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Public Bill Committee

HEALTH AND CARE BILL

Nineteeth Sitting

Wednesday 27 October 2021

(Afternoon)

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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

(Afternoon)

[Steve McCabe *in the Chair*]

Health and Care Bill

The Chair: Before we start, I remind hon. Members about electronic devices, masks and notes to *Hansard*.

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, read the First time, and Question proposed (this day), That the clause be read a Second time.

2pm

Question again proposed.

Karin Smyth (Bristol South) (Lab): It is a pleasure to see you in the Chair, Mr McCabe. I am grateful for the Minister's comments, but I am a bit disappointed. The Minister basically set out what was already required, but that was not the issue. Many Members will have found that what is required is not our experience. Meetings are held in private. In my comments this morning I said that increased throughout the '90s and the noughties. That is not a party political point: it is to do with the increasing competition. The Minister cites Acts from the 1960s, but that is not our experience.

Some foundation trusts have taken the view that they can hold private meetings for their own reasons. It is our experience that decisions are regularly taken before consultation even begins. The consultation that those bodies embark on is often simply about the how, when it should be about the what. The major projects go ahead and procurement commences without what anyone would recognise as a proper business case, with no proper external validation by a gate or any other review. Again, that is the Government's own policy.

Trusts regularly ignore freedom of information guidance. Businesses cases are withheld because they are contentious, not because they threaten commercial confidentiality—that is a screen behind which people hide. The new clause tries to send the message that the NHS should try harder. The Minister's response should be to completely agree. He should tell his Department to behave in the way that the Cabinet Office and the Treasury expect, and send that message to the NHS much more strongly.

What does the Minister thinks he has done on compliance? Who is enforcing this? What do MPs and members of the public do when those bodies do not do what we expect them to do? In my experience of recourse to the Secretaries of State, there is no monitoring and compliance, and no real sanctions on people who flaunt the requirements expected. Thankfully, we are not talking about markets and competition, so all the need for secrecy should have gone. I hope the Minister can be stronger within his Department and with the NHS about the standards we expect. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

Sarah Owen (Luton North) (Lab): On a point of order, Mr McCabe. Today, new guidance was published in the House that all members of staff in Parliament should wear masks. I am truly shocked that, given we are debating the Health and Care Bill, the majority of the Members on the Government side cannot put on a mask and set an example. Is there anything we can do to remind Members that we all have a duty of care to everyone who works here and their safety?

The Chair: I thank the hon. Lady for her point of order. I should point out that this is not a matter for the Chair. Mr Speaker has encouraged everyone to wear masks when they are not speaking. It would be extremely helpful if people were to abide by that. The hon. Lady's point is on the record and I am sure it will be drawn to Mr Speaker's attention.

Justin Madders (Ellesmere Port and Neston) (Lab): Further to that point of order, Mr McCabe. I understand that it is out of your hands, but this is an important matter for the safety not only of Members but of all staff here. We are in a smaller room than we have been recently, so circulation is probably not as good as we would like. When was the most recent risk assessment on this Committee meeting, and what did it say about the wearing of masks?

The Chair: I have just been advised that there was a statement from the Commission yesterday, but I do not believe there has been a specific assessment in relation to the Committee meeting in this room or any update on that. Again, I point out to the hon. Gentleman that it is not an issue for me. His point is on the record and it will be drawn to Mr Speaker's attention. I am not sure there is a great deal more that we can achieve at this stage.

Jo Gideon (Stoke-on-Trent Central) (Con): Further to that point of order, some Members may have medical conditions that we do not wish to disclose meaning we cannot wear masks. I have been sitting in the Chamber for three hours now, and I struggle with wearing a mask for a specific medical reason. I would therefore like to put on record that it is not necessarily a political decision not to wear a mask—sometimes it is for a medical reason. That needs to be understood.

The Chair: I thank the hon. Lady for that further point of order. I have to say to all of you: this is not the venue for this debate. If Members really want to have this debate, they need to speak to Mr Speaker. I have heard what people have said and it is on the record. You are entitled to take it up with Mr Speaker. I am going to move on.

New Clause 8

NHS Good Governance Commission

"(1) Regulations must provide for the establishment of an NHS Good Governance Commission as a Special Health Authority.

(2) The Commission has responsibility for ensuring that anyone appointed to, or elected into, a non-executive role on an NHS body—

(a) is a fit and proper person for that role; and

(b) has been appointed or elected by a process that the Commission considers appropriate.

(3) For the purposes of subsection (2) a Chair or ordinary member of an Integrated Care Board must be considered to be a non-executive role.

(4) NHS England may publish guidance, which must be approved by the Commission, about how appointments are made to NHS bodies.

(5) The Commission must publish an annual assessment of diversity and inclusion in decision-making by NHS bodies and in appointments to executive and non-executive roles in NHS bodies.

(6) For the purposes of subsection (2) an NHS body is—

(a) NHS England;

(b) an Integrated Care Board;

(c) an NHS Trust;

(d) an NHS Foundations Trust; and

(e) a Special Health Authority."—*(Karin Smyth.)*

This new clause returns to the position prior to 2012 by recreating a body with independent oversight of important NHS appointments.

Brought up, and read the First time.

Karin Smyth: I beg to move, That the clause be read a Second time.

At the risk of my career, I am again trying to be helpful to the Government. During the debate, we have come round in a circular way about the lack of accountability in the Bill and the quite astonishing levels of power taken directly by the Secretary of State. Those may be two separate things, but, in terms of the culture that we want to embed in the health system, they are really quite worrying.

The Bill puts into law the organisational changes of the last few years—based on what the NHS, I agree, has been asking for—on a population basis, not on competition or autonomy. Most of us genuinely welcome that: we want to see better population health, people working together, and services rooted in the community; we want to empower local people and guarantee service levels locally. We want to ensure transparency on funding to see if one area is funded more favourably than another. Historically, there have been problems with that and we want to understand that. We want to know why certain services operate in one area and not another.

Opposition Members often talk about a postcode lottery. I do not always agree with that terminology because if the population shows that it needs different levels of services in different parts of the country, then the local NHS needs to reflect that. My own city, Bristol, is a very young city; we have a very small population of over-85s. Further to the south-west, in nearby Torquay and Torbay, that situation is reversed. I would expect to see different population levels of healthcare in Bristol and Torbay.

Dr Philippa Whitford (Central Ayrshire) (SNP): When we talk about a postcode lottery—something I have worked against my entire career—it does not really refer to the area of the postcode, but the access of individuals. At the end of the day, 85-year-olds in Bristol should get the same service as 85-year-olds in Torbay, even if there are fewer of them. Everyone should get the mandate of the service both health and social care deliver, even if it is delivered in a different way because of geography or demographics.

Karin Smyth: I thank the hon. Lady for her intervention, and I do not disagree. The terms are bandied around and people often do not know what we mean by them, which is why, without going back into the past too much, I was a strong supporter when we were in Government of the national service frameworks and certainly of guaranteeing a level of care and access, as she says.

However, it is the case that different health systems will have different demands on them, and therefore should respond differently. On that basis, my point is that that local difference should be reflected: it should make the system accountable to and understandable by local people, and should involve them in the decisions made on their behalf. That seems self-evident.

[Karin Smyth]

We often hear in this Committee about the Minister's, the shadow Minister's and my other colleagues' experiences in local government, but I think people would agree that the experiences of people involved in local government and people involved in the health service are so far apart as to be completely unrecognisable, in terms of the national accountability that the health service seems to have and the local accountability that local government has.

These bodies are deeply troubling. I have called them local cartels, in their form as integrated care boards. They have no accountability to the local people they serve, or nationally through Parliament. We have heard that the chair and chief executive are to be chosen in London according to criteria we know not, with all power vested in the Secretary of State and some promise of further detail in secondary legislation.

However, the logical conclusion of the Bill, and the way out of the problem for the Government, is a system, as we have tried to suggest, of elected chairs akin to the police and crime commissioners or metro Mayors. Elsewhere in the debate, my hon. Friend the Member for Ellesmere Port and Neston and I have highlighted the vast discrepancy in money and powers that exists between police and crime commissioners, or even my local Mayor, and the health service. Health service spending dwarfs both of them.

I will not press the new clause to a Division, because I would like to see it picked up elsewhere in the debate as the Bill progresses through this place, and I would like to leave it as something helpful for the Government to keep considering. If the Government do not want to go down the election route, and we heard the reasons from the Minister, bringing back some form of the Appointments Commission, which disappeared in the coalition's bonfire of the quangos, would be very helpful. There, we had clear role descriptions and person specifications for people who sit on those bodies, a transparent recruitment and interview process, and performance oversight and accountability. I was subject to that when I was a member of the primary care trust in Bristol North some time ago.

The other vital change is to try to bring in some genuine openness and transparency and some independent oversight of the process of appointment. The new boards and integrated care systems are a radical departure from the past 30 years. Earlier in the Committee, I made us pause momentarily as we saw off section 75, autonomy and competition. This is a big moment, and the new systems will need very highly skilled and experienced people to develop them to their potential, because, as we have heard, it is not clear how they are to be run.

The Government keep talking about permissiveness. The systems will be run by people on the ground, and the sort of people we want in charge must be imbued from the off with the culture that we want to see. The hon. Member for Central Ayrshire talked the other day about the safety board being strangled at birth, and there is a danger that these bodies, some of which have been operating quite well, will not fulfil their potential and will be strangled at birth, because that culture of feeding up accountability just to NHS England and not to local populations will make them not work in the way they should, and certainly will make them not work well with local government.

This huge culture change is a culture change for clinical leaders as well as managers. There are some great opportunities here for population-based health, but we are asking clinical leaders—clinical leadership is already a real problem in these bodies—not to look to their own departments in the first instance and their own institutions in the second, but to look outwith their institutions, working with clinicians across the primary-secondary interface, and at a population-based approach rather than their own specialty-based approach. Again, that is a massive sea change for them. Having the clinical leaders doing that at the board level and giving them the support they need to do that in their specialities requires people who are highly skilled and who will be respected locally for their experience and skills, and for, I would argue, their independence from not being hand-picked by the Secretary of State.

The Government continue to lurch from one cronyism charge to another. A transparent process would help them get over that problem—again, I kindly offer the Government some help through their difficulties. The NHS should be seen as an exemplar for appointments and recruitment. The NHS has a terrible problem with diversity. Yesterday, I chaired a meeting of the all-party parliamentary group on social mobility on the work the civil service is trying to do around improving recruitment, particularly at the higher levels, of people from lower socio-economic backgrounds and black and minority ethnic backgrounds. The NHS has also failed that test over many years, and I believe that a more representative local selection—I would like it to be elected, but it could be selected through an appointments process— would help.

2.15 pm

The key aim of the last 30 years was to have local responsibility for financial performance as close to the patient as possible. We need to understand clearly where the money went for the population as locally as possible. It does seem counter-intuitive that a Tory Government are completely abandoning that aim with these new organisations and not going down a route of a locally elected and accountable chair. The new clause offers a good governance commission, and I do not know anyone who could disagree with good governance given what we have gone through in the last year. A good governance commission would be based on clear transparent criteria to start building a better culture in the NHS and make our local NHS more accountable to local people.

Justin Madders: It is a pleasure to follow my hon. Friend the Member for Bristol South, who gave a superb analysis of why the new clause is important and she picked up on many of the themes that we have already debated. The topicality of NHS senior management is there for all to see, with some of the recent headlines being orchestrated to divert from the growing waiting list crisis in the NHS.

Our view is that NHS senior management cannot be all that bad because they have seriously outperformed the private sector on efficiency for nearly a decade. If the NHS is one of the most efficient services in the world as many international studies have demonstrated,

that is a credit to the managers who form a relatively small proportion of the overall workforce. I hope the Minister will join us in congratulating NHS managers, along with all the other brilliant staff, who have got us through the pandemic over the last 18 months—although, as we know, we are not through it yet. The contrast with some of the political decisions made has been exposed recently by the joint report by the Health and Social Care Committee and the Science and Technology Committee.

As we have discussed on a number of occasions, the Bill seems to specialise in the centralisation of power, with more and more being explicitly given to the Secretary of State. Do we want the Secretary of State appointing every chair, non-executive and chief executive, even in bodies that are meant to be independent from the Department? Amendment 18, which we debated earlier, would have gone some way to addressing that: alas, it was not to be. This is a serious issue that needs tackling. My hon. Friend is an expert on these matters through her own knowledge and experience, and I absolutely support what she has said.

While good governance might sound a little cheesy, I am sure that we could spend a lot of time discussing what exactly this new clause should be called.

I think we can all understand what good governance means and what it should look like, because we have certainly seen what it does not look like in how the Department operates at the moment. As my hon. Friend said, there was something similar in place previously, before it was burned in the bonfire of quangos under the coalition Government. Something should be in place, be it a revitalised appointments commission or even some independent standing committee or panel—something that has independent oversight of these very senior positions.

As we have said before, we would like more direct democracy in our integrated care boards. We are not going to get that, by the looks of it, but we would at least like some independence in appointments. When my ICB chair is finally appointed, I want him or her—it is a "him" at the moment, and it is an interim position—to be looking outwards, not upwards to NHS England all the time. That is something that a good governance panel would help facilitate.

A fit and proper person test should be applied independently, even to get on a shortlist, and there should be some process for removing those who should not be on there. This needs to be applied by people who are independent and competent, and not people who are already on the lists or making the appointment decisions. Perhaps we should even have some people who have oversight of how people in senior positions are appraised, trained and supported. There is a lot of experience and expertise out there that we could harness. I hope that, whatever this body ends up looking like, it can assist the NHS in dealing better with issues such as diversity, succession planning and leadership—all areas on which we can always strive to do better.

I hope that nobody mentions bureaucracy or cost as an excuse to leave things as they are. We know from published NHS experience that having an appointments commission was not really an overhead; in fact, it was a valuable resource that, in the end, saved money. We know how much it costs to replace someone who has proved unsuitable, and to undo the mistakes that they made. Appointing the right people in the first place is the best solution. The Minister will, of course, be aware of the importance of recruitment and retention across the whole NHS. I think that we can do more in respect of senior leadership roles.

As my hon. Friend the Member for Bristol South said, transparency is key throughout the systems. Where the funding goes is a key question that will become even more key as we move into the ICBs, with larger areas and different funding streams merging into one. Transparency will be important there. Of course, there will be local differences, as she said, but there should still be accountability to someone for where that money goes and who is taking those decisions. We have what we have described as a permissive approach to running ICBs at the moment, but that does not mean that we cannot have transparency and accountability. That is why we support the new clause.

The Minister for Health (Edward Argar): It is nice to see you back in the Chair, Mr McCabe. I am grateful to the hon. Member for Bristol South. Although we may not fully agree, again I take the new clause in the spirit in which she tabled it. I will reflect on what she said, but I will also set out why I cannot accept what she is proposing. I will always reflect on what she says and proposes; when she proposes things, they are well thought out. We may come to different conclusions, but the points she made are certainly deserving of reflection. I can give her that assurance up front.

As in our oral evidence sessions, I join the hon. Lady and the shadow Minister in paying tribute to those in our amazing NHS and care workforce. It is also important that we recognise, as I think she said during questioning of witnesses, that the complexity of the organisations we are talking about—the complexity of an acute trust, for example—means that strong and effective leadership, both financial and administrative, are hugely important to the overall success of the enterprise of our NHS. I therefore join her in paying tribute to those staff who often find themselves, particularly in media commentary and similar shorthand critiques, on the receiving end of criticism. People may ask, "What are they there for?". They are hugely valuable—just as much as frontline clinicians, nursing staff and those who work in the canteens or clean the wards. It is a team.

Dr Whitford *rose—*

Edward Argar: I will give way to the hon. Lady, as I am sure she will amplify this point. She has worked in clinical settings and will know that a whole team is needed to make things work.

Dr Whitford: I cannot resist the opportunity to amplify that point. Having spent over three decades working in hospitals as a surgeon, I know that it is a team sport that depends on everyone. Sometimes when cuts are made we hear the definition of "frontline" or "back-room" services. If I am in a clinic on my own without the patient records, the patient or the laboratory results, I am a complete waste of space. It is critical to recognise that. To get all the moving parts working well, really good managers are worth their weight in gold. They are part of the team and should be valued as such.

[Dr Whitford]

We heard with reference to fit and proper persons that the Kark review did not go far enough and should have suggested suggest registration or licensing of senior managers. Sometimes when the system does not work, we see the same people move out of one place and into another in this kind of revolving door manner.

Edward Argar: Although I do not always agree with the hon. Lady, I find myself in complete agreement with her. She made a couple of points that referred back to those made by the hon. Member for Bristol South. The hon. Lady is absolutely right that the system needs high-calibre, high-quality people with the right skills, particularly given what we are seeking to do with integrated care systems. We must foster an environment in which those high skills are valued, continually reinforced and refreshed.

On the point about the Kark review, the hon. Member for Central Ayrshire is right. How should I phrase this delicately? People may move on, or be moved on, from posts because it was not a success for whatever reason; I will phrase it like that. We need to look at the challenge posed by those people suddenly reappearing in another equivalent senior post in a different part of the country. There may be a reason why someone has not been a success that is not due to particular circumstances or something beyond their control, and we need to look at the recycling of those people who have not been found to have hit the mark. We need to look at that carefully.

Justin Madders: Will the Minister give way?

Edward Argar: I see the look on the shadow Minister's face, which makes me wonder what is coming.

Justin Madders: I am not trying to catch the Minister out. I can think of a specific example where what he mentioned has happened. I am, frankly, angry that this individual has been able to do that. What does the Minister think can be done to ensure that the revolving door is shut on those whom it deserves to be shut on?

Edward Argar: The shadow Minister is right. It is a challenge, and it is something I continually reflect on, because it intersects with legal employment rights, the nature of the terms on which someone leaves, how these matters work and the fact that NHS trusts around the country are individual. It is not a simple issue. It is one that I continue to reflect on. I hasten to add that it is not just the shadow Minister but Members from both sides of the House who have, on occasion, raised the issue. It requires further thought and reflection.

New clause 8 would involve creating a new special health authority, effectively, to provide independent oversight of NHS appointments. I recognise the importance of such appointments, and everyone would agree that good governance arrangements should and must be in place for managing them. Appointments to NHS trusts, NHS England and special health authorities are public appointments; they are managed in line with the principles of the governance code for public appointments and are regulated by the Commissioner for Public Appointments. The chair of an ICB would be appointed by NHS England, with the approval of the Secretary of State. That reflects a point that has been considered on a number of occasions during the passage of the Bill, namely that the ICB is accountable to NHS England and, through it, to the Secretary of State and, ultimately, Parliament, as part of a national health service.

I acknowledge what the hon. Member for Bristol South said about the need for people to be answerable and responsive to their local community. The counter-challenge is avoiding the fragmentation of the national health service and the vertical arrangement. She mentioned police and crime commissioners, and although our police forces operate in a similar way, the difference is that we have never had a national police force. Each force is based on a county—or a city, in the case of the Metropolitan Police Service—and works on a locality basis, as local authorities do.

2.30 pm

The national health service has, since its inception in 1948—the legislation was in 1946—moved in a different direction. It moved away from local, voluntary and local government arrangements for the provision of health services, patchy as they were, and towards a national model. That is the tension that we have wrestled with when we considered different clauses of the Bill.

With regard to NHS foundation trusts, it is for the council of governors at a general meeting of the council to appoint or remove the chair and the other non-executive directors. Governors are under a legal duty to represent the interests of the trust and the public, and must discharge this duty when making decisions on appointments. Foundation trusts must be assured that the decisions they make and their performance can stand up to public scrutiny on the grounds of public interest and quality of care. We believe that those existing provisions and processes provide Ministers, Parliament and the public with the necessary assurances when making appointments that good governance expectations are being met.

The process by which different appointments are made to the boards of NHS bodies has now been made public, and NHS England will continue to ensure that the process remains transparent. For appointments to NHS boards, such as those managing NHS trusts, or indeed to NHSE's own board, NHS England will continue to assess diversity data and promote diversity and inclusion.

The hon. Lady made a valid point in that context. When I took over responsibility for workforce a few weeks ago, on top of my other responsibilities, I undertook the exercise of asking about, among other things, the gender split and the black, Asian and minority ethnic proportions at chief executive officer level. It will not surprise the hon. Lady to know that the answer was not clear cut, because then there was the challenge, "Ah, but what's a CEO versus a managing director? What counts and what doesn't?". There is still a little bit of to-ing and fro-ing over definitions. However, I think the hon. Lady will be encouraged to learn that at the CEO level, the gender balance is very good compared with swathes of the public sector. On my preliminary assessment, however, there is a lot more work to do in terms of diversity and inclusion, so she raises an important point.

Justin Madders: This is a slightly cheekier question than my last one. Has the Minister conducted a similar exercise in his own Department?

Edward Argar: In respect of Ministers or senior civil servants? When it comes to Ministers, though I suspect that is not the point he wishes to push—

Justin Madders: I think we can see who the Ministers are, at least this week. I was referring more to the senior civil servants.

Edward Argar: I like to think that I am a constant in the Department, this week and in previous weeks. It is piece of work that we have done. If one looks at the very senior civil servants—the directors general and permanent secretaries—there is a good gender balance. He is absolutely right, however; having assumed responsibility for workforce more broadly a few weeks ago, it is a piece of work that I want to do. I was responsible for the implementation of the Lammy review and race disparity audit when I was at the Ministry of Justice, and it is an interest that I have taken with me to my new Department. The last year has been a little bit busy, but it is something of which I have not lost sight.

I do not believe that it is necessary to create a new body to oversee appointments, given that good governance arrangements are already in place. I therefore remain unconvinced by the argument. As ever, and as behoves me when the hon. Lady proposes something, I will continue to reflect on it carefully.

Karin Smyth: I am grateful for the Minister's comments. I will not press the new clause to a Division, but I hope to see this matter further debated during the passage of the Bill. I say gently to the Minister that the gender split for CEOs and managing directors in the health service may be 50:50, but the workforce, and certainly managerial post holders, are overwhelmingly women; however, that is not reflected further up.

Edward Argar: The hon. Lady makes a point that I should have made earlier. When I was looking at this matter in the Ministry of Justice, I was not just looking at prison governors. We need to look at the layers below, the succession plan, and the mix coming up through the system—the next generation of leaders. She is right to highlight that; forgive me for not having mentioned it.

Karin Smyth: I am afraid that these bodies have not proven themselves good at doing that, and it is not good to have them police themselves, so we need to progress the debate. On the national/local question, I am generally more Morrison than Bevan, so I will continue to plough that furrow, but this is also about being seen to do things properly for local people. My fundamental point remains that as we ask people to spend more money—we are talking about a huge proportion of our GDP, and it will be increasingly so under any Government—we need to be able to demonstrate to them what is done with it, and how and why it is done, and we need to involve the public.

That is my view of the future of the health service, and that is why I will continue to pursue this argument. When it comes to cost, it is a moot point whether this is done quietly in the corridors of NHS England; whether it is done by the Secretary of State; whether names mysteriously appear in the local economy; or whether there is due process. I am not saying that the old system was perfect. It is quite hard to recruit people to these bodies, but they are powerful people, spending billions of pounds of local money in the local economy. They need to be more representative and accountable, and we need to know who they are. As I said, I will not pursue the matter now, but I would like to see it debated further over the passage of the Bill, and we will come back to it another time. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 9

DUTY TO PROMOTE RESEARCH

"For Section 1E of the National Health Service Act 2006 substitute—

'Duty to promote research

The Secretary of State must—

(a) support the conduct of research on matters relevant to the health and care system,

(b) provide funding for research on matters relevant to the health and care system, via ring-fenced funding for the National Institute for Health Research, and

(c) promote the use in the health and care system of evidence obtained from research.'"—*(Chris Skidmore.)*

This new clause would require the Secretary of State for Health and Social Care to have a duty to support, fund and promote the use of research in the health and care system in England, via ring-fenced funding for the National Institute for Health Research.

Brought up, and read the First time.

Chris Skidmore (Kingswood) (Con): I beg to move, That the clause be read a Second time.

The clause would introduce for the first time a duty to promote research, particularly on the Secretary of State. The Committee may remember that in discussion on clause 19, I spoke extensively on integrated care boards' duties to promote research. This reflects the importance that research plays in our healthcare system. We recognise the value of being able to carry out real-term clinical trials in the single health ecosystem that is the NHS. That not only enormously benefits patients, in terms of health outcomes, but underpins a whole life sciences industry, in which, as we have seen from the pandemic and our vaccine response, the UK is truly world leading.

It is not simply because of profit that I wish to speak to the new clause. It is also clear, as I discussed on clause 19, that research can underpin and strengthen the healthcare ecosystem. It can help with retaining staff, who become inspired by the research that they do in the course of their careers. It also improves health outcomes for patients, and the investment in research is ploughed back into healthcare services. Everyone benefits from spending money on research and development. The hon. Member for Central Ayrshire made the point to me that research also plays an important part when it comes to the accountability and transparency of the NHS by underpinning clinical auditing processes, by which we can then demonstrate healthcare inequalities and map out where NHS services need to improve. That can drive better integration of services by seeking to identify where the inequalities are and closing them.

Promoting research is not simply about R&D and big pharma; it is about changing how we look at our health service. We need to move from a healthcare service that is still primarily reactive to one that can recognise patient population issues around chronic disease, and identify which interventions can be made earlier. That is

[Chris Skidmore]

something that we are beginning to understand far better through the application of genomics and precision medicine. The UK became the first country in the world to code 100,000 genomes in the 100,000 Genomes project, and there is the Biobank project. That has all come about thanks to initial investment in research and development, and it has opened up a whole new area of healthcare services that the NHS will benefit from in decades to come.

It is very important to invest in R&D. Since our morning sitting, the Chancellor has announced an additional £44 billion of investment in the NHS over three years to 2024-25, taking total spend in the NHS up to £177 billion. I welcome that huge investment in healthcare services. It is not yet clear exactly what investment is to go into healthcare R&D, although the Budget leaks in *The Sunday Times* and beyond suggest that roughly £5 billion of that will be spent on health R&D over five years. I welcome that funding. There was also mention of additional money being spent on genomics.

If it is the case that healthcare research is to receive £5 billion over three years, it is not just about the money; it is about the use that money is put to, and making sure that it goes as far as possible and has the best possible outcomes. We can only do that by ensuring that we have the structures and frameworks in place to make sure that the money is well spent. New clause 9 places a duty on the Secretary of State to

"(a) support the conduct of research on matters relevant to the health and care system,

(b) provide funding for research on matters relevant to the health and care system, via ring-fenced funding for the National Institute for Health Research, and

(c) promote the use in the health and care system of evidence obtained from research."

The positive feedback mechanism is important. We do not want to commission research that will gather dust on the shelves. We want to make sure, through real-time evidence and clinical trials, that the R&D money goes as far as possible, for the benefit of patients.

I said that paragraph (b) would ringfence funding for the National Institute for Health Research—a long-term ask of research organisations and companies involved in the active process of healthcare R&D. If I am honest with you, the process has often been a hand-to-mouth exercise. NIHR has received about £1 billion a year to spend on R&D. The most important thing in R&D is to provide not simply the funding, but the long-term certainty over that funding. When I was Science Minister, one reason why I was so committed to ensuring that the UK was associated with Horizon Europe was that it is a seven-year multiannual financial framework—those researchers have security for seven years. The level of participation is a different question, but the scientist or healthcare researcher commits to research projects that last several years at a time. What they cannot have is uncertainty, every year, that the research might suddenly be pulled. That leads to the disintegration of research partnerships and a lack of commitment at the start to even beginning to understand what might be achievable.

Ringfencing funding for the NIHR will provide the certainty as well as the money, so it will make the money go further. Individuals will be able to commit to projects, knowing that they have funding not for one year, but several years.

Dr Whitford: I spent a few years in cancer research while doing my doctorate. Does the Minister recognise that when there is that hand-to-mouth need to get a publication so as to get another grant, researchers are taken away from what we might call blue-sky or imaginative research that may not work out? People end up researching something they virtually already know the answer to, because that way they will get a publication and then get another grant. It is not just about their personal insecurity—it skews the type of research that gets done.

Chris Skidmore: Absolutely. I thank the hon. Member for making that point. When I was Science Minister, we recognised the need to look again at some of the processes that underpin research applications for UK Research and Innovation, for instance. We have the bureaucracy review that is currently being chaired by Adam Tickell, current vice-chancellor of the University of Sussex who is moving on to the University of Birmingham. We need to end this cyclical process of time—which is ultimately the greatest commodity that anyone has to offer—being taken away from researchers whose expertise is far better spent focusing on their research in the laboratory or performing clinical trials, and ensure that they can get on with what they do best rather than having to worry about the administrative burden of applying and form-filling every year.

2.45 pm

Ringfencing funding not only provides security of purpose but sends a strong signal that the Prime Minister wants the UK to be a science superpower. If there is one thing we can be science superpower with, it is life sciences and healthcare, a sector where we are already world-leading. Let us send that strong signal by demonstrating that we want to ringfence funding to give that security in the longer term. Funding has been about £1 billion a year and that has been, relatively, a flat cash settlement in recent years. Ringfencing it would provide an opportunity to grow that base, particularly if the ringfence is around a percentage base so it can carry on in an uplift as overall NHS funding grows.

It is important to place this in the wider context of the overall funding umbrella announced by the Chancellor. It was not quite what I wanted, but it is good enough for the moment. There was a manifesto commitment to spend £22 billion by 2024-25 that has just been cut by £2 billion in the Budget to £20 billion by 2024-25, but we will now reach the manifesto commitment of £22 billion by 2026-27. I can see what the Chancellor has done: he has taken the £22 billion, which was the public funding, and allied that with the 2027 strategy to reach 2.4% of GDP, both public and private, on R&D by 2027. We now have the calculus, as it were, to understand the amount that the Government are spending on R&D and how much will need to come in from the private sector, which roughly equates to two thirds of that overall spend. If the Government are putting in £22 billion, we need the private sector to put in about £70 billion a year by 2027. It is not doing that at the moment, so we probably need more time to get there, but time is running out on the 2.4% commitment, which in 2017 was just the OECD average.

South Korea and Israel are spending 4.5% of GDP on research and development. The States is spending 3% and China is on the way to hit 3% and Germany will

hit 3% by 2030. We are just going to fall further and further behind, so the rhetoric of the science superpower message is all well and good, and I welcome it, but we have got to be able to deliver. The only way we can deliver in this particular Bill on this particular issue is by ensuring that the Secretary of State has the legal authority to place on his own person that duty to promote research, in the same way as he has a duty to promote the closing of health inequalities and several other duties.

When I was Science Minister, healthcare research was an afterthought. It sat separately from BEIS. Let us make sure that it is a priority, right at the forefront of the Secretary of State's mind. That is why I am keen for the Minister to reflect on this. It would be a strong signal if the Government adopted the amendment. It would curry favour with the Prime Minister to demonstrate that he, as a Minister, has taken forward the Prime Minister's message on delivering a science superpower. I am sure that he will be keen to do so. Let us put R&D on a statutory footing in the healthcare service for the first time in 70-something years. It is long overdue and this is the time to make it happen.

Alex Norris (Nottingham North) (Lab/Co-op): It is a pleasure to resume with you in the Chair, Mr McCabe. I commend the right hon. Member for Kingswood for his new clause and for the persuasive case that he made for it. I will cover much of what he said in my contribution, but I highlight his point about long-term certainty, because I was not going to cover that. Those points were very well made. If we want to embed a culture of research in this country and to be world-leading, as surely we do, we must give our researchers that long-term certainty.

I am going to start with the National Institute for Health Research, which was, of course, established by the previous Labour Government in 2006. We are very proud of that, and since then, in partnership with NICE and other organisations, it has delivered on its mission to improve on the health and wealth of the nation through research. I refer any colleagues who have not had a chance to look at it to the 2016 RAND report, which identifies 100 examples of positive change resulting from the institute's research. You may be pleased, Mr McCabe, to hear me say that I do not intend to read out all 100, but I do want to highlight the role that it has played since in fighting covid-19 by funding, enabling and delivering lifesaving research throughout the pandemic and now in this current phase. I will not list all the ways in which that has been done, but I will highlight the recovery trial that discovered dexamethasone. That was the first drug to reduce covid-19 mortality in hospitalised patients, cutting deaths by one third, and it was funded and supported by the NIHR. It is a great organisation, which we should be backing and should be very proud of.

On research more generally, there is a shared vision and a shared ambition across this place: the UK should be at the very forefront in science more generally, and particularly in research on health and care. We have all the assets to do that, if we link everything up and invest in it, and to make the UK the destination of choice for clinical research. The new clause offers the Government the chance to put that on a statutory footing, and to make good that commitment, ringfencing funding and mandating the Secretary of State's support and interest in leadership. As the right hon. Member for Kingswood said, we would expect the Secretary of State to make many things a personal priority. We would argue that this is one of those things.

As in many of our proceedings, we are tidying up on the Health and Social Care Act 2012, and this is a good opportunity to do so again. The Minister smiles; I am always here to offer those opportunities. My hon. Friend and I have been ever so accommodating in that regard. The 2012 Act only included the duty for clinical commissioning groups to promote research. I would direct colleagues to the cross-sector written evidence headed up by the Academy of Medical Sciences, which said that the NHS's lack of ability

"to prioritise the resourcing and delivery of research has been a major impediment to improving the UK's clinical research environment over the last decade."

According to that submission, that has subsequently been a contributing factor to wide-ranging disparities in opportunities for patients to engage in research. When it talks about that, we should listen. As with so many things, we have chance to right that wrong in the 2012 Act and to show in the Bill that we want an active research culture in the NHS, building on the last 18 months.

Evidence shows that a strengthened research mandate would bring many benefits. First, patients treated in research-active NHS organisations have improved outcomes. They have lower mortality rates and higher confidence in the care they receive, which really is a big prize. Secondly, at a time when the NHS is dealing with many work force issues, this increases job satisfaction, with most doctors surveyed by the Royal College of Physicians wanting to be more involved in research and two thirds more likely to apply for a role with dedicated research time. We know it is what our excellent clinicians want too. Thirdly, it brings economic investment into this country; £2.7 billion was generated by NIHR clinical research network-supported activity in 2018-19, making the NHS around £350 million from life science companies. So we win here both coming and going; it is better for our patients, better for clinicians and better for our economy.

There really is a lot in this very good new clause with regard to both the NIHR itself and research more generally. I hope that the Minister will look favourably on the new clause. If he does not, I hope that he will give the Committee comfort on how this will be not just a broad priority for the entire system, where it is not quite clear who is responsible, but something that he as a Minister, and the Secretary of State, will be driving personally and taking as a personal responsibility. As I say, the prizes are very great indeed.

Dr Whitford: Although this would obviously apply in England and not Scotland, and the NIHR does not generally fund a lot of clinical research that comes from Scotland, I absolutely support the principle. When I was lead clinician in the west of Scotland, we put trial support staff into all 13 breast cancer units around the west of Scotland. That drove up participation in trials, which, as the hon. Gentleman just said, is what generates confidence among patients and results in better outcomes. Most trials come with a lot of bureaucracy, and people working in very busy clinical jobs in district generals

[Dr Whitford]

often do not engage because of that. Putting trial staff out in district generals can actually mean that, instead of research being within academic units, it is suddenly available to all patients. That is really important.

Having a questioning mind should be part of being any doctor. All junior doctors are encouraged to develop auditing and clinical ideas as an approach. The hon. Gentleman—I have forgotten the constituency, I am afraid.

Alex Norris: Nottingham North.

Dr Whitford: I was going to guess some other city and get it wrong, but it is somewhere north. The hon. Member said that having access to research time as a clinician, which the right hon. Member for Kingswood mentioned is a way of retaining staff, is quite important. My local health board now employs younger, as opposed to older, doctors as clinical fellows, and they have a day a week as part of their contract. It is not just one or two doctors; the board are doing it as a standard approach. It has become really popular and has certainly helped with our workforce issues in Ayrshire and on Arran. It is important to see laboratory and trials research and frontline outcome audit and clinical ideas research from all young clinicians, and we should encourage that. The money is great, but we then have to work out how the money feeds into the health service to generate the biggest impact.

Edward Argar: I am grateful to my right hon. Friend the Member for Kingswood for bringing this discussion before the Committee today. It behoves me to pay tribute to his work as Science Minister in the past. He is correct to have mentioned that he is the only person to have held that post and my current role one after the other. In fact, I think he sandwiched my current post between two stints as Science Minister, so he knows a lot about the subject and has done a lot of work on it. I pay tribute to him for that.

The amendment seeks to legislate for an additional duty for the Secretary of State with respect to research and to ringfence funding for the National Institute for Health Research—the NIHR. The NIHR is the delivery mechanism through which the Department of Health and Social Care funds high-quality, timely research that benefits the NHS, public health, and social care. I understand and appreciate the intention behind new clause 9. When discussing previous amendments, I alluded to the fact that I can recognise what my right hon. Friend is seeking to achieve. The benefits of research funded through the NIHR have proved invaluable to us during the pandemic, and the great work of the NIHR is addressing much-needed research into better ways to tackle a host of other health and care challenges that we face.

However, referring to the NIHR in primary legislation and proposing ringfencing of the research budget would not be appropriate, as the NIHR is not a legal entity separate from the Department and funding for the NIHR needs to be considered in the round alongside other elements of the Department's funding—of which it is a component part—all of which are aimed, ultimately, at improving health and wellbeing.

New clause 9 seeks to broaden the wording of the Secretary of State's duty to promote research, so that it includes the care system in addition to the health service. I recognise that the intention of my right hon. Friend is to ensure that social care is considered a priority area and does not get neglected in the face of demands from health. However, the NIHR already funds both health and social care research. Adult social care is a strategic priority for the NIHR and its research for patient benefit programme has an annual competition specifically for social care proposals.

The amendment seeks to modify the existing duty of the Secretary of State to "promote research", and to become a duty to

"support the conduct of research".

It imposes a requirement for the Secretary of State to

"promote the use in the health and care systems of evidence obtained from research".

We consider that the existing statutory duty has ensured that research has been championed, and that evidence obtained from research has been well and correctly used. The Secretary of State already supports health and care research through funding to the NIHR, and NIHR research evidence is widely used to underpin improvements across the health and care system. Many examples of NIHR impact have been documented in published NIHR annual reports.

For those reasons, I gently encourage my right hon. Friend not to press the new clause to a Division, but I am happy to reflect on the matter further and I suspect that their lordships may well return to this theme in the other place as well.

3 pm

Chris Skidmore: I thank the Minister for his forensic dissection of the new clause; it is greatly appreciated. He makes a strong point about the legal status of the National Institute for Health Research potentially making the new clause defective, and there would be little point in pressing the measure to a vote for that reason. However, to reiterate what I said earlier, it is a goose that will continuously lay golden eggs for the Minister. If he went away to look at how the new clause might be better shaped to deliver on the priorities and frameworks that he has just mentioned, I am sure that he would be richly rewarded in turn, particularly by all the organisations that recognise the value that research can bring, and by patients and staff, who would welcome the certainty arising from placing future research operations on a statutory footing.

I am a generous person. I remember tabling a ten-minute rule Bill back in February calling for the banning of essay mills in universities and other educational settings. The Government gave a similar response—the proposals were slightly defective in who they covered—but they have now tabled their own amendment to the Skills and Post-16 Education Bill to ban essay mills. That goes to show what can happen when we take the time to table amendments, either through ten-minute rule Bills or in Committee. I say to any Back Bencher, "You are not going to get in trouble with the Whips, trust me." It is important that we use our parliamentary and democratic duty to push ideas forward, because someone will eventually take them up, whether in this or another Government.

I hope that, when the Bill reaches the Lords, the Minister will reflect on and look at this as an opportunity to deliver significant reform to the health service. For the reasons that I have outlined, I beg to ask leave to withdraw the motion.

The Chair: Therein lies a lesson for us all.

Clause, by leave, withdrawn.

New Clause 11

Consultation with staff and patients on service changes

"(1) The Secretary of State must consult staff, staff representatives and patient representatives on any changes in services which fall within the definition of reconfiguration of services or which impact on the roles of more than 20 staff and publish the results of the consultation.

(2) NHS England, ICBs, NHS Trusts and FTs must publish a response to the results of consultations undertaken under subsection (1) and have due regard to the outcome of any consultation.

(3) Where significant changes to services are proposed by any NHS body, that body must produce a business case using the Five Case Model recommended by Her Majesty's Treasury, or other requirements as set out in guidance prepared and published by the Secretary of State under this section.

(4) The business case mentioned in subsection (3) must be published for consultation and the responses to the consultation taken into account when a decision is taken whether to implement the change."—*(Justin Madders.)*

Brought up, and read the First time.

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

We have wandered down the avenue of reconfiguration before in this Committee, and I am sure that we will do so again. The Opposition have been far from reassured about the Secretary of State's ability to intervene at any moment when there is the slightest hint of movement in a podiatry clinic or a change of hours at a walk-in centre, but that is where we are.

We all know that in a few more White Papers' time, there will be more changes in the NHS and in social care, and possibly more integration—who knows what is in store for us? There will be changes in the way that services are delivered, with, we hope, the aim of making them better. For more than three decades, there has been an acceptance that changes to services can be of vital interest to the patients who receive them and the staff who deliver them.

The Committee has already discussed several times the importance of involving people in those debates, and there is an acceptance that there must be a process that engages with patients and all service users. That is what we are trying to achieve through new clause 11. I hope we all agree that any proposals to change the way that services are delivered have to be subject to consultation with patients and, as we have seen in other parts of the Bill, with carers. I hope that we start from that uncontentious common ground. The big issue is just how well that consultation is delivered in practice.

At this point, I take the Committee to the Cabinet Office guidelines of 2018 and the consultation principles, particularly paragraph D, which states:

"Consultations are only part of a process of engagement. Consider whether informal iterative consultation is appropriate, using new digital tools and open, collaborative approaches. Consultation is not just about formal documents and responses. It is an on-going process."

The NHS does not always understand that they should consult before making a decision, and not on a decision that has already been made, using consultation as a tick-box or rubber-stamp exercise. Genuine consultation, with open dialogue on both sides, before decisions are made almost always results in a better decision in the end.

Of course, the Minister will tell us that the NHS constitution talks about those things and pledges,

"to engage staff in decisions that affect them and the services they provide, individually and through their representative organisations and local partnership working arrangements, and empower all staff to suggest ways to deliver better and safer services for patients and their families."

That is a pledge, not a requirement, and those fine words are often ignored when it comes to consultations with staff groups.

Even the Health and Social Care Act 2012—the Lansley Act—accepted that there were issues, because it states:

"In exercising functions in relation to the health service, the Secretary of State must have regard to the NHS Constitution."

Having due regard to the constitution also formed part of the licensing conditions for NHS Providers.

We know what "due regard" means and we have already debated its limits. We know that it means that there must be some sort of formal documentation to demonstrate that consideration has been given to representations. Even that sometimes does not happen, or it happens after a decision has been made. On a number of occasions, no attempt has been made to empower staff and proactively ask for their views on how to deliver the service in a better or safer way for patients. A decision is made and presented as a take it or leave it.

A helpful factsheet that was issued for the 2012 Act states:

"Our reforms will enable change to be driven from the bottom-up, by the clinicians who know the health needs of their patients best, and underpinned by proper local engagement, partnership working and effective local authority scrutiny."

I draw the Committee's attention to the words "partnership working". Again, the NHS can do better in respect of that.

In the new clause, we are trying to codify something that the NHS should be doing anyway when we look at the documents, guidelines, explanatory notes and good intentions, but on a number of occasions fails to do. We therefore move from "due regard" to an actual requirement. That is a beacon of best practice, which we should aim for rather than watering it down. What harm can it do? What is the disbenefit of involving the people who know the service best and deliver it on the ground? That is why there must be consultation with patients, their carers and staff.

The latter part of the new clause provides that there has to be an agreement to provide a business case. Any significant proposal should have a business case attached to it. Paragraph C of the Cabinet Office guidelines states:

[Justin Madders]

"Give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated impact assessments of the costs and benefits of the options being considered when possible; this might be required where proposals have an impact on business or the voluntary sector."

It stands to reason that giving people the full pictures means that they can give a fuller and more informed response. That is at the heart of the new clause. It will mean delivering better outcomes, better services for patients and better engagement with staff. If we refer back to the evidence sessions—gosh, some six weeks ago; it seems longer but it was only six weeks—this was one of Unison's highest priorities. Witness Sara Gorton said of principal staff involvement

"I think trade unions and staff would feel as though they had a stake and would be reassured that they had involvement in future decisions with workforce implications made by those new bits of the system if that pledge were placed in the legislation and were the underpinning principle."—[*Official Report, Health and Social Care Public Bill Committee,* 9 September 2021; c. 93, Q119.]

That is what we are seeking to do here.

It goes without saying that any significant service change should have the business case disclosed, as we discussed earlier with the new clauses tabled by my hon. Friend the Member for Bristol South. Business cases are where proposals are developed and where challenge, and teasing out of alternatives and improvements, can be found. That is the heart of what good consultation should be. We value our staff and the input they can have. We value the impact that service changes can have on patients and the importance of involving them at an early stage with full information. That will improve decisions in the long run and that is why new clause 11 should be supported.

Edward Argar: I am grateful to the shadow Minister for giving us the opportunity to debate this issue further. As he suggested, we have touched on it at various other points in the passage of the legislation, but it is right that we debate it again.

The new clause would require the Secretary of State to consult staff, staff representatives and patient representatives on any reconfiguration of services or any service change impacting more than 20 staff. NHS bodies would be required to publish their response to the results of any such consultation and an NHS body proposing significant changes to services would need to produce a business case in a specific model to be published for consultation.

Health service bodies are already under wide-ranging duties on public involvement and consultation on proposals for changes in commissioning arrangements and the reconfiguration of services set out under the National Health Service Act 2006 and regulations made under the Act. In addition, the current guidance issued by NHS England makes clear the importance of engagement and appropriate consultation. That approach will continue to be reflected under new guidance produced under the reconfiguration provisions in the Bill, set out at paragraph 8 of new schedule 10A inserted into the 2006 Act.

Guidance can provide a level of detail that is not always suited to inclusion in primary legislation and allows for flexibility so that the system can work as efficiently as possible. That approach has worked well under the current reconfiguration system and guidance has played an important part. The Government are unconvinced that there is a need for an additional duty to consult patients' representatives when NHS commissioners and providers must already involve service users in any proposals to change health services delivered to those users and which service users can access.

Moreover, it would not be appropriate for the Secretary of State to carry out a consultation for each reconfiguration or service change affecting staff. To run national consultation for every local change would be disproportionate. It would not be the best use of resource or lead to the local level of engagement that is so important. It is right that NHS bodies responsible for arranging for or providing health services should lead the consultations on proposed changes. These should be done primarily at local level with local expertise. There is always a challenge between the national and the local. I was not quite sure whether the hon. Member for Bristol South was alluding to that when she said that she was more Morrison than Bevan, and suggested that I was more Bevan than Morrison in my approach. Neither comparison has been made about me in the past, but when I next see her, I will ask. There is a real challenge in the local-national balance that runs through several clauses and in respect of the way the NHS has operated for decades.

The new clause would require consultation not just of patients but of staff and staff representatives. Staff views are of course vital in the design of service changes. That is made absolutely clear in the current guidance issued by NHS England, which repeatedly emphasises the need to involve clinicians whose practices would be affected by proposed changes. This approach will not change in the future, and updated guidance will continue to reflect that position and ensure that affected staff provide meaningful input.

3.15 pm

NHS commissioning bodies already produce business cases when proposing significant planned changes to services, and NHS England requires planned reconfigurations to follow a rigorous assurance and planning process, as is right for substantial change. NHS England already sets out its guidance to commissioners on planning, assuring and delivering service change for patients, including the need for business cases. Therefore, we consider that requiring a particular model would be unnecessarily prescriptive. Putting the proposed level of detail in primary legislation would risk preventing the NHS from being able to keep up to date with developments or changes in the way business models are prepared.

Her Majesty's Treasury's five-case model, which the hon. Lady referred to under one of her previous amendments, is relevant where service change schemes also require significant capital investment for them to be implemented. Not all service change schemes will require material capital, so completing the full HMT model may not always be necessary or proportionate.

This new clause would require consultation on any reconfiguration or change in services impacting 20 or more staff, with no exception for temporary service change where patient safety is at risk or where—as we have seen in the course of the pandemic, for example—changes are made for a short period in response to

specific circumstances. It is vital that local areas are able to make important operational decisions, including temporary changes to services, to keep patients safe.

I may or may not be successful but, for the reasons that I have set out, I encourage the shadow Minister not to press his new clause to a Division.

Justin Madders: We are not going to push the new clause to a vote, because we recognise when the Minister is not for turning—I am not sure whether he likes that comparison. But I have a couple of reflections on what he said. He was obviously very keen that the Secretary of State not get involved in lots of consultations, but of course he gives himself the power, under the Bill, to do that in relation to any reconfiguration of any size, anywhere in England. That does, I think, highlight a little bit of inconsistency.

The Minister said that there was plenty of guidance and the Government did not want the inflexibility that putting something in legislation would develop. We take the view that actually what we are trying to show is that the guidance does not work to the extent that we would want it to, which is why we think that having something in legislation is an important baseline. It does not prevent further guidance and flexibility from being built in on top of that. I know when we are not going to persuade the Minister, but I think that this is a matter that we will need to return to many times. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 12

NHS as the preferred provider of NHS contracts

"(1) The NHS is the preferred provider of NHS contracts.

(2) NHS contracts must be provided by NHS suppliers unless the NHS supplier is unable to fulfil the terms of that contract.

(3) Where the NHS is unable to fulfil the terms of a contract, a competitive tender must be held to identify an alternative provider.

(4) For the purposes of this section—

(a) 'alternative provider' means private companies and independent sector treatment centres, and

(b) general practice and GP-led community services are NHS suppliers."—*(Justin Madders.)*

This new clause would establish NHS suppliers of services as the preferred providers of NHS contracts. Independent sector providers could hold NHS contracts after winning a competitive tender.

Brought up, and read the First time.

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

The Committee divided: Ayes 6, Noes 9.

Division No. 39]

AYES

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

NOES

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

Question accordingly negatived.

New Clause 14

Appropriate consent to transplantation activities when travelling abroad

"The Human Tissue Act 2004 is amended as follows—

(1) Section 32 (prohibition of commercial dealings in human material for transplantation) is amended as follows.

(2) In subsection (1), after paragraph (e) insert—

"(f) travels outside the United Kingdom and receives any controlled material, for the purpose of transplantation, where the material was obtained without—

(i) the free, informed and specific consent of a living donor, or

(ii) the free, informed and specific consent of the donor's next of kin, where the donor is unable to provide consent;

(g) receives any controlled material for the purpose of transplantation for which, in exchange for the removal of organs—

(i) the living donor, or a third party, receives a financial gain or comparable advantage, or

(ii) from a deceased donor, a third party receives financial gain or comparable advantage.

"(1A) For the purposes of paragraphs (f) and (g) in subsection (1), it is immaterial whether the offence of dealing in controlled material for transplantation is caused by an act or an omission.

(1B) For the purposes of paragraph (g) in subsection (1), it is immaterial whether the acts or omissions which form part of the offence take place in the United Kingdom or elsewhere.

(1C) In subsection (1)(g), the expression "financial gain or comparable advantage" does not include compensation for loss of earnings and any other justifiable expenses caused by the removal or by the related medical examinations, or compensation in case of damage which is not inherent to the removal of organs.

(1D) Subsection (1F) applies if—

(a) no act which forms part of an offence under subsection (1) takes place in the United Kingdom, but

(b) the person committing the offence has a close connection with the United Kingdom.

(1E) For the purposes of subsection (1D)(b), a person has a close connection with the United Kingdom if, and only if, the person was one of the following at the time the acts or omissions concerned were done or made—

(a) a British citizen,

(b) a British overseas territories citizen,

(c) a British National (Overseas),

(d) a British Overseas citizen,

(e) a person who under the British Nationality Act 1981 was a British subject,

(f) a British protected person within the meaning of that Act,

(g) an individual ordinarily resident in the United Kingdom,

(h) a body incorporated under the law of any part of the United Kingdom,

(i) a Scottish partnership.

(1F) In such a case, proceedings for the offence may be taken in any criminal court in England and Wales or Northern Ireland."

(4) In subsection (3), after "subsection (1)" insert "(a) to (e)".

(5) In subsection (4), after "subsection (1)" insert "(a) to (e)".

(6) After subsection (4) insert—

"(4A) A person guilty of an offence under subsection (1)(f) or (1)(g) shall be liable—

(a) on summary conviction—

(i) to imprisonment for a term not exceeding 12 months,

(ii) to a fine not exceeding the statutory maximum, or

(iii) to both;

(b) on conviction on indictment—

(i) to imprisonment for a term not exceeding 9 years,

(ii) to a fine, or

(iii) to both."

(7) Section 34 (information about transplant operations) is amended as follows.

(8) After subsection (2) insert—

"(2A) Regulations under subsection (1) must require specified persons to—

(a) keep patient identifiable records for all instances of UK citizens who have received transplant procedures performed outside the United Kingdom; and

(b) report instances of transplant procedures performed on UK citizens outside the United Kingdom to NHS Blood and Transplant.

(2B) Regulations under subsection (1) must require NHS Blood and Transplant to produce an annual report on instances of UK citizens receiving transplant procedures outside the United Kingdom.""*.—(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 15—*Regulation of the public display of imported cadavers*—

"The Human Tissue Act 2004 is amended as follows—

In subsections (5)(a), (6)(a) and (6)(b) of section 1 (authorisation of activities for scheduled purposes) after "imported" insert "other than for the purpose of public display"."

Alex Norris: In speaking to these new clauses, I stand on the shoulders of the inestimable work done in this place by my hon. Friend the Member for St Helens South and Whiston (Ms Rimmer) and in the other place by the noble Lord Hunt of Kings Heath, who is with us for a little while longer before he has an oral question to dispose of in the other place. I note my thanks to them for their leadership. I hope that we can move this important issue on as part of our consideration of the Bill.

In this country, since April, around 2,000 people have received an organ transplant. A person voluntarily deciding to give an organ in life or after their death gives the most precious gift of all. It is an incredibly selfless act that allows another person to live. It is a wonderful thing. We should be very proud of Britain's record on organ donation over the years, of the research and development in that area and the work that I have no doubt we will yet do.

However, there is a sinister underside to organ donation that I ask the Committee to consider with these two new clauses. In some parts of the world organs are not given freely but are taken by force. Extensive research has shown organ harvesting to be prevalent particularly in China, where the number of organs transplanted swamps the official number of voluntary donations. The organs are generally destined for high-paying customers and come from people such as political dissidents, prisoners of conscience and ethnic minorities.

The Chinese Government say that it does not happen. The World Health Organisation has backed that up, based on a self-assessment made by the Chinese Government, which I did not find very credible. What I do find credible is that, in 2020, the independent China Tribunal found that forced organ harvesting has been committed for years throughout China, on a significant scale. Falun Gong practitioners have been one source—probably the main source—of organ supply. Victims include both the dead and the living. There are whistleblower reports of corneas being harvested.

In January we made progress on the issue through the Medicines and Medical Devices Act 2021—I am sure the hon. Member for Central Ayrshire remembers the exchanges fondly. That opened the door to further regulation of human tissues and I hope that we can move further in this Bill.

Existing legislation does not deal with British citizens who travel abroad. New clause 14 attempts to close that loophole by making it a crime for British citizens, residents and other specified people to be involved in the kill-to-order organ trade. It would end the opportunity for someone to travel to pay for black market organs from a prisoner of conscience and to return to the UK for NHS-funded anti-rejection medication. We must make it clear that involvement in this trade is reprehensible and unacceptable. I think that is a point of consensus across the House, but I am yet to hear what the mechanism is to close the loophole—I think new clause 14 presents a very good one.

New clause 15 deals with the display of human bodies. I used the word "grim" earlier in proceedings, and this is very grim indeed. Regrettably, this is not a theoretical conversation. In 2018 the Real Bodies exhibition took place in Birmingham. Adults and children paid to look at deceased corpses that had been injected with silicon and transformed into real-life mannequins. The bodies were sourced from a lab in Dalian in China. The bodies were able to be displayed without any documents or proven consent, and from a lab that we know receives bodies from the Chinese police.

Whether that sort of exhibition counts as entertainment is a matter for individuals—it is certainly not my sort of entertainment. New clause 15 would ensure that the trade is tightly regulated, so that something like that could not happen again. It would prevent the display of dead bodies of political prisoners and guarantee that proper consent has been received, ensuring dignity and respect for the deceased and their families. I think this is a matter of interest to the Committee, which is why I am seeking to put it in the Bill. It is also of significant interest in the other place. I know there will be conversations on the issue as the Bill progresses.

I am keen to hear from the Minister on these two points. I do not doubt that we are of one mind on the matter. What I would like to know now is what the Government are going to do about it, because these are pressing issues and need action now.

Edward Argar: I can certainly tell the hon. Gentleman that I think there is a consensus across the Committee, and indeed across both Houses, condemning the reprehensible behaviours and practices that he has highlighted. As he says, the challenge is the mechanism, particularly given the concept of extraterritoriality that applies here, so I will talk about that a little bit. I fear we may have to return to this; I suspect, given the complexities, that it may well be their lordships' House that grapples

with it a little further. Although it is not normally the done thing to recognise those in the Public Gallery, as they are not in the Chamber, were there to be a distinguished Peer in the Public Gallery, I would also pay tribute to their work on this. I hope that just about keeps me in order, Mr McCabe.

New clause 14 seeks to extend the provisions in section 32 of the Human Tissue Act 2004, which prohibit commercial dealings in human material for transplantation. The amendment would make it an offence for someone to travel outside the UK to receive such material without free, informed, and specific consent or in exchange for a financial gain or comparable advantage.

We believe that much, albeit not all, of what the clause seeks to achieve is already covered by different aspects of existing legislation. I will talk first about those travelling from the UK, forcibly or otherwise, and the protections available for them from having their organs harvested, and then I will turn to those travelling from the UK to receive organs.

Provisions in the Modern Slavery Act 2015 make it an offence to arrange or facilitate another person's travel, including travel outside the UK, for the purposes of their exploitation in any part of the world. Travelling covers the arrival or departure from any country, or within any country, and exploitation includes the supply of organs for reward. The Modern Slavery Act applies to the activities of UK nationals regardless of where the travel or the arrangements for it take place.

A person found guilty of that offence could be liable for life imprisonment, and those guilty of aiding, abetting, counselling or procuring it are liable for up to 10 years' imprisonment. This means that existing extraterritorial legislation already makes it an offence for a UK citizen to purchase an organ for transplant overseas, provided that the purchase involves arranging or facilitating a person's travel for the purpose of the removal of their organ for sale.

Furthermore, section 32 of the Human Tissue Act already prohibits the giving of a reward for the supply, or for an offer to supply, any controlled material. If a substantial part of an illicit transaction takes place in England, Wales or Northern Ireland, it will constitute an offence under this provision. It could, for example, be an offence to arrange a purchase and pay for an organ from a UK bank account and, likewise, it could be deemed against the law if somebody were to take steps in the UK to find someone who would sell them an organ overseas.

By adding an explicitly extraterritorial offence, as this amendment seeks to do, the interpretation of the existing provisions could be restricted, thereby potentially weakening our existing tools under those two pieces of legislation. As this amendment would prohibit travel outside the UK to receive an organ without the specific consent of the donor or next of kin, there is a chance that it could also inadvertently make it an offence for someone from the UK to receive an organ in a country with deemed rather than explicit consent provisions. This is at odds with our domestic position, where deemed consent is accepted as an appropriate form of consent for organ donation.

There is also the possibility of an unintended consequence of criminalising the recipient, as opposed to the supplier and buyer, of a trafficked organ. It is not difficult to imagine a case of a vulnerable person receiving a transplant abroad, perhaps through arrangements made by relatives, and having been misled as to the provenance of their organ. Under these circumstances, we believe that those who made the arrangements to purchase and supply the organ should be prosecuted and deemed liable, as they already can be under the Human Tissue Act and the Modern Slavery Act.

Dr Whitford: There is a problem with the shortage of organs for transplant generally within the UK. While making it an opt-out system will hopefully help with that, is there not a need to have legislation here so that the market is discouraged or prohibited, and therefore we do not have customers for those organs overseas? If there are customers, the business will exist.

Edward Argar: I take the hon. Lady's point. I will turn to new clause 15 in a moment, but we are as one in our concern to ensure that the current legislation is as effective as possible and that it does what we want it to do. I will make some further remarks on my future thinking when I conclude.

3.30 pm

New clause 14 also seeks to introduce an obligation for specified persons to record and report instances of UK citizens travelling overseas to receive a transplant, but it does not define who the specified persons might be. We would be concerned if doctors and other NHS staff were expected to undertake that role.

Finally, there are some additional minor drafting issues with the new clause. For example, there is inconsistency in the use of terms: "organs" is used interchangeably with "controlled material", which has a slightly broader meaning, but that is a technical drafting point rather than at the heart of what the hon. Member for Nottingham North is trying to get at.

New clause 15 seeks to modify section 1 of the Human Tissue Act 2004 to prohibit the import of bodies or parts of bodies for the purposes of public display. I believe that the intention behind the new clause has already been met by recent changes to the Human Tissue Authority's regulatory requirements for public display, through its revised code of practice. Since concerns were raised during the passage of the Medicines and Medical Devices Act 2021 regarding the origin and consent of bodies used in public display exhibitions, the Government have worked closely with the Human Tissue Authority to ensure that robust assurances on consent are fully received, considered, assessed and recorded before any display licences are issued. The Human Tissue Authority strengthens and revises its code of practice on public display, which lays down its expectations for any establishment seeking a licence to display human tissue. The new code, which was laid before Parliament in July, sets out clearly that the same consent expectation should apply to imported bodies and body parts as to such materials sourced domestically. The Human Tissue Authority has made the new code provisions explicit to public display establishments and given specific notice to plastination companies that it believes have been involved in arranging public displays.

Those changes mean that it is already the case that in order for an exhibition of imported bodies to receive a public display licence, it would first be expected to provide proof of the donor's specific consent to be

displayed publicly after they were deceased. If it failed to do so, it would be denied a licence by the Human Tissue Authority for not meeting its standards.

It is for those reasons that I ask the hon. Member for Nottingham North to consider not pressing the new clauses to a Division. However, I believe that more thought can be done in this space. I think that Members on both sides of the Committee, and of the House, seek the same outcomes. I would prefer to see that work done through the existing legislation covering those loopholes. However, if there are gaps and loopholes, I am happy to reflect further on what more might be possible in this space. I hope that is helpful to the hon. Gentleman.

Alex Norris: I am grateful to the Minister for his full reply. I do not intend to stress the consensus we have by dividing the Committee. He has given others who may want to look at this at a later stage quite a bit to go at. On resolving the point made in new clause 14, I heard what the Minister said about the scattering of the different parts across the statute book, but a judgment may have to be made about whether that is an effective way to organise the powers. Perhaps creating a consolidated offence would be a more practical and meaningful approach. That is my personal view, but as I have said, there will be lots to go at elsewhere.

I got quite a bit of satisfaction from the Minister's response to new clause 15. I will go away and look at the Human Tissue Authority's work. Obviously, primary legislation is always best, but I will see whether that is effective.

Edward Argar: In that context, may I make the hon. Gentleman an offer? If he thinks there is anything specific that my officials could provide to assist him in his reflections, could he let me know and I will be very happy to facilitate it?

Alex Norris: That is a very kind offer and I am almost certainly going to avail myself of it. On that basis, I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 16

LICENSING OF BEAUTY AND AESTHETICS TREATMENTS

"(1) No person may carry on an activity to which this subsection applies—

(a) except under the authority of a licence for the purposes of this section, and

(b) other than in accordance with specified training.

(2) Subsection (1) applies to an activity relating to the provision of beauty or aesthetics treatments which is specified for the purposes of the subsection by regulations made by the Secretary of State.

(3) A person commits an offence if that person contravenes subsection (1).

(4) The Secretary of State may by regulations make provision about licences and conditions for the purposes of this section.

(5) Before making regulations under this section, the Secretary of State must consult the representatives of any interests concerned which the Secretary of State considers appropriate.

(6) Regulations may, in particular—

(a) require a licensing authority not to grant a licence unless satisfied as to a matter specified in the regulations; and

(b) require a licensing authority to have regard, in deciding whether to grant a licence, to a matter specified in the regulations."—*(Justin Madders.)*

This new clause gives the Secretary of State the power to introduce a licensing regime for cosmetic treatments and makes it an offence for someone to practise without a licence. The list of treatments, detailed conditions and training requirements would be set out in regulations after consultation with relevant stakeholders.

Brought up, and read the First time.

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

It will be noted that new clause 16 has attracted considerable support from a wide range of Members across the House. I pay tribute to the beauty, aesthetics and wellbeing all-party parliamentary group, whose work in the area has been influential in producing the new clause. Many of the Members who put their name to it are also members of that group. I pay tribute to a constituent of my right hon. Friend the Member for North Durham (Mr Jones), Dawn Knight, who has been assiduous in this area, as has my right hon. Friend himself. Their tireless campaigning, which I suspect will continue for some time, has been vital so far. This is such an important area and it needs an awful lot of attention. We know there is a lot more to be done.

As we know, cosmetic treatments can include a wide range of procedures aimed at enhancing or altering appearance. Many common treatments are offered on the high street and include lip fillers, injectables, thread lifts, semi-permanent make-up, laser treatments, piercings and—one that we are more familiar with—tattoos. Perhaps one day the Minister will show us all of his. If the Minister wants to respond on that point, he is more than welcome to.

Edward Argar: He clearly knows something I do not.

Justin Madders: Many of these procedures are becoming increasingly popular. There is a well-articulated concern that non-medically and medically trained practitioners are performing treatments without being able to evidence appropriate training, or the required standards of oversight and supervision. One need only look on Facebook, for example, to see the proliferation of adverts for all types of treatments. These are usually done by unlicensed individuals who call themselves doctors. We have talked recently about the lack of proper regulation of social media. Although such a debate is not for today and falls outside the scope of the new clause, it is a matter that also needs to be addressed.

Cosmetic treatments can cause serious harm if not carried out correctly, in a safe environment and by competent, trained practitioners. Anything that punctures the skin carries the risk of the transmission of blood-borne viruses. There are countless tragic stories of people who have had life-changing injuries and conditions as a result of poor treatments. The amendment seeks to put the protection of the public at the forefront by giving the Secretary of State power to bring into force a national licensing scheme for cosmetic procedures. It would be a departure from the wild west we face at the moment. We recognise that significant research and engagement with all stakeholders would be needed to develop a scheme that will work well for all cosmetic treatments, as well as providing a practical and efficient system that will be understood and adhered to by members of the public, regulators and practitioners.

Any new scheme would have to have some flexibility in order to capture new cosmetic treatments coming on to the market in future. It would need to be able to set standards for training, qualifications and competency requirements of practitioners, including, we think, periodic checks of premises. Importantly, it would provide for continuous professional development of the practitioner. There would be a requirement for indemnity insurance and access to redress schemes for members of the public to be provided, should complications arise as a result of any aesthetic procedure. There are a number of sad stories about supposedly reputable companies doing damage to their customers, going into liquidation and their insurers then refusing to pay out. I do not think any Member wants to see that happening anymore if we can do something about it.

We would hope that any licensing scheme would have the characteristics that I have set out, and there would be accompanying sanctions for those who contravene it. At present, there is no provision to ensure that prescription-only medicines, such as Botox and anaesthetic creams, adrenaline and hyaluronidase, which are prescribed by regulated prescribers, are actually prescribed in accordance with safe practice. For example, beauty therapists are reliant on registered prescribers prescribing injectables, such as Botox, which they are unable to obtain without a prescription.

Although doctors are required to have a face-to-face individual assessment of each service user prior to prescribing to third parties, such as beauty therapists, a significant body of evidence exists to confirm that individual assessments are not actually taking place in many cases and that telephone prescriptions are being provided remotely. The proposed licensing scheme would provide a requirement for all prescribers to be officially named and to operate in accordance with required practice standards.

Of equal importance is the need for a licensing scheme to close the loophole that currently exists relating to the import of unlicensed injectable products from Korea, such as Botulax. There is a registration scheme in England for certain specialist treatments, such as electrolysis, tattooing, piecing, semi-permanent make-up and acupuncture. However, some of the riskier and newer types of cosmetic treatment cannot be included within the scope of the current regulatory regime. The system also does not allow regulators to specify conditions, qualifications or competency requirements, or to remove anyone from the practitioner register.

Only a small handful of areas across England have introduced their own licensing schemes in order to protect the public—London, Nottingham and Essex are notable examples. There are currently two Professional Standards Authority-approved voluntary registers of accredited practitioners, and one voluntary register of approved education and training providers that operate in the sector. However, joining is not mandatory, which means there are many unaccredited practitioners providing treatments to members of the public without any checks.

The creation of a national licensing scheme in England for practitioners of cosmetic treatments would ensure that all those who practise are competent and safe for members of the public, and it would also cover some of the newer practices not covered by existing licensing laws. There is a large body of support for such a move, including the Chartered Institute of Environmental Health, the Royal Society for Public Health, the Institute of Licensing, the Joint Council for Cosmetic Practitioners, the UK Public Health Network, the Faculty of Public Health and Save Face, as well as about 90% of the public, accordingly to at least one survey.

The Minister is keen on giving the Secretary of State additional powers, but I know that he is also keen on finding savings wherever possible. Were he to support this new clause, there would undoubtedly be a saving to the wider NHS in the long run—for example, through reduced visits to A&E and GPs to correct mistakes made by poorly trained and unregulated practitioners.

Here are some examples of the impact on the NHS of that lack of regulation: outbreaks of infection at skin-piercing premises, resulting in individuals being hospitalised and, in some cases, disfiguration and partial removal of the ear; second and third-degree burns from lasers and sun beds; allergic reactions due to failure to carry out patch tests or medical assessments, which have led to hospitalisations; and blindness in one eye caused by the incorrect administration of dermal fillers. Those are all tragedies for the individuals involved and mistakes that could be avoided. They are a cost to the NHS and to wider society. I believe that a system of licensing would put a stop to a lot of those tragedies.

Dr Whitford: I rise to support the new clause. As a surgeon working in general surgery, I know that, as many of these new techniques emerged, the pressure on the NHS became obvious—for example, as a result of local infections and extensive necrosis. Fillers can also migrate. That might seem a minor side effect, but it can create a lot of psychological and mental health distress for the person who went ahead with the procedure and ended up disfigured because the filler was incorrectly administered. Botox has become ubiquitous, but we should remember that it stands for botulinum toxin, which is one of the most dangerous toxins on the planet. It is used in tiny doses, but it can still cause problems if incorrectly administered.

In addition to these aesthetic techniques, which have become extensive because they appear minor and are often delivered by people without significant training—part of their danger is that they are projected to the public as being very simple techniques—we have the issue of more extensive cosmetic surgery, such as breast surgery, abdominal uplifts, liposuction and so on, which involve anaesthetic—often a general anaesthetic—and major intervention. The public think that plastic surgeons and cosmetic surgeons are the same. Although a plastic surgeon, who is a trained and licensed NHS surgeon, may also carry out cosmetic surgery, there are many clinics providing cosmetic surgery that is not carried out by plastic surgeons. Here the side effects and repercussions for a patient can be quite extensive, and indeed they have previously led to loss of life, which in some cases has been well publicised.

If this issue is taken forward, I would like to see a recognition that both these minor aesthetic interventions and cosmetic surgery should be regulated.

3.45 pm

Edward Argar: I am grateful to the hon. Member for Ellesmere Port and Neston for bringing this discussion before the Committee today, and I join him in paying

[Edward Argar]

tribute to my right hon. Friend the Member for Romsey and Southampton North (Caroline Nokes) and the right hon. Member for North Durham. I know that both are tenacious campaigners, and both are due to meet me in the coming days to discuss their work in the context of the all-party group and the constituency case, exactly as the hon. Member for Ellesmere Port and Neston mentioned.

I also pay tribute to my hon. Friend the Member for Sevenoaks (Laura Trott) for her success, within a year or so of coming to this place, in getting her private Member's Bill through. It imposed some further restrictions in relation to botulinum toxin treatments or procedures, particularly in terms of the age limit from which they could be undertaken.

This new clause would give the Secretary of State the power to introduce a licensing regime for beauty and aesthetics treatments, and make it an offence for a cosmetic practitioner to practise without a licence. I appreciate the intention behind the new clause, and I am sympathetic to its intended purpose. As we are aware, cosmetic treatments are an ever-expanding, multi-million pound industry, and we need to ensure that that industry operates in a safe way.

The breadth of the recent beauty, aesthetics and wellbeing all-party group inquiry into non-surgical procedures, which the shadow Minister alluded to, demonstrates that this is an extremely complex area to tackle and address. There is a huge range of non-surgical cosmetic procedures available, which vary in their level of complexity and invasiveness. The Government are carefully considering the findings of that report and the need for additional regulation in this area in the light of it.

We are considering the case for a licensing system alongside the other specific, and in some cases more narrow, recommendations made in the all-party group's report. As part of that, we need to work further with stakeholders and within Government to clarify the scope of any further regulation and which procedures it might apply to. The private Member's Bill introduced by my hon. Friend the Member for Sevenoaks came into force at the start of October. It prohibits the availability of botox and dermal fillers to under-18s, apart from in a very narrow set of defined circumstances. We will consider the impact and effectiveness of this important legislation in parallel with the all-party group's report in assessing whether to expand further the role of local authorities in overseeing cosmetic procedures.

I reassure the Committee that my priority is to ensure that the right regulatory framework is in place to provide consistent and high standards of practice, and the Government are committed to improving the safety of cosmetic procedures through better training for practitioners and clear information so that people can make informed decisions about their care. I hope I can reassure the Committee that we are actively considering whether increased oversight of practitioners performing some of the most invasive non-surgical procedures is the right way forward, and one that we could work with.

We continue to explore carefully how to achieve a proportionate system of practitioner regulation. The all-party group's report is a very valuable contribution to that work and that active assessment. As soon as that work has been done, we will look to determine the need for and scope of further regulation in this area, and we look forward to reporting our conclusions from that assessment in early 2022. I therefore encourage the shadow Minister not to press the new clause to a Division, and I invite him to work with us in looking at the issue.

Justin Madders: I am encouraged by what the Minister has said. I am pleased to hear that he is meeting the right hon. Member for Romsey and Southampton North and my right hon. Friend the Member for North Durham shortly, and that we will hopefully have some progress on this in the new year. In the light of that information, I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 17

SECRETARY OF STATE'S DUTY TO MAINTAIN SAFE STAFFING LEVELS

"After section 1G of the National Health Service Act 2006 (but before the italic heading after it) insert—

'1GA Secretary of State's duty to maintain safe staffing levels

The Secretary of State has a duty to maintain safe staffing levels in the health and care service in England.'"—*(Justin Madders.)*

Brought up, and read the First time.

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

This is a probing new clause, and I will not press it to a vote. I am not sure that this is the best legislation for it, but we are trying to make some points about the importance of patient safety. I hope we can all agree that for good care to be central, there need to be enough staff, not just notionally through some measure of the number of posts, but by ensuring that those people are actually in place at the time of giving care. We can have a debate about what level of staffing is enough. For a long time, the issue was left to the good sense of managing clinicians but, of course, that has always been strongly impacted on by the level of budget that could support staff.

Across the world, much attention has been placed on setting out what levels of staff and skill are needed in various settings to achieve the required levels of safety. The debate is not at any fixed point in time, because pathways, models of care, and staffing skills and mixes develop and evolve, but there will always be a correlation between safe staffing and levels of funding. It is a sad fact that our NHS, which should find planning easy as a single national system, has struggled for some time in almost every of aspect of workforce planning. It has shied away from asking questions about safety that come when the available workforce is not matched to the resources. At the end of the day, it is the patients who lose out when we are in that situation.

Much of the discussion on this topic historically has focused on the nursing workforce, which is by far the biggest of the staff groups. The Royal College of Nursing put out guidance pre-covid and during covid and set out where the legal responsibilities lie. It also pointed out recently:

"These are unprecedented times. Nursing staff in almost all settings are facing challenges beyond what were ever expected. Staffing levels are poor in many places, on most shifts and care is being compromised as a result"—

"care is being compromised" can be read to mean unsafe staffing levels.

New clause 17 calls for a duty to be placed on the Secretary of State to ensure that there are in fact safe staffing levels, even if there is not a specific legislative requirement in England. I say in England because in Wales, Labour has led the way with the Nurse Staffing Levels (Wales) Act 2016. In Scotland, the Health and Care (Staffing) (Scotland) Act 2019 became law, although I understand that covid has meant that there has been some delay in its implementation. I also understand that Scotland included social care staff in that remit.

A decade ago, research showed that low levels of nurse staffing are linked to worse patient outcomes and unsafe conditions. Before 2013, decisions to assess and review staffing levels were made locally, with little national guidance. However, the Francis inquiries in 2010 and 2013 identified nurse staffing as a patient safety factor that contributed to the care failings identified at Mid Staffordshire NHS Foundation Trust. They highlighted that decisions about nurse staffing were made without full consideration of the risks to patient safety. Francis said:

"So much of what goes wrong in our hospitals is likely, and indeed it was, in many regards, the case in Stafford, due to there being inadequate numbers of staff, either in terms of numbers or skills".

In response to that statement and the Francis inquiries, the Department of Health developed four strands of policy that aimed to create safe nurse staffing levels in the NHS. The National Institute for Health and Care Excellence published guidance for safe staffing in all NHS acute hospitals in 2014. It endorsed the safer nursing care tool to help hospitals to plan their staffing. There was a National Quality Board report outlining the principles that NHS trusts were expected to apply in relation to planning staffing, and trusts were required to monitor the differences between planned and achieved nurse staffing levels and to report them through NHS Choices.

A lot of emphasis was placed on the providers of care, and rightly so. They should use their staff effectively and efficiently to keep patients safe. However, there is also a wider responsibility on commissioners—that is where I think we have fallen down—to ensure that providers do what is required, and on system managers and others who allocate the resources, to ensure that they do it in a way that permits safe levels of staffing. Community, maternity and learning disabilities are all nursing specialities where shortages are most acute. Our new clause makes it clear that all settings would have to adhere to the same standards, with no distinctions, because we believe that good and safe care should be for everyone.

In 2013, the National Quality Board set out 10 expectations and a framework within which organisations and staff should make decisions about staffing that put patients first. The document, entitled "Putting people first", made it clear that safe staffing was both a collective and individual responsibility and central to the delivery of high-quality care that is safe, effective, caring and responsive. In England we have a website full of guidance, and NHS boards are required to take that guidance into account or have regard to it, but there does not appear to be anything similar for social care. Of course, the point I am trying to make, rather unsubtly, is that that is just guidance.

Looking more broadly, the NHS entered its new planning mode from 2015, and we had the emergence of sustainability and transformation partnerships. There was a requirement for them to design local plans to develop, recruit and sustain levels of staff with the right skills, values and behaviour in sufficient numbers, and in the right locations, to ensure the safety of patients. The plans were developed in great haste, but they did not actually go anywhere. Now we are to have more structured ICBs and new plans, but we still do not have a national workforce plan, which means that ICBs cannot plan properly either.

It would be good to know not just the levels of vacancies, but the gap between the staffing needed to maintain safe levels of working and what is actually in place. We touched on this aspect earlier, and we hope the Government respond positively even if they do not accept the new clause. I am sure the Minister will agree that safe staffing levels are better than unsafe levels. We should all agree that it is possible and desirable to enshrine in law guidance from experts on what constitutes safe levels of staffing in various settings and scenarios. We should absolutely be allowed to know when unsafe levels of staffing occur, especially when it becomes an endemic issue due to staff or funding shortages.

As we have mentioned before, we do not want to overburden the Secretary of State, because he already has a number of new powers under the Bill that will keep him busy. We have tried to remove the attempts to give him more work through the power grab, but it would not be for the Secretary of State to do the rotas or phone round for additional staff in the mornings. He just has to ensure that the duty to have staff levels of staffing is fulfilled by those delivering the service. Any wisdom that the Minister can provide on issues around defining, establishing and enforcing safe staffing, and on who carries the systemic responsibilities, will be greatly appreciated.

Dr Whitford: There is no question but that the workforce in both health and social care is one of the biggest challenges across all four nations of the UK. As the shadow Minister highlighted, both Scotland and Wales have passed legislation and aspire to having in law what level should be aimed at, which is quite important. Although covid has impacted in terms of staff leaving the service and the demand on the service, Brexit has also had a huge impact, in that there was an almost 90% drop in European nurses coming to the UK within just months of the referendum. The situation has not recovered, and that impacts right across the system and indeed in social care, where European citizens represented a significant part of the workforce.

When I first came to this place, the former Health Secretary, the right hon. Member for South West Surrey (Jeremy Hunt), talked very much about patient safety but claimed that, in essence, doctors were not really available in the NHS outwith nine to five, and that this was causing what were called "weekend deaths". Having worked long hours for over three decades, I was a bit afraid that my husband would think I was having serial affairs if I was working only nine to five in the hospital,

[Dr Whitford]

so I refuted that utterly. However, the evidence available at the time was that the only staff ratio that had any provable impact on patient outcome was that of fully trained, registered nurses—not trainees, not associates and not assistants—to patients. Obviously, that ratio changes, based on the dependency of the ward—whether it is an ordinary ward, a high-dependency ward or an intensive care ward. That is what leads to the basic formula in safe staffing legislation, and England does not have it.

Although covid, Brexit and other things have impacted on the ability of Scotland and Wales to achieve what they aspire to, the guidance has been there for years and it has not been achieved, as the shadow Minister said. Having safe staffing ratios in hospitals is critical, but what action should be taken if that safe level of staffing is not there? What work should not be done so that patients with emergencies can be cared for properly? Otherwise, there is pressure on management to get things done where they want to see throughput. Sometimes, staff simply end up between a rock and a hard place, and that drives staff out of the service. Ultimately, coming home after an exhausting shift feeling that they have delivered poor care because they were covering too many patients is demoralising. It undermines the retention of staff and adds to the problem.

4 pm

Edward Argar: I am grateful to the shadow Minister, the hon. Member for Ellesmere Port and Neston, for his framing of the new clause in his opening remarks.

The new clause would place the Secretary of State under a statutory duty to maintain safe staffing levels in the health and care service in England. I fear that its effect would be to detract from the responsibility of clinical and other leaders at a local level to ensure safe staffing, supported by guidance—I certainly take on board the point about guidance made by the hon. Member for Central Ayrshire—and regulated by the Care Quality Commission. I am afraid that the Government cannot agree with the new clause as worded for a number of reasons, which I will enunciate for the shadow Minister to illustrate my thinking.

First and foremost, we do not believe that there is a single ratio or formula that could calculate what represents safe staffing. It will differ across and within an organisation and, indeed, across organisations. Reaching the right mix requires the use of evidence-based tools and, crucially, the exercise of professional judgment and expertise and a multi-professional approach.

Consequently, we think that responsibility for staffing levels is best placed with clinical and other leaders at a local level, responding to local needs and supported by guidelines, all overseen and regulated by the CQC. Those guidelines, notwithstanding the challenges posed by the hon. Lady and the shadow Minister, are issued by national and professional bodies such as the National Quality Board and National Institute for Health and Care Excellence. They are based on the best available clinical evidence and are designed to ensure patient safety.

Appropriate staffing levels form a core element of the CQC's registration regime for health and social care providers. Providers are required by the CQC to provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the care and treatment needs of the people using the service at all times. Staff must also receive the support, training, professional development, supervision and appraisals necessary to carry out their role and responsibilities.

Secondly, the new clause would require the formulation of safe staffing ratios against which performance could be assessed. I fear that that could be a retrograde step and inhibit the development of the skill mixes needed for a more innovative and productive future workforce, which will be crucial to the successful implementation of the new models of integrated care that the Bill is intended to support. Just as there is no one-size-fits-all approach for the new models of care, there will be no identikit approach to the mix of staff needed. The ultimate outcome of good quality care is influenced by a far greater range of issues than how many of each particular staff group are on any particular shift, according to a prescribed ratio. It requires the professional expertise and judgment of those who know the situation best in a given circumstance. The point I seek to make is that, although those numbers are a key part, they are not the only part.

This is, perhaps, more of a technical point than a point of substance, but the specific wording of the new clause is incredibly broad. It would potentially require the Secretary of State to assess safe staffing levels across all healthcare settings across the whole of England for all medical and clinical staff. Such a duty would, I fear, be challenging to implement, notwithstanding the shadow Minister's assertion that he would not expect the Secretary of State to sit there each morning going through shift rotas and shift patterns himself. It would be challenging for not only the Department but the wider system and, in particular, clinical leaders in individual settings.

For those reasons, while I appreciate the sentiment and the objective sought by the shadow Minister, I do not believe the new clause is the appropriate practical solution.

Justin Madders: I am grateful for this Minister's response. I am not surprised that he is not prepared to the support the new clause. Unfortunately, I think there is a large chasm where responsibility for workforce issues probably lies, and this is an example of that. It was certainly not our intention to expect the Secretary of State to deliver each individual setting, but for someone in the system to have that responsibility of advising the Secretary of State. No doubt we will return to this. We will see the practice in the devolved nations and how that has proved to be a success or otherwise, which may strengthen or weaken the argument. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 18

Workforce responsibilities of integrated care boards

"(1) Each integrated care board must at least every two years publish a report setting out an analysis of the current workforce, the workforce requirements to enable the Board to fulfil its duties over the following 2, 5 and 10 years, and the plans the Board has to close any gaps identified.

(2) In drawing up the report the Board must consult—

(a) the Trusts and Foundation Trusts that provide services in its area,

(b) providers of primary care in its area, and

(c) the recognised trade unions."—*(Justin Madders.)*

Brought up, and read the First time.

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

We are back on the workforce. We had a brief discussion about the proposals in clause 33 on the Secretary of State and workforce planning, and how they are by universal acclaim wholly inadequate. Now is not the time to repeat that debate, although I may shoehorn in one or two references to it. We hope that at some point there will be a better proposal on the national efforts to assess and meet workforce needs.

The new clause tries to repeat the intentions of the amendment to clause 33, and to take some of that thinking and translate it to ICB level. That makes a lot of sense to us, and in an ideal world some of the national plan would be made up of individual local assessments of need and add together the 42 ICBs into one national workforce plan. We will see where we end up with that. As I said, we have had some attempt at this with each STP trying to produce its own plan to a very abrupt timetable. I do not think anyone actually added up all their assessments to come up with a national figure. Because of the truncated timetable they faced, there was not a great deal of engagement with the workforce on that.

There is therefore a bit of a precedent in the work that was done on that. It is probably what you would call a gap analysis: what is needed against what we are likely have unless something is done to close that gap. The new clause follows that approach, which has had some support in some other areas. We felt that a two-year cycle was about right, with reporting on that two-year cycle covering short, medium and longer-term need.

It is hard to see why we will not have local plans if we are going to have national plans, to make sure that there is alignment when, as we hope, the Government come back with something better on clause 33. Looking at the total staff in the NHS and social care for an ICS, some of the larger ones will be running into hundreds of thousands of people. It is hard to think of any system with that many staff where some sort of workforce planning is not going on. If we are looking at things across system level, as the ICS is, surely workforce needs across the system would be part of that. We know that ICBs, together with the relevant trusts and foundation trusts, have the general duty to produce a plan annually, setting out how they propose to exercise their functions over the next five years. They will not be able to do that without the right staff.

A lot of the ground work entailed in the new clause will have been done already. It is our intention that it will try to remove any possibility of blame shifting, where inadequate resources lead to reduced services and the service providers are blamed, rather than those who hold the purse strings in Whitehall. The reporting required by the new clause will make it clear whether there are enough staff to meet all the reasonable requirements of the ICB.

The other key point covered by the new clause is who is consulted in the local planning process. We believe it vital that recognised trade unions are involved. That should be a given anyway, in the light of the general commitments from the NHS over partnership working, but as we have covered before, we think that needs to be explicit in the legislation because of the behaviour of a few NHS bodies in trying to marginalise staff involvement in recent times.

The ICBs will new bodies, and they will need to understand the importance of partnership working from day one. If the levelling-up and devolution agendas are to continue to flourish, surely the regional and sub-regional identification and development of skills in this important area ought to be part of the mix. It feels, I am afraid, as though the whole issue of workforce is being assiduously side-stepped by the Department. That is the Department's prerogative, but it is a mistake and it is those on the frontline who will bear the brunt. We need someone to take responsibility, so why not the ICBs?

Without its workforce, the NHS is nothing. We are grateful to each and every one of its staff for the work that they do. We owe it to them, the patients and the taxpayer to have in place a proper system of workforce planning. Although we do not pretend that the new clause is the whole answer, it would begin to put in place the building blocks to achieve that.

Edward Argar: The new clause would place a new statutory responsibility on integrated care boards to publish, at least every two years,

"a report setting out an analysis of the current workforce, the workforce requirements to enable the Board to fulfil its duties over the following 2, 5 and 10 years, and the plans the Board has to close any gaps identified."

Under the new clause, ICBs drawing up that report would be placed under a statutory duty of consultation with the trusts and foundation trusts in their area, providers of primary care and the recognised trade unions. The Government's view is that that is an unnecessarily prescriptive duty on ICBs, and that clause 33 —alongside our non-legislative work and investment— remains the right way to develop the NHS workforce.

On the workforce nationally, what is needed is greater transparency and accountability for the various bodies involved in workforce planning. Clause 33 requires the Secretary of State to produce a report describing the workforce planning and supply system—including the roles of DHSC and its arm's length bodies; NHS bodies, including ICBs and others; and how they work together—to provide that greater transparency.

To support local ICBs on workforce matters, work is already being taken forward on workforce planning through NHS England and NHS Improvement's draft guidance to ICBs on the discharge of their functions. The draft NHSEI guidance, published in August 2021, states that the intended outcomes for ICBs will include,

"Growing the workforce for the future and enabling adequate workforce supply",

as well as,

"Leading coordinated workforce planning".

The guidance notes state explicitly that ICBs will have the responsibility to develop

"plans to address current and future predicted workforce supply requirements",

which I believe addresses the core intention of the shadow Minister's new clause.

[Edward Argar]

The production of those plans will require ICBs to develop and regularly refresh collaborative workforce plans for their integrated care area, with demand and supply planning based on population health needs. As part of that work, we can expect ICBs to work with local stakeholders in their areas. ICBs will also be supported by Health Education England on such workforce planning matters. Under the guidance, ICBs will also have the responsibility to provide workforce data to regional and national workforce teams to support workforce planning and inform the prioritisation of workforce initiatives and investment decisions.

We join the shadow Minister in putting on the record our gratitude to our health and care workforce, but we think that that guidance already sends a strong signal to the system about the importance of the issue, and we therefore do not support his new clause.

Justin Madders: I am not surprised, although I am a little saddened, that the Minister has once again adopted the permissive rather than prescriptive approach. We think that the issue is so important for the NHS that it needs a firmer hand. I am sure that I will quote back to him his comments about the need for greater accountability and transparency in workforce planning, because that is something that we absolutely agree on. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 19

SECRETARY OF STATE'S DUTY TO PROVIDE ACCESS TO OCCUPATIONAL HEALTH SERVICES TO NHS STAFF

"After section 1G of the National Health Service Act 2006 (but before the italic heading after it) insert—

'1GA Secretary of State's duty to provide access to occupational health services to NHS staff

The Secretary of State must provide access to occupational health services to meet the reasonable requirements of all persons who are employed in an activity which involves or relates to the provision of services as part of the health service in England.'"—*(Alex Norris.)*

This new clause would place a new duty on the Secretary of State to provide access to OH services to meet the reasonable requirements of all NHS staff. The duty would apply to all healthcare professionals delivering health care including doctors, dentists, nurses, midwives, pharmacists, healthcare scientists and the allied health professions.

Brought up, and read the First time.

4.15 pm

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

The past 18 months have made clearer than ever the health risks that our health workers face at work, as they have dealt with unprecedented pressures during the pandemic. Occupational health is a multidisciplinary approach to maintaining the wellbeing of those employed in a workplace, preventing and removing ill health and developing solutions to keep staff with health issues at work, the most common problems being mental health and musculoskeletal issues.

Occupational health services occupy a unique position as neither the employer nor the employee. I remember in my time as a union official helping NHS staff with issues at work, and we would howl at times at things that occupational health came up with. Then we met management and realised that they were howling about it too, so we realised that the occupational health practitioner was probably in the right place. That is a very specific and special place, in the NHS and beyond, and we should want our wonderful NHS staff to have proper access to it.

Currently, the NHS provides access to occupational health services to the vast majority of staff in acute trusts, but the policy is inconsistent. While NHS England is making efforts to expand access through the growing OH programme, those efforts need to be accelerated and supported, which is what the new clause would do.

In secondary care, the provision of services tends to depend on legal requirements on safety, for example checking for blood-borne viruses in advance of performing surgical or other procedures that could pose a risk to patients from the infected clinician, rather than occupational health provision that supports individuals to remain at work based on other needs they might have.

Similarly, the co-ordination of occupational health services in primary care has suffered since the abolition of primary care trusts in the Health and Social Care Act 2012. As a result, there is far less provision in primary community care settings. Some of the funds previously allocated to PCTs in support of occupational health services were diverted to the practitioner health programme—PHP—which provides mental health support for NHS staff. While that is valuable, the PHP is not a replacement for specialist occupational health services that are ready to work with both employer and employee on issues beyond mental health. That means that key parts of the NHS workforce—GPs, practice nurses and pharmacists—lack full access to occupational health services, and that has real implications. We worry about burnout in all those groups, especially after the 18 months we have just had. For some of our staff, A&E is the only avenue for treatment, in cases of exposure to infectious disease or a needle stick, for example. That is unsuitable and we could do much better than that.

We think it is vital for NHS staff wellbeing and staff retention that all NHS workers have access to occupational health services when they need them. We are not asking for something extra or beyond the scope of current conception. In 2016, NHS England introduced a commitment for OH services to be provided across the NHS, stating its intention to achieve

"a nationally standardised Occupational Health Service…that is equitable and accessible."

That is a very good commitment, but five years on it remains unfulfilled. The new clause would put that on a statutory footing and get it going.

The Secretary of State already has several duties to NHS staff, in relation to education and training, for example, under the 2012 Act. The new clause would fulfil the 2016 commitment and meet the needs of NHS staff by requiring the Secretary of State to meet any reasonable OH requirements for anyone employed by the NHS directly or indirectly. It would be really good for our staff and, in turn, for the health service and those it serves. I hope that the Minister will give it positive consideration.

Edward Argar: As the hon. Member for Nottingham North set out, the new clause seeks to legislate for an additional duty on the Secretary of State to provide access to occupational health services to NHS staff.

The NHS is what it is thanks only to the hard work of its staff. The Government and Members of Parliament on both sides of the Chamber are immensely grateful to them. Caring for people throughout the pandemic has required a phenomenal effort from so many people, ranging from students and trainees to new recruits, established staff and those returning to the workforce. The dedication and resilience of NHS staff has been incredible—indeed, humbling—to witness. They have consistently placed the needs of patients before themselves, as indeed they do year in, year out, but they have done so in particularly challenging circumstances over the past year and a half or so.

If healthcare staff are to provide excellent care to patients, they need to receive excellent support themselves. Occupational health services play an important role in ensuring that staff get the support that they need to do their jobs and to flourish in them. Throughout the pandemic, we have placed a strong emphasis on supporting staff wellbeing. In July 2020, we published the NHS "People Plan", which prioritises staff health and wellbeing. That was supported by the roll-out of a comprehensive national health and wellbeing support offer, which has been accessed by staff across the NHS.

The past 18 months have seen many NHS organisations respond with empathy and agility to the pandemic, and occupational health teams have developed innovative ways of supporting their colleagues. As we move towards, or into, the recovery phase, there is a great need to build on that focus and momentum, to ensure a healthy, sustainable workforce going forward. As we look to the same workforce who have taken us through the pandemic to tackle the waiting lists and waiting times, we must recognise, and be open with those who watch our proceedings and listen to us, that that task of rebuilding and getting the waiting lists down will be challenging. We owe it to the staff to be clear about that, because they are the same staff. They are physically and emotionally exhausted, and we have a duty of care to them, and must enable them to rebuild their physical and emotional strength after what they have been through over the past year and a half.

That is why the NHS priorities and operational planning guidance, published in March 2021, puts staff wellbeing and the recovery of the workforce right at the top of the list of priorities for the NHS. To support that, NHS England and NHS Improvement have launched a new programme to strengthen and improve occupational health across the NHS. That will look at how we can improve occupational health services, grow the occupational health workforce, develop their capability, empower local leadership and bring a strengthened focus on proactive and preventive care. It will build on best practice across the country and will inform future blueprints for potential service delivery models, with the aim of having a five-year service improvement strategy for occupational health in the NHS. It is being developed with the support of Dr Steve Boorman and the Faculty of Occupational Medicine, the Society of Occupational Medicine, the Council for Work and Health and the NHS Health at Work network, as national occupational health partners that both represent the voice of and link directly with occupational health professionals. That work, and the broader programme of work through the NHS "People Plan" to transform the NHS as a place to work, demonstrates our strong commitment to supporting staff health and wellbeing in the NHS.

As a result, we do not believe that this new clause is necessary, although we appreciate the sentiment, objective and aims sitting behind it. Our concern is that drawing out occupational health over and above other aspects of health and wellbeing support does not necessarily help to drive forward the other work done, which I have alluded to and which provides staff with a more comprehensive package that can be tailored to individual or group staff needs. There is a risk, though I suspect it is a small one, that occupational health could become a tick-box exercise to comply with, which would detract from the full journey of health and wellbeing support. Occupational health is part—indeed, a vital part—of that, but it is not the solution in and of itself, alone.

For the reasons that I have set out, I ask the hon. Gentleman to consider not pressing the new clause to a Division at this point.

Alex Norris: I am grateful for that response. I do not intend to push this new clause to a Division. I have made my case about the importance of occupational health, and I understand what the Minister said about the broader range of interventions. Of course, we would support those, too, but particularly here, we really need to get to the point of having full coverage. Only NHS England has committed to that. I hope that today we have at least sounded the signal that the pace is too slow, and that we ought to get on with it. I hope that the Minister will keep the matter under consideration. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 23

CAP ON PRIVATE CHARGES

'(1) Section 43 of the National Health Service Act 2006 is amended as follows.

(2) Leave out subsection (2A) and insert—

"(2A) An NHS foundation trust does not fulfil its primary purpose if the proportion of the total income of the NHS foundation trust in any financial year derived from private charges is greater than the proportion of the total income of the NHS trust derived from such charges in the financial year ending 31 March 2022.

(2B) For the purposes of subsections (2A) and (2C) "private charges" means charges imposed in respect of goods and services provided to patients other than patients being provided with goods and services for the purposes of the health service.

(2C) An NHS foundation trust does not fulfil its principal purpose if in any year the proportion of the total income derived from private charges is greater than the proportion of the total income of the NHS trust derived from such charges in the previous financial year unless—

(a) the appropriate integrated care boards and integrated care partnerships have been notified of the intention that this increase will occur;

(b) that intention has been published with a statement of the reasons why it is considered to benefit the NHS;

(c) the appropriate integrated care boards and integrated care partnerships have used reasonable endeavours to consider any responses to the publication mentioned in (b); and

(d) any integrated care board which has commissioned services from the trust, and the integrated care partnership for the board, have informed the NHS foundation trust that the proposed increase is justified."'—*(Justin Madders.)*

This new clause would prevent NHS foundation trusts increasing their income from private patients year on year unless the conditions set in subsection (2C) are met.

Brought up, and read the First time.

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

One of the livelier arguments during the passage of the Lansley Act was about trusts doing lots more private patient work. Under the Act, up to 50% of a trust's income could be derived from private patients. That was obviously an attempt to take the NHS in a whole new direction. The previous private patient cap was removed, and a new definition of "principal purpose" was brought in.

We need to be clear that this new clause is not about the parallel argument that we sometimes have about private providers doing more NHS-funded work, though that is a major concern when we hear the news that the private sector is now doing more hip replacements for NHS patients than the NHS. We are in a slightly ludicrous and paradoxical situation: private providers are doing more NHS-funded work, while NHS providers are doing more private work. The new clause tries to put the brakes on that. We say: why not just build up NHS capacity to the point where it does all NHS-funded work, so that the need to keep dipping into the private sector is removed?

The 2011 argument is mirrored in the way the original foundation trusts, when invented, were allowed to develop private patient income, but only to a very low level. That was not a great situation, but it recognised that there were already a few NHS organisations, mostly in London, for which private patient income was so significant that there would be a risk of destabilisation if that income were blocked. The point at the time was that the amount permitted then was acceptable, but that it should go no further. Incidentally, the plain-old NHS trusts could do as much private patient work as they were allowed to by the Secretary of State, who could direct them to do it. If memory serves, he allowed one trust to become the private patient income league table toppers at one point. It did not want to become a foundation trust. What a strange and paradoxical world we live in.

Anyway, in 2011, the cap was raised from 3% to 50%, which started many hares running. We heard predictions of a whole new generation of private patient units being built, and that we would be back to the old days when the NHS was the largest provider of private patient care. Fortunately, that never happened. In the real world, there are now only around a dozen trusts that have any significant private patient income, and it is not increasing at a significant rate, although recent developments in Oxford suggest that the issue has not gone away.

One might argue that in those circumstances there is no need for the new clause, but we would say that there is every need to renounce the approach set out in Lansley, and to go back to a public NHS. The only reason for gaining income from private patients is to benefit the NHS as a whole, not to benefit one NHS organisation. This is a real and live issue, as we saw during covid. There were tensions, and every spare bed was vital; indeed, every spare bed is vital now to support the mammoth effort that is needed to bring down waiting lists. In all seriousness, why would we sanction a trust's building more private patient capacity, when waiting times for NHS treatment continue to go up? Then we go, as we have done in recent times, cap and wallet in hand to the private providers and pay them huge sums to allow the NHS the option of using their services and capacity, as we did during covid. As we saw recently, that did not get used anything like as much as it should have been. That might be a fortunate thing, but it was a shocking lack of value for money. The report by the Centre for Health and the Public Interest on the contract with the private sector found that none of the five objectives set for the contract were achieved, with large amounts of healthcare resources wasted.

4.30 pm

Private hospitals delivered just 0.08% of covid care, and for 59% of the days in the year that the contract ran, only one or no covid patients were being treated. Paradoxically, private hospitals also delivered 43% less non-covid healthcare than in the year before the pandemic, despite the large increase in purchase capacity. Of course, they were protected by the Government's contract, which guaranteed operating costs, paid weekly in advance; that put them in a strong position to capitalise on the waiting list situation.

Mystery remains about the total cost of the deal. To go back to our earlier discussions on freedom of information requests, we know that a number of FOI requests trying to get to the heart of those costs have remained unanswered. We have never seen the actual cost to the taxpayer in real terms of treating NHS patients through the private sector. What is the overall impact on the NHS of having private patient businesses? Can we have some assessment of that?

Every consultant, anaesthetist and nurse undertaking private procedures for an NHS trust is being taken away from doing that same work directly for the NHS. We need to reverse that 2012 change and go back to ensuring that NHS private patient work is constrained to those small areas where it may genuinely benefit the NHS as a whole. With this new clause, we seek to put some sense back into the system, which has got hopelessly confused and does not benefit the taxpayer or patients.

Edward Argar: The hon. Gentleman's new clause would effectively prevent NHS foundation trusts from increasing their income from private patients year on year unless a number of specified conditions were met.

If hon. Members are students of history, they will recall that in 2012 we abolished the private patient cap, while clarifying that the foundation trusts' principal purpose was

"the provision of goods and services for the purposes of the health service in England",

meaning that foundation trusts must make the majority of their income from NHS activity. That was a more rational and sensible way of managing the issue than the previous cap, which caused practical problems for some NHS organisations that wanted to become foundation trusts and were prevented from doing so by the prescriptive nature of the previous regime. We also retained the requirement that additional income be used to benefit NHS patient care. It has been used across the system to offset maintenance costs, finance alternative transport such as park and ride, and fund patient care.

I should also be clear that we are talking about a very small percentage of the NHS's income. The most recent set of provider consolidated accounts for 2019-20 shows income from non-NHS sources as 2% of income, of which less than 1% relates to private patients. Again, all that income has gone to improving care for NHS patients.

The new clause introduces a new cap by a different door; it creates a requirement for foundation trusts to agree with their ICB and ICP their income from non-NHS sources, and if they raised more than in the previous year, they would no longer be fulfilling their primary function as a foundation trust. That would be a significant bureaucratic and administrative burden on foundation trusts, and it would require them to either forgo raising additional income, or seek agreement via a multi-stage process before raising it.

The provision would also mark a significant new restriction on foundation trusts' freedoms and autonomy, and could potentially dissuade some from wishing to become foundation trusts. As all non-NHS income must benefit NHS patient care, and an NHS foundation trust must always have as its primary purpose the delivery of NHS services, I fear that would potentially be putting ideological purity over practical interests and the practical working of the system.

New clause 23 would only apply to foundation trusts, as I read it, not NHS trusts. NHS trusts do not have a limit on the amount of income they can raise from private patients, and a very small number of trusts raise significant income in this way. Putting an additional requirement on foundation trusts before they can raise non-NHS income, but not doing the same for NHS trusts, would potentially further unbalance the playing field and give an additional nudge in the direction of foundation trusts.

The hon. Gentleman raised the issue of the costs or spending on the independent sector in the context of the pandemic response. I have been clear throughout that when the accounts are fully consolidated and audited, those figures will have to be reported. I cannot say exactly when that process will be complete, but it is a requirement that those accounts be gone through, consolidated and audited. I would hesitate to give him an inaccurate figure, but it is my intention for those figures to be made available at the appropriate time. With that, I invite the hon. Gentleman to consider withdrawing his new clause.

Justin Madders: I hesitate to withdraw the new clause, because I have to say that the Minister's arguments about not wanting to deter foundation trusts from making applications rang a little hollow, but we would not want to be accused of preventing that procession from continuing. We have set out very clearly why we do not think this residue from the 2012 Act should remain on the statute book. We think it sends out the wrong message and is actually unhelpful at this time, but we will not push the new clause to a vote. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 24

REQUIREMENT FOR NHS TRUSTS TO PUBLISH ROYAL COLLEGE INVITED REVIEW REPORTS

"Each NHS Trust in England must publish the reports produced by Royal Colleges of invited reviews of the Trust, including any conclusions and recommendations."—*(Justin Madders.)*

This new clause would require Trusts to publish Royal College invited review reports.

Brought up, and read the First time.

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

The clause seeks to require all trusts to publish reports produced by royal colleges following invited reviews, including any conclusions and recommendations. Invited reviews are advisory, non-regulatory and non-statutory ways for healthcare organisations to assure patient safety and improve patient care through the use of a collaborative, independent, objective and expert review process undertaken by medical royal colleges when asked. Invited reviews have a clear and important role in supporting improvements in services. They aid trusts in understanding issues within departments or teams, particularly where these are multifactorial and involve team dynamics. An independent, external expert opinion is often invaluable in helping senior clinicians see a different viewpoint and in articulating where and why professional differences of opinion in practice are occurring.

The reports can help move issues of contention forward and improve relationships. Trusts value the insight and objective evidence of these reviews, particularly where quality issues have been raised. They are often a vital tool in resolving a complex, seemingly intractable issue. They are also invaluable in ensuring the NHS can continually learn, improve and deliver the safest and best quality care for patients. However, we think that can only be achieved if the information and learning within the reports is shared for the benefit of others across the system.

Independent and external expert reviews are a key part of any assurance process. To us, their value is beyond dispute. How the organisation being reviewed responds to the report produced is again crucial. Although we would expect in most cases the organisations to accept those recommendations and do what is required, we know that does not always happen. Shockingly, BBC "Panorama" revealed that, of 111 invited service reviews over five years, only 16 were put into the public domain. Panorama accuses trusts of burying important reports on patient safety. The invited reviews are organised by the Academy of Medical Royal Colleges, which follows the published framework. The framework has a section on openness and transparency:

"Where a healthcare organisation has commissioned an invited review of clinical activity in response to concerns about the quality of patient care, they should also be open and transparent with patients, their relatives and the public…Healthcare organisations should also work closely with their regulators and share information about invited reviews with them proactively where necessary to ensure that the safety of patients can be maintained."

As with all such external reviews, there is a balance between protecting certain information, for example by attributing views or comments, and being open. For such reviews it is necessary that those interviewed or otherwise asked to become involved are happy to do so and happy to speak out confidentially. As we discussed earlier, ensuring that staff and whistleblowers feel safe to come forward and disclose information about an incident is critically important.

The new clause does not intend to get in the way of that protection. It is deliberately not prescriptive about the timing of publication, so that trusts maintain appropriate control. It is not about blame or ensuring that trusts are named and shamed when improvements are needed; it is about transparency. In the NHS, after mistakes have been made, it is vital to have transparency to ensure that necessary improvements are made.

[Justin Madders]

It is concerning that so many reports produced by royal colleges have not been shared with the public and therefore we do not know whether they have been acted upon. As part of the conditions of an invited review, trusts are in effect signing up to publishing and showing the findings. Yet, as we know, that is not happening.

Everything favours openness, although patient-identifiable information would of course have to be redacted. On some occasions, there may be other reasons for part of the report to be withheld, but not the overall conclusions and certainly not the recommendations. That would ensure proper accountability for the follow-up and implementation of the recommendations or, in some cases, a justification for why the organisation did not accept or act on the recommendations.

We have talked several times already about the defensive culture that pervades parts of the NHS and how it sometimes gets in the way of what patients and families want. They want answers and assurances. Most of all, they want the truth. These reviews are part of that truth. We have had the same argument many times, because, although the NHS claims to be open and transparent, it is often not.

Given the fragmented and convoluted set of organisations within the new structure, it is harder to know sometimes who will be responsible for what. With the present system, there is always the issue of who owns the report, who controls what is published and who follows up and ensures that the necessary changes are made. That is why we believe that that the disinfectant of sunlight is vital. We should know everything unless there is a good reason for us not to, not the other way round. We should not be required to protect the reputation of bits of the NHS or even the reputations of those individuals who have failed to do their jobs properly.

We have heard in the many scandals how things were known by a few, but they failed to act and prevented anyone else from acting on the information they had. Sadly, it is necessary to be clear about rules. There ought to be some sort of sanction for those who have broken rules of publication. It may not always be easy for the individuals or the individual organisations, but it is almost certainly always going to be in the interests of the NHS as a whole.

The Academy of Medical Royal Colleges and the CQC are looking at guidance on invited reviews at the moment. The new clause seeks to focus the Minister's mind on an issue that has not gone away. I know it is controversial. I hope the Minister can give us some assurances that his Department is committed to developing a system that works better in this area and puts patients at the heart of everything that happens.

Unfortunately, in the last financial year prior to the pandemic, there were 472 serious patient safety issues classified as never events across the NHS in England. There is work to be done to get the NHS to the level of patient care and safety that we would want to see. It is only by seeking to understand why these events happened in the first place and the circumstances that led to them that we can ensure they never happen again. That is the heart of what most patients and their families want to know.

We believe that the safety of patients should be a golden thread running through every aspect of healthcare delivery and we will do everything in our power to make sure that the NHS is one of the safest and most supported healthcare systems in the world. I ask the Minister to tell us why the reviews should not be published on a regular basis. Is 16 reports out of 111 being published good enough? We certainly do not think it is.

I will finish on a quote from the Francis report. We have mentioned this one already, but it needs repeating as it is so important. He said:

> "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."

We hope that this new clause, by requiring publication of the reviews, will go some way to restoring confidence and increasing the transparency that patients deserve.

4.45 pm

Edward Argar: The new clause would require each NHS trust in England to publish any report by a medical royal college of an invited review of the trust. That includes any conclusions and recommendations. It is right, as the hon. Gentleman mentioned, that trusts are open and transparent in managing any concerns about the quality and safety of their services, and, in particular, regulators should have access to any royal college invited review of a trust.

I have considerable sympathy with the intention of the new clause. We all want to improve patient safety and care, and I recognise the key role that transparency can play as part of that. However, I will explain why I am not convinced that this objective is best advanced by acceptance of this particular new clause. Managing concerns about clinical quality openly and transparently is essential for trusts if they are to provide consistently high quality, safe care, to show quality of leadership and to maintain trust in the trust and the service it delivers.

When the CQC finds that there has been a failure to do so or that fundamental standards of care are not being met, it is reflected in the CQC's reports and ratings and in the range of enforcement powers it can use. The CQC's inspection teams maintain ongoing engagement with trusts and make it clear that they expect trusts to be open and honest about issues of quality and safety of services. Furthermore, the CQC has been clear with trusts that reports, including invited reviews by royal colleges, should be made available to relevant commissioners and regulators, including the CQC. The CQC, NHS England and NHS Improvement expect trusts to take prompt actions to address appropriate recommendations, and the framework for invited reviews from the Academy of Medical Royal Colleges is clear that trusts and royal colleges undertaking reviews should share any serious patient safety issues from reports with the CQC.

As part of the CQC's monitoring and inspection activity, it assesses how trusts have acted on recommendations from these reviews, including implementing any learning to make improvements. Since July 2018, the CQC has set a very clear expectation on trusts to share copies of the full final report of external reviews, including those by royal colleagues, and to inform it of steps they are taking to implement any recommendations. The CQC, working with providers, NHS England, NHS Improvement

and the Academy of Medical Royal Colleges, has seen improvement in the development of an open and transparent culture.

The CQC has powers to compel a trust to share an invited review where it is aware of that review. Where serious issues of care are uncovered, NHS England and NHS Improvement can also compel a trust to take whatever steps are necessary to address them. This includes the sharing of an invited review to itself. The CQC is now reviewing its regulatory model, including its approach to monitoring and gathering evidence from providers. In doing so, it will continue to work with trusts and royal colleges, including on sharing and responding to findings from external reviews to encourage a culture of openness and transparency.

There are robust and transparent systems in place to ensure that providers learn from and improve their services. This includes publishing more than 100 reports every year, covering 40 clinical specialisms as part of the clinical audit programme by NHS England and NHS Improvement. NHS England and NHS Improvement also publish regular data on patient safety incidents, other safety indicators and patient safety alerts. They also provide support to challenge providers to improve governance and culture.

Invited reviews are a voluntary process. They are an advisory, non-regulatory and non-statutory way for trusts to assure patient safety and quality of care through the use of an independent review, but compelling the publication of the full report could lead to some unintended consequences. First, it could discourage some trusts from commissioning these invited reviews. That could lead to trusts overlooking specific actions to address safety and quality concerns and opportunities for improvements and learning. Secondly, it could lead to trusts inviting consulting firms and other professional bodies with less expertise in the delivery of clinical care than a team from the royal college to undertake reviews. Thirdly, invited reviews can vary widely in their scope and may not be directly patient safety-related. Therefore a blanket requirement to publish all reports may not be appropriate.

Fourthly, the specific information that a trust can make publicly available will vary from review to review, depending on the circumstances. Invited reviews can often involve sensitive and complex circumstances and cover confidential issues about staff and patients. Trusts need to take account of legislation on patient confidentiality and data protection each time a report is developed. It may therefore not be possible for every invited review to be a published document. The Academy of Medical Royal Colleges recommends that trusts should take steps to make available to the public a summary of the review and the steps they are taking.

Finally, requiring publication of invited reviews could attract attention in a way that affects staff morale and organisational learning, and not in a constructive way. It could make future invited review reports weaker or drive necessary conversations and actions off the record. For these reasons, while I can understand the hon. Gentleman's point and where he is coming from, we believe that the mechanisms already in place are sufficient and achieve the right balance.

Justin Madders: I am slightly heartened by what the Minister said there. He obviously takes the matter seriously. We are not going to press this to a vote, because we recognise that there is some concern in the sector about this proposal. I ask him to reflect on what he said about a requirement possibly discouraging trusts from seeking invited reviews in the first place. That shows that reputation management is still at the forefront of their considerations rather than patient safety. That is the heart of the problem that we have been seeking to tease out with this new clause. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

New Clause 25

"Secretary of State's duty to report on disparities in maternal mortality rates

The Secretary of State must prepare and publish a report each year on variation in the quality and safety of England's maternity services and disparities in maternal mortality rates in England, including the steps being taken to address these disparities and improve outcomes for patients."—*(Justin Madders.)*

This new clause lays a duty on the Secretary of State to prepare and publish a report on variation in the quality and safety of England's maternity services and disparities in maternal mortality rates in England, including what steps his department is taking to address these disparities and improve outcomes for patients.

Brought up, and read the First time.

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

This clause, in the words of Ronseal, does exactly what it says on the tin. It lays a duty on the Secretary of State to prepare and publish a report on variation in the quality and safety of England's maternity services and disparities in maternal mortality rates in England. The report would include details of the steps that the Department was taking to address these disparities and improve outcomes for patients. We all know that this issue is of paramount importance and has been debated in the House several times recently. I hope that the Minister agrees that it is important that we take whatever steps we can to tackle all forms of inequality in our society and this is another example of how that manifests itself.

Covid has sharpened our awareness of health inequalities, but it is clear that it is not just with respiratory viruses where health outcomes can be staggeringly different for different groups. Maternity services are one of the areas where we can and must do far better. The Care Quality Commission report "Safety, Equity and Engagement in Maternity Services", published in September, highlighted continued concern about the variation in quality and safety of England's maternity services and presented analysis of key issues that persisted in some maternity services. It also highlighted where action was still needed to support vital improvements. In the UK's poorest areas the stillbirth rate is still twice that in the UK's most affluent ones, with pre-pandemic figures showing that babies in the poorest areas have a 73% excess risk of neonatal death. All mothers and babies deserve the very best care and it simply cannot be right that where people live might dictate the quality of the maternity care received. Action is needed to eradicate maternal inequalities.

It is not just geographical and socioeconomic inequalities that need to be tackled but ethnic inequalities. Evidence from MBRACE-UK—Mothers and Babies Reducing

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Risk Through Audits and Confidential Enquiries across the UK—shows that the maternal mortality rate is more than four times higher for black women compared with white women. The maternal mortality rate for Asian women is almost twice as high compared with white women. Those inequalities are an injustice, and we need action to address them.

I recognise that many black, Asian and minority ethnic women also do not feel that they are listened to during childbirth. A lack of cultural competency and medical training means that complications are not always spotted early enough. For example, black women have shared experiences of how anaemia has not been picked up soon enough because of their skin colour. We really ought to be doing better than that.

The Government have said that they have hosted several roundtables with experts and have commissioned more research to better understand the issue. However, they believe that a target to address maternal mortality disparities would have limitations in improving the quality of care. Why do they hold that view? NHS England's long-term plan includes targets for addressing health outcomes in other areas. We need action to address the unacceptable disparities in maternal mortality rates as well.

The Joint Committee on Human Rights found that over 60% of black people did not believe that their health was equally protected by the NHS compared with white people. As we know, covid has had a disproportionate impact on BAME communities.

If not a target, then a report would ensure accountability and focus minds to address these unacceptable injustices. New clause 25 would put explicit accountability on the Secretary of State not only to monitor and report on variation in maternity services but, crucially, to set out the steps needed to tackle it. We need a national strategy to address this country's health inequalities, which must include serious and urgent action to end the mortality gap between black, Asian and ethnic minority women and white women. The new clause is, of course, not the complete answer, but I hope the Minister will agree that it would be a welcome step in the right direction.

Edward Argar: Again, I am grateful to the shadow Minister. The new clause would require the Secretary of State to publish a report each year on variation in the quality and safety of England's maternity services and on disparities in maternal mortality rates in England. Again, I understand the intention behind the new clause, which the hon. Gentlemen set out clearly, as it is paramount that we do all we can to ensure the safety of expectant mothers and their babies, which involves understanding and taking steps to address the variation in quality and safety of England's maternity services and disparities in outcomes.

However, several organisations and bodies already publish reports each year on the variation of quality and safety of England's maternity services and the disparities in maternal mortality rates. First, the CQC monitors, inspects and regulates maternity services across England to ensure they meet standards of quality and safety. Following an inspection, it provides findings, recommendations and an overall rating of the trusts. It also publishes monthly reports following inspections of maternity services and annual reports that explore areas for improvement in maternity services across England.

Secondly, "Better Births", the report of the national maternity review, recommended that a nationally agreed set of indicators should be developed to help local maternity systems to track, benchmark and improve the quality of maternity services. In response, NHS England and NHS Improvement, in partnership with NHS Digital, have produced a national maternity services dashboard. The dashboard enables clinical teams in maternity services to compare their performance with their peers on a series of clinical quality improvement metrics, or CQIMs, and national maternity indicators, or NMIs, for the purposes of identifying areas that may require local clinical quality improvement.

Thirdly, MBRRACE-UK publishes annual reports on maternal deaths, stillbirths and neonatal deaths across the UK. Stillbirth and neonatal mortality rates are provided for individual NHS providers, commissioning boards, and local authorities in England, Scotland, Wales and the Crown dependencies. It would not be possible to report annual maternal mortality rates by NHS trusts because the numbers are very small—it would not be a meaningful statistic. That would also potentially risk individuals being identified and could result in contravention of data protection legislation.

The reports by MBRRACE-UK also look at health inequalities; its analysis has identified significant differences in maternal mortality rates, which the shadow Minister mentioned, between women from black or Asian minority ethnic backgrounds and white women, and between women from lower and higher socioeconomic backgrounds.

Finally, the National Maternity and Perinatal Audit, or NMPA, is a large-scale audit of NHS maternity services across England, Scotland and Wales. The NMPA publishes trust-level data and evaluates a range of care processes and outcomes to identify good practice and areas for improvement in the care of women and babies.

5 pm

We have also already proposed a new triple-aim duty in the Bill to ensure that NHS bodies, including NHS trusts, foundation trusts, ICBs and NHS England, have regard to the wider effects of their decisions. A key limb of the triple-aim duty is that those bodies must consider the impact of their decisions on the quality of services provided or arranged by relevant NHS organisations, including their own.

The Department has already set out details of the work it is doing to address disparities in care and outcomes for women and babies from different ethnic or socioeconomic backgrounds. On 6 September 2021, NHS England and NHS Improvement published their equity and equality guidance for local maternity systems, which focuses on actions to improve equity for mothers and babies from black, Asian and mixed ethnic groups and those living in the most deprived areas, and to improve equality in experience for staff from minority ethnic groups. The guidance asks local maternity systems to work in partnership with women and their families to draw up and publish equity and equality plans by 28 February 2022. The NHS will measure progress against its equity aims for mothers and babies through metrics set out in that guidance.

As set out in the Government's response to the Health and Social Care Committee reports published on 21 September, the Department has also commissioned the University of Oxford's policy research unit in maternal and neonatal health and care to undertake research into disparities in near misses, and into the development of an English maternal morbidity outcome indicator. The research will explore whether the indicator is sufficiently sensitive to detect whether the changes made to clinical care result in better health outcomes.

Due to the significant number of projects the Department has already undertaken in relation to the matter, and to avoid the potential additional burden of reporting and validating data on maternity staff and the duplication of the publication of information, I argue that—while I appreciate the intent behind it—the new clause is not necessary, and I would therefore encourage the shadow Minister not to press it to a Division.

Justin Madders: I will disappoint the Minister this time. We will push the new clause to a vote, because we think that it is really important. While the Minister has set out a whole range of reports that have been issued and work that is being done, due to the scale of the injustice we have set out, there needs to be a concrete commitment from the Secretary of State to not only publish the data, but set out the steps he is taking to address the inequalities.

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

The Committee divided: Ayes 6, Noes 8.

Division No. 40]

AYES

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

NOES

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

Question accordingly negatived.

New Clause 27

DUTY AS TO WORKFORCE AND TRAINING INNOVATION

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

(2) After section 1F(1) insert—

'(1A) The Secretary of State must support the transformation of the health and social care workforce for integrated care systems, working with universities and colleges to train the future workforce through investment in technological and interprofessional innovation.'"—*(Chris Skidmore.)*

This new clause would require the Secretary of State for Health and Social Care to support the transformation of the health and social care workforce, including by working with universities and colleges and through investment in technological and interdisciplinary innovation.

Brought up, and read the First time.

Chris Skidmore: I beg to move, That the clause be read a Second time.

The Chair: With this it will be convenient to discuss new clause 28—*Duty as to education placement capacity and innovation*—

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

(2) After section 1F(1) insert—

'(1A) To meet the integrated workforce requirements of integrated care systems, the Secretary of State must—

(a) ensure that there is sufficient placement capacity in the health and social care system in England to educate and develop a sustainable health and social care workforce,

(b) support, fund and promote the use of innovation in healthcare higher education to meet health and social care workforce needs, including new approaches to interdisciplinarity, digital technology and simulation, and

(c) consult universities, health and social care service employers, providers and other persons deemed necessary to develop practice placement capacity and innovation in higher education for health and social care to meet the needs of the health and social care workforce.'"

This new clause would require the Secretary of State for Health and Social Care to develop and support education practice placement capacity across integrated systems and to support innovation in higher education for health and social care.

Chris Skidmore: Thank you for allowing me to speak to these two new clauses together, Mr McCabe. They are essentially interrelated and were the product of a roundtable that I put together and hosted with Universities UK and the deans of medical colleges in my role as co-chair of the all-party university group. These were the two asks that the universities and medical colleges had for the Bill. I offer these new clauses as part of that consultative approach, so I will not be pushing them to a vote.

Basically, we are at a crux. I raised this question on clause 33 of the Bill, but when it comes to workforce planning and training, we take a siloed approach, focusing on what the Department of Health and Social Care, NHS England and Health Education England set out as their vision, and the funding flows from that. Not included in that vision, although clearly there are consultative opportunities, is a recognised role and responsibility in legislation for healthcare education providers, the universities and the deans of the colleges in providing the clinicians, doctors and nurses of tomorrow. Nor is there recognition that the workforce is changing. While we have the Government's commitment to the retention of nurses and doctors, that retention can take place only if there is continuous professional development.

When I was a Health Minister, I was very concerned to ensure an uplift in the budget of Health Education England to 3.4% to match that of NHS England. It had always been thought of as the poorer relation; the money would always flow later, and it took a great deal of lobbying from the relevant organisations to make the point that we needed to put that workforce training money aside, particularly for continuous professional development.

New clause 27, in summary, reflects the fact that if we are to have an integrated care system, and if the new White Paper is to look at how to integrate social care with healthcare, we will need to provide huge retraining opportunities for both NHS and social care staff to

[Chris Skidmore]

enable them to work across whatever that new landscape may be. I do not think it is practical to send everyone back to university, or even always to have physical in-work training opportunities, important though those may be. We will clearly need to have digital opportunities, online courses and a whole technological revolution in how we deliver those retraining opportunities.

Those opportunities are out there. If we look at the universities and the role of EdTech, it is important that the health service grips that opportunity with both hands while it has the chance to do so, because it will be coming down the tracks. If we want to implement reform via the integration of services, it will only be as good as the people working in those services, as we all know, and those people will be as good as they can be only if they are given the appropriate opportunities to train and retrain during their career.

The need for new clause 28 has become more pressing as a result of recent developments. It sets out a duty for education placement capacity; I will not go into the detail of the new clause, but effectively it is about place planning and ensuring that the universities and royal colleges are involved with that at the very outset. In the debate on clause 33, I talked about the paradox of our having a cap on places, which is causing a bottleneck in post-18 education—those pupils who are desperate to become doctors or nurses, but who find a cap on their aspiration.

That cap is there, as we know, because medical places are expensive; they cost not £9,250 a year, but more like £70,000 over the course of a medical student's training lifetime. At the same time, however, we have a cap on places for those 18-year-olds entering the system and then—surprise, surprise—we find we do not have enough doctors and nurses in the system, and we have to start retraining from abroad.

Dr Whitford: Obviously, there has been a drive to expand medical student places in universities right across the UK, but one part of the system that is controlled centrally is foundation places, which a medical graduate has to spend their first two years in. This year, for the first time, there was a shortfall of about 400 places. Hopefully all those graduates have now got a foundation doctor place, but they cannot practise outwith a foundation place, which lasts two years, so they simply cannot work as doctors, nor can they work as doctors until they complete that two-year foundation role. There is no point in expanding medical school places if those at the end of the production line get turfed out to be unemployed or go and work as something else. It is not just about university places; there is also the issue of placements as foundation doctors for the first two years of their career.

Chris Skidmore: The hon. Member is absolutely right. When it comes to the foundation year, I was interested in looking at what future reform might come in the workforce. We would need to work with the royal colleges and vested interests on a replacement, or at least on what could make the foundation process more flexible so as to allow in-work training on that foundation year pathway. That is a huge opportunity, and, if I was still a Minister, I would be pressing for a White Paper to look at how we could deliver workforce innovation, because I do not think we can continue to sustain our trajectory using infrastructure and systems designed in the early to mid-20th century. There is a balance to strike, in that we need to ensure that the safety of patients is accounted for, but technology and training has moved on to a different space. We do not see this constriction in other countries, which can offer fast-track routes through medical training processes, particularly post degree and into the foundation stage.

The issue of placement has become incredibly pressing—it is actually a real-time issue. During the pandemic, because the grade threshold was lowered and teacher assessment was used, an additional 1,900 students were accepted to take up medical places in September 2021. Whatever we think about that, those students were all given a place because they had achieved the right threshold, but to train them, an additional £60 million is needed. However, the Government have capped the training budget at £30 million, so although students have been accepted on to courses, universities are finding that they must make a loss of £2,460 per student in the academic years 2020-21 and 2021-22, and the Government are not opening their books to change that cap on finances.

The cap is therefore returning from this coming year, and as a result 1,000 fewer students will be trained each year. In effect, we will see a reduction in the number of students coming on board to be trained. There is currently this one-off moment that universities are taking forward, but as a result we will go backwards when we know that we need more doctors. The demographic changes that I spoke about in debate on clause 33 are coming down the tracks, but we will end up just recruiting from abroad. It is not that there is necessarily anything wrong with those qualifications; I would just prefer a sustainable and, in effect, sovereign pathway.

The post-Brexit narrative is that global Britain will ensure that we can stand on our own two feet and have a sustainable skilled workforce. That could be recognised if we had a placement strategy for medical students. However, we can do that only if we involve the universities and the education sector. The problem is that the Department for Education controls the purse strings for that budget, and I do not think that it realises the long-term consequences on our healthcare system.

The new clause would close a loophole that is kneecapping the Minister and the Department of Health by placing artificial caps on aspiration and—worryingly—on the future number of doctors entering the healthcare system. I will not press my new clauses to a vote, but the issue is extremely pressing. We will see 1,000 fewer students enter medical places next year than did so this year; and students going through the system have no funding for their places, despite having been given those places. That is a real-time issue that has resulted from the wider policy issue not being resolved. The new clauses would help resolve it, but I will not push them to a vote.

5.15 pm

Alex Norris: I congratulate the right hon. Member for Kingswood on his excellent new clauses and the case that he has made for them. We strongly agree that the training and development of staff ought to be to the

fore. We must take the opportunity of understanding that we have a workforce crisis at a time of significant technological development.

Take cancer services, for example. We are all concerned about gaps in cancer provision. We need to take the opportunity to turbo-leap forward, rather than trying to restore services to where they were pre-pandemic, when targets were being missed, and had been missed for a number of years. Let us train and develop our staff to use new and innovative approaches, such as new radiotherapies. There is real opportunity there. With respect to new clause 27, the right hon. Gentleman makes a strong case for harnessing the ability of our universities and colleges, and putting that together with our workforce to develop and improve our services.

On new clause 28, the right hon. Gentleman mentioned the paradox of us having profound workforce shortages—in August, there were about 94,000 vacancies, including for nearly 40,000 nurses—while 14,000 applicants were not accepted on to nursing courses in 2018. I understand that there was a significant increase in 2019, but it was not big enough to meet our shortfalls, so that is a real paradox. Our services are not sustainable until and unless we take deliberate action to increase capacity. I know that the right hon. Gentleman does not intend to push the new clause to a Division, but I hope to hear from the Minister about what conscious decisions are being taken. This concerns not just those big courses either, but smaller ones, such as paramedic science and radiography. University Alliance members have reported 1,000 applications for 40 to 50 places, so there is demand. Of course, they cannot just take everybody and there has to be a filtering process, but it feels very over-geared to have 20 or 25 times the applicants per place.

I will not repeat the right hon. Gentleman's arguments about GPs, but they were good. We should use this moment to change our approach to how we grow our GPs. What do we know about GPs? We know that we do not have enough of them, and that we certainly will not have enough of them in five or 10 years' time. We know that certain communities find it particularly hard to attract GPs, but also that GPs tend to stay where they train or, if not, they are more likely to go back to where they grew up. As part of any so-called levelling up, we need to focus on growing our own GPs in poorer communities such as mine, and similar midlands communities—perhaps you share some of that vision, Mr McCabe—but we do not quite put this together.

Many of my constituents tend to enter education quite a way behind; they really close the gap over their 14 years of formal education, but fall just short of those very high standards that are needed at the age of 18 to go on to university. Should we be writing off those young people? Could we be doing better at getting them on courses to be GPs? I suspect that we would be able to retain them in Nottingham, or at least attract them back there, and to the surrounding towns, which desperately need GPs. Similarly—this is not a long-term answer, but it is certainly one for the short term—one of my foundational moments in my views on migration came from working in a shop the year after finishing school and before going to university. I was often on the rota with a man from Iraq, who was a trained civil engineer in Iraq, but could not afford to convert his qualification. He could not work in that field and instead worked with me in that shop. It always seemed to me like a significant waste of his skills.

I will take this moment to plug a wonderful project in Nottingham called the phoenix programme, in which students at the University of Nottingham School of Medicine work with migrants to this country who have medical qualifications at home but cannot practise because they need to convert the qualifications and often cannot afford to. Those medical students are working on language, functional skills and all the different aspects of the exams that those individuals will take, in order to help those people become doctors in this country. What a wonderful thing to do.

If we think about however many hundreds of thousands it costs to train a GP in this country, we realise what a saving they are making for us, too. I think that is a wonderful thing. We need that level of creativity on workforce in order to deal with our gap.

I will make no further points—I do not want to repeat what the right hon. Member for Kingswood said—but if those are not going to be the answers, I hope we hear from the Minister what the answer is. If we go for more of the same, we will just see growing workforce gaps and we really will have profound problems in our health service.

Edward Argar: I am grateful for the opportunity to address new clauses 27 and 28 together. First, new clause 27 seeks to place a specific duty on the Secretary of State to support the transformation of the health and social care workforce for integrated care systems by working with universities and colleges to train the future workforce through investment in technological and inter-professional innovation.

I take on board the broader points made by my right hon. Friend the Member for Kingswood, but we do not believe that the new clause is necessary, as that work is already covered by section 1F of the NHS Act 2006, which the new clause seeks to amend. Section 1F(1) sets out that the Secretary of State has a duty

"to secure that there is an effective system for the planning and delivery of education and training to persons who are employed, or who are considering becoming employed, in…the health service".

Discharge of the duty under section 1F(1) is largely delegated to Health Education England through section 97 of the Care Act 2014. To meet its statutory duties and to ensure that an effective education and training system is in place, HEE undertakes a variety of work, including with further and higher education providers and regulators. Part of that work includes the curriculums for the healthcare professions. Those curriculums are set by approved education providers at an institutional level. HEE can influence the content by representing the employer voice to ensure that the training that individuals receive is relevant and remains up to date.

As part of that work, HEE is particularly keen to ensure that technological and medical advances are included in teaching, alongside new ways of working. Those measures would support newly qualified professionals to be suitably prepared to launch their careers in the NHS. To support that work and engagement with universities, HEE commissioned the Topol review, published in February 2019—probably in association with my

[Edward Argar]

right hon. Friend in one of his previous ministerial roles—on how to prepare the healthcare workforce to deliver the digital future.

That review made recommendations that will enable NHS staff to make the most of innovative technologies such as genomics, digital medicines, artificial intelligence and robotics to improve services. The recommendations support the aims of the NHS long-term plan and the workforce implementation plan, helping to ensure a sustainable NHS. The progress report was published by HEE in 2020 and, as part of the implementation report, HEE has launched a digital readiness programme to continue to lead on developments in preparing the workforce to deliver the digital future.

On inter-professional working, we want a workforce that is less siloed and more flexible and adaptable, and work is ongoing to take that forward in England. For example, at the national level, we are looking at new skill mixes to meet new service models. Those new mixes could include upskilling existing staff, so that more staff are able to do things that have traditionally been limited to a smaller group of professionals—for example, prescribing—or making better use of the wide range of skills and contacts available to reduce duplication.

At ICS level, national guidance on the ICS people function also set out the expectation that the ICB, working with the ICP, will have responsibility for enabling workforce transformation across the health and care system, including through the use of technology and innovation, as well as for work with educational institutions to develop the local future workforce. Nationally, arm's length bodies will support and enable ICBs to deliver those responsibilities at a local level. I hope that that highlights some of the work being done under the existing statutory duty in section 1F of the 2006 Act.

Secondly, new clause 28 seeks to place three new statutory duties on the Secretary of State. That, in a sense, is at the heart of what my right hon. Friend the Member for Kingswood was getting at. They are: a duty to ensure a sufficient number of clinical placements for the number of students; a duty to ensure innovation—his new clause outlines greater interdisciplinary working, digital technology and simulation as three examples—is supported and funded in the education and training system; and a duty to consult universities and others on clinical placement availability.

We have carefully considered my right hon. Friend's new clause, but we do not feel that those additional specific statutory duties are necessary, in addition to the existing statutory duty on the Secretary of State in section 1F of the 2006 Act, which my right hon. Friend seeks to amend. Section 1F sets out that the Secretary of State has a duty to ensure that there is an effective system for the planning and delivery of education and training to persons who are employed, or who are considering becoming employed, in the health service. Discharging the duty under 1F(1) is largely delegated to HEE through section 97 of the Care Act 2014.

As the hon. Member for Central Ayrshire said, clinical placements are a vital part of healthcare students' education and training. Good experience during a placement can lead a student to seek employment at their placement provider. As a result, ensuring that there is sufficient placement capacity remains a priority for HEE in order to meet its statutory duties and ensure that an effective education and training system is in place.

Dr Whitford: Just to clarify, I was not referring to placements as students, which are absolutely vital; I was referring to the two foundation years that those individuals have to do afterwards. Otherwise, they simply cannot function as doctors.

Edward Argar: I am grateful to the hon. Lady for clarification, but she illustrates that placements, both as students and in the context she describes, are vital to enable students to understand and learn the reality and skill of their profession. It is also important that placements are rewarding for students.

HEE has successfully worked with education providers and placement providers to ensure there is sufficient placement capacity for the record number of nursing students that we now have. Such work includes payment of the education and training tariff, which pays a contribution to the costs of providing placements. The Government have also supported HEE through the provision of additional funding, enabling it to launch its clinical placement expansion programme. The programme has seen HEE commit £15 million to fund additional clinical placements across nursing, midwifery, allied health professionals and healthcare science in 2021-22. This funding will increase the number of placements offered to nursing, midwifery and AHP healthcare students from September 2021, which was last month, and it will enable HEE to deliver the future health and care workforce in sufficient numbers, and with the skills that the NHS needs.

Before I turn to innovation, I will address two points that were made by my right hon. Friend the Member for Kingswood and alluded to by the hon. Member for Nottingham North. First, the shadow minister touched on those who come from abroad via normal immigration routes or as refugees, the skills they have and how we need to make it easier for such people to utilise their skills and work in our NHS. He is absolutely right, and we continue to look at how we can make the process easier. We need to balance that with making sure that we can evidence and reference those skills for the safety of patients and those qualifications, but where that can be done and where those skills are commensurate, we need to make it as easy as possible for them to requalify or go through the necessary safety processes to be able to work in our NHS. The only other thing I would say is that we have to be very careful that any recruitment is ethical and that we are not denuding countries of the ability to utilise the skills of clinical professionals in rebuilding their own countries.

The second point made by my right hon. Friend the Member for Kingswood was about the challenges posed for maintaining quality, in terms of people going through relevant courses, and for the operation of the cap. I will not criticise any other Government Department, but he highlights the juxtaposition that often occurs between the Department for Education and the Department of Health and Social Care, or between other Departments where two Departments have an interest in the same policy but different incentives for their policy making. There will always have to be a financial test. There is always a limited budget, and my right hon. Friend

highlighted how expensive some of the training courses are. However, it is right to expand the number of medical schools and training places, as we have done—he probably presided over it.

I remember going to the University of Lincoln, when I had just been appointed. Those I met were disappointed that I was not my right hon. Friend, but they were none the less very welcoming to me. The University of Lincoln works very closely with the University of Nottingham, which is in the constituency of the hon. Member for Nottingham North, in setting up a new medical school and drawing on the curriculum and expertise that was already in Nottingham. It is a great example. I very much hope that, when I am not in this Bill Committee, I might be able to go once again to visit the University of Lincoln and perhaps come and see the hon. Gentleman's local medical school over in Nottingham.

Finally, on innovation, HEE currently works with universities, training providers and regulators on the curricula for the healthcare professions to ensure that they reflect the latest technological innovations. Although curricula are set, as I have said, at institution level, HEE can influence the content by representing the employer voice, to ensure that the training that individuals receive is relevant to what employers need.

In relation to consultation, HEE already works with universities, placement providers and others on the availability of placement providers to assess and ensure that there are the right number and types of placement. As I have mentioned, the number of placements has expanded. That is a direct result of the constructive dialogue and engagement that HEE has with placement providers. At ICS level, national guidance on the ICS people function set out the expectations.

I hope that I have set out that work on the areas highlighted by my right hon. Friend the Member for Kingswood is being taken forward—some of it was started by him a few years ago—under the existing statutory duty under section 1F of the NHS Act 2006. Therefore, at this point, we do not think that further specific duties are necessary, but I suspect that, in the further passage of this legislation, we may well return to the sort of themes that we have discussed today.

Chris Skidmore: As I said, I will not push the new clauses to a vote, but I will just reiterate that there clearly is a massive structural supply and demand imbalance. I do not believe that the status quo will be sustainable in the longer term. I do appreciate the Minister setting out the ecosystem as it exists, but I fear that that ecosystem, in the longer term, cannot keep up with the changing demands on the healthcare system and the expansion of the healthcare system thanks to the budgetary announcements today about the amount of money that is being spent. None of this will cut through effectively if we do not have the trained workforce in place to be able to deliver healthcare on the ground. Mention has been made of general practitioners and the shortfall that we are going to see as a result of the demographic and retirement bulge that is going through the system at the moment. These are problems coming down the track, and I would always recommend in policy, as in life, that if we see a problem and know that we are going to have to take a decision, it is better to take the decision sooner rather than later, because the costs will only be less now and greater later on.

I will not push these new clauses to a Division, but I have, Cassandra-like, sent out a warning cry of what will happen in the future if we do not act soon. I beg to ask leave to withdraw the motion.

Clause, by leave, withdrawn.

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

5.32 pm

Adjourned till Thursday 28 October at half-past Eleven o'clock.