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Public Bill Committee

HEALTH AND CARE BILL

Twenty Second Sitting

Tuesday 2 November 2021

(Morning)

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Saturday 6 November 2021

The Committee consisted of the following Members:

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

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

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Public Bill Committee

Tuesday 2 November 2021

(Morning)

[Steve McCabe *in the Chair*]

Health and Care Bill

9.27 am

The Chair: As Members have possibly worked out, I am a last-minute stand-in for Peter Bone, which has always been my ambition in life. *[Laughter.]* Seriously, Peter has been caught up in some kind of road traffic incident. I think he is fine; he has just been delayed, so that is the reason for the delay in proceedings.

I remind Members of all the usual things: please switch electronic devices to silent, and remember that no food or drinks are permitted. I encourage Members to wear masks, as per the House of Commons Commission rules, and to give their notes to *Hansard* or to send them to hansardnotes@parliament.uk.

New Clause 58

Duty on NHS England to promote evidence-based public health programmes

"(1) NHS England must promote to integrated care boards the value of evidence-based public health programmes.

(2) NHS England must publish a report each year on the state of evidence-based public health programmes within England and their impact."—*(Alex Norris.)*

Brought up, and read the First time.

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

I have heard about the fastest gun in the west; I think you might be the fastest-moving Chair in the west midlands, Mr McCabe. Turning to the substance of the new clause, covid-19 has shown the value of public health programmes in building this country's resilience and improving public health outcomes, yet there is no duty in the Bill on NHS England to promote such public health programmes to integrated care boards or to evaluate their impact. New clause 58 seeks to change that.

During proceedings over the past couple of months, I have highlighted on multiple occasions the damage caused by the short-sighted health cuts we have seen over the previous 11 years, so colleagues will be relieved to hear that I am not going to repeat those points. However, we should be looking to do better now and to use this Bill as a watershed moment. As the Association of Directors of Public Health noted when the White Paper was published, there is a limited focus in the Bill on the health inequalities that have been exposed and exacerbated by covid-19 and, again, this new clause seeks to improve that situation. With the changes to Public Health England and the announcement of the new Office for Health Improvement and Disparities, it is vital that the Government make a belated recommitment to public health and prevention.

There are a number of ways in which that commitment could be manifested. Public health programmes are particularly crucial to the prevention agenda, and it is right that NHS England promotes the value of those programmes, looks at them, assesses them and reports on their impact. To draw on one example that is linked to an item we will be discussing later—dental services—community dental services and oral health public health programmes have shown that significant savings and significant improvements in individuals' lives can be generated through effective, evidence-based public health programmes. Social enterprises such as those can bring a number of additional benefits. They exist not to make a profit but to deliver on a social mission and to reinvest any surplus in improving local services.

That is what the public health grant traditionally funded. When I first had responsibility for the public health grant in 2014, 85% of that money went into commissioned services. That funding will have been diluted by the cuts in recent years, but largely that money went to community-based, not-for-profit, evidence-based schemes. Public health programmes really improved our communities, but we have lost them, and that is a sadness. We need to recommit to them and have a real focus on getting integrated care systems to commit to them, demonstrating what works in one part of the country and promoting it across the rest of the country. That is what this new clause seeks to achieve.

The Minister for Health (Edward Argar): Mr McCabe, it is a particular pleasure to see you in the Chair this morning, allowing us to get going.

I very much welcome the opportunity to debate and put on record again the Government's commitment to improving and protecting the public's health and to supporting evidence-based interventions. Like the shadow Minister, the hon. Member for Nottingham North, I can think of no better example than the remarkable speed of this country's roll-out of covid vaccinations and the response to the pandemic, saving lives and supporting our economic recovery. That, of course, is testament to the hard work and dedication of our NHS and public health professionals in rising to the greatest infectious disease challenge of modern times.

Our commitment to evidence-based public health is also writ large in many of the Bill's provisions, our wider programme of public health reform and the proposals set out in the Government's recently published plan for health and care, "Build Back Better". We made it clear in that document that although the Government's immediate priorities for the NHS must be dealing with covid and recovering from the elective backlog, the long-term priority is to shift the NHS towards prevention. Prevention must be a central principle in delivering a sustainable NHS and levelling up. That means fixing the underlying causes of ill health, which is at the heart of the mission of the new Office for Health Improvement and Disparities and the new UK Health Security Agency.

As new clause 58 hints at, a focus on prevention, coupled with a strategic approach to population health more generally, will also be at the heart of integrated care systems. The new triple aim will bind NHS bodies to consider wider effects on health and wellbeing, alongside a duty to reduce inequalities in access and outcomes. Integrated care boards will be required to seek advice from persons with a broad range of professional expertise on public health and prevention, complementing the role, already set out in regulations, of local government and directors of public health to provide advice. Moreover, each integrated care partnership's strategy will be clearly

rooted in, and draw extensively on, local place-based joint strategic needs assessments so that real needs and priorities can be addressed at local level. The ICB's plans must have regard to that strategy.

I entirely concur with the shadow Minister that evidence-based public health practice is always desirable, and a learning culture essential, but the Government do not see the need for a specific legal duty on NHS England to promote that to ICBs—as envisaged by the new clause—although it undoubtedly will have a role in exhorting and supporting them to their best efforts. The Office for Health Improvement and Disparities and the UK Health Security Agency will also have an important role in this regard, and the National Institute for Health and Care Excellence will continue to issue evidence-based guidance on public health topics referred to it.

There is already a broad obligation on NHS England and NHS Improvement to promote continuous improvement in the quality of services provided across the NHS and, in doing so, to have regard to evidence-based public health quality standards. That includes having regard to quality standards prepared by NICE.

It follows from the rejection of the first limb of the new clause that the Government cannot support the second. However, as set out in "Build Back Better" the Government will bring forward separately from the Bill a new requirement for NHS England

"to introduce a yearly prevention spend, outcome and trajectory reporting criteria, including an assessment of the 10-year spend and outcome trajectories…of the major preventable diseases such as diabetes."

It may not, but I hope that that goes some way towards meeting the intent behind the shadow Minister's new clause.

There is a somewhat different matter where public health programmes are commissioned directly by the NHS itself, in exercise of the Secretary of State's public health functions. That is the case with, for example, national screening or immunisation programmes. These programmes are currently commissioned by NHS England but are rooted in expert advice from the UK National Screening Committee and the Joint Committee on Vaccinations and Immunisations respectively. NHS England is already prepared to report to the Secretary of State on its performance against these functions.

Were any of these functions to be delegated to ICBs to deliver in future, we would expect NHS England to clearly convey the requisite standards and performance expectations for those evidence-based programmes, and overall information about performance and effectiveness will be provided to the public.

In summary, there is a good deal of unity of aim and objective, but I fear there is a difference as regards methods. On that basis, I encourage the shadow Minister not to press the new clause to a Division.

Alex Norris: I share with the Minister the desire for a shift to prevention. My anxiety, from the Government action we have seen over the last decade, is that that is a rhetorical shift rather than a substantial shift in policy, and definitely not a substantial shift in resourcing. Nevertheless, the Minister's answer on the documentation that NHS England will be asked to publish is a suitable substitute for a provision being on the face of the Bill. On that basis, I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 63

YOUNG CARERS' NEEDS ASSESSMENTS FOLLOWING HOSPITALISATION

"In the Children Act 1989, after section 17ZC, insert—

'17ZCA Young carers' needs assessments following hospitalisation

(1) An NHS trust or NHS foundation trust must ascertain during hospitalisation whether a patient when discharged will be cared for primarily by a young carer.

(2) Where an NHS trust or NHS foundation trust ascertains that a patient when discharged will be cared for primarily by a young carer then the NHS trust or NHS foundation trust must give the local authority where the patient lives notice that a young carer will require a needs assessment.

(3) The local authority receiving notice under subsection (2) must carry out a needs assessment, and in doing so must—

(a) ascertain whether it is appropriate for the young carer to provide care, and

(b) identify what support or services need to be in place for safe discharge of the patient.

(4) The needs assessment required by subsection (3) must be conducted before the patient is discharged.'"—*(Karin Smyth.)*

This new clause would ensure that the needs of young carers are assessed before a patient who they care for can be discharged.

Brought up, and read the First time.

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

It is a pleasure to see you in the Chair, Mr McCabe. I will not delay the Committee too long on this new clause, but it is an important one to consider. We had a good discussion last week on the needs of carers, although I am not sure we resolved it satisfactorily. Carers do a huge amount of work on behalf of their families. As my hon. Friend the Member for City of Durham so eloquently said, they want to do that work, but many of them essentially keep our services going. Without them, the demands on our services would be so much greater.

[MR PETER BONE *in the Chair*]

All of us who have met or who know young carers recognise the particular stresses and strains on them from caring for their relatives. They do astonishing work. Again, as my hon. Friend said, many feel that they are doing it because these are their loved ones; they do not feel like they are carers in many cases, but they are. Often people then do not come forward, if they are not known to the authorities, to make that clear. That is often because of fear of what that might mean for the family set-up they find themselves in.

The new clause draws attention to the needs of young carers, particularly following hospitalisation. It would require trusts and local authorities to be cognisant of who is caring for a person when they are discharged, particularly where young carers are involved. When the issue was first drawn to my attention—particularly the need to highlight the different needs of young carers—I must confess that I thought that these things were routine in good care settings. Obviously, the situation into which someone is being discharged should be fully known and recognised, and their needs met. We had a good discussion about that and we know that that does not happen, but the pressure on young carers is particularly acute. As part of that discussion last week, I almost intervened on the Minister to ask that when we are considering carers more generally, we highlight young

[Karin Smyth]

carers separately. A hospital needs to know and understand that the person going back home will be in the charge of a young carer, and the local authority needs to make sure that a needs assessment is conducted.

The new clause suggests that should happen before the patient is discharged. Clearly, the Bill is instigating a new process, which will look at post-discharge. We had a good debate about that. As my hon. Friend the Member for Nottingham North said from the Front Bench, doing that assessment differently may be better in the long run—we do not know. In particular, when it comes to young carers taking up that role, it is even more acute that it is recognised in the new arrangements.

I will not move the new clause to a vote, but I would like the Minister to be cognisant of young carers and assure us that these needs will be highlighted to hospital trusts and local authorities in the discharge planning process.

Justin Madders (Ellesmere Port and Neston) (Lab): It is a pleasure to see you in the Chair, Mr Bone. I thank my hon. Friend the Member for Bristol South for introducing the new clause. She set it out very well and she is right to highlight the interplay with the section 78 provisions in the Bill, because there is a risk of some jarring if we do not get this right.

As we know, the 2011 census reported that there are almost 166,000 young carers between the ages of five and 17 in England. However, research carried out by the University of Nottingham and the BBC in 2018 suggested the figure could be much higher, with around 800,000 children providing care. It is estimated that nearly 260,000 of those carers are providing high levels of care, so there is certainly an issue out there.

As we know, being a young carer has a significant impact on children and young people. Caring for other family members inevitably affects school attendance and exam results, with many young carers paying a heavy price for their dedication to their families. It often limits their ability to take up their full academic options. On average, young carers achieve a grade lower than their peers in their GCSEs and are less likely to go to university. Every single classroom in the UK is likely to have at least one young carer.

As my hon. Friend said, the new clause would ensure that arrangements for discharging patients without a care needs assessment do not unduly impact on young carers. Their needs must still be identified when an adult is discharged from hospital. But the new clause goes further than that: it applies to all discharges, so there must always be a check to see if a young carer is involved. One might think that a check ought to done anyway, but evidence shows that it is patchy at best. Before covid, hospitals were struggling with the many issues we have discussed in relation to staffing. It is not always easy for people to do everything they would want to do before discharge. The new clause would put into law what is already being done in the best-practice examples.

There is already, in theory, a general right to an assessment under the Children and Families Act 2014 and the Care Act 2014. The Children and Families Act states that all young carers under the age of 18 have a right to a needs assessment as a responsibility of the local authority, which

"must take reasonable steps to identify… young carers within their area who have needs for support."

However, Barnardo's 2017 report "Still Hidden, Still Ignored" identified that young carers were "slipping through the net." The report led to many recommendations, including Barnardo's calling for hospital staff to actively ask questions to identify young carers at the point of discharge. Hospital staff are in a key position to ask questions to ensure young people do not slip through the net, and it is clear that more needs to be done in this area. The new clause offers one way of reducing the possibility that young carers slip through the net.

As my hon. Friend said, young people are often reluctant to identify as young carers. They do not want to get their parents into trouble sometimes, and it can be a difficult conversation. The new duty would take a lot of that pressure away because the responsibility would sit with the hospital professionals to ask the patients on discharge. That would stop the young person feeling responsible for involving official services in family life. Of course, we want local authorities to be able to identify these people to ensure the right support is in place.

9.45 am

Many of us will have come across examples of young carers and the impact that caring has on their lives. I want to give one real-life case study from Barnardo's to emphasise how important the issue is:

"a young carer told us that despite repeated visits to a GP both for herself, her little brother and her mum, she was never referred to a young carers' service. The same young carer visited and cared for her mum and her new-born brother in hospital and she would divide her time between caring for both of them. She was very tired and stressed, constantly missed school but felt there was no other option. Upon discharge, there was no assessment from the hospital about what support was needed for either the mother or the new-born brother and the young person became the sole carer for both over the next few years leading to her leaving school and becoming increasingly isolated. It was only when a health visitor for her infant brother picked up the amount of caring she was doing that she was finally referred to Barnardo's."

That example sets out very clearly what we hope the new clause will prevent from happening in the future. It is tragic that so many opportunities to give that young person some support were missed.

The new clause would not, of course, resolve all the issues with support for carers and young carers, but it would go some way to plugging a known gap and making sure that there is an opportunity for young carers to be identified in a systemic way that ensures support is delivered.

Edward Argar: It is a pleasure to see you in the Chair this morning, Mr Bone. The new clause would introduce a requirement for an NHS body to notify the relevant local authority once it had identified that a young carer had primary responsibility for caring for a patient on discharge. The local authority would be required to carry out a young carer's needs assessment before discharge to establish the appropriateness of the young carer providing care and what support should be in place to enable safe discharge.

I entirely understand the sentiment and intention behind the new clause, which the shadow Minister and the hon. Member for Bristol South set out very clearly. We have touched on the importance of this issue in

previous debates about carers. Young carers often do not even realise that they are carers. They undertake their caring responsibilities, go to school, come back again and undertake caring responsibilities again. They are arguably some of those most in need of support and identification. These young people are essentially having caring responsibilities for a loved one, family member or friend thrust on to their shoulders at a very early age. However, I am not convinced that the cause is best advanced by the new clause and I will try to explain why. In her response, the hon. Member for Bristol South may agree or say she is unconvinced by my explanation, as is her right.

Existing legislation already requires local authorities to carry out an assessment of need for all young carers on request or on the appearance of need. That assessment must consider whether it is appropriate or excessive for the young carer to provide care for the person in question, in the light of the young carer's needs, wishes and circumstances. Regulations already provide a detailed framework, including the matters to be considered in such assessments and the skills of the person undertaking it.

As members of the Committee will be aware, the discharge clause in the Bill, which we debated some days ago, revokes the existing requirements for hospitals to issue assessment and discharge notices as part of the discharge process for adults, because they contribute to lengthy discharge delays. The current requirements trigger local authority duties to assess the person's long-term social care needs, prior to the person's discharge. We know delayed discharges have a negative impact on patient outcomes.

My concern about the wording of the new clause is that making young carers' assessments a requirement of discharge would risk reimposing further significant delays, at a time when supporting the safe hospital flow of patients has never been more important. I am also unclear how such an assessment system would be enforced.

Current discharge guidance clearly sets out that, as part of discharge planning, consideration must be given to any young people in the household who have caring responsibilities or may have some on discharge. Guidance states that they may be entitled to a young carer's needs assessment or to benefit from a referral to a young carers service.

We will work with the Department for Education to ensure that protections for young carers are reflected in new statutory discharge guidance, accepting the sentiment behind the new clause. That will include setting out as part of the discharge planning process how young carers should have a needs assessment arranged, where appropriate, before a patient for whom they provide care is discharged. That is the more appropriate way to capture or operationalise, for want of a better way to put it, the sentiment behind the hon. Lady's new clause. It is up to her whether she feels that that is sufficient, but I have set out our response to the new clause she proposes.

Karin Smyth: The Minister will not be surprised to hear that I do not think that is sufficient. I will not press the matter to a vote, but, as my hon. Friend the Member for Ellesmere Port and Neston said, when it comes to things being on request it is problematic, and that is the crux of the matter, as in the guidance that the Minister read out. I understand the need for hospitals to not have lengthy discharges—and it is not good for the patient—but sorting out the hospital's problem on the backs of young people and carers is not a good message that we want to send from here.

I appreciate that the Minister in his final comments said that this would be very much part of the thinking about discharges, but we should also remember that these young people have really had the most shocking experiences in the last two years with covid, and are already—again, as my hon. Friend said—falling massively behind. Added to the destruction from covid, many young carers live in some of the most disadvantaged families, really keeping those families together, so they are further left behind.

On the Minister's exhortations to the service and local government, it would be helpful to further underline the strength of those, and I am sure that most of the Committee feel that. Young carers have had probably the worst of times during covid and for them now to have to shoulder more responsibility because of the discharge problem and the need to get people out quickly would further exacerbate the situation. They need more help, not less, and I hope that that will be communicated back to the service. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 65

Review of the surgical consultant appointment process

"The Secretary of State must review the National Health Service (Appointment of Consultants) Regulations 1996 and its most recent guidance and, within six months of the passage of this Act, publish a report on the surgical consultant appointment process."—*(Justin Madders.)*

This new clause requires a review of the legislation which governs the NHS surgical consultant appointment process.

Brought up, and read the First time.

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

The Chair: With this it will be convenient to discuss new clause 70—*Appointment of surgical consultants*—

"(1) The National Health Service (Appointment of Consultants) Regulations 1996 (S.I. 1996/701) are amended in accordance with subsection (2).

(2) In paragraph (1) of regulation 2, in the entry for 'relevant college', in sub-paragraph (d), for 'and its associated Faculty of Dental Surgery', substitute ', the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and each of their associated Dental Faculties'."

This new clause would add the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and each of their associated dental faculties to the colleges who may be involved in the appointment of NHS consultants.

Justin Madders: The proposed new clause was inspired by the Royal College of Surgeons of Edinburgh, who made representations about what we think is a lacuna in the current regulations that needs filling. According to the National Health Service (Appointment of Consultants) Regulations 1996 and subsequent guidance issued by the Department in 2005, only the Royal College of Surgeons of England is permitted to review surgical consultant job descriptions and send a Royal College representative to the advisory appointment committee.

[Justin Madders]

Although the process applies only to non-foundation trusts, the 2005 guidance encourages foundation trusts to follow that process as it provides a structured, quality approach to consultant appointments. Given that the 2005 guidance remains the most up-to-date advice available to trusts, the Academy of Medical Royal Colleges continues to recommend that foundation trusts follow the process.

The net effect of the regulations and guidance has been to formally exclude the Royal College of Surgeons of Edinburgh from the entire surgical consultant appointment process. Given its size and the distribution of its fellowship throughout England, it is keen to help trusts, whether they are foundation trusts or otherwise, in their ability to appoint and retain senior surgical professionals. I understand the Royal College of Surgeons of Edinburgh has raised this anomaly with the Department on a number of occasions—I can see the Minister nodding—and it has been told that any changes to the regulations or the guidance would require legislative approval, so the opportunity has been taken today to slip the new clause in to try to resolve that.

As we know, we have record waiting lists of some 5.7 million—probably rising. It is clearly an important priority for everyone that the backlog is tackled, and the new clause would go some way to ensuring that the NHS is a resilient and sustainable surgical body to be able to meet the challenge. We see it as a tidying-up exercise that is long overdue.

New clause 70, tabled by the Scottish National party spokesperson, the hon. Member for Central Ayrshire, goes a little further than new clause 65 in terms of the requirements put on the Department. I hope the Minister understands the sentiment behind our tabling the new clause. This long-standing issue needs legislative remedy, and I hope that this is the opportunity to put it right.

Dr Philippa Whitford (Central Ayrshire) (SNP): I rise to speak to new clause 70 and in support of new clause 65. I agree with the shadow Minister that these are very much technical new clauses to correct an anomaly. There are three royal colleges of surgeons in the UK: the Royal College of Surgeons of England, the Royal College of Surgeons of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow. Consultant surgeons may be appointed from among the fellows of any of the three colleges. The exams they sit and the qualifications they carry are considered absolutely equal.

The challenge when recruiting a new consultant, as the shadow Minister highlighted, is that the appointment panel, which must review the job description and take part in the interview, is limited purely to those who have graduated with their fellowship from the English college. The appointment panels have a mix of representatives from local organisations, specialty bodies, if it is a specialty surgical appointment, and the royal colleges, so while fellows of all the royal colleges may be involved in appointments to English trusts as specialty representatives—such as breast cancer, which was my specialty—some are excluded from being college representatives. It is often really challenging to bring these panels and committees together.

The aim of the new clause is simply to widen the pool of assessors available to trusts in England and, indeed, as the shadow Minister highlighted, to foundation trusts. It is simply an anomaly that two of the colleges in the UK are not included. The new clause aims to correct that and to make the appointment of new consultants easier for trusts and foundation trusts in England. I hope that the Minister will accept both the spirit and the detail of new clause 70.

Edward Argar: I am grateful to hon. Members for bringing this issue before the Committee: I think we have all received correspondence on it from the various royal colleges. New clause 65 would amend the Bill so as to require that a review is undertaken of the National Health Service (Appointment of Consultants) Regulations 1996 and its most recent guidance. It is important that the regulations governing consultants and the accompanying guidance ensure that prospective consultants are highly capable and safe to practise while not hindering effective recruitment.

The current regulations govern the appointment of all consultants to NHS trusts and special health authorities. Reviewing the regulations only in relation to surgeons would risk diminishing consistency in the regulations. We believe the current regulations ensure consistent standards across all specialties. Those regulations are kept under review, and we therefore do not believe that this new clause would improve what already exists under the current policy. Similarly, responsibility for reporting on recruitment practices relating to a specific specialty would fall to the royal colleges rather than the Department. Should the royal colleges recognise an issue with recruitment and appointment to a particular specialty, the Department would expect the relevant royal college to report on that, which we would always consider in detail.

New clause 70, tabled by the hon. Member for Central Ayrshire, would amend the National Health Service (Appointment of Consultants) Regulations 1996 to confer authority on the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and each of their associated dental faculties to sit on the panel concerned with the appointment of consultants in England. I sympathise with that. The Government agree that including those colleges would potentially be significantly advantageous. However, the challenge is that the National Health Service Act 2006 stipulates that consultation with affected parties must be undertaken before any changes to these regulations can be made. As such, our concern is timing: it would go against normal practice and not necessarily be appropriate to make such a change without consulting the relevant parties.

Dr Whitford: I have no objection to the need to consult. The Royal College of Physicians and Surgeons of Glasgow would indeed like section 2(1) of the regulations changed so that its members could be involved in the appointment of consultant physicians. I was unable to consult with the Royal College of Physicians of Edinburgh in time to allow the new clause to include that. I totally recognise that there is a role for consultation in order to get the change to those regulations right. However, surely with such legislation going through, this is the opportunity to agree to correct this anomaly, and therefore make appointments of new consultants in English trusts simpler.

10 am

Edward Argar: I think that is where the hon. Lady and I slightly diverge; we do believe that it is right that we follow the normal process of consultation before

bringing any changes forward. I hope, in my final paragraphs, I can give her a little reassurance in respect to her intent. I hope that I can reassure her that, although the Royal College of Surgeons of Edinburgh and the Royal College of Physicians and Surgeons of Glasgow are not formally named in the regulations as relevant colleges in relation to the appointment process, the regulations do not prevent trusts from seeking alternative members to contribute to the process. That does provide discretion to involve these colleges where appropriate.

My further reassurance, which I hope will go some way towards satisfying the hon. Lady, is that the letters and requests came in relatively late in the Committee's proceedings: I will undertake to review that request with my officials. I will look at whether what we have already got is sufficient, or whether there is merit there that does not require that consultation and those changes—

Dr Whitford *rose—*

Edward Argar: I have one sentence to go, so the hon. Lady gets in just in time.

Dr Whitford: A trust could include other members of the panel, but they could not be recognised as the Royal College representative. That is often one of the challenging roles, because the panel cannot go ahead if it does not have a Royal College representative.

Edward Argar: I hope I can reassure the hon. Lady that in respect of the specific request that the two Royal Colleges have made, I will take that away, look at it and consider whether it works now, or whether there is something we can do. That will be either in this legislation, or following consultation, via another mechanism to address the underlying issue that they have drawn to our attention.

The Chair: I call Dr Justin Madders.

Justin Madders: Thank you, Mr Bone, but I am sure you would not want me to attempt any medical procedures.

I have heard what the Minister has said; clearly it is still under active consideration by the Department. As we know, there will be many more legislative opportunities in the coming months and years—I hope we will get an opportunity to crack this. I beg to ask leave to withdraw the clause.

Dr Whitford: I accept the Minister's reassurance that they will finally look at correcting this anomaly; I hope that he will take that forward. It is something that we will be looking for. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 66

SUPPORT PROVIDED BY THE NHS TO POPULATIONS AT RISK OF MALNUTRITION

"(1) Each integrated care board must—

(a) assess, or make arrangements for the assessment of, the need for support for patients and/or populations at risk of malnutrition, including social and clinical/disease related malnutrition, using their services;

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

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

(d) designate a malnutrition lead.

(2) An integrated care board that publishes a strategy under this section must, in carrying out its functions, give effect to the strategy.

(3) Before publishing a strategy under this section, an integrated care board must consult—

(a) any local authority for an area within the relevant Integrated care board's area; and

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

(4) For the purposes of subsection (3), 'local authority' means—

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

(b) a London borough council.

(5) An integrated care board that publishes a strategy under this section—

(a) must keep the strategy under review;

(b) may alter or replace the strategy; and

(c) must publish any altered or replacement strategy.

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

(7) The power to make regulations under subsection (6) may, in particular, be exercised to make provision about—

(a) the procedure to be followed by an integrated care board in preparing a strategy;

(b) matters to which an integrated care board must have regard in preparing a strategy;

(c) how an integrated care board must publish a strategy;

(d) the date by which an integrated care board must first publish a strategy; and

(e) the frequency with which an integrated care board must review its strategy or any effect of the strategy on the provision of other provision in its area.

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

(a) all integrated care boards; and

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

This new clause would require integrated care boards to publish a strategy for the provision of support for patients and/or populations at particular risk of malnutrition using their services, and designate a malnutrition lead.

Brought up, and read the First time.

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

This new clause would put responsibility on integrated care boards to take the lead on tackling malnutrition in their community. We spoke about malnutrition in the context of hospital food standards, and we were not able to move the Minister to extend those hospital food standards to other care settings. I thought that was a shame, and I hope the Government will continue to look at the issue. I want to broaden the conversation on malnutrition to try, via another way, to improve the standing of our communities.

Malnutrition is a serious condition that occurs when a person does not get the energy or vitamins that their body requires to function properly. It affects at least 3 million people every year, and it costs the health and social care system £23.5 billion each year. The condition is particularly common amongst certain groups. Those groups are: older people; hospital patients; people in mental health units and care homes; people living in

[Alex Norris]

sheltered housing; and those living with chronic diseases, such as cancer. Malnutrition can seriously threaten patients' health. Hospitalised malnourished patients are three times more at risk of infection than the well-nourished, while hospital patients at high risk of malnutrition are 12 times more likely to die early than those at no risk. It is a very significant issue. Unfortunately, the figures are not moving in the right direction. The number of adults being admitted to hospital with malnutrition has more than doubled in the last decade—that is the bill for austerity. The evidence is clear that malnutrition impacts a wide range of people in different health settings; again, those are hospitals, mental health units, care homes and sheltered housing. It has a knock-on effect on other conditions.

Earlier this year, the media reported the death of a young disabled woman after a routine operation. Her death was partially caused by malnutrition, and the coroner said there had been a gross failure of care in managing her nutrition. A July 2021 report on malnutrition called it a widespread yet historically overlooked and undertreated issue in the NHS and social care, and attributed that to two factors that block progress—a lack of understanding, and a lack of systematic leadership. The new clause seeks to address that at a local level, which is why we think it is a good one.

The tragic case that I have mentioned shows how important it is to have a clear strategy to tackle malnutrition, to have designated leads and to have targets and co-ordinated policy. The Government say that integrated care boards are about ensuring proper integration between health staff and community services, and this is a really good example of a way in which that could be done. I am keen to hear the Minister's assessment of the new clause, which should be included in the Bill. We have a significant issue that we are not addressing and that is getting worse, so what are we going to do differently?

Edward Argar: We recognise and know that malnutrition can be a significant problem that can be both a cause and a consequence of ill health. We remain committed to improving the NHS and public health systems, which is helping to improve health and secure early diagnosis of major diseases, tackling some of the root causes of malnutrition. That is backed by the development of the outcomes frameworks covering public health, the NHS and social care, and the development of specific disease outcome strategies.

Individuals, carers and professionals all have a role to play in tackling malnutrition, and there are tools and guidance in place through a range of organisations to help health and social care professionals identify and treat the problem of malnutrition, and to access appropriate training. I note that e-learning modules are currently in place through the Royal College of General Practitioners and the managing adult malnutrition in the community pathway, which was set up by a multidisciplinary group and is widely endorsed by professional bodies aimed at healthcare professionals.

I hope I speak for the whole Committee when I say that we all agree that the NHS can play a vital role in protecting vulnerable people. As part of that, it should have strategies and processes in place for supporting patients and vulnerable people in the community who are at risk of malnutrition. I hope I can reassure the Committee that placing in the Bill a formal duty on ICBs to develop a separate strategy is not strictly necessary, as there is a range of ongoing activity across health and care.

As we have previously discussed, there are already significant existing duties, and duties proposed in the Bill, to prepare plans, including joint local health and wellbeing strategies made at a local authority level by health and wellbeing boards, the integrated care strategy that is to be developed by the integrated care partnership, and the forward plan that is to be developed by the integrated care board. All those plans should be informed by local joint strategic needs assessments, or JSNAs. All the strategies can, where appropriate, consider malnutrition and populations at risk of malnutrition. We have previously debated the range of guidance available to inform thinking on both JSNAs and strategic plans, and we will of course work with NHS England to consider whether it is necessary to include specific references to malnutrition in the guidance.

Should the Bill pass into statute, we expect clinical commissioning groups and ICBs to consider the needs of patients and vulnerable people in their communities, including people who may be at risk of malnutrition. That includes working across health and social care partners to undertake needs assessments on malnutrition, and developing and implementing a work plan to maintain high standards of nutrition through integrated pathways of care. NHSEI's enhanced health in care homes implementation framework sets out best practice guidance for primary care networks and others in relation to hydration and nutritional support for care home residents. The framework supports the implementation of minimum standards in relation to enhanced health in care homes in the Network Contract Directed Enhanced Service for 2020-21.

The malnutrition task force has also published a series of guides offering expert advice on the prevention of and early intervention in malnutrition in later life, which will support health and care bodies. Alongside that, we have published an independent review of hospital food, which made recommendations for addressing malnutrition in hospitals, and a review of what works in supporting older people in the community to maintain a healthy diet. This "what works" review included a range of examples of good practice at local authority level that others can learn from, and we have provided in the Bill for powers to impose requirements on hospital food standards.

We are helping to raise awareness of malnutrition among individuals and carers through the nhs.uk website, and through the NICE quality standard on malnutrition, which gives a clear and authoritative statement of a quality service. There are ongoing inspection requirements, including for unannounced inspections of health and care settings by the Care Quality Commission, which will continue to ensure expected standards are met.

The new clause would place a requirement on ICBs to have a malnutrition lead. The Bill intentionally allows for flexibility in the make-up of ICBs above the minimum membership requirements that we have previously debated in Committee. They could, if they wished, include condition-specific officers, but we do not want to bind their hands by specifying that they must. That once again returns to the permissive versus prescriptive thread that has run through many of our debates.

However, I do see a huge opportunity for ICPs to consider how best to improve services for people at risk of malnutrition through better partnership and joint working and planning of services, given the complementary services that the NHS and local authorities offer in this context. The new Office for Health Improvement and Disparities is committed to improving the diet of the population and supporting people to maintain a healthy weight.

I hope I have given the Committee some reassurance that we are taking this issue extremely seriously and are committed to enabling the NHS and the wider health and care system to effectively tackle malnutrition.

Alex Norris: I was a little surprised to hear the Minister defend the status quo. The state of play in this country is not good enough and is getting worse, so I dare say that more of the same will beget more of the same. The Minister said that the new clause was not necessary because of the range of ongoing activity, but I reiterate that what is happening is not sufficient and is not addressing this really important issue.

The two areas for development that were offered were local prioritisation through integrated care strategies and the Office for Health Improvement and Disparities. They are obviously relatively new actors in this space, so it is probably right that we give them time to see whether, as the Minister says, they will prioritise this, choose to make it a top-rated issue and do something about it. I am very sceptical of that, and I suspect that we will be back at this sooner rather than later. However, in the meantime, I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 67

REVIEW OF THE CAPACITY OF THE DENTAL LABORATORY SECTOR

"The Secretary of State must within six months of the passage of this Act publish a report assessing the capacity of the dental laboratory sector in the UK to meet the needs of patients."—*(Alex Norris.)*

This new clause would require the Secretary of State to review the capacity of the UK's dental laboratory sector.

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 68—*Access to NHS dentistry*—

"The Secretary of State must within one year of the passage of this Act publish a statement setting out what measures the Government is taking to ensure universal access to NHS dentistry."

This new clause would require the Secretary of State to publish a statement of what measures it is taking to ensure universal access to NHS dentistry.

Alex Norris: The two new clauses refer to two linked but distinct sectors of the heath service—dental laboratories and dentistry. In each case, we are seeking for the Secretary of State to publish a report about the health of these important sectors.

On new clause 67, the dental laboratory industry manufactures dental appliances to assist in the provision of oral care, such as crowns, bridges and dentures. The British dental laboratory industry plays an important part in the wider oral health landscape, and it is vital for patients, dentists and other registered dental care professionals. This is an unheralded industry, but it touches all our constituencies, and enables our constituents to live without pain. It also provides skilled work in an economy that has too little of it. It is based in communities all over the country, not concentrated in big cities or in London and the south-east. In many ways, it is a towns industry in a country that desperately needs more towns industries.

However, the industry is struggling. It was struggling prior to the pandemic, but it has particularly struggled during it. In the early stages and indeed even today, dentists have rightly—we supported this—been paid full contract for reduced output to reflect the challenging circumstances in which they are operating, but there has never been an obligation to pay this forward to their suppliers. Whereas we might normally expect dental labs to account for 6% to 7% of a dentist's outgoing, as output has fallen so has that outgoing, so the sector has suffered, but dental labs have needed to stay open to meet need, so they have not been able to completely avail themselves of support.

The messaging around dentistry at a local and national level has also had knock-on impacts for dental laboratories trying to make insurance claims for business disruption, because there has been a misunderstanding, shall we say, about whether they are operating, and how they are operating or not operating.

10.15 am

The Dental Laboratories Association is a professional body that covers about 80% of dental laboratories in the UK. Last June, it warned of financial ruin for dental laboratories. In recent conversations that I have had with its representatives, they said that demand has increased, but it is not back to its usual levels, particularly regarding NHS services, and the previous impact is still being felt heavily, such that the industry remains in dire straits.

We will lose this sector, or big chunks of it. We will lose British jobs. I know, because I have had conversations with Ministers and the Government on this, that the Government are relaxed about this issue, because they think there will be ample supply from the continent or from China, and in those places, this industry is growing. That is a real mistake, because we would lose control over our understanding of the quality, and particularly the employment and the supply chain. Personally, I think this is an area where we should be once again prioritising buying British, at a time when that seems to be off the Government's radar, which is really sad.

The new clause is a pretty modest ask in that context. It says that the Secretary of State should enter this space, should have an understanding of what is going on, and should in some way account for it, before we lose this very important industry.

I turn to new clause 68. NHS dentistry also faces significant challenges. Dentistry is now the No.1 issue raised with Healthwatch, which in the context of 35 million lost NHS dental appointments is probably not surprising. However, there are continued access issues, which of

course will deepen health inequalities. I would argue that the impact of the pandemic means that these access problems are now on an unprecedented scale in all our communities. Some patients requiring specialist services under sedation are now facing waits for treatment for as long as four years, which is leading us to these horror stories of patients performing DIY dentistry on themselves, or travelling for hours to access the help that they need.

Ahead of last week's Budget, the British Dental Association warned of a "last-chance saloon" for NHS dentistry, stressing that Government spending on NHS dental services has fallen by a third in real terms over the last decade. Sir Robert Francis QC, the chair of Healthwatch England, who gave evidence to the Committee, joined the BDA in urging the Treasury to commit adequate funding to ensure the recovery and long-term sustainability of our dental services, highlighting that it would take an additional £879 million just to restore resourcing back to 2010 levels. That, of course, was the theme of the Budget, was it not—pretending that the last decade had not happened? Yet in this area there was no new funding, and we have not heard a commitment that a single penny of the billions pledged for the recovery of NHS services will go to dentistry.

Justin Madders: As my fellow shadow Minister quite rightly points out, this is a huge issue for most constituency MPs. I am not surprised to hear what he said about this being the No.1 complaint to Healthwatch, because behind GP access, dental access is now a huge issue. Before the pandemic, dental services in the Cheshire area were contracted to attend to 55% of the local population's dental health needs. Clearly, that is insufficient, but the challenges of the pandemic have only made matters worse. I encourage my hon. Friend to continue to raise this very important issue.

Alex Norris: I am grateful for that intervention. It is sobering to hear that 55% was what we started with; we know that it will be less than that now. That rather picks away at the idea of a universal healthcare service.

To finish where I was going with my previous point, if I am wrong about where recovery funding for the NHS is going, and there is to be investment in dentistry, I hope that the Minister will correct me. I would be delighted if that was the case, because the BDA is warning—again, this is something that we will have picked up on in our constituencies—that morale among NHS dentists is at an all-time low. Almost 1,000 dentists in England have stopped providing NHS services in the last financial year. There was the failed contract—I know there is enthusiasm for contract reform in the Department and we will support the Department on that, but we are running out of time to have anything ready for April. In fact, we are probably already too late in that regard. The shambles of the negotiations before Christmas last year that led to the breakdown and the imposition of targets really whittled away at good will and caused a lot of upset.

Almost half of NHS dentists are saying that, unless things change, they intend to hand back their contracts or reduce their NHS commitment. This exodus of dentists from the NHS will have a disastrous and lasting impact on our ability to access NHS dentistry. If 55% is the summit of our ambition, goodness me, where will we go from there? The British Dental Association talks about the last-chance saloon; it is not hyperbole to say that we will not have NHS dentistry in the medium term if we do not have a course change.

More and more people are being pushed into the private sector. That creates market forces that mean that it is almost a self-fulfilling prophecy that dentists—both new ones entering the profession and those who have come to the end of their tether with their NHS contract—go into the private sector. We are seeing significant growth in that space as people living in pain seek drastic action. We will see more pushed on to dental insurance if people do not want to be worried about their finances. That is what privatisation looks like. We will not have NHS dentistry in the medium term unless we do something about this issue—that is the wrong way forward.

New clause 68 makes a very modest ask; it asks the Secretary of State to do what any Secretary of State should want to do: commit to universal access to NHS dentistry and say how it will practically be achieved. At the moment, we have a yawning gap. In that lack of leadership, we will see the drip, drip, drip of the loss of NHS dentistry, until we no longer have it.

Dr Whitford: I rise to support new clause 68, which is linked to new clause 67. We are aware of the impact of the pandemic, particularly on dentistry. Using a drill on someone's teeth generates aerosols in their mouth, and that would vastly increase the risk of spreading covid to the dental staff, or to any patient who entered the space soon afterwards. Despite that impact, there has not been significant funding from the UK Government for the dental industry in England to fund the establishment of ventilation and air purification systems. The Scottish Government have committed £5 million specifically for this. As the hon. Member for Nottingham North highlighted, the pandemic impact comes on top of an underlying issue, the core of which is the 2006 dental contract in England and Wales, which breaks provision down into units of dental activity. It does not reward preventive dentistry. It does not reward any practice for taking on someone who already has dental issues, because it will not be properly funded for that.

Out of that comes the failure to focus on child dental health and making sure that this generation of young children grow up with good dental health. Scotland set up Childsmile in 2007, and Wales set up Designed to Smile in 2011. There is plenty of data from both of these programmes to show that providing free dental treatment to children—along with supported tooth brushing at school, fluoride coating and so on—can decrease caries found in children in primary school and at the beginning of secondary school.

Poor dental health has a big impact on general health and self-confidence, yet we hear repeated reports of families and children struggling to access an NHS practice. In the last five years, NHS practice numbers in England have dropped by over 1,250. BDA surveys suggest that almost half of remaining NHS practices are planning to reduce their NHS commitment over the next 12 to 24 months. There was a promise that the contract would be changed by next April, and 100 practices have been trialling a new method of contract. According to the BDA, it has been warned of a return to using units of dental activity from next April. This would be an enormous missed opportunity to improve NHS dental access for everyone, and particularly to take the further step of

ensuring that every child in England does not just have access to a dental practice, but is involved, as they grow up, in a programme promoting good dental health.

Edward Argar: As ever, I am grateful to hon. Members for highlighting issues relating to new clauses 67 and 68 for debate.

I reassure the Committee that the Government continually assess the capacity of the dental laboratory sector in the UK. It is an important issue, as was highlighted by the shadow Minister, and one we already take seriously. However, it is not necessary to include a specific report requirement, especially as that could focus activity away from addressing the recovery of activity in the sector.

As colleagues will know, and as the hon. Member for Nottingham North set out clearly, dentistry has been significantly impacted throughout the pandemic due to the specific risks associated with aerosol-generating procedures, as the hon. Member for Central Ayrshire set out. The steps we have had to take during the pandemic to ensure the safety of dental patients and staff has led to a reduction in the number of NHS patients who can be seen, although activity continues to grow quarter on quarter. This reduction in NHS dental activity, including for band 3 treatments such as crowns, bridges and dentures, has had a knock-on effect on the laboratory sector. The Government recognise this, and we are already taking steps to secure the capacity of the sector.

First, throughout the pandemic, dental laboratories, where eligible, have been able to access a range of financial support that Her Majesty's Treasury has made available to private-sector businesses and individuals affected financially by covid-19. Dental laboratories that satisfied the eligibility criteria were able to access financial support through the coronavirus business interruption loan scheme and bounce back loans. In addition, up to September 2021, technicians and lab workers had been able to access the coronavirus job retention scheme, known colloquially as the furlough scheme. The recovery loan scheme, now open until 30 June 2022, supports access to finance for UK businesses as they recover from the pandemic.

During the pandemic, we carefully considered the impact on the sector, including on dental laboratories and their important role, partly through work led by the chief dental officer. We continue to work closely with all relevant parts of the sector. I am happy to confirm that officials from the Department, together with the chief dental officer and others, will be happy to again meet representatives from the dental laboratory sector to better understand their concerns on capacity, what they are seeing in terms of the recovery of their business and trade, and what further action may be needed as we work to recover from the pandemic and safely increase levels of dental activity, for patients, the profession and the industry surrounding it.

Secondly, we are committed to building and maintaining a robust dental workforce and appreciate the important role played by laboratory technicians as part of that. In September, Health Education England released their "Advancing Dental Care" review, which provides recommendations on the reform of education and training for dental care professionals, including dental technicians.

Although this is not directly in my portfolio of responsibilities, I have asked officials to work closely with HEE on the recommendations and actions of this report, including, where it falls into my area of work more broadly, how apprenticeship places for clinical dental technicians are developed, based on an assessment of the role they could play in the delivery of NHS care. The Government are therefore already taking action to help secure the capacity of the dental laboratory sector and ensure it continues to meet the needs of patients in this country.

I turn to new clause 68. It would require the Secretary of State to publish a statement on measures taken to ensure universal access to NHS dentistry. In addition to the actions I have highlighted, I assure the Committee that this Government are taking action to ensure access to NHS dentistry and, again, I do not consider it necessary to include a requirement to make a statement on this issue on the face of the Bill.

Dr Whitford *rose—*

Edward Argar: I will give way to the hon. Lady—not least so that I can have a glass of water.

Dr Whitford: That is not the least of my reasons for intervening. Rather than just stating that the Government are taking action, does the Minister plan to explain what action they will be taking?

Edward Argar: The hon. Lady is psychic, because I was just turning to that.

Dr Whitford: I am only thinking of the Minister's welfare.

10.30 am

Edward Argar: I am very touched by her medical concern for my welfare.

In light of the reduction in activity within dentistry due to the pandemic, dental practices have been asked to deliver as much care as possible, with their first priorities being urgent care, care for vulnerable groups and for children, and then delayed planned care. I put on the record my gratitude to the profession for its hard work and efforts during this time, and I am pleased to note that the levels of urgent care being delivered have now returned to pre-pandemic levels, because of the over 700 urgent care centres established in practices to improve access for people during the pandemic. Throughout the pandemic, we have worked closely with NHS England and NHS Improvement to consider the level of NHS dentistry that can be delivered safely. Activity thresholds for full renumeration are based on data showing what is achievable while maintaining compliance with infection prevention and control measures.

The pandemic has reinforced the fact that transformation in NHS dentistry is essential. As has been alluded to, NHSEI is leading ongoing work on reforming the current dental system, working with a wide range of stakeholders and system partners. We acknowledge that, even before the pandemic and the imposition of limitations that it necessitated, access to NHS dentistry was sometimes a challenge in some areas and for some people. Putting that right will require action to both reform contractual arrangements and ensure that there are trained and qualified dental teams providing NHS services throughout the country.

[Edward Argar]

Since the announcement in March that NHSEI is leading on the next stage of dental system reform, it has continued to work closely with system partners and stakeholders, including the British Dental Association in particular. The NHSEI dental system reform will deliver against a number of fundamental aims, including delivering improved health outcomes, an increased focus on preventive dental work, affordability for patients, and recognising that changes need to be supported by the profession. Making the NHS dental contract more attractive to the profession is a key part of helping with vital recruitment and retention. I know that will be particularly welcome to hon. Members from rural and coastal areas, as it has been highlighted that there is a particular challenge in some of those communities.

A key objective of this work is to improve patient access to NHS care, with a specific focus on addressing inequalities. We will set out our proposals in that area next year, in addition to the provisions in this Bill that will allow the Secretary of State to expand water fluoridation schemes. In addition, Health Education England's "Advancing Dental Care" programme will, over the next four years, deliver its blueprint for change to reform education and training, develop skills, enable modernised flexible working, and widen access and participation among the workforce.

Together, we believe these measures will address the key challenges that impede the delivery of NHS dentistry, and improve patient access to NHS care. The Government will carry on with this essential work, and will continue co-operating with HEE and external stakeholders on this important issue. For that reason, I ask—possibly in vain—that the hon. Member for Nottingham North considers withdrawing the new clause.

Alex Norris: I am grateful to colleagues for their contributions. I am particularly glad that the hon. Member for Central Ayrshire brought up units of dental activity, which are a Treasury way of understanding activity, not a public health way of understanding oral health. Although they are effective for setting balanced budgets on an annual basis, they are really bad for saving money—in fact, they have cost money. There is broad consensus that UDAs are long out of date, and that after 15 years, it is time to move away from them.

Dealing with new clause 68 first, I was glad to hear the Minister at least suggest that this is an active process, because it was the first sign I have seen that the move away was not just a conceptual one. On that basis, I will not press the new clause to a Division, because we will not prejudge that process. However, I gently say that we really need to get on with this, because lots of dentists are waiting on the outcome of that process before making their judgment as to whether or not NHS dentistry is in their future. I was also glad to hear the Minister acknowledge that the system was not good enough before the pandemic. In response, I would say that removing a third of the real-terms funding was perhaps a significant reason why it was not very good anymore, and in future the answer may lie in tackling that point.

Turning to new clause 67, I was of course glad to hear the Minister say that this issue is being taken seriously. However, I was not clear on what "taken seriously" means beyond the existing support there is for businesses generally, not least because dentists have operated in this half space of still being open but not having the fullest demand on their order books, which has often meant that they have fallen between stools. However, I think the offer of that meeting is better than the new clause and, on that basis, I will pursue the route of that kind offer. I beg to ask leave to withdraw the clause.

Clause, by leave, withdrawn.

New Clause 69

NATIONAL LEAD FOR POLICY RELATED TO ALLERGIES

"Within 6 months of the passage of this Act the Secretary of State must direct NHS England to designate a national lead for policy related to allergies."—*(Alex Norris.)*

This new clause brings in a requirement for the Secretary of State to ensure the appointment of a NHS England allergy lead.

Brought up, and read the First time.

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

New clause 69 is very important indeed. It requires the Secretary of State to direct NHS England to appoint a tsar to lead on policy related to allergies.

In 2016, 15-year-old Natasha Ednan-Laperouse tragically lost her life after suffering an allergic reaction to a Pret A Manger baguette. Since then, her parents have campaigned tirelessly to ensure that her death was not in vain and to stop other parents and loved ones having to suffer as they are suffering. They set up the Natasha Allergy Research Foundation and their campaigning has already successfully led to Natasha's law, which was implemented just last month and requires food retailers to display full ingredient and allergen labelling on foods made on premises and prepacked for direct sale. That is a tremendous achievement, and it will make a significant difference to lots of people. I have met the Ednan-Laperouse family, with their MP, my hon. Friend the Member for Hammersmith (Andy Slaughter); they are inspiring people and tremendous campaigners. The new clause is very much in the spirit of their latest campaign—I certainly would not bet against them.

The World Health Organisation has described allergic disease as a "modern epidemic", while Allergy UK estimates that up to 21 million people in the UK are affected by allergies. Allergic disorders can have a detrimental impact on patients' quality of life, as they not only have the obvious health effects, but can mean that social interactions that others take for granted—such as eating out, or even going to work—are a major health risk. Allergies can be complex: patients can suffer from several disorders at the same time, each triggered by different allergies.

In the 20 years to 2012, hospital admissions for anaphylaxis rose by 615%. Despite that, allergies are not particularly high up the political agenda for conversation and there is a perception of poor management across the NHS due to a lack of training and expertise. At the root of that is the fact that we have a very small number of consultants in adult or paediatric allergy and the fact that GPs receive basically no training in allergy.

Following the inquest into the death of Shanté Turay-Thomas—another tragic teenage death—the coroner highlighted the lack of a national allergy lead in her prevention of future death report, which was sent to the

Department of Health and Social Care. I think today is a chance to make good on that, and I would be very interested to hear what the Minister has to say on those suggestions. Natasha's foundation, with the support of Shanté's mother, subsequently made the call for an allergy tsar.

Two weeks ago, the all-party parliamentary group on allergy, in conjunction with the National Allergy Strategy Group, launched its report, "Meeting the challenges of the National Allergy Crisis". The report

"calls for an influential lead for allergy to be appointed who can implement a new national strategy to help the millions of people"

suffering. There is a real coming together across our communities of people in this space calling for this measure, and this the moment to do it.

Otherwise, as I have suggested, NHS allergy services will continue to get little attention, little prominence and little investment. Care is patchy and we know that people deserve much better support. An allergy tsar would act as a public champion for those with allergies, helping to deliver a national plan to join up GP and hospital services so that patients have a consistent and coherent NHS care pathway, and helping to promote the training of more specialist allergy doctors, consultants and GPs. It would make a difference to millions of people. I hope that the Minister will look upon the new clause favourably and give the answer that millions of people are waiting for.

Edward Argar: As the shadow Minister set out, the new clause would place a statutory responsibility on the Secretary of State, requiring him or her to direct NHS England to appoint an allergy lead. The shadow Minister rightly highlighted that tragic case that demonstrated to the country the issues and challenges in this space. I entirely sympathise with the intent of the hon. Gentleman, but I hope I can provide him with some reassurance that the amendment is not necessary, because NHSE is already able to appoint an allergy lead, or allergy tsar—call it what you will.

There is no specific national clinical director or specialty adviser for routine allergy services, but I am advised that NHS England and NHS Improvement keep their clinical leadership, including the national clinical director and national specialty adviser roles, under review to ensure alignment with the strategic priorities of the NHS and need. I am sure that NHSE will reflect carefully on the points made by the hon. Gentleman, and I will undertake to acquire a copy of the *Hansard* to pass on to NHS England and request that it considers the points he made in this context.

I also recognise that, more broadly, it is vital that NHS England and commissioners receive appropriate clinical advice in this area. That is currently provided by the clinical reference group for specialised immunology and allergy services. The CRG covers specialised treatment of certain immunological and allergic conditions. The allergic conditions include severe, complex and/or rare sub-groups. People with allergies continue to be supported through locally commissioned NHS services but, to support patients with more complex conditions, NHSE also directly commissions some specialist services. To support the implementation of coherent care pathways, NICE has also published guidance on a range of allergy conditions, including food allergy in under-19s, anaphylaxis and drug allergy.

We therefore do not believe that the new clause needs to be included in the Bill. Notwithstanding whether the hon. Gentleman decides to press it to a Division, I undertake to ensure that his comments and the case he makes for the role are passed on directly to NHS England. NHSE already has the power, should it wish to exercise it, to put such a person in post.

Alex Norris: I am grateful for that offer. I hope that when NHS England has a chance to consider what has been discussed in Committee, that will generate an offer to meet campaigners to understand what they are after and, we hope, to move positively on it. Beyond that, I am afraid that the Minister's answer was too much in defence of a status quo that does not work for too many people for me to accept it. In the spirit of elevating the matter up the political agenda and creating that blinking light on someone's dashboard to generate action, I will press the new clause to a vote.

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

The Committee divided: Ayes 5, Noes 9.

Division No. 45]

AYES

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

NOES

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

Question accordingly negatived.

Question proposed, That the Chair do report the Bill, as amended, to the House.

The Chair: The final question that I must put is that I report the Bill, as amended, to the House.

Edward Argar: On a point of order, Mr Bone. Craving your indulgence, may I take this opportunity as we complete the lengthy passage of this legislation through Committee to put on the record our gratitude to the Clerks of the Committee, to the *Hansard* team and to the Doorkeepers? I also thank you and your fellow Chairs, and colleagues on the Committee. It would be remiss of me not to put on the record my gratitude for the amazing work done by my officials in the Department in preparing the Bill and in helping us to be ready to take it through the detailed scrutiny that has rightly happened in Committee. Thank you, Mr Bone.

The Chair: Thank you for that bogus point of order.

Justin Madders: Further to that point of order, Mr Bone. I echo the Minister's thanks, not only to you and the other Chairs, Mrs Murray, Mr McCabe and Ms Elliott, but to the Clerks, who have been described to us as very patient and helpful—great qualities in such a long Bill Committee—and to the other parliamentary staff, the Doorkeepers and the *Hansard* Reporters. As the Minister

[Justin Madders]

said of his officials, we too have a great team—though probably a smaller one—of researchers who have been fantastic in giving us the information that we need to make the arguments. I also thank the Whips—it would be remiss of me not to—without whom none of this runs as smoothly as it does. On that note, I thank the Committee for its indulgence.

Question put and agreed to.

Bill, as amended, accordingly to be reported.

10.46 am

Committee rose.

Written evidence reported to the House

HCB110 NHS Providers
HCB111 Prof John Wattis
HCB112 The College of Optometrists
HCB113 Sue Ryder
HCB114 Breast Cancer Now