HOUSE OF LORDS

Terminally Ill Adults (End of Life) Bill Committee

Corrected oral evidence: Terminally Ill Adults (End of Life) Bill

Wednesday 5 November 2025

2.15 pm

Watch the meeting

Members present: Lord Hope of Craighead (The Chair); Baroness Berger; Baroness Berridge; Baroness Finlay of Llandaff; Lord Goddard of Stockport; Lord Goodman of Wycombe; Baroness Hayter of Kentish Town; Lord Markham; The Lord Bishop of Newcastle; Lord Patel; Baroness Scotland of Asthal; Baroness Smith of Newnham; Lord Winston.

Evidence Session No. 12 Heard in Public Questions 148 - 164

Witnesses

I: Stephen Kinnock MP, Minister of State, Department of Health and Social Care; Professor Sir Chris Whitty KCB FRS, Chief Medical Officer, Department of Health and Social Care; Jason Yiannikkou, Director for System Oversight and Integration, Department of Health and Social Care; Professor Meghana Pandit MBBS FRCOG MBA, National Medical Director, NHS England.

Examination of witnesses

Stephen Kinnock, Professor Sir Chris Whitty, Jason Yiannikkou and Professor Meghana Pandit.

Q148 **The Chair:** Welcome to the 12th session of our inquiry into the Terminally Ill Adults (End of Life) Bill. We are joined at this session by Stephen Kinnock MP, Jason Yiannikkou, Professor Meghana Pandit and Professor Sir Chris Whitty. You are all extremely welcome and we look forward very much to your evidence. We would be grateful if you would introduce yourselves as I call upon you one by one and add anything, very briefly, to the written statements that you have given to us, for which we are very grateful.[1]

Today's meeting is being broadcast and a verbatim transcript will be taken for subsequent publication. It will be sent to you to check for accuracy, so I hope you will be able to do that in due course.

Stephen Kinnock: I am the Labour Member of Parliament for Aberafan Maesteg and the Minister of State for Care. I have a short opening statement. I do not know whether you would like to hear that now.

The Chair: Yes, if it is very short. A minute or so will be fine.

Stephen Kinnock: I would like to thank the committee for inviting us to discuss the Terminally Ill Adults (End of Life) Bill. I am appearing today alongside officials from the Department of Health and Social Care and NHS England. I am making this opening statement on behalf of the whole panel. To be clear on my role, I will be speaking as a Government Minister. I will not be commenting on my personal views.

I recognise the seriousness of the subject matter of this Bill and that the Government would be responsible for implementing an assisted dying service should Parliament decide to pass this legislation. As such, I am pleased to be here today to help provide any information I can to support the noble Lords in their consideration of the Bill. As I have said throughout this process, the Government and NHS England are neutral on the principle of assisted dying. The Government has decided, as noble Lords will be aware, that this Bill should be treated as a matter of conscience in Parliament.

Following the second reading of the Bill in the House of Commons, the Government, with input from NHS England, has been providing technical support to the sponsors. This includes providing advice on the technical and legal coherence of the Bill as a whole and of individual provisions within it and on proposed amendments. It also includes advice on practical and operational considerations relevant to effective implementation of the Bill and of individual provisions.

The policy choices within the Bill and those that have been set out in the amendments, whether put forward by the sponsors or other Members,

[1] This comment was made in error, as the witnesses did not submit written statements.

are the choices of the sponsors and are ultimately for Parliament to decide on. We have maintained a clear distinction throughout between the technical advice provided by the Government and the policy choices made by the sponsors and Parliament.

I will finish by saying that the Government have also provided various documents, such as the impact assessment, to support parliamentary debate. These are, of course, not intended to justify any specific policy choices but I hope that both Houses of Parliament have found these documents helpful in their deliberations.

Jason Yiannikkou: I am the lead director within the Department of Health and Social Care for the Bill.

Professor Meghana Pandit: I am National Medical Director, here representing NHS England.

Professor Sir Chris Whitty: I am the Chief Medical Officer for England and a consultant physician at University College London Hospitals.

Q149 **Lord Patel:** Thank you all for coming this afternoon to help and assist us with this evidence session. I will start with the Minister and then I have questions also for Sir Chris Whitty and Professor Pandit. Minister, what are the pros and cons of having an assisted dying service as part of the NHS, as opposed to standalone outside of the NHS?

Stephen Kinnock: The choice of having a service that is free at the point of use, as is specified in Clause 41(5) of the Bill, is a choice of the sponsor, who has set out the policy intent of the Bill. The pros and cons of that are not something that the Government would comment on, because it is a matter for the sponsor to choose the policy intent. I can confirm that, once the sponsor made clear to the Government that her intention was to be able to provide a service that is free at the point of use, through an NHS commissioning process, I and officials worked with the sponsor to ensure that the Bill was able to facilitate that policy intent.

Lord Patel: Lots of times in our discussion, we have heard about the provision, and implementation particularly, of assisted dying, and whether it should be in a statute or in regulation has often come up. In your view, what aspects of this legislation should be in statute and what aspects should be in regulation? I will give you some examples: the list of medicines or substances that will be used, training, protocols, processes of eligibility, et cetera.

Stephen Kinnock: The Government's basic position is that primary legislation should be setting the foundations for the policy that needs to be implemented. Secondary legislation, through regulations, codes of practice and guidelines, et cetera, is for putting the detail in place. The reason that you need to get the balance right between primary and secondary is because we are often dealing with an evolving landscape in terms of medical practice and clinical and operational changes. Technology is constantly changing as well.

It is the Government's view that it would be counterproductive to have items on the face of the Bill in primary legislation that would be so narrowing to the Government's ability to respond, react and have the flexibility that is required to deliver a service that is of the highest quality and the highest safety levels for the population. That debate is constantly a live debate around what is right to have on the face of the Bill in primary legislation and what is right to leave to secondary regulations. That is where the dividing line has sat for us in terms of the development and evolution of this Bill.

Lord Patel: It is universally agreed, no matter what side of the argument about legislation you might be on, that high-quality palliative care is something that this country should provide. We all know that it is not fully funded. What are the plans the Government have—and I hope that this Bill will act as a catalyst—to provide high-quality palliative care that is fully funded?

Stephen Kinnock: I agree absolutely with the premise of your question, which is that, irrespective of what one's position is on this assisted dying Bill, it is absolutely vital that we provide the compassion and care, in terms of palliative and end-of-life care, across our country. It needs to be better than where it is now. We are the first to recognise that.

I am very proud of the fact that this Government have provided a £100 million capital funding boost to hospices across the country, which do amazing and inspiring work in our communities, and an £80 million allocation for children's hospices, which I think has been very important in terms of giving them the stability and certainty they need to be able to plan three years into the future. The situation we inherited was annual funding cliff edges. We have now changed that to £26 million over a three-year period. When you adjust that for inflation, it is, we think, approximately £80 million.

Those are important first steps in terms of showing how dedicated and committed this Government are to upgrading palliative and end-of-life care across our country. I am the first to recognise that there is a lot more to do and I would be happy to discuss that perhaps further in our discussion.

Lord Patel: Professor Sir Chris Whitty, do you think that palliative care and assisted dying services could be run in tandem?

Professor Sir Chris Whitty: In practical terms, it is whatever Parliament decides. I am going to preface it by saying this now and not say it repeatedly. Whatever Parliament decides can be turned into some form of practical reality. It is clear that many people involved in palliative care would not choose to be part of an assisted dying service. Equally, there would be people who would be prepared to do that, and of course there will be many people who are prepared to do both. Therefore, to see them as a single service would be a mistake. It would walk away from one of the principles of the Bill, which is that individual clinical

practitioners, for whatever reason, who wish to not be part of an assisted dying service should not feel under any obligation to do so.

Lord Patel: One thing that has come up repeatedly is whether there are enough safeguards in this Bill. Some say that there are too many and some say that there are not enough. There are amendments to increase the number of safeguards in various aspects. You have said that dying patients should not be "stuck in a bureaucratic thicket". If we increase and have more and more safeguards, are we liable to do that?

Professor Sir Chris Whitty: It is always tempting to try to deal with problems by layering layer upon layer of complex bureaucracy on top of one another. I would hope that, if this is passed, Parliament will resist that temptation. The best regulations are ones that are simple, clear and where, if you asked 10 people, you would get 10 understandings of the regulations that are there. The key thing is that Parliament is clear what it is aiming to achieve by those and then aiming to achieve it by the simplest mechanism possible.

I was very struck by the evidence of Sir Nicholas Mostyn this morning to your Lordships, where he was pointing out that there is already complexity in this Bill. The key thing is that Parliament should decide what it is trying to protect and then what is the simplest way to achieve that end. That will almost certainly also be the best way.

Lord Patel: This is a tricky question and the last question. Thank you for your letter that you sent to us, clarifying what you had said to the House of Commons committee about mental capacity. My question, though, is different. How well do you think mental capacity assessment is embedded in professional practice generally?

Professor Sir Chris Whitty: I am going to repeat in different words something I said to the House of Commons select committee on this, because it is quite important, not just for mental capacity but for other areas. Wherever possible, it is far better to use systems that people are used to and that are tested both in practice and, where necessary, in law.

The advantage, in my view, of the Mental Capacity Act is that it has been used since 2007. Up and down the country, all doctors, nurses and other health professionals use it the whole time. To be clear, most of the Mental Capacity Act is irrelevant to this Bill, because it is about what happens if someone does not have mental capacity, at which point, in a sense, for the purposes of this Bill, were it passed, the thing stops. For the testing of mental capacity, that is absolutely established practice and there will be no doctor, nurse or other health professional who is not doing it repeatedly in their professional life, using current guidelines.

I have a concern that you could have a conversation in one bed in a hospital where someone is talking about, for example, an operation where they might well lose their life, because they are frail and there is the operative risk, done under the Mental Capacity Act, and, in the next-door bed, someone is trying to do the same process of having a

difficult conversation about someone who might die, or could definitely die, as a result of that decision, but using a different legal framework. The risks that that could lead to confusion are not trivial. Therefore, I hope your Lordships will at least consider that, where possible, we should use established mechanisms, if those fit the purpose.

Lord Patel: Professor Pandit, the issue of coercion and pressure is something that has often come up in our discussion. What is your understanding of how clinicians explore issues of coercion, burden and pressure? For example, patients might have refused life-saving treatment that might be beneficial to them. You are more used to dealing with decisions that people might make about their pregnancy.

Professor Meghana Pandit: I will address it as a generic question in the first place. Doctors, particularly in certain specialties, such as palliative care and oncology, are very used to dealing with patients who need to make complex and difficult decisions and taking views and opinions of the patients and their families into account to bring the best interest decision for the patient into effect. It is very commonplace for doctors, during their medical training, to get to a point where they are able to see through that and help the patients.

You rightly point out about my training in obstetrics and gynaecology. Personally, yes, as an obstetrician in my clinical career, I have had to face making difficult decisions about patients, taking into account differing opinions, mostly about childbirth, and make decisions about that in conjunction with the patients.

Q150 **Baroness Berridge:** Thank you, Minister Kinnock, for coming today. I have placed in front of you a letter that was written to six MPs and published in the local newspaper from all the Plymouth senior palliative medicine doctors on 12 June of this year. I will quote from the third paragraph down: "It appears to us that the idea of doctor-assisted suicide being introduced and managed safely within the NHS is out of touch with the gravity of how the current mental health crisis and pressures on staff influence real-life decision-making. The Bill's proposed process changes would significantly worsen the delivery of our current health services in Plymouth through the complexity of the conversations required when patients ask us about the option of assistance to die".

Minister, your party promised to fix the NHS, not significantly worsen the delivery of current health services. Are there not going to be areas of the country where massive numbers of locums are going to be needed, at additional costs, when there are gaps in staffing. Will this not in fact end up as a postcode lottery, with this service only for the wealthiest in parts of the country?

Stephen Kinnock: It is absolutely right that the palliative and end-of-life care sector is facing a number of pressing challenges. Working closely with officials, we have identified six core challenges: unwarranted variation in local and regional provision of care in terms of both access

and quality; unwanted variation in approaches to commissioning providers to meet the health needs of those receiving palliative care; too few people being identified as likely being in the last 12 months of life; too many emergency hospital admissions involving people who are in the last 12 months of life, most of whom neither want nor need to be there; too many people dying in hospital, again very often not in keeping with the wishes of individuals or their loved ones; and significant workforce challenges.

We are very clear about those six core challenges. Those six core challenges are driving the work that I have been doing quite intensively with officials since taking up this post 15 months ago. I am confident that, in the near future, we are going to be able to come forward with a plan that addresses those issues, looks at the issue of strategic commissioning and ironing out unwanted variation between areas of the country and looks at workforce training, so we have a workforce that is able, with care, compassion and skill, to have honest conversations with people. I absolutely recognise that there is quite a long way to go on this. We inherited a broken situation and we are working at pace to fix it.

Baroness Berridge: I think you are accepting that the locums are within that workforce, but I will move on to my next question. Minister, NICE often has, sadly, to refuse effective life-saving drugs on value for money grounds. Not only could this pressure be investigated now as a criminal offence under Clause 34 of the Bill, but does this not also mean that your Government's spending decisions could be complicit in vulnerable people seeking an assisted death?

Stephen Kinnock: I would refer the committee to the impact assessment, which sets out a range of potential scenarios. I would underline the fact that it is not a forecast. It is an estimation of a spectrum of impacts developed independently and drawing, to a large extent, on the experience in other jurisdictions that have established an assisted dying service.

When one looks at the cost pressures that could potentially be engendered by an assisted dying service, we, as a Government, are confident that those cost pressures can and would be handled within the standard spending review process. We are very alive to the potential cost pressures that you refer to, but, having done the assessments and estimations that are in the impact assessment, the Government is confident that those can be handled.

Baroness Berridge: Sir Chris Whitty, thank you for coming today. We have heard strong and compelling evidence this morning from an expert in the mental capacity law, Mr Ruck Keene KC. He stated to us that, by importing the mental capacity test, if a clinician is in doubt that the person has capacity, that Act requires the presumption that they have capacity to apply. Do you not see that that is quite dangerous when you are talking about someone ending their life with medical assistance?

Professor Sir Chris Whitty: It is important for committee members to remember that these very complex decisions are happening the whole time as we speak. Up and down the country, people are making decisions on, for example, deprivation of liberty or allowing someone to go forward to an operation where they are highly likely to lose their life, but that is seen to be the lesser of two risks to that person, based on the Mental Capacity Act as it stands.

The principle, which I explained not terribly well the first time I came before the House of Commons committee, is that a more complex decision inevitably means that someone has to take even greater pains to ensure that someone has capacity than if it is a more trivial thing like, "Will you have your blood test?" or something of that sort. It is important to understand that it is not something that is never done. This is done the whole time for very serious, including potentially life-ending, decisions under current legislation.

Q151 **Lord Markham:** Sir Chris, I think I am hearing from you that your professional opinion is that the Mental Capacity Act should be used in these assessments. Is that correct?

Professor Sir Chris Whitty: I am very cautious about making any kind of legal point on this. Indeed, there are people round the room who are, in my view, better placed to make both legal and technical comments on this. There is plenty of evidence, and it goes with common sense, that, when people use an existing system that they have used for many years, that they are used to and that has been tested in the courts, they are far more likely to be able to follow a reproducible and sensible pattern of making decisions than if they are faced with a completely new approach which they have not used previously and in which there may well be legal ambiguities the courts have not yet adjudicated on. My reasons for being in favour of it are not in any sense philosophical. They are purely practical, which is to do with the fact that people use it the whole time and therefore understand it.

Lord Markham: Minister Kinnock, I think I heard you mentioning a kind of a commissioning approach here, where I assume ICBs would be commissioning both NHS and voluntary organisations, as happens with hospices and so on. Is that the thinking behind the model?

Stephen Kinnock: We have not defined the operational model in detail because we do not think that it is right for our work to pre-empt the will of Parliament. We think that it is very important that we move forward with this, in terms of the detail, if and when the Bill gains Royal Assent.

It is clear from Clause 41(5) of the Bill that the policy intent of the sponsor is for this to be an NHS service, in the sense that it will be free at the point of use. The NHS, almost entirely across everything that it does, works on the basis of commissioning. ICBs are responsible for identifying the health needs of their population and commissioning services accordingly. So whilst I definitely do not want to jump the gun or put the cart before the horse, the spirit of 41(5) does lean in that direction.

Lord Markham: Sir Chris, there have been lots of debates about the second stage and whether it should be a High Court judge or the panel approach, which seems to be more, dare I say it, patient-focused in terms of their medical standing. In terms of the panel, do you think that we have achieved the right balance there?

Professor Sir Chris Whitty: I do not think that that is a medical question. That is very firmly one for Parliament to decide. The one thing I would say, though, is that I hope that people, in their considerations, start with the fact that you are dealing with someone who is in the last six months of life and may well be in pain or other distress, and do not do anything that does not have that as the first point for making their decisions. Beyond that, I really do not think that it is a thing for me, as a doctor, to comment on.

Lord Markham: I know that you are very knowledgeable about what happens all around the world. What are the main lessons, do you believe, that we can draw on from what we have seen where assisted dying is in place in other countries?

Professor Sir Chris Whitty: The understanding about other nations is already happening, but is in its infancy. Many countries have started some form of medically assisted dying. Different terms are used in different places. For quite a lot of them, we do not yet have systematic information. It is accumulating quite rapidly. I fully agree with comments that have been made elsewhere that, as time goes by, we will have more information.

The Nuffield Trust did a good summary, I thought, of lessons you can draw, which I am not going to try to summarise in the one minute I am sure the Chair would not want me to extend beyond. I would direct your Lordships to that report as a good summary.

Q152 **Baroness Berger:** My questions are to the Minister, and thank you so much for joining us. I have four questions that I hope will require just short answers. As you will be aware, and this has been slightly touched on during the session so far, the Bill now confers 42 delegated powers to the Secretary of State. I listened to your response to Lord Patel.

The extent of delegated legislation in this Bill has been strongly criticised by two committees here in the House of Lords, both the Delegated Powers and Regulatory Reform Committee and the Constitution Committee. These committees have said that it is "highly inappropriate" that we have before us "skeleton legislation" and that the Bill contains "sweeping, unspecified and unjustified powers to the Government while removing Parliament's scrutiny role for provision that should be in primary legislation".

In the absence of some of these principal aspects of policy, we are obviously very keen to hear directly from you what the Government's intention is, should Parliament pass this Bill into law in the coming months. I certainly do not intend to ask you about each of the 42 delegated powers, but I am going to ask you to pre-empt on some of the

key issues.

You have just told us, Minister, that this will be a service free at the point of use, commissioned by the NHS. You have also previously said that you are comfortable with privately owned clinics delivering assisted dying services. Can you confirm to us today whether the private sector will be allowed to participate in the provision of an assisted dying service?

Stephen Kinnock: Yes, as it is set out in the Bill, the relevant clause of the Bill relates back to the National Health Service Act of 2006, which includes the potential provision of services privately, as well as through free-at-the-point-of-use national health services. That is confirmed and on the face of the Bill.

Baroness Berger: Are you able to share with us, please, what levels of profit the private sector will be able to generate if it is operating assisted dying services commissioned by the NHS?

Stephen Kinnock: No, that is impossible to say because it is based on too many hypotheticals and variables.

Baroness Berger: You will understand that, for us as parliamentarians considering this Bill, that is a key issue that many Members will want to know about in advance of us deliberating on this legislation. On the specific issue around money, you will be aware that this committee invited a Treasury Minister to give evidence, but they declined the invitation. We have heard from a number of witnesses over the course of the past three weeks about additional costs that have not been accounted for in the impact assessment and the modelling. There are one or two examples, including the additional training that might be required of medical examiners and certainly assessments that need to be done at a local authority level.

In the context of the response you just gave about palliative care, just last week we heard from the NAO that hospices have seen a 10% reduction to their budgets in real terms over the past two years. The Secretary of State for Health and Social Care is on record as saying back in June that there is "no budget" for this. Can you please share with us where the money is going to come from to fund the creation of this service and when we might get a more accurate assessment of the costs that will be incurred?

Stephen Kinnock: There are two sides on the funding. One is what is within this current spending review period, which goes through to 2028/2029. Within this spending review period, if Parliament passes this Bill, every key member of the Government is on the record as having said that the Government will implement the will of Parliament.

There is a well-established way of looking within spending review periods to reprioritise funding and identify the funding that is required in order to execute the will of Parliament. That is what will happen within this spending review period. I, of course, cannot forecast or predict what happens in further spending review periods, but the constant will be that

the Bill will have become an Act and will have to be implemented and the budget made available accordingly.

I would again refer yourself and the committee to the impact assessment, which sets out a range of scenarios. In the early years of an assisted dying service, the numbers that would be potentially partaking of that service are relatively small. That is a factor in terms of the overall costs that are being forecast for the service.

Baroness Berger: Will we see a more updated impact assessment in terms of the costs in light of the evidence that we have received over the last few weeks?

Stephen Kinnock: I might turn to officials for that. My initial response on that would be that, if the Bill is changed in the Lords in a significant way that could potentially have an impact on the draft of the impact assessment that we currently have, I would assume that the impact assessment would need to be updated accordingly. It depends on the moveable feast that is the Bill going through the Lords. Jason, you might want to add to that.

Jason Yiannikkou: Yes, we would normally do a revised impact assessment at the end of the process.

Baroness Berger: My final question is around advertising. You will be aware that there are some delegated powers in the Bill around advertising. It would be really helpful to hear from you directly, Minister, about what specific types of advertising the Government or the Secretary of State may allow, should this Bill pass through the House of Lords.

Stephen Kinnock: It was made clear during the Bill committee that some tightening up on advertising was required in terms of the definitions. Officials worked with the sponsor to amend that policy intent. The outcome of that is that there is a very clear distinction between information and advertising. Advertising is completely excluded.

It would not be an acceptable or legal thing to do, because the Bill explicitly excludes advertising, but it also enables medical practitioners to share information. Some of that information would be in written form, so it might be in the form of a pamphlet or leaflet, which is for purely information purposes, as opposed to anything that looks promotional, which is explicitly excluded on the face of the Bill.

Q153 **Lord Winston:** I have one question, which maybe I could put to each of you, because you are each concerned with the National Health Service in an important way. I have had a huge number of letters from people who I do not know, many of whom I have tried to answer, but not all, who have argued that one problem is that the National Health Service is now in quite a lot of disarray and there are a good deal of problems with morale. That might, in fact, hit on how people are affected, particularly elderly people, with the issue of assisted dying and the risk that their care might in some ways be compromised because of that, or they might

feel that it is going to be compromised. I wondered whether each of you might answer that, because each of you will have a slightly different perspective.

Professor Sir Chris Whitty: It is a difficult question because, in reality, there is an incredibly wide range of views on this among patients and the medical profession, as among parliamentarians. I suspect that some people would feel, as you say, some sense of significant concern. Others might feel some sense of, "This allows me a route to go down if things do not go the way I want them to". It is impossible to know how many will be proportionately in one or the other, both among medical practitioners and, more importantly, among the public and patients as a whole. We should all acknowledge that both positions will exist simultaneously.

Lord Winston: Many of those letters have been from medical practitioners, which is one of the reasons why I asked the question.

Professor Meghana Pandit: There was a mention about the NHS being in disarray. This is a period of change. All the people working in the NHS are aware of the complexities involved. The 10-year health plan that was published earlier this year is a strategic plan that sees developments and changes that are particularly important. There is a focus on neighbourhood health, so improving care for the people local to where they are, rather than moving them as per where the care is available. That is a good change. Alongside that, there is a focus on the frail and elderly and on developing modern service frameworks, particularly for severe mental illness, frailty and dementia. Those will help in terms of practice.

In terms of the workforce, we will of course work with the Government, if the Bill is passed, to make sure there is specific training for the workforce for assisted dying when it becomes law. The workforce in the NHS is used to delivering new services and novel therapies and there are many examples of this. Specific training for assisted dying is important and will be developed in conjunction with the Government.

Jason Yiannikkou: Speaking as a government official, your question leads me to the thought that, for implementation, we would need to take a structured, thoughtful and sensitive approach to taking this into practice. That would mean, as colleagues have said, working very closely with practitioners and others.

Lord Winston: I am in favour of the Bill, but I wonder what you feel, as Minister, with regard to this particular issue. Do you feel that that is something that the NHS can cope with properly?

Stephen Kinnock: On your first point around concerns around our NHS, the Secretary of State is on the record as having said that we inherited an NHS that was broken. That is the position of the Government. We are also straining every sinew and working every day to get it back on its feet and fit for the future. We have set out a 10-year plan. Across my portfolio, we are working to get 2,000 more GPs on the front line. We

have the adult social care commission. We have an emerging plan for palliative and end-of-life care. We are getting 700,000 more dental appointments out there.

There is a lot of work going on, but I accept that these things are incremental and people are possibly not yet seeing the benefits. I am absolutely convinced that we will. As the next few months and years go by, we will start to see those benefits.

I would add to what my colleagues have said by saying that we have a four-year commencement period in this Bill. I believe that, if Parliament gives its assent to this Bill, there would be two processes going on. One is about the training, the capacity building and the confidence building, if you like, in the assisted dying service itself. At a more strategic level, there is the improvement, reform and investment that is going on into the NHS more broadly.

Lord Winston: Presumably communication is important.

Stephen Kinnock: Absolutely, yes. Lord Winston, you touched on perhaps another area that is somewhat broken, which is the relationship between the public and politicians, and the Government more broadly. It is clear that trust has been corroded and there is a huge amount for us all to do. Communication is an extremely important part of that, but you also have to show delivery. You have to show that you are taking the action that is required to deliver and improve the quality of life of our people.

Q154 **Baroness Smith of Newnham:** All of my questions are to the Minister. Thank you very much for coming today. In your introductory remarks you stated that your remarks are on behalf of the Government and restated the Government's commitment to implement this legislation if it is passed. You noted that it was a matter of conscience for parliamentarians, and that is true. Each of us has a vote individually and we can exercise our conscience.

The legislation also allows a variety of opt-outs, or potentials for opt-outs for medical professionals. It does not seem to allow for any sort of opt-out for a parliamentarian who might be potentially going to be appointed to the Department of Health and Social Care. There seem to be a lot of powers attributed to the Secretary of State. Does that mean that future Secretaries of State, and potentially other Ministers, would not be able to take on roles in the Department of Health and Social Care if this Bill were passed and they did not agree with the legislation?

Stephen Kinnock: Ministers, from the Prime Minister down, have stated that, if Parliament gives its assent to this Bill, Government will implement it. That clearly indicates that the Government, as a body corporate, will implement this Bill.

In any issue where an individual member of the Government has an issue of personal conscience that would lead him or her to be unable to be involved in the implementation, overseeing the role that Ministers

generally play in any area of DHSC policy, that would be a matter for a discussion between that Minister and the Secretary of State. If it is the Secretary of State, it would be a matter for a discussion between the Secretary of State and the Prime Minister. I suspect that the usual channels, the Whips, may also have a view on that because it relates to the general position of the Government.

There is not a hard and fast position on this. I would also note that, where matters of conscience have been implemented through Private Members' Bills, for example on abortion, the death penalty and same-sex marriage, there are examples of individual Members of Parliament who perhaps have not been in favour of the legislation but have then been involved in its delivery. There are various precedents that one could draw on.

Fundamentally, the position of the Government as a body corporate will be to implement the Bill, but I suspect that there may well be some individual conversations that need to happen on a case-by-case basis.

Baroness Smith of Newnham: My other suite of questions relate to the cost of this service. It keeps being referred to as an assisted dying service. Lord Patel, in his opening question, asked about the pros and cons of the service being inside the NHS.

Ministers, including your colleague Sarah Sackman, who came last week, have stated that you will implement the Act as it is passed by Parliament, if it is passed by Parliament. You have also, Minister, in line with many other evidence-givers, stressed how important palliative care is and the importance of enhancing that.

If that is to be done at the same time as introducing an assisted dying service, given that the Treasury refused to come to give evidence, one can only assume that any funding is going to have to come from within the NHS or the Department of Health, and yet you said you had not really modelled provision at the moment because the legislation has not gone through. If that is the case, is the impact assessment adequate? Does it really cover the costs that might be entailed by this legislation?

My very final question is about suicide prevention. The Government's manifesto, and indeed my party's manifesto, made commitments to reducing lives lost to suicide. As Baroness Hayter pointed out in a previous session, we are talking about suicide, however uncomfortable that is. Is there any danger that this legislation could have an impact on other suicidal ideation?

Stephen Kinnock: On your first question on costs as estimated in the impact assessment, I would reiterate that impact assessments are not specific forecasts. They are a spectrum based on a range of scenarios. However, I have tremendous respect for the teams that have produced this impact assessment. It contains a lot of very detailed modelling based on, to quite a large extent, experience in other jurisdictions. In that sense, it is quite firmly anchored in the costs that have been incurred in other parts of the world. If you look at the estimation that between 273

and 1,078 people might come forward to use the service in year 1, rising to 1,737 to 7,598 in year 10, and project the potential costs associated with those numbers, my overall view is that that does not send a signal of a very high degree of cost if you look at the overall £200 billion-odd budget of the National Health Service.

On your point about suicide prevention, the sponsor has made very clear from the outset that her policy intent is that there should be very strong safeguards. I think she is on the record as having said her view that this would be the safest assisted dying service in the world. Those are her words, not mine.

The point there would be that there are those safeguards, in terms of the two doctors, the panel and the training that is involved. It is very clear on the face of the Bill that anyone involved in this, in terms of the panel, should be trained in issues of coercion and pressure and identifying mental health issues because you refer specifically to the suicide aspect. All that is catered for on the face of the Bill, as aligned with the sponsor's policy intent. The Government's position is that the Bill, as currently drafted and before the Lords, is workable and is safe. Clearly, it is with the Lords and so our view on that is provisional and depends on what is finally passed, if it is finally passed.

Q155 **Baroness Hayter of Kentish Town:** To be clear on a point that arose from my colleague, Baroness Berger, where she talked about the fact that it could be in the private sector, I assume we are really talking about charities and hospices, not necessarily money-making ones. Is that your understanding of the other suppliers.

Stephen Kinnock: The independent sector might be a better way of phrasing it, yes.

Baroness Hayter of Kentish Town: It comes to this cost issue. If it was 7,000 in the future, they are probably all being treated by the NHS at the moment. We are not talking about an additional group, probably, of patients. Your staff are probably looking after them at the moment.

I am someone, as I am afraid some of you will know, who keeps agitating the Department of Health to pay for fracture liaison services to help with osteoporosis. I am quite interested about how big an element of this for assisted dying you see would be added to the budget that you have to do compared with, for example, another new service that we are trying, such as a fracture liaison service. Is this an enormous one for 7,000 people, or is it within the scope of something that you occasionally have to add because of changes in medical practice, AI or whatever?

Stephen Kinnock: I might pass that to colleagues on the panel because it is quite specific on some of the clinical services side of things and they are probably better positioned than me.

Baroness Hayter of Kentish Town: I am trying to get a relative cost.

Professor Sir Chris Whitty: I think that this is a cost question, if I understood the question properly, and therefore it is probably a policy or political question.

Jason Yiannikkou: It is difficult to precisely scale this from where we sit today. There are probably two elements. The Minister has alluded to one, which is the likely level of demand. As the impact assessment tried to do, drawing on other countries, we have some sense of the likely level of demand and how it might increase over time, but of course we are a distinct country and may travel in a different direction than other countries.

The other driver of cost that will be at the beginning of the process will be the setting up of the service. That is around training, information, guidance and so on. That will be, if you like, probably a one-off cost. I would not want to hazard a number, because I think that that would be unhelpful. As the Minister says, within the overall scope of the NHS's budget, which is considerable, it would represent a relatively small proportion.

Baroness Hayter of Kentish Town: Is it about a million GP meetings per day?

Jason Yiannikkou: I am going to stay away from numbers, if that is okay.

Baroness Hayter of Kentish Town: I was very struck by something that Professor Pandit said at the beginning. I do not know whether she said to concentrate on it, but what is important would be the best decision for the patient. We should all bear that in mind. Also, someone talked about the dying having a lot of pain and distress.

I am quite interested in what happens at the moment. There will be choices that dying people are taking at the moment, for example to stop taking chemotherapy. There may be other things as well—I am not a medic—where they also take that decision. Presumably at that point there could be coercion. There could be pressure at that point. It seems to me that there is no input then either from a social worker, a lawyer or anyone. So, presumably those decisions are taken with the help of doctors, day by day, on something that has the effect of also hastening someone's death.

Professor Meghana Pandit: I will start and then defer to Professor Whitty. I will start by explaining some of the palliative care services. There is provision of end-of-life care, palliative care and specialist palliative care. You are absolutely right in terms of patients declining or refusing treatment. These are discussions that are had with doctors, nurses and everybody who works in the health service, day in and day out.

The key principle that guides doctors through this is informed consent and the detailed explanation and communication, as pointed out earlier.

Clarity of communication is essential and doctors and nurses are trained in making sure that the consent process is absolutely crystal clear, so that everybody understands what the patient needs and wants. If somebody refuses chemotherapy or an operation that might be considered to be life-saving, the important aspect is that the doctor is able to confirm that they have capacity to understand and make a decision for themselves.

Professor Sir Chris Whitty: Your question about coercion is a very important one and happens the whole time. Sometimes, listening to the debate, I have had the impression that people think that all coercion is due to people doing it for nefarious reasons. You also get coercion, including from family members, who, in their own view, are doing their best for a relative they see is in distress. They are imposing their views on the individual, who themselves may have a different view.

The whole point of people having adequate consent as an adult is that, provided they have capacity, they should be taking the decisions. It is perfectly right and proper that family members can give views to support them but, ultimately, it is their decision. You need to be alert to this form of coercion, in addition to the more nefarious coercions that have been talked about, quite appropriately, through the debates that have happened in this committee.

Baroness Hayter of Kentish Town: The coercion can be both ways. It can be persuading someone to have the life-saving operation and to keep them alive as long as possible.

Professor Sir Chris Whitty: That is correct. This is surprisingly common.

Baroness Hayter of Kentish Town: We use "coercion" as if it is always towards death, but it can be exactly the opposite way. Is that correct?

Professor Sir Chris Whitty: That is right.

Baroness Hayter of Kentish Town: I would also like to ask, similarly, about equitable access to this. The Minister talked about free at the point of use. At the moment there is assisted dying. It happens in Dignitas in Switzerland. It is certainly not free at the point of use.

I know that it is difficult because you are not taking a position on this. To some extent is this making it more equitable, in that some people who cannot afford to go to Dignitas or anywhere else, if it goes through or when it goes through and is implemented, would have that choice that they do not have now because of cost.

Professor Sir Chris Whitty: Who are you aiming that at?

Baroness Hayter of Kentish Town: I am aiming it at anyone who is brave enough to answer.

Professor Sir Chris Whitty: In a sense, the narrow question that you ask of whether it would provide better equality of access compared to now is not a question for me. The reason I wanted to give an answer to it is that it is important that, if this is passed, we do not have a situation where the rules are so complex that only people who can afford a good lawyer or themselves are a KC who frequently appears on issues of consent, to take a completely non-random example, are able to get through the process.

Most people who are dying of whatever cause have an average—literally an average—level of understanding of and education in the law and all these other issues. It is important that it is clear and simple enough that they can understand what is going on and get through the system in the last six months of their life, at a point when they are going to be under stress for many other reasons.

Issues of equality have been brought up throughout the debate quite rightly, but one point of equality is that people of all walks of life who are capable of taking the fundamental decision should be able to navigate the process subsequently. It is important that people think about that as they go through the debates that follow this committee.

Stephen Kinnock: I would agree with what the CMO has said. Our job is to facilitate the policy intent of the sponsor, and the sponsor has made clear to us throughout that we are looking to strike a balance here between fair and equitable access and safety. That has been constantly, if you like, the balancing act that the Bill has had to go through, deliver and achieve. The view of the Government is that, in terms of workability, it strikes that balance between access and safety. Of course, if one were to amend the Bill in one direction or the other, that may then create questions about the workability of the Bill in the context of the sponsor's policy intent.

Q156 **The Lord Bishop of Newcastle:** Can I start by following up on the matter of private sector raised by two of my colleagues with the Minister? I am aware that in New Zealand, for example, assisted dying services are available in funeral homes. I wondered whether the Minister had a view on whether this was in the purview of the Bill in terms of private sector. We know that funeral homes are not regulated. We know some of the significant issues that there have been in that domain.

Stephen Kinnock: It is clear from Clause 41 of the Bill that the Secretary of State will, by regulations, set out a detailed operating model. The key parameter for that is that it should be available as free at the point of use. The delivery mechanism for it is simply not something that we have set out in detail, because we want to respect the need for Parliament to go through this process. We think that it would be wrong, particularly on a Private Member's Bill, to pre-empt the will of Parliament in that way. In the Bill we have the foundations for the Secretary of State to be able to make regulations in that context.

On the delivery mechanism, whether it is independent or charities, if you look across the NHS we use all sorts of different entities to deliver a service, although that service is free at the point of use, for example general practitioners. PCNs, in effect, operate as small businesses, for want of a better word, that have one key contract, which is with the Department of Health and Social Care and then, through that, to the ICBs to be commissioned according to what the population needs are, as identified by the ICB. We work with a whole range of partners and delivery vehicles. The service is free at the point of use but is often delivered through a range of different mechanisms.

The Lord Bishop of Newcastle: This is a question for Sir Chris concerning vulnerable populations and the Bill. Currently, the Bill, as drafted, would allow the prison population to access an assisted death if they met the other eligibility criteria. We know that the rates of mental ill health, self-harm and self-inflicted death are higher in prisons than they are in the general population. Are you concerned that, if the Bill passes and is available to prisoners, they may be disproportionately impacted by the Bill? Are you concerned that this will also impact on the suicide prevention work that happens in prisons?

Professor Sir Chris Whitty: As it happens, I am releasing quite a large report on prison health tomorrow, which does not address this question directly but deals with things such as suicide in prisons, which you might be interested, as you have asked this question, to look at. You are absolutely right that the prison population is very vulnerable. They are vulnerable usually, medically speaking, before they go into prison. That vulnerability increases in a prison environment for many of them, not, to be clear, for all, because a structured environment sometimes reduces their vulnerability, but that is a point to one side.

One of the main points that I make in the report is that the prison population is currently younger but ageing quite rapidly, and will continue to age over the next period, so this is not a theoretical question. At the moment, I have a concern, even before this, that the appropriate levels of palliative care are not available to prisoners. It is absolutely essential that we address that point first.

The point you raise is a real one. The principle of prison medical health is that people in prison should have the same rights to health as any other individual, neither more nor less, because it is not to reduce their health that they have been consigned to prison by the law. I think, whatever we do, it should be seen as equally available to prisoners but with all the concerns that you raise addressed perfectly reasonably, because they apply across a whole sweep of prison health, as the report I will release tomorrow shows.

The Lord Bishop of Newcastle: Can I just then briefly draw that back to the Minister with a related question? According to Marie Curie, 90% of people who die are estimated to need palliative care. Would you feel content if a person who would benefit from receiving this care decided to access an assisted death because they could not access the palliative

care that they needed to live comfortably in the final months of their life? How realistic is a prospect of that with this Bill?

Stephen Kinnock: I think it is vital that everybody is able to access high-quality, compassionate palliative and end-of-life care. That is something that we are working on, and I hope that the £100 million uplift that we provided will go some way to helping on that.

We know that there needs to be more research as well into medical conditions that are receiving palliative care treatment but where that palliative care treatment is not being effective, and sometimes, even though palliative care treatment is being provided, the person is still in considerable pain and suffering.

We are investing £3 million in a new policy research unit that will specialise specifically in palliative and end-of-life care. We also work very closely with the Voluntary Community and Social Enterprise Health and Wellbeing Alliance programme. They are a highly valued partner—people with real expertise from the hospice sector, experts in palliative and end-of-life care— who are constantly feeding back to us in terms of how we can improve the offer and the services across palliative and end-of-life care.

Then there are also the six challenges that I mentioned earlier in my comments that are going to form the basis of a new palliative and end-of-life care strategy and implementation plan. We want to eradicate regional variation, improve strategic commissioning, and improve training. This is really important and urgent work. We are absolutely seized of this as a priority, and I absolutely see, but one thing I would probably welcome is the fact that I think the passage of this Bill through Parliament has served to highlight the importance of palliative and end-of-life care, highlight the vital role that hospices play in our community, and that is integral to our 10-year plan for the future of our health and care service.

The Chair: Before I open up to supplementary questions from the committee, can I ask whether any of you have any points you would like to add?

Stephen Kinnock: No, I do not think so, Chair. Thank you.

Jason Yiannikkou: No.

Professor Meghana Pandit: No, thank you, Chair.

Professor Sir Chris Whitty: No, thank you.

Q157 **Baroness Finlay of Llandaff:** I am glad to hear recognition of the importance of specialist palliative care, and recognition that that is different to general palliative care. In your first answer, I think it was, you said that you plan for this to happen in the near future. How near is the near future, and do you see access universally to specialist palliative care for those people whose pain or distress is not coming under control being available before this Bill goes through? I think I have heard the

phrase "in the near future" for decades now.

Stephen Kinnock: Thank you very much, Baroness Finlay. I would just like to start by thanking you for the outstanding leadership that you have shown in this sector, and also for the report that you did with my colleague Rachael Maskell, which I read with great interest, and I enjoyed our meeting and our discussion about it. Your report has absolutely helped to inform our thinking about the plans and changes that we need to implement.

I am in a position to say that in the very near future—I know that you may well not like that phrase, but I cannot be much more specific—and I would say in a matter of weeks, we will be able to come forward with a plan that sets out our response to those six core challenges that I mentioned, which I think closely reflect the challenges that you set out and the recommendations you set out in your report.

In terms of the implementation of that, there will be a need for some consultation to ensure that we really, if you like, put meat on the bones. I am very keen to see this moving very rapidly, and I think the passage of this Bill through Parliament has served as a catalyst for the work that we are doing in palliative and end-of-life care, and has helped as well to push it up the political agenda. I am leaning into that and working closely with officials so that we can ensure that we do have this offer in place along the lines of the timing that you have just proposed.

Baroness Finlay of Llandaff: Thank you for your kind comments about the report. It was a lot of work.

Stephen Kinnock: Yes, I can see that.

Baroness Finlay of Llandaff: Can I just turn to Sir Chris Whitty, then? You pointed out that people might be in pain or distress, and I would hope that everyone with unrelieved pain and distress that has gone on for more than 48 hours should have access to specialist palliative care input.

Within the way that the Bill is written and in the impact assessment, it seems as if it could be very inexperienced doctors who have these conversations with people, and I wonder whether you feel that it is appropriate or whether these difficult decisions should be ones taken by senior doctors and should have input from a consultant in the specialty, but also whether there should be a role of getting information from the family and, where there are children, making sure that the children know that the person is dying, because we have a lot of evidence that, where children do not know what is happening, the incidence of complicated grief and long-term morbidity is very, very much higher.

Professor Sir Chris Whitty: I essentially agree with the underlying sentiments of all the stems of your question, but I am going to flesh them out slightly.

First, I quite strongly think that, although the initial discussion that someone may choose to raise could be with someone at any level—that is up to the individual patient, so I think we would all accept that, and it might be quite a junior member of staff they first talk to, because they tend to have more prolonged contact—the more complicated discussions, including the multiple options, including the assessments of capacity and all of those things, should, undoubtedly, be done by senior people. For the more formal purposes, they need to be done by senior people who have had specific training for that role. I think that really quite strongly.

Baroness Finlay of Llandaff: Can I just pursue that a little bit? Take a patient in front of you in palliative care who is expressing suicidal ideation. It seems to me that you now have two types. You have those where you go for suicide prevention, and there are those where you go for facilitating of assisted suicide, assisted death, and take them down that road, and they are in diametrically opposite directions.

My experience when I was in the Netherlands really showed me that, when you start to go down one road, it is quite difficult to reverse and look at reversible causes of the distress, and so I wonder whether you feel everybody who is beginning to raise this topic must have a specialist palliative care assessment before proceeding further on down this road.

Professor Sir Chris Whitty: I think it would depend, in reality, because palliative care resources, as you have rightly said, are very constrained in the UK in a way that none of us would welcome.

Baroness Finlay of Llandaff: But we have heard they are going to be expanded.

Professor Sir Chris Whitty: Let us start with where we are at the moment. What I would not want is to make this a pro forma situation where the reason for the request is not one that would normally be one where palliative care input is requested and where that is unlikely to change the situation. On the other hand, there are many people where exactly the opposite would be true and where you think, in fact, this should be the trigger for a referral, if it has not already happened, to specialist palliative care.

I would not want this to be seen as you have to go down the flow chart which includes palliative care, where that is not going to be an appropriate intervention, and that is where, going back to your first question, the experience of the senior doctor who is making that judgment is important, because they can help to determine the difference between those two situations.

Q158 **Baroness Berger:** I have two quick follow-ups from the questions I asked earlier. Just to be clear, although I am sure that charities and the voluntary sector may fall under the umbrella of the independent sector, my earlier question about the role that the private sector may play was specifically about profit-making businesses providing assisted death services, albeit commissioned by the NHS.

What I heard from you, Minister, is that profit-making businesses will be allowed to participate but that an acceptable level of profit has yet to be decided. On that basis, the Bill says that doctors are only allowed to receive reasonable remuneration under Clause 56. If the Minister cannot comment on what profit can be generated by private providers commissioned by the NHS, how will the Government define what "reasonable remuneration" means?

Stephen Kinnock: I think it is important to point out that the detailed delivery model—what the delivery agents of this might be—has not been defined. That will be defined by regulations, by the Secretary of State. It is possible that the private sector will be part of that. It is possible that the private sector will be excluded, and that it would only be the not-for-profit sector or other agents, TBC.

Our previous conversation was hypothetical, in a sense. It was, if the Secretary of State, through regulations, agrees that private sector organisations can be included in the scope of this, then there is a conversation to be had about profit, but, because I am not in a position to say whether they will be involved, I cannot give you a specific answer on what the profit levels might be, because I think that would be a lot of hypotheticals in one calculation. First of all, you need to establish who is going to do the service. Then you can have a conversation about some of the other factors that you just pointed to.

Baroness Berger: I reiterate the point that, with all these delegated powers, we do not have this information, and many will say that this is critical information that we need to be equipped with in order to vote on the Bill.

My last question is about advertising. You said that the Bill prohibits advertising. I did not have the legislation in front of me, but, looking at point 2 in Clause 43, it does say that the regulations on the prohibition of advertising that the Secretary of State will bring forward "may contain exceptions", including "the provision of information" to both users and providers of services. We know that, in the Commons, the Bill sponsor rejected an amendment to totally ban advertising as we currently have in place for things like surrogacy or tobacco.

Can I just press you further on this issue? Can you confirm that it will be the Secretary of State's intention to ban all advertising? In particular, I think we have concerns in this committee around the promotion of assisted dying that may surface online, particularly via things like influencers, TikTok videos, video games. Has his department had conversations and meetings with DSIT, which is responsible for that whole element and issues to do with the Online Safety Act?

Stephen Kinnock: I was certainly reminding myself of Clause 43 and the spirit and letter of the discussions in the committee stage, and also hearing from the sponsor on this. My clear takeaway from that and interpretation of this clause is that all forms of advertising are prohibited, including advertising on social media, including whether influencers or others might be involved. It does not specifically say social media or

influencers, but that is certainly my interpretation, because it says that, "The Secretary of State must by regulations make provision prohibiting … the publication, printing, distribution or designing (anywhere) of advertisements, whose purpose or effect is to promote a voluntary assisted dying service". That strikes me as quite comprehensive.

Baroness Berger: It is subsection (2), so the Bill does still allow for exceptions. Because we do not know what those exceptions are, we are quite keen to understand exactly what that means in practice, because it is not outlined on the face of the Bill.

Stephen Kinnock: I will ask Jason to come in on this, but my interpretation, again based on the extensive discussions we had in Bill committee, is that there is a very clear interpretive line driven between information and promotion. There might be exceptions. For example, take a printed leaflet. (1)(a) prohibits printing. I think what (2) does is say, "Printing is okay as long as it is for the purposes of information. Printing is not okay if it is for the purposes of promotion".

Jason Yiannikkou: Yes, that is probably right. Just to confirm, we have, in providing the technical support for developing this clause, worked with others across Government who are closer to the regulatory framework concerned. I think the balance that the clause is seeking to strike is, as the Minister says, to prevent promotional activity but allow for the necessary flow of information within the system, and that is broadly what it achieves.

Q159 **Lord Goddard of Stockport:** This is probably to most of the panel, but maybe Chris mostly. We do rely on doctors' judgments in all these cases. I am following on from Baroness Finlay and the excellent work she does. All the supporters of this Bill also believe that palliative care needs to be improved and needs to get better quality.

I am from the north. I am a pretty practical person. What I am trying to get to is not a hypothetical question. It is what is the actual question. At the moment, what choices do people have that want to die sooner than they are supposed to die? They are having care, so they are refusing life sustaining treatment, for example. What safeguards are in place for those people now? If someone just said, "I am going to stop having chemotherapy", is he visited by a panel? Does he get visited by a psychiatrist? What are the mechanics of that?

Whatever we try to do, over 600 people with terminal illness commit suicide every year. That, to me, is not quite working satisfactorily, if that is the outcome in the present situation. I am just keen to know—and I am not trying to be Machiavellian or trick anybody—what the process is now when someone says, "I do not want to take any more of this" or, "I am not having any more of that". What do you do then?

Stephen Kinnock: I think colleagues have set out this principle of informed consent that underpins all of the decisions that are made around end of life and around choices people make. There are also

provisions around do not resuscitate, but I think colleagues on the panel are probably better placed than me to set out exactly how that works in an operational context.

Professor Sir Chris Whitty: Every day, discussions like this are had between patients who are severely unwell and the doctors who look after them, in multiple different areas. They might be within palliative care. Most of us would wish that they could be where that is possible and where that is appropriate. There are many other areas. Stopping chemotherapy would be a very classic one, where people are clearly told that there is a relatively limited chance of future success, they are finding the side effects intolerable, and they make a reasonable and rational decision, having the capacity to do so and supported by their families, to stop that treatment.

We will all die, and people have to make these reasonable decisions. For some people, the decision to eke out every possible extra day of life is the right decision. That is their choice. For others, the quality of life really matters and they may prefer a better quality of life for a shorter number of days, and that is a perfectly sensible decision that people make, with their families, all the time.

In those situations, you usually are not going to be having a big panel or anything. The more a decision that is taken seems to be one that is surprising—they are entirely entitled to that—the more you have to think about whether they have the capacity to take that decision. For example, patients who are trying to walk out of hospital and you are worried they may be a bit confused and, if they walk out, you think they will come to serious harm because of where they are. That is a situation where assessing capacity does become very important, and then the Mental Capacity Act clicks in.

For the great majority of decisions that are taken like this, they are made relatively straightforwardly, because it is reasonably clear to all concerned that they have the capacity to make the decision they are taking.

Q160 **Lord Goodman of Wycombe:** Could I just follow up Baroness Berger's question that follows on from advertising in this way? Just suppose for a moment you are a vulnerable person with a terminal illness. I am a TikTok influencer, and I go on and make a TikTok video about why it is a good thing for you to consider assisted suicide. I do not think that would be caught by the advertising ban, because it is not an advert. It is someone giving a view. Similarly, I might be a vulnerable person who types an inquiry into an AI search engine, and up comes the recommendation that I could consider assisted suicide.

Is that something that you think should be discouraged by Government, or does it fall under the ambit of free speech? If it falls under the ambit of free speech, how is it going to be consistent with the point Baroness

Smith raised about the anti-suicide strategy? I am really asking a question about culture and, once assisted suicide gets into the culture, does that not have quite serious implications for the strategy to which you are committed in your manifesto?

Stephen Kinnock: Thank you for that. I am not a lawyer, but, when I read 43(1), the key word in there is "promote". This is about "prohibiting … the publication, printing, distribution", et cetera, "of advertisements whose purpose or effect is to promote a voluntary assisted dying service". My reading of that is that any activity, whether it is a TikTok video or any other kind of advert or any other kind of promotional activity, would be caught by 43(1). It would be prohibited and the person committing that offence would be punishable with a fine.

Q161 **Baroness Berridge:** We have not spoken about the large numbers of vulnerable groups of people yet; maybe that is our fault for our questions. Minister, we heard from Lady Grey-Thompson that there is not a disability organisation that is happy with the state of the Bill.

Are you happy that the panel would have to approve, once all the criteria are in the Bill—the six months, that they have not been pressured—if the panel became aware that what is going on with that very sick, disabled person is that they have not got proper service provision or something has gone wrong in their home and they cannot now get access to get outside? There is no power in the Bill for that to be a reason for the panel to say, "Let us pause. Let us call the local authority. Let us call the health services. Let us get that person that support and see whether they do, indeed, want to bring forward the time of their death".

Do you think that is acceptable for disabled people, most of whom will be in the constituencies of your MPs, that that lack of service provision will not lead to investigation or any change of circumstances for them?

Stephen Kinnock: The equality impact assessment that we published alongside the impact assessment, I think back in May, looks at the potential impact on the people who are named under the Equality Act 2010—the nine protected characteristics—and it does look at people with disabilities, which I think is at the heart of your question.

In terms of the assessment that we make when one looks at the nine characteristics, and then the safeguards that are in place in the Bill—the two doctors and the panel—the conclusion of the EQIA is that those nine protected characteristics do receive adequate protection within the framework of the Bill.

Baroness Berridge: But the panel has no power to get the deficits of unmet needs—that is usually the term, I have learned—sorted out. You will have heard Dr Hussain on your Public Bill Committee, Minister. She is concerned that we are shifting the risk of bad deaths to much larger, more vulnerable groups of people. If the panel does not have that power, is she not right?

Stephen Kinnock: This is just a question around the workability of the safeguards and, therefore, important for the Government because we are about the workability and implementability of the Bill. The safeguards that are in place include, of course, that you have to have less than six months to live, with an irreversible diagnosis. If that threshold is met in terms of eligibility, is that not the key threshold that addresses the question that you are asking?

Baroness Berridge: No, but I will move on.

Q162 **Baroness Scotland of Asthal:** I just want to follow up that question from Baroness Berridge. I think the situation she is imagining is something like this. You have a person who has been told, "You are going to die in six months, and it is irreversible". They also do not have access to appropriate palliative care, because it just is not sufficient in their area. They do not live in good accommodation, and they have few people to care for them—maybe no family and only a few friends. In that position, they feel that the better course for them is to choose an assisted death to be able to avoid the aberrant consequences of the situation they find socially. That is what I think we are talking about.

In those circumstances, is there a valid choice? It is all about autonomy. My autonomy is to decide how I am going to die. If there is not social care to enable me to die well, I may choose assisted dying, not because that is what I want, but because I feel that is the only option available to me. That is what I think Baroness Berridge is talking about.

Stephen Kinnock: The sponsor has made clear, I think, throughout this process that the Bill is about choice. Clearly, the policy intent should be that the choice to engage with an assisted dying service is what would result from this Bill if it were to become an Act.

My job as the Minister for Care is to ensure that we have a palliative and end-of-life care service that is fit for purpose, and that is why we are prioritising the work that needs to be done to fix the less than adequate or inadequate aspects, I should say, of the service that we currently see. Those two things are, in a sense, happening at the same time.

Baroness Scotland of Asthal: What I wanted to ask you is about money, because we know we have a very tight fiscal envelope to do all of this in. What are we not going to be able to do in order to create the money and the space for this new service?

Stephen Kinnock: As I mentioned, in the impact assessment, there is a broad budgetary estimation of what would be needed within this spending review period. Ministers from the Prime Minister down have said that, if this Bill passes, the Government will implement it, and that has some financial implications. By definition, there will need to be some reprioritisation, identifying funding.

I am not in a position at this time to be very precise about what we might stop doing, or do in a different way, implement in a different manner, partly because we do not yet know the final shape of the Bill. It may well

be that it is amended substantially as it goes through the Lords. Until we are very clear on what the final shape of the Bill is, it is not possible to exactly state what the budgeting will be and then how we might make that funding available, but I would return to the first principle of this, which is that the Government have stated very clearly that they will implement the will of Parliament.

Q163 **Baroness Hayter of Kentish Town:** We also heard from Professor Tom Shakespeare, who said something along the lines of—I am not going to get his words right—"Just because I am disabled, it does not mean I will not want assisted dying if I got something else". It seems to me there is the bit of autonomy then for disabled people, whether they are blind or deaf or have lost an arm. I do have a concern. I am just interested, because, presumably, you have spoken, albeit at international conferences, to your equivalents from countries where they do use this, where presumably they also have disabled people. How have they dealt with them? Is it a particular issue that they feel they are vulnerable, or do they deal with it? What is their experience?

Do we have to be slightly careful that we do not put all disabled people in a category that needs an extra layer? I assume there is going to be a disability advisory panel, if I have got the right words, who presumably will review the numbers coming in. If there are a lot of them who happen to be blind or something, they will say, "This is a bit odd. Have we got it right?" Have your international interlocutors given you any advice, or have you just heard about how these things are dealt with in other jurisdictions where they have assisted dying?

Jason Yiannikkou: We have looked at some of the evidence internationally. I think, were the Bill to become law, we would need to delve more deeply into what other countries have done. I think the thrust of your question is right: that we would need to try to strike the right balance between respecting the autonomy and wishes of all people, as we would do throughout other services, while also being mindful of vulnerabilities that people have. People come in with many things that are true about them, and we would need to adapt our systems to be as inclusive as possible, and we would certainly want to learn a lot from international evidence. Sadly, I have not been able to go abroad yet, so perhaps that is to come.

Baroness Hayter of Kentish Town: I am sure the Minister will now manage to find a way of getting you there.

Q164 **Lord Patel:** I just have a very simple question to Sir Chris Whitty. The question has been brought up that it should be defined in primary legislation what medicines and substances could be used for assisted dying purposes. Do you think that is right?

Professor Sir Chris Whitty: With the important caveat that Parliament is sovereign in this, and there are many experts on medicines in this room—I am not going to comment on expertise in Parliament; you can judge on that yourselves—I think that the bigger risk is that this is a very rapidly moving evidential field, where many countries are now using this,

and you could have a situation very easily, in my view, that, were this passed and were the medicines on the face of the Bill, you may have trials coming out in other countries that made clear that that was the less good option for people, but you would then not be able to change what was done to take account of this new information, because it was on the face of the Bill, until you could find time for primary legislation, which is not, as you will know, a straightforward process. That is the practical risk. There are other risks as well, but that seems to me the biggest one.

Lord Patel: While the Parliament will decide, and we may pretend, in our own House, that we have lots of experts, those experts may have their own personal views about things. Is it not right, as we do in other areas of medicines guidance, that a panel of experts should decide what medicines should be used?

Professor Sir Chris Whitty: Certainly, that would be more conventional practice, and I think for a good reason. This is going to be quite a fast-moving field in terms of the evidence coming in from around the world, and I think it is important that people who have particular expertise with the drugs that we are talking about, which, at the moment, are largely from anaesthetics and palliative care, among others, are the people who are consulted about the drugs, but we should take a lot of attention about the emerging evidence from around the world as it comes in. I think that is a technical question, principally, rather than a policy question.

The Chair: Thank you very much indeed. I am going to have to bring this session to an end. Can I say thank you to all of you for coming and for being very patient in answering our questions? Can I remind you that the transcript of the evidence will be sent to you to look at? Please check that the transcript is an accurate record of your evidence. If there are any errors, let us know. With that, I bid you a very good afternoon. Thank you.