental health, whether or not they are generally regarded as a profession, such as senior managers and leaders.

The UK model of regulation for healthcare professionals is rigid, complex and needs to be flexible and to change to better protect patients, support our health and care services and to help the workforce meet future challenges. The case for reforming professional regulation has long been acknowledged. Stakeholders have long expressed concern that having nine separate professional regulatory bodies is inefficient and confusing to the public. Our 2019 public consultation response reflected the desire for fewer regulatory bodies to deliver benefits to the professional regulation system. In addition, an independent review of the regulatory landscape, in particular the existing roles of regulators, has been commissioned and is due to report by the end of this year.

The powers in clause 123 will enable future changes to be made to make the professional regulatory landscape more streamlined and work more flexibly. The powers will also make it easier to ensure that the professions protected in law are the right ones and that the level of regulatory oversight is proportionate to the risks to the public.

3.30 pm

Secondary legislation made using the new powers will be made subject to the existing provision in schedule 3 to the Health Act 1999, namely with a public consultation and under the affirmative parliamentary procedure. That will ensure that any use of the power will be informed by experts and other stakeholders, and subject to high-level scrutiny in public and in Parliament.

The policy decisions underpinning the powers also take into consideration the Government response to the Law Commission's review of UK law relating to the regulation of healthcare professionals and the recent review, led by Tom Kark QC, of the fit and proper persons test. This clause forms part of a wider programme aimed at creating a more flexible and proportionate regulatory framework for healthcare professionals that is better able to protect patients and the public, and I commend it to the Committee.

Justin Madders: As the Minister has told us, the clause seeks to amend section 60 of the Health Act 1999 in relation to making changes to the professional regulatory landscape through secondary legislation. It will simultaneously widen the scope of section 60 and extend the Secretary of State's powers. Members may have picked up a theme by now: whenever there is a chance for the Secretary of State to seek more power, he uses this Bill to obtain it.

At the moment, the Government have powers to bring new professions into regulation or make modifications through secondary legislation, but can remove a profession from regulation only through primary legislation. This clause will enable the removal of a profession through secondary legislation and makes it clear that a profession would be removed from regulation only when that was no longer required for the purpose of protecting the public—but then I would hardly expect a statement from the Government about deregulating only where there is a risk.

While at one end of the spectrum one could argue that virtually all interactions with patients might have some element of risk, the more balanced view might be that while not all interactions carry the same risk, it is likely that all professions at some time undertake acts where the consequences of mistakes for the patient will be significant.

I am left wondering exactly what the yardstick will be and what criteria will be used to determine when there is no longer a need to protect the public. Is that the only criterion to be applied? Does professional regulation not also help to facilitate consistent common standards? What is lacking at the moment is any sense of the principles that will be followed to inform decisions to bring professions into regulation or to remove them. Will patient organisations, representative bodies and regulators be consulted on any new criteria to be applied?

I appreciate that, as the Minister said, section 60 of the Health Act 1999 already contains requirements that legislation should be published in draft, subject to a three-month consultation, specifically with affected professionals and service users, but it would be helpful if he confirmed that that is the absolute minimum. I have to say, though, that even if the answer to that is yes, it seems a fairly minimal procedure for abolishing an entire profession. I am not sure that will cut it in terms of Parliament, never mind the public being satisfied that due diligence has been done to assess the overall risk profile of any particular role in the system. I am concerned about where that would leave matters such as professional indemnity insurance, as well as about any knock-on effect on the reassessment of bandings under agenda for change.

The more one looks at this, the harder it is to see how it could be done properly in the timescales envisaged. There are just under 700,000 registered nurses in the UK. One can see how resource-intensive it would be if every one of them responded to a consultation to abolish their profession. I suspect the Minister will tell us that he has no plans to abolish professional regulation for doctors and nurses, but imagine if he did. This process would be wholly inadequate, which leads to the question: what exactly does the Minister, or more accurately the Secretary of State, have in mind when it comes to these powers? If we got some answers on that today, it might help us to decide whether these procedures were adequate and also whether the powers are necessary at all.

Moving the power to abolish professions to secondary legislation is not putting scrutiny and transparency at the forefront, and doing so without putting any indication on the record of which professions are being considered for derecognition under this power does not instil confidence that this power grab has been considered properly or is in fact needed at all. The implications for the devolved nations, particularly Scotland, are also important. There are differences in regulation and it is not clear what would happen if there were a difference of opinion between England and the devolved nations.

Clause 123(2)(d) inserts new subsection (2ZZA) into the Health Act 1999. I would welcome the suggestion that the scope of regulation could be extended to others who might not necessarily be regarded as professionals. It remains to be seen who or what this power will be used for, but I question whether the vehicle proposed is sufficient. More needs to be done. The 2019 Interim NHS People Plan states:

> "It cannot be right that there are no agreed competencies for holding senior positions in the NHS or that we hold so little information about the skills, qualifications and career history of our leaders. A series of reports over the last decade have all highlighted a 'revolving door' culture, where leaders are quietly moved elsewhere in the NHS, facilitated by 'vanilla' references. These practices are not widespread, but they must end."

I do not know whether this will be the right vehicle for tackling this issue, but it certainly needs tackling.

On clause 123(3) and the power to abolish regulatory bodies, the case has been made rather better—most notably by the Health and Care Professions Council, which sees this as an opportunity for some much needed modernisation, with a multi-professional regulatory model that would allow regulators to retain their individual identities and independence. That would see each regulator continue to operate its own register, oversee fitness to practise processes, liaise with relevant professional bodies and set its own educational standards relating to the professions they regulate, but there would be greater collaboration, with shared back-office services and other resources, which would presumably improve efficiency.

That approach has some benefits although I am also mindful of the evidence submitted by the Professional Standards Authority, which warned:

> "Any mergers would be likely to lead to a period of turbulence of three-to-five years."

It may be of interest that the authority also said that in the coming five or so years, it expected turbulence in the NHS and referred to the Bill as part of that turbulence. Of course, there are also the issues that we have discussed many times in this place about the pandemic's impact.

On the overall impact of clause 123, I am sure that we can all agree on the need for robust, independent processes to ensure that any decisions made are in the public

[Justin Madders]

interest and based on a clear assessment of the risk of harm arising from practice. It is an obvious thing to do. It is important that individuals belong to a profession because that provides a framework of standards to uphold, encourages expertise and respect, and brings a higher level of professionalism, and, crucially, accountability to the public. However, it is far from obvious how the clause will assist those aims or why in going down the road of deregulation we would want to put those important principles at risk.

Edward Argar: I am grateful to the shadow Minister. His points coalesce around a number of key themes that I shall seek to address. He highlighted his concern about why we would do this and the potential disruption of either a lack of regulation in some spaces were we to abolish regulators or of that caused by moving functions. The key point here is that this is about creating a power that enables flexibility in the system that is not currently there. It is not that we have any direct or immediate plans to do this but about creating, in the context of the opportunity provided by the legislation, a framework whereby we could move powers around. There are some points sitting underneath that which I shall try to address.

The current section 60 powers are limited in terms of the changes they can deliver in the professional regulatory framework. We can use secondary legislation to bring a new profession into regulation and create a new regulatory body, but we do not have equivalent powers to remove a profession from regulation or close a regulatory body and move functions without primary legislation. Widening the scope helps us to ensure that professional regulation delivers public protection more consistently and efficiently, recognising the dynamic, to a degree, nature of evolving professional regulation.

On his concern about abolishing regulators, I know the hon. Gentleman will appreciate that there is no intention of doing that. But he rightly asks, "But what if?" It is the role of the Committee to look at that. Were a regulator to be abolished, that would not necessarily mean that the professionals they regulate would cease to be regulated. Current legislation allows a number of professions to be regulated by a single body, and that creates the mechanism to allow those movements and transfers.

To give an example that some might raise, would that mean that the GMC could be abolished? It is an extreme example, but hopefully it illustrates the point. The scope of the power to abolish a regulator covers all health and care professional regulators. However, the key point is that a regulator will be abolished only if the professions have either been moved to another regulator or removed, or deemed to be removed, from regulation altogether. Any use of this power is subject to existing legislative provision, namely a public consultation and the affirmative procedure. However, to take the example I gave, there are no plans to abolish the GMC, because clearly there would always be a need for continued regulation of medical practitioners. Therefore, given that the GMC regulates them, it would continue to do so.

Underpinning that concern is whether the removal of a specified profession entirely from regulation would increase in any way risks to public safety. Again, a profession would only be removed entirely from regulation following an assessment that showed the profession no longer required regulation for the purposes of public protection and that risks could therefore be safely managed, effectively and efficiently, outside statutory regulation. Given the nature of the professionals that we are talking about here, that would be highly unlikely in any of those spaces and I do not anticipate it. Any use of the power to remove a profession from regulation would be subject to consultation and, again, the affirmative parliamentary procedure.

The counterpoint could be why more professions are not included in regulation. From time to time we debate particular professions as new treatments, such as cosmetic treatments, emerge. Given the risks that some may pose, the question of whether there should be greater regulation then arises. Although statutory regulation is sometimes necessary where there are significant risks in the use of services that cannot be mitigated in other ways, we believe that it is not always the most proportionate or effective means of assuring the safe and effective care of service users. Therefore, each situation needs to be assessed carefully on its own merits. We have seen colleagues from the across the House making the case for regulating different aspects of professions, or service providers that have effectively become professional or are providing a service that is regularly used. Rather than a blanket approach, we believe that remains the right way.

Dr Whitford: I wonder whether, within this, there is a consideration of the issues within the cosmetic surgery and treatment field, particularly the use of Botox and the injection of fillers, which often result in side effects, and the fact that even cosmetic surgeons, as opposed to plastic surgeons, are not regulated in the same way. The problem is that whenever those medical terms are used, the public assume that they are dealing with a licensed medical professional who is both registered and regulated.

Edward Argar: The hon. Lady makes an important point. I pay tribute to my hon. Friend the Member for Sevenoaks (Laura Trott) for her private Member's Bill, which began putting a framework around Botulinum fillers and who could or could not access them, with age limits. My right hon. Friend the Member for Mid Bedfordshire (Ms Dorries) was then the Minister responsible, but she was self-isolating and awaiting test results, so I had the privilege of speaking in that debate. As often happens on Fridays, it was an interesting and well-informed debate, rather than a political to and fro, as occasionally happens in the Chamber. The hon. Member for Central Ayrshire highlights an important point.

My right hon. Friend the Member for Romsey and Southampton North (Caroline Nokes) has taken a close interest in the issue, as have hon. Members across the House. I am due to meet her to discuss this more broadly in the context of this legislation. I do not want to pre-empt that meeting and the upshot of it, but I take on board the point made by the hon. Member for Central Ayrshire.

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

The Committee divided: Ayes 9, Noes 7.

Division No. 34]

AYES

Argar, Edward	Higginbotham, Antony
Crosbie, Virginia	Robinson, Mary
Davies, Dr James	Skidmore, rh Chris
Double, Steve	Timpson, Edward
Gideon, Jo	

NOES

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

Question accordingly agreed to.

Clause 123 ordered to stand part of the Bill.

Clause 124

Medical examiners

3.45 pm

Justin Madders: I beg to move amendment 116, in clause 124, page 106, line 34, at end insert—

"(4A) In subsection (4) in paragraph (e), after "examiners" insert "including the requirement to investigate stillbirths and deaths related to childbirth"."

This amendment would extend the medical examiner remit to look at still births and maternity cases.

This place has come a long way in recognising, discussing and acting on the tragedy that is baby loss. It has taken us a long time to get there, and there is still a long way to go, but we hope that this amendment will help us to continue on that journey.

The Minister will be aware of the November 2017 announcement on the possibility of coroners being asked to conduct inquests into stillbirths and the subsequent consultation—I believe he was the Minister who initiated that consultation, which was needed. In 2017 the Court of Appeal highlighted the need for reform. It said that the law relating to coronial investigations of stillbirths had not changed since 1887, and:

"Still-birth is a tragedy that continues to befall many families in advanced societies but it was a phenomenon more common in the past… The public interest in establishing whether a child was or was not stillborn, and if it was not how it came by its death, is apparent and continuing."

I am sure those words will resonate with all Members, who will recognise that during the tragedy of stillbirth, parents will want to know why it has happened to them. Although a coronial investigation is no guarantee that answers will be forthcoming, it may relieve the sense of loss that they feel and may help in some small way.

The Government response to the consultation has been delayed somewhat, and they have said that they are not seeking to replace the role of the NHS in investigating stillbirths, but coronial investigations would

"supplement and support those investigations and ensure that coroners can contribute to the learning and play a role in reducing the stillbirth rate."

Any update on when the response to the consultation will be published would be appreciated.

In essence, the amendment seeks to build on the comments made by the Royal College of Pathologists, which stated when that announcement was made back in 2017 that medical examiners should in fact play a far greater role in investigating stillbirths, as

"medical examiners are ideally placed to identify trends relating to deaths"

and to highlight areas for further improvement. The Government's roll-out of medical examiners so far has not included investigations into stillbirths. The purpose of the amendment is to get underneath the rationale for that and to press for the issue to be reconsidered. If we are to have a separate debate on clause stand part, I will leave my comments there in order for the Minister to respond.

Edward Argar: I am grateful to the hon. Gentleman for giving us, through amendment 116, an opportunity to debate and discuss this issue. Every stillbirth and death related to childbirth is a tragedy, and it is only right that we remain absolutely committed to supporting parents and families during such a difficult time. However, we are not convinced that this amendment is necessary in order to do that, and I will explain why in due course.

Following the passage of the Bill, the Secretary of State will make, in relation to England, regulations underpinning the medical examiner system, which will set out that the functions of medical examiners include confirming the cause of non-coronial deaths as stated by the doctor on the medical certificate of cause of death. The intention is that that will include confirming the cause of deaths of mothers in childbirth. As part of proposals to improve and digitise the medical certificate of cause of death, we are proposing the introduction of a new section on the certificate that will allow information relating to pregnancy at the time of death to be recorded. Recording information relating to pregnancy on the medical certificate of cause of death will provide a more accurate way to measure maternal deaths, and bring the certificate used in England and Wales in line with certificates used in other countries.

On stillbirths specifically, it is the case that between March and June of 2019, as the hon. Gentleman alluded to, the Ministry of Justice—I was in the Department at the time, as he set out—and the Department of Health and Social Care jointly consulted on proposals for coroners to investigate term or post-term stillbirths. The proposals are intended to improve the independence and transparency of reviews through independent investigation by coroners as judicial office holders outside the NHS. Work on analysing the responses to the consultation was delayed during the covid-19 pandemic, but the Government hope to publish the response to the consultation as soon as possible.

The Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019 also requires the Secretary of State to make arrangements for the preparation of a report on whether and how the law ought to be changed to require coroners to investigate stillbirths, and provides a power to make those changes within five years. At such a time as the response to the consultation on proposals to provide coroners with new powers to investigate term stillbirths is published, it will be appropriate for the position on medical examiners also, potentially, to be considered.

[Edward Argar]

There are existing processes for investigations of stillbirths, including the perinatal mortality review tool, introduced in 2018, and investigations by the Healthcare Safety Investigation Branch. I would like to highlight the importance of parents having the opportunity to be involved in the reviews and investigations. In early 2018 the perinatal mortality review tool was introduced to support NHS maternity and neonatal units in England, Wales and Scotland to undertake high-quality, standardised reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death. The aim of the perinatal mortality review tool is to support objective, robust and standardised reviews to provide answers for bereaved parents about why their baby died, as well as ensuring local and national learning to improve care and, ultimately, prevent future baby deaths.

Since April 2018 the Healthcare Safety Investigation Branch has been responsible in England for all NHS patient safety investigations of maternity incidents that meet the criteria for the Royal College of Obstetricians and Gynaecologists' Each Baby Counts programme, of which there are approximately 1,000 cases each year. That includes all cases in which a term baby was considered to be alive and healthy at the onset of labour but the birth outcome was severe brain damage, intrapartum stillbirth or neonatal death, and maternal deaths, to identify common themes and influence system change.

Both the perinatal mortality review tool and the Healthcare Safety Investigation Branch provide the opportunity for parents' involvement in the investigation of stillbirths, which is essential to help provide answers for bereaved parents and to improve care.

I will not prejudge what the response might be to the consultation that we spoke about earlier, but I invite the shadow Minister to perhaps draw his own conclusions about my thinking on this, given that I believe it was my signature on the front of that document and I was the Minister who fought to be able to launch it. On that basis, I gently encourage him to consider not pressing his amendment to a vote on this occasion.

Justin Madders: In the light of the Minister's encouragement, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

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

Edward Argar: Clause 124 will amend the statutory medical examiner system in the Coroners and Justice Act 2009 so that English NHS bodies may appoint medical examiners to scrutinise deaths, instead of local authorities. Appointment of medical examiners by NHS bodies will facilitate their access to patient information in order to scrutinise the proposed cause of death while remaining clinically independent of the case. The medical examiner system will introduce a level of independent scrutiny, improving the quality and accuracy of the medical certificate of cause of death and thereby informing the national data on mortality and patient safety.

The medical examiner system will increase transparency and offer bereaved people the opportunity to raise concerns. It will provide new levels of scrutiny to help identify and deter criminal activity and poor practice. New duties on, and powers for, the Secretary of State to ensure enough medical examiners are appointed by English NHS bodies and are provided with sufficient resources and monitoring will help to facilitate and develop this system. As a result of the introduction of the medical examiner system, all deaths would be scrutinised by either a medical examiner or coroner, irrespective of the decision to bury or cremate, thus bringing the system on to an equal footing. I therefore commend the clause to the Committee.

Justin Madders: As the Minister has outlined, the purpose of medical examiners is to provide greater safeguards to the public by ensuring proper scrutiny of all non-coronial deaths; to ensure the appropriate notification of deaths to the coroner; and to provide a better service for the bereaved and, importantly, give them an opportunity to raise any concerns to a doctor who was not involved in the care of the deceased. It will also hopefully improve the quality of death certification and mortality data. These are all worthy aims that we can support, so the challenge for the Minister is to set out how the Government will benchmark the success or otherwise of medical examiners in achieving those aims. For example, can he tell us what improved quality of mortality data will actually look like? Does he envisage this leading to further system changes down the line, or is it too early to tell?

Another area I would be grateful for a little more detail about is set out in proposed new section 19(A3) of the Coroners and Justice Act 2009, which gives the Secretary of State the power to

"give a direction to an English NHS body—

(a) requiring the body to appoint or arrange for the appointment of one or more medical examiners,"

setting out the funds and resources that should be made available to such employed medical examiners, or setting out the means and methods that may be employed to monitor the performance of those medical examiners. Can the Minister tell us exactly who that body might be? Does the Secretary of State have a view on how many medical examiners might be needed, and what the appropriate level of funding might be?

I also want to ask about clause 124(8), which amends section 20 of the 2009 Act. That section provides a power to make regulation to require a fee to be payable in respect of medical examiners' confirmation of cause of death. The clause will require any such fee to be payable to an English NHS body, rather than a local authority. Does the Department have a position on fees? Are they desirable? Has a level been set for them? What consultation has taken place about that level, and indeed the principle of charging a fee? It would be a shame if medical examiners were not accessible to the majority of people because of a barrier being created by a fee. If the Minister could answer those questions, it would be appreciated.

Dr Whitford: The recommendation to introduce a medical examiner system was one of the strongest recommendations from the Shipman inquiry, and Shipman was convicted in 2000, over two decades ago. As a professional, we saw an entire industry of appraisals and various other systems introduced to the NHS that took up hours and hours of clinical time, whereas there was nothing to actually review death certificates—either their accuracy or who was issuing them—and to spot

unusual patterns. Obviously, it can be the case that a GP practice covers a hospice or some other setting where there are likely to be increased numbers of deaths and, therefore, death certificates, but it has taken an awfully long time to get to this point. Scotland introduced its medical examiners six years ago, in 2015.

The Minister has talked about all certificates being reviewed, but I would be interested to know the degree of depth to which they are going to be reviewed. It is unlikely to be possible to have a detailed inquiry on every death certificate, so in what way will they be streamed for further intervention, review or interaction with clinicians to understand what happened? That may not be clear from just looking at the certificate. Clearly, patterns of certification and patterns of death would become obvious to a medical examiner and may produce very interesting and useful information.

4 pm

Edward Argar: A number of points have been raised. The shadow Minister, the hon. Member for Ellesmere Port and Neston, asked whether we would envisage this leading to system change if a pattern was identified and whether it could be a catalyst for that change. Absolutely—that is part of what we hope would come out of this. I am pleased that we are legislating now on this issue, but the hon. Member for Central Ayrshire is right about the time it has taken. I acknowledge the example from Scotland; I do not always agree with everything done in Holyrood, but to give credit where it is due, I recognise the progress that Scotland has made in this space.

The hon. Member for Ellesmere Port and Neston made a number of points generally revolving around resources, fees and similar issues. I hesitate to put a figure on exactly how many medical examiners or what level of resource would be needed at this stage, but I will seek to address his point about fees and resourcing in broader terms. He will know that, in the non-statutory system, medical examiners are funded through the existing fee for completing medical cremation form 5, in combination with central Government funding for medical examiner work not covered by those fees. With the temporary removal of cremation form 5 as a provision of the Coronavirus Act 2020, all costs are currently covered by central Government, but that is temporary. The Coroners and Justice Act 2009 includes provisions for making regulations to introduce a new fee for the service provided by the medical examiner, and any such regulations will be subject to further parliamentary debate and scrutiny before their passage.

On the overall cost, the reality is that our estimated cost will be informed by the impact assessment published in 2018 and the data gathered from the non-statutory medical examiner system introduced in the NHS in 2019. We have seen a slightly atypical year or 18 months, so I hesitate to put an exact figure on this, but we have a broad evidence base from which to extrapolate. It predates the pandemic but it probably still has relevance. I am sorry that I cannot give him more direct data, but I would not want to pluck out a figure for him and then, quite rightly, be held to account for it in due course. I cannot do that but I hope that I have given him and the hon. Member for Central Ayrshire some reassurance on those points.

Question put and agreed to.

Clause 124 accordingly ordered to stand part of the Bill.

Clause 125

ADVERTISING OF LESS HEALTHY FOOD AND DRINK

Dr Whitford: I beg to move amendment 113, in clause 125, page 107, line 12, at end insert—

"(2) Regulations made by the Secretary of State under any section of the Communications Act 2003 inserted by Schedule 16 may only be made with the consent of the Scottish Ministers, the Welsh Ministers and the Northern Ireland Ministers."

This amendment would require the Secretary of State for Health and Social Care to obtain the consent of the devolved governments before the powers granted by Schedule 16 clause are exercised.

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

Clause stand part.

Amendment 139, page 216, line 5, in schedule 16, at end insert—

"(da) a drink product is 'less healthy' if it is an alcoholic product in accordance with the Department for Health and Social Care's Low Alcohol Descriptors Guidance, published in 2018, or future versions of that guidance;"

This amendment ensures that alcohol is considered a "less healthy" product and therefore liable to the watershed proposed for TV programme services.

Amendment 140, page 217, line 3, in schedule 16, at end insert—

"(da) a drink product is 'less healthy' if it is an alcoholic product in accordance with the Department for Health and Social Care's Low Alcohol Descriptors Guidance, published in 2018, or future versions of that guidance;"

This amendment ensures that alcohol is considered a "less healthy" product and therefore liable to the watershed proposed for TV programme services.

Amendment 141, page 218, line 27, in schedule 16, at end insert—

"(fa) a drink product is 'less healthy' if it is an alcoholic product in accordance with the Department for Health and Social Care's Low Alcohol Descriptors Guidance, published in 2018, or future versions of that guidance;"

This amendment ensures that alcohol is considered a "less healthy" product and therefore liable to the online ban.

That Schedule 16 be the Sixteenth schedule to the Bill.

New clause 55—*Nutrient profiling model*—

"Before making any adjustments to the nutrient profiling model used for the purposes of regulations under the Communications Act 2003, or of any other enactment, the Secretary of State must undertake a full and open formal consultation."

This new clause would insert a requirement for a consultation before any changes can be made to the Nutrient Profiling Model.

Dr Whitford: Basically, clause 125 is just schedule 16—there is nothing very much in clause 125. I sat on the Health and Social Care Committee when we talked about trying to tackle obesity, which is a growing harm across the UK, giving rise to heart disease, diabetes and so on, and the difficulties of trying to regulate the advertising of unhealthy foods, particularly foods with high fat, salt and sugar. I welcome the fact that there is an attempt to tackle that issue in broadcasting, streaming and particularly online.

[Dr Whitford]

I have concerns that the exemption for small and medium-sized enterprises could be worked into a loophole at a later date by large companies simply employing multiple small advertisers or restructuring themselves to get away with still advertising. I would be grateful if the Minister could explain that exemption, because unhealthy food is just as unhealthy whether made by a small or a big company.

Broadcasting and online regulation are clearly reserved matters, and I totally respect that, but public health is devolved, so I would welcome clarification from the Minister on exactly how the devolved Ministers will be involved, how their public health policies will be respected, and how they will be consulted.

Proposed new section 368Z20(3) of the Communications Act 2003 gives power to amend by regulation Acts of the devolved Parliaments, and proposed new subsection (4) states that the Secretary of State can consult who they think appropriate. I am surprised that at that point there is no mention of consulting the devolved Governments. I totally accept that it would not be a matter of consent, but yet again there is absolutely no mention of consultation with or involvement of the Public Health Ministers in the devolved nations.

Alex Norris: It is a pleasure to speak to this important clause, which sets out restrictions on advertising less healthy food and drink. I echo what the hon. Member for Central Ayrshire said about its importance and the general commitment to it across the House. Importantly, it also gives me an opportunity to put on the record a message of thanks to the hon. Member for Bury St Edmunds (Jo Churchill) for all the work she did in this area while a Health Minister. She has moved to a new post during the Bill's consideration, but she championed this provision for a long time and fought very hard for it, so I have no doubt that she will be glad to see it included in the Bill.

These measures form part of the Government's obesity strategy, which is coming through the system bit by bit. The strategy has largely come through in secondary measures, so I welcome the fact that this provision has been included in the Bill, because it gives us an opportunity to propose improving amendments. Is the Minister able to explain why other provisions in the strategy have not been brought forward in this way? For example, we have considered a statutory instrument on showing calories on menus, which I dare say all Members will have received something about in their mailbags, because it is a contentious and emotive topic, with many shades of grey. That provision would have been improved if we had had a chance to amend it, so I am sad that we instead got a "take it or leave it" measure. I do wonder why the entire obesity strategy was not put through in this way.

Turning to what is before us, ensuring that we do not see the aggressive promotion of products high in fat, sugar and salt, particularly to our nation's children, is an important step in reducing the obesogenic environment we live in. We know that one in three of our children leave primary school overweight and one in five are obese, and we know the lifelong impact that that has on physical and mental health, such as the links to diabetes, musculoskeletal ailments and depression. We also know the impact on children's education, as they go to secondary school and beyond, and on their prospects in the world of work.

It is a well-established and long-standing precedent in this country that we try to protect children from exposure via the television by using a watershed, so it makes sense to consider these products within that scope. Of course, the nature of the content we all consume—children are no exception—has changed beyond all recognition in my lifetime. The explosion of the internet and its pre-eminence in our lives has provided new advertising space for traditional means—banner ads, pop-up ads and similar—but there is also a much broader platform. Today is probably not the day, certainly not in the witching hour of this Committee, to get into the influence of culture and how the entertainment landscape is changing—not least because I feel woefully underqualified to talk about it—but the point is that there are extraordinarily novel ways of connecting with people, especially young people. It is therefore right that we in Parliament enter this space to try to create the safest possible environment.

I will say, alongside this, that I am surprised that we have not yet seen the online harms legislation—it seems to have been coming through the system for a very long time indeed—because it would sit very neatly with this. I hope there will be a sense of trying to weave this in with that in due course.

The Government's answer here goes beyond a watershed and into full prohibition. I hope that the Minister will take us through how that decision was reached. I understand from my conversations with industry, particularly those working in digital media, that they have offered a solution that would act as a de facto ban for children without being an outright ban. Given that we genuinely lay claim to being world leading in advertising in general, and in digital media in particular, we ought to listen if there are more elegant ways of doing that. I hope the Minister can cover the conversations being had with the sector and why this approach was chosen, not a slightly more nuanced one. Perhaps it was considered too complicated, but we need to know that.

As the hon. Member for Central Ayrshire says, clause 125 inserts schedule 16 into the Bill. As that is where the meat is, I want to probe the Minister on a couple of points. First, on the fines regime, what are the sanctions in the Government's mind? Secondly, the schedule provides for regulations to follow. I suspect we will see a full regime, but when are we likely to see it? How far along are we, and what sort of consultation will there be? Thirdly—again, this will be a matter for regulations, but I hope the Minister might be drawn on it now as a concept—who does the burden fall on? Is it the advertiser or the platform? It might be both, and obviously it could not be neither. That will be a very important point going forwards.

Adding to the case the hon. Member made about small and medium-sized enterprises, we supported that conceptually in the statutory instrument on calories on menus because there was agreement that it was reasonable to say that these things would be a significant burden for a small operator, which might have only one or two members of staff. I do not think that applies in the advertising space. Again, we would be keen to understand how the Minister and his colleagues reached the conclusion they did.

Amendments 139 and 141 deal with alcohol. One of the few parts of the obesity strategy where we have departed from the Government's view is the curious decision to remove alcohol, particularly with regard to calories and labels. We all know that alcohol is a less healthy product—I may well be the billboard for that, certainly when it comes to weight—so why has it been left out? Our amendments are more probing than an attempt to actually change the Bill, because I hope that alcohol has already been covered. However, in the obesity strategy in general, it seems to have disappeared, which seems very odd. I hope that the Minister can explain his thinking on that.

New clause 55 seeks to protect the nutrient profiling model. According to gov.uk, the NPM

"was developed by the Food Standards Agency in 2004-2005 as a tool to help Ofcom differentiate foods and improve the balance of television advertising to children. Ofcom introduced controls which restricted the advertising of HFSS foods in order to encourage the promotion of healthier alternatives."

So far, so good. We would say that that principle is sound today and will be sound going forward; that is why we are keen to see it in the Bill. It is crucial that we continue to uphold those standards, but we know that foods change. We know that our understanding of what different nutrients mean for us or our children changes over time. We know that the biggest prize in this space is about reformulation, as much as it is about anything else, which would put more stresses on the NPM. I am keen to hear a full commitment from the Minister today that before meaningful changes are made to the NPM, they will be put out to proper consultation and that industry and consumer groups will be properly engaged, along with anyone else who may have an interest.

I will finish with amendment 113, in the name of the hon. Member for Central Ayrshire. I have made the arguments around engagement through consent, mutual good faith and co-operation from Ministers multiple times, and I hope to hear that in closing.

Clause 125 is very important, and we would like to know a bit more about schedule 16. I would be keen to hear that the issues raised in our amendments are covered elsewhere or at least to have a commitment to that. Finally, I would like to hear a bit about the nutrient profiling model.

Edward Timpson: Briefly, on clause 125 and schedule 16 in particular, I want to pick up where the hon. Member for Nottingham North left us, on the issue of obesity. I think we all share concerns that a rising number of children continue to leave primary school either overweight or obese. Much of the answer to tackling that lies in making physical education and sport part of the core curriculum in schools, but we need to look at all measures, including on what children look at and are exposed to in the changing and more digital age in which we live. I welcome measures to tackle that head on, particularly in primary legislation, although I recognise that regulation will flow from that.

4.15 pm

I want to concentrate in particular on the liability for non-compliance with the high-fat, sugar and salt advertising restrictions that are to be brought in through schedule 16. The restrictions stipulate that television broadcasters and UK-regulated on-demand programme services, as defined by the Communications Act 2003, would be liable for any breaches of the HFSS TV watershed. Conversely, advertisers would be liable for any breaches of the paid-for online prohibition. Not only does that go to the heart of trying to understand where responsibility for advertising lies under this new regime, but the online harms Bill, which we hope to debate soon, will address the wider issue of where responsibility should lie for content that is put before children in a still very unregulated online world, and what the consequences should be if restrictions are breached.

At the moment, broadcasters have in place a system to pre-clear any adverts, so they know whether they are in line with whatever regulations are in place. The consequences, from large fines all the way to potential licence revocation, are also clear, and the broadcasters are regulated by Ofcom and the Advertising Standards Authority in equal measure. There is a clear system there.

The online publishing of adverts—where the responsibility for it lies and where the control of that output comes from—is rather more opaque. I would be interested to hear the Minister's views on that, and perhaps he and colleagues in the Department could take the matter away for consideration. There is some ambiguity in the Government's response, which I will come to, but in the proposed legislation, that responsibility will lie with the advertiser, which means that despite being the publisher and having control of the content, the platforms will have no responsibility for anything that goes wrong. What we are looking for here is a level-playing field where the likes of Google, Facebook and TikTok play by the same societal rules as the rest of us. We have an opportunity to tackle that head-on not only in this Bill, but in the online harms Bill. There could be some refinement of this very welcome change, whether through an enabling power or a much clearer direction for the regulator on where responsibility lies under the new regime.

The Government's response states that the extent of a platform's liability for unlawful advertising generally would be considered as part of its online advertising programme, and that it would be for the regulators to determine whether an online platform should be treated as an advertiser. That is where the ambiguity lies. There is a chance to make those expectations clearer through primary legislation or in regulation. What we do not want is for the intent of the measures not to be reflected in the actions of those types of platforms. We are also setting a precedent for the way that we will engage with the online world, and how we protect children, whether from advertising or even more sinister parts of the internet, which are still unregulated for many children. If the legislation is to do what we want it to, how will some of that start to be pulled together in a way that demonstrates that there is a level playing field, and that those who are ultimately responsible for the content that children have pushed in their direction online will play their part or face the consequences of not doing so?

Hywel Williams: I will not repeat the points that my hon. Friend the Member for Central Ayrshire made about what is sometimes called the jagged edge of devolution—in this respect, that public health is devolved, but the regulation of broadcasting is not. I am not

[Hywel Williams]

contesting that this afternoon, but I seek assurance that the Welsh Government, along with the Scottish Government, will be properly consulted, and their views listened to.

I will make two points on schedule 16. On the point that the hon. Member raised about small and medium-sized enterprises, in Wales, particularly rural Wales, food and drink businesses are overwhelmingly microbusinesses employing one, two or three people. It would be unusual indeed to have such a company employ more than 250 people, which I think is the definition of an SME. I therefore assume that those small producers will not be affected by the schedule, and will be exempt.

A point that has been made to me—perhaps the Minister could give me an answer to this—is that there are umbrella bodies that promote certain foods. The one that springs to my mind is Hybu Cig Cymru—the red meat authority in Wales—which promotes lamb and beef. It promotes red meats extensively, and advertises, particularly on S4C, the Welsh language channel, which I think helpfully has lower advertising rates. Would that particular umbrella or trade body, and others, be affected by the legislation?

Edward Argar: This is an important clause and set of amendments, so I fear I may detain the Committee on them for a little while. However, it is important that we air a number of points. I am grateful to my hon. Friend the Member for Eddisbury, the hon. Member for Ellesmere Port and Neston and others, because when we talk about digital platforms, including in other pieces of legislation and, indeed, in democracies around the world, we are essentially grappling with whether they are platforms or publishers responsible for content. I think it is fair to say that that debate continues in legislatures around the world, which presents a fundamental challenge.

I will pick up on a few questions while they are fresh in my head, and I suspect that I will cover the others in my prepared remarks. The hon. Member for Ellesmere Port and Neston asked why there is no watershed equivalent online, and how that might operate. The short answer is that it reflects the nature of online media: it is on demand, rather than linear, as with a terrestrial or satellite broadcast, though we see slight changes to that now, with Sky boxes—other online platforms are available for TV—the ability to record things, catch up, and so on. The situation is changing, and is not quite as binary as it used to be, but that is the primary reason.

If it is agreeable to you, Mr McCabe, I will discuss the amendments first, then turn to clause 125 and schedule 16. I hope that, with my extensive notes, I will be able to mop up and scoop up a number of the questions asked. If I do not, I will ask my officials to have a scan of *Hansard,* and I will endeavour to write to hon. Members prior to Report to cover any points that I omit. I will then address new clause 55, which relates to the clause and schedule.

I am grateful for the opportunity to discuss amendment 113, which would require the Secretary of State for Health and Social Care to obtain the consent of the DAs before any of the regulation-making powers granted by schedule 16 of the clause were exercised. As I am sure members of the Committee will be aware, the provisions in clause 125 and schedule 16 on advertising less healthy food and drink will extend to the whole of the United Kingdom.

We consider the provisions in this part of the Bill to be primarily focused on online services and broadcast restrictions, which are not devolved realms of responsibility. I appreciate that the hon. Member for Central Ayrshire and her colleagues in the Scottish Government might have a different interpretation of the same point—it is in the nature of the constitutional settlement that such discussions occur—but telecommunications and internet services remain reserved matters under the devolution settlement. The UK Government have made it clear that the primary purpose of the provision on the advertising of less healthy food and drink on TV and internet services is to regulate content on reserved media, internet and broadcasting. On that basis, we hold to the view that it is reserved. The purpose is not incidental—hence our argument that it does not fall within the devolved provisions and the devolved remit—but I suspect that we may return to this debate in the coming months.

Dr Whitford: I totally recognise, as I recognised in my remarks, that this area is reserved, both as regards broadcasting and online, but obviously the nations consider taking different public health approaches. Given that this is a UK-wide approach, it is important that it is joined up. I totally accept that the Minister is not interested in accepting consent, but there is no mention in the clause of consulting. I would have thought it important that there be discussion of the public health approaches of the four nations, in order to ensure that centralised policy in this Parliament lines up and reflects policies across the UK.

Edward Argar: I take the hon. Lady's point. Although we did not think it necessary to put "consult" in the Bill, I accept that a joined-up approach to public health matters across the four nations of the United Kingdom is beneficial. I expect close working at both official and ministerial level to continue, and I therefore expect consultation and discussion to be ongoing.

As I am sure members of the Committee would agree, the restrictions on advertising on TV and internet services are crucial in contributing to the Government's goal of tackling childhood obesity, and I welcome what I think is cross-party support for that goal. Through these provisions, we have the opportunity to remove up to 7.2 billion calories per year from children's diets in the UK. None the less, for the reasons that I have set out, the Government believe that amendment 113 is not appropriate in this context, so I hope the hon. Lady will withdraw it.

I am grateful for the opportunity to address amendments 139 to 141. As the Committee will know and as I have said, tackling obesity is a priority for the House, irrespective of which side one sits on. That has been brought into sharp focus throughout the covid-19 pandemic. Introducing advertising restrictions for less healthy food and drink products is one of the many policies that the Government are bringing forward to tackle this issue. Following extensive consideration of the evidence submitted and comments made by stakeholders during the consultation exercise, we have announced that we will introduce a 9 pm TV watershed for advertising for less healthy food and drink products, and a restriction on paid-for advertising of such products online.

Amendments 139 to 141 would expand the definition of "less healthy products" to include alcohol, which would have the effect of making alcohol advertising liable to the watershed proposed for TV programme services, and to the online restriction of paid-for advertising. The UK Government are committed to ensuring that children and young people are suitably protected from alcohol advertising and marketing through a set of rules in the UK advertising codes. Restrictions and limitations laid out in the UK advertising codes provide that alcohol advertising may not be featured in any medium where more than 25% of the audience is under 18. Alcohol advertising must not be likely to appeal strongly to young people under 18, reflect or associate with youth culture, or show adolescent or juvenile behaviour—I make no comment there about the behaviour of the House on occasions. No children, and no one who is or appears to be under the age of 25, may play a significant role in advertising alcoholic drinks. The advertising codes apply to broadcast media and non-broadcast media, including online advertising. We do not believe it is necessary to consider alcohol a less healthy product in this context, or to apply the new restrictions to it.

As we will discuss in more detail shortly, clause 125 and schedule 16 are aimed at reducing the exposure of children to advertising for less healthy food and drink, and at reducing the impact of such advertising on child obesity. Less healthy food and drink products are unique, as they are not age-restricted at the point of purchase, unlike alcohol.

4.30 pm

In addition, the 2019 and 2020 consultations on advertising restrictions for less healthy food and drink did not consult on including alcohol within the restrictions, either online or on TV. We therefore cannot be sure of the impact the amendments would have on the advertising industry, the regulator, the alcohol industry or wider public opinion. Introducing such measures without consultation could present unforeseen challenges for industry and may not result in the right measures to tackle that important issue.

It is our plan to legislate for the categories of food and drink in scope of the restrictions via secondary legislation. Therefore, the product categories in scope of the restrictions are not specified in the Bill. In addition, the UK Government have measures in place to protect children and young people from alcohol advertising through the UK advertising codes, as was set out earlier.

Material in the broadcast code and non-broadcast code relating to the advertising and marketing of alcohol products is already robust. That recognises the social imperative to ensure that alcohol advertising is responsible and, in particular, that children and young people are suitably protected. If new evidence emerges that clearly highlights major problems with the existing codes, the Advertising Standards Authority has a duty to revisit them and take appropriate action. For those reasons, I encourage the hon. Member for Nottingham North not to press the amendments to a vote.

I turn to clause 125 and schedule 16, which I propose stand part of the Bill. Clause 125 introduces schedule 16, which amends the Communications Act 2003 and provides for new restrictions for less healthy food and drink advertising on TV, on-demand programme services and online. As I have said, covid-19 has brought the dangers of obesity into sharper focus, with evidence demonstrating that those who are overweight or living with obesity are at greater risk of being seriously ill and dying from the virus. These advertising restrictions are an important part of our strategy to tackle childhood obesity and help to promote public health, not just at this pressing time, but for the future.

Schedule 16 inserts new sections into the 2003 Act. As per proposed new sections 321A and 368FA, it will enable Ofcom to prohibit advertising of less healthy food or drink between the hours of 5.30 am to 9 pm on TV, and on those on-demand programme services that are regulated by Ofcom. It will also prohibit paid-for advertising of such food and drink online, as outlined in proposed new section 368Z14.

Childhood obesity is one of the biggest health problems that this nation faces, with one in every three children in England leaving primary school overweight or living with obesity. Obesity is associated with reduced life expectancy and is a risk factor for a range of chronic diseases, including cardiovascular disease, type 2 diabetes, some types of cancer, and liver and respiratory disease.

We know that adverts for less healthy food and drink can affect what and when children eat, and their long-term food preferences. To date, existing less healthy food and drink restrictions that apply online and during children's TV programmes and other programming of particular appeal to children have been set by the ASA in the broadcast and non-broadcast advertising codes that we discussed in relation to the amendments. Although breaches of the codes can result in referrals to Ofcom, at present, online breaches cannot be referred to Ofcom.

Despite the current less healthy food and drink advertising restrictions, we estimate that children were exposed to 2.9 billion less healthy food and drink TV impacts and 11 billion impressions online in 2019, which shows that tighter controls are needed and proportionate, and that is why the Government have decided to legislate. Proposed new section 321A outlines the 9 pm watershed restrictions on TV, and proposed new section 368FA mirrors the restrictions for on-demand programme services.

We know that children increasingly spend more time online. Therefore, in line with consultation feedback, the Government will introduce, via proposed new section 368Z14, online restrictions that will apply to all paid-for online less healthy food and drink advertising. That will reduce children's exposure to less healthy food and drink advertising and mitigate the migration of advertising from television to online after the implementation of the 9 pm watershed.

Proposed new section 368Z14 states that advertising of less healthy food or drink paid for from 1 August 2021 to be placed online on or after 1 January 2023 will be deemed a breach of the restrictions. Proposed new sections 321A, 368FA and 368Z14 outline the Government's definition of "advertisements" to include those under a sponsorship agreement. Products are deemed identifiable if a person could reasonably be expected to identify the advertisements as being for that product. This means that brand advertising is not in scope of the restrictions, as the purpose of the restrictions is to prohibit identifiable products. Products are determined to be less healthy via a two-stage approach. They first need to be included in one of the product categories that will be set out in regulations, then the nutrient profiling model will need to be applied. These sections also give the Secretary of

State the power to change the technical guidance in the future, should the evidence suggest amendments to it are needed.

To ensure that the restrictions outlined in sections 321A, 368FA and 368Z14 are proportionate, they will apply only to advertising of products that are of most concern to childhood obesity. These sections also outline a number of exclusions and exemptions in order to balance health benefits with impacts on business—a point raised by the shadow Minister and others. This includes exclusions online for business-to-business advertising, and advertisements paid for by parties that do not carry on business in the UK that are not intended to be accessed principally by persons in the UK. There is a small to medium-sized enterprise exemption, and exemptions for regulated radio services. The detail of the exemptions will be set out in regulations.

The proposed new sections allow the Secretary of State the power to make new exemptions in the future to keep pace with new technology and, crucially, where the evidence suggests exemptions are needed. In the first instance, we intend to use this power to exempt audio-only content from the online restriction. The Government have taken care to ensure the exemption is only used by SMEs. The definition of SME will be set out in secondary legislation. It is our intention to conduct a short consultation on the clarity of the definitions in these regulations; we anticipate that will be towards the end of this year or the beginning of next year. Some Members have expressed concerns about franchises. It is our intention for a franchise to be treated as part of the franchisor business, not as separate for the purposes of determining the number of employees in a business, nor seen as a way of getting around this exemption for SMEs.

I will reflect on the point made powerfully by my hon. Friend the Member for Eddisbury. Broadcasters and on-demand programme services will be liable for breaches of the 9pm watershed. Advertisers will be liable for breaches across on-demand programme services not regulated by Ofcom and paid-for advertising online. Ofcom will continue to enforce advertising restrictions on television and on-demand programme services, continuing its relationship with the Advertising Standards Authority as the frontline regulator. The Government will also appoint Ofcom as the appropriate regulatory authority to enforce these new restrictions online, granting Ofcom the ability to appoint a frontline regulator and the power to provide funding to this body, as outlined in section 368Z19. Aligning the enforcement of the online restrictions with the current process for television will ensure consistency and familiarity for industry.

The Bill outlines the enforcement mechanism for these new restrictions. It allows the appropriate regulatory authority to give enforcement notices and outlines the remedial action that can be taken. The Government propose that Ofcom have the power to issue fines and more serious sanctions for breaches. Section 368Z16 outlines the maximum amount of financial penalties and confirms the definition of a relevant business. Section 368Z17 then gives the appropriate regulatory authority the power to gather information for the purpose of carrying out their functions. However, it is expected that the chosen frontline regulator will in the first instance use non-statutory powers, such as naming and shaming and takedown requests, before referring non-compliant broadcasters or advertisers to Ofcom. This will ensure that sanctions are proportionate to the scale of the breach, mirroring the current regulatory framework that industry is used to.

The Bill gives the appropriate regulatory authority the power to draw up and review guidance, and sets a requirement to consult the Secretary of State before doing so. The Government will support the regulators as they produce guidance to make the new restrictions straightforward to understand and adhere to. The Secretary of State has the power to amend this part of the legislation to extend the prohibition to non-paid-for advertising—for example, to owned media, such as a company's own website or social media page—in the future if evidence suggests this amendment is needed. This amendment is subject to a requirement to consult.

Part 3 of schedule 16 outlines the amendments that need to be made to the Communications Act 2003 to ensure that the new provisions detailed in the Bill are in line with the rest of the 2003 Act. We estimate that introducing a watershed for the advertising of less healthy food or drink on television, and a restriction on paid-for advertising, could remove up to 7.2 billion calories a year from children's diets in the UK. That does not reflect the fact that the restrictions might have a larger impact on certain children, such as those living in households in lower socioeconomic groups or individuals already living with obesity.

We know that obesity is associated with significant financial costs, and it is estimated that obesity-related conditions cost the NHS £6.1 billion a year. The total cost to society of the conditions is estimated at £27 billion a year, and some estimates are much higher. These crucial measures introduce advertising restrictions to tackle childhood obesity and help to promote public health, so I commend the clause and schedule to the Committee.

I am grateful for the opportunity to debate new clause 55, which would require a consultation before any changes could be made to the nutrient profiling model used for the purposes of regulations under the 2003 Act or any other enactment. I am sure that the Committee is aware that the less healthy food and drink advertising restrictions outlined in schedule 16 use the two-step approach to determine whether a product is less healthy, and therefore in scope of the policy. I set out the details of that model earlier. The Secretary of State has the power to make regulations to change the meaning of the relevant guidance, such as if nutritional advice changes on what constitutes more or less healthy. The power is subject to the affirmative procedure, which ensures that any changes will receive sufficient parliamentary scrutiny.

Hon. Members might be aware that work has been under way over the past three years to update the nutrient profiling model in line with updated dietary recommendations, but it is not our intention to apply that to the less healthy food and drink advertising restrictions policy that we are debating. We were clear throughout the 2019 and 2020 consultations that if we wanted to use the updated NPM, we would need to consult and invite the views of interested stakeholders.

I appreciate the concerns that underpin the new clause, so I want to provide reassurance to the hon. Member for Nottingham North, the Committee and

industry. I therefore propose to table an amendment to schedule 16 on Report to require the Secretary of State to consult before making any changes to relevant guidance. Such a minor and technical amendment will not change our policy intent, but it is clear from discussions with colleagues that it is important to provide further assurances on the matter. While I recognise the intention behind the new clause, it will be preferable to amend schedule 16 to provide for the requirement, rather than doing so through a new clause. In addition, given the new clause's breadth, it might create undesirable consequences.

I hope that I have reassured hon. Members. The amendment that we will table on Report will focus on the powers under schedule 16 to amend the definition of relevant guidance for the less healthy food and drink advertising restrictions, but will not affect other powers in the Bill.

I have probably spoken enough on this important clause. As I look longingly at my glass of water, I commend the clause to the Committee.

Dr Whitford: I do not plan to press my amendment to a Division, but I encourage the Minister to put in the Bill the consultation that is required. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 125 ordered to stand part of the Bill.

Schedule 16 agreed to.

Clause 126

Hospital food standards

Alex Norris: I beg to move amendment 137, in clause 126, page 107, line 18, leave out "hospital".

This amendment would make the power to impose food standards applicable to all premises within the remit of the Care Quality Commission, rather than just hospitals.

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

Amendment 138, in clause 126, page 107, line 28, leave out paragraph (c).

This amendment is consequential on Amendment 137.

Clause stand part.

4.45 pm

Alex Norris: It is a pleasure to speak on the important topic of hospital food standards. We very much support the substance of the clause, and its inclusion in the Bill. What we consume before, during and after we engage with a hospital can have a profound impact and long-lasting effects on the ailment that brought us there, and affects our experience while we are there.

Even prior to being in hospital, malnutrition is a feature in many people's lives. It affects about 3 million people in the UK, and health and social care expenditure on malnutrition is estimated at more than £23 billion a year across the UK. Around one in 10, or 1.3 million, older people are malnourished or at risk of malnutrition, and older people are disproportionately represented in malnourished groups. Of course, malnutrition plays a significant role in hospital admissions; around one in three patients admitted to hospital are malnourished, or at risk of becoming so.

This is the right time to act on this issue. We ought to expect that a person's time in hospital will be used as well as possible, and what a person consumes while they are there should be seen as part of their care, reablement and rehabilitation. It is a good idea to make sure that our hospitals promote that view, and we therefore support the clause. Our amendments 137 and 138 would improve it, and I hope to find the Minister in listening mode on this.

The whole point of the Bill is that while hospitals are one element of our health and social care system, there are many other places in the system that people are more likely to find themselves in. They may be in community-based care facilities, in step-up or step-down care, or a care home, which could be their permanent home. We argue that anything within the purview of the Care Quality Commission ought to adhere to the standards set out in the clause. The evidence bears that out. Somewhere between a third and 40% of patients admitted to care homes, and one in five patients admitted to a mental health unit, are at risk of malnutrition, so clearly they would need this sort of support.

For those in long-term care settings, nutrition is a vital part of their care. Research has shown the importance of good nutrition to people with dementia; it slows the loss of independence or functional decline. Research shows that nearly 30% of dementia patients experience malnutrition, and that is associated with a much more rapid functional decline over five years. It is really important that we make sure this provision is in place for them; it is fundamental to their life and their future.

Of course, the issue with the two amendments and the clause is resourcing. I am interested to hear from the Minister how the Government intend to resource the clause, because we do not want pressure on hospital settings—and settings in the community, if our amendments are accepted—to make cuts elsewhere. It would be a pyrrhic victory if the clause led to better nutrition but worse care. We need to see the measures as not only the right thing to do—of course, it is what individuals should expect when in the care of the state—but a good investment that will bring us a good return. This is an important issue, and I look forward to hearing the Minister's response.

Edward Argar: As matters stand, the enforcement of standards for food and drink in hospital is not on a statutory footing. That has resulted in variance in compliance across the sector. The clause will grant the Secretary of State the power to make regulations imposing requirements and improved standards for food and drink provided and sold on NHS hospital premises in England to patients, staff, visitors or anyone else on the premises. As the hon. Gentleman set out, providing good-quality, nutritious food is a cornerstone of patient care, and placing these requirements on a statutory footing will ensure a level playing field when it comes to compliance across the sector with nutritional standards in hospitals.

The Care Quality Commission will ensure that any requirements in regulations made under the clause are fulfilled, pursuant to its existing statutory powers of

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enforcement under the Health and Social Care Act 2008. The clause demonstrates that we are committed to acting on a key recommendation from the independent review of NHS hospital food, published in October 2020, to ensure that hospital food standards are enshrined in law and sufficiently enforced .

To address amendments 137 and 138, as I have set out, the clause has been drafted specifically in response to the independent review of NHS hospital food, which was published on 26 October 2020. That independent review was announced in August 2019, following the deaths of six people linked to an outbreak of listeria in contaminated food in hospitals. The review's aims were to improve public confidence in hospital food by setting out clear ambitions for delivering high-quality food to patients and the public. The review was intentionally limited to hospitals only because specific issues had been identified in relation to hospital foods that necessitated a prompt and meaningful response by the Government.

The report was prepared following considerable research, investigation, hospital visits and expert advice from within and outside the NHS specifically in relation to the provision of hospital food. The review recommended that ambitious NHS food and drink standards for patients, staff and visitors be put on a statutory footing. We support that recommendation and have included the clause in the Bill because we believe that giving the Secretary of State powers to place hospital food standards on a statutory footing sends a clear message about the importance of standards for the provision of good hydration and nutrition in the NHS. Covid-19 has highlighted the importance of good nutrition in recovery and rehabilitation, were such a reminder needed.

I reassure hon. Members that the Government are committed to the health and wellbeing of patients in all healthcare settings. Each setting presents unique issues and challenges. Although there may be some common themes, if the clause were to be broadened beyond hospitals, the provision of food in other healthcare settings would need to be researched, investigated and carefully considered in the context of those individual settings and in consultation with their service users and stakeholders to ensure that the legislation was fit for purpose and met their individual needs. Challenges affecting the provision of food in other healthcare settings were not considered as part of the scope for the independent review of hospital food. Therefore, although there are common themes, we cannot be sure that the amendment would adequately and fully meet their needs and requirements.

The recommendations from the review, and the introduction of the clause, form a key part of our policy to improve public confidence in hospital food. I commend the intention behind the amendments to expand the clause to capture all premises within the remit of the Care Quality Commission.

The CQC already has some important powers over other healthcare settings. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provide the CQC with powers to prosecute providers that do not provide people in their care with nutrition and hydration to sustain life and good health and reduce the risks of malnutrition and dehydration while they receive care and treatment. That power ensures that basic nutrition standards are provided.

The clause goes further and is not about basic provision. The root-and-branch independent review made recommendations on how NHS trusts could prioritise food safety and provide more nutritious meals to staff and patients. The clause is a key component of our plan to fulfil the recommendations of the review. I reassure hon. Members that the CQC remains vigilant about the provision of nutrition and hydration in other healthcare settings, as evidenced by the CQC's powers.

For these reasons, I urge the hon. Member for Nottingham North not to press the amendments. Ultimately, the clause cements the Government's commitment to patients in this regard and sends a clear message about the role that food plays in patient care and recovery. I commend it to the Committee.

Alex Norris: I appreciate the Minister's response. I understand that the genesis of the clause was a hospital setting. The case that the Minister mentioned was exceptionally serious, and it is right that action was taken, but I feel that there is a slight lack of ambition to say that the activity must stop at hospitals—it is a slightly blinkered approach. I heard the point that extending the provision to broader care settings would take research and careful consideration. I probably support that principle, but I would like to have heard that that process is under way, and I did not hear that.

At the end of the day, the goalposts do not move that much. Basic nutritional and hydration standards are either being met or they are not. Taking the learning from hospital settings should have made it easier to widen the process, rather than harder. The point that the CQC inspects those settings is true and fair. It is also true of hospital settings. Setting some standards would probably have been prudent. I will not press the amendment, but I think we will return to the issue at some point. I hope the Minister and his officials will reflect on the opportunity to go further with the provision .

Edward Argar: I am always happy to reflect on the sensible suggestions made by the hon. Gentleman.

Alex Norris: I am grateful for that and, on that basis, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 126 ordered to stand part of the Bill.

Clause 127

FOOD INFORMATION FOR CONSUMERS: POWER TO AMEND RETAINED EU LAW

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

Edward Argar: I can reassure the Committee that I will be a little briefer than in my remarks on clause 125.

Clause 127 amends the Food Safety Act 1990 to make provision for domestic legislation to modify retained EU regulation 1169/2011 concerning the labelling, marketing, presentation or advertising of food and the descriptions that may be applied to food. The current

powers to amend the regulation are limited in scope. This power will afford the Government an additional necessary lever to introduce domestic changes that better suit and support consumer needs and priorities for food information. We know that consumers want transparency and clear information about the food and drink that they are buying, and such information can inform people's choices. Scientific information and evidence on labelling and consumer needs continue to evolve. We want the ability to respond quickly to those changes and that changing evidence base as and when required.

Retained EU regulation 1169/2011 sets requirements on labelling and food information in the UK. It was designed to apply to EU member states. Now that we have left the EU, primary legislation is required to modify the retained legislation. Clause 127 will help us to settle this issue by conferring powers on the Secretary of State in England, and Ministers in Scotland and Wales, to modify requirements on food labelling using regulations. The regulations made under this power will be subject to the affirmative procedure, which will ensure that any changes introduced are debated and actively approved before implementation.

The clause will be vital in supporting the Government to deliver on a range of policies being developed as part of our obesity strategy, which includes commitments to consult on front-of-pack nutrition labelling and whether to mandate alcohol calorie labelling. The power will enable us to make improvements to food and drink information more effectively while retaining a level of scrutiny on any proposed changes. The clause can also help us to deliver on wider Government objectives, including options for the forthcoming food strategy White Paper, which sets Government ambitions and direction for food system transformation. I commend clause 127 to the Committee.

Alex Norris: The Minister and I have had these Brexit-type statutory instruments time and time again, so I am not going to get too involved in the conversations that we have had. As we said in the discussion on clause 146, we would like to see greater safeguards. We are glad about the use of the affirmative procedure but we do not think that there is a strong mandate for Ministers to march across the statute book. I hope to hear that this power will be used to the minimum extent necessary to implement the decisions that we have taken.

Edward Timpson: I want to put on record my support for the clause and for the opportunity that it presents for our domestic market and the promotion of locally grown produce, the high standards of animal welfare across the UK and our eco credentials. We do not want to make labelling too complicated for people—we want to make it accessible and simple to decipher—but this power is a chance to put that to the forefront so that consumers get produce that is good for them but also good for the UK market.

Edward Argar: I just want to give the shadow Minister the assurance he seeks that I believe that the powers under this clause would be used sparingly and proportionately.

Question put and agreed to.

Clause 127 accordingly ordered to stand part of the Bill.

Clause 128

FLUORIDATION OF WATER SUPPLIES

5 pm

Alex Norris: I beg to move amendment 149, in clause 128, page 108, line 22, at end insert—

"(za) in subsection (3)(a)(i), after "Secretary of State" insert "or relevant local authority";"

The Bill removes the ability of local authorities to commence fluoridation schemes and gives that ability to the Secretary of State. This amendment, together with Amendment 150, seeks to allow local authorities to commence schemes as well as the Secretary of State.

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

Amendment 150, in clause 128, page 108, line 26, after "Secretary of State" insert "or relevant local authority".

See explanatory statement to Amendment 149.

Amendment 151, in clause 128, page 108, leave out lines 33 to 36.

This amendment would remove the ability of the Secretary of State to pass the cost of fluoridation onto another public body.

Clause stand part.

Clause 129 stand part.

Alex Norris: I am really pleased that we have reached clauses 128 and 129, on fluoridation of water supplies. This is something that I am personally very enthusiastic about, so I want to make a few points on it. Fluoridation is a very important venture. Oral ill health can be a hidden and very personal but insidious ailment. It is the single biggest reason for hospital admission among our children. A 2015 review of children's dental health found that a quarter of five-year-olds have decayed teeth, with an average of 3.4 per child.

Dr Whitford: I wonder whether the hon. Member, like me, is surprised that the opportunity offered by this Bill has not been used to introduce a child dental health programme in England similar to Childsmile, which has existed in Scotland since 2007, or the scheme that Wales has had since 2011. Although there was agreement a couple of years ago to establish pilot sites across England, data on the impact in Scotland, where many areas had significantly poor dental health, has been available for four years. I am just surprised that something like that has not been included in this Bill, when we are talking improving the dental health of children and addressing the fact that, as the hon. Member mentioned, dental clearance—the removal of significant numbers of teeth—is the commonest reason to administer a general anaesthetic to a child. That is quite a shocking indictment.

Alex Norris: I am grateful for that intervention; I was going to turn to that issue next. Not only have opportunities been missed over the last decade to invest in oral health, but we are actually going backwards. Supervised tooth brushing and other high-quality evidence-based interventions, such as the models that the hon. Member mentioned, have disappeared because of this Government's cuts to the public health budget. Of course, the savings from those cuts are hoovered up very quickly by the costs that they generate elsewhere in the system. It is very sad, it results in a lot of pain and lost potential for the individual, and it is bad for the collective.

Fluoridation is one element in trying to put that right. Putting fluoride in our water is a really good, evidence-based intervention that is proven to work. For

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every pound spent in deprived communities, there are savings of nearly £13 within just five years, and of course every independent review of fluoridation has affirmed its safety. As a nation, we ought to be creating new fluoridation schemes targeted at the communities that would benefit the most. The current system does not work, as I remember well from my time in Nottingham. Currently, a local authority has to decide to enter into this space, build support, and then, with support from Public Health England and the Secretary of State, move to implementation. However, that generally fails for two reasons.

First, our political boundaries do not match up very accurately with our water boundaries, so where we would physically tip in the bag of fluoride does not fit with our political geographies. That creates issues between authorities such as mine, where the case would be very strong because of our oral health outcomes, and bordering authorities that would have less interest because they have better oral health outcomes. Secondly, this issue is contentious. Local authorities have an awful lot on, and it is very hard for a local council to make this the one totemic fight in its four-year term. There are only so many big things that a council can take on at once, and fluoridation gets beyond the bandwidth of local authorities.

We support the principle behind clause 128; bringing the Secretary of State into this is a very good idea. The position of the Secretary of State, once removed from the entire country, can make different geographic decisions sensibly align with water boundaries. He is perhaps also in a stronger position to help with some of the political issues, so in concept we support that.

Amendments 149 and 150 are a pair. Why are the Government keen to swap the current local system for one that is nationally driven, when we could have both? As I have said, we support adding the heft of the Secretary of State to the local expertise of our councils, but why remove councils from the process? Although clause 128 gives new powers to the Secretary of State, our argument is that local authorities should be able to retain their powers in the event that they might want to use them. This is a cost-free proposal. It merely expands the range of possible approaches and paths towards fluoridation, and it promotes local decision making.

Clause 128(2)(d), which inserts new subsection (6B) into section 87 of the Water Industry Act 1991, is a little bit naughty, and amendment 150 seeks to address it. According to page 43 of the Government's community water fluoridation toolkit, if a local community can successfully get itself together to get a scheme going, Public Health England is required to meet the reasonable capital and operating costs. I presume that that responsibility ported to the new Office for Health Improvement and Disparities when it came into force at the beginning of this month. However, subsection (6B) removes that provision and instead allows the Secretary of State to direct another body—I presume it will be the local authority—to pay for the scheme. Therefore, instead of being paid for nationally, the scheme will be paid for by a body chosen by the Secretary of State. That will be a barrier to the creation of a scheme.

I think that local authorities will be less keen to engage with the Secretary of State in implementing a scheme if they feel that they will have to pay for it. Their budgets are exceptionally stretched—I suspect they will not get much support tomorrow—and the benefits do not generally go back to local authorities. Of course, the benefit goes to the community in general, but in terms of organisations and cashable benefits, they would be health service benefits rather than local authority benefits. I do not think that the proposal promotes integrated thinking. The amendment seeks to address that, and I hope that the Minister will reflect on it. As I have said, I think that, broadly speaking, the clauses do the right thing, but their current effect will be to replace a locally led system with a nationally led one, when actually we could just have both.

To conclude, over the past year we have stood shoulder to shoulder with the Government in expressing to communities up and down the country that vaccines are not only safe but necessary. The objections that we receive come from those who argue in the face of evidence or who rely on conspiracy theories. The same is true of arguments against fluoridation. It is an evidence-based, safe and highly effective intervention. That is not to say that it is easy to do. It does not require behaviour change but it has a remarkable impact, so I am keen to hear from the Minister not only that the Government want to put this in the Bill, but that they want to get on with doing it in communities such as mine, which will benefit. If they do that, we will stand shoulder to shoulder with them again, and I think it will be an exceptionally important breakthrough in oral health in this country.

Edward Argar: The hon. Gentleman is absolutely right in the points he makes about fluoridation and the parallels he draws with the vaccine. Although there have been times over the past 20 months when he and I, and our respective Front-Bench teams, have not necessarily agreed on every aspect of the response to the pandemic—that is appropriate, as the Opposition seek to challenge and question the Government—may I pay tribute to him and his colleagues in the shadow health team for what they have done to highlight the importance of the vaccine and to counter the misinformation that some have spread about it?

I will speak to amendments 149 and 150 together, as the former is consequential on the latter. They would allow for local authorities to bring forward proposals for new fluoridation schemes and to enter into arrangements with water companies. As has been set out, tooth decay is a significant, yet largely preventable, public health problem. In 2019-20, more than 35,000 people aged 19 or under were admitted to hospital for the extraction of decaying teeth. In the same year, the cost of hospital admissions for tooth extractions among that age group was estimated to be £54.6 million.

As we know, fluoride is a naturally occurring mineral found in water and some foods, and at the right levels it has been shown to reduce tooth decay. If five-year-olds in England with low levels of fluoride drank water containing at least 0.7 mg of fluoride per litre, the number experiencing decay would fall by 28% in the most deprived areas, and the number of hospital admissions for tooth extractions due to decay would reduce by up to 68%.

We have seen no new water fluoridation schemes implemented for the past 40 years. Both major parties in the House must accept our responsibility for that.

That is not a fault of the NHS or local government, but because responsibility in our view has sat fundamentally at the wrong level for driving forward such a health intervention. Local authorities currently have the responsibility to initiate new water fluoridation schemes or to propose that existing schemes are varied or terminated. We have heard their frustration with the overly burdensome and complex processes in place for initiation and variation of schemes. The steps we are proposing to take through the Bill are intended to make it simpler to expand schemes. We all share the same ambition.

Transferring responsibility to central Government will allow us, for the first time, to move away from the limitations of local authority boundaries and to look more strategically across the country, to where oral health is the poorest. Subject to funding being agreed, we will be able to expand schemes across larger areas to make an impact on a bigger scale. We know it is less cost-efficient to operate schemes across individual local areas.Allowing local authorities to continue to bring forward schemes and to enter into arrangements with water companies separately would run counter to our ambitions to manage expansion at a higher level, again adding extra complexity, which we are eeking to remove.

We understand that some local authorities have begun the process to bring forward schemes, and we appreciate that they are passionate about their schemes and the benefits that they would bring to the populations they serve. I want to provide assurance that we share the ambition to expand schemes so that more of the population can benefit from water fluoridation, which we know is both safe and effective.

Any plans to expand schemes will of course take into account oral health across the country as well as areas that have already began to progress schemes. We want to engage and listen to local areas so that together we can make the biggest impact on oral health improvement that we know fluoridation will provide. For those reasons, I ask the hon. Member for Nottingham North to consider withdrawing his amendment.

On amendment 151, we are taking powers in the Bill to remove the operational burden associated with bringing forward new schemes. Prior to 2013, both the NHS and local authorities had, at different times, responsibility for funding both revenue and the capital cost associated with fluoridation schemes. There are no current proposals for cost sharing, but given the cycle of legislation and the infrequency with which such opportunities present themselves, we have taken the decision to include such measures in the Bill.

We have discussed the provisions with both NHS England and NHS Improvement and the Local Government Association, and I can assure the Committee that should we bring forward any plans to cost share in the future, we would seek to fully engage with relevant groups at the earliest opportunity. Under the Bill, any plans to cost share with public sector bodies would be subject to regulations on which there is a requirement to consult.

A precedent has been set over the decades for the funding of water fluoridation schemes. We believe that, to move forward, it would be best to have the flexibility to work collaboratively across industry and the public sector to effect what could be the most significant improvements in oral health that we have seen to date. For those reasons, I ask the hon. Member for Nottingham North to consider not pressing the amendment to a Division.

Clause 128 would transfer the power to initiate, vary or terminate water fluoridation schemes to the Secretary of State. The clause also allows for the Secretary of State to make regulations that will enable the sharing of costs for fluoridation schemes with water undertakers and/or public sector bodies that may receive benefit from such schemes. However, before making any such regulations, the clause imposes a duty on the Secretary of State to consult. The clause also requires the Secretary of State to consult water undertakers on whether any proposal for new fluoridation schemes, or whether any termination or variation of an existing scheme, is operable and efficient prior to undertaking any public consultation, for which there will also continue to be a duty.

The clause requires us to set out in regulations the process for consulting the public, for example on any new proposed schemes. That will ensure that those affected will continue to have a voice. In September, the chief medical officers for England, Scotland, Wales and Northern Ireland made a joint statement confirming that water fluoridation is an effective public health intervention for improving the oral health of adults and children. Such schemes have been in operation for more than 60 years, and no credible evidence that they cause health harms has emerged. It is time we take action that will enable us to reduce the oral health inequalities across the country, and I commend clause 128 to the Committee.

I turn briefly, and finally, to clause 129. We have a number of existing water fluoridation schemes across England that have been in place for decades. We want to ensure that those existing arrangements can be treated in the same way as any new schemes created using the powers in clause 128. Clause 129 simply provides for the existing arrangements to be treated as if they were made under the new statutory regime for fluoridation. The clause also provides that all previous England fluoridation arrangements shall be treated as if they were entered into between the Secretary of State and the water undertaker. The Secretary of State has the power to modify the detail of these existing arrangements to give effect to this, provided he first seeks to agree the modifications with the water undertaker.

I therefore commend these clauses to the Committee.

Alex Norris: I take the Minister's point about current powers. I agree that they are clearly at the wrong level, because these schemes simply are not coming through, so the system is obviously not working. As I say, I would rather we added what we are putting in the Bill today to what we already have, but I have probably made my point, so I do not intend to press amendments 149 or 150 to a Division.

The Minister has made the point that there are currently no schemes in the system. I hope that when it decides which schemes to prioritise or pilot, the Department might at least look fondly on local authorities—such as the city of Nottingham—that have made such commitments in their council plans.

Finally, on amendment 151, I have heard what the Minister said about cost sharing. That gave me some comfort, so I will not press that amendment to a Division either. I beg to ask leave to withdraw amendment 149.

Amendment, by leave, withdrawn.

Clauses 128 and 129 ordered to stand part of the Bill.

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

5.17 pm

Adjourned till Wednesday 27 October at twenty-five minutes past Nine o'clock.

Written evidence reported to the House

HCB107 Equality and Human Rights Commission

HCB108 Action on Salt and Action on Sugar (joint submission)

HCB109 The Incorporated Society of British Advertisers (ISBA); the Institute of Practitioners in Advertising (IPA); the Internet Advertising Bureau (IAB); and the Food and Drink Federation (FDF) (joint submission)