# PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

## Public Bill Committee

# HEALTH AND CARE BILL

*Eighteenth Sitting*

*Wednesday 27 October 2021*

*(Morning)*

CONTENTS

Clauses 130 to 135 agreed to.
New clauses under consideration when the Committee adjourned till this day at Two o'clock.

No proofs can be supplied. Corrections that Members suggest for the final version of the report should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor's Room, House of Commons,

**not later than**

**Sunday 31 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

*Wednesday 27 October 2021*

*(Morning)*

[Mrs Sheryll Murray *in the Chair*]

## Health and Care Bill

9.25 am

**The Chair:** Before we resume, it might be helpful for me to give the Committee a few preliminary reminders. Please switch all electronic devices to silent. No food or drink are permitted during sittings of the Committee except for the water provided.

I encourage Members to wear masks when they are not speaking, in line with current Government guidance and that of the House of Commons Commission. Please also give each other and members of staff space when seated and when entering or leaving the room. *Hansard* colleagues would be grateful if Members could email their speaking notes to hansardnotes@parliament.uk.

I remind Members and staff that they are asked by the House to take a covid lateral flow test twice a week if they are coming on to the parliamentary estate. That can be done either at the testing centre in the House or at home.

### Clause 130

Power to make consequential provision

**Dr Philippa Whitford** (Central Ayrshire) (SNP): I beg to move amendment 114, in clause 130, page 111, line 15, at beginning insert "Subject to subsection (4),".

*This amendment is consequential on Amendment 115.*

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

Amendment 115, in clause 130, page 111, line 25, at end insert—

"(4) Regulations may only be made under this section with the consent of—

(a) the Scottish Ministers insofar as they make provision for any matter which falls within the legislative competence of the Scottish Parliament,

(b) the Welsh Ministers insofar as they make provision for any matter which falls within the legislative competence of Senedd Cymru, and

(c) The Northern Ireland Ministers insofar as they make provision for any matter which falls within the legislative competence of the Northern Ireland Assembly."

*This amendment would require the Secretary of State for Health and Social Care to obtain the consent of the relevant devolved government before powers in this clause falling within the legislative competence of a devolved institution are exercised.*

Clause stand part.

Clauses 131 to 135 stand part.

**Dr Whitford:** I rise to speak to amendment 115, which is the main amendment. Amendment 114 is consequential on it. The amendment comes back to the main theme: the clause contains significant Henry VIII powers for the Secretary of State to change the Bill or any Act of the devolved Parliaments relating to it.

When the Minister rises to speak, he will say that the power is only for tiny things such as changing names or tidying up, but the Bill is so extensive that the power to introduce some of the themes and policies contained in it into the NHS in Scotland is something that people in Scotland—and, I am sure, in Wales and Northern Ireland—would not be happy with. There is no limitation to this power.

Again, there is no mention of consulting, let alone consenting. It has been the convention for over two decades that if the UK Government legislate in clearly devolved areas, there should be legislative consent. Before this Henry VIII power is used by a Secretary of State, legislative consent should be sought from the devolved Parliaments in Scotland, Wales and Northern Ireland.

**The Chair:** I call the shadow Secretary of State—sorry, the shadow Minister.

**The Minister for Health (Edward Argar):** Ah, a promotion—almost.

**Justin Madders** (Ellesmere Port and Neston) (Lab): Mrs Murray, it really is a pleasure to serve under your chairmanship this morning. I echo the comments from the Scottish National party spokesperson. She is correct that the Bill gives the Secretary of State extensive powers—almost carte blanche in some areas—to change the law. We think that taking back control means Parliament taking back control. Elected politicians are meant to serve the people, not the other way round. Some very valid points have been made about the themes and issues across the Bill, and we echo those.

**Edward Argar:** It is a pleasure to see you in the Chair again, Mrs Murray, and to hear of the inadvertent promotion of the shadow Minister. I am sure it is only a matter of time, certainly if his longevity in his current post and being master of his brief are anything to go by.

I am grateful to the hon. Member for Central Ayrshire for raising this matter. I will address amendments 114 and 115 together, as one is consequential on the other, and then I will address the clauses. As the hon. Lady rightly says, she has raised this matter with me not only in this Committee but outwith it. I would have been surprised had she not wished to air it in Committee, which is exactly what we are here for.

The amendments would require the Secretary of State to seek the consent of Ministers of the relevant devolved Administrations before making a consequential amendment to any matter that falls within the competence of the devolved legislature. Provisions such as clause 130—she suggested I might say this—are perfectly common in UK Acts of Parliament, and we believe they remain within the spirit of the devolution settlement. The UK Government's clear position is that, in and of itself, clause 130 would not give rise to the legislative consent motion process, for reasons that I will set out. We deem that a requirement for the consent of the DAs for its use would therefore be inappropriate.

This power will enable the UK Government to make consequential amendments that might be necessary following the passage of the Bill. That includes most of the amendments that need to be made to secondary legislation as a consequence of the Bill's provisions As such, amendments were not included in the Bill. There may also be minor changes, such as amendments to

names of particular bodies—the hon. Lady knows me and the position that Her Majesty's Government take on these things extremely well—as a result of measures in the Bill.

It is also prudent to retain the power to amend legislation in the event that anything has been missed. It is important for everyone concerned that we have the ability to make such amendments should they be needed to ensure that the legislation works as intended and that we are able to do so quickly, as required.

As I said, this power is quite common in UK legislation, particularly in a Bill as large as the Health and Care Bill, which—as we know, as we reach the end of the current set of clauses—comprises 135 clauses and 16 schedules. There are many examples of similar powers to clause 130 in existing legislation. Perhaps the one with the greatest relevance, giving the most directly analogous example, is section 303 of the Health and Social Care Act 2012.

As a general principle, it is appropriate that the authority passing the legislation makes the consequential provisions that flow from it, as that authority will be most familiar with the provisions of the legislation and the changes to other legislation that it necessitates. We are seeking legislative consent from the devolved Administrations in respect of a number of provisions in the Bill and we have debated those in recent days, but clause 130 does not, in and of itself, give rise to the LCM process. It is the substantive provisions in the Bill, on which any amendments under clause 130 would be consequential, that do or do not, as the case may be, give rise to the LCM process.

Finally, although this power will enable the UK Government to make consequential amendments to devolved legislation, in practice, any amendments would be discussed with the DAs, officials and legal advisers prior to and throughout the drafting process. These arrangements follow wider good practice and expectations of collaborative working.

**Dr Whitford:** Will the Minister give way?

**Edward Argar:** Yes, but I am not sitting down just yet, so the hon. Lady will have more opportunities to intervene.

**Dr Whitford:** I just remind the Minister that the Cabinet Secretaries in the devolved nations saw this huge Bill the day before it was launched, so although there may have been engagement with officials, that does not suggest that there was engagement with the Governments, which he is saying we should depend on, along with close working.

**Edward Argar:** I take the hon. Lady's point but, on engagement with officials, I would argue that it is in a sense a matter for officials in the Scottish Government whether they communicate with the Cabinet Secretary. They were not prohibited from doing so. I will not go into the inner workings of the Holyrood machine, just as, I suspect, the hon. Lady would not wish to go into the inner workings of the Department of Health and Social Care. However, that dialogue has taken place since February this year. I appreciate that there has been a slight challenge with that, given the Holyrood elections and purdah, where, although officials can continue to talk, there was rightly a bit of stepping back at a political level so that democracy could take its course. It took its course and the same party continues to run Scotland, so those conversations resumed. My point is that those discussions at official level have been long standing and extensive, I would hope. I suspect that officials have shared elements with the Cabinet Secretary—perhaps not the entirety, but they have been very much engaged.

I hope that that explanation provides some reassurance to hon. Members, although I suspect that it may not. I suspect that the hon. Lady anticipated that explanation, and it may therefore not add further reassurance, but I hope that it does to a degree.

Let me move on to clauses 130 to 135 stand part of the Bill. As we heard in the foregoing debate, clause 130 allows the Secretary of State to make provision by regulations, which is consequential on the Bill. The Bill contains a significant change to the legal framework of the health service. As a result, numerous consequential amendments to other pieces of primary and secondary legislation are required to reflect those changes.

The power is limited to making amendments consequential to the competence of the Bill and is therefore a narrow power. It is, as I said, a standard provision in a Bill of this size and complexity. A considerable amount of secondary legislation will require amendment following the merger of NHS England and NHS Improvement and the change from clinical commissioning groups to integrated care boards. It would not be appropriate to use primary legislation to list all of those secondary legislative changes. Therefore, the consequential power will be used to make such changes in secondary legislation.

The power extends to making consequential amendments to primary legislation passed by the devolved legislatures, because devolved legislation contains references to UK legislation or bodies that may need to be amended in consequence of this Bill. The power applies only to existing primary legislation—this Bill itself, or primary legislation passed during this Session—and therefore future primary legislation may not be amended under the power conferred by this provision.

Clause 131, again, is a common part of a Bill. It sets out the scope of regulation-making powers in the Bill generally and the parliamentary procedure for making such regulations. Subsection (1) provides that regulations made under the Bill may include

"consequential, supplementary, incidental, transitional or saving provision"

and can make

"different provision for different purposes."

Subsections (3) and (4) set out the parliamentary procedure for making regulations under this legislation.

Clause 132 is also a standard clause concerning financial provision. It simply provides that any expenditure incurred by the Secretary of State under the Act shall be paid out of the consolidated fund, in accordance with the Supply and Appropriation (Main Estimates) Act 2021.

Clause 133 sets out the territorial extent of the provisions of the Bill. It provides that while most of the provisions in the Bill extend only to England and Wales, a small number extend UK-wide. In addition, the bulk of the England and Wales-only provisions—in particular, the vast majority of part 1—will in fact apply only in England, as they concern the health service in England only. The following provisions, listed in subsection (2), extend to England, Wales, Scotland and Northern Ireland:

*[Edward Argar]*

the renaming of NHS England in paragraphs 1(3) and 1(4) of schedule 1; the Secretary of State's powers to transfer and delegate functions in part 3 of the Bill; and the carve-out of the health services safety investigations board from any legislative provision to require disclosure of information in clause 109.

In addition, the amendments to other legislation made by the Bill will have the same territorial extent as the provision that is being amended. Examples of this include clause 120, which makes provisions about reciprocal healthcare arrangements, and clause 85, which allows provision to be made for the establishment of medicines information systems. A full analysis of territorial extent and application in the UK can be found in the explanatory notes. In earlier sittings, we debated the consequences of the Bill in Wales, Scotland and Northern Ireland and any issues relating to devolution as and when they have arisen. I suspect we may return to those issues on Report, and that their lordships may wish to debate them in the other place.

Clause 134 sets out when the provisions in the Bill will come into force once it has been passed. Most of the Bill will be brought into force on a date to be set in regulations, as provided for in subsection (3). Again, that is a common approach for a Bill of this type, and allows for flexibility. While the Government are committed to implementing the vital reforms to the health service that are contained in the Bill, we will be able to confirm the precise date on which provisions will come into force when it has completed its parliamentary passage—clearly, we cannot pre-empt Parliament. It is likely that it will be appropriate to bring different provisions of the Bill into force at different times.

Finally, clause 135 provides that, once passed, the Bill may be cited as the Health and Care Act 2021. I therefore commend these clauses to the Committee.

**Dr Whitford:** I appreciate that the vast majority of consequential changes that might be made by the Secretary of State would be minor, and most of them would apply to England. However, I am sure the Minister will also understand that the United Kingdom Internal Market Act 2020, which has taken away powers over certain aspects of public health, environmental control, infrastructure and so on, is felt in Scotland as a direct threat to devolution. Such clauses are therefore seen as threatening, in that the Bill is so big that it would allow extensive consequential amendments, particularly—as the Minister referred to himself—under clause 131(1)(b), which allows for

"different provision for different purposes."

Many Opposition Members find the undefined scope disquieting, and we have seen this extensively over the past three years. I would therefore wish to press amendment 114 to a Division.

*Question put,* That the amendment be made.

*The Committee divided:* Ayes 6, Noes 9.

**Division No. 35]**

**AYES**

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

**NOES**

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

*Question accordingly negatived.*

*Clauses 130 to 135 ordered to stand part of the Bill.*

**The Chair:** That completes line-by-line consideration of the existing clauses of the Bill, and we will now consider new clauses. New clauses that were grouped for debate with amendments to the Bill will not be debated again, but if the Member who tabled the new clause indicated in their speech that they wished to divide the Committee, they will have the opportunity to do so. I remind Members who wish to press a grouped new clause to a Division that they should indicate their intention when speaking to the clause. We start with Government new clause 59, which was debated yesterday.

## New Clause 59

CARE QUALITY COMMISSION REVIEWS ETC OF INTEGRATED CARE SYSTEM

"(1) Chapter 3 of Part 1 of the Health and Social Care Act 2008 (quality of health and social care) is amended as follows.

(2) After section 46A (inserted by section 121 of this Act) insert—

'46B Reviews and performance assessments: integrated care system

(1) The Commission must, in accordance with this section—

(a) conduct reviews of—

(i) the provision of relevant health care, and adult social care, within the area of each integrated care board, and

(ii) the exercise of the functions of the following in relation to the provision of that care within the area of each integrated care board: the board; its partner local authorities; and registered service providers,

(b) assess the functioning of the system for the provision of relevant health care, and adult social care, within the area of each integrated care board (taking into account, in particular, how those mentioned in paragraph (a)(ii) work together), and

(c) publish a report of its assessment.

(2) The Secretary of State—

(a) must set, and may from time to time revise, objectives and priorities for the Commission in relation to assessments under this section, and

(b) must inform the Commission of the objectives and priorities.

(3) The Commission—

(a) must determine, and may from time to time revise, indicators of quality for the purposes of assessments under this section, and

(b) must obtain the approval of the Secretary of State in relation to the indicators.

(4) The Secretary of State may direct the Commission to revise the indicators under subsection (3).

(5) Different objectives and priorities may be set, and different indicators of quality may be determined, for different cases.

(6) The Commission—

(a) must prepare, and may from time to time revise, a statement—

(i) setting out the frequency with which reviews under this section are to be conducted and the period to which they are to relate, and

(ii) describing the method that it proposes to use in assessing and evaluating the functioning of the system for the provision of relevant health care, and adult social care, within the area of an integrated care board, and

(b) must obtain the approval of the Secretary of State in relation to the statement.

(7) The statement may—

(a) make different provision about frequency and period of reviews for different cases, and

(b) describe different methods for different cases.

(8) Before preparing or revising a statement under subsection (6) the Commission must consult—

(a) NHS England, and

(b) any other persons it considers appropriate.

(9) The Secretary of State may direct the Commission to revise the statement under subsection (6).

(10) The Commission must publish—

(a) the objectives and priorities under subsection (2),

(b) the indicators of quality under subsection (3), and

(c) the statement under subsection (6).

(11) For the purposes of this section—

"adult social care" means social care for individuals aged 18 or over;

"partner local authority", in relation to an integrated care board, means any English local authority whose area coincides with, or includes the whole or any part of, the area of the integrated care board;

"registered service provider" means a person registered under Chapter 2 as a service provider;

"relevant health care" means—

(a) NHS care, or

(b) the promotion and protection of public health.

(12) Regulations may amend the definition of "relevant health care" to include health care which is provided or commissioned by a public authority (but which does not amount to NHS care).'

(3) In section 48 (special reviews and investigations), in subsection (2), after '46A' (inserted by section 121 of this Act) insert 'or 46B'.

(4) In section 50 (failings by English local authorities), in subsection (1), after '46A' (inserted by section 121 of this Act) insert 'or 46B'.

(5) In section 162 (orders and regulations: parliamentary control), in subsection (3), after paragraph (c) insert—

'(c) regulations under section 46B(12) (amendment of definition of relevant health care),'."—*(Edward Argar.)*

*This new clause imposes a duty on the Care Quality Commission to carry out reviews and assessments into the overall functioning of the system for the provision of NHS Care and adult social care services within the area of each integrated care board.*

*Brought up, read the First and Second time, and added to the Bill.*

## New Clause 60

### Default powers of Secretary of State in relation to adult social care

"(1) In section 7D of the Local Authority Social Services Act 1970 (default powers of Secretary of State as respects social services functions of local authorities)—

(a) in subsection (1), for the words from 'imposed' to '2002'substitute 'referred to in subsection (4)';

(b) after subsection (3) insert—

'(4) Subsection (1) does not apply in relation to a duty imposed by or under—

(a) the Children Act 1989,

(b) section 1 or 2(4) of the Adoption (Intercountry Aspects) Act 1999,

(c) the Adoption and Children Act 2002, or

(d) Part 1 of the Care Act 2014.'

(2) The Care Act 2014 is amended in accordance with subsections (3) and (4).

(3) After section 72 insert—

*"Default by local authority*

72A Default power of Secretary of State

(1) Where the Secretary of State is satisfied that a local authority is failing, or has failed, to discharge any of its functions under or by virtue of this Part to an acceptable standard, the Secretary of State may give to the local authority any directions that the Secretary of State considers appropriate for the purpose of addressing the failure.

(2) The directions may include provision requiring the local authority—

(a) to act in accordance with advice given by the Secretary of State or a person nominated by the Secretary of State,

(b) to collaborate with the Secretary of State or a person nominated by the Secretary of State in taking steps specified in the directions, or

(c) to provide the Secretary of State or a person nominated by the Secretary of State with information of a description specified in the directions, on request or otherwise.

(3) If the Secretary of State considers it necessary for the purpose of addressing the failure, the directions may include provision—

(a) for specified functions of the local authority to be exercised by the Secretary of State or a person nominated by the Secretary of State for a period specified in the direction or for so long as the Secretary of State considers appropriate, and

(b) requiring the local authority to comply with any instructions of the Secretary of State or the nominee in relation to the exercise of the functions.

(4) So far as is appropriate in consequence of directions given by virtue of subsection (3), a reference (however expressed) in an enactment, instrument or other document to a local authority is to be read as a reference to the person by whom the function is exercisable.

(5) If directions given by virtue of subsection (3) expire or are revoked without being replaced then, so far as is appropriate in consequence of the expiry or revocation, a reference (however expressed) in an instrument or other document to the person by whom the function was exercisable is to be read as a reference to the local authority to whom the directions were given.

(6) The Secretary of State may, for the purposes of cases in which directions are given under subsection (3)(a), make regulations disapplying or modifying an enactment which confers a function on the Secretary of State in respect of a function of a local authority.

(7) Directions under this section may require the local authority to provide financial assistance to the Secretary of State, or a person nominated by the Secretary of State, for the purpose of meeting costs incurred by the Secretary of State or the nominee as a result of the directions.

72B Default power of Secretary of State: supplementary

(1) Before giving directions under section 72A the Secretary of State must give the local authority concerned an opportunity to make representations about the proposed directions, except so far as the Secretary of State considers that it is impractical to do so for reasons of urgency.

(2) The power to give directions under section 72A includes a power to vary or revoke the directions by subsequent directions.

(3) Subsection (1) does not apply in relation to proposed directions varying previous directions if the Secretary of State does not consider the variations to be significant.

(4) Directions under section 72A must be in writing.

(5) The Secretary of State must publish—

(a) any directions given under section 72A, and

(b) the reasons for giving them.

(6) Directions under section 72A are enforceable, on the Secretary of State's application, by a mandatory order."

(4) In section 125(4) (regulations and orders subject to affirmative procedure), after paragraph (k) insert—

'(ka) regulations under section 72A(6) (modification of enactments where local authority functions are exercised by the Secretary of State or a nominee);'."—*(Edward Argar.)*

*This new clause would create a new power for the Secretary of State to intervene where local authorities are failing in the exercise of functions under Part 1 of the Care Act 2014 (adult social care) and make consequential amendments.*

*Brought up, and read the First time.*

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

*The Committee divided:* Ayes 9, Noes 5.

**Division No. 36]**

**AYES**

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

**NOES**

| | |
|---|---|
| Foy, Mary Kelly | Owen, Sarah |
| Madders, Justin | |
| Norris, Alex | Smyth, Karin |

*Question accordingly agreed to.*

*New clause 60 read a Second time, and added to the Bill.*

9.45 am

## New Clause 61

CARE QUALITY COMMISSION'S POWERS IN RELATION TO LOCAL AUTHORITY FAILINGS

"(1) The Health and Social Care Act 2008 is amended as follows.

(2) In section 48 (special reviews and investigations), in subsection (6) omit 'or (3)'.

(3) In section 50 (failings by English local authorities)—

(a) in subsection (2), in the words before paragraph (a), omit 'subject to subsection (3)'; for subsections (3) and (4) substitute—

'(3A) Nothing in subsection (2) prevents a report published under section 46(1)(c), 46A(1)(c), 46B(1)(c) or 48(4) from specifying respects in which the Commission considers a local authority to be failing and making recommendations to the local authority for addressing the failure.'"—*(Edward Argar.)*

*This new clause would remove the power of the Care Quality Commission under section 50 of the Health and Social Care Act 2008 to give a notice of failure to an English local authority.*

*Brought up, and read the First time.*

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

*The Committee divided:* Ayes 9, Noes 5.

**Division No. 37]**

**AYES**

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

**NOES**

| | |
|---|---|
| Foy, Mary Kelly | Owen, Sarah |
| Madders, Justin | |
| Norris, Alex | Smyth, Karin |

*Question accordingly agreed to.*

*New clause 61 read a Second time, and added to the Bill.*

## New Clause 62

PHARMACEUTICAL SERVICES: REMUNERATION IN RESPECT OF VACCINES ETC

"(1) Section 164 of the National Health Service Act 2006 (remuneration for persons providing pharmaceutical services) is amended as follows.

(2) In subsection (8A) for 'special medicinal products' substitute 'any of the following—

(a) drugs or medicines used for vaccinating or immunising people against disease,

(b) anything used in connection with the supply or administration of drugs or medicines within paragraph (a),

(c) drugs or medicines, not within paragraph (a), that are used for preventing or treating a disease that, at the time the regulations are made, the Secretary of State considers to be a pandemic disease or at risk of becoming a pandemic disease,

(d) anything used in connection with the supply or administration of drugs or medicines within paragraph (c), or

(e) a product which is a special medicinal product for the purposes of regulation 167 of the Human Medicines Regulations 2012 (S.I. 2012/1916).'

(3) In subsection (8D)—

(a) for 'special medicinal products are' substitute 'anything within subsection (8A)(a) to (e) is';

(b) in paragraph (b), for 'special medicinal products' substitute 'that thing,'.

(4) In subsection (8E), omit the definition of 'special medicinal product'.

(5) After subsection (8E) insert—

'(8F) Where regulations include provision made in reliance on subsection (8A)(c) or (d) and the Secretary of State considers that the disease to which it relates is no longer a pandemic disease or at risk of becoming a pandemic disease, the Secretary of State must revoke that provision within such period as the Secretary of State considers reasonable (taking into account, in particular, the need for any transitional arrangements).'"—*(Edward Argar.)*

*This new clause expands a power to make regulations under section 164 of the National Health Services Act 2006 (which, among other things, provides for circumstances in which no remuneration needs to be paid to persons who provide pharmaceutical services in respect of products because they are supplied by a health service body).*

*Brought up, and read the First time.*

**Edward Argar:** I beg to move, That the clause be read a Second time.

New clause 62 adds to section 164 of the National Health Service Act 2006, enabling regulations to be made that would allow further products to be centrally stocked and supplied free of charge to community pharmacies without the need for reimbursement under the standard NHS arrangements. This would allow Ministers to create limited additional exemptions to the exemptions that can already be created by the regulation-making power introduced in 2017 for unlicensed medicines, more commonly known as "specials".

As was recognised in 2017, the legislative framework for pharmaceutical remuneration established by section 164 is predicated on the basis that community pharmacies will be reimbursed for the products they supply. Unique conditions required the unlicensed specials medicines amendment to be tabled in 2017 due to an unconventional supply chain. Unusually, there was no competition and, therefore, no incentive for community pharmacies to seek value for money for unlicensed medicines.

Under normal conditions, a virtuous competitive circle would encourage community pharmacies to try to source the lowest cost product and, in doing so, force overall prices down. The 2017 amendment allowed for regulations to be made so that the process of sourcing the relevant products could be by central procurement and subsequently there could be direct supply to community pharmacies. No such regulations have yet been made, but the matter remains under review.

The amendment only seeks to further add, in a limited way, to the current powers to make regulations to provide for an exemption from the ordinary requirement to reimburse. The only products that it will cover are vaccines, pandemic treatments, and associated products such as diluents and syringes. There are various reasons why we may seek to procure centrally vaccines or products used to treat a pandemic, for example when the typical competitive supply chain and reimbursement arrangements cannot be relied on, because pressures from global demand mean that central purchasing and direct supply to community pharmacies is critical to maintaining continuity of supply for UK patients.

In those circumstances, if centrally purchased products, rather than being supplied directly to pharmacies, were sold to wholesalers, that would risk wholesalers exporting or selling the stock at a much higher price than is usually paid, thereby playing the market. In this example, that would defeat the original purpose of the central stockpile.

When supplying products directly to pharmacies free of charge, we do not want to reimburse pharmacies as well as purchasing the stock, as that would mean the Government or taxpayer paying twice. Currently, as I have indicated, the legislative framework only makes provision for the reimbursement price of specials to be set at zero. We are restricting those to vaccinations and immunisations, medicinal products used for the prevention or treatment of disease in a pandemic, and associated products. By carving out these niche, critical—but understandable, I hope—exceptions in the legislation in that way, we recognise the importance of not undermining the supply and reimbursement arrangements more generally and broadly across the piece. Furthermore, the legislation will also ensure that in the case of pandemic treatments, once the disease is no longer a pandemic, the appropriate arrangements will be put in place to transition back to normal supply and payment arrangements.

The new clause is important to ensure that centrally purchased stock of essential medicines intended for patients in England can be distributed to community pharmacies to meet clinical need and support patient access, whether that applies to a vaccination or treatment in connection with a pandemic. For those reasons, I ask the Committee to support the new clause.

**Alex Norris** (Nottingham North) (Lab/Co-op): It is a pleasure to serve again with you in the Chair, Mrs Murray. As I said yesterday, we are grateful for the Minister writing with his explanation of this and the other new clauses ahead of time. That was helpful.

As the Minister explained in his letter, the new clause will simplify and safeguard the process of remuneration where the Government centrally procures vaccines, immunisations or products used to treat a pandemic, as well as other listed products, replacing "special medicinal products" under the previous legislation, in particular when there is significant international demand. That is very topical and we have a rich understanding of it given the events of the past 18 months, so it makes sense to the Opposition and we will not dwell on it long, nor will we press the new clause to a division. However, I seek clarity from the Minister on a couple of issues.

In the Minister's letter, he cited the risk of wholesalers exporting the products or selling them at a much higher price if they were fed into the conventional supply chain. He characterised that as market failure. Community pharmacies would then be claiming reimbursement from the NHS based on the drug tariff determinations. I do not doubt the risk of that, and it is a foreseeable one, but am keen to hear from the Minister whether he is able to quantify the risk or demonstrate examples in either case. For example, during this pandemic, did that happen at the beginning? What was the cost if that took place? Have there been examples of profiteering preventing necessary products from reaching the patients for which they were intended?

In a second point, I am curious about the arrangements put in place to transition back to normal payment arrangements, once the disease in question is no longer pandemic or at risk of becoming pandemic. Again, I think we would always want restoration of normal circumstances at the first appropriate moment. In his letter, the Minister describes the arrangements as "appropriate", while the new clause reads:

> "Where…the Secretary of State considers that the disease to which it relates is no longer a pandemic disease or at risk of becoming a pandemic disease, the Secretary of State must revoke that provision within such period as the Secretary of State considers reasonable".

Given that section 164 of the National Health Service Act 2006 also allows the Secretary of State to determine remuneration, that feels a little like the Secretary of State being allowed to mark their own homework. It could leave such measures in place for as long as suits them, rather than for as long as necessary, because the only determination of their need sits with that person. Will the Minister offer some reassurance that the power is for an emergency and is exceptionally limited, and give the Committee some comfort about the oversight

*[Alex Norris]*

and how Parliament perhaps will be given the chance to challenge the Secretary of State, so that the measures are not kept in place for any longer than necessary?

**Dr Whitford:** I have a small comment following on from the hon. Gentleman, who was asking for evidence of profiteering on specials. I was on the Committee considering the Health Service Medical Supplies (Costs) Act 2017 and brought the issue of specials before the Committee. These are often personalised medicines. In Scotland, they are produced centrally by the NHS, but there is certainly huge evidence of profiteering on them within NHS England, with hundreds of pounds being charged for simple ointments. While we may not have evidence on vaccines, evidence of profiteering on specials is long standing.

**Edward Argar:** I am grateful to the hon. Lady for helping to reduce the number of the shadow Minister's questions that I need to answer. The hon. Lady makes her point well. We saw early on in the pandemic the challenges of a globally competitive market and the incentives and disincentives that can create around supply. I will not go into other aspects of supplies purchased for the NHS during the pandemic, but we have seen what happens when a market becomes super-saturated with demand versus a very limited supply, hence why we believe the steps in the new clause are prudent.

The shadow Minister will be familiar with approach in the new clause; it was used, for example, for covid vaccines, which were centrally secured and supplied directly to pharmacies. While we felt that supply could be justified on the basis of conventions of statutory interpretation that allowed us necessary flexibility in those exceptional circumstances, we think it is appropriate that we put such measures on a proper legal footing—through debate and, if necessary, Division in the House—to future-proof our arrangements. We are not trying to radically alter NHS pharmaceutical service provision or the payment mechanism. The aim is actually to strengthen the legal basis, and indeed the democratic oversight of that legal basis, through this debate in this Committee, for scenarios in which usual supply routes need to be bypassed.

The shadow Minister also raised a couple of other points, mainly about the Secretary of State's power and Parliament's role going forward, if I may paraphrase it in that way. I take his point. Judgments will obviously be based on advice from officials and legal and scientific advisers, but to a degree it is in the nature of ministerial accountability that there is an element of subjectivity when the Secretary of State is obliged to make a judgment. I appreciate the point, which I echoed in my remarks, on the need to turn these arrangements off or transition out of them as swiftly as possible, but we can see this pandemic declining and coming back at various times—that is the nature of the lifecycle of a pandemic; there are ups and downs before it finally burns itself out—and therefore the Secretary of State will ultimately need a degree of discretion and subjectivity in their judgment about the right moment, although obviously they will take advice.

On the House's ability to challenge that, as the shadow Minister will possibly expect me to say, he and his colleagues and other Members will have ample opportunity, not only at Question Time but also, as I have discovered, through urgent questions, which I have answered on behalf of colleagues in the Government on occasion. There are plenty of opportunities for Members to summon Ministers to the Dispatch Box, or through written questions, to challenge and to probe and hold Ministers to account. I hope that hon. Members feel that this is a pragmatic and proportionate measure to address something we have identified in the course of the pandemic as needing resolution, and in so doing to put it on a surer and clearer statutory footing.

*Question put and agreed to.*

*New clause 62 accordingly read a Second time, and added to the Bill.*

## New Clause 1

PROHIBITION OF VIRGINITY TESTING

"(1) A person is guilty of an offence if they attempt to establish that another person is a virgin by making physical contact with their genitalia.

(2) A person is guilty of an offence if they provide another person with a product intended for the purpose, or purported purpose, of establishing whether another person is a virgin.

(3) A person is guilty of an offence if they aid, abet, counsel or procure a person to establish that another person is a virgin by making physical contact with their genitalia.

(4) No offence is committed by an approved person who performs—

(a) a surgical operation on a person which is necessary for their physical or mental health; or

(b) a surgical operation on a female who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.

(5) The following are approved persons—

(a) in relation to an operation falling within subsection (4)(a), a registered medical practitioner; and

(b) in relation to an operation falling within subsection (5)(b), a registered medical practitioner, a registered midwife or a person undergoing a course of training with a view to becoming such a practitioner or midwife.

(6) There is also no offence committed by a person who—

(a) performs a surgical operation falling within subsection (4)(a) or (b) outside the United Kingdom; and

(b) in relation to such an operation exercises functions corresponding to those of an approved person.

(7) For the purpose of determining whether an operation is necessary for the mental health of a girl it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual.

(8) This section applies to any act done outside the United Kingdom by a United Kingdom national or resident.

(9) A person who is guilty of an offence under this section is liable, on summary conviction, to imprisonment for a term not exceeding 12 months, to a fine, or to both.

(10) The court must refer the case of any person guilty of an offence under this section who is subject to statutory professional regulation for investigation by the relevant regulator."—*(Alex Norris.)*

*Brought up, and read the First time.*

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

**The Chair:** With this it will be convenient to discuss new clause 2—*Prohibition of hymenoplasty*—

"(1) A person is guilty of an offence if they undertake a surgical procedure for the purpose of re-attaching membrane tissue, creating scar tissue or otherwise attempting to re-create the hymen in the vagina of a patient.

(2) A person is guilty of an offence if they advertise the service of hymenoplasty or any service that purports to 're-virginise' or otherwise re-create or re-attach the hymen of a patient by way of surgical procedure.

(3) A person is guilty of an offence if they aid, abet, counsel or procure a person to undertake a surgical procedure for the purpose of re-attaching membrane tissue, creating scar tissue or otherwise attempting to or re-creating the hymen in the vagina of a patient.

(4) This section applies to any act done outside the United Kingdom by a United Kingdom national or resident.

(5) A person who is guilty of an offence under this section is liable, on conviction, to imprisonment for a term not exceeding 5 years.

(6) The court must refer the case of any person guilty of an offence under this section who is subject to statutory professional regulation for investigation by the relevant regulator.".

**Alex Norris:** I want to speak to new clause 1 in my name and seemingly in the name of half the House. With pleasure, we have reached the new clauses. A central theme runs through the new clauses that my colleagues and I have tabled. If the Government are adamant that now is the time for this Bill, and we have well-established issues with that, then given the significant and growing challenges facing health and social care in this country we really ought to put things in the Bill that will make a difference. Too much of what we have discussed over the previous 18 sessions—give or take—has been about structures and moving things around; this is fundamentally likely to make little to no difference on the frontlines to practitioners or the people that we work for. These new clauses, and the new clauses in general, seek to try and redress that balance and put things in the Bill that will make an impact in this country.

10 am

If we look at the amendment paper, new clauses 1 and 2 have very broad support across parties—all parties are represented there. It would be safe to say that all schools of thought politically, and certainly within women's issues, are represented on the order paper as well. I will not make a judgement about who is the most left-wing or right-wing Member in this place, but we span the breadth. That is an interesting sign of the strength of feeling here; I hope that the Minister has taken this clear signal as to how strongly hon. Members feel about this issue, and how urgent the need is to act now, whether through these new clauses or an alternative—if the Minister has one up his sleeve. It is time for action on this.

These clauses deal with what I hesitate to call practices: I would not want to give them the legitimacy of saying that they are medical practices—they are practices of abuse. First, they deal with virginity testing: so-called examinations to establish if a woman has ever had sex before. Secondly, they deal with hymenoplasty: a so-called procedure to reattach tissue to recreate the hymen in a woman's body. If those sound like grim processes, that is because they are exceptionally grim processes. They are practices of abuse.

Starting with new clause 1, in relation to so-called virginity testing; the Royal College of Midwives says,

"We are clear that virginity testing is a violation of women's and girls' human rights. In addition to being wholly indefensible and offensive, there is no medical benefit to virginity testing, and it is in any event not possible to conclude through an examination of the hymen whether or not a woman or girl is a virgin (even if such an examination was justifiable)."

Of course, I am sure we are all united in thinking that such examinations are not justifiable. This is also a global issue; the World Health Organisation is one of many who call the practice a violation of human rights, which can cause incredible harm to its victims, physically, psychologically and socially. I hope that we take the opportunity today to add it to the Bill so that it will be outlawed when this Bill has finished its journey. Perhaps we can make further commitments for it to be considered as what it actually is when the victim is under 18—child abuse.

There are other issues, of course, relating to this practice. Making it an offence alone is unlikely to eliminate it entirely; if someone is the type of person who is willing to find ways to inflict this sort of harm on another, they will likely seek other ways to do so. However, this will help us to build a more comprehensive response, and it would be a very strong first step in sending a clear message that this is unacceptable behaviour.

Turning to new clause 2 on hymenoplasty: according to the Royal College Obstetricians and Gynaecologists,

"There is no reason why either virginity testing or hymenoplasty, or any other procedure under a different name that seeks to reconstruct or repair the hymen, would need to be carried out for medical purposes. Both are harmful practices that create and exacerbate social, cultural and political beliefs that a women's value is based on whether or not she is a virgin before marriage."

Again, these are serious practices with no medical benefits; nor do they work in service of the goal that they are supposedly pursuing. I am conscious that, particularly with hymenoplasty, the scale of the issue is unclear, so once again, a wider response will be needed. However, I strongly share the views of the many groups who believe the Government are overcomplicating this issue. I know that the Government's preferred course of action on hymenoplasty is to convene an expert panel. However, I have struggled to find—the Minister may have views on this—a likely participant in that panel; whether it is the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, or any third sector organisation that works in this space. Any of those bodies that are likely to be on that expert panel are already strongly of one voice—there is absolutely no disagreement between those experts. They all agree that such practices should be outlawed, particularly hymenoplasty, because there is no good reason for them. There is no medical benefit—hymenoplasty does not even fit its perceived purpose—but even if it did, it is an abusive practice against women, and that is all that matters. Women must have ownership of their own sexual and reproductive health and these amendments are an important part of ensuring that.

No doubt there will be, as an important part of the legislative process, questions about whether the Bill is the best way to do that. I think that all members of the Committee are only in service of a goal here, rather than in service of a particular clause in the Bill, so if there is a better way, we are all ears. However, I do not think that the substantive point—that it is time for

action on this issue—is in dispute now. So I hope to hear from the Minister that the Government are ready to move on this issue-

**Dr Whitford:** I rise to support new clauses 1 and 2. Although this issue would be within the devolved space, as a doctor, I think that any practice that is in essence being called a medical practice but is not for the benefit of the patient is unjustifiable. I have to say, I think that extends to X-raying child refugees' teeth or exposing their limbs to radiation for no clinical reason; I find that unjustifiable. The difference with what these two new clauses deal with is that both involve absolute violation of women and girls, and therefore they are way beyond what we would discuss in other spheres. Although these measures would not apply in Scotland, they are about things that are indefensible, as are other practices that we have heard about, such as female genital mutilation, and so on, which some have tried to disguise as cultural, religious or other practices. Therefore, I totally support the principle and the idea behind these new clauses.

**Edward Argar:** While, on occasion, there has not been unanimity in this House, I share the sentiments expressed by the hon. Lady and the shadow Minister, the hon. Member for Nottingham North.

I am grateful, first to my hon. Friend the Member for North West Durham (Mr Holden) for his private Member's Bill on this issue, which originally raised it, and I am also grateful to the shadow Minister. I do not always say that about some of his amendments, but I am grateful to him and his colleagues for tabling this new clause, which gives us the opportunity to debate this issue in Committee. I am aware of the work that my hon. Friend has done to raise the issue and I know how strongly the shadow Minister feels about it as well.

First, I want to reassure the Committee that safeguarding vulnerable women and girls is a key priority for the Government, which is why on 21 July we announced our commitment to ban virginity testing in the Home Office-led tackling violence against women and girls strategy, so I think we are of one mind on the principle. I will talk a little bit about the mechanism, the drafting and similar, but it is fair to say that we are of one mind on the principle here. Such tests are, as the shadow Minister said, a violation of human rights and are clearly known to have an adverse and long-term impact on women and girls' physical, psychological and social wellbeing.

New clause 1, which the shadow Minister tabled and spoke to, gets to the very heart of what we intend to do with regard to virginity testing: ban it. I wholly agree with the spirit of new clause 1; however, I fear that we cannot accept it as drafted. There are several reasons for that, which I will outline. Nevertheless, I hope that in my opening remarks I have reassured him that we are of one mind on this issue, and I will set out the next steps.

By way of further reassurance, may I also say to the Committee that the Government have clear plans to introduce our own legislation, at the appropriate moment and at the nearest opportunity, to criminalise virginity testing? There is work to be done on the drafting and, as the shadow Minister would expect, through discussions within Government. However, I can put on the record in this Committee that it is absolutely our intention to legislate in this space.

While the wording of that legislation will differ slightly from the wording of the new clause, I want to reassure the shadow Minister and other Members that the policy intent and policy outcome will be exactly aligned. Parliamentary drafting is not only an art but a significant skill, and a very technical one. Therefore, we are utilising the best drafting we have available to see how we might achieve the outcome in the appropriate way, subject to cross-Government approvals.

I will also say that the Government absolutely share the shadow Minister's concerns about how virginity testing is essentially driven by a repressive approach to female sexuality and is a form of violence against women and girls that must be eradicated.

Our concerns about the drafting of the new clause include that it does not specify where in the United Kingdom the offence would apply. It is unclear whether the offence would apply in each of the four nations of the United Kingdom or in England only. That is a drafting technicality, but we think that clarity is important. We are in the process of seeking four-nation-wide agreement on virginity testing in each of the nations, and we are working through options on what that might look like, reflecting our shared view that virginity testing has no place in any part of our United Kingdom, and that the safety of women and girls is paramount wherever they are in the four nations.

Another concern about the drafting is the inclusion of defences. The new clause would provide that in certain circumstances, such as in the course of a surgical procedure undertaken by an appropriate medical professional, an offence would not be committed. The Department's internal review of virginity testing and hymenoplasty found that virginity tests have no clinical or scientific merit, as the hon. Member for Nottingham North said. There is no reliable way to establish virginity, nor is there any clinical reason to know if a woman or girl is a virgin. As such, we are clear that there is no clinical reason for such an examination or operation to be carried out, and we therefore question the legitimacy of including such a defence in the new clause.

I have set out some of the key drafting challenges in the new clauses and I hope that I have given a flavour of the Government's thinking. The drafting detail of our policy approach is being carefully considered, with the safety of vulnerable women and girls as our guiding principle. The hon. Gentleman may be reassured that the spirit and policy intention of the new clause will be reflected in future legislation as swiftly as we can draft it and secure agreement to bring it forward.

New clause 2, which was tabled by my hon. Friend the Member for North West Durham and supported by the hon. Member for Nottingham North, seeks to ban hymenoplasty in the United Kingdom. While the Government share the concerns underpinning the new clause—that hymenoplasty is driven by a repressive approach to female sexuality and closely associated with virginity testing, so it is right that we debate the new clauses together—we also have concerns about timing and process.

After the Department of Health and Social Care conducted an internal review of virginity testing and hymenoplasty, the Government announced in the tackling violence against women and girls strategy that they would convene an expert panel to explore the clinical and ethical aspects of the procedure in more detail. The

Government's primary concern after the initial review was that there was no clearly defined consensus on whether hymenoplasty should be banned. As a Minister, I will not go as far as the hon. Member for Nottingham North while a review has been commissioned, or comment on what that review might say in detail. Arguments have been made on both sides. The hon. Gentleman has a clear view, and he may suspect he knows what my view is, but it is right to allow the expert panel to do its work swiftly and clearly and to use it as our evidence base.

It is fair to say that the overwhelming majority of stakeholders are clear that hymenoplasty perpetuates harmful myths about virginity and could constitute a form of violence against women and girls. Concerns have been expressed about whether banning the procedure could push the practice underground. It is important that the expert panel bottoms out those arguments and gives us a clear basis for proceeding. My challenge with the new clause is simply a matter of timing: it is important that we have the report from the expert panel.

To ensure balance and impartiality, the expert panel is co-chaired by Professor Sir Jonathan Montgomery and Dr Pallavi Latthe, both of whom are well respected in their areas of expertise. Both have extensive experience in this area of health ethics, and it is important that we let them do their work and then consider what they say. We will consider their recommendations as soon as they are brought forward, and I hope that will happen swiftly.

The recommendations will need to be fair, objective and based on evidence, so I hesitate to go beyond that in expressing a view on the substance of the new clause until I have that expert panel report before me. It will be presented for Ministers' consideration, and I assure the hon. Gentleman—I can see where he might go with this—that the intention is to publish it before the Christmas recess. It is a swift piece of work. We will consider the report and, depending on its contents, bring forward legislation if or as appropriate, considering everything it contains in the context of vulnerable women and girls' safety.

10.15 am

I hope that I have given the Committee a clear rationale for why, although we are entirely aligned on the new clause's policy objectives and intent, there are a number of drafting and other factors that we need to work on a little. However, I am hopeful that in short order we will be able to bring forward legislation and clauses that will be satisfactory to both sides of the House.

**Alex Norris:** Let me come back briefly on a couple of issues. First, I am grateful for the contribution of the hon. Member for Central Ayrshire and, in particular, her point about non-medical practices dressed up as medical practices. That is a particularly insidious way to inflict abuse on another person, and I completely agree with her that that is an absolute violation—it is as totemic as that.

We will all have taken great encouragement from the Minister's response. I am grateful for that. I associate myself with the comments he made about the hon. Member for North West Durham—I should have said that in opening. Between us, we will ensure that he sees a copy of the proceedings, and he can take great encouragement from what the Minister said.

It was particularly welcome to hear that the Government intend to legislate in this space, with the intent for that to be at the earliest opportunity. That is good news, and the Opposition will support them in that process. I gently say—I know he enjoys these exchanges—that we are currently considering primary legislation, so this is definitely the earliest opportunity. If there are moments for the Government to revisit this issue on Report or in the other place, he will find colleagues very welcoming of that.

I do not want to shatter the consensus that has grown by dividing the Committee, so I do not intend to press either new clause to a Division. However, on new clause 2, we will look at what the expert panel says. I will be interested to see the divisions in opinion—I have not been able to find them. We look at these things on their merit, but the commitment to see the report before Christmas was welcome and will give great heart to campaigners in this space. The Opposition look forward to seeing the proposals and will be keen to support them if they can achieve the goals that we seek. I beg to ask leave to withdraw the motion.

*Clause, by leave, withdrawn.*

## New Clause 3

ANNUAL PARITY OF ESTEEM REPORT: SPENDING ON MENTAL HEALTH AND MENTAL ILLNESS

"Within six weeks of the end of each financial year, the Secretary of State must lay before each House of Parliament a report on the ways in which the allotment made to NHS England for that financial year contributed to the promotion in England of a comprehensive health service designed to secure improvement—

(a) in the mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of mental illness."—*(Justin Madders.)*

*This new clause would require the Secretary of State for Health and Social Care to make an annual statement on how the funding received by mental health services that year from the overall annual allotment has contributed to the improvement of mental health and the prevention, diagnosis and treatment of mental illness.*

*Brought up, and read the First time.*

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

The Minister referred to my longevity in post, which gives me the advantage of having had this debate with him previously. That does not make it any less important; in fact, the subject has only risen in importance in the intervening period. That is why the Opposition were pleased to put our name to the new clause, which was tabled by the hon. Member for Newton Abbot (Anne Marie Morris).

In March, the Centre for Mental Health reported:

"There are…many areas where parity of esteem has not yet been realised. Mental health problems account for 28% of the burden of disease but only 13% of NHS spending."

Parity of esteem is the principle by which mental health must be given equal priority to physical health. Many of us assumed that it had always been there, but debates have gone on over the years and, as that figure suggests, it is still some way from being achieved. The founding National Health Service Act 1946 spoke of a comprehensive health service, securing the improvement of both physical and mental health, and the National Health Service

*[Justin Madders]*

Act 2006 said the same. That principle was enshrined in the Health and Social Care Act 2012—at least, the parts of it that remain.

In operational terms, the Government require NHS England to work for parity of esteem for mental and physical health through the NHS mandate. However, there are reports that this requirement falls down at a local level. Certainly as a constituency MP, I have a whole range of stories of people not being able to access treatment in a timely manner, or being pushed around the system with very little effect and discharged from care before it was appropriate, with consequences we can all imagine. It is difficult to overestimate how challenging that is, not just for the individuals, but for the local commissioners when they face competing pressures.

We are not suggesting that the 20% to 30% gap should be closed entirely, but we should be looking to at least get on the road towards delivering true parity. There was a missed opportunity earlier in this Bill when we suggested that one of the mandated positions on the integrated care board should be a mental health representative. Should that have been accepted, the ambitions behind the new clause would have been much easier to achieve. It is about not just getting on the road to financial parity, but actually changing the culture so that disparities can be addressed. It does sometimes seem that mental health is the Cinderella service: the one that gets cut first at the expense of the more visible services where people, understandably, can see if a particular service is shut down.

It should go without saying that it is part of the Secretary of State's normal duties to promote mental health care, but that is something that has been sadly missing. While we do not want to get into an exact science on spending, we do think that much more can be done in terms of delivery and outcomes. Looking at some of the hard facts, it is clear how far we have to travel. One in four mental health beds has been cut since 2010; just last year, 37% of children referred by a professional to mental health services were turned away. That is a shocking statistic, and I am sure most Members will have similar stories from their own constituencies of people in desperate need of help—young people whose entire lives could change by getting the right help at the right time, but who are not able to access services despite there being an obvious clinical need.

That must change. We need parity to mean something in practical terms. We hope that the new clause would create a shift in culture by requiring the Secretary of State to lay a report before Parliament addressing whether the aim of parity of esteem has been delivered.

**Dr Whitford:** The shadow Minister speaks about people who have been referred to mental health support but are not able to get it. Is there not a need to be moving that further upstream? Young people in particular struggle to access child and adolescent mental health services, and often that is because there is not resilient support within schools and there is no counselling at an early point when they are struggling that might mean they do not need to go to a specialised service. As there is none of that, their mental health may deteriorate until the only option is to join a long queue to attend a hospital unit. Therefore, should we not shift to looking at wellbeing—both physical and mental wellbeing—and the resilience of children and young people who have suffered over the past 18 months?

**Justin Madders:** I am grateful for the intervention—that is a very fair point. I recently spoke to a CAMHS worker who made that very point. One of their frustrations was that problems were not being addressed by early interventions, which only stores up more difficulties for later. Again, that is a symptom of the fact that we do not have parity of esteem, because early interventions can ultimately make a huge difference. We would like to see better access to services and appropriate waiting times being established for a wider range of mental health services, so that people with mental health problems know the maximum time for treatment, as is the case for people with physical health problems. I know the Department has been consulting on that fairly recently, and we think it would be a step change in how we assess and prioritise mental wellbeing.

Parity of treatments is required. Psychological therapies that are approved and recommended by the National Institute for Health and Care Excellence should be delivered as per the NHS constitution, and they should be put on a par with NICE-approved drugs. People need 24/7 access to mental health teams. The A&E presentations that we hear so much about have to be considered—that is probably not the optimum way to deal with such issues. There is a whole range of matters that really could make a practical difference in delivering parity of esteem, and we think that the report proposed in the new clause would be a way to drive through some of those changes.

I will not push for a vote on new clause 3, but we wanted to highlight the urgent need for more support for mental health services throughout the UK. Hopefully, the Minister will at least acknowledge that more needs to be done in this area.

**Edward Argar:** I welcome the spirit in which the shadow Minister brings this issue to the Committee. He is right to highlight not only the words "parity of esteem" but what they mean in practice, the importance of mental health services—particularly after the past year and a half with the rise in people suffering from mental health problems—and the challenges posed every day to our mental health services, irrespective of the pandemic. I suspect that throughout their time in this place, all Members present will have had multiple pieces of constituency casework relating to this issue, and particularly to CAMHS.

It is absolutely right that the shadow Minister has focused our debate on ensuring that mental health services are sufficiently funded to improve access, care and outcomes for patients. We know that, historically, mental health services under successive Governments have not received the same level of funding as NHS-funded services for physical health. By virtue of section 1(1) of the National Health Act 2006, which was inserted by the Health and Social Care Act 2012, the Secretary of State has a "duty to promote comprehensive health service" in England

"designed to secure improvement—

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of physical and mental illness."

Although there may be many things in the 2012 Act that I suspect Opposition Members do not agree with, I suspect they will agree with that clear objective. Given what the shadow Minister said, I am sure they do.

In line with that duty the Secretary of State, through the NHS mandate, ensures that NHS England must seek to treat mental health with the same urgency as physical health. That is monitored through three metrics: mental health services' real-term expenditure growth, the number of people accessing Improving Access to Psychological Therapies services, and the number of children and young people accessing NHS-funded mental health services. The Secretary of State has a legal duty to keep under review the progress in meeting mandate objectives. NHS England and NHS Improvement provide reports on the above metrics for the Government's review on a regular basis, and they have governance mechanisms in place to monitor both mental health spend and service delivery.

10.30 am

NHS England and NHS Improvement also require that local CCGs and, in future, ICBs once they become operational will ensure that local funding for mental health grows at least in line with the growth in their overall funding allocations. That is referred to as the mental health investment standard, as set out in NHS England and NHS Improvement's planning guidance.

The mental health dashboard, published by NHS England quarterly, includes information on the number of CCGs meeting the mental health investment standard. I am pleased to say that in 2020-21 all CCGs met that standard. Funding for mental health, including learning disability and dementia, across local CCGs and NHS England's specialised commissioning reached £14.3 billion in the financial year 2020-22, up from £13.2 billion in 2019-20. Under the NHS long-term plan, mental health services, excluding learning disability and dementia, are set to continue to receive a growing share of the NHS budget, with funding to grow by at least £2.3 billion a year by 2023-24.

Those commitments to growth in future funding support for our mental health service transformation ambitions set out in the long-term plan, alongside the reporting and accountability arrangements that we already have in place, are sufficient measures in terms of process in the context of the current time, but of course I share the shadow Minister's underlying sentiment that whatever progress has been made, there is always more that we can and should do in this space. It is not just about the inputs but the outputs and the service that people experience, so I share his sentiments.

We are in no way complacent and will not rest on our laurels. We will always be happy to consider how we can make further non-legislative improvements to the existing arrangements to make them more effective and to deliver the service that we all want to continue to see delivered and improved for our constituents. I am grateful that he does not intend to press the amendment to a Division. I suspect that on Report we might further debate mental health services in this country, and rightly so, but I hope I have reassured him that we continue to take this extremely seriously, and I share his sentiment about the need to keep a clear focus on the issue.

**Justin Madders:** I am grateful for the Minister's comments. If the investment standard is being met across the board, perhaps it is the investment standard that needs looking at rather than the services themselves. We are all aware that there is a lot more to do in this area. As the Minister rightly says, no doubt we will return to it, so I beg to ask leave to withdraw the clause.

*Clause, by leave, withdrawn.*

## New Clause 5

SUPPORT PROVIDED BY THE NHS TO VICTIMS OF DOMESTIC ABUSE

"(1) Each Integrated Care Board must—

(a) assess, or make arrangements for the assessment of, the need for support for victims of domestic abuse using their services;

(b) prepare and publish a strategy for the provision of such support in its area;

(c) monitor and evaluate the effectiveness of the strategy;

(d) designate a domestic abuse and sexual violence lead; and

(e) publish an annual report on how it has discharged its duties relating to the provision of services to victims of domestic violence under the Care Act 2014.

(2) An Integrated Care Board that publishes a strategy under this section must, in carrying out its functions, give effect to the strategy.

(3) Before publishing a strategy under this section, an Integrated Care Board must consult—

(a) any local authority for an area within the relevant Integrated Care Board's area;

(b) the domestic abuse local partnership board appointed by the local authority for an area within the relevant clinical commissioning group's area under section 58 of the Domestic Abuse Act 2021; and

(c) such other persons as the relevant local authority considers appropriate.

(4) For the purposes of subsection (4), "local authority" means—

(a) a county council or district council in England; or

(b) a London borough council.

(5) An Integrated Care Board that publishes a strategy under this section—

(a) must keep the strategy under review;

(b) may alter or replace the strategy; and

(c) must publish any altered or replacement strategy.

(6) The Secretary of State may by regulations make provision about the preparation and publication of strategies under this section.

(7) The power to make regulations under subsection (7) may, in particular, be exercised to make provision about—

(a) the procedure to be followed by an Integrated Care Board in preparing a strategy;

(b) matters to which an Integrated Care Board must have regard in preparing a strategy;

(c) how an Integrated Care Board must publish a strategy;

(d) the date by which an Integrated Care Board must first publish a strategy; and

(e) the frequency with which an Integrated Care Board must review its strategy or any effect of the strategy on the provision of other provision in its area.

(8) Before making regulations under this section, the Secretary of State must consult—

(a) all Integrated Care Boards; and

(b) such other persons as the Secretary of State considers appropriate."—*(Alex Norris.)*

*This new clause would require Integrated Care Boards to publish a strategy for the provision of support for victims of domestic abuse using their services and designate a domestic abuse and sexual violence lead.*

*Brought up, and read the First time.*

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

For Opposition Members in Committees of this type, as we assemble the issues that we prioritise in proceedings, we have to be a bit of a magpie and pinch things along the way, so I want to recognise that this new clause is pinched from the hon. Member for Newton Abbot. I am grateful to her for tabling this and for the level of thought that she put into the amendment, which is a very good one.

Earlier in the proceedings, we discussed integrated care board plans and their responsibility to engage with the Domestic Abuse Commissioner. I was grateful for the commitments that the Minister made. There was a common understanding that the health and social care system has a crucial role in both preventing and tackling domestic abuse and in supporting victims and survivors. That sounds self-evident, but we are not in that position in this country yet, and we could do much better. I hope we can build on that consensus with the new clause, which requires integrated care boards to publish a strategy for the provision of support for victims of domestic abuse using their services and to designate a domestic abuse and sexual violence lead.

I will not repeat the arguments that I made earlier regarding the scale of domestic abuse, but it is worth reiterating top lines, particularly the global statistics from the World Health Organisation, which show that 30% of women have experienced some form of physical and/or sexual violence by an intimate partner in their lifetime. In this country it is one in four, so it is of a similar order of magnitude. The Government's own estimate is that it costs health services £2.3 billion annually. A common refrain from the sector, with which I meet a lot, as I did before coming to this place, concerns the impact it could make with a fraction of that money if it was put into statutory services or the services that it provides. We should think about that investment model.

In discussing the new clause, I want to take the opportunity to cover something that we have not previously considered, namely domestic abuse, which tends to be against women but also concerns people with disabilities. According to Stay Safe East, disabled people and, most specifically again, disabled women, experience higher rates of domestic abuse than those who do not have disabilities. Abuse against women with disabilities is likely to be more violent and to happen over a longer period before the victim discloses it or can access help. The really sad thing is that if the victim—who is living with a disability—is not heard, there is a significant risk that they will then be sent home by the system to be cared for, in the very loosest sense, by their abuser. None of us would want that but it is the sort of thing that happens at the moment because we do not have a strong enough grip. I hope that we can use the new clause and the Bill generally to take more active steps to address that problem.

There is clearly a significant need for specialist domestic abuse services, which are crucial to enable women's recovery in particular. Often, such services take on the work of statutory services and provide vital advocacy for women facing health exclusion, particularly in respect of services supporting black and minoritised women. It came out strongly in the debate on what is now the Domestic Abuse Act 2021 that we need specific and specialised services for those who are at greatest risk of being excluded. We did not quite get there in those provisions. I confess to using every legislative and parliamentary opportunity to keep pushing at this because it is really important and we can do much better.

We know that medical staff receive some training in adult safeguarding and, in a few hospitals, even on domestic abuse and sexual violence. But the skills and time to communicate with people with, say, learning disabilities or cognitive issues, with deaf survivors or with very elderly people who might be less likely to disclose personal information are not always available, and certainly not universally. The new clause seeks to put the onus on the integrated care system to get organised around this, to specialise and to prioritise it. It should be a priority across the system.

**Dr Whitford:** Does the hon. Gentleman think that we also have a job to do socially in reducing the stigma? I have worked in casualty departments and as a surgeon facing women who had clearly been abused but were standing or lying there making excuses for their abuser and saying why it was their own fault. As well as women with disability, there are women with insecure immigration status or insecure financial status who have no money of their own and feel that they have nowhere to go. I support the principle here, but we have a much bigger job to do around domestic abuse, which is endemic across the UK.

**Alex Norris:** I am very grateful to the hon. Lady for that intervention and completely agree with everything she said. For my part, and that of many of our colleagues, our way to tackle all those different barriers is to seek to put this in every bit of legislation. Most domestic legislation touches on these issues.

What is pertinent to this debate is thinking about the barriers to reporting. One barrier is the fear of not being believed. Of course, there is a bigger fear around prosecutions, which the Minister took a personal interest in when he was a Justice Minister, but it is clear from the evidence that we are not making enough progress. We have heard lots of positive sounds from the Government but no concrete proposals for change. We could do much better there.

On the barrier of not being believed, one way to create a better environment for a survivor to disclose what has happened to them is by their knowing that the person they are talking to in that healthcare setting has had training and works in a system that prioritises the safe disclosure of abuse. That would do a lot to build confidence. On the hon. Lady's point about migration status, it is important that we talk about that. It was a key theme in the Domestic Abuse Act. There must be safeguards in place so that the disclosure of abuse trumps immigration status. The practitioner that they work with must be someone whose role is to help them address those issues, not someone who will be speaking to the Home Office. That first knock on the door will be

someone trying to help them deal with the abuse and its impact on their life; it will not be from someone trying to resolve their migration status. That is an important principle.

Returning to the new clause, meeting with a professional social worker who ought be trained in assessing risks, including domestic abuse, might be the significant moment that an older or disabled person discloses domestic or other abuse. If given time and asked skilful questions in a safe environment, the person may disclose or express their fears, knowing they can do so in a protect manner. But across the country, such interventions are not falling into place on their own.

Women's Aid's data shows that in 2019-20, no refuge services responding to its survey were commissioned by their CCG, and just 10% of community-based services were. This is a multi-agency issue. I fought very hard to persuade the hon. Member for South Derbyshire (Mrs Wheeler) when she was Housing Minister that there ought to be investment and support going into the services through local government. She took that on, which was a good thing. Local authorities alone cannot tackle this issue. The picture that emerges from the evidence is that health agencies are not delivering as they ought to.

To be clear on what our modest ask is, subsection (1) states that each board must

"assess, or make arrangements for the assessment of, the need for support for victims of domestic abuse using their services".

That is pretty basic. Following that, it must prepare a strategy, monitor that strategy and have an annual report on it, but particularly, under paragraph (d), it must

"designate a domestic abuse and sexual violence lead",

because we know that in organisations such as the police or health organisations, where they have designated such a person, that person has been impactful. Those are pretty basic requirements. On many occasions the Minister has said that the point of the system is to be a permissive one and to let local areas shape services in the interests of their population, depending on the challenges they face; but the reality is that this problem is in every community, and we ought to be clear to ICBs that we expect this kind of activity. Subsection (3) includes a modest ask for consultation, which is reasonable and desirable.

Women in particular, and all our communities, desperately need this issue to be given deliberate focused attention. There is a high degree of consensus on it, but that does not lead to action frequently enough. The appointment of a Domestic Abuse Commissioner, which we have discussed, was a welcome step, but from a health and social care perspective we need to do more in the system. At the moment, that is not happening. That is not because I think that commissioners, leaders and decision makers do not think it is important, but they have an awful lot on. This can be a hidden crime that goes on behind closed doors, and as such drops down the list of priorities because of the urgent pressures on them; but we cannot let it go. As well as the leadership that we try to display on a national scale, we must do more to encourage this on a local scale. In this case, that is in the strategies and plans of the ICBs. We should make sure that happens.

To conclude—this is in the same vein as what I said when we debated new clauses 1 and 2—we should in our remaining time seek to put in the Bill things that will change people's health outcomes, and outcomes in life more generally. New clause 5 is one of those things, so I hope the Government are in listening mode.

10.45 am

**Edward Argar:** I put on record my gratitude to my hon. Friend the Member for Newton Abbot and to the hon. Member for Nottingham North for enabling this discussion to take place in Committee today. I find myself in deep agreement with the idea that the NHS can play a vital role in protecting vulnerable people and, as part of that, it must have strategies and processes in place for supporting victims of domestic abuse, sexual violence and other forms of harm.

The hon. Gentleman was kind to refer to my stint at the Ministry of Justice, when as Victims Minister I took a close interest in this issue with Dame Vera Baird, the former Member for Redcar, in her role as Victims' Commissioner—I pay tribute to her—and with the Minister of State, Ministry of Justice, my hon. Friend the Member for Louth and Horncastle (Victoria Atkins). My hon. Friend and I worked on the early stages of the Domestic Abuse Act 2021, and she saw that work through—I had moved to this role by then—before receiving a well-deserved promotion. I took a close interest in this issue when I was in the MOJ, and hon. Members from across the House will have found that it is not forgotten or left behind; we always reflect on it and see how we can continue to play a part when in other roles.

The hon. Member for Central Ayrshire was right to highlight the challenges that many people feel. The stigmas are completely unjustified, but people feel them because of the nature of the abuse and the controlling and coercive behaviour to which they have been subjected. When I was at the MOJ, I discovered the limitations of legislation in this space. We can and should legislate in certain areas, but a lot of this is about how services work on the ground, how we talk about this as a society, and how we break down the stigmas. One of the key things that I took away from my time at the MOJ was that tackling domestic violence and abuse is not just the responsibility of the justice system or the NHS; it is our responsibility as a society. I hope I can reassure the shadow Minister. On some areas, we tend to find ourselves in agreement rather more than is perhaps good for either of our political careers, but on this I entirely share his sentiments.

Turning to new clause 5, I hope to reassure the Committee that placing in the Bill a formal duty on ICBs to develop a separate strategy is unnecessary and not the best approach, but I hope the Committee will allow me to expand on my reasoning. There are already several duties on CCGs to consider the needs of victims of violence, including victims of domestic abuse, through the joint strategic needs assessment process. CCGs must respond to identified needs through health and wellbeing strategies. The duties will be transferred to and continue to apply to ICBs once CCGs are abolished, and will be further strengthened by the requirement on ICBs to develop system level commissioning plans. Through the Government's landmark new Domestic Abuse Act 2021—it would be churlish of me not to

*[Edward Argar]*

recognise the Opposition's work on it—local healthcare systems will be required to contribute to domestic abuse local partnership boards.

I slightly caution against requiring ICBs to create further additional strategies and plans, separate from those already in the Bill. I recognise the impulse to require NHS bodies to do this, because the theory is that a separate strategy will attract particular attention. My note of caution is because in doing so, we are saying, "We will put that over there, in that strategy" rather than having it as a thread that runs through all the strategies, underpinning strategic documents and plans of the local NHS and the ICB. We risk separating it and putting it in a different compartment from the wider span of integrated responsibilities, which is where it should sit.

The new clause also places a requirement on ICBs to have a domestic abuse and sexual violence lead. We agree with the principle, but we believe we can do that effectively through existing legislation and guidance. As set out in the Government's recent violence against women and girls strategy, the Department of Health and Social Care will be engaging with integrated care systems and providing guidance to promote best practice in addressing violence against women and girls, domestic abuse and sexual violence. That could well include advice on designated leads and those internal structures and processes.

Beyond ICBs, I see a huge opportunity for integrated care partnerships to support improved services for victims of domestic abuse, sexual violence and other forms of harm through better partnership working. I am sure we have all undertaken visits to women's refuges or to other charities that support women who are victims of domestic abuse. I should just say that it is, of course, true that men and women can be victims of domestic abuse. I refer to women in this context because an overwhelming number of victims are women, but it can happen to anyone, irrespective of gender.

In my previous role, I had the privilege of meeting survivors of domestic abuse, who were willing to talk to me about what had happened and their recovery from and survival of domestic abuse. In those conversations, people would often say, "I dealt with one agency, but it did not talk to this agency and this bit did not join up." There is a real opportunity for the ICPs to work with housing providers, local authorities, the NHS and other voluntary and third sector organisations to help to bring together a more coherent and joined-up approach.

More broadly, I assure the Committee that the NHS will be at the forefront of stepping up to its responsibility to play its part in tackling domestic abuse, sexual violence and violence against women and girls. NHS England is developing enhanced trauma-informed mental health support for victims with the most complex needs within the sexual assault and abuse pathway. The DHSC's new office for health promotion will work with the newly merged NHS England to review and build on workforce policies to ensure safe, effective processes are in place to support staff affected by domestic violence and sexual violence.

I hope I have reassured the Committee that we take this issue extremely seriously. Although we do not think that the approach proposed in the new clause is the right one, I am open-minded and happy to work across the aisle to see if there is more we can do in this space, in keeping with the strategy set out by my hon. Friend the Member for Louth and Horncastle when she was at the Home Office, and to see if there are other ways to achieve essentially the same objective.

**Alex Norris:** I have listened carefully to what the Minister has said, and I agree with significant elements of it. I take the point about existing duties on CCGs, and I am very mindful of those. The reality is that they do not work, or they certainly have not worked to date. I have no confidence that anything will change if current arrangements are just ported over to integrated care boards, which is what will happen. I do not think anything will change. I cannot imagine what will have changed in that moment to make it different, and I cannot therefore agree with the characterisation that the new clause is unnecessary.

I accept that we would not want to see a proliferation of further strategies. By making it a requirement, the new clause seeks to put the treatment, assessment and care of domestic abuse on the same footing in integrated care as elective care or major diseases. It should have that status, and at the moment it does not. It needs to be elevated to that level. I do not disagree at all with the Minister's point about domestic abuse being a thread that runs through all policies. The reality is that we have been saying that for a really long time. What actually happens is that it is in everything and, as a result, it is in nothing, and things do not change. Certainly, they are not changing quickly enough in the health space.

Finally, on the point about integrated care partnerships, I hoped that the Minister would not say what he did, because that is the problem. The fundamental issue is that those who are making the direct daily decisions about health and care in our communities are downgrading the issue by considering what they do not as operational, daily, immediate, crucial decisions—in the way they would with elective care or cancer care—but instead as partnership work.

I would never talk down the pledges that we sign or the awareness days we do. I have signed all the pledges and gone to all the awareness days, and I will keep doing that because it is an important way of keeping the pot boiling. However, I am not convinced that they have done enough to make my constituents safer or give them a better health service. I have seen no evidence of that yet. This is not partnership work, but daily, crucial work that ought to be done by system decision makers, who ought to be prioritising it every day, but I do not think that is the case.

**Edward Argar:** If I was unclear, I apologise; that was not the intention of what I was saying. I sought to say that that partnership work brings together organisations that, I believe, do focus on the issue day to day and have it as an operational priority, but often still operate in silos. In some of the best partnerships in the best local authority areas, those silos are much less evident. My point about the ICP was not as an alternative to making this front and centre, and asking "What are you doing in your operational decision making?"—be it about elective care, cancer or domestic abuse, and treating them the same—but that often it operates in a way that is internal to those organisations, rather than across them.

That was the point I was trying to make about partnership: not only do we need that internal process and urgency—I totally share the hon. Gentleman's view on that—but we need the ICPs to offer an opportunity to do that by bridging organisations. I hope that adds a little clarity, if I was unclear.

**Alex Norris:** It does, and of course I would not want to misrepresent what the Minister said. My point is that, while of course we should seek to work across the partnership and have a cross-partnership approach to tackling this issue in our communities—that is a very good thing to do—the problem currently is that that means we are not doing enough in the health and care space. There has to be something that says to health leaders, "Yes, work in partnership, but there are bits that you have to do yourselves that at the moment you are not doing well enough, so please do them." This is my "something". That was my logic in tabling this new clause, and it is why I intend to push it to a Division.

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

*The Committee divided:* Ayes 6, Noes 9.

**Division No. 38]**

**AYES**

| | |
|---|---|
| Madders, Justin | Smyth, Karin |
| Norris, Alex | Whitford, Dr Philippa |
| Owen, Sarah | Williams, Hywel |

**NOES**

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

*Question accordingly negatived.*

## New Clause 7

TRANSPARENCY OF DECISION-MAKING BY NHS BODIES

"(1) All meetings of NHS bodies must be held in public and reasonable provision must be made for access to meetings other than by physical attendance.

(2) All—

(a) agendas; and

(b) other papers

to be considered at meetings of NHS bodies must be published at least 10 days before the date of the meeting.

(3) For the purposes of this section an NHS body is—

(a) NHS England;

(b) an Integrated Care Board;

(c) an NHS Trust;

(d) an NHS Foundation Trust; and

(e) a Special Health Authority.

(4) An NHS body may, by resolution, exclude the public from the whole or part of a meeting if it considers that publicity would be prejudicial to the public interest because confidential business is to be transacted at the meeting or for other reasons stated in the resolution.

(5) A resolution to exclude the public from a meeting under subsection (4) must be published at least five days before the date of the meeting and must explain—

(a) what is covered by the resolution; and the reason publication is not in the public interest.

(6) Any responses from the public to the publication of the resolution under subsection (5) must be considered in public at the meeting.

(7) All major decisions taken by an NHS body must be based on—

(a) a business case prepared to the standards required by HM Treasury and published at least one month before the decision is to be considered;

(b) a Stage Gate Review or similar external independent assurance review, the summary of which must be published at least one month before the decision is to be considered; and

(c) consideration of any responses from the public, patients or staff representatives to the business case.

(8) For the purposes of subsection (7) neither the business case nor any part of it nor any record of the consideration of the case by the NHS body may be considered to be commercially confidential under the Freedom of Information Act 2000.

(9) For the purposes of subsection (7) a 'major decision' includes, but is not restricted to, any proposal for—

(a) capital expenditure in excess of £5m; the award of any contract with a value in excess of £1m to any organisation that is not an NHS Trust or NHS Foundation Trust; and

(b) any change in the organisation of the provision of services that will involve or may involve—

(i) more than 10 staff; or

(ii) more than 10 patients or service users.

(10) NHS England may publish guidance on the consideration of major decisions under subsections (7) to (9)." *—(Karin Smyth.)*

*This new clause requires all NHS organisations to hold meetings and make decisions in an open and transparent manner and allows the public and patients to express views on important proposals.*

*Brought up, and read the First time.*

**Karin Smyth** (Bristol South) (Lab): I beg to move, That the clause be read a Second time.

It is a pleasure to serve under your chairmanship, Mrs Murray. I think I tabled these new clauses back in August; recalling my brain to that time, summer seems like a long time ago now.

New clause 7 may seem self-evident, and I think the Minister may respond, "Yes, we are happy for them to do this, and parts of this have been included in the Bill." I will not seek to press the clause to a vote, but I had a short conversation with the Minister to indicate that this is really good practice and that we need some assurance that the NHS will abide by the Government's rules. That is all I seek to do with this new clause. It is self-evident that papers should be published in advance and made available to people, and that due process should be followed, but we all know that that often does not happen. Sometimes there are emergency reasons for that, but in my experience, it rarely needs to happen at the last minute.

11 am

The very welcome removal of section 75 of the National Health Service Act 2006 and of the need to put things out for competition, as we have discussed, means that the rationale—mostly quite spurious, in my experience—of commercial confidence to explain late papers, and to explain not involving the public or having meetings in public and so on, should be banished from the lexicon of the NHS and of all public bodies.

When I was a board member in the early noughties, I served under an excellent chair in Mr Arthur Keefe, who had been a director of social services in a hung authority. He would always challenge the chief executive to tell us exactly what the rationale was for not making everything public. There was a creeping sense throughout the '90s and the noughties, under both Conservative and Labour Governments, that the threshold for keeping things in commercial confidence and in private sections of papers was brought really quite low. Our good chair, who had experience of local government, put that question much more firmly and placed a much higher bar for allowing a taxpayer-funded public authority to have private meetings and resolutions.

The first part of the new clause should reiterate good practice. As I have said, the removal of competition should cover all but the most extreme in-confidence decisions. We discussed only yesterday coroners' courts, extreme cases of complaints, deaths and the safe space issue. Clearly, in some trusts, some matters will pass that threshold, but the bar should be really high.

The second part of the new clause, of which all hon. Members need to be aware, is slightly technical and relates to major projects. My interest in that matter is motivated by my experiences as a board member, but also as a Member of Parliament who wants to understand and get to grips with why local health services and re-procured services have gone out to competition, and what the fundamental business case for those decisions has been. I do not think those decisions have passed the basic tests that the Government set themselves. I think we would all agree that good management and control of programmes and projects, particularly large capital buildings, needs to demonstrate value for taxpayers' money.

The Infrastructure and Projects Authority gate review process is designed to provide a realistic view a programme or project's ability to deliver agreed outcomes on time, cost, benefits and quality. I am sure the Committee is aware that the IPA is part of the Cabinet Office. I am seeking only to ensure that the Government, through the Department of Health and Social Care, abide by their own Cabinet Office and Treasury rules. It might seem a slightly odd proposal from an Opposition Back-Bench MP, but I am sure it is one that nobody will disagree with.

Since 2010, the NHS seems not to have been following all the gateway processes in the way that it should. Some major projects have gone ahead without a proper five-case business case and a proper assurance framework. As far as I can see, no studies have been done on that or on the cost of badly managed projects against any claimed savings or reduced bureaucracy. The NHS sometimes seems to be one of the few outposts of the public sector that can get away with skirting around the Treasury's rules.

As the Government talk about and invest more in new capital projects—regardless of whether we believe in the 40 new hospitals, or how we define a hospital, there are capital projects that will happen at some stage—then we must be clear on the business case for those projects at the outset, on the benefits that they are designed to deliver and on understanding them. I would support the Government's own process for doing that, and I think that the Department needs to ensure that the health service abides by its own processes, particularly by those Treasury rules, so that we understand what the benefits are, that the rigour of those passing through those processes into the health service is absolutely endemic, and crucially, that people are trained on how to do that.

One reason why the NHS is not as rigorous as it should be is that the people required to produce such business cases and assess them are highly skilled and qualified people. They are expensive, and are not frontline clinicians. It is easy for politicians of all hues to suddenly decide that they want to quickly slash management budgets, and those are some of the people and processes that are quick to go. Ultimately—I would argue, but we cannot prove this, because we do not have any evidence by which to do that—that is a short-sighted approach, resulting in many costly mistakes that our colleagues in the Public Accounts Committee and other bodies in this place are often left looking at.

There are good reasons why, without singing their praises even more, the Government's and the project authority's view on major projects generally—in trying to get better processes and better value for money—is frankly a good thing. A key part of those processes is involving local people in understanding the scope of the project and its benefits.

That brings me back to some of the themes I have been trying to pursue in this Bill. If we are asking local people to pay, and are promising them something, then they should be involved, at a very early stage, in what that looks like. If the new hospital is not going to be what we might all think of as a new hospital—if it is a new wing or an urgent care centre instead of an accident and emergency centre, or whatever—then involve people very early on in that discussion. Take them with you. That is, surely, a much better way for the Government to persuade people that we do need upgrades for our estates, particularly, but also for other projects, and that sometimes compromises have to be made—sometimes the promised building might not be the one we get—but that there are reasons and rationales for that. All of that is involved in the scoping, costing and benefits-realisation process of a well-managed project.

For us, as Members of Parliament acting on behalf of our constituents, I am sure I am not the only person in this room who has felt like I am bashing my head against a brick wall in trying to understand when, where and how a promised local service will come forward and to understand the clear processes, which should all be public, even for a re-procurement or a new building. Whatever the project is, it should be totally transparent to the general public, but also for us, as Members of Parliament, to understand what that is. The gate process allows one to do that.

The Minister earlier indicated that we could talk about some parts of this. Really, his comment should be "Yes, the NHS should abide by the Government and Treasury's own rules," so it should be fairly straightforward, but it does not happen. If the Government are serious about embarking on improvements in the next few years, then they need to get that rigour back, support the NHS, get the skilled people there to deliver it and work with the Cabinet Office and the Treasury to do that properly and quickly, particularly on the estates, which are crumbling. We have these severe backlogs; it is a terrible use of taxpayer money. I await the Minister's response, but very much hope that this could be taken as good practice and encouragement for the future.

**Justin Madders:** It is a pleasure to follow my hon. Friend the Member for Bristol South, who said what should not really need saying, but still needed to be said, because being open and transparent is the highest form of accountability. Given the history of the NHS as the archetypal public service, one would expect it to be the model of openness and transparency. Maybe it was at one point, but we are a long way from that now. In a public service on the scale of the NHS one would expect the sharing of best practice to be the norm and openness to be the standard. Unfortunately we know that it is not, and one has to ask what it is people want to hide from others.

We know of classic examples of how a secretive approach has made matters far worse than they were. The various inquiries have shown that these methods have not only prevented things from being released, but have actively protected colleagues, units and even trusts from what might, at the very least, be considered reputational damage. Many have said that the best disinfectant is sunlight—or words to that effect—and the best governance comes when things are open and transparent. The best checks and balances are only possible if all information is shared properly.

I will quote from the code of conduct for NHS boards, agreed two decades ago between the NHS Appointments Commission and the Department of Health. I believe it is as valuable today as it was then. It says,

"Health needs and patterns of provision of health care do not stand still. There should be a willingness to be open with the public, patients and with staff as the need for change emerges. It is a requirement that major changes are consulted upon before decisions are reached. Information supporting those decisions should be made available, in a way that is understandable, and positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000."

I think we all understand what that seeks to achieve: be open and transparent, listen and engage. History suggests that this has been applied patchily at best.

One of the inevitable consequences of the shift to a belief in the markets was the idea that bits of the NHS were only semi-attached to the greater body and had their own paths to travel and own priorities. Some of these bodies were expected to behave like businesses and were given the illusion of having a bottom line or a surplus. They were told that their incomes depended on how many customers they had through their doors and that they would win more through competition with other providers in a quasi-market. That led them to become more insular, self-serving and closed. Why would they want to share information with their competitors? That may sound a little extreme, but there are plenty of examples of that kind of behaviour, which tips over into, essentially, reputational management—being seen to be good and one of the best, but actually covering up some of the worst.

Openness and transparency have been eroded as a result. We saw in the Francis report a renewed focus on openness and transparency, which was meant to lead to better patient outcomes—in theory, at least. The renewed interest in openness gave rise to this statement from the report:

"It is a basic and just expectation of the public that organisations are open, honest and transparent about their performance standards, about the rights of patients and about what happened, and why, if things go wrong. This is the only way to begin to restore full public trust in the NHS."

Sadly, that was not the end of the matter.

The Lansley Act—the Health and Social Care Act 2012—pushed, I am afraid, many trusts in the opposite direction. Despite the Francis report and talk of duties of candour, we still have horrific reports of failures within the NHS. Those failures often illustrate a refusal to be open and honest, showing a scant regard for whistleblowers and a culture of denial and refusal to accept the challenges. In part, this is another remnant of the Lansley Act. Once the emphasis is on competition, reputation management and business-like behaviours and away from public services, we begin to lose openness and transparency.

Let us go back to the key principles of the NHS as a public service that is accountable to us all, as public services should be. NHS business should be conducted in a way that is socially responsible. The NHS is one of the largest employers in many communities, and it should be forging an open, positive relationship with local communities, working with staff, partners and stakeholders to set out a vision for the organisation in line with the expectations of their communities, patients and the public. None of that can be done in secret, behind closed doors. NHS organisations should not only discuss but demonstrate to the public that they are concerned about and determined to deal with the wider health of the population, including how it relates to the organisations' own impact on the local economy, the local environment and so on. They should reflect the values of engagement, which should be at the forefront of all decision making, and transparency, which should be there in all dealings.

11.15 am

New clause 7 sets some valuable benchmarks for enforcing the kind of regime we need to deliver those ambitions. The Minister will no doubt tell us that it is unnecessary—*[Interruption.]* The Minister is chuckling, so we may be able to anticipate what he will say. Experience shows that the matter needs to be looked at. What is there to lose by making it a defined requirement to publish papers and meet publicly? If there is an exception—as my hon. Friend the Member for Bristol South said, there will be exceptions—at least put an onus on people to explain why, with a chance for that to be challenged. That should be a minimum for every public service, and it should apply equally to the NHS.

If that is the settled position for routine actions, it should also apply to the challenges of how major changes are dealt with. We know from countless examples that at least some major NHS bodies decide in advance and then consult on the consequence of the answer they have predetermined. Those most usually impacted are patients, and although there is some nominal right to consult them and staff, both those groups are often left in the dark until decisions have already been taken. There is a need to put beyond doubt the reasons why a major decision is required and how that decision is taken in a way that can be shared with the public—not every change of a lightbulb, clearly, but decisions that have a significant impact. The best trusts already do that, but we must ensure that it applies across the board.

As my hon. Friend said, a lot of major projects are coming through the pipeline, although we could have a long debate about exactly how many new hospitals we are talking about—I challenge the Minister to go into the Dog and Duck and explain his VAT reference to the

customers. It is important that all those projects, whatever they amount to, are done in an open and transparent way. Business cases need to be published; as my hon. Friend said, there has been too much hiding behind commercial confidentiality, which we will come back under another new clause later. That has been a get-out on far too many occasions. The Minister has experience in local government, as does my hon. Friend the Member for Nottingham North, where the culture is the other way round: papers are published in all circumstances unless there is a good reason not to. That is the kind of culture that we need to instil in the NHS, as set out in the new clause, and we need to ensure that it is applied consistently.

We have a problem with the accountability of ICBs, as we have discussed. We will not be able to change all of that in this Bill, but the new clause will be a good start.

**Edward Argar:** I am grateful to the hon. Member for Bristol South for tabling this new clause. Much of what we discussed in relation to amendment 34 is relevant here as well. She says she seeks to be helpful by tabling the new clause. I take it in that spirit and will seek to respond in that spirit, although we may not agree on our conclusions.

As I said when we debated amendment 34, we agree with the shadow Minister, the hon. Member for Ellesmere Port and Neston, and the hon. Lady that it is right that ICBs involve the public in their decisions in a transparent way. That also holds true for NHS England, NHS provider organisations and special health authorities. The new clause would require NHS trusts, foundations trusts, proposed ICBs, NHS England and special health authorities to hold their meetings in public except if it would be prejudicial to the public interest to do so. It would also require those bodies, when making major decisions—defined by thresholds of cost or impact on patients or staff—to do so having produced a business case, undertaken a stage gate review or similar external assessment, and considered comments from the public, patients or staff representatives. The comments, business case and review could not be considered commercially confidential under the FOI Act.

As I mentioned when discussing amendment 34, much of that is already the case. First, the Public Bodies (Admission to Meetings) Act 1960 places a similar and analogous set of requirements to involve the public in meetings as the new clause. NHS England and NHS trusts are already included in the schedule to the 1960 Act, so are subject to the requirements of that Act. Schedule 4 to the Bill provides for integrated care boards to be added to the schedule to the 1960 Act as well, thereby bringing their activities within its competence.

The position of special health authorities is that where the regulations establishing them provide as such, they are to be subject to the requirements of the 1960 Act. That gives the flexibility to include them as appropriate. For example, NHS Blood and Transplant and the NHS Trust Development Authority—which the Bill proposes merging with NHS England—are included at present.

By having the requirements for public notice of, and attendance at, meetings of those bodies set out in the 1960 Act, we keep NHS bodies in line with the requirements placed on other public bodies, meaning that everyone is clear about the legal requirements and what the public can expect from them. Foundation trusts are not formally covered by the 1960 Act, but it is mandatory that they make provision in their constitutions that their board of directors' meetings and their annual meeting of members be held in public. They are also under the same duty as NHS trusts to involve those who use their services in their decisions regarding service provision, as set out in section 242 of the National Health Service Act 2006. In practice, therefore, foundation trusts are guided by similar principles to other NHS bodies.

Turning to the point about setting in legislation a decision-making process for "major decisions", we of course agree that it is vital that NHS bodies follow a robust process when making decisions. Integrated care boards, for example, have clear duties to use their resources efficiently and effectively. For practical reasons, however, we would not want to subject every major decision to a single fixed approach, not least because there is no provision in the amendment for responding to emergencies or rapidly emerging situations, including those related to patient safety.

I hope that I can, however, give some degree of reassurance that there are, as set out in the 2006 Act, broad duties on NHS bodies in respect of consultation and public involvement. NHS England involves those who are affected by decisions about commissioning in the decision-making process, either by consulting them or by providing them with information in other ways. A similar duty will be imposed on ICBs by clause 19. NHS trusts and foundation trusts have a similar duty in respect of public involvement and consultation when making decisions about the services they provide, again set out in the 2006 Act.

The Committee is also aware that the Treasury is committed to seeing business cases where capital spending, or whole-life cost spending for IT, is more than £50 million, and we expect ICBs to align with that standard. Furthermore, NHS England has a broad range of powers to issue guidance on how ICBs and others make decisions, spend capital and involve patients and the public in those decisions. Placing those processes in guidance, rather than on the face of the Bill, gives not only the flexibility to set different approaches in different circumstances, but the ability to respond to changing best practice.

On procurement and transparency, as we have discussed, the Bill introduces a power to bring forward new procurement regulations, which will set out the new provider selection regime. Regulations and statutory guidance will set out rules to ensure transparency and scrutiny under the new regime, which will be designed to ensure open, transparent and robust decision making, and will require decision-making bodies to demonstrate the rationale for their decisions. The decision-making process will be recorded internally by NHS bodies and audited annually. While decision-making bodies will be required to publish contracts awarded and intentions for the method of procurement, with a rationale for both, the bodies will not be required to publish every detail of their decision-making process.

Regarding FOI requests, I recognise the impulse to be as transparent as possible and agree that, unless exemptions apply, information should be released under the FOI Act. I am advised that confidentiality, which is

an absolute exemption, and commercial confidentiality, which is a qualified exemption, are two separate exemptions already in that legislation. Where parts of the decision-making process are exempted on the grounds of commercial interests, those exclusions exist to protect the release of information that could prejudice a commercial decision. That could put NHS bodies at a disadvantage in ongoing negotiations and would be detrimental to the public purse.

I am advised that this is a qualified exemption and therefore disclosure would still be required unless the public interest in withholding disclosure outweighs the public interest in disclosure being made. I recognise that that is a tricky balance to strike, but I do not think it is to the benefit of the NHS that information held by NHS bodies that could be commercially damaging and does not meet a public interest test should be released.

I hope that that offers some reassurance to the Committee. I encourage the hon. Lady not to press her new clause to a Division.

**Karin Smyth:** I am grateful to the Minister. I was going to—

11.25 am

*The Chair adjourned the Committee without Question put (Standing Order No. 88).*

*Adjourned till this day at Two o'clock.*