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House of Lords

Wednesday, 30 November 2011.

3 pm

Prayers—read by the Lord Bishop of Liverpool.

Jobseeker's Allowance: Interns

Question

3.06 pm

Asked By ***Lord Lucas***

To ask Her Majesty's Government whether they will require that interns who work for an organisation for longer than two months should be paid at or above the rate of Jobseeker's Allowance.

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): My Lords, the Government have no such plans. Internships and work experience, paid or unpaid, offer an excellent opportunity in helping to bridge the gap between education and the workplace. It is important that we do not close down these opportunities.

We are asking businesses to offer internships openly and transparently and provide financial support to ensure fair access. This financial support could consist of either payment of at least the appropriate national minimum wage rate or alternatively payment of reasonable out-of-pocket expenses in compliance with national minimum wage law.

Lord Lucas: My Lords, I am grateful for half a loaf. Will the Government encourage all employers—and notably Parliament—to take on more interns at a time when that would be a service to the nation, particularly those children and young people who cannot afford to go without income? Will she, in the spirit of the youth contract announced yesterday, ask my right honourable friend the Chancellor of the Exchequer to make sure that there are no prosecutions or fines for those employers who choose to make up for hard-up interns the jobseeker's allowance which they lose by becoming interns?

Baroness Wilcox: In answering this Question, I find it interesting to discover that there is no such thing as an intern; there is no legal definition of an intern at all. One is either a worker or a volunteer. Therefore, I can agree with pretty well everything my noble friend has said, because some people will be paid and some will not be paid. In the Chancellor's Autumn Statement yesterday, my right honourable friend said:

"In order to make the education and skills system more responsive to employer needs",

the Government would, among other things,

"increase young people's access to high quality work experience".

I hope he finds that answer helpful.

Lord Lea of Crondall: My Lords, I congratulate the noble Baroness on her high-class piece of sophistry a moment ago about there being no such thing as an intern, when we have been debating it off and on in this House for many months. The issue must be that, if people are doing what anyone else would call work, it is biased in favour of the people who can afford to have mummy and daddy give them enough to live on, as opposed to those people who are not in that position. Therefore, there should be a minimum that people get paid.

Baroness Wilcox: Internships can be paid or they can be worked on as volunteers, where we would encourage travel expenses to be paid. We are committed to improving social mobility; we are clear that job opportunities should be based on what you know and not just who you know. We are encouraging businesses to provide internships with financial support to ensure fair access. I am sure that is what the noble Lord wanted me to say.

Lord Razzall: Bearing in mind the noble Baroness's statement that there is no such thing as an intern, why was the Prime Minister auctioning an internship at a Tory fundraising event? Does she not agree—and it is implicit in her answer to the previous questions—that the question of payment for internships is an issue of social mobility? Will she confirm that the Government firmly believe that interns should not be just from the wealthy middle class, but also people who cannot afford to work?

Baroness Wilcox: We are concerned that requiring all interns to be paid would actually reduce the number of available internships. With so many of our young people not able to get jobs at this time, we think that anything that will give them experience of the workplace and help them is a very good thing. We want to strike a balance between reducing exploitation and maintaining the maximum number of internship opportunities. As I have said, we are committed to improving social mobility and that what matters is what you know, not who you know. As the Chancellor made clear yesterday, we will work hard wherever we can to support youngsters trying to get into work and get the experience that they so badly need.

Lord Brooke of Alverthorpe: The Chancellor announced yesterday that he is asking the public service independent pay review bodies to examine by next July the possibility of introducing regional or local pay. Could the Minister please confirm that the Government have no plans to follow the logic of that and in turn to examine the possibility of paying allowances and benefits, such as the jobseeker's allowance, on a regional or local basis?

Baroness Wilcox: As far as I know, we are sticking with the minimum wage as the basis of what we are doing. Internships are paid based on the minimum wage. Anything which is paid above that is purely a voluntary arrangement. Arrangements made between employers and employees are based upon that.

Baroness Wheatcroft: My Lords, we should never condone exploitation masquerading as internships. I am sure many of us have come across those, not least in the media industry. However, does the Minister agree with me that one of the most effective ways of fostering workplace experience is to get schools and universities to have ever closer links with employers?

Baroness Wilcox: Yes, I agree with my noble friend Lady Wheatcroft about closer links with employers, schools and colleges, and explaining the opportunities available. Often people miss out on opportunities because they do not know about them. Maybe their home backgrounds have made it impossible for them to know, so it is absolutely essential that we get closer links. I do so agree with her.

Lord Young of Norwood Green: My Lords, following the point of the noble Lord, Lord Razzall, will the Minister say how she will ensure fair and equal access to internships, regardless of parental income?

Baroness Wilcox: There is fair and equal access to internships. We will watch to make sure that we continue it. We have made it clear through updated guidance what internships must provide to comply with the law. As the noble Lord knows, guidance for employers is at businesslink.gov.uk; and guidance for individuals is at direct.gov.uk. There are plenty of places where people can go to make sure that they have got the right information.

Baroness O'Cathain: My Lords, will my noble friend consider a proposition that my noble friend Lord Lucas and I have discussed in our office? We propose that if people were brought into an internship, the payment they would get would be equivalent to the benefits that they would receive if they were not working. That would probably be an answer to everybody. If, for example, the benefits were about £40 a week and if that could be transferred to pay them as an intern, there would be a win-win situation for everybody.

Baroness Wilcox: I am interested in what my noble friend says. I am sure that if she writes to me, I will be able to have a proper exchange with her on this.

Interpol

Question

3.14 pm

Asked By ***Lord Harries of Pentregarth***

To ask Her Majesty's Government what means they have to hold Interpol to account, especially where United Kingdom citizens are involved.

The Minister of State, Home Office (Lord Henley): My Lords, Interpol facilitates international police co-operation. It does not have executive powers and its agents do not make arrests. Interpol is held to account by its member countries, through processes including the annual general assembly and the Commission for the Control of Interpol's Files.

Lord Harries of Pentregarth: I thank the Minister for his answer. Is he aware that the Interpol red notice system is being abused by some Governments for political reasons? In particular, I have in mind Benny Wenda, the West Papuan independence leader, who was granted asylum in this country. As a UK citizen, he has suddenly been served with a red notice. Will the Minister agree to take up with Interpol the question of whether this notice violates Article 3 of the Interpol constitution, which expressly forbids such notices being served for political reasons?

Lord Henley: My Lords, the first point I ought to make is that the United Kingdom will not arrest or extradite any person solely on the basis of a red notice. I cannot confirm or deny, in the particular case the noble and right reverend Lord referred to, whether Mr Benny Wenda has or has not received a red notice from the Indonesian Government through Interpol. I can confirm that there are arrangements in place whereby objections can be made to what Interpol have done. I referred in my opening answer to the Commission for the Control of Interpol's Files. I would hope that those who are interested in this will take up those measures as is appropriate.

Lord Hunt of Kings Heath: My Lords, will the Minister answer the more general point raised by the noble and right reverend Lord, of whether the Government will institute discussions with Interpol about whether, at the Interpol level, they can mitigate the use of red notices for political reasons? He has given some assurance to the House in regard to the specific case mentioned by the noble and right reverend Lord, but there is a much more general issue at stake here.

Lord Henley: I accept what the noble Lord says, and I will take note of that. He will know that Interpol's constitution enshrines neutrality, and its Article 3 forbids Interpol's involvement in political, military, religious and racial matters. The noble Lord will also know that all notices that are issued should be—I stress "should be"—checked by Interpol's secretariat to ensure that they meet Interpol's criteria for neutrality. Any that do not should not then be published. The wider point of whether the United Kingdom Government should take this up, or whether it should be taken up by Mr Benny Wenda or his friends, is another matter. However, there are two ways this can be done. First, member Governments can intercede with Interpol, and secondly, there is the procedure by which complaints can be made through the CCF, the Commission for Control of Interpol Files.

Lord Mackay of Clashfern: My Lords, I wonder if my noble friend can say whether there is jurisdiction in courts in the United Kingdom to set aside a red notice on the application of a person on whom it has been served?

Lord Henley: My Lords, I am not aware that there is. I want to make it clear that the United Kingdom Government will not either arrest or extradite a person solely on the basis of a red notice. If we are going to extradite someone, it will go through the usual and proper procedures under the Extradition Act 2003.

Lord Blair of Boughton: My Lords, Interpol has suffered for some years, or perhaps for 100 years, from two structural problems. First, it is an organisation that every country in the world, including some very unpleasant ones, can become members of and share intelligence, and secondly, cases like this one arise from time to time.

At the moment both Interpol and Europol work out of the Serious and Organised Crime Agency, which is to be abolished. Will Her Majesty's Government,

and the Minister, be able to reassure the House that when this function moves to the National Crime Agency, a little more attention will be given to both Interpol and Europol as their powers gradually expand?

Lord Henley: My Lords, I am very grateful for the remarks from the noble Lord, who brings enormous experience to these matters, and I can assure him that we will be taking particular notice of this as SOCA moves into the NCA, over the coming months and years, and will make sure that these points are taken up.

I also note what he said about Interpol covering a very large number of countries, some of which we would recognise as having systems similar to our own, while some have systems that are somewhat dubious. Nevertheless, as I made clear earlier, its constitution does enshrine its neutrality. That is very important and we will continue to try to get that across. The United Kingdom Government will make their views clear in the appropriate manner, through the annual general assembly.

Lord Judd: My Lords, while completely associating myself with the concern about this particular case, would the Minister not agree that when we talk about the need for the international rule of law in international justice, we need to be very certain that when action involving individuals is taken, we do not lose sight of holding to account the Governments and people who were responsible for the events which led this man to make his stand.

Lord Henley: My Lords, I repeat that I do not want to comment on this particular case but I think we all know which case it is, because the noble and right reverend Lord has already referred to it. As I said, it is very important to recognise that no one can be extradited solely on the basis of a red notice that has been issued by the Indonesian Government through Interpol. I repeat everything that I said earlier about it being important to keep under review how we work with Interpol, and as an Interpol member the United Kingdom Government will continue to do that.

Baroness Hamwee: My Lords, as an extension to the question put by the noble Lord, Lord Blair, are the Government satisfied that our own structures are such as to make the best use of the resources available through Interpol, and will be so when we have the reorganisation? I am thinking in particular of missing persons. The cross-matching with unidentified bodies is a very important activity, and currently the Missing Persons Bureau is in the NPIA which will be subject to changes.

Lord Henley: My Lords, Interpol is largely about exchanging information between the member countries, and that is virtually all countries in the world. However, my noble friend makes a very valuable point about the changes that are coming about through the removal of SOCA and its replacement by the NCA. I take on board what she said; it is very important that we ensure that with those changes, we still have the appropriate relationship with Interpol.

Community Justice Centre: North Liverpool

Question

3.22 pm

Asked By ***Lord Storey***

To ask Her Majesty's Government to what extent the North Liverpool Community Justice Centre has met its intended objectives, what plans they have for this centre, and what improvements they would envisage to this model if it were to be further replicated.

The Minister of State, Ministry of Justice (Lord McNally): My Lords, we are evaluating the impact of the centre on reoffending, and on the efficiency of court processes and use of resources. The result will be published by the Ministry of Justice. The centre is continuing to operate and we continue to share its learning across the criminal justice system and court estate.

Lord Storey: I am grateful for my noble friend's reply. He will know that there is little real hard evidence of this pioneering community court's work, particularly its involvement in the community itself. What criteria will be used and will those criteria involve the community court itself?

Lord McNally: My Lords, the inquiry is looking at the impact on reoffending and the efficiency of process. Its findings are not yet available for release because that work is not yet completed, but I would find it inconceivable that the court itself and those who work in it had not fed into that inquiry.

The Lord Bishop of Liverpool: My Lords, could the Minister could tell the House whether the Ministry of Justice has done an assessment of areas of deprivation in other cities where a community justice centre would be appropriate?

Lord McNally: No, my Lords, we will look at the impact of this centre before we would contemplate doing this in any other cities, but I take the point made by the right reverend Prelate the Lord Bishop of Liverpool that this is operating in an area of very high deprivation, which I hope will be part of the assessment which the inquiry is making, taking note that it is in a particular area.

Lord Bach: My Lords, in answering a question by the right reverend Prelate on 21 June, the Minister told the House that the evaluation that the Ministry of Justice, I think, is doing internally, would be completed later in the summer. We have had very clement weather for the last few months, but no one could say that it was still summer. Has the evaluation been completed yet? If it has not, when will it be completed, and will the results be published?

Lord McNally: My Lords, it is always dangerous to give even vague dates, like "summer", in making commitments. The study is still going on. I am confident

[LORD MCNALLY]
of the integrity of the research, which is being carried out by Ministry of Justice analysts under the Government social research code. The research will be published by the Ministry of Justice. I think the safest commitment I could make now would be "as soon as possible"

Lord Alton of Liverpool: My Lords, before that research is published, will the noble Lord be wary of comparing oranges with apples? What this North Liverpool Community Justice Centre does is very different from other existing systems elsewhere in the country. This is a pioneering scheme. It was introduced on the advice of my noble and learned friend, Lord Woolf, and was opened by the noble and learned Baroness, Lady Scotland. Will the noble Lord ensure that their advice is taken into account and that a genuinely independent assessment is made, and that it will be not be abandoned simply for cost-cutting reasons, which may appear prudent at the time, but in the long term might not save anything at all?

Lord McNally: I hear the "hear, hears", but of course cost does have to come into all these things. I do genuinely believe that this is being looked at. It is a freestanding experiment, as the noble Lord said, based upon the Red Hook Community Justice Center in New York. The truth is that we are looking at various experiments across the piece, some of which were started by the previous Administration, to find out about the effective administration of justice. I can promise that we are looking for legislative time for a justice reform Bill and that we are also looking at justice delivery in the north-west. The inquiry that the noble Lord, Lord Storey, asked about will be seen as a freestanding contribution without prejudice to the decisions that we have to make in that area.

Lord Greaves: My Lords, this is a unique and very innovative scheme. Can my noble friend, who has given quite positive answers so far, tell us whether the valuation is basically a statistical evaluation based upon reoffending rates, the cost per case and so on, or will the evaluation also involve discussions and interviews with offenders who have gone through the system and hopefully benefited from it, and with other people living in the community who have been affected by it?

Lord McNally: I would hope that it is the kind of more holistic inquiry that my noble friend suggests. That is what we are trying to do, obviously within budgetary constraints. We are examining various ideas and experiments in the United Kingdom, the United States and around the world, to see how best practice and best efficiency can be achieved. That is what we hope will be the outcome of this inquiry and future development of policy.

Baroness Scotland of Asthal: My Lords, I wonder whether the noble Lord will be able to tell us whether the learning from the North Liverpool Community Justice Centre that was spread to places like Salford has been and is going to be continued.

Lord McNally: As I understand it, it is continued. As I said in my opening remarks, it is spread across the estate and will continue to do so. I had better not say that it will continue as long as the centre is open, because then you will think of something dubious about that, but it will continue to be spread across the estate.

Education: Music

Question

3.30 pm

Asked By ***The Earl of Clancarty***

To ask Her Majesty's Government what support they will give to music education under the National Plan for Music Education published on 25 November.

The Parliamentary Under-Secretary of State for Schools (Lord Hill of Oareford): My Lords, the National Plan for Music Education will ensure that all pupils in English schools have the opportunity to learn to play a musical instrument, to make music with others, to learn to sing and to progress to the next level of excellence. We will also continue to fund national youth music organisations, to continue our support for In Harmony and for the internationally recognised Music and Dance Scheme.

The Earl of Clancarty: My Lords, there are big questions about this plan, despite the broad welcome that it has received within the music world. What is the thinking behind the disappointingly massive cuts, of over 30 per cent, to music education as a whole up to 2014? If costs are going to be parked with parents, charities and the private companies who could become music education hub leaders, then this plan will surely not deliver a comprehensive service. Would the Minister agree that if music is dropped from the national curriculum as a guaranteed subject for five to 14 year-olds, then all the fine words in this plan will come to mean very little?

Lord Hill of Oareford: My Lords, as to the second question on whether music will continue to remain a part of the National Curriculum, the noble Earl will know that that is part of what we are looking at in the review of the National Curriculum, and we will make further announcements on that in the next year. I am not able to go further than that.

On his more general point, clearly we are having to work in an environment in which there is less money than we would like. Given that context, the funding that we have managed to retain for these new education hubs is £82.5 million this year, the same as last year, and, I think, £79 million next year. There are further reductions to come; the noble Lord is absolutely right about that. Clearly, our hope is that, through the education hubs that are going to bid for the money and bring together a range of other organisations, they will be able to make sure that there is funding. Other sources of funding—for example, through the pupil premium—could also play a part, but we need to look at that.

Baroness Walmsley: Does my noble friend the Minister agree that to implement the national music plan at the speed at which the Government propose requires a large cadre of very hard-working music teachers? In the light of that, will he try to persuade his right honourable friend the Minister for Schools that the EBacc requires a sixth pillar that includes cultural and vocational subjects, including music? As things stand at the moment, we are losing a lot of music teachers across the country.

Lord Hill of Oareford: My Lords, I think one of the reasons why we are losing a number of teachers at secondary school and, in particular, the number of music teachers is dropping is that the number of pupils at secondary schools is dropping. I agree with my noble friend entirely about the importance of making sure that we have really good teachers able to teach music particularly at primary level, and we have plans to improve initial training for music teachers. As far as the EBacc is concerned, my noble friend knows well the Government's position, which is to concentrate on a small number of subjects that give children the greatest chance of going to strong universities. The Russell Group supports the choice of subjects. However, I know how strongly she feels and that there are pressures from all sides of the House for us to extend the number of subjects in the EBacc.

Baroness McIntosh of Hudnall: My Lords, I know that the noble Lord's department no longer has responsibility for higher education, but, following on from the question asked by the noble Baroness, Lady Walmsley, would the Minister agree that music teachers have to be trained, that the places where they are mostly trained is in small specialist institutions, such as music conservatoires, and that those conservatoires are currently very anxious about the effect on them of the changes to higher education funding? Will the Minister ask his colleagues in the relevant department to give us an assurance that those institutions will be protected, thus guaranteeing a supply of high-quality music teaching in the future?

Lord Hill of Oareford: I will take up that point, as the noble Baroness asks. As far as my department is concerned, she will know, through the Music and Dance Scheme, that we will continue to make funding available in order to get talented young children going into those conservatoires, which is part of the solution. I will take up her point.

The Lord Bishop of Exeter: My Lords, is the Minister aware of the very considerable body of evidence that attests to the value of music and indeed dance to the personal development of those with special needs, whether it be physical, learning or emotional? Can he give assurances about the continued levels of support and resourcing for music in the special needs sector of our national education system?

Lord Hill of Oareford: Yes, my Lords, I agree with the right reverend Prelate about the important role that music and dance can play. In our national plan there is quite a lot about the role that music technology can play, particularly for those who might have special educational needs. In terms of monitoring how the plan works, we would obviously want to look at and hold to account providers for the way in which they provide services for children of all abilities.

Baroness Warnock: Does the Minister agree that one of the cheapest and most effective forms of music education is choral singing? I know that is mentioned in the pronouncements that he has referred to. Can the Minister confirm whether it might be worth considering having people who are not qualified teachers coming in to schools to set up choirs and get choral singing off the ground? We all know that there are very talented choir masters who have not necessarily qualified as teachers.

Lord Hill of Oareford: I agree very strongly with the noble Baroness about the important role that choral singing and being part of a choir can play. I hope that one of the ways that these new hubs will work is to draw in a much wider range of providers. They will be covering a broader area so that one can get that kind of specialism that one could then extend to a range of schools in an area.

Baroness Jones of Whitchurch: My Lords, there is a great deal to welcome in the national music plan. We particularly welcome the fact that funding—although it involves significant cuts—will be ring-fenced for music education. Does this mean that the Government have now been converted back to the idea of ring-fencing? What does that mean for other children's services such as Sure Start?

Lord Hill of Oareford: I am grateful to the noble Baroness for her welcome overall for the shape of the plan and what we are trying to do with it. We are distributing the funding in the way that we are—which relates to the point that I was just making to the noble Baroness, Lady Warnock—because the kind of services that we will provide go across areas where an individual school could not be expected to have that degree of specialism or that range of services or instruments. We think it makes more sense to deliver that through a bigger area.

Business of the House

Timing of Debates

3.37 pm

Moved By ***Lord Strathclyde***

That the debate on the motion in the name of Lord Lamont of Lerwick set down for tomorrow in Grand Committee shall be limited to four hours.

Motion agreed.

Renewable Transport Fuel Obligations (Amendment) Order 2011

Motion to Refer to Grand Committee

3.38 pm

Moved By ***Lord Strathclyde***

That the draft order be referred to a Grand Committee.

Lord Palmer: My Lords, these obligations are covered by no less than four different government departments. Which of the noble Lord the Leader of the House's ministerial colleagues will be taking this through Grand Committee? I ought to declare an interest as a member of the gang of four who originally persuaded the last Administration to accept the original renewable transport fuel obligation.

The Chancellor of the Duchy of Lancaster (Lord Strathclyde): My Lords, it is good to hear the noble Lord's interest in the subject. The lead department is the Department for Transport. The departmental spokesman in this House will be speaking to this particular Motion. My noble friend Lord Attlee on the Front Bench will be briefed by other government departments and will speak for the whole Government. Therefore, other government departments who have an interest in this subject will answer any questions that the noble Lord or anybody else will have.

Motion agreed.

Legal Aid, Sentencing and Punishment of Offenders Bill

Order of Consideration Motion

3.39 pm

Moved By ***Lord McNally***

That it be an instruction to the Committee of the Whole House to which the Legal Aid, Sentencing and Punishment of Offenders Bill has been committed that they consider the bill in the following order:

Clauses 1 to 8, Schedule 1, Clauses 9 to 23, Schedule 2, Clauses 24 to 30, Schedule 3, Clauses 31 to 37, Schedule 4, Clause 38, Schedule 5, Clause 39, Schedule 6, Clauses 40 to 59, Schedules 7 and 8, Clauses 60 to 64, Schedule 9, Clauses 65 to 82, Schedule 10, Clause 83, Schedule 11, Clauses 84 to 98, Schedule 12, Clauses 99 to 102, Schedule 13, Clause 103, Schedule 14, Clauses 104 to 111, Schedule 15, Clauses 112 to 114, Schedules 16 and 17, Clause 115, Schedule 18, Clause 116, Schedule 19, Clauses 117 to 121, Schedule 20, Clauses 122 to 124, Schedule 21, Clauses 125 to 128, Schedule 22, Clause 129, Schedule 23, Clauses 130 to 137.

Motion agreed.

Charities Bill [HL]

Third Reading

3.39 pm

Bill passed and sent to the Commons.

Health and Social Care Bill

Committee (9th Day)

3.40 pm

Relevant documents: 19th report from the Delegated Powers Committee, 18th report from the Constitution Committee.

Amendment 138

Moved by ***Baroness Emerton***

138: Clause 20, page 20, line 2, at end insert—

"13O1 Duty as to staffing ratios of registered and non-registered staff

(1) The Board must, in the exercise of its functions, establish for health services, and may subject to regulations establish for other services, the ratio of registered to non-registered workers required at any given time by reference to any appropriate register established for workers in those areas.

(2) In the discharge of this duty the Board must publish a list of appropriate registers for the purpose of subsection (1).

(3) The Board must produce guidance to health services to assist in the maintenance of ratios for the purpose of subsection (1).

(4) The Board must also issue guidance on the maximum and minimum numbers of patients per registered nurse."

Baroness Emerton: My Lords, while workforce planning is to be a devolved activity at local commissioning level, this Bill states that the overall duty of the national Commissioning Board is to arrange the provision of services for the purposes of the health service in England. Therefore, it would seem appropriate that the national board undertakes to give guidance on a range of issues, as some have already stated, and I would like to see this amendment added. I declare an interest as recorded in the register, speaking as a retired nurse, not named, on the NMC effective register.

The commissioning of the nurses, midwives and health visitors workforce is complex. It covers the community and hospitals; projecting numbers to meet the training requirements; commissioning university places with the right numbers for the services to be provided; and establishing the right number in the right place at the right time. In practice, this requires skilled planners who understand 24-hour service and the different levels of dependency in each speciality, to effect holistic care in hospitals and the community. The economic situation we find ourselves in is already having an effect on workforce numbers. Only a week ago the Royal College of Nursing reported on the effects that the Nicholson £20 billion cut is currently having on services. The detailed analysis by the RCN of 41 trusts revealed that clinical posts were affected, or were planned to be affected. An analysis of the trusts in England showed that the reductions are not only contained within administration, management and other back-room offices, but also affect nursing. Registered nurses are being affected by the freezing of their posts, leading to lower staffing levels, the down-banding of high-grade nursing posts, the loss of specialist skills and those working in preventive services, and cuts in the mental health field, where demand for nursing is rising.

This spells disaster for patients and their families. We know that in Mid-Staffordshire the nurse staffing ratios were changed from 60 per cent registered and 40 per cent support workers, to 40 per cent registered and 60 per cent support workers, in order to make financial cuts, but at what expense? It does not need much intelligence to see that nursing care suffered and the effect was dire.

International research evidence clearly demonstrates that low nurse staffing levels correlate with higher patient mortality and morbidity. We know from evidence in the UK, the United States and Australia that the quality of patient care is affected by the ratios of registered nurses to support workers. The higher the ratio of registered nurses to support workers, the higher the

quality of clinical outcome, providing faster throughput and reduced infection rates that in turn reduce readmissions. In addition, the patients receive safe care, and they favour it by way of experience.

To give an example, in a US study, every one patient added to the average hospital-wide nurse workload increased the risk of death following common surgical procedures by 7 per cent. There was a 31 per cent difference in mortality between hospitals in which registered nurses cared for eight patients each and those in which nurses cared for four patients each, taking into account the severity of the patients' illness, comorbidity conditions and the level of technology and teaching status in the teaching hospitals.

A study in the UK in 2007 found that patients in NHS hospitals in the upper quartile, where nurses had the heaviest patient workload, were 26 per cent more likely to die overall and 29 per cent more likely to die following a complicated stay in hospital. The nurses in the hospitals with the heaviest workload were between 71 per cent and 92 per cent more likely to show negative job outcomes, burnout and job dissatisfaction, and to rate the quality of care on their wards as low and the quality of care in their hospitals as deteriorating. Similar evidence was produced in Australia.

The Bill works towards high-quality, integrated holistic care. Equally important as plans for the hospital workforce in nursing and midwifery are those for the community workforce: community nurses, midwives and health visitors. Last week, the Queen's Nursing Institute published a report entitled *Nursing People at Home*, which demonstrated worrying trends in community nursing that could be remedied if more nurses were specifically trained, year on year, to work in the community. It recommended that there should be support for the newly qualified through preceptorship; that healthcare assistants should be regulated; and that commissioners of services should set standards for the qualifications of community team leaders. Likewise, the Royal College of Midwives launched a report last week into the state of maternity services in 2011, recommending that more births take place in midwife-led units and at home, that properly trained and supervised midwife support workers should be appropriately deployed and calling for a guarantee not to cut midwife training places.

There is a common thread running through the recommendations of all three professional bodies that, in essence, supports the amendment. There is widespread concern across the professions that, unless the national Commissioning Board issues guidance on staffing ratios, local commissioning of the workforce could lead to unsafe ratios of trained to untrained staff, resulting in unsafe care and increased cost to the NHS. It is a false economy to meddle with safe ratios. It would be more effective to move quickly towards a totally registered nursing workforce in hospitals, knowing that patients were receiving holistic, high-quality care, leading to shorter stays and reduced readmissions to hospital, resulting in bed closures and real savings.

There is no need for me to go in to more detail. The current situation is very bleak and we are in the midst of amending a Bill that aims to improve the health of the nation and provide high-quality care in hospitals and the community. The latest report and front-line survey by the Royal College of Nursing expresses concern, especially on the urgent issues that face the nursing profession if growing demand is to be met, with the demographic figures showing an urgent need for care of the elderly, the vulnerable, those suffering from long-term conditions and those requiring end-of-life care. We continue to trot out, at every opportunity, that evidence-based clinical care is essential. Will the Minister consider the inclusion of guidance concerning the issues raised by this amendment as a duty of the national Commissioning Board? I beg to move.

Lord Alderdice: My Lords, I have a good deal of sympathy with the thoughts behind the amendment in the name of the noble Baroness, which she has put forward in her usual forceful but thoughtful way. However, there is difficulty in some areas.

The amendment does not state so clearly but it appears to assume that registered and non-registered are the same as trained and untrained. I also draw your Lordships' attention to something to which I have returned fairly regularly for more than 10 years, the fact that psychotherapists and counsellors are not registered. There is no statutory registration, and yet there are areas of care—for example, in alcoholism and drug addiction, child and adolescent psychiatry and psychotherapy, the care of some very disturbed patients—where psychotherapists, particularly trained ones, and counsellors are extremely important.

Many of these are people with very long trainings, much longer than would be the case, for example, for a nurse. They are well trained people and they are well supervised but there is no register and therefore they would fall foul of a proposal like this. Were it the case that all the appropriate people were not only trained but registered and that therefore one knew that those who were not registered were not fully trained and supervised, I would have a great deal more sympathy with the detail of it.

I have difficulty not the thought behind this amendment but with the fact that it seems to some extent to ignore some quite important groups. My fear is that if we move down this road, in the new world the pressure will be further against the employment of people that have had substantial psychological training. It has been made clear to me—this is one of the reasons why I use this opportunity—that some of those with a high level of training and a substantial length of experience are already feeling themselves marginalised because the larger professional groups that have registers are using that to strengthen up their stance of their members, which is entirely justifiable and entirely reasonable.

I would be much more reassured and much more be able to support the amendment if either it was very clearly and simply referring to trained and registered nurses or unregistered people who are working in nursing, rather than the more general statement which is in the amendment, or—perhaps even better—if my noble friend the Minister was able to indicate that the Government were going to make progress on the registration on those other groups that need to be registered; that involves in particular, from my point of view, psychotherapists and counsellors. However, I do have a good deal of sympathy with what the noble Lady says.

Baroness Murphy: We have been urged to hurry up today; we have all heard of speed dating so this is going to be speed debating!

When I first read the amendment of the noble Baroness, Lady Emerton, I did not agree with it on the basis that if you legislate for a minimum number of registered people or nurses, there is a tendency for people to adopt the lower level. I have looked at international evidence and I know that 10 years ago in California they mandated by specific legislation a minimum qualified nurse staffing level in surgical wards in intensive care. It has had a dramatic effect not only on the wards in those hospitals but on other hospitals in California where the standards has risen, mortality rates have fallen. There has been a very large study of 8,000 patients in California, and the other two comparative sites were in Pennsylvania and New Jersey; there is no doubt whatever that there has been a dramatic change and a very positive change, and most hospitals staff above the minimum. Those fears have not been founded.

The Dr Foster document that came out this week clearly showed the relationship that we know about internationally between poor staffing levels on wards for older people and mortality rates and care levels, and its relation to the morale of staff who work on those wards. I am, almost reluctantly, driven to accept the wisdom of the amendment of the noble Baroness, Lady Emerton, which I support.

Lord Walton of Detchant: My Lords, I, too, wish to support the principles underlying the amendment proposed by my noble friend Lady Emerton. However, one concern I have particularly relates to paragraph (4) of Amendment 139. Concerns have been expressed in many quarters over the past two years about the variable quality of the health care assistants employed in many of our hospitals. Some of them are absolutely excellent, but some of them—particularly in certain care homes—have had very little training and there is no process at the moment by which such care assistance can be registered; nor is there any formal requirement of a specific training or educational programme for these individuals. The time is approaching when there must be minimum standards of education and training laid down for such people. I trust that, in relation to what is said in paragraph (4), we can have an assurance from the Minister that this is an issue that the Government will consider.

As the noble Lord, Lord Alderdice, said, the same problems arise in relation to psychologists. Clinical psychologists have a formal training programme but not all psychotherapists, who do not hold a medical qualification—they do not have any such programme, although many of them make an outstanding contribution. The regulation of psychologists has been discussed for several years but little progress has been made. Can the Minister tell us whether that is still under consideration?

My final point relates to the fact that, the regulation and registration of many of the other professions working in the NHS, in hospitals and the community—occupational therapists, physiotherapists and others—of course comes under the Health Professions Council. This is a Health and Social Care Bill. Only two years ago, a statutory authority for the registration and regulation of social workers was created, the General Social Care Council, and that body is in existence. I want to ask the Minister: is it proposed, as I believe is the case, that the Government are going to bring that body within the ambit of the Health Professions Council, or are they going to make it subject to the oversight of the council for regulatory excellence? That is a matter upon which the Committee needs to be reassured.

Lord MacKenzie of Culkein: My Lords, my name is down on this group of amendments. I very much agree with what the noble Baroness, Lady Murphy, said about the situation in California, because the importance of being attached to the mandated levels of staff is self-evident from that.

This issue has been around for as long as I can remember. It was around when I was practising a long time ago. It was around when as a leader of a predominantly nursing trade union I had discussions with health departments in the days when there was perhaps more famine than feast in nursing levels. However, Ministers and Secretaries of State never seem to want to make a real effort to engage with stakeholders on this difficult issue.

There have been a number of efforts over the years, a number of tools used to measure patient dependency to staffing levels and to skill mix ratios as an adjunct to professional judgment. Some of these were useful, some—particularly imports from abroad—were much less so. I can remember one of them, an import from the USA, probably at some considerable expense, which was known by the particularly ugly acronym of GRASP. That stood for, if I remember correctly, "the Grace Reynolds Application and Study of PETO"—I am never quite sure who or what "PETO" was. It sought to measure direct care activities and interventions, so that the correct nursing staff levels were always available. In reality, that tool caused uproar, because far too often it managed to show that wards were overstaffed when the reality was that staff were struggling.

There have been other, more useful, tools and systems, but some of them used up a lot of nursing time on paperwork, and more often than not, nurse managers had to retreat in the face of financial pressures. They have to retreat in the face of financial pressures because there is no mandate to defend a professional judgment in the face of these financial pressures. There is no agreed ratio of nurses to numbers of patients, and no agreed ratio of trained nurses to healthcare assistants.

That is the issue addressed in these amendments, and if the wording is defective, as the noble Lord, Lord Alderdice, is suggesting, I really want to concentrate on nursing here, and if need be we can bring that back at Report. We cannot escape the fact that the correct levels of staffing, with the correct skill mix ratios, are vital for the proper level of care, whether that is in acute wards, in primary care or in care homes.

Healthcare is complex, and I am not suggesting for one moment that the correct staffing level will in itself always guarantee good technical and good compassionate nursing care. However, it is a sine qua non that getting staffing and skill-mix ratios wrong means that it is difficult, if not impossible, for nurses and midwives to deliver anything like the high quality care that they

want to deliver. We know that outcomes and mortality are affected, and I associate myself with the figures given by the noble Baroness, Lady Emerton.

Given the fears about financial pressures relating to future reductions in clinical posts—and certainly in relation to frontline nursing posts—it is no good for the Government to express expectations that quality is going to be improved or maintained without taking steps to ensure that their expectations are translated into reality and into practice. There will be more problems to come, as in the recent CQC report, as evidenced in the inquiries into the Mid Staffordshire NHS Foundation Trust, unless the steps proposed in these two amendments, or something like them, are taken on board.

We all want the best for patients and these amendments will go some of the way to ensuring that that will be the reality for the future. A mandated guarantee of safe staffing levels and ratios is essential for one principal reason and one principal reason only—patient safety and outcomes. These amendments have my wholehearted support and I look forward to the Minister's response.

4 pm

Baroness Finlay of Llandaff: My Lords, I added my name to these amendments, so eloquently introduced, with the evidence behind them informed by my noble friend Lady Emerton. It is important to state that these amendments may not be perfectly worded, as the noble Lord, Lord Alderdice, has pointed out, but the principle behind them has a lot of evidence to it. This is not about protection of a certain number of jobs; this is about the fact that you cannot substitute without having skills, competencies and attitudinal evaluation within a particular area.

There may be staff at different grades who will work in a complementary way and there is complementarity, but you cannot substitute. Physio assistants cannot be used to do what physiotherapists do. The same applies right across the piece. It is not just baseline qualifications, however; it is all the other layers as well. You do not want to be in an intensive care unit nursed by trained nurses who are not fully trained in those ventilators that are in use on that unit, who do not have all the additional skills as well and cannot communicate with patients in that situation and with their families.

As the noble Baroness, Lady Murphy, said, the evidence is overwhelming when you look at intensive care units but it goes right across the piece. I would like to cite briefly what we tried to do in Wales in my own discipline. We set minimum levels for the level of staff and the competencies for palliative care across the whole of Wales. It was not easy to do but it has worked and it has been a lever to drive up standards and drive up quality and to get some people to increase their training and go back to doing more training, without it incurring additional cost.

I recommend to the Minister that the Government look carefully at this amendment and think about some way of ensuring that patients across the whole of the UK will know that they will be looked after by people with the appropriate competencies and that, in times of financial stringency, we do not find that people revert to substitution as a misguided way of saving money which will be at the expense of quality if not at the expense of more than that.

Lord Newton of Braintree: My Lords, I wonder if I might come in on the side of the "sympathy but" brigade, which makes me a member of the same club as all those who have spoken before me. I have a lot of sympathy with the purpose of the amendment of the noble Baroness, Lady Emerton, but I worry about the rigidity of their terms in relation to specifying ratios and a maximum number of people that any nurse can deal with. It seems to me that this is a prescription for a degree of inflexibility that could end up closing wards for reasons that would not be sensible.

I am scarred by something that happened at Birmingham Children's Hospital in my period as Minister for Health; it arose from a shortage of paediatric intensive care nurses. I do not know whether they are still in short supply but that is the kind of problem that would be exaggerated by this kind of rigidity. Nevertheless, the basic thrust of the amendment must be right.

There is only one other point I really want to make. As I understand it, my noble friend is likely to say that this is not something for the health Commissioning Board, but for the Care Quality Commission. I do not accept that. The Care Quality Commission will be doing snapshots, perhaps a bit more vigorously than it has done in the past, sometimes unannounced and so forth, but nevertheless more often than not there will be a snapshot of the situation at a particular time. I cannot see that the Commissioning Board can commission services without specifying something about the standard at which it expects that service to be provided, and that is relevant to this question of staffing levels in a general sense. So while I believe that it would be wrong to say this is all a matter for the Care Quality Commission, equally I do not believe it would be right to be as rigid as some parts of the amendments are at present.

Lord Patel: My Lords, I have my name to this amendment and I support it. I agree with all the comments that the noble Baroness, Lady Emerton, has made. I have only two brief comments. One is based on the evidence and the strength of that evidence. The noble Baroness, Lady Murphy, mentioned California, which passed a law based on the evidence. So what is the strength of this evidence? I have looked at the literature, particularly at meta-analysis of all the literature that is produced relating to staffing levels and patient outcomes, including mortality. Meta-analysis involves looking at all the published literature and its methodology, and only those publications with a methodology that is felt to be good are included in the meta-analysis. The meta-analysis clearly shows that if you look at mortality, infection rates, response to arrest and serious episodes, the staffing ratios of registered, trained nurses to patients—I agree with the noble Lord, Lord Alderdice, that training is important—are important in delivering good outcomes.

The second issue is related to whose responsibility it might be to produce the guidance. If it is not the national Commissioning Board, then it ought to be the commissioners of services—the commissioning

[LORD PATEL]
groups—that should be asked to consider the staffing ratios of each and every department in the provider's unit before making contracts with them.

Baroness Pitkeathley: My Lords, we shall have extensive debates about regulation at a later stage of the Bill, but it is important to remind the Committee that the ability to regulate healthcare assistants and quality assure them already exists for employers without the need for further statutory regulation. Perhaps in my role as chair of the Council for Healthcare Regulatory Excellence it might be convenient for the Committee and perhaps save the Minister a little time if I respond to the points made by the noble Lords, Lord Alderdice and Lord Walton of Detchant.

The Council for Healthcare Regulatory Excellence, in its new guise as the Professional Standards Authority, will be given the role of quality-assuring voluntary registers. Talks with psychotherapists are already under way and are going very well. The General Social Care Council is going to become part of the HPC, which will in turn change its name and be overseen by what will then become the Professional Standards Authority. That is just for the clarification of the Committee.

Baroness Howe of Idlicote: My Lords, I have listened to what has been said by all these expert professionals and I am very much persuaded in favour of something along the lines of this amendment. I think that one of the most worrying things from the public viewpoint has been the sheer number of concerns about nursing that we have had in the press—not least, I may say, about the mortality rates et cetera going up during weekend staffing. Quite clearly there is a need for better reorganisation.

I go back quite a long way, to the time when I sat on the Briggs committee on the future of the nursing profession, and will never forget one of the nurses saying to me at the time: "I've been nursing for"—however long it was; she had just got her qualification—"and now I'm going to have a rest", which was roughly what she was up to. I had a great deal of sympathy with her from that viewpoint.

I hope the Minister will bear in mind—I am sure that he must be more than aware of it—that the number of cuts in nursing staff are considerable in the present plan. Something like 8.3 per cent of qualified nursing jobs are to be lost. As the Royal College of Nursing pointed out in its briefing, that is on top of something that was done no less than about 18 months ago and is more than 10 times the original figure. Axing up to a quarter or a third of nursing posts will undoubtedly have a deep and potentially dangerous impact on patient care. Of course the training of the nurses—the experts in the really expert places—is essential. The training and up-skilling of those nurses on the real needs of patients is vitally important, but so are the numbers.

Baroness Thornton: My Lords, I thank the noble Baroness, Lady Emerton, the noble Lord, Lord Patel, and my noble friend Lord MacKenzie and other noble Lords for bringing these important amendments into Committee. Amendments 138 and 139 make provision for the NHS Commissioning Board to mandate safe nursing staffing levels and the number of patients a registered nurse is designated to care for. At the risk of stating the absolutely obvious about safe and effective staffing levels and patient ratios, where there are insufficient nurses and too many patients allocated to care for, then the level of care that can be administered will be affected. These amendments are about patient safety and well-being and the noble Baroness, Lady Murphy, hit the nail on the head. In response to her remark about speeches and the length of speeches, my observation, which is shared on these Benches, is that the Cross-Benchers are not the problem. They have been making admirably short and speedy comments. I hope that mine will be also. Other noble Lords might think about that.

This is a current problem as well as a long-term problem. As my noble friend Lord MacKenzie said, it has been with us for a long time, but it is current at the moment. The Royal College of Nursing tells us that some NHS trusts are diluting the skill mix on wards and in other care environments. This dilution is when non-registered healthcare support workers are employed in the place of a registered nurse. Healthcare support workers are paid—as one might guess—significantly less than registered nurses due to their comparative lack of vocational qualifications, so are seen by employers as a cheaper option. We think that that potentially puts patient safety at risk. Recent research by the *Nursing Times* has highlighted a significant variation in skill mixes between different hospitals in different regions. It seems to us that when cost becomes the overriding factor at the expense of the quality of service, patient outcomes and even patient safety become endangered. The most high-profile recent example of this was the care failings of the Mid-Staffordshire NHS Trust. Sadly, due to a range of factors—including financial pressures—costs were cut, nursing staffing levels were reduced and patient safety declined. It is vital, therefore, that stakeholders, including the RCN, work together with the national Commissioning Board to set the appropriate staffing levels and standards. There is some evidence from the NHS Information Centre that there is an accumulating problem here. Between January and August, the decline in terms of full-time equivalents in nursing, midwifery and health visiting staff in England fell by 1.6 per cent, from 310,989 to 306,028. There is evidence of a growing problem.

I would like to ask the Minister about an exchange in October when the Secretary of State gave evidence to a Select Committee. He stated that he was not aware of the down-banding, which is the issue at stake here, relating to the ratio. He was not aware that this was a problem or that the Royal College of Nursing had raised it with him. The Director of Nursing at the Royal College of Nursing then gave evidence to the same Select Committee the following day. She claimed that the Secretary of State was aware of down-banding practices; that the Royal College of Nursing, among others, had drawn it to his attention; and that it was a matter of some concern. I ask the Minister whether the department is aware that this is a problem and what it is intending to do about it.

These Benches support the amendments, and we are keen that this issue should be addressed robustly.

4.15 pm

Earl Howe: My Lords, these amendments from the noble Baroness, Lady Emerton, clearly reflect an important issue: that there should always be appropriately skilled staff available to meet a patient's healthcare needs. I appreciate the concern behind the amendments and recognise the central point of principle; nor am I in a position to contest the evidence that has been cited by various noble Lords. I do not wish to do that. Where I am afraid I part company with the noble Baroness is in her argument that it would be appropriate for the board to mandate staffing levels or skills mix within local services. Although she would probably expect me to say this, these decisions really are best made by local clinicians and managers on the ground.

As the noble Baroness will know, determining staff requirements is not an exact science. The number of staff on wards and ratios between nurses and patients, and between nurses and healthcare assistants, will vary according to such things as the individual needs of patients, their levels of acuity and dependency, the nature of the clinical care they require and the layout of the clinical area. It is right that nurse leaders, doctors and managers have the freedom to agree their own staff profiles. This gives them the flexibility to respond swiftly to changes in patient demand to ensure safety and quality. Rigid ratios really are not the way to do this.

In being responsive to different situations, providers of NHS services are expected to meet their obligations under the NHS constitution—which, incidentally, they do not have in California. This states that patients have the right to be treated with a professional standard of care by appropriately qualified and experienced staff. Suggested nursing staff ratios and the proportions of registered to unregistered staff are, of course, available from, for example, the Royal College of Nursing. But it would itself say that these should be used only as a guide and as the basis from which to ask questions about staffing if there are wide variations from the suggested norms. The amendments say the board's duty is to establish or mandate "the ratio" as a legal requirement. That is simply not appropriate.

The other reason why I resist these amendments is that there is already a regulator overseeing these kinds of safety issues. All providers of regulated activities, including NHS providers, must be registered with the Care Quality Commission and meet the essential requirements around safety and quality. These include a requirement to take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. That is an essential standard. Compliance with it is assessed as part of the registration process as well as ongoing monitoring. So it is not, as my noble friend Lord Newton suggested, just a question of a snapshot.

What follows from this is that it is unacceptable for organisations to persistently fail to ensure that there are enough skilled and competent staff to deliver the care required; and the Care Quality Commission can take independent action where an organisation is not taking appropriate steps to ensure that there are sufficient numbers of suitable staff at all times. If the CQC judges that an organisation has failed to comply with any of the requirements for registration, then that organisation has committed an offence. That is a very powerful sanction. So while I completely agree that it is important to monitor these issues carefully, I do not agree that it is necessary to create a role for the board in this regard. A role for the board would prevent the necessary flexibility in local decision-making, and interfere with the role of the Care Quality Commission, and indeed the future role of Health Education England. That would not be desirable.

Various questions were asked of me about other professional groups besides nurses. I happen to know that, in answer to the noble Lord, Lord Walton, clinical psychologists are already subject to mandatory registration with the Health Professions Council under the title of practitioner psychologists. As regards other groups, a number of points were raised about non-registered workers, including their education and training, and the Government's position with regard to those matters. I suggest that we will come to those matters when we reach Part 7, and it is perhaps more appropriate that we tackle them at that point.

The noble Baroness, Lady Thornton, asked me whether the Department of Health was aware of the problem of down-banding. We are aware of concerns in this area from the Royal College of Nursing and others. We are of course committed to ensuring that safety is a priority across the NHS, and we are looking at the concerns within that context.

That is essentially the Government's position. It is not that we are unsympathetic to the point of principle to which the noble Baroness has drawn attention, but we think that there are mechanisms already in place to address those issues, and that it is essentially a matter of local and clinical and managerial judgment.

Baroness Emerton: My Lords, I thank the noble Lords who have taken part in this debate, which has opened up many questions. I thank the Minister for his answer. There is one point that I would take issue with, which is the Care Quality Commission, because it is almost too late if the Care Quality Commission comes in when there is a failing. We are trying to prevent failings, and move forward. There is an issue there, in determining the ratios.

I agree that it is for the local commissioners to be involved in the planning, but it is such a complex issue that, as we move into the care quality groups, there is an issue in terms of their expertise in being able to do this. This is why I raise the issue, supported by the Royal College of Nursing, which is very close to the scene. I appreciate that that is where it should be, and perhaps the way forward is to make sure that there is training in the workforce planning issues. It is complex. As has already been said, it concerns not just nursing but also the other disciplines. The evidence that has been shown ought to be followed up, and I ask that the Minister take that away, so that we can look at the evidence. There is an article today in the nursing press demonstrating quite clearly that morbidity and mortality is reduced by a higher level of trained staff. On that basis, I beg leave to withdraw the amendment.

Amendment 138 withdrawn.

Amendments 139 to 145A not moved.

Amendment 146

Moved by ***Lord Warner***

146: Clause 20, page 21, line 19, at end insert "including its annual operating costs as defined in subsection (6)"

Lord Warner: My Lords, I rise to speak to Amendments 146, 148 and 149 in my name, and in support of Amendment 151, which the noble Lord, Lord Patel will speak to. These amendments are about keeping in check the cost of running the biggest quango in the country and holding it to account, through published information on its financial and service performance in the main part of its job, which is commissioning NHS services either directly or through clinical commissioning groups. My Lords, I fully accept that it is not common to put budgetary control of new bodies in the Bill that creates them. However, it is not that common to create a new huge quango that will be spending in excess of £80 billion pounds a year. As someone with long experience of quangos, I am only too aware of their capacity to grow their management budgets and roles, often through mission creep and always with plausible reasons for doing so.

When these bodies have regional and local arms, as seems increasingly likely to be the case with the national Commissioning Board, their scope for consuming more taxpayers' money is only increased. These bodies are notoriously difficult to control in terms of their running costs and their activities over time. The history of British public administration is littered with examples of Parliament setting up bodies and then finding a decade later that they have grown in size and cost much more to run than was originally intended. That is why every so often, under successive Governments, we have culls, mergers and budget cuts to these bodies, as we have seen recently, and it particularly occurs when their running costs clearly become disproportionate to what they are actually delivering.

I do not usually do prediction, but I can predict with absolute certainty that the national Commissioning Board will follow the trajectory I have outlined, whatever well-meaning assurances the Minister gives us and whatever honeyed words are uttered by its chairman and chief executive. Our job in Parliament is to frame the Bill so that they are more likely to deliver those assurances in practice. I suggest that from the outset the Bill should impose constraints on the board's running costs, not only to ensure that the maximum amount of NHS budget goes on delivery of front-line services but also to thwart the growth of bureaucratic procedures and curb the temptation for the board to become excessively controlling of local initiatives. We are already hearing concerns from clinicians who will be undertaking commissioning about the board becoming too controlling and, some would say, too big for its boots.

It is to these ends that I have framed Amendments 146, 148 and 149. Amendment 146 makes it clear that the board's annual business plan must clearly state its proposed operating costs. This will enable everyone to see what they are as a proportion of total expenditure and to make comparisons over time. Amendment 148 is the really meaty amendment in this trio because it tries to make clear that from the outset the board's operating costs are going to be controlled. It proposes that its base operating costs should be 30 per cent lower than those incurred by the predecessor bodies whose functions will be transferred to the board.

The Government say they want to cut bureaucracy—here is an opportunity to show what they are made of. Figures would be audited under this amendment by the National Audit Office but the Secretary of State could change the discount rate of 30 per cent shown in this amendment if he published reasons for doing so. In subsequent years the board's operating costs could not go up by more than a price increase in line with the consumer price index, unless authorised by the Secretary of State. I am sure there will be lots of arguments about these kinds of amendments being inappropriate in primary legislation and the inflexibility they will cause—well, they are intended to cause a bit of inflexibility—but if the board's operating costs increased by just 1 per cent of the total expenditure over a number of years, that would be another £1 billion spent on administration rather than service delivery.

In the tight financial climate that all public services face, it is incumbent upon us as parliamentarians to reduce from the outset the risk of the board's operating costs getting out of control, given the size and scale of its expenditure. Amendment 149 tries to complete the controls by requiring the board's annual report to include a statement on the financial and service performance of its own commissioning and that of clinical commissioning groups collectively. We need to know on a regular basis what the board is delivering for a given amount of money. If my wording can be improved, I would be delighted, but this is too important and potentially expensive an issue to be brushed aside by vague assurances. I promise the Minister I shall be terrier-like on this particular issue.

4.30 pm

Lord Beecham: My Lords, these amendments deal specifically with the national Commissioning Board, but of course the issue of costs and bureaucracy extends well beyond this particular creation of the Bill. In fact, the Bill establishes something like a new health solar system, at the centre of which of course will be the Secretary of State, a perhaps rather dimmer sun that we would like to see—some of us, at any rate—but nevertheless at the centre of a system in which he will circled by a veritable constellation of boards and bodies. Along with the national Commissioning Board and its wonderfully euphemistically named "field offices", which, as we understand it, will effectively be local commissioning boards of some kind, there will be Monitor, the clinical commissioning groups, clinical senates, clinical networks, directors of public health embedded in local government, Public Health England with perhaps four regional hubs, and 25 local units of the Health Protection Agency. There will still be some special health authorities and of course NICE. All of this is a formidable complex of organisations and the risks to which my noble friend has referred of the escalating costs of bureaucracy are self-evident.

There are particular examples of that, and the noble Lord, Lord Warner, touched on the question of support for commissioning. The recent draft recommendations that the Government have produced

about that raise concerns about how that will function and about the costs involved. My noble friend referred to the National Audit Office looking particularly at the national Commissioning Board, but it seems to me that the abolition of the Audit Commission is something that the Government and the public generally may come to regret. Its rather more extensive and comparative work in looking at the way the health service operates, and indeed the way local government operates, will not be entirely replicated by the National Audit Office, perhaps ultimately to the detriment of the service.

I want to look not just at the long-term future but at the immediate costs of the reorganisation envisaged by the Bill, because this week saw the publication of the aptly named *Operating Framework for the NHS in England 2012-13*, which contains a reference to a requirement for all primary care trusts to set aside 2 per cent of their recurrent funding for non-recurrent expenditure purposes. That has been the case for the last couple of years and that non-recurrent expenditure has been effectively devoted to the service itself. The current framework suggests that:

"The non-recurrent cost of organisational and system change … will need to be met from the 2 per cent"—

in effect, the cost of this Bill and its implementation. Is the Minister in a position to say how much of that 2 per cent, which is estimated to amount to some £3.4 billion, will be devoted to these non-recurrent costs of the system change? Can he also give an indication of the costs of working through the structures of the national Commissioning Board and other bodies that the amendments directly address?

I have sympathy with the aspirations of my noble friend in moving these amendments although, as he acknowledged, it would be somewhat unusual to place restrictions of this kind on the face of the Bill. It will be important to hear the Minister's views about how the future finances can be managed.

Baroness Tonge: Before the noble Lord sits down, I would like to remind him and the House that several Committee sessions ago, I asked the Minister to find out how much it is going to cost to disband the primary care trusts and how much it will cost to set up the clinical commissioning groups. I think this is all very relevant in this question—that we have absolutely no idea at all how much the change in bureaucracy is going to cost.

Lord Beecham: The noble Lady encapsulates in about two minutes the thrust of what I said in five; she is precisely right. There are clearly going to be costs—redundancy costs, relocation costs and property costs—which we have not yet seen clarified in the case of the Audit Commission which I mentioned despite the fact that the proposal has been around for 18 months. It would be enlightening if the Minister responded to my question and that of the noble Baroness.

Lord Mawhinney: I share the view expressed by the noble Lord, Lord Beecham, of extending appreciation to the noble Lord, Lord Warner, for raising this issue because it seems to me to be one of some significance. Those of us who strongly support my noble friend and what the Government are doing in establishing commissioning-led services do so because, first, we think patients are likely to get a better deal out of it than they get under the present bureaucratic system and, secondly, because we have concerns about the efficiencies of SHAs and PCTs; in my case, that relates particularly to the activities of the East of England Strategic Health Authority.

I hope my noble friend will not deem a probing amendment about cost to be antagonistic or inappropriate. My reaction to the amendment of the noble Lord, Lord Warner, in its present form is much the same as the reaction of the noble Lord, Lord Beecham. I like the idea, I think it is helpful to this Committee to have more information although I am not sure that this form is actually the way in which that should be done. I hope my noble friend will be as generous as he instinctively and normally is in giving us as much information about costs as he can. If 30 per cent seems very high to him, as it does to me given the realities of setting up a new system, perhaps he would indicate what savings he thinks might be achievable if there was a sufficiently stringent regime in place to control costs.

Earl Howe: My Lords, I recognise from everything the noble Lord, Lord Warner, said that these amendments have been proposed with the best of intentions. I start by making it clear that an independent, accountable, transparent and efficient NHS Commissioning Board is a key component of our proposals, so I hope I can reassure the Committee on these issues. In doing so, I hope my Lords will forgive me if I touch on similar ground to that covered during the debate on Schedule 1.

Let me first assure the Committee that we want to reduce the amount of NHS funding spent on back-office bureaucracy. Indeed, as we stated in last year's White Paper, the NHS simply cannot continue to afford to support the costs of the existing administrative structure. Management costs in PCTs and SHAs more than doubled in the decade up to 2009-10, to £1.85 billion, increasing by more than £220 million in 2009-10 alone.

The noble Lord, Lord Warner, posed the question: what is different this time? Well, I believe a great deal will be different, and that is exactly why Clause 21 provides the Secretary of State with the power to set a limit on the use of resources by the board itself and by the board and CCGs together in relation to administrative matters. The meaning of what is to be considered as administrative matters will be defined through parliamentary regulations for the first time. The board has the power to set similar limits for individual CCGs. The changes that we are making will cut the overall cost of administration by one-third, and Clause 21 gives us the legislative basis to do that.

The Bill includes clear procedures around the publication of the board's annual accounts, annual reports and performance assessments of CCGs; and I hope that I can provide reassurance in this area as well. The requirement to publish an annual report applies to all of the board's functions, including its commissioning and financial functions and its performance assessments of clinical commissioning groups. The board is also under a separate duty to publish a report each year containing a summary of

[Earl Howe]
the results of each performance assessment. So I do think that the provisions in the Bill already address the concerns embodied in Amendments 146, 148 and 149.

On Amendment 151, which is grouped here, the board's power in new Section 13X(b),

"to acquire and dispose of property",

is necessary for the board to acquire any premises that it needs to accommodate itself for the purpose of carrying out its functions. Likewise, should it find itself with property surplus to its requirements, it would need to be able to divest itself of that property. The power simply replicates the power that PCTs currently have.

My noble friend Lady Tonge asked about the costs of transition. The modernisation programme will have one-off costs of between £1.2 billion and £1.3 billion, spread over the lifetime of this Parliament. It will reduce expenditure on administration by £1.5 billion a year from 2014-15 onwards. That is reducing the administrative spending across the system by one-third, and over this Parliament the modernisation will save £4.5 billion gross, or £3.2 billion to £3.3 billion net. So the up-front costs are expected to be more than recouped by the end of 2012-13. With those explanations, I hope that the noble Lord, Lord Warner, will be somewhat reassured. I am sure that I have not completely reassured him, but I hope that I have done so sufficiently for him to withdraw his amendment.

Lord Warner: Can the noble Earl explain to us, in writing, the comparison between the current costs of the bodies carrying out functions that are going to be transferred to the board, and what the Government's current estimate is of the first year's fully fledged activities of the board in discharging those functions? It would be very helpful and certainly more convincing to me and, I suspect, other Members of this House if we could see the comparative figures just for the board. I am not asking him to go into Monitor or CQC; I am asking for the figures just for the board taking on the functions that it will be taking on.

Secondly, his response did not really deal with the issue of how you keep these costs under control as the years go by. Is he relying only on the Secretary of State being eagle-eyed and briefed by his civil servants to do it, or do the Government have in mind an up-rating mechanism that would curb unnecessary growth in this area?

Earl Howe: This is one area where the Secretary of State has a direct interest to ensure that administrative costs are kept low. In answer to the noble Lord's first question, of course I would be happy to write. There is already a great deal in the impact assessment, to which I would direct noble Lords' attention. However, I shall be happy to write an individual letter to him and copy it to noble Lords in answer to the questions that he posed.

Lord Beecham: When the Minister writes to us about the risk register, would he indicate whether this topic of the cost will be referred to?

Earl Howe: My Lords, I am not sure what question the noble Lord is asking me.

Lord Beecham: Do the list of issues that are covered in the risk register include the question of the costs of transition and reorganisation?

Earl Howe: My Lords, the cost of transition was certainly very much an issue that was thought about when the risk register was put together.

Amendment 146 withdrawn.

Amendments 146A to 150A not moved.

4.45 pm

Amendment 150B

Moved by ***Baroness Bakewell***

150B: Clause 20, page 21, line 39, at end insert—

"( ) how effectively the NHS services meet the needs of the older population"

Baroness Bakewell: My Lords, I rise to speak to Amendment 150B and 320ZB. As with the others that I have proposed to this Bill, my amendments are all associated with one running theme: meeting the needs of older people. First, I propose that the annual report of the NHS Commissioning Board should be measured by how effectively it meets the needs of older people. Thus, I am separating out a particular cohort of people for whom particular attention needs to be made. Why do I do that? It must surely be obvious every day that we read the papers and every occasion when stories run in the media of inappropriate treatment of older people in hospitals, care homes and nursing homes. They are not getting the treatment that they should and the public know this and care about it.

My major amendment stands aside from the many other amendments to this Bill so far that have dealt with new structures, responsibilities, commissioning and safeguards. The purpose of this amendment is to test views on the creation of a role of commissioner for older people. There are many reasons why such a post becomes increasingly pressing. You may well be familiar with them. First, there are the demographics. The statistics are familiar and frightening. There are 10 million people now over 65 in the UK. By 2034, 23 per cent of the population will be over 65. Of them, 3.5 million will be over 85. Such proportions of the population will constitute by far the highest percentage of users of healthcare and specifically of social care in this country. Old age is not a condition you cure. We are not hoping that old people will get better. Scientific advances will not find miracle cures that reduce the incidence of old age. Medical science will paradoxically be increasing the numbers in this cohort. This change constitutes one of the largest challenges that developed societies have to face. The situation is the same in Japan, America and Canada. This is where the human race is going. I feel that there is little appreciation of the scale of what it is to meet those needs.

All the detail and complexity of this Bill and the debates that we are having about it concern the replacement of one complex structure of the NHS

with another. We have been debating in detail the network of relationships between the NHS Commissioning Board, the CCGs, HealthWatch England, the CQC, the local HealthWatch organisations and the role of Monitor. All this abundance of well intended organisational ways of meeting the needs of patients does not take on the bigger picture facing the future.

The old are a different cohort. We will all one day be patients. Before that, as people age they become needful of different provisions of social care. Social care is in the title of this Bill. They will need meals on wheels, transport provision, adapted housing and all the things that provide for a living that, while not being an illness, is not as independent as it once was.

Such a commissioner for the old already exists. Such an independent statutory body with an overview of all people aged 60 and over was created in Wales in 2006. It exists to promote the interests of older people and improve their lives. Among the crucial things its first commissioner, Ruth Marks, does is to promote awareness and challenge age discrimination. She also offers ongoing assistance for older people who contact her with problems. She is often dealing with complex issues that involve all the various public bodies and that individuals cannot cope with. In the commissioner, they have one person that they can turn to to help them through this web of public bodies. This unique help, individual to individual, through the complex world of health and social care provision, seems to me to be of overriding merit and appropriate in the discussion of this Bill. Northern Ireland also has such a figure, known as the Older People's Advocate, currently in the person of Dame Joan Harbison. We already have a Children's Commissioner, created by the Children Act 2004. This could act as a template for a commissioner for the old—to hear and then promote the views and concerns of individuals and to involve them in the discharge of the health service function.

In 2008, I was invited by the Government Equalities Office initially to be a champion, which I thought was bit aggressive; then I was invited to be an ambassador, which sounded rather diplomatic; and I volunteered to be a voice. Not only because I am a broadcaster, I thought that people want a voice and they know what it means. When Harriet Harman asked me to do this, she nodded in my direction and said that of course it was uncharted waters. Indeed it was. Neither of us realised what the reaction would be. I was inundated with complaints of every conceivable kind. Health sometimes, hospitals often, pensions frequently, but also things like the closing of public loos or ex-pats in Spain worrying about their heating allowance.

Some of them were very strange requests indeed—how would I get people's savings out of the Icelandic financial system? I had to respond by sorting out the networks of support that exist—Citizens Advice Bureaux, Age UK, MPs and local authorities. It was a rigmarole of roundabout ways in which people could have a satisfactory answer to their personal problem.

Time has moved on. My role was a part-time, amateur job. We are now into the serious matter of considering the old. Old age now has a high profile. The newspapers are on board. The media follow such stories. We owe to them the revelation of the many scandals that exist. Architects are concerned and interested in designing lifelong homes. The co-housing movement is on the go. Martha Lane Fox is campaigning to get the old on the internet. There is a multiplicity of age-related websites. You can adopt a granny. You can adopt an old person's garden. There are thousands of such websites but none of them answer the single requirement to have one person who is on your side. The Liberal Democrat conference in September debated such a policy motion, calling for a commissioner for the old. This is an idea whose time has come. I beg to move.

Baroness Finlay of Llandaff: My Lords, I apologise to the House for missing the noble Baroness, Lady Bakewell's opening remarks. I simply point out that we have an Older People's Commissioner for Wales, Ruth Marks. In March 2010 led an inquiry into care in hospitals, called *Dignified Care?*. By November this year, she was satisfied that the 12 recommendations from its in-depth and hard-hitting report had been met. She is now using her powers to drive forward additional adult protection legislation and a nursing home review. It is only with legal powers and leadership that we can really turn care round. I believe that such a post is more than cost-effective. I really recommend that the Government look hard at having an older people's commissioner for England because we know that there is a big problem there. Such a post will more than save its cost.

Baroness Jolly: My Lords, I support the noble Baroness, Lady Bakewell, in her plea for a commissioner for older people. As she indicated, it has been a long-standing commitment of our party, which was put into party policy last September. Prior to the general election, we had a spokesman in the other place on older people's issues, and there was a general election manifesto commitment. So we were right there and, as the noble Baroness has indicated, she has form in this regard too.

The Welsh commissioner for older people actually started life in your Lordships' House before going to the other place, and the appointment was made in 2008. I have talked to Welsh colleagues over the last week and they have been really enthusiastic about the work that has been done and the progress made in Wales. So if it can happen in Wales, maybe we need to think about England too. The Welsh ambassador has similar responsibilities to those in the noble Baroness's amendment. The role also has powers of investigation, entry and interview. I wish that we could be more ambitious with this older persons' commissioner and extend the scope. As the noble Baroness said, there are so many issues that worry old people. Health and social care are clearly at the top of the list, but there are also pensions, housing, transport, leisure, even banking. Clearly there is a need for some sort of signposting centre for old people which somebody has to grasp and make it work.

The Government start a consultation on social care in the new year, and I know that my honourable friend Paul Burstow, the Minister for social care, is also keen on this particular issue, so I am really pleased to support this. Could my noble friend the Minister

[Baroness Jolly]
clarify whether an older person's commissioner, or something similar, would be on the list of possibles, probables or definites for the next Bill?

5 pm

Lord Walton of Detchant: My Lords, it will not surprise your Lordships to learn that this is an issue in which I take an increasing personal interest. Having said that, I should add that there are islands of great excellence in relation to studies of the care of the elderly in the UK. Professor Linda Partridge is doing wonderful work in University College Hospital, and I have an avuncular interest in the important Institute for Ageing and Health, chaired by Professor Tom Kirkwood, in Newcastle. These are islands in which the care of the elderly and the research into ageing processes is being carried forward. The problem is far wider. The problem is with standards of care in the community, in care homes and in our hospitals, where it is perfectly clear that standards have become very uneven. We have heard all too many stories in the press about inadequate care. For this reason, I believe that it is absolutely right to follow up the proposal made by the noble Baroness, Lady Bakewell. I think that England needs a commissioner. There is even a possible case to be made out for establishing a clinical network relating to the care of the elderly. Basically, most clinical networks have been disease-orientated, related to specific diseases, but this problem is now one of such increasing importance in the country at large that the Government ought to support establishing a commissioner and a clinical network for the care of the elderly.

Baroness Pitkeathley: My Lords, in rising to speak in strong support of the amendments moved by my noble friend, I want to remind the Committee of the large number of older people who are not in receipt of health and social care services but are actually providing them. Of course, I refer to the increasing numbers of very elderly carers. Although the peak age for caring is still 45 to about 60, we are increasingly looking at elderly spouses looking after their elderly spouse, or much older parents looking after a child with special needs who is living very much longer than anyone would have expected hitherto. So the services that we think about—housing, transport, care services—must be tailored to the needs of these older carers too.

Of course we also have economic reasons for doing so, because many people have become poor in their old age by virtue of the fact that they provided care, and they are often in poor health as a direct result of their caring responsibilities. I remind your Lordships that these are the people who are most affected at the moment by cuts in local authority services and the voluntary sector. I hope that the Minister will be able to give an assurance that the needs of older carers will also be included in government priorities.

Lord Owen: My Lords, I had not expected to speak but I thought that the case put forward by the noble Baroness, Lady Bakewell, was extremely convincing, particularly this issue that age is not an illness but a reality, and above all a numerical reality.

Listening to the arguments, I would put just one other thought. Commissioners can sometimes be listened to and effective in government. This largely depends on the structure of government, and in particular probably either the personality of the Prime Minister or the person who is leading on health. We used to have Health and Social Security under one Secretary of State, which the noble Lord will remember very well, since he was Barbara Castle's private secretary. He may remember too that a decision was taken in 1974 to make a Minister for the Disabled. It was scoffed at by many people within government, but there is very little doubt, looking back at the record of having successive junior Ministers responsible for disablement, that there has been a formidable achievement both in legislative activity and in activity across the board. The former Prime Minister, John Major, was at one time a junior Minister for disablement, and in fact in many ways he won his political spurs in that position.

It is a constant reminder to the Cabinet sub-committees that deal with issues like this that there is a voice there that speaks up and represents it and that is close to the source of power and decision-making. A commissioner often does not have either that access or that power. There is very little doubt that we hear and see all these problems of the aged, or that these problems are increasing. Incidentally, I think that the amendment is well worth while on its merits in relation to a National Health Service commission, but that is, as everybody has admitted, only one, relatively small issue.

There is a much deeper political issue which the present politicians are not able to grapple with. If we look at the response to the old people's heating allowance, there is a growing feeling among a substantial number of people who do not need this money that, if we are going to be serious about grappling with the problem of the aged, we have to be serious about the whole question of the now very considerable cumulative sum that is pushed to elderly people purely and simply because of their age. I enjoy my free travel pass greatly and am wholly in favour of it, but I do not need it. In fact, I ought to be walking more frequently rather than taking the Underground or the bus. I think that we need to have a fresh look at this. The initiative on these issues will probably come from the body politic. It would be much easier to persuade people that the time has come to be more selective on some of these issues if it were ensured that the money saved was earmarked, for a while, specifically for projects for the elderly.

I would not want to endorse the proposition of a commissioner at this stage. I would be more attracted to the idea of a junior Minister for the elderly who is in government and can attend the housing, welfare, health, social care and all the other Cabinet sub-committees where the really crucial decisions are taken in terms of legislation and, often, finance.

Baroness Wall of New Barnet: My Lords, I, too, support Amendment 327ZB, tabled by the noble Baroness, Lady Bakewell, and her earlier amendment. However, I want to make this point. I would not want the people at the sharp end—the nurses and healthcare assistants dealing with patients—to feel that this in some way exonerates them from taking the care that they should.

We need to be sure that Amendment 327ZB, which describes the activities that the commissioner for older people should cover, is not an escape route for anybody who is face to face with patients, suggesting that they do not need to take responsibility. I hope that the amendment reinforces this point, but we need to be sure that this is not an opportunity for these people to claim that there is someone else who will look after their patients.

Baroness Wheeler: My Lords, I am pleased to speak in support of Amendment 150B from my noble friend Lady Bakewell, requiring the annual report of the NHS Commissioning Board to include an assessment of how effectively it meets the needs of the older population. We know that nearly two-thirds of NHS patients receiving consultant-led care and 60 per cent of people admitted to hospital are aged 65 and over, so it is highly appropriate that this requirement be added in the Bill to the specific items that the board must report on to Parliament and the Secretary of State.

Under the umbrella of this amendment on the needs of older people, I would like reassurances from the Government on how they intend to improve commissioning for essential community and prevention services for older people. It is widely recognised that these are currently undercommissioned, specifically falls prevention, audiology and continence. In terms of community services, I stress the inclusion of older people in residential care. Age UK research shows that nearly 400,000 people living in care homes currently face real difficulty in accessing GP and primary care services.

We know that undercommissioning of community and prevention services is widespread and that the healthcare system needs to be much more effective in commissioning primary health and preventive services. For example, Age UK estimates that falls prevention services could save the NHS £2.3 billion per year in preventing hip fractures alone. Falls represent the most frequent and serious type of accident in the over-65s and are a serious cause of morbidity and mortality. A recent national clinical audit to investigate the organisation of services for patients who have fallen and fractured their hip, wrist, arm, pelvis or spine showed how variable commissioning of falls services is, rarely providing a co-ordinated falls and fractures strategy. Few GPs assess the risk of falling among older patients, and arrangements in hospitals for case finding and secondary prevention are inadequate. Half of all patients suffering a hip fracture never regain their former level of function and mobility. How is this situation to be addressed in future commissioning arrangements?

On hearing, the estimates are that up to 6 million people in the UK would benefit from a hearing aid but that only 2 million have one. Waiting times for hearing aids continue to be a major problem. In some areas people can wait up to one to two years between their GP referral and having their first hearing aid fitted or for a digital upgrade of their hearing aid. Audiology is excluded from the general 18-week NHS waiting time target. How will the current shortcomings in commissioning for audiology services be addressed?

Finally, effective and dignified continence care for older people is an essential service, particularly for those whose long-term conditions, such as cancer, stroke, spinal cord injury, spina bifida, Parkinson's and other neurological conditions, require continence management to be integrated into their care and treatment pathways. Commissioning for managing these conditions in the home, in residential care and in hospitals, and for general continence services, requires specialist knowledge and understanding of the different needs of continence care in primary and secondary care settings. The system is so often geared towards containment through pads and catheters rather than assessments or treatments of incontinence, or recognition, for example, that patients in hospital using catheters or other products over a short term will need reassessment and probably different products and support to cope with day-to-day life at home or in residential care. As a trustee of our local carers' support organisation in Elmbridge, I know that effective support for carers who are managing a person's continence issues can often make the difference between whether that person can be supported and cared for at home or has to go into residential care. Is the Minister confident that clinical commissioning consortia will have the expertise and the will to prioritise much-needed improvements in effective continence care?

My noble friend Lady Bakewell's separate amendment calls for a commissioner for older people, and I hope the Minister will take this away and give the proposal serious consideration. In particular, we need to see what we can learn from similar posts in Wales and Northern Ireland, and the observations of the noble Baroness, Lady Finlay, are very helpful on this. The intention behind the proposal is to provide a cross-government overview and strategy on the needs of older people. It is why my own party has appointed a shadow Minister for care of older people. We also know that making progress on improving NHS care and treatment of older people, addressing the future funding of social care through Dilnot and other key measures all require champions and leadership at the highest level of government, and I look forward to the Minister's—we hope sympathetic—response.

Earl Howe: My Lords, let me begin by saying that I am sympathetic to these amendments, moved with customary persuasiveness by the noble Baroness, Lady Bakewell. I completely understand what has prompted them. The improvement of services for older people is vitally important and I can reassure the noble Baroness that this will continue to be a priority for the Government.

I have written to the noble Baroness following the debate in Committee on 7 November on her Amendment 18B, explaining how the NHS outcomes framework will hold the NHS to account for improving the effectiveness of care for older people. It will act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and in behaviour, including a renewed focus on tackling inequalities in outcomes. There may well also be specific objectives in the Secretary of State's mandate to the board in relation to services to be provided to older people.

[Earl Howe]

Now, the real question posed by the noble Baroness's amendments is how can we improve older people's care and how can we ensure that services are joined up? The UK Advisory Forum on Ageing, co-chaired by my honourable friend the Minister of State for Care Services, Paul Burstow, and the Minister of State for Pensions, Steve Webb, already provides advice across government on the additional steps that the Government and their partners need to take to improve well-being and independence in later life. We already have a champion for older people's health, and that is Professor David Oliver, the national clinical director for older people. In order to ensure quality outcomes for older people during the transition to the board and CCGs, Professor Oliver and relevant bodies and partners will function as a motor for change to encourage best practice locally and to promote the messages around QIPP—Quality, Innovation, Productivity and Prevention—and long-term conditions.

Professor Oliver's overall remit is to promote better care of older people across the NHS and social services, and to provide clinical leadership for cross-government work on older people. He is doing good work. Nor, as I say, is he working in isolation. Regular meetings take place between officials, Professor Oliver and organisations including Age UK and WRVS. Recent examples of co-operation include Age UK's active participation in reference groups chaired by the national clinical director and the director of social care leadership and performance on the draft social care and public health outcomes frameworks.

5.15 pm

If we look at the wording of the noble Baroness's amendment, some of the functions that it lists are also those currently carried out by existing bodies, namely the CQC, the Parliamentary and Health Service Ombudsmen and the Equality and Human Rights Commission. However, let us take a look at what the Bill says.

The Bill in fact does a great deal to support collaborative working across the care services, which, as the noble Baroness knows, is vital to the effective care of the elderly. The existing duties on the board and CCGs to involve patients in their care, involve and consult the public in commissioning decisions, improve quality, obtain appropriate advice, reduce inequalities and promote integration, innovation and research, are as applicable to older people as they are to any other age group. Surely that is as it should be. Of course older people are an important group; I am the first to recognise that. But what I think the Bill should avoid is any suggestion that a person is less of a patient or less of a service user if they do not fall into this or that category. That, I think, is a danger with part of the noble Baroness's approach.

That said, clinical leadership will always be important. It is worth noting that Sir David Nicholson has said in terms, in the document entitled *Developing the NHS Commissioning Board*, that the board will include clear arrangements for key service areas which would gain particular benefit from dedicated professional and clinical leadership. These might include children's services, mental health, older people's services, dementia, learning disabilities, maternity and primary care.

I understand that the noble Baroness will be meeting my honourable friend the Minister for Care Services in the near future to discuss this important issue. He is indeed, as my noble friend said, passionate on these issues. I will certainly share with him her thoughts from this debate, and those of other noble Lords, and of course I look forward to hearing the results. I am sure that the discussions will very usefully inform our further thinking in this area.

My noble friend Lady Jolly asked whether an older person's commissioner is going to be in the next health Bill. We certainly do not have a closed mind on this issue. While at this time we are not in a position to make any commitment about future legislation, I can confirm that this issue is certainly not on any "definitely not" list. The noble Baroness, Lady Bakewell, as I said, puts across a strong case for a specific commissioner for older people. It is an issue that ministerial colleagues are looking at. I will discuss the issue further with them, as I have said, and I am the first to agree leadership in this area is vital.

Turning to Amendment 150B, I do not think that it would be sensible to include a specific reference in primary legislation requiring the board's annual report to contain an assessment of how effectively NHS services met the needs of the older population. I say that because, again, it would be hard to justify why one group or service was listed rather than another and it might, by implication, suggest that other groups and services are less important. I genuinely think that the best approach is the one taken by the Bill already, which recognises the essential principle that the NHS is meant to be a comprehensive service, available to all, whatever their age.

In fact, the existing duty to produce an annual report includes all of the board's functions, including the exercise of the duty to reduce inequalities, and this is in addition to the duty to publish information to demonstrate compliance with the public sector equality duty at least annually, starting by 31 January 2012, and to prepare and publish equality objectives at least every four years starting by 6 April 2012.

The noble Baroness, Lady Wheeler, asked me a number of questions about audiology, falls prevention and so on. I will happily write to her. However, I would just say to her, as I am sure she knows, that the key to this is in primary care. Making clinical commissioners directly responsible for the financial consequences of their clinical commissioning decisions will be a powerful driver. It is a direct incentive on them to focus on prevention, first because the cost of unplanned hospital admissions is huge, and secondly because they will be held to account under the commissioning outcomes framework for the outcomes that they achieve for their patients.

I think that the Bill already contains the mechanisms necessary to protect the interests of older people. I think that there are already arrangements working very successfully on the ground to champion the needs of elderly people in terms of clinical guidance and clinical leadership. On a point of principle, I think that it would be wrong to give explicit emphasis in the Bill to one group of the population at the inevitable expense

of other groups. On that basis, I hope the noble Baroness will feel it appropriate not to press her amendment.

Baroness Bakewell: I thank the Minister for that detailed response to the amendment. I also thank my noble friends for drawing attention to what is going on in Wales and in Newcastle, for mentioning the issue of older carers, and for discussing the nature of this particular group. Everyone in the population, we hope, will one day belong to that group. It is not an exclusive cohort.

I think that there is a small point of philosophical difference here. This forest of a Bill bristles with well-meaning organisations that are listening, speaking, consulting each other and offering clinical leadership. It is dense with such things. What it does not have is the single sapling of a commissioner standing alone in the desert and speaking for us, not us talking about them. To that extent, I think that the debate has been particularly fruitful. I hope to continue discussions with noble Lords, and with that in mind, I beg leave to withdraw the amendment.

Amendment 150B withdrawn.

Amendments 150C and 151 not moved.

The Deputy Chairman of Committees (The Countess of Mar): Before I call Amendment 152, I have to tell noble Lords that if Amendment 152 is agreed to, I cannot call Amendment 153, in the name of the noble Baroness, Lady Williams of Crosby.

Amendment 152

Tabled by ***Lord Hunt of Kings Heath***

152: Clause 20, page 23, line 29, leave out from beginning to end of line 5 on page 24 and insert—

"(1) The Secretary of State may give directions to any of the bodies mentioned in subsection (2) about the exercise of any functions.

(2) For the purpose of subsection (1) the bodies are—

(a) NHS Commissioning Board

(b) clinical Commissioning Groups"

Lord Hunt of Kings Heath: My Lords, that is exactly the point I was going to raise. Originally my Amendment 152 was grouped with Amendment 153 and other groups. For some reason I have been divorced by the Liberal Democrats, who are going to have a second debate on the same issue. This is a complete waste of time. I think that the best thing is for me not to move my amendment now, but I will speak to it in the next group.

Amendment 152 not moved.

Amendment 153

Moved by ***Baroness Williams of Crosby***

153: Clause 20, page 23, line 34, leave out from "failing" to ", and" in line 35 and insert "to exercise its functions in a way that the Secretary of State considers to be in the best interest of the National Health Service"

Baroness Williams of Crosby: My Lords, may I offer a quick explanation to the noble Lord, Lord Hunt, and the Members of the Committee, as to why we have asked for these amendments to be separated? I am very conscious, as I sit in the Committee, of what is often said on the "Today" programme, when somebody is asked the question "How would you improve the health of the entire population", and the interlocutor says "Please answer briefly", which means "You have four seconds". I shall be as quick as possible.

This amendment, along with Amendment 152—which we are not debating at present, as I am merely explaining why we have separated them—is deeply significant. This will emerge much more clearly when my noble friend Lord Marks of Henley-on-Thames speaks in a few moments' time, but it is important because it deals with the fact that the earlier Amendment 152—I have to refer to it to make any sense of my current remarks—would actually remove all powers of intervention in the current Bill. The powers of intervention associated with the Secretary of State are directly related to the failure of the board or of the CCGs.

The deletion that the noble Lord, Lord Hunt, and the noble Baroness, Lady Thornton, have moved, would take the whole of the failure regime out of this Bill. It would therefore be directly in conflict with one of the principles of the Bill, which is the principle of decentralisation. It moves back to the Secretary of State only the direct intervention with the board and the CCGs. It is well known now, from the long and explanatory speeches around this whole debate, that the Secretary of State passionately believes that decentralisation is one of the major principles of the Bill.

Therefore, my noble friend will explain why Amendment 153 is not on the same lines at all as Amendment 152. It is a different argument: there should be the right of intervention by the Secretary of State, but it should be limited in a way that saves the decentralisation principle. Why does it do that? It does that by referring back to the Secretary of State's overall responsibilities for the health service as a whole—which we all accept as a crucial element of the constitutional discussions now going on—as distinct from a direct intervention at the level of the board and the clinical commissioning groups, which would be to restore the very central principle that the Bill has rejected. This is not a deceptive amendment simply about some powers; it is in fact to make it clear that there is a distinction between decentralised responsibilities by the board and the CCGs and the essential, ultimate right—expressed, for example, in the amendment of the noble and learned Lord, Lord Mackay of Clashfern, at an earlier stage—of the Secretary of State to have responsibility for a comprehensive health service while not intervening in a detailed way in the clinical commissioning groups or the Commissioning Board. I will now pass the further part of the argument on to my noble friend Lord Marks of Henley-on-Thames. I beg to move.

Lord Marks of Henley-on-Thames: My Lords, this is a most significant area of the Bill, as my noble friend Lady Williams of Crosby has said. This group concerns the regime whereby, in the event of a significant failure, the Secretary of State can intervene in the board's exercise of its functions. That is in Amendment 153. The board in its turn can intervene in the exercise by a clinical commissioning group of its functions. That is

[Lord Marks of Henley-on-Thames]
the purpose of Amendments 220ZAA and 220ZAB. I would add Amendment 220ZA, which is not currently in the list of the group, which simply amends the title of the proposed new Section 14Z19. Also in the group is Amendment 277, which removes the restriction on the Secretary of State's intervening where there has been a significant failure by Monitor to act in relation to a particular case.

May I first address the question of the Secretary of State's intervention in the board's exercise of its functions? When we debated at some length Clauses 1 and 4 and the proposed new Section 13F, noble Lords were clear that whatever may be the outcome of those discussions and debates on those clauses, this House must ensure that the Secretary of State will have powers and functions that are up to the job of enabling him or her to carry out those overarching duties. Those duties involve him or her in carrying ultimate responsibility and accountability to Parliament and in the courts for the NHS. We should remind ourselves that my noble friend the Minister and my honourable friend Mr Paul Burstow have repeatedly assured Parliament that the Government are determined to make it clear that the Secretary of State will remain responsible and accountable for the NHS in Parliament and at law.

5.30 pm

In considering how far the proposed intervention powers meet those objectives, two features of the Bill are central. The first is the devolution of the commissioning arrangements to the CCGs, which is, as my noble friend mentioned, at the heart of the Bill. The second is the supervisory role of the board over commissioning. The board is to act on the mandate of the Secretary of State and will implement regulations laid by the Secretary of State and approved by Parliament. That certainly gives the Secretary of State considerable responsibility. However, the Secretary of State cannot exercise that responsibility effectively unless he is able to intervene appropriately when the board does not act in accordance with the best interests of the NHS. Under the arrangements presently proposed, the continuing responsibility of the Secretary of State for the functioning of the board and, hence, for the whole system, is disconcertingly weak.

The problem is not that the powers given to the Secretary of State are inadequate, if he is in a position to intervene. They are adequate and admirably drafted. He may give a direction to the board to exercise its functions and say how it should do so. If the board fails to comply, the Secretary of State can take over. The problem lies in the threshold, because the bar for intervention is set far too high and it is only in very limited circumstances that the Secretary of State is to be permitted to intervene by the Bill. He may give a direction to the board only if it is failing or has failed to discharge any of its functions or has failed to do so properly, and the failure is significant. The board could therefore say, if challenged, that it was carrying out its functions properly, even if it was acting entirely contrary to the views of the Secretary of State, as to what the best interests of the NHS required. The reason for that is that failing to exercise its functions properly would almost certainly be interpreted by the courts as acting in a way in which no reasonable board, having the duties of the NHS Commissioning Board to perform, could rationally act. It would not matter to that argument if the board decided to act, or declined to act, in a way that the Secretary of State considered to be entirely contrary to the best interests of the health service.

The situation is made much worse by the duty to promote autonomy that has been adjourned for further discussion. Even independently of the autonomy clause, the high threshold for intervention is offensive to the notion that the Secretary of State remains responsible for the health service. There is no accountability in a Secretary of State who is debarred from intervening when his own views can be so comprehensively traversed by a body whose supervision is supposed to be in his charge.

At first blush, the requirement that a failure be significant to justify intervention might appear to raise the bar still further. I am, however, satisfied that, provided the word "significant" is given its usual interpretation of "not insignificant" or "more than trivial", that limitation is sensible. It would, though, be helpful to have a Statement from the Minister—in Parliament—saying that the use of the word "significant" is intended to eliminate the unimportant or inconsequential rather than to import into the Bill some test of higher seriousness.

The same considerations apply to the board's right to intervene in the clinical commissioning group's exercise of its functions. The Secretary of State sets the board the mandate, the board is obliged to comply with it, and if a CCG is acting in a way that is inconsistent with the mandate and inconsistent with the strategy the mandate represents, the board must, I suggest, be able to intervene. Yet the limitation, as currently drafted, does not meet that objective. It is far from clear that a departure by a CCG from the objectives set by the Secretary of State for the board, in the mandate, would justify the board in saying that the CCG was not acting properly, given the way in which I believe that term would be interpreted. So the whole structure of accountability is at risk of being found impotent, because there could be a significant failure by a CCG and no means of redress by the board. Our amendment would enable the board to intervene if it considered that the CCG was failing to act in a way the board considered to be in the interests of the health service.

I turn finally to Amendment 277, which is concerned with the prohibition in Clause 67(3) on the Secretary of State intervening in Monitor's operation in relation to a particular case. Monitor's regulatory functions involve regulation of all NHS foundation trusts, some of which are very substantial. Things can go wrong, as the Mid-Staffs inquiry demonstrates, and they can go wrong with Monitor. Monitor has a plethora of functions that are directed to individual cases, not least the entire licensing procedure for NHS foundation trusts. Each trust must apply for a licence, and it is Monitor that determines the application and then sets the conditions. I appreciate that there is an appeal against refusal or revocation of a licence. However there is no appeal against a grant. In those circumstances it is simply illogical that the Secretary of State has a general

power of intervention where there has been a significant failure by Monitor in relation to the exercise of its functions, but that that power cannot be exercised in a particular case because of Clause 67(3). Our amendment would remove that illogical distinction.

Lord Owen: My Lords, I have followed with great interest the career of the noble Lord who has just spoken. He has now reached great eminence in his profession, and he has succinctly explained exactly what this Bill needs. This is by far the most important amendment that we have had before us. I welcome both of its parameters. It would be a terrible failure if we did not pass such a Bill. It is inconceivable that a person could even call himself Secretary of State for Health and not have this power. It would be impossible for him to stand before the House of Commons, where he is most likely to be holding that great office, and be unable to say if he felt that there had been a failure to carry out the responsibilities with which he is charged. How could he hold the office? It would effectively be a resignation issue on an important matter if he did not have that power and was not able to exercise it, and not to give him that power is effectively to strip the Secretary of State of his substance and his standing. This amendment is therefore utterly crucial. I personally think the wording is correct.

I would just like to deal with this word "significant". Until a few weeks ago I would have queried whether or not the word "significant" would be adequate. However, if you look at the legislation that this House has already examined in great detail and which has now been passed into law, namely the European Union Act 2011, which was given very close scrutiny, there is an issue—I think it is in Article 48—that I suspect we will be debating quite soon. This allows the Government, in circumstances in which they think a change has been made to the EU legislation that is not significant, to give up having a referendum. It has already been indicated to the rest of the eurozone countries that there are some circumstances under which the British Government would consider a eurozone amendment predominantly the concern of the eurozone and not significant, and therefore it would be able to be passed with unanimity and not need a referendum in the UK. So this word "significant" has already been crawled over with a great deal of care by a large number of people, not least the Eurosceptic element within the Conservative Party.

It has also been made clear that that would be subject to judicial review, which might be another safeguard that you would have to see. I think it is implicit in the wording—the noble Lord would know the legal consequences better than I—but I personally could live with the "significant" because there is an important issue here that if decentralisation is to be effective, there must not be micromanagement. I looked at putting down an amendment using the word "micromanagement" and then I came to the conclusion that micromanagement is in the eye of the beholder; it is not really a word that we could carry through in legislation. I think the combination of wording that the noble Baroness has used is the correct one: you have got the right to intervene but it is qualified by the fact it has to be significant, and it might be that that significance could be challenged. I very much hope that, having given it due thought, the Government will rise today to tell us that it is going to be accepted. If they do not do so, I hope it is pushed to a Division, whether that is now in Committee or on Report is up to the noble Baroness, Lady Williams, whose judgment I always accept—almost always.

Lord Hunt of Kings Heath: My Lords, I remain very puzzled by what the noble Baroness, Lady Williams, said. There is no disagreement at all, it seems to me. My original amendment and the amendments of the noble Lords on the Liberal Democrat Benches are entirely about the whole question of what is an appropriate intervention by the Secretary of State. Perhaps the noble Earl is going to accept this amendment and the Liberal Democrats want the glory of having it accepted—who knows? I agree entirely with the analysis of the noble Lord, Lord Marks, that the powers of the Secretary of State have to be sufficient to enable the Secretary of State to discharge his or her accountability to Parliament and to be responsible for the overall performance of the National Health Service. I agree with him that the current intervention powers are too weak in terms of the threshold and I agree that they are set too high. I also agree with his analysis about the relationship between the board and clinical commissioning groups.

It is very interesting as this Bill has progressed—somewhat slowly but none the less some progress has been made—that we have seen a number of interventions by the Secretary of State into the affairs of the National Health Service during that time. They have included coming down very hard on primary care trusts that were making people wait longer on the waiting list, although within the 18-week target period in order to save money, and on NHS trusts that, once a patient missed the 18-week target, let them wait many more months. I make no complaint about those interventions. I believe the Secretary of State was entirely justified. One of the questions is, how would that happen under this legislation?

When we debated this last week, the noble Earl, Lord Howe, essentially said that provision could be made in the mandate set for the board by the Secretary of State. That in itself risks the mandate becoming prescriptive and potentially another way to micromanage the National Health Service as one thing after another is added on. He was not very keen on my noble friend Lord Warner's suggestion that the mandate be restricted to, I think, five objectives and five desirable objectives. I suspect that when we see the mandate it is going to be very detailed because the Secretary of State will seek to cover himself so that when blame comes it will fall entirely on the NHS Commissioning Board.

It may be that in writing the mandate there are some events or issues that could not be anticipated in advance. However, in the circumstances that I have mentioned, the noble Earl, Lord Howe, could say, "Well, you have the intervention powers contained in Section 13Z1 on page 23". As the noble Lords, Lord Owen and Lord Marks, have suggested, the problem is that the intervention has to be based on a failure,

"properly to discharge any of its functions, and the failure is significant".

[Lord Hunt of Kings Heath]
The intervention is based on the consideration of the Secretary of State. The Secretary of State will be properly advised by his officials and possibly by the Government's law officers. However, what if the NHS Commissioning Board rejects the Secretary of State's view? What if clinical commissioning groups which had contained costs took the view that, in the case of non-urgent treatments, it was legitimate to make patients wait a few weeks if they were none the less treated within the overall 18-week target? Looking at the robust evidence given by the chair of the NHS Commissioning Board to the Health Select Committee, which scrutinised his appointment, it is just possible that the NHS Commissioning Board might tell the Secretary of State to back off. I do not think that is right. I am firmly on the side of Mr Lansley, since he is the Secretary of State and firmly answerable to Parliament. In the way that the Bill is currently constructed, I worry that the Secretary of State will be inhibited from necessary interventions.

5.45 pm

I listened with great interest to the remarks of the noble Lord, Lord Marks. I can see the logic of his amendments. The only point that I would raise is this: is it really necessary to add,

"considers to be in the best interest of the National Health Service"?

I do so in two regards. First, it adds words in a way that is potentially open to challenge and might lead us to the problem of judicial reviews, et cetera, which will certainly arise in the case of the Bill as it is currently drafted. Secondly, in my Amendment 152—which I invite noble Lords to give some consideration to—I have used the kind of wording that has been used ever since the NHS was established. Surely by definition the Secretary of State could only give directions if he thought it was in the best interests of the NHS because a Secretary of State must be bound to act in the best interests of the NHS. Perhaps the noble Lord, Lord Marks, will accept that perhaps my wording is rather more straightforward and less challengeable.

Overall, however, I would say to the noble Baroness, Lady Williams, that I do not think that there is any real disagreement of substance. What is clear is that the Secretary of State is, in the end, the boss and accountable to Parliament. He or she must have intervention powers. They should not be qualified.

Lord Newton of Braintree: My Lords, I wonder whether I could chip in, starting with an apology. As a result of the apparent abandonment of the previous set of amendments, I did not realise that this one had started and, therefore, have not followed everything that has been said. My remarks will be correspondingly brief. However, I have heard enough to know that I want to declare my general broad sympathy with the thrust of what the noble Baroness, Lady Williams, proposes and to link myself with the remarks that have just been made by the noble Lord, Lord Hunt, and not least those that were made while I was in the Chamber by the noble Lord, Lord Owen. They all echo something that I, and my noble friend Lord Mawhinney, have tried to say on a number of previous occasions—that there is beginning to be an absence of realism in the Government's attitude to some of these matters. As I have said several times—and as has been said in other ways by other Peers during this debate—at the end of the day the House of Commons will not accept a Secretary of State who says, "Nothing to do with me, guv", when something has clearly gone seriously wrong.

If the Secretary of State judges that something is happening that is not in the best interests of the health service, I do not see how he can fail to do something about it; and if he does not have a clear power to do something, I can tell you what will happen. The Government will scratch around in every corner of the Act until they find something that enables them to do something, because the Secretary of State will not be able to tell the House of Commons that he can do nothing. There is a real danger that the Government will immolate themselves, in this House at least, on the basis of an absurd proposition that the Secretary of State can somehow stand back and wash his hands of things when they are going wrong. I hope that this amendment will not be pressed to a Division tonight, because I do not think it would be sensible. We need to reflect on what the Minister says, but he needs to reflect on what is being said to him and to be prepared to come back with something different on Report.

Lord Warner: My Lords, I am beginning to feel sorry for the Minister. He is getting a kicking from both sides of him, left and right, and in front. I am puzzled by this amendment and the arguments being put forward, both the one by my noble friend Lord Hunt, and the one in the names of the noble Baroness, Lady Williams, and the noble Lord, Lord Marks. The reason why I am puzzled is because I keep coming back and looking at this Bill, particularly at Clauses 17 and 20. I know that the Minister did not think much of my restrictions on the number of items in the Secretary of State's mandate under Clause 20, but let us set that aside for the moment. Let us assume that the Secretary of State does exactly what my noble friend Lord Hunt does and lays out a very large number of items, and not what David Nicholson does, listing them on one side of A4.

The beauty of the mandate is that it has to be related to money and the Secretary of State can, in certain circumstances, change the mandate. He also has considerable powers to make standing rules changes under Clause 17. So I am slightly puzzled about the set of circumstances that my noble friend and the noble Lord, Lord Marks, are making for this additional provision. I am interested to hear what the Minister says about why this additional requirement may be necessary, because of the inadequacies of the combined effects and powers of Clause 20 and Clause 17.

Lord Hunt of Kings Heath: Perhaps I could try to answer my noble friend. There are two reasons why this is important. First, there is a real risk that the mandate will become so large and extensive to cover the Secretary of State—who wishes to transfer responsibility to the national Commissioning Board—that we will end up with a real fudge about who is actually responsible. Secondly, there are circumstances. Until last week,

I do not think that many people knew that once a trust had allowed its waiting times to go beyond 18 weeks, there was a problem with some of them taking their eye off the ball. If a patient missed the target, often he might have to wait for weeks. It is quite possible that even if the mandate is as extensive as I suggest it might be, there will be circumstances in which the Secretary of State may need to intervene. It is not the case of having time to rewrite or edit the mandate, or look at the standing rules. The Secretary of State may need to intervene on the day that an issue arises. All that I want to do—and I suspect the noble Lord, Lord Marks, also wants this—is to make sure that the Secretary of State is able to intervene in circumstances that we cannot necessarily anticipate but, knowing the health service, we suspect will arise from time to time.

Lord Mawhinney: My Lords, the contributions of the noble Lords, Lord Marks and Lord Owen, demonstrate again why this Chamber is frequently held in the highest regard for the strength, clarity and coherence of the arguments that are advanced within it. I am not going to repeat what they said because I agreed with both of them. My noble friend Lord Newton and I are in danger of becoming Tweedledum and Tweedledee when it comes to trying to persuade the Government that there is a real world out there with around £130 billion worth of responsibility. Lots and lots of people are doing their best, but human beings have the inescapable ability of getting things wrong from time to time, no matter how good their intentions.

I have to say to the noble Lord, Lord Warner, that one of the interesting things about this Bill is that it talks about a mandate. I think of my time in Richmond House when something had gone seriously wrong and civil servants came in to say, "Well, there's a mandate, Minister," and I would say, "Isn't that fantastic?".

Let us get down to the reality of what we are going to do about this latest mishap. That is not an argument for not having a mandate, it is an argument for not putting all your eggs in one basket, even if this particular basket is as widely constructed as the noble Lord, Lord Warner, thinks. I have not resiled from what I have previously said in this Committee in that the Secretary of State is responsible. He has to be responsible to Parliament, he has to be responsible in law, and in reality he has to be responsible in the health service. I am relaxed about the Government putting in place arrangements which they believe—it will all have to be tested over the next few years—will provide a more coherent way of delivering a better and more efficient service than we currently enjoy. I do not resile from the fact that when push comes to shove—and it will, because that is one of the characteristics of the Department of Health, more than any other single department in Her Majesty's Government in my 30-odd years in this building, one end or the other—it must be clear that the Secretary of State can act, and in a way where the people of this country believe he is acting for them and on their behalf.

Lord Marks of Henley-on-Thames: My Lords, if the noble Lords, Lord Mawhinney and Lord Newton, are Tweedledum and Tweedledee, they make a splendid double act in this Chamber. It has been heartening to hear the support for these amendments from all sides of the House. Adding to what the noble Lord, Lord Hunt, said about the observation made by the noble Lord, Lord Warner, the simple distinction is that the mandate and the regulations are intended to be and should be—if they are not to be entirely unwieldy and inappropriately used—prospective. They should set objectives and requirements as to how the strategy of the health service is to be implemented. The intervention powers are intended to be, and must be, reactive. It is the power to react effectively that is important, and as the noble Lord, Lord Hunt, pointed out, it has been used on a number of recent occasions.

May I make one observation to explain our position on Amendment 152, and the difference as we see it? It is not over what is included so much as in what is left out. What is left out is effectively the whole of the intervention regime and what is substituted is a general power to give directions which would take us back to Section 8 of the 2006 Act, which I know that the Government believe is undesirable. I also suggest it is undesirable because it reverts to an unacceptable kind of micromanagement, even though I quite accept the point made by the noble Lord, Lord Owen, about that term being difficult to use in legislation.

Finally, the noble Lord, Lord Hunt, suggested that I might explain why we used the words,

"in the best interest of the National Health Service".

It is right, I suggest, that there should be a criterion for the intervention by the Secretary of State. The criterion that we have chosen is the interest of the health service. It is, of course, what the Secretary of State considers to be in the interest of the health service. That phrase finds repetition in the Bill, so amendments are consonant with the wording of the Bill elsewhere. I am bound to say that if I was called upon in a court of law to challenge the Secretary of State on what he or she considers the interest of the health service to be, on judicial review I would be very cautious about advising my clients of any prospect of success.

6 pm

Lord Hunt of Kings Heath: My Lords, does not the noble Lord make my point for me, apart from believing that the 2006 Act is perfectly formed in every way? Surely the point is that it should not be open to any doubt whatever. In the end, if a Secretary of State intervenes, it must be because he considers it in the best interest of the National Health Service. Why should we complicate matters by potentially giving at least an argument for judicial review when, in the cases mentioned, the Secretary of State simply will need to, or be required to, intervene?

Lord Marks of Henley-on-Thames: The answer is that we are not at one about the vulnerability of my amendment to judicial review. I rather hope that that is never tested; nevertheless, I hope that the amendments are accepted.

Earl Howe: My Lords, the policy of the Government and the vision that we have consistently set out is that Ministers will be responsible for overseeing and holding

[Earl Howe]
to account the national bodies, backed by extensive powers of intervention in the event of significant failure. I say to my noble friend Lord Newton that that is what the Bill provides for. These powers are essential if Ministers are to be able to retain ultimate accountability for the health service, for the very reasons that he stated. I have to say that some of his phraseology was, in my view, unnecessarily extravagant, if I may use that phrase. The Secretary of State will not stand back; nor will he wash his hands of what is going on, as my noble friend put it. The Bill enables the Secretary of State to intervene where he believes that Monitor, the board, the Care Quality Commission, NICE, HealthWatch or the Information Centre are failing or have failed to exercise their functions, and that failure is significant. In the event that Ministers use these intervention powers, they will be required to publish the reasons for doing so, including an explanation of why they consider the failure to be significant. These requirements will provide transparency to the decision-making process.

I will deal with the question posed by my noble friend Lord Marks. Why should we use the word "significant"? The clear aim of its use is, exactly as my noble friend suggested, to stop Ministers intervening in inconsequential matters. There is no case law on the meaning of "significant failure". The Secretary of State will need to decide whether a failure is significant. However, cases have considered the meaning of "significant" in other contexts and have taken the approach that, while a dictionary definition of "significant"—

"noteworthy; of considerable amount or importance"—

is not to substitute a different expression for the statute, it remains a helpful indication of what the term means. There is a degree of flexibility inherent in the term "significant", and I believe that that is helpful in the context of the arguments put forward by the noble Lord, Lord Owen—who is not in his place—and my noble friend Lord Mawhinney.

I will first deal with Amendment 152. I respectfully suggest that there is a gap between that amendment and that of my noble friends Lord Marks and Lady Williams. Amendment 152 seeks to amend the Bill to give the Secretary of State wide powers to direct the board and clinical commissioning groups in how they carry out their functions. I said "wide powers", and that fundamentally cuts across the vision of a health service free from political micromanagement. It therefore gets us back into exactly the territory that we want to get away from.

Of course it is important, as I have said, that there are intervention powers if things go wrong and those powers are in the Bill. The Bill also sets out a robust system by which the board will hold CCGs to account. I will come on to that in a moment. Creating a sweeping power of direction would seriously undermine the autonomy of the board and local commissioning groups and allow Ministers to use directions or indeed the threat of directions to second-guess operational decisions. In addition, any direct power over CCGs would duplicate and undermine the role of the board which is responsible for overseeing local commissioning.

Amendment 153 makes a more subtle point. It seeks to enable the Secretary of State to direct the board should he consider it to be failing to carry out its functions in the best interests of the health service. Let me reassure my noble friend of what I am sure he does not need to be told. We would always expect the board to act in a way that is consistent with the interests of the health service. This is made clear by the duty on the board to promote the NHS constitution and the duty set out by proposed new Section 1E(2), which ensures that the board is also subject to the duty to promote the comprehensive health service. If the board were acting in a way that was not consistent with those duties, then it would be acting unlawfully. That may constitute a significant failure by the board to exercise its functions properly or indeed at all in relation to which the Secretary of State would consider intervening.

Lord Marks of Henley-on-Thames: My Lords, I am sorry to intervene at this stage but does my noble friend the Minister not accept that there may well be two divergent views of what the best interests of the health service are, and that the board may hold one view, the Secretary of State an entirely different view—or, on the other hand, CCGs may hold one view and the board an entirely different view—and that undermines any notion of accountability if the Secretary of State has to stand up in Parliament and say, "I do not believe what the board has done is in the interests of the health service but the board does and I cannot do anything about it"? That is the mischief at which these amendments are directed.

Earl Howe: I take the point but I hope my noble friend will agree that I have an answer. The crucial point is that, while we would expect the board to have a clear shared understanding of what the interests of the health service are, the Secretary of State has mechanisms over the board which he can use if necessary to clearly set out what these interests are. He can do that by setting objectives and he can hold the board to account for those. So he has other levers.

Amendment 277, also in the name of my noble friend Lady Williams, would prevent the Secretary of State from intervening in specific cases where he considers that Monitor has failed or is failing to perform its functions. We believe that it is important for the Secretary of State to be able to intervene in the event of a significant failure by Monitor to perform its functions. That intervention power does not exist at all under current legislation, and we believe it should. We do not believe Ministers should have the power to intervene in individual cases. Such a power would risk politically motivated interference and undermine the independence of the regulator. That point is extremely important.

However, there is an important exception to this rule in relation to the continuity of services. Amendments introduced in another place allow the Secretary of State to intervene in relation to proposals for securing access to services where a provider has become unsustainable. The Secretary of State would be able to exercise a veto if Monitor and clinical commissioning groups have failed to discharge their functions, to follow the proper procedures or to secure access to services.

We are clear that the wording of the clause as it stands strikes the right balance, enabling the Secretary of State to intervene when necessary to address systemic failure, while ensuring that Monitor is able to carry out its functions free from potentially time-consuming and politically motivated interventions relating to individual cases. The NHS Commissioning Board will also have powers of intervention, as set out in new Section 14Z19, to support CCGs and take action where necessary if there is evidence that they are not meeting their statutory duties or that there is a significant risk of them failing to do so.

I recognise that the intention behind Amendments 220ZAA and 220ZAB, which look to ensure that the board only intervenes in a CCG when it is satisfied that the CCG is failing, or is at significant risk of failing, to exercise a function in the best interests of the NHS. However, as the Bill is drafted, the board can determine when a CCG is not exercising its functions properly and that is surely the better approach. We are giving the board discretion to determine when intervention is necessary, based on the terms of each statutory function that CCGs have, not in relation to a separate criterion. The amendment would actually narrow the grounds on which the board would have power to intervene, which I do not think would be at all helpful.

Finally, I would like to address the point put to me by the noble Lord, Lord Hunt, about waiting time objectives. The noble Lord implies that Ministers would be powerless in the face of waiting times. That is simply not the case. Ministers' main weapons on this issue would be the standing rules and the NHS constitution. Current contractual requirements relating to waiting times, such as 18 weeks, are covered by the constitution through the handbook and will form a key feature of the standing rules pending passage of this Bill. If the Secretary of State wanted to act on a new waiting time issue, the option is there for the NHS constitution handbook to be revised and the standing rules updated accordingly.

I hope that I have provided enough detail on these clauses to enable my noble friend to withdraw the amendments.

Baroness Armstrong of Hill Top: Will there be issues around the National Health Service that Members of Parliament will not be able to question Ministers about or to get clear answers from Ministers on? I have listened very carefully to the Minister, but I am still very confused about the accountability to Parliament and what the Minister will answer questions on and what he will say is the responsibility of Monitor, the NCB or whatever.

Earl Howe: There are no areas that will be out of bounds to parliamentarians in the sense that the noble Baroness has said. What may happen is that the Secretary of State or other Ministers may respond directly, or in a way that draws upon advice that they have received from, let us imagine, the NHS Commissioning Board; they may quote what the board has said and say that this is the advice that they have received, or they may, as with some agencies at the moment, refer the parliamentarian to that body directly. It will vary. The main question that the noble Baroness asks is whether parliamentarians will be inhibited in some way. The answer is no.

Baroness Williams of Crosby: I should like to add a few words before considering whether or not to withdraw this amendment. The noble Earl, Lord Howe, has obviously made the best possible case he can, but given the very extensive doubts on all sides of the House, I feel that he ought to be asked to address this issue very clearly. It is bound up in many ways with the whole issue of the responsibilities and accountability of the Secretary of State which is under discussion at the present time. I will withdraw the amendment on the understanding that it will come back on Report when we have had an opportunity to see how this fits into the whole structure of responsibilities of the Secretary of State.

Perhaps the most simple answer to the question that was asked by the noble Baroness, Lady Wheeler, is that on the basis of Amendment 153 it would be impossible for the Secretary of State to say, "Not me, guv" in response to the point made by the noble Lord, Lord Newton of Braintree. This is so central, and so serious, that in withdrawing the amendment I make it absolutely clear that I do so in order to give an opportunity to the department and to the Minister to consider how this may be best fitted in to the responsibilities and accountabilities of the Secretary of State over the whole of the health service. I beg leave to withdraw the amendment.

Amendment 153 withdrawn.

Amendments 153ZZA to 153ZA not moved.

Clause 20 agreed.

6.15 pm

Clause 21 : Financial arrangements for the Board

Amendments 153A and 153B not moved.

Clause 21 agreed.

Clause 22 : Clinical commissioning groups: establishment etc.

Amendment 154

Moved by ***Lord Hunt of Kings Heath***

154: Clause 22, page 29, line 2, after "services" insert ", primary dental services, primary pharmaceutical service, primary ophthalmic services and primary nursing services"

Lord Hunt of Kings Heath: My Lords, my Amendment 154 brings us to a group of amendments which consider a number of interesting points about clinical commissioning groups and their relationship with GPs, other contractor services and local authorities. They also allow us an early canter at probing exactly where the Government's policy on clinical commissioning groups currently is.

[LORD HUNT OF KINGS HEATH]

My first Amendment 154 is partly probing, but it is also to ask why membership of a clinical commissioning group is only confined to general practitioners or, in the jargon of the Bill, providers of primary medical services. What about the other contractor professions within primary care: the dentists, the pharmacists and the ophthalmologists? What about primary and community nurses? I would not in any way seek to undermine the potential leadership role of general practitioners, but they are part of a primary care team. It is rather unfortunate that other members of the primary care team were not considered worthy of membership of a clinical commissioning group.

I must say that I have yet to hear any rational explanation as to why GPs only have been singled out for this exalted membership of a clinical commissioning group. It would have been perfectly possible to have brought all the contractor professions and, I would hope, primary care nurses, into membership of a clinical commissioning group, and then to have a governance structure which none the less recognised the pivotal role of GPs but did not exclude the other professions. One could have had a weighted voting system or some other way of reflecting that yes, GPs are clearly a very important profession in primary health care, but they are not the only one.

I am curious to know why the Government did not adapt that approach, and how they expect clinical commissioning groups to really relate to the other professions. How can they bring them on board? I think of rural clinical commissioning groups and rural dispensing, and how there can be terrible tensions between GPs who dispense in rural areas and community pharmacists in those areas. If I were a community pharmacist, I would be rather concerned that the rural clinical commissioning group is not at all going to act in the interest of community pharmacy. It is almost bound to act in the interest of rural dispensing general practitioners.

I would be interested therefore, if the noble Earl, Lord Howe, could give some further explanation as to the construct of clinical commissioning groups. I should say to him that, having talked to dentists and community pharmacists, they are really concerned that they will be excluded from the decision-making process within clinical commissioning groups, and that it will be purely GP-dominated. Some of the people most concerned, and quite rightly, are primary care nurses, whose voice should be heard. One fears that the traditional approach will be to exclude them from those discussions when they have an enormous amount of expertise to bring to the table.

Amendment 158 is a probing amendment. It relates to the areas of clinical commissioning groups and argues that clinical commissioning groups ought to be co-terminus with the boundaries of a local authority or contiguous group of local authorities.

I stress to the noble Earl, Lord Howe, that this is a probe. If health and well-being boards are to work well, there clearly needs to be an integration of public health and commissioning between the various groups at local level to make sure that they come together in a cohesive plan and at interventions. It is very important that clinical commissioning group areas at least do not go over into other local authority boundaries. There is an argument for coterminosity, but of course I do accept that in some areas that would make the clinical commissioning groups far too large and that is why I stress to the noble Earl that this is a probing amendment.

In the county, non-metropolitan district areas where you still have a two-tier system, I would have thought there is some concern about the involvement of the non-metropolitan district councils in the arrangements for liaison between local government and clinical commissioning groups. While it does not strictly come within the remit of this amendment, it is a matter to which I suspect we will want to return at Report stage.

Beyond that, this is a good opportunity to ask some serious questions about clinical group commissioning. It seems to be clear that there is now increasing anxiety among GPs that the likelihood of them having significant control of commissioning is becoming remoter by the day. The noble Earl will be aware of the BMA's decision to come out decisively against the Bill. But I have also noted with great interest a press release by the NHS Alliance, which of course has been very much a flag waver for the Government, in which it complained about bullying taking place by the system in relation to clinical commissioning groups. The headline is that doctors leading the NHS reform changes report coercion and bullying in the way the organisations are being set up, which followed a survey of a number of pathfinder clinical commissioning groups. The survey asked: "Do you believe that your clinical commissioning group is being coerced or bullied in how you are setting up in ways that conflict with what you feel would benefit your local population?" Out of the 67 clinical commissioning groups surveyed, 60 per cent answered yes. So much for this hands-off approach that we have been promised. Clearly things have changed. When this started the assumption was that we would have a large number of clinical commissioning groups covering fairly small areas where GPs would actively be involved around the table in commissioning decisions. It has been made abundantly clear that CCGs would not be authorised unless they merged into much larger organisations covering very large population bases.

I wonder whether the noble Earl could perhaps say how many clinical commissioning groups he now expects to be informed. Can he also confirm that they are going to be forced to obtain external commissioning support? Indeed, they have been promised the delight of a bureaucratic procurement process for that support lasting, I understand, up to 12 months. So they are also clearly being leaned upon to use the private sector for such support and they are being forced also to merge commissioning for large-scale commissioning projects. No wonder some GPs are beginning to wonder what this is really all about and whether one beast is being replaced by another. Today Dr Michael Dixon, the chair of the NHS Alliance, told the annual conference about the challenges ahead for clinical commissioning groups or, as he called them, the nation's future clinical commissioners. He said that they will be confronted by the demons of self-interest, factional politics, ignorance, laziness and raw emotion. They will be hated by all of those who have fed from the gravy train of the current system.

I am a longstanding admirer of Dr Dixon, not least because of his pressure when I was in government to give support to complementary medicine, which I suspect that noble Earl, Lord Howe, now enjoys as well. But I think he made those remarks because he knows, deep in his heart, that the game is up. Whatever one thinks of the Government's reforms and whatever changes have been made as a consequence of the listening exercises, I had always clung to the thought that the Government were serious about giving GPs control of commissioning. It has become abundantly clear that this is not the case. GPs have been sold a dupe and so too has Parliament, I fear. I beg to move.

Lord Warner: I speak to Amendment 157 which is aimed at containing the number of clinical commissioning groups and their total operating costs. I have some sympathy with the remarks made by my noble friend, but before I go into the detail of these particular amendments, I want to give a little context.

My Lords, there has been a great deal of concern expressed by many people who are well versed in the background and activities of the NHS about the number and small size of clinical commissioning groups that might emerge. I do not condone bullying, but we have a problem. The smallest population size for a CCG that I have come across is 18,000 for Radlett, near Watford. I asked the Minister for the Government's latest estimate of the number of clinical commissioning groups likely to be operational in April 2013. In his answer to me on 9 November, he said:

"It is too soon to estimate the number of clinical commissioning groups that will be operational in April 2013. There are, however, currently 266 pathfinder CCGs covering 95% of GP practices in England".—[*Official Report*, 9/11/11; col. *WA 58*.]

So it is possible that there could be about 280 clinical commissioning groups when all practices are covered. This is far too many to be effective, for reasons I will explain in a moment. We are getting into an extraordinary position. It seems almost an article of faith, or really bold ministerial courage, for the Government to be embarking on this massive NHS reorganisation, at a time of great financial challenge, without knowing, 16 months before they go live, how many clinical commissioning groups—the bodies that will be handling large chunks of this money—will be in place. That seems a pretty racy way to live with a national icon like the NHS.

We will come to the competency tests for CCGs in later amendments. If those competency tests are to mean anything, a significant number of these groups could, presumably, flunk them. Or will all the geese suddenly become swans? What light can the Minister throw on the likely failure rate for clinical commissioning group applicants? When will we have more reliable data on how many clinical commissioning groups we are likely to end up with? For the purposes of discussing the amendment, I will assume that the Government anticipate having something of the order of 250 clinical commissioning groups by April 2013. For many of us, this would seem far too many, and totally fails to learn the lessons of history. As someone who had to learn the lessons of history in the area of commissioning the hard way, I want to share some of that experience with the House.

In 2002, the previous Government set up 302 primary care trusts to undertake commissioning. To some extent, in doing this, it was following the course that this Government are trying to pursue—of getting commissioning closer to local populations. That was one of the arguments for doing it and it is not one which I would quarrel with, in principle. But, like clinical commissioning groups, small PCTs were expected to be able to carry out most of the functions of a commissioner. They needed to have all the skills to undertake commissioning, they needed to be effective demand managers, they had to have the muscle to stop acute hospitals gobbling up too much of the money and they had to be able to secure a more appropriate balance between community-based and hospital-based services in their delivery. They failed, and their failures were shown by a number of reports by the Health Select Committee in the House of Commons. They failed because many of them were simply too small and there were too many of them for the commissioning capability nationally available to be able to staff and run that number of bodies. We are heading down exactly the same path with clinical commissioning groups. The manifestation of the failure of the PCTs was the financial meltdown of the NHS in 2005-06. This meltdown occurred after several years of 5 per cent real terms growth in NHS expenditure and in the middle of a financial year with 5 to 6 per cent real terms growth. This is not the situation that clinical commissioning groups will be faced with.

6.30 pm

After the 2005 election I tried to reduce the number of PCTs. We got down to 150; we should have got down to many fewer. We have now ended up in a position where there are, effectively, 51 clusters of PCTs running commissioning in this country. So we have actually ended up, after rather a painful journey, at roughly the right number of bodies that have the effective capability to run a commissioning of services for this country. We are going to throw that away and have a go at doing it with clinicians—whose increased engagement I support—but starting all over again with a number which could be four to five times the number of the PCT clusters. That is a pretty risky strategy in current financial circumstances.

Amendment 157 is an attempt to persuade the Government to have another look at all this and to get real about a credible, effective and affordable number of clinical commissioning groups. It is certainly not 250; it is probably not 150; it is probably nearer the number of PCT clusters that we currently have; it could be even smaller if you wanted to align them more with Health and Wellbeing Boards. The amendment only caps the number at the number of PCTs, but it does enable the Secretary of State to go lower which, in my view, he would be wise to do. If the Government do not get real, we will end up over the next few years —I am in the business of forecasting this afternoon—with a blizzard of mergers and failures, simply because we will not be able to run and operate that number of bodies. Fantasy football management is great fun, but there is no case for extending its approach to NHS commissioning which, on the whole, lacks an adequate supply of star strikers and defenders to keep 250 teams going.

[Lord Warner]

The second part of Amendment 157 tries to contain the overall management costs of clinical commissioning groups to that of PCTs less 20 per cent, with an NAO audit of the figures. This approach would also curb the enthusiasm for an excess of clinical commissioning groups. The Government seem to be struggling to establish what the management costs of clinical commissioning groups will be. In his Written Answer of 9 November, to which I referred earlier, the Minister told me that CCGs' management allowance,

"could be in the range of £25 to £35 per head of population by 2014-15". —[*Official Report*, 9/11/11, col. *WA58*.]

That is a pretty wide range and it could have significant budgetary implications. How would those range figures compare with current PCT costs and when will we have firmer figures and a clear global sum for the running costs of CCGs? I hope the Government will not simply brush aside amendments of this kind. It will give me no pleasure to say "I told you so" in a few years' time.

Lord Newton of Braintree: My Lords, perhaps I may chip in once again in seeking that my noble friend should at least listen very carefully to what has been said by the noble Lord, Lord Warner. I probably ought to declare a sort of interest in that my wife is currently a member of a PCT board. I would like some clarity about just what the situation is in this respect. As the noble Lord, Lord Warner, indicated towards the end of his remarks, the contrast between what is being put in place at the moment and what is prospectively going to be put in place is even greater than the actual number of PCTs at present because of what has been done about clustering. At the moment—I do not know the exact figure on clusters—there is an even bigger contrast between, as I say, the number of clusters and the potential number of clinical commissioning groups, with all the costs, potential fragmentation and the rest of it that that might entail.

There is another issue and I just want to find out exactly how the Minister sees the position. Clustering has been achieved not by abolishing or merging PCTs but by appointing the same people to the boards of several PCTs. I think that the House should be clear about that. I want to know from the Minister exactly what is the number of PCTs at the moment; whether that number has in any way been affected by clustering; and whether the PCTs, which still exist as legal entities alongside the clusters which are not legal entities, continue to have all the responsibilities and duties that are assigned to them under the statutory basis on which they were set up in the first instance. PCTs remain the statutory entities. The clusters have no statutory basis at all, and we need to be absolutely clear what the situation is, how many PCTs we have and what their responsibilities are.

Baroness Finlay of Llandaff: My Lords, I have an amendment in this group. At first sight the group might seem loosely hung together but there is a common theme running through all this, and that is: how much is all this going to cost? The back-office functions for commissioning are not inconsiderable, and the more that clinical commissioning groups come together, the more some of those back-office functions can be merged and cost-savings made—or at least the more that expenditure can be decreased, because it is not really cost-saving. The document *Developing Commissioning Support* is quite interesting because it reveals the complexity of many of the back-office support functions that clinical commissioning groups will certainly need. Indeed, GPs themselves are independent contractors to the NHS. In many ways, that is why the amendment in the name of the noble Lord, Lord Hunt, is so sensible. Many of the other people working in the community are actually salaried, so they do not get any financial gain from contributing to a clinical commissioning group, whereas there are financial incentives for general practitioners in different ways of commissioning. For example, they often run out-of-hours services and may effectively be commissioning those from themselves within a particular area.

I want to draw the Committee's attention to the need for collaboration in commissioning for those patients and groups of patients who have relatively rare but not terribly rare conditions. I shall take motor neurone disease as an example. In Nottingham, there is a properly commissioned neurological network that works across different PCTs with a lead PCT and the patients with motor neurone disease are able to access a pathway of care—a complete package of care—that is consistent with the Motor Neurone Disease Association's own Year of Care pathway, which it developed to inform commissioning some time ago.

In another area, Southampton, no end-of-life care has been commissioned for motor neurone disease patients over the past five years. That means that patients even have to move to other areas, such as Gloucester, simply to access specialist palliative care when they are aware that they are going to need it at the end of life. That cannot be right. We know perfectly well that when you provide good integrated care, the quality of patients' lives as their disease progresses can be improved by appropriate interventions. However, without it, it is a council of despair. The PCTs in that area have refused to fund end-of-life care for motor neurone disease patients, and it is an ongoing problem. Recently, two of the commissioners in the PCT were so concerned that they made a business case, but it was not backed by the PCT on financial grounds, because it is short of funding.

There is another problem, and another reason that clinical commissioning groups need to come together and collaborate. Quite a few seem to be looking at using the map of medicine as a basis to inform their commissioning decisions, but the map of medicine was not devised and written to guide commissioning. It was meant to guide clinical decision-making, and it is not complete in any one sector. You need to put the different parts of it together. For example, if you take chronic obstructive pulmonary disease, it does not have end-of-life care within its module. So if you use that module, you will not get the complete package that patients need. You also have to go to the end-of-life care module. Some of us who have looked at it in detail do not think that it is an appropriate template to use for comprehensive commissioning of services integrating processes early in the disease and right on through.

The commissioning groups are going to be on a very steep learning curve. They are going to find things very difficult, and with many small groups, the cost of them trying to do the commissioning will go up, and that is before they have used their funding to actually commission the services for patients that they have responsibility for.

These are very important amendments. This group and the next one get right into the heart of some of the problems that are beginning to emerge over the way that clinical commissioning groups are defined in the Bill.

Lord Mawhinney: My Lords, the noble Baroness, Lady Finlay, was right when she said that these are important amendments because they get to the heart of one of the big issues of the Bill. They pose a problem that only the Government can help us to understand and resolve. The noble Lord, Lord Warner, introduced us to the concept of clusters. Although I am deeply tempted—for I agree with what my noble friend Lord Newton of Braintree said about them—as we are supposed to be brief, I shall resist expressing my views on clusters until we get to the amendments that I have put down to Schedule 6, which deals with these issues, save to say that, at that point, the House is unlikely to be confused about what I think.

The noble Lord, Lord Warner, pinpointed the issue. From my Second Reading speech and also from conversations which he and I have had, my noble friend will know that I am enthusiastic about this Bill because it introduces GP commissioning. I have strong memories of the great advantage that GP fundholding presented to those patients who were the patients of GP fundholders. So I was drawn to be supportive, because I understood that the groups were going to be relatively small. They would benefit from the inter-reaction of GPs and patients, and nobody in the health service knows better than GPs what is in the best interest of their patients.

On the other hand, I recognise the point made by the noble Lord, Lord Warner, that if you have too many of them—as the noble Baroness, Lady Finlay, has pointed out—you run into other difficulties. Were we to wind up with a smaller number of large bodies, then clinical commissioning starts to mean something entirely different from what those of us who were supportive of the Bill believed to be the case initially. The noble Lord, Lord Warner, said there was a danger in all of this and a number of GPs would wind up being very disappointed. I have to say to my noble friend that if we get in to big organisations, there will be more than a few GPs who will be disappointed at the direction of government-policy travel.

6.45 pm

Baroness Jolly: My Lords, I have supported the idea of co-terminosity from when I first saw the Bill in January. It struck me as being straightforward and sensible that if health and social care were put together, the health boundaries would be aligned with the social care boundaries. That clearly happened in the middle of the last decade, when PCTs were grouped together to be coterminous with social care boundaries. There are all sorts of issues. If you have a large clinical commissioning group, then there is a capacity issue in that you have one clinical commissioning group that might need to work with several local authorities' health and well-being boards, directors of public health, healthwatches or whatever. If you have a small group, then you have many CCGs working with all those bodies. It struck me that if there were a direct fit, everything would look quite neat and hunky-dory. I parked the thought in my mind that everything was fine.

Then I started to look at what was happening around me locally in the south-west. Torbay has been mentioned many times in your Lordships' House. It provided a care trust—health and social care together. One of the areas they are really anxious about is that if they become part of Devon, an awful lot might get lost. So there are special circumstances around that integration. They know that they are small and they are trying to look at making themselves bigger by working with other parts of Devon, all of which take their acute services from one DGH. The same sort of thing is happening in Plymouth. Noble Lords will remember from the Bill about constituency boundaries in January that there was a huge big deal about Cornwall being all on its own. Cornish patients, believe it or not, actually do cross the Tamar in order to go to hospital in Plymouth. A fifth of Cornish hospital patients actually do that, so a whole group of Cornish GPs who face that way, along with some in south-west Devon who face that way, along with Plymouth, have discussed the possibility of working together as a group, simply because they all face one DGH. It was a common bond, if you like.

Therefore, we have a county or a district or a borough seen as one possible common bond. We have an idea that commissioning groups who commission from a particular hospital, trying to work together in a pathfinder mode, is not peculiar to the south-west; a lot people seem to think it would be a good idea. There are lots of issues, so how do we solve this? I still think that, for an awful lot of situations, co-terminosity is the right answer. The test really has to be: what actually can be deemed to be in the interest of the patient? The whole thing has to be taken in the round; it has to include care providers and health providers and there has to be an element of size capacity. My head—and my heart—say co-terminosity, but then I look at certain other areas where there are groups that have—

Lord Hunt of Kings Heath: Would the noble Baroness give way? She has raised an interesting point. Could I describe the situation in Birmingham? My understanding is that although there will be more than one clinical commissioning group, there will clearly be one HWWB group and the membership has now reached 25. There is one place for providers on it. One gets the feeling that there is a risk that it will become a talking shop. Secondly—and I declare my interest as chair of an NHS foundation trust in Birmingham—if you excludes the providers from those key discussions, you will not get a buy-in. Think of patient discharge and the relationship between reducing length of stay, preventing admissions and the support that social services needs to give packages of care. One worries that you reach a situation where the whole thing is so unwieldy that it will not really work.

Lord James of Blackheath: My Lords, could I ask the Minister a question that is definitely not medical and about which he might wish to take note for further advice later? In a cluster, does each component maintain its own solvency or do they have a collective solvency? If there is an imbalance in the size of those components and a marginally solvent large component, you run the risk of creating insolvency for the two smaller ones. That would be a severe risk for the trustees of those components.

Baroness Jolly: I have lost my thread. We are talking about Birmingham, which is humongous, and presumably any large city would have exactly the same sort of issues. Is the noble Lord arguing for co-terminous clinical commissioning groups?

Lord Hunt of Kings Heath: My point is that my amendment was a probing amendment to get some information from the Government about their intent regarding boundaries. Clearly, one of the problems that we are discussing is size and the larger you make clinical commissioning groups, the less influence GPs will have on their deliberations. The whole point about clinical commissioning groups was to put GPs in the driving seat. I do not know if Ministers know how much pressure within the system is being put upon potential clinical commissioning groups, but they are being told that they have to get large. The numbers who put themselves forward at the beginning were basically told that there was no way that they would get approval, so they have been forced into big marriages.

I simply point out that even if you take Birmingham, where there will be very big clinical commissioning groups, you will still end up with an unwieldy health and well-being board. One has to think through the implications of this if you are then trying to get a cohesive strategy on public health and on joint commissioning that pulls all of the players together—while still excluding the providers from those discussions. We started from an original prospectus that was going to give GPs real control over commissioning. That is gone. I agree with the noble Lord, Lord Mawhinney. I do not think that there is now any chance in the system that is being forced upon the service, that individual GPs will have any influence. As with the noble Lord, Lord Mawhinney, it is clear that GPs are realising this now, and that the prospectus is a false one.

Baroness Jolly: I think that the noble Lord's point is well made. The noble Baroness, Lady Finlay, however, talked about the element of size and back office, which needs to be quite large. Small CCGs will need to share a back office, simply because that is the way it is. There will need to be shared commissioning arrangements. I think that the noble Earl, Lord Warner, was saying much the same thing: these things will not work if they are tiny but might if they are larger. I remember primary care groups, which became primary care trusts, which became bigger primary care trusts. What is a reasonable size to make all those linkages work? What we do not want is for all of these organisations to spend their days going to meetings. If we are not careful and clinical commissioning groups go over local authority boundaries then they will have to serve more than health and well-being board.

The ideal would be to have some co-terminosity but clearly it will not work in really enormous situations. My background and experience is in rural areas, where it strikes me as the most obvious way forward. Even if that is not how it starts, that is how it probably should end up. As for the Torbay example, the PCTs are very small. However, they are also perfectly formed and have done a really good job. They are desperate to keep what they did, and did well, but they are being pressured to join a Devon PCT—which also has pressure on Plymouth, which is also part of the Devon PCT. So it is not a straightforward picture. When clinical commissioning groups put their case to the board, there needs to be some sort of nuancing in application.

Baroness Murphy: My Lords, is not the whole point of the formation of clinical commissioning groups that it should be a local solution that fits the configuration of a particular urban or rural area and that it should be decided locally with the Commissioning Board what the best fit is? I take the point made by the noble Lord, Lord Warner, that size is an important issue as to whether one is favouring individual GP commissioning of a personal family health service or whether one is going for the much bigger purchasing of population services. Surely the big difference with this Bill is that PCTs had no real central support for developing commissioning in the way that clinical commissioning groups will have very explicit support from the Commissioning Board. I can see that the noble Lord, Lord Warner, is shaking his head, but I think that makes a huge difference because we have seen the concentration of emphasis by the Department of Health on the acute sector, and to get a way towards having much greater leadership from the centre in developing commissioning seems to me a very positive thing.

The noble Lord, Lord Hunt of Kings Heath, asks why is it only GPs—why do all professionals not get involved? All local primary care clinical professionals should have an input to the groups' deliberations, but surely the obvious answer is that it is GPs who specifically use resources for their patients from secondary care. They actually determine the costs in secondary care through their use of secondary care hospitals; they intervene to stop secondary care—they have the possibility of doing it through provision of primary care; and they have enormous control over the funding, potentially, of the hospital system. It seems absolutely obvious that it should be GPs. The input of local dental practitioners, opticians and pharmacists is vital but they do not play the same financial role and that is why it seems to me it has to be GPs.

We cannot in this Chamber fix this Bill to lay down rules for the development of clinical commissioning groups. It would be absurd. The Commissioning Board and local people who are going to contribute to it have to make that decision. They have to be the ones to make it work. If they need to come together to commission services for rare conditions, that is fine.

Lord Warner: There are very few things in health policy on which I disagree with the noble Baroness. However, this House needs to look at what the evidence base from GP fundholding and practice-based commissioning shows us. The evidence base shows

that GPs did quite well in commissioning some services. However, their actual impact on reshaping services out of acute hospitals was virtually zero. There have been some very good evaluations of GP fundholding and some less good evidence from practice-based commissioning. These showed that GPs got very close to their patients, understood what they wanted and reshaped some services. The transaction costs were seriously high in GP fundholding, which demonstrated that doing good commissioning requires a lot of data collection and analysis, which does not come cheap.

We need to understand the issue of muscle. People like the Nuffield Trust have done some good work on this. At the end of the day, the GP commissioners we have had so far were not strong enough and did not have big enough budgets or the analytical capabilities to call the shots with acute hospitals. That is the bottom line. I strongly support GP commissioning in principle. However, we are in danger of repeating the mistakes of the past and not learning from those experiences.

Baroness Murphy: I do not disagree with the noble Lord, Lord Warner. It is absolutely true that there is a balance and that size is important. Nevertheless, at the moment we are going back to a size that is approximately the same as the old district health authorities that we had between 1983 and 1992. They survived for quite a long time—

Lord Patel: Too small.

Baroness Murphy: I agree; they were too small. However, if you want to get that balance and that advantage of the clinical commissioning, it seems that, with a different sort of central support, it would be possible. With some local responses and reconfiguring of commissioning groups and the old PCTs, it can work. I do not feel quite as depressed about the clinical commissioning groups as other people.

Lord Greaves: I was going to make merely a brief intervention on this group on the question of coterminosity. However, this has extended into a much more important debate, which is coming down to some very fundamental issues in relation to clinical commissioning groups. The noble Lord, Lord Hunt, is to be congratulated on introducing this debate because it is absolutely crucial. We have to have it some time—if we are having it on this amendment, fine.

The noble Lord said in passing that the same issues keep coming round at different stages of the Bill. On this Bill the same issues keep coming round in different sessions in Committee. This is the second time we have talked about coterminosity. I think previously it was on an amendment from his colleague, the noble Baroness, Lady Thornton. I will not repeat everything that I said then, except to say that there has to be some flexibility. There are very good arguments for saying that CCGs should not cross local social care authority boundaries. However, the point I made previously was that in very large counties, like Lancashire or North Yorkshire or, if I think about the south of England—which I force myself to do occasionally—Hampshire and Kent perhaps, at the very least they ought to have the ability to not have a very large CCG forced on them that covers a whole county, which would be very remote indeed.

We have heard about Cornwall and Devon from my noble friend. We have heard about Birmingham. I am going to say a few things about Lancashire. I am very interested to know whether there are any noble Lords in Committee today who are very clear about what is happening in relation to setting up CCGs in their own areas, how it will work and what will come out of it. Asking colleagues on the Liberal Democrat Benches while this debate has been going on, nobody seems to know; chaos and confusion seem to be the impression. I am not saying that it is chaos and confusion, but as far as ordinary members of the public are concerned, let alone other people like myself who try to take a more direct interest, it is not very clear at all what is happening, or if what is happening is clear, it is not clear why and how it is happening. This comes back to the points raised by the noble Lord, Lord Hunt, about the fact that there are very clear pressures from above that are moulding the system that is going to take place. I very much take the point from the noble Baroness, Lady Murphy, that there ought to be local discretion and local decision-making here. However, that is not happening. People are being forced into decisions, and that goes against what she was saying.

Let me tell you about where I live, in east Lancashire. At the moment there are two PCTs. There is a Blackburn with Darwen PCT, because Blackburn with Darwen escaped from Lancashire County Council at some stage in the past and became a small unitary authority, so it has its own PCT. The other five districts, which are part of Lancashire County Council, have an East Lancashire PCT which, as the noble Baroness pointed out, had been formed by amalgamations over the years. There is one East Lancashire Hospitals NHS Trust that effectively covers the two PCTs, so there are two PCTs and one hospital trust at the moment. The PCTs have been combined with the rest of Lancashire into a county-wide cluster, but the East Lancashire PCT still exists.

I have recently been given a whole set of minutes and agenda papers, a great big thick file, from a relatively recent meeting—in the last few weeks—of the East Lancashire PCT. Although they find it increasingly difficult to keep going because all their chief officers have gone, there are still functions taking place at the PCT level; there are functions taking place at the cluster level, and for somebody like me who takes an interest in but is not directly involved in the health service nowadays—I used to be on a district health authority, an area health authority and a community health council, but am not now—I find it very difficult to find out where the decision-making is taking place.

Back when CCGs came along, the original idea was that they would be quite small, as the noble Lord, Lord Mawhinney, quite rightly said. They would be groups of GP practices within a recognisably local area. Whether that was a good or a bad idea—and in many ways it was an attractive idea—that has clearly now gone by the wayside. People were told that the minimum that you could get away with in east Lancashire was district-wide—that is the lower tier—so people were getting together and forming proto-CCGs at the district level.

[Lord Greaves]

In terms of population, Rossendale is about 70,000 and Pendle is probably the biggest of the five at about 90,000; it is that sort of range. The doctors who were getting together and working on these CCGs—and certainly in both Burnley and Pendle they were working closely with the district authorities to share back-room services and so on when they were set up—were told that this will not do any more. I am not at all clear who told them, but it has been made absolutely clear that there now has to be a new CCG covering the five districts, an area of 450,000 people. It is a very significantly different proposition, however you define significant, from groups of local practices, where the whole thing started off.

Blackburn and Darwen, because it is a unitary authority, is insisting that as far it is concerned, it will have its own CCG, which will be coterminous with the relatively small unitary authority, which has a population of around 140,000.

Lord Hunt of Kings Heath: Has that potential CCG been told that it will not get authorised? I would think that that is the way in which the system will force it into a larger merger.

Lord Greaves: I assume so, but I have no personal knowledge of the processes that are leading to these outcomes. All I hear about—from talking to people who are professionals and politicians involved in these systems and through the normal bush telegraph—is the outcome. The outcome is that there is almost certainly going to be a CCG 450,000 bigger, as I understand it, than any of the doctors involved would really like, and there have to be far fewer doctors involved from each of the districts. In my own district, it was going to be a Pendle-wide organisation where all the doctors involved would be known to a lot of people in Pendle, but now there will be just a small number from Pendle and some from Rossendale and some from far-flung parts of the Ribble valley. Meanwhile in west Lancashire, along the Fylde coast, where there is a string of small holiday towns with Blackpool in the middle and then a large area of countryside, are the two districts of Fylde and Wyre while Blackpool itself, the main town of the Fylde coast, is a unitary authority. What we understand is going to happen there—I have no direct evidence of this, it has come through the bush telegraph—is a CCG of Fylde and Wyre, a relatively smaller one, with Blackpool on its own. Of course all the hospital services and everything else are mainly in Blackpool. There does not seem to be any logic about what is going on, even though it is being defined by local authority boundaries.

I ask the Government to provide some clarity over what is happening in two ways. First it would be very helpful to have clarity on what is actually happening in each area, and for this whole process to be taking place in a much more public way. But it is not. It is all taking place out of the public gaze, and unless there are local journalists who are particularly interested in it and try to research it, nobody has the slightest idea what is going on, whether or not it is being decided locally.

More importantly, I accept what the noble Baroness, Lady Murphy, says, but I think that we need an understanding of the sort of pattern which is going to result from this Bill once it is enacted and the CCGs are set up. We want a clarity of vision from the Government. What sort of number are they talking about? What range of size will be thought to be permissible? If they are saying that it could stretch from areas of 15,000 right up to a major city of half a million or so, and that sort of thing will be left to some sort of diffuse local decision-making, then that is okay, but we need to understand that. If, on the other hand the Government are saying that a lot of the groups that have been looking at this are far too small and they have to be much larger, then they are really moving towards what I might call the Lord Warner position, and again we need to understand that. We have a right to know what the outcomes of this legislation are likely to be before we allow it to go forward.

Baroness Wall of New Barnet: My Lords, the noble Baroness, Lady Jolly, has made a very strong argument for what might happen in her part of the world. However for London it is very different, and I want to remind noble Lords that this is about health and social care, and relate what happened in my area.

My trust is part of north central London and that cluster is now going to be merged with north east London. The cluster has been a great improvement on the separate PCTs, not just because of the way they do things, but in the whole vision they have of the health economy. One of the things that we suffered from in Barnet and Chase Farm and North Middlesex was that we were all separate, independently operating providers. We just took notice of what we were providing and what was happening around us. The BEH—Barnet, Enfield and Haringey strategy—made us look beyond that at the whole health economy. The evidence is that we have been failing in not providing social care or community care because each individual provider was looking at what was happening for them and its importance to them.

I can only share the experience that is happening in London. My view is, and our experience as a trust is, that the bigger the cluster has been and the bigger the cluster will become, the more opportunity there is to ensure that the whole health economy of the people that we serve is going to be taken into account, rather than that minuscule Barnet PCT, Enfield PCT or Haringey PCT. I know that they are much closer than Lancashire, and I come from Lancashire, so I recognise some of those areas. People are questioning what is happening in London, and it is very different. The smaller the groups, the worse it is, in my experience, because we are not addressing the whole economy.

I believe, as the noble Lord, Lord Warner, has said, that we need a much broader and wider experience in the sense of the numbers that we might have. I do not know how big is big or how good is big. What I do know is the difference that it has made, in my experience, across London, that the bigger we have got in the sense of the clusters, the better the service has been and the more able we have been to take our eye away from just acute providers to looking at what is going

on in the community. We have failed to do that, and all the debates that we have been hearing in the House during the passage of the Bill have identified how much we have been failing. Most of the social care issues that we have discussed are about how we failed. In my view, as a chair of an acute trust, it is about us being focused on patients coming in to hospital rather than patients being able to have their provision elsewhere. From my experience in London, we need less of them, so that we get a complete health economy view.

7.15 pm

Lord Greaves: What the noble Baroness, Lady Wall, says is very interesting. Does she understand what the future pattern of CCGs in that area is going to be in relation to the borough PCTs and the clusters that she is talking about?

Baroness Wall of New Barnet: In my experience, the PCTs, in a sense, do not exist any more, in my part of London; I am not sure about elsewhere. Contrary to what the noble Lord, Lord Norton, suggested, it has not happened in London. All the PCTs have not been absorbed into the cluster. The chair of each of the PCTs that were in place before the cluster and the growth of the cluster has been seconded as chair of their particular PCT. For me, the important thing is who is making the decisions about the commissioning and what view they have. What is the panorama that they are looking at, rather than the closeness of the individual boundaries? Certainly from the PCTs in London, the clusters are taking over the way that is going more and more; and their relationship with the GP commissioners is much closer than it ever was in separate PCTs, and that has been part of the issue.

Lord Greaves: I am really impressed by the enthusiasm shown by the noble Baroness. I understand exactly what she said. The way in which the clusters have been put together is exactly the same, as I understand it, as in Lancashire. What I am trying to get her to tell us, if she knows, is how many CCGs there will be in the area of her cluster once the clusters have disappeared.

Baroness Wall of New Barnet: I cannot answer for the whole of London. I really do not know. What I do know is that the more the clusters emerge, obviously the more those PCTs will be absorbed into them. My noble friend will be much more able to give you more detail about that.

What is happening in real life in north central London is that the PCTs are being absorbed into the cluster. Contrary to the experience of the noble Lord, Lord Norton, the clusters have not just taken over the whole PCTs, including staff and everything else; they have not. In fact, the chief executive of the cluster in north central London did not come from north London at all. So that is very different, I think, from some of the experiences that other people have. However, I cannot give you the view of the whole of London because I really do not have that knowledge.

Lord Hunt of Kings Heath: My Lords, perhaps I could intervene to say that I echo everything that my noble friend said about the work of the clusters. They are covering, in my case, some 1.3 million and clearly are trying to get to grips with the strategic leadership that is required on the whole issue of reconfiguration of bed numbers and all the things that have been put off for so long. My understanding is that they go on as local field offices of the NHS Commissioning Board. That is the whole point. The question that then comes back, and where I am completely puzzled, is where on earth is GP commissioning in this? It is abundantly clear that the clinical commissioning groups are going to have very little influence. When you come to the issue of the individual GP, which was what this was all about, it is very hard to see what on earth they will be doing in terms of commissioning.

Lord MacKenzie of Culkein: May I intervene briefly, as I have my name down to Amendment 168? This has been a very important debate, and I want to return briefly to the issue of collaboration. Whatever the outcomes in size of the clinical commissioning groups, there will be a need for joint commissioning. I refer particularly, as the noble Baroness, Lady Finlay, has said, to some of the rare conditions, such as many of the neurological conditions, which will require a population, as I understand it, of some 250,000. For motor neurone disease this will be a population of some 500,000. It is vital that we have in the Bill something about joint commissioning for long-term illnesses. We will come back to that issue in a later group of amendments, but I want to emphasise its importance.

Baroness Tonge: My Lords, before the Minister gets up, I would like to ask him a very simple question. Noble Lords will have all realised by now that I have no faith in this Bill whatever, and never have had. I think it is totally unnecessary in the current economic circumstances, let alone other circumstances. Will the Minister tell us honestly what the reason was for clinical commissioning groups? Why could we not have kept the PCTs in whatever clusters they have formed together, and put clinicians, GPs, dentists and nurses into those groups to lead the commissioning process? Why did we have to have this massive upheaval to achieve what, according to what most of the speakers here tonight think, is not going to be achieved anyway, as the GPs will not have much input? Perhaps he could explain.

Lord Newton of Braintree: My Lords, I apologise for intervening a second time. I want to link with things I raised the first time, because I have been left in some confusion by the noble Baroness, Lady Wall—which is not her fault—about what has been happening in London. My understanding is that at the beginning of the year the department issued a document suggesting four possible ways of doing clustering. One was along the lines that the noble Baroness spoke about. I forget what all four were, but one was that PCTs should informally group in clusters, create an informal board, and have one of the chairs, perhaps a rotating chair in some cases, who would oversee the informal cluster board. The legally existing boards would continue.

At the back end of September, the department, at least as interpreted in the east of England, issued an edict saying that there were no longer four options.

[Lord Newton of Braintree]
There was to be one, and it would be clustering, based on appointing the same people to more than one PCT board. That raises a number of issues, as my noble friend Lord Mawhinney has indicated with unmistakeable clarity, to which he and possibly I might wish to return later. Meanwhile, how many legally separate PCT boards exist at the moment, who is on them, and were different policies pursued by the department in different parts of the country? What the noble Baroness—my noble friend—Lady Wall said suggested that a different policy had been pursued in London—not for the first time, I may say—than was being pursued in the east of England at least, and possibly everywhere else. We need some clarity, not just on what the future is going to be, but what the present is.

Earl Howe: My Lords, the principle behind clinical commissioning is that decisions about local services should be made as close to patients as possible by those who best understand their health needs. This is why the membership of CCGs should comprise GP providers, rather than other primary care providers, such as dentists, opticians and pharmacists who do not have the same relationship with patients or responsibility for a registered list. I hope this answers the question posed by the noble Lord, Lord Hunt, in his Amendment 154. However, of course effective commissioning will require the full range of clinical and professional input.

Although the members of clinical commissioning groups will be GP practices, the groups will be required to obtain advice appropriate for enabling them to effectively discharge their functions from a broad range of healthcare professionals. So this is not a matter of other professions being shut out; quite the opposite. Other professionals may also be invited by the CCG to be members of the CCG governing body and, as regards nurses, regulations may require that governing bodies include certain healthcare professionals, such as a nurse and hospital doctor. Also, other clinicians could be directly involved in influencing the decision-making of the CCG through, for example, membership of a committee of the CCG, without needing to be members. The basic point is that the function of clinical commissioning is directly linked to the function of the general practitioner and we should not risk diluting the effectiveness of the proposed approach.

The noble Lord, Lord Hunt, suggested that CCGs will not be led by clinicians. I am surprised to hear the noble Lord say that, especially as he has been paying tribute to the work of the NHS Alliance and Dr Mike Dixon for whom I, too, have a high regard. I understand that when Dr Dixon spoke at the NHS Alliance Conference this morning he said that we stand close to liberation of clinicians on a grand scale. That indicates to me that he believes that this is a huge opportunity for primary care clinicians.

My noble friend Lady Tonge asked what this is all about. The philosophy behind these new organisations is different from what we currently have. Clinical commissioning is about placing the financial power to change health services into the hands of those NHS professionals whom the public trust most and giving GPs the flexibility within the legislative framework to join together in the group they want to form, just as they will have the flexibility to commission services in the ways that they judge will deliver the best outcomes for patients.

The Bill sets out high-level requirements for working together, including at new Section 14Z1 in Clause 23 provision for CCGs to enter into arrangements with other CCGs to exercise their commissioning functions. That addresses the point that was made earlier about commissioning for groups of patients who are smaller in number in a small area. One has to commission at the right level. These can include both joint and lead commissioning arrangements and this may be a topic which the board chooses to cover in its commissioning guidance.

The process of the local development of commissioning organisations is well under way, with pathfinders—emerging CCGs—coming together to begin to explore approaches to commissioning and building up their organisations, supported by the PCT clusters, about which I will talk in a moment. The board will be responsible for undertaking a rigorous assessment of all prospective CCGs, prior to authorisation, to ensure, for instance, that they are of an appropriate size, that they cover an appropriate area and have put the appropriate arrangements in place to be effective commissioners. I would say to my noble friend Lady Jolly that there will be a presumption in favour of coterminosity with local authority boundaries. But as we have previously discussed, and as advised by the Future Forum, local flexibility must include, in exceptional circumstances, the flexibility to cross a local authority boundary where that is appropriate to patient flows.

I am afraid that I do not agree that we should place arbitrary constraints on the number of CCGs or on their budgets as Amendment 157 would do. I appreciate the keenness of noble Lord, Lord Warner to ensure that the maximum resources available are devoted to patient care. The Government share that concern, but way to do this is to ensure appropriate controls over administration costs and ensure good governance on how that money is spent and the outcomes that it delivers.

Lord Mawhinney: My noble friend said that they would have to decide on the appropriate size. Does he know what that size is approximately likely to be, and if so could he share it with us? Or is that something that is still to be determined?

Earl Howe: I am grateful to my noble friend and I was coming on to that very point, which was a question posed by the noble Lord, Lord Warner and others—my noble friend Lord Greaves expatiated on that theme. Our starting point is this: we do not wish to be unduly prescriptive about the size of clinical commissioning groups. There have been widespread variations in the size and population coverage of PCTs and there is no evidence to suggest that there is a single right size. If one looks at the history of the National Health Service over the last 20 years it has been an attempt by successive Governments to find a right size and we never quite succeeded. It is important that solutions develop from the bottom up and are not imposed from above.

Lord Greaves: I apologise for intervening, but if that is the case can my noble friend the Minister tell me who told the group of GPs in Pendle, who had been developing proposals for a CCG, that they would have to go in with the other four districts in East Lancashire?

Earl Howe: My Lords, in those instances, and they are very few, where a pathfinder CCG is of a manifestly unviable size, then it is right that they should receive advice to that effect at an early juncture. Advice is the word. The initial thinking is simply suggesting that emerging groups should be considering the impact of their proposed configurations on their organisational viability and the degree of sharing roles and functions or the use of commissioning support that they might need.

Lord Greaves: Is my noble friend, therefore telling me that a well defined borough with a population of 90,000 is manifestly unviable for this purpose?

Earl Howe: No my Lords, I am not aware of the specific circumstances that my noble friend refers to and of course I will find out and give him greater chapter and verse if I can.

Lord Warner: I thought I would get my question in before the noble Lord gets warmed up again. He said there is no indication from the evidence from the past of what the right size for a PCT was, but there is some evidence from the past. I do not think that there was ever constructed a PCT of under 100,000 population, which compares with 18,000 in Radlett for a CCG. If you actually look at what happened when we asked PCTs and SHAs to work together and engage in local consultation in 2005-06 on reformulating PCTs, the general thrust of what they came forward with was twofold: it was to be bigger in size and to be a better match with the boundaries of the upper-tier local authorities, which were the social services authorities. So there was some evidence that people themselves, when engaged in an exercise of reorganisation, moved towards bigger organisations and coterminosity with social care authorities.

Earl Howe: Earlier on I noted that the noble Lord drew parallels between CCGs and his attempts when he was a Minister to reduce the number of PCTs. I do feel there is a critical difference. The decision to establish a certain number of PCTs was taken in Richmond House by Ministers. I am not saying those decisions were arbitrary—of course they were not—but they certainly were not bottom-up. With CCGs, the onus is on GP practices to determine the most appropriate size and configuration for their local population. As I have said, the board will then rigorously assess whether this proposal will result in the CCG being able to fulfil its functions. That is a judgment, but it is a proper fitness for purpose test which PCTs never had to go through. I simply do not accept that, come April 2013, there is likely to be a raft of CCGs failing. If a CCG's proposed constitution is not robust, then it will not receive full authorisation.

Lord Hunt of Kings Heath: I do not think that is quite fair, since I was involved in setting up PCTs. I accept the strictures of my noble friend about whether we made them too small. As for the idea that Ministers came up with PCTs, it was of course the service which, basically, came and made recommendations. Frankly, the same tiers are deciding on CCGs as decided on PCTs. There has been huge pressure on CCGs to come together and merge. Yes, it started as a bottom-up idea, but I have to put it to the Minister that the reason why I quoted Dr Mike Dixon is because he, like many people, knows that the "forces of bureaucracy", as the noble Earl, Lord Howe, likes to put it, have been very strong and have basically said to CCGs that they will not get anywhere unless they merge.

Earl Howe: Yes, the noble Lord, Lord Hunt, suggested earlier that there was a process of shoe-horning CCGs into certain shapes and sizes, forcing them to take up external support and merge commissioning functions. I emphasise that CCGs will not be forced to take up external support or merge functions. What is happening at the moment is a process of advice and information from the centre. Obviously, the board will not authorise the establishment of any CCG which could not satisfy the board of its ability to discharge its functions and be an effective commissioner. We want to ensure that the process is not too bureaucratic or cumbersome. The noble Lord suggested that it was likely to be, but I do not accept that. We are working with stakeholders to ensure that emerging CCGs can articulate their requirements for commissioning support. I do not accept the picture that he has painted.

My noble friend Lord Newton spoke about the clustering of PCTs. Clusters bring together PCTs to prepare for and support the transition to clinical commissioning. Until PCT abolition in April 2013, they continue to exercise their functions and remain statutorily responsible for their functions until abolition. Pathfinders, or emerging CCGs, can act as sub-committees of PCTs until this time. The role of PCT clusters during the transition is to support clinical commissioning groups, not dictate how they operate. For the reasons that I have stated, it is important that CCGs have the freedom to develop their own solutions from the bottom up and that they are fully supported in doing so. The latest operating framework for the NHS emphasises this and we will see that it is acted upon.

My noble friend Lord James queried the legal arrangements. The process of clustering has been open and transparent. If it is acceptable to noble Lords, I can provide a written update on the latest position, giving the numbers, locations and so on, to save time.

Lord Greaves: If a CCG pathfinder can operate in the mean time as a committee of the PCT, will it act as a sub-committee of the PCT or of the cluster?

Earl Howe: Of the PCT, because the cluster has no legal standing.

Lord Hunt of Kings Heath: My Lords, I thank the noble Earl, Lord Howe, for his response. This has been a really good debate, which has gone to the heart of the Bill and the Government's intentions. I would like to come back to a point that the noble Baroness, Lady Murphy, made when she reminded us of the central tenet of the Secretary of State. Essentially it is that

[Lord Hunt of Kings Heath]
GPs are responsible, like GPs the world over, for most expenditure in the NHS, either through their referrals or through their prescribing decisions. The clear intent was to put budgetary responsibility with referral and prescribing responsibility, in the hope that it would lead to a more cost-effective system. I think the issue that many noble Lords have is that in the way this has emerged and in the guidance that has been given by the board and the department it is becoming clear that the influence of the individual GPs within this huge structure that is being established is likely to be very limited. On the other hand my Lords, because of the mantra of the Bill and the reforms, patients are likely to believe that it is their GPs who are making the commissioning decisions. Therein lies trouble, because I think the GPs are going to be in a very unenvious position. We as patients will hold them to account for commissioning decisions in a way they have never been held account before, but their influence on commissioning is going to be very limited indeed. I think this has been a very good debate, I beg to withdraw my amendment.

House resumed. Committee to begin again not before 8.41 pm.

Prevent Strategy

Question for Short Debate

7.41 pm

Asked By ***Lord Noon***

To ask Her Majesty's Government what are the implications for integration and extremism in the United Kingdom of their Prevent strategy.

Baroness Stowell of Beeston: My Lords, I hope noble Lords will find it helpful if I remind the House that the next debate is a time-limited debate and, with the exception of the noble Lord, Lord Noon and my noble friend the Minister, speeches are limited to four minutes. The right reverend Prelate the Bishop of Hereford has also requested to speak in the gap.

Lord Noon: My Lords, the Government's revised Prevent strategy was presented to Parliament in June this year. It is an integral part of the broader fight against terrorism and I welcome the opportunity to have this short debate about the implications of this strategy, and of extremism and integration. The thinking behind Prevent was that there needed to be a proactive response to the threat of so-called home-grown terrorists. I do not want to speak about the merits or failure of the original strategy. Other noble Lords, including my noble friend Lord Carlile, who provided the important independent oversight for the review of Prevent, are much more of an authority on this issue than me.

I am not a policy man, I am a businessman and I like to speak my mind in a straightforward way, which, in business as in life, is usually the best way. You may be aware that I have been a victim of deadly terrorist attack not once but twice. The extreme fear that I and my family experienced, the shocking uncertainty of being sandwiched between life and death, brought home forcefully the grief and devastation of the families who suddenly, unexpectedly lose loved ones. We have seen this horror here in the UK with the 7 July terrorist attacks in London. What is worse is that the 7/7 attack was carried out by young men born and brought up in the UK. The Prevent strategy is supposed to stop people from ever going down this path. It is about confronting people at an early point so that they do not become extremists.

Christians, Jews, Muslims, Hindus, Sikhs, Jains and Buddhists all have the right to practise their religion freely in Great Britain. The strong civil rights movement here ensures that we can express our religious and political beliefs freely. At the same time, there is a thousand years of tradition of the supremacy of the law—we must abide by the law even as we practise in private the faith of our choice. What has gone wrong is that a tiny minority refuse to accept that. Instead they wish to impose their beliefs on the majority. Noble Lords will agree with me that the majority of Muslims are law-abiding, peaceful and patriotic citizens, as was reported in the *Sunday Times* on 20 November. I see no conflict between practising Islam and abiding by the rules of the law of this country, and I speak as a Muslim.

I have expressed my views many times, in speech as well as in print. People who do not accept the British way of life should find another acceptable country where they can live happily, and leave us alone. Often they come here as economic migrants and then oppose our common values. In many cases, they are running away from harsh regimes that do not permit dissent. I am a staunch supporter of the British values of democracy, decency, fairness and integration. I say, live and let live. We should give a robust retort to those who oppose integration: we cannot have small, independent enclaves within our country that are a law unto themselves. I agree with the Prime Minister's words in Munich earlier this year that we have not done enough in standing up to those who oppose our way of life.

I find it confusing that the Prevent strategy makes a distinction between two things. On one hand, the strategy says that having a strong sense of belonging and citizenship makes people more resilient to extremism. Then, on the other hand, it states:

> "Policy and programmes to deal with extremism and with extremist organisations more widely are not part of Prevent and will be co-ordinated from the Department for Communities and Local Government".

Could the Minister tell me what these wider policies and programmes are that are not part of Prevent? Surely these are things that promote cohesion, interfaith dialogue and citizenship. If the success of the programme depends on our sense of belonging—which is what I call integration—then how could this not be a part of Prevent? By separating integration and extremism, the Prevent strategy will create its own pitfalls. How do local councillors know what to do? Where is the guidance that explains how to know the difference between an extremist acting against our country and others who need support and direction to become more integrated? Where is the line drawn between dealing with extremists and promoting integration? Surely these are two sides of the same coin.

What about young people? How will the youth worker or the teacher know what to do? We need a strong initiative for the youth; after all, it is the youth who get lured into extremism at youth clubs and universities. The hunting field for fresh recruits to terrorism are the stamping grounds of young people. That is where we need to be: to reorient them into a life of decency; to give them a sense of belonging; to make them proud to be British; and to make them see that using religion as an excuse for violence goes against its very tenets.

What about the police? I often speak to them on this issue. I ask them why individuals or groups who are violently opposed to our way of life and the laws of this country are allowed to be here. The police say that their hands are tied; they often have no case. It seems that the human rights of criminals outweigh those of the rest of us law-abiding citizens. Even when they manage to bring such a person to court, the Crown Prosecution Service tells the police that the criminal is the one who needs protection. It strikes me that in trying to make Prevent more focused, the Government have risked making it less effective. Even more seriously, I believe that this fudge makes things much worse. It risks further alienating those communities that feel the most stigmatised and targeted by Prevent, especially the Muslim community.

The danger of focusing only on a certain religious group was made clearer to us by the terrible events in Norway in July this year, when a right-wing extremist not only set off a bomb in the city, killing eight people, but then went on to shoot and kill 69 innocent children and young people who were taking part in a summer school. Such acts of extreme violence are not restricted to ideology, whether religious or political. Rather, these terrible acts are born of hatred, racism and ignorance. We ignore these risks at our peril.

In summary, I have a very simple bottom line, which is that preventing terrorism depends on strengthening integration. In my straightforward way of looking at things, there is definitely a problem because the strategy actually causes confusion about this issue. I welcome the idea that we need to confront people more when they express extreme ideas such as threatening to burn poppies, abusing our brave soldiers returning home from the front line in Basra or asking for Sharia law in this country. Let us not forget honour killing, although I do not know what honour there is in killing. Surely this is not acceptable. We need to go further. We need to ensure that we not only confront these people but that we actually deal with them in order to protect the citizens of this country. We need to be clear that this is about anyone who opposes our way of life, anyone who does not clearly stand up for democracy and freedom of choice. Integration is our greatest strength and we must not allow our resolve to protect it to be weakened by a muddled approach to extremism.

I am sure that noble Lords will have many further issues that they wish to bring to this debate, and I look forward to hearing them.

7.51 pm

Lord Ahmad of Wimbledon: My Lords, first, I thank the noble Lord, Lord Noon, for initiating this debate.

9/11 and 7/7 changed Britain and the world. From London to Lahore, from New York to New Delhi, terrorism cannot be ignored. A new kind of terror emerged with 9/11, as we saw on 7/7, attacking the very basis and basics of British society—a society enriched by its secular democracy, multitude of faiths and diversity of communities. The terrorists used the ultimate weapon, destroying their own lives to take the lives of others. They sought legitimacy then, as they do now, 10 years on, by cloaking their vile and heinous acts in the name of religion—of Islam. Yet these criminal acts are far removed from the principles of Islam which, not only in its teachings but in the essence of its very name, stands for peace. Islam unreservedly and totally rejects all forms of terrorism and violence. Islam—indeed, all religions—cannot sanction violence and bloodshed of innocent men, women and children in the name of God. However, the reality is that there are some who seek to hijack noble religions and principles, to perversely interpret them and through their misguided actions, often fuelled by extremist preachers, seek to bring about terror. As 9/11 and 7/7 demonstrated, they succeed in carrying out such acts.

Against this backdrop of real and present danger which surfaced 10 years ago and continues to this day, we need to take action on prevention and, more importantly, a permanent and lasting solution to eradicating this evil from our society. Therefore, I welcome the new Prevent strategy, for it recognises the need to tackle the ideological challenge and the threat from those who promote terror and extremism. It is not aimed at those with legitimate religious beliefs. As my right honourable friend the Prime Minister has said, to be devout in faith should not be equated to extremism; indeed, if you are truly devout about faith you are anything but an extremist.

Prevent deals with all forms of terrorism, but I seek my noble friend the Minister's assurance that, while wider programmes dealing with extremism and its implications do not fall under the regime of Prevent—they are co-ordinated by the Department for Communities and Local Government—there is no disconnect between the two, as the noble Lord, Lord Noon, has said. I would further ask that educational programmes aimed at curbing the rise of extremism in our future generations—such as the excellent 9/11 Education Programme, launched nationally in September this year and already rolled out to 20 schools, supported by many, including my noble friend Lord Fink—are also co-ordinated with a more cohesive programme. I would also seek the Minister's assurance that stringent steps are taken to eradicate these extremist preachers who come to our shores to preach hate. There should be a simple message sent to them: they are not welcome.

Prevention of terrorism, integration of communities —as the noble Lord, Lord Noon has said—and education of our future generations are all part of the same equation. They are three essential components which form the basis of eradicating extremism, protecting the deep-rooted and long-established traditions of our country and providing the lasting solution we all greatly desire.

7.55 pm

Baroness Hamwee: My Lords, the noble Lord, Lord Noon, has asked a most important question. In the short time available I want to focus on integration and make one point. I wonder whether the answer to the noble Lord's question is partly characterised by the speakers list that we have tonight—10 speakers. How many of us are what my late noble friend Lord Jenkins termed "ancient Britons"? I think it is a fair bet that the eighth Baron Henley is. I do not want to make assumptions about the noble Lord, Lord Rosser, but excluding the Government and Opposition Front Benches, look at our names. Mine is because my family, not very long ago, came from Hama in Syria—a place where I am very glad not to be.

Is it that our speakers tonight feel a particular responsibility to take part, and should it rest only on their shoulders? Beyond this House, have we made assumptions about who should integrate with whom, about who needs to take active steps and who can sit back and dissociate themselves from the issue? Have we made assumptions about "us" and "them"? Have we made assumptions about what Britain today is or should be? It is not the same as when I was born. It is not the same as when Victorians ruled the world—and on that subject I have said before in the context of immigration that I find the term, "the brightest and the best", whom we are seeking to attract, very difficult because of its implications. It takes us to the question of what we think is the Britain into which we are seeking integration. Integration, of itself, does not secure loyalty to a set of values or instil patriotism; they are more than learnt behaviours. It is about a view of society and one's place in it, and perhaps we should be talking more about social cohesion in a wider sense.

I know that far more is going on than just the Prevent strategy. Both noble Lords who have spoken have referred to this, but I think it is important not to do anything to consolidate the widespread view that a particular ethnic background or a particular faith and terrorism are in any way synonymous.

7.57 pm

Baroness Prashar: My Lords, I, too, want to thank the noble Lord, Lord Noon, for initiating this debate. The new Prevent strategy states that a clear distinction between counterterrorism work and integration strategy is necessary if it is to succeed and that the two must not be confused but, as has already been said, there is a fundamental link between fighting home-grown terrorism and creating a more integrated society. While the government strategy recognises that, we do not have a clearly understood and clearly articulated policy on how to develop a sense of belonging, how to create support for our core values or how to encourage integration. If anything, it is rather muddled.

Britishness was seized upon as a way of building a cohesive society, and multiculturalism was seen as divisive, but cultural diversity and pluralism do not threaten cohesiveness; inequality does. They are in fact the essence of Britishness. For a plural society to be successful, we need shared respect for and loyalty to the law of the land. In seeking to promote diversity, we must not stifle robust discussion or debate on issues that are of legitimate public concern, no matter how unpalatable they are. We need more, not less, freedom of speech to combat the propaganda promoted by extremism. We need open, frank dialogue and debate to enhance understanding between different communities and religious groups. We need to cherish diversity without undermining our common bonds of citizenship and respect for the law, thus helping what I call the evolution of a plural society through democratic processes. We need to work to inculcate this in our citizens, particularly the young. The Prevent strategy recognises the need to work with sectors and institutions where there is a risk of verticalisation. Universities are such institutions, not just as informers, though that may be necessary, but as promoters of free speech. Universities are reluctant, for they fear to be seen as curbing freedom of speech. Propaganda machinery must not be allowed to hide behind the pretence of freedom of speech and claims of human rights. Distorted and loaded messages that manipulate the young must not go unchallenged. Universities are well placed both to challenge propaganda designed to radicalise students, and also to provide experience of rational debate in safe spaces. As John Ruskin said,

> "Education does not mean teaching people to know what they do not know—it means teaching them to behave as they do not behave",

as members of the family, of the community, of the nation and of the world. To succeed in the long run we need to challenge and deal with those promoting extreme ideology, but also to provide safe spaces like universities and other educational institutions, where learning about citizenship can take place. We also need to develop a consistent narrative about what a vibrant, diverse and integrated society is. I hope the Government will promote that.

8.01 pm

Lord Sheikh: My Lords, this coalition Government spent over a year reviewing the Prevent strategy and produced a clear, focused strategy on tackling extremism, as well as focusing resources on key institutions like universities, prisons, schools and colleges. This strategy looks at countering the ideology rather than just the violent action of extremists. This is the fundamental difference between the previous Government and this one.

People who espouse extremist views may be more prone and susceptible to being primed and moulded towards extremism, especially if they live in segregated communities and have little interaction with other communities. Extremism is also based on people being excluded and separated, and these are ideas that we should not allow in our communities whether they are al-Qaeda inspired, or whether they are far right or EDL-inspired. Separation and segregation have no part to play in our modern state. These phenomena have been rejected globally and they must equally be rejected here. There is a link between extremism and a lack of integration, and we need to acknowledge this.

However we must be more nuanced in our understanding and approach towards communities. We must acknowledge that there are groups of individuals

who are integrated in every sense of the word. They work, they speak English, and they are living quiet and happy lives in different parts of our country. Yet they choose not to engage with other communities and they may also feel aggrieved and angry at what is taking place regarding international or domestic issues that affect their fellow brothers and sisters. These people cannot be viewed as being non-integrationist, but they may hold extreme views. They may, however, not be patriotic about this country, though that is different from not being integrated. The link between extremism and a lack of integration is not clear in these cases, and we must be aware that there are a set of competing circumstances affecting different communities. I firmly believe that we have moved in the right direction in terms of the Prevent work, which is now being undertaken, which is much more focused on interventions and countering extremist ideology. There is no simple solution around integration, and we need to look at situations in different parts of the country and with different generational groups, through multiple lenses and not through one single lens of understanding. Yet a lack of integration may leave some persons more susceptible to manipulation and thereby be used to promote extremist ideology. Sometimes the lack of integration can be self-imposed and the individual concerned may be completely devoid of extremist narratives and ideologies. Yet we can all agree that communities need to celebrate being part of their local areas and do all they can to make these areas places where they feel that they have a future.

At the very least this is the healthiest option we can take. I would like to end by saying there was a survey published in the *Sunday Times* a few weeks ago which found that Muslims are more patriotic than the rest of the population. This shows Muslims have gone a long way towards integrating with society and shows Muslims in a different light compared with what is being portrayed in the media. Islam is a religion of peace and this philosophy is shown visually in my coat of arms.

8.05 pm

Lord Patel of Bradford: My Lords, I am most grateful to my noble friend, Lord Noon, for having introduced this debate. Prevent is a very important strategy and one that I am very familiar with, having been asked by the previous Secretary of State for the Department of Committees and Local Government to undertake a rapid review of the original Prevent strategy. Over a period of several weeks, I visited 12 local authority areas and spoke to more than 700 people about their experiences of and attitudes to the Prevent strategy. The confidential report that I produced for the Secretary of State outlined a number of areas where I thought there needed to be improvements. Some of these issues have been addressed in the current revised strategy, which on the whole I welcome, but there are two particular issues which I believe need further clarification. Firstly, how are people, especially young people, engaged in Prevent? Secondly, how are professionals and elected officials being given the skills and confidence they need to challenge extremism and the way in which this causes further segregation between communities?

I shall speak first about the engagement of young people, and as the chairman of an organisation called the International Forum for Community Innovations, otherwise known as TIFCI. TIFCI works with a wide range of community groups across the country and has just finished a piece of work on extremism and the risks for young people from radicalisation. The work explored the issues for young people and the particular risks they face from radicalisation and extremism. During the course of the work TIFCI spoke directly to over 130 young people and children of both sexes, from a wide range of ethnic, religious and cultural backgrounds. In the first place, the risk they most strongly identified was that from the far right, particularly the EDL, which they perceived to be causing disruption and harm to their sense of belonging and community cohesion. We very clearly should not take our focus off the threats posed by the far right. But what struck me even more strongly was the near universal view that, as young people—a key group who are identified as being most at risk—they were not actively consulted or involved in finding solutions and strategies to deal with the problems. Many of them said, when commenting on the work programme of TIFCI, that it was the first time anyone had even asked them about this issue. Does the Minister agree that young people, especially those at risk, should, wherever possible, be involved in and actively engaged with any work undertaken in this area and could he say something about what is being done to encourage this?

From my experience, including the work that I did reviewing the previous Prevent strategy, I believe that the second key issue concerns the skills and confidence among professionals and elected officials on the ground and their ability to challenge people and to address some of the issues that divide our communities. I strongly believe that they have not been adequately equipped to do this. Sadly—I have seen evidence of this many times in my work on community engagement—there remain deep divisions in our society and too many communities live separate lives, having little or no contact with their neighbouring communities even within their same town or ward. I agree with my noble friend Lord Noon that it is this division, the lack of community cohesion integration that is the greatest threat to our security. It is in this failure to have people meeting and interacting with each other outside their immediate family and community networks that this greatest risks of extremism and radicalisation take hold. If we recognise this then we can start to move away from thinking simply about one religious group or another and begin to work with whole communities and finding solutions that truly promote integration and challenge extremism. This is going to take high quality training for professionals and elected officials and at local levels we need to see clear implementation plans that provide direction and leadership. I would be very grateful if the Minister in his closing remarks could explain what plans are being developed to implement training and capacity building for professionals, youth workers, social workers, and very importantly, elected officials, to ensure that they can take the leadership on addressing these important issues at a local level.

8.09 pm

Lord Hameed: My Lords, I convey my tribute to the noble Lord, Lord Noon, for introducing this subject this evening. In 2011 we live in a world of extraordinary progress and opportunity and yet it is a world in which 1 in 5 people lives in abject poverty. One in 6 children never reaches their fifth birthday and 115 million children worldwide do not even go to primary school; and with poverty comes a multitude of other bad things. And yet, it is nothing like the only reason why one group resents another, but it is a big reason.

Poverty is also a reason for our concern about terror, and the real and perceived threat of violence, locally, nationally and internationally from radicalised or marginalised people. Their route to terrorism can be found in many things: in fate, ethnicity, culture, nationality, poverty, economic and political causes, and more. A lot of people readily associate terror with religious fundamentalism. Any religion can be vilified, and indeed in this country we have known militant Christianity and militant Islam. The great contradiction of fundamental politics—its epic flow—is that it cannot deliver on the greatest problem that provokes its rise, which is economic deprivation.

Rage is not an economic policy. Violence is not the antidote to economic progress. It can succeed at moments of high social stress, or public rage. Ordinary people hunger for bread, not guns. This is what keeps the overwhelming majority away from fundamentalism. The bad news is that it takes less than 1 per cent to wreak havoc upon us.

We have here in the United Kingdom a multi-religious and multiethnic society. Here dialogue is the only way forward for addressing our differences. We ought to celebrate our commonality and discuss our differences based on mutual respect and trust in each other. It is imperative that we engage in a continuing dialogue. This dialogue is no longer the luxury of a few well-meaning individuals. It has become a necessity, demanding action, without which only catastrophe stares us in the face.

The other message that should go out from us is that Islam, like other faiths, prohibits not only the killing of innocent people, but is most severe on the act of suicide. There is a clear Koranic instruction against taking one's own life. Therefore, let me state clearly, for all to hear, that exploding bombs and firing bullets in an act of suicide, with the intent to kill, and is totally un-Islamic and against the teachings of the Koran. All Muslims must therefore do everything to stop this evil depravity.

The 1.5 billion Muslims who live in this world are peaceful and law-abiding. They also make good neighbours and exercise responsible citizenship, and resent being stigmatised with negative religious profiling, which is inflammatory.

Finally, many Muslims believe that the savage cruelty and cynicism mirrored in the abuse at Abu Ghraib prison, Guantanamo Bay and at Bagram in Afghanistan, as well as rendition flights, waterboarding, and other methods of interrogation are not helpful in our pursuit to harmonise the radicalisation of young people because, more than anything, they are the best recruitment ground for the terrorists.

8.14 pm

Baroness Flather: My Lords, may I first thank the noble Lord, Lord Noon, for giving us this opportunity to say how we feel about this issue? It is a very important issue, and I have given it much thought, over a long period of time. There are now cities in this country with areas where no white people live and no white people go, and usually they are Muslim areas. It is very sad, because in fact the people who live there have no desire to mix with the white people. There is of course a reason for it, and I think the noble Lord, Lord Hameed, has very properly touched on it.

They feel they are disliked by us. The Muslims now feel that people of this country think of every Muslim as a terrorist. That has had a very important and negative effect on relationships. We all know, of course, what Islam is like, but do they know what Islam is like? I am surprised that none of your Lordships has mentioned what happens in mosques, which are the crucial areas where recruitment and "extremisation" of people takes place.

Lord Sheikh: You have made a statement about mosques. Where is your evidence?

Baroness Flather: I will get you evidence, but I do not have it to hand at the moment. I hope you realise that it is happening. Schoolchildren go to mosques every day; they have no time to do their homework and they are falling behind in education. What is wrong with seeing that the imams are properly educated, that they can speak English and that they know what Islam teaches? One of the most important aspects of starting integration is making sure that people who go to a mosque are taught Islam in the proper way, as has been spoken about in this Chamber. I am sorry to say this is not happening.

The second point, which I am very keen on, is that the young—young men in particular—are not skilled in anything. It is time we started programmes for skilling them. Education is important, and they are lagging behind in it, but if we can give them a skill to earn their living, we might see a change in their lives. We do not want young people to not get jobs, to live on benefits all their lives and then start the trend again. Their fathers may be on benefits, they are going to be on benefits, their children will be on benefits. This is what happened in Northern Ireland. We must stop this somewhere. We have to start doing programmes, we have to skill them, and we have to make sure that they are capable of holding proper jobs. This will give them self-respect and respect from other people as well, which is very important. I repeat that we must make sure the imams in the mosques are properly educated and are teaching the people proper Islam, not what they think is Islam. If you talk to young Muslim people, they do not think like that. They do not say "Islam is a religion of peace". They say that they want this country to become Islamic; they want to change this country into an Islamic country.

I am also very concerned about the advent of Sharia, particularly because it is discriminatory against women. That is not the way we live in this country. We have an Equality Act, yet we allow Sharia, which is totally discriminatory to women, to deal with family situations. No boy over seven is given to the mother—he automatically goes to the father. Property rights are not respected. I hope that your Lordships, especially those of you who are Muslims, will do your best to change these things.

8.18 pm

The Lord Bishop of Hereford: My Lords, I am grateful for the opportunity to contribute to this debate. The first objective in the Prevent strategy is,

"challenging the ideology that supports terrorism and those who promote it".

It slightly surprised me that the word "ideology" is used in the singular, when, as other noble Lords have said, there are—sadly and tragically—many ideologies that, in their own different ways, support terrorism. The counter to any bad ideology, whichever it may be, is not no ideology but good ideology. The report refers to core values. The counter to bad core values is not no core values but good core values. The counter to bad religion is not no religion but good religion.

This begs questions for us: how do we learn our good ideologies and our good religion? As we know, these things are not just taught but caught. Therefore, the approach has to be surely one that covers the areas that the report refers to: education, and all the aspects of that to which reference has already been made, but I would also love to see a greater emphasis on the sense of relationship, community-building and integration to which the noble Lord, Lord Noon, and others have referred. There is the need for us to make sure that not only are good ideology and good vision is caught, but there are plenty of examples and that people have the opportunity to catch them because they see them and hear them. I also endorse the truth in the report that this is about process. The catching and the teaching are always about the process, not single steps or single actions. This therefore also emphasises to me the need for integration and cohesion, to which reference has been made by many noble Lords.

Isolation in all its forms needs to be countered. Where individuals or small groups of people are cut off from others, it can help contribute to and provide a soil in which extremism, and the distorted thinking that goes with any kind of extremism, whether it leads to terrorism or in any other way, can more easily flourish and grow. Again I would totally endorse the comments that have been made about the way in which poverty, among other social ills, provides that isolation.

One strategy does not stand alone. I would be delighted to hear the Minister talk about the way in which this strategy sits alongside other strategies and work on community cohesion, the development, building -up and strengthening of our communities and the avoidance of those social ills that cause the very divisions that can further isolate. A strategy like this has to be put within a total context that helps us to strengthen the relationships within communities. As others will know, a research project was undertaken by Vivien Lowndes and Leila Thorp on the Prevent strategy. They identified a community safety focus, a community cohesion focus and a community development focus in three different cities. All of these are about developing community.

Again, the Minister may wish to comment on those insights and help us to understand more about how the Government are working to overcome people's isolation, identify those most at risk to stop them being isolated and stop the unemployment and the other things that help fuel the isolation so that the integration—the interfaith and Muslim forums and so on—can all play their stronger part in helping stronger communities and cohesion and therefore community safety for us all.

8.23 pm

Lord Rosser: My Lords, I add my thanks to my noble friend Lord Noon on securing this debate and for speaking in such a forthright way about his personal experiences and his strong concerns and reservations. Following the bombings in London in July 2005, much work was done on the development of Prevent—work which was largely breaking new ground since it was needed to disrupt the process of radicalisation when there was no previous experience to draw on. The strategy was launched in 2007 and its objective was to seek to stop people becoming terrorists or supporting terrorism both in the UK and overseas. It was the preventative strand of the then Government's counter-terrorism strategy.

In view of the fact that it was breaking new ground, there was clearly going to be a need to review and update the Prevent strategy in the light of experience, including experience of the different approaches adopted. This Government have undertaken such a review as part of their wider review of counterterrorism. An independent oversight of the Prevent review was provided by the noble Lord, Lord Carlile of Berriew. In his preface to the Government's Prevent strategy, the noble Lord said, among other things, that generally, Prevent had been productive.

The Government have said that their Prevent strategy will involve work with sectors and institutions where there are perceived to be risks of radicalisation which need to be addressed. On this point, perhaps the Minister could say what has happened since the review was published in June. We know that the Secretary of State has healthcare providers and universities in mind, so what is she expecting the NHS and universities to do that they have not previously been doing? What has been their response, bearing in mind previously expressed views by Universities UK and the BMA on this issue?

Last June, the Secretary of State said that Prevent was about acting on information from the police, security and intelligence agencies, local authorities and community organisations to help those specifically at risk of turning towards terrorism. Since it involves the security and intelligence agencies, can the Minister say whether the Intelligence and Security Committee will be involved in evaluating the effectiveness of the Prevent strategy? Could he also say against what criteria and objectives will the Government assess the effectiveness or otherwise of the Prevent strategy?

[Lord Rosser]

The Government have said that Prevent depends on a successful integration strategy, which will be the responsibility of the Department for Communities and Local Government. What kind of financial resources will be available next year and in future years, since there have already been significant cuts from the Prevent funding for local councils this year and there appear to be further cuts to come? Police budgets and numbers are also being cut. What kind of priority have police forces committed themselves to give to the Government's Prevent strategy, since the Government have said that Prevent is about acting on information from the police?

The Government have also said that public funding for Prevent must be rigorously prioritised and comprehensively audited. What does that statement mean in terms of the amount of funding for Prevent—not least on training and personnel—that will be provided in future from the Home Office and other departments? Will funding be going up or will it go down? What link-up will there be between the Home Office initiatives and the DCLG integration strategy to ensure that they complement each other? In the House of Commons on 7 June, the Home Secretary said that the Government's Prevent strategy,

"will stop the radicalisation of vulnerable people. Above all, it will tackle the threat from home-grown terrorism".—[*Official Report*; Commons, 7/6/11; col. 54.]

Note that the Home Secretary did not say that the strategy was designed to achieve those objectives, or that it would make an important contribution to achieving them. She said it would achieve those objectives. If it remains the Government's view that their Prevent strategy will single-handedly and without doubt achieve those objectives in full, then I fear that the Government have underestimated the complexity and difficulty of what they are quite rightly seeking to achieve, or that they are as interested in rhetoric as they are in seeking to build on, develop and update in a consensual way the work that has already been done under the Prevent strategy.

8.28 pm

The Minister of State, Home Office (Lord Henley): My Lords, before I deal with the major part of this debate, there are three points I want to make. The first is that my noble friend Lady Hamwee, looking at the names on the list of speakers, possibly said that I was a very ancient Briton. The important thing to explain at this stage is not that I am an ancient Briton, but I am about as Anglo-Saxon as you can get. I will go on to say that I live in a village which I think has a Norse name; my nearest town, the county town of Carlisle, has an old British name; and I live in the county of Cumbria. As the late Lord Cledwyn of Penrhos—a great friend of mine and of noble Lords opposite—always reminded me, Cumbria is exactly the same word as Cymru. They are of the same etymological origin.

I make this point not for any flippant reasons, but to point out that in the United Kingdom we have experienced immigration of one sort or another for many, many years. We have adapted and have place names that reflect the vast array of different people who have come here at different stages and different times. We have gone on accepting immigrants from year to year and over the years. This is something that we should be proud of: the Huguenots who came here, the Jews who had been expelled, and others such as the Normans who came here under rather different circumstances. Possibly we objected to that at the time, but we got used to it later on. These things have been going on for some time. We are all mongrels in this country, and it is something that possibly we should all be proud of. I hope that we can all continue to integrate in the best possible way.

The second point that I want to make before I get on to the substance of the debate relates to the remarks made by the noble Baroness, Lady Prashar, about the need for more freedom of speech, particularly in universities. This touched me particularly as a former spokesman for higher education in this House, both quite recently and before 1997. I certainly agree with her that at times the universities should be faintly embarrassed by what they have or have not allowed to happen in terms of freedom of speech. We should all take note of that point, and I am very grateful to the noble Baroness for reminding us of it.

The third introductory point that I want to make refers to the opening remarks of the noble Lord, Lord Noon, when he talked about that 1,000-year tradition of the rule of law. Whether it is a 1,000-year tradition I am not sure. Sometimes that has wavered a bit, and there have been weaknesses here and errors there. However, I think that he is right to point out that there is something that we can be proud of, something that we should sing about and shout about, and something that, certainly in promoting this country and everything that goes with it, we should talk about and be proud about.

The substance of the debate from the noble Lord, Lord Noon, is on integration and extremism and how they will be affected by the Prevent strategy. There is good evidence that, by international standards, the United Kingdom has a relatively well integrated strategy. That is why I wanted to start with what might have seemed flippant remarks about where I lived in Cumbria and the mixed nature of that over the last 1,000 years; that will happen again in the future. We are told that 92 per cent of people across all ethnic groups say that they feel part of British society; 86 per cent feel that people from different backgrounds get on well in their area; 88 per cent say that they get on well with their neighbours; and 97 per cent agree that it is everybody's responsibility to obey the law. These figures show that we have much to be thankful for and that the Government's approach to integration is building on solid foundations that, again, we can be proud of in the citizenship of this country.

Of course, those figures do not tell the whole story. There are differences from area to area and within areas. For example, a high proportion of people in country towns are likely to say that they get on well with their neighbours, but in some inner-city boroughs the proportion can fall below half. Again, that obviously needs to be addressed. It is in those areas with a lower level of integration that the greatest challenges have to be faced.

It is also in these less well integrated areas that the advocates of extremism are often most active. Groups like the English Defence League and the recently proscribed Muslims Against Crusades seek to spread fear and mistrust in order to generate and perpetuate division and separation rather than integration. Successful policies to promote integration must also, therefore, be capable of countering extremism, in non-violent as well as violent forms.

My right honourable friend the Secretary of State for Communities and Local Government plans to make a Statement to Parliament and publish a document setting out the Government's approach to integration later this year. I hope that the noble Lord, Lord Rosser, will be able to wait for that Statement. In the mean time, the elements of that approach are beginning to take shape. It will be an approach that emphasises what we have in common rather than what is different; draws out the responsibilities that we have to each other and to society; enables people to realise their potential to get on in life; gives people opportunities to work together and to take decisions for themselves; and ensures a firm response to threats to integration like discrimination, extremism and disorder.

These objectives cannot be achieved by top-down design by the Government. Government can create the conditions which enable integration but it is for people themselves in neighbourhoods and in voluntary and community organisations to take responsibility for making it happen in their areas.

To illustrate what Government are doing to create the conditions that support integration, let me give three examples, which have also been touched on by a number of other noble Lords in this debate. First, without a common language, integration will always be constrained and so we are looking at what additional support we can offer to local areas to help isolated women in particular and other priority groups to learn English. Secondly, understanding and co-operation between people of different faiths is pivotal to integration and that is why the Government awarded £5 million to the Church Urban Fund's Near Neighbours scheme, which fosters precisely these ends. Thirdly, we have made integration one of the three objectives of the National Citizen Service. In 2012 this will enable up to 30,000 16 year-olds from different backgrounds to meet each other, to break down the misconceptions that put up barriers between them and to get on together.

As I have said, intolerance and extremism are a threat to integration and to initiatives that support it, such as those I have described. Therefore we must challenge extremism in all its forms, both violent and non-violent, and whether manifested through propaganda, public disorder or incitement to hatred and violence.

If extremists break the law they will feel the force of the law, but even if they keep within the law we shall not stand by. Extremists will be challenged if they use public spaces to promote their ideology and if they publish offensive material on the internet members of the public will be able to ask the police to investigate.

Integration and the Prevent strategy are not the same thing. They are linked but distinct. In the past the distinction between them became blurred and that is partly why the Government initiated a review of the Prevent strategy late last year. The review found that the old Prevent strategy was too far-reaching. It confused counter-terrorism with social cohesion and "securitised" social policy. It was in danger of stigmatising Muslims—a point made by various noble Lords—and reinforced a misperception that all Muslims could be extremists. It created division between Muslims and other communities. It was unfocussed and wasteful of resources. It was concerned only with Islamist terrorism and not other forms. It generated allegations of being a cover for spying on communities. It treated some extremists as allies rather than as part of the problem. It was unable to show that it was effective in preventing terrorism.

The new strategy published in June this year deals with these shortcomings by reaffirming Prevent's place within CONTEST, as part of the United Kingdom's counter-terrorism strategy. In common with the rest of CONTEST, Prevent now deals with all forms of terrorism and extremism, whether violent or non-violent, that contribute to support for terrorism. This includes extreme right-wing and Northern Ireland-related as well as al-Qaeda-inspired terrorism. At the same time, the Department for Communities and Local Government has taken responsibility for integration and non-terrorist related extremism.

These changes mean that Prevent should no longer be seen as "securitising" integration. Rather than ranging far and wide, as it did previously, it is now more tightly focused, proportionate and prioritised. It is a national programme concentrated on certain localities and sectors, concerned with extremism conducive to terrorism, including non-violent forms as well as terrorism itself, is based on allocation of resources according to risk and will use law enforcement, regulation, civil challenge and support as appropriate.

I will conclude, as my Whip is beginning to kick my legs to indicate that time is running out. Although they are linked, we make it quite clear that integration and prevention of terrorism must not be conflated. With the new Prevent strategy the Government have taken decisive action to ensure that they are not. Prevent is now able to concentrate on what it is supposed to do, to stop people from becoming or supporting terrorists, while the Department for Communities and Local Government is enabled to get on with creating the conditions in which integration can grow and extremism can be challenged and reduced.

Health and Social Care Bill

Committee (9th Day) (Continued)

8.41 pm

Amendment 156

Moved by ***Baroness Thornton***

156: Clause 22, page 29, line 2, at end insert—

"( ) Subsection (1) shall not apply to any providers who have any financial interest, directly or indirectly, in the provision of any service that the clinical commissioning group may be required to commission."

Baroness Thornton: My Lords, I also speak to my other amendments in this group. Over supper my noble friend reminded me that the late lamented Lord Carter, a previous Government Chief Whip, used to say to Ministers and others that if we needed to save time, the thing to do was to speak only from every other page and see if anybody noticed. What I intend to do is to try and speak from every other paragraph.

These issues deal with the serious potential conflicts of interest that GPs will face in their new role as commissioners of health services. When this group of amendments first started out it contained only two amendments but it has now, quite rightly, grown substantially to address the major concerns of transparency, integrity and patient confidence and the issue of trust that must be addressed in their new role. In passing, I would say that the publication of the Government's recent draft guidance on commissioning, *Developing Commissioning Support: Towards Service Excellence*, in effect decrees that by 2016 the real work of CCGs will be outsourced, presumably to large private providers, which makes me start to question what is left for CCGs to worry about. However, the issue that these amendments deal with is a fundamental issue of the Bill.

We all have high regard for our GPs and we trust them as experts and advisors. We know from the evidence that they do a cost-effective and good job. Our national system of GPs may be quirky, half in and half out of the NHS, but it works. At its best, it is the very best system in the world.

We are concerned that the Bill endangers the trust that patients have for their GPs and, essentially, these amendments seek to explore and to test that. GPs are going to be decision-makers across the whole breadth of commissioning, making decisions about priorities and standards, things that may often be unpopular, and reconfigurations of service. They will handle huge amounts of money, own budgets and get bonuses for good financial performance. So patients need to be assured that they can continue to trust their GP and that their GP will always act in the patient's best interest. This concern has been flagged up by the BMA and the Royal College of General Practitioners, so I hope that the Minister can tell the House how we will be able to protect the image and reputation of our GPs after the first CCG goes wrong. Amendment 156 starts with the obvious necessary safeguard that providers of primary medical services who have a direct or indirect financial interest in the provision of services that a CCG is required to provide must not be members of the CCG. Amendment 161 is also key in requiring the Secretary of State to issue guidance which must be incorporated into CCG constitutions on how conflicts of interest must be dealt with by consortia as part of their decision-making. Transparency and clarity about how potential conflicts of interest would be managed is essential if the confidence of the public is to be maintained.

Openness and transparency are supported by Amendment 176A, requiring CCGs to maintain a publicly accessible register of all potential conflicts of interest of individuals involved in any part of their commissioning process. Taken together, Amendments 176A and 224 reinforce this, and call for regulations to stipulate that no provider should be a member of a CCG if they have any financial interest in the provision of any service the CCG is required to commission; in other words, open book accounting.

We do not think it is enough, as Amendment 228 proposes, for a CCG member merely to declare their financial interest in a commissioning decision being taken by their CCG, or absent themselves from decision making on that provider. We expect our councillors to operate under this regime. We should expect other people responsible for public money to do the same. Indeed, this transparency and openness, and the declaration of interests, should be extended to their families, in the same way that it is for other public servants.

Finally, I want to underline that we recognise that we recognise that extending GP commissioning and setting up CCGs has the potential to give GPs freedom to innovate, improve services and use commissioning to develop new models of care in the interests of the communities they serve. The safeguards against conflicts of interest proposed in these amendments are not designed to shackle CCGs. As I have said, the Department of Health commissioning guidance already does that. The safeguards will ensure that they abide by the reasonable rules, regulations and codes of practice that we would expect of any statutory body responsible for taxpayers' money worth millions of pounds.

The public needs to be assured that robust governance arrangements are in place for commissioning consortia, and that conflicts of interest will be managed effectively. I beg to move.

Baroness Williams of Crosby: My Lords, I have a great deal of sympathy with the intention behind this amendment. Noble Lords will remember that from the very beginning of the discussion about this Bill, there has been a great deal of concern about the conflict of interest that could so easily arise. Many of us recognise that the relationship between patients and general practitioners crucially depends upon that relationship being one of trust. The same will apply, if the commissioning groups work well, to the relationship between them and the patients who are within the practices of which they are part. So I sympathise very much with what the noble Baroness, Lady Thornton, has proposed, and also with what the noble Baroness, Lady Finlay, has proposed in Amendment 161.

Our concerns on this side of the House are not with the whole motivation behind this. We believe that that is extremely important and we completely share it. It is our feeling, rather, that the remedies are not adequate to the scale. We feel, for example, that one of the weaknesses of both amendments is the lack of any effective sanctions against those who breach what would be a relationship of trust. At the moment there is not provision within the Bill for effective sanctions, which can be used to ensure that these high-minded and perfectly proper principles are lived by.

The Nolan principles have been very effective in local government—as we all know—and increasingly effective in national Government. There are references to those in the course of the Bill, but there is no specific determination that members of the partnership

groups or the CCGs would be dealt with, if they were in breach of the requirement that they should not ever put their own interests ahead of those of their patients.

I suggest to the noble Baronesses, Lady Thornton and Lady Finlay, and her associates in moving these various amendments, that they would look at the amendment we have put down—and I suggest this with due humility—which effectively brings into practice powerful sanctions. We believe these will be effective in ensuring that this relationship of trust is upheld, and also that powerful requirements lie on every CCG, as well as on the board itself, that it would be absolutely clear that all interests must be declared publicly.

These will ensure that once people's names are on the register, and they have made a declaration of the appropriate kind about their own interest never being put forward as the reason for a decision, there are then effective measures that will enable the whole issue to be dealt with in detail, with appropriate requirements of sanctions and of effective punishment for those who breach them. We believe this to be absolutely central to the working of the clinical commissioning groups and to the whole relationship of doctors to their patients.

So, with those few words, I hope I can persuade the noble Baronesses, Lady Thornton and Lady Finlay, to have a look at the proposals that we have put forward, which, I am pleased to say, have at least to some extent the support of the noble Baroness, Lady Finlay.

Baroness Finlay of Llandaff: My Lords, I certainly support the amendments tabled by the noble Baroness, Lady Williams, who has just spoken, and they go further than the amendments to which I have added my name. I would just draw the attention of the House to the conflicts of interest guidance from the General Medical Council, which makes it quite clear that doctors,

"must be honest in financial and commercial dealings with employers, insurers or other organisations or individuals".

It goes on to say:

"If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest".

I would also remind the House that the ultimate sanction is to be struck off, and that if you are struck off, you lose your livelihood. I have a concern that when it comes to the implementation, warnings may actually be issued rather than stronger sanctions taken against those who might breach such guidance, because this is guidance, and it is therefore subject to interpretation.

This whole group of amendments has really gone to the heart of the problem of conflicts of interest, both for the individual general practitioner, who would be on a clinical commissioning group, but also their families and all those others around. It may be friends of theirs, who they know really well, with whom they are inclined to place some commissioning contract, or enter into some arrangement. There is a really fine line between having a personal interest, and going to that person because professionally you think that they are the best person to do the job.

Of course, I will say as a doctor, we all know the doctors that we would like to be referred to, and we all know the people who we want to work with in our teams. That is human nature. It is a mixture of competence and attitude, but there is also something about having a shared set of values, and so on, because you tend to gravitate towards people who share the same set of values as yourself. The highest principles and values would of course fall, I would hope, outside of the conflicts of interest, but financial interest is a really difficult one.

While I would suggest that none of these amendments are absolutely perfect, this group of amendments illustrates the fact that we need to come back to this at Report with a definitive amendment that really crystallises the whole problem around conflict of interest in commissioning.

Lord Greaves: My Lords, I spoke on an earlier amendment this afternoon about issues that come round and round, and this one comes round across Bills. We had a great deal of quite difficult discussion on these matters in the Localism Bill—now the Localism Act—and achieved what we hoped will be a satisfactory compromise in the Bill.

It is all about standards in public life and the importance of all bodies that deal with public funds and public functions being part of the regime of standards in public life. I assume that clinical commissioning groups, while not part of local government, are certainly part of local governance, or they will be part of local governance as far as the health service is concerned. They will deal with a lot of authorities that have the standards of public life regime as part of their own practice. I wanted to go very quickly through the basic principles that need to be established in my view before this Bill is finished. First of all there have to be clear rules The Localism Act they are set out in Part 1, Chapter 7, across 11 pages and in parts of the schedules. There need to be set out on the face of the Bill so that everybody knows where we are.

There needs to be a code of conduct, whatever it is called, which is based on the Nolan principles. We came to the view in the Localism Bill, now the Act, that those principles needed to be set out again on the face of the Act: selflessness, integrity, objectivity, accountability, openness, honesty and leadership. In my view they ought to be set out on the face of this Bill.

There needs to be a system which members of commissioning groups have to register appropriate interests and again in the Localism Act some of these were pecuniary interests, going back to the old wording which is now on the face of the new Act. There are interests other than pecuniary interests which also need to be registered even if they do not debar people from taking part in decisions. If we are going to be open about what interests people have, then they ought to be there on record. There needs to be a register of interests—there is no point in registering if there is not an open public register. Then there needs to be a system in which people taking decisions and taking part in decision-making meetings have to declare interests at the point of that decision, as in the system that we have in your Lordships' House. As the noble Baroness said, it needs to involve close families and partners as well as the individuals concerned.

[Lord Greaves]

Then there is no point in having that unless you have a system of dealing with complaints. It needs to be very clear what the system is, how such complaints are investigated and what penalties there are for breaching the rules. There may be different penalties for different rules. Clearly breaching the system in relation to financial pecuniary interests is much more serious than breaching one for non-pecuniary interests.

The penalties need to be clear and understood and the system for judging on them needs to be clear. The whole system has to be in the public domain. The system itself has to be open and transparent and all the actions taken under the system, whether it is just registering an interest or dealing with a complaint and the results of that complaint, have to be open, transparent and in the public domain. It seems to me that those are the principles. The details will quite rightly differ according to different organisations and different contexts. I am not suggesting the details of the local government scheme, although the amendment of my noble friend Lady Williams picks up some of the wording from the Localism Act, I think. Clearly CCGs are different from local authorities, but they are not sufficiently different that the basic principles should not apply, or the basic rules and regulations about avoiding conflicts of interest and declaring those interests when they exist and enforcing those interests within the framework of a broad code of conduct. That in my view has to apply and I hope that when the Bill leaves this House, it will incorporate sufficient detail to give those assurances.

9 pm

Lord Warner: My Lords, I just wanted to make a couple of observations and ask the Minister a question on this group of amendments. First, this is a not a new area that we are getting into. The same issues arose with GP fundholding and with practice-based commissioning. We have managed, as I recall, to sail through those two areas where we have involved GPs in the commissioning of services where there was potential for conflicts of interest without any great scandals. Has the department looked at the experience on this issue of conflicts of interest with practice-based commissioning and GP fundholding and seen whether there was a major issue? My recollection of all this from the research on GP fundholding was that there was not an issue and it was handled perfectly sensibly.

Secondly, if we actually have bigger clinical commissioning groups—and I promise the Minister I am not going to reopen the debate we have already had, no doubt to much relief in your Lordships' House—the smaller the risk, I would suggest, of conflicts of interest. There is a different set of considerations if you have got a clinical commissioning group for a population of 18,000, where inevitably there is going to be much greater potential for a conflict of interest, to one in which you are commissioning for 400,000. There is a different order of magnitude and I wonder whether that is an issue that the Government have looked at.

Thirdly, if there is concern about sanctions, the thing which really counts with doctors is the prospect of being reported to their professional bodies. It is the GMC and professional misconduct which is the big issue. We should not invent a system which is based too much on local government. It should be bedded into the professional body and the misconduct issues, because that is likely to be the way that it will have most effect with doctors involved in commissioning.

Lord Marks of Henley-on-Thames: My Lords, I rise to speak to Amendments 175E, 176AA to AD, 213C and 220A, all in the names of my noble friend Lady Williams, the noble Lord, Lord Patel and myself, and in the case of 220A in the additional name of my noble friend Lord Clement-Jones. The purposes of these amendments are first to secure on the face of the Bill a thoroughly robust regime to avoid conflicts of interest sullying the commissioning process, and secondly to ensure transparency in the commissioning process to the greatest extent that is commercially possible. Taking the point made by the noble Lord, Lord Warner, a moment ago, that this is not an entirely new area, I suggest that the arrangements for commissioning proposed in this Bill risk raising the threat level from conflicts of interest in the commissioning process from "moderate" to "severe", if I may use the intelligence services' scale. That is because of the greater involvement of practitioners in the commissioning process, which is of course to be welcomed for many reasons, and the increased likelihood that many practitioners may also be providers of other healthcare services or have interests in such providers.

Our task is to reduce the threat at least to "substantial", and then to manage the threat in such a way as to avoid commissioning decisions ever being skewed by the private interests of those making the decisions. Much of what we propose ought to be uncontroversial, and merely represents good practice, but we suggest, and in this I agree with my noble friend Lord Greaves, that it is important that our commitment to best practice is made clear on the face of the Bill. Amendment 220A would impose on any provider of medical services who is also a member of a CCG a duty to declare any financial interest in a commissioning decision—a bare minimum proposal, I suggest. Amendment 213C would impose on the NHS Commissioning Board a duty to refer a member of a CCG to his or her relevant professional body for material breach of the provisions or of the guidelines we propose. I entirely agree with the further point made by the noble Lord, Lord Warner, that this is an appropriate way of dealing with offending by practitioners. It should not be for the board to act as, or to set up, a disciplinary tribunal, but it is sensible and a greater deterrent, I suggest, for the professional bodies to do so.

However, the meat of our proposals is in Amendments 176AA to 176AD. We propose a thoroughly transparent regime as the best and most effective way of protecting commissioning from the insidious effects of conflicts of interest. I say insidious—and this is a point in which I pick up on what was said by the noble Baroness, Lady Finlay— because it is not only when a public decision-maker acts deliberately to favour his private personal interests that conflicts arise and threaten the system. It is also when the decision-maker at least persuades himself that his interests and the public's interests coincide. It is only public scrutiny of the process that can properly test that.

The provisions in the Bill permitting some public access to the meetings of governing bodies of commissioning groups are, I suggest, over-cautious and too limited. The system should be made more open. The public should not be excluded from governing body meetings during the all-important discussions involving a choice between potential providers. I entirely accept that that would involve a new openness about commercial transactions and decision-making. However, these decisions are about choices between providers at public expense; I question the need for meetings to be held behind closed doors in relation to them.

Secondly, in the case of other decisions where the public are excluded from governing body meetings in the public interest, then a record of decisions made should at least be published, and quickly. That is the subject of Amendment 176A.

Our amendments set out a code for dealing with conflicts of interest in new paragraphs to go into the schedule. There would be a requirement for a register of interests of all CCG members. That register should be kept up to date. It should be kept available for public inspection. Then there would be a provision to exclude from the governing body of any CCG a director of a healthcare organisation or anyone with a significant financial interest in such an organisation if there is a contract in existence between that CCG and that organisation.

Thirdly, there would be a provision to ensure that a member of such a governing body who would be excluded if such a contract came into existence would have to stand down from the governing body while any negotiations for such a contract were in progress.

Finally, our amendments import the admirable guidelines produced by the General Medical Council, entitled *Good Medical Practice*. Those are the guidelines to which the noble Baroness, Lady Finlay, referred. I am grateful to the GMC for producing a document of such clarity and for welcoming our use of it in these amendments. The emphasis of the guidelines is on honesty and openness; that is what we are trying to achieve in this Bill. I believe it is what the Government are trying to achieve in this Bill. These are probing amendments, intended to give the Government an opportunity to consider how they might import such guidelines into the Bill at Report stage. However, our central point is this: we believe that the present provisions of the Bill do not display the seriousness, the clarity or the robustness that are required to meet the risks posed by the new arrangements. I suggest that the Bill cries out for a code in this area such as the one we have proposed.

Baroness Finlay of Llandaff: My Lords, there is an additional area which I think means that the provisions in this Bill have to be different from other previous legislation. We face a huge financial challenge across the whole of healthcare, with budgets squeezed in a way they have not been squeezed before. So the potential for conflict of interest will go up as very difficult decisions are made. One can envisage the situation where somebody on the governing body of a clinical commissioning group will have a relative with a certain condition—and I refer back to the example I used previously, motor neurone disease. Say that person needs end-of-life care, and say that is a clinical commissioning group that has decided that it is not commissioning it in its area. There would be a direct personal conflict of interest, because that person would obviously want that care for their relative, but they would need to stand back. With the financial stringencies, the proposed amendments become even more important. While they are probing amendments, I hope the Minister in responding will recognise the importance of this area and agree to come back to it—hopefully, with a Government amendment—at a later stage.

Lord Greaves: My Lords, in brief response to the noble Lord, Lord Warner, I am not suggesting in any way that the regime should be identical to the local government regime, but that the decision-making body in clinical commissioning groups will be the board. Under the new Section 14A, the board will include lay members and possibly other people. So merely relying upon professional standards and professional systems of discipline will not be sufficient.

Baroness Masham of Ilton: My Lords, I spoke on Second Reading of the need for safeguards. These are important amendments. They are safeguards which are necessary. Many people are worried about the conflict of interest.

Earl Howe: My Lords, I know full well that noble Lords have some concerns about the potential for conflict of interest in a system of clinical commissioning groups. Those are natural concerns, but I hope to show that the approach that we are advocating has some very specific and robust safeguards within it, which meet the intentions of the amendments in this group.

The CCG constitution provides for dealing with conflicts of interest and specifies arrangements for securing transparency about the decisions of the CCG and its governing body. The governing body must in turn ensure that the group has arrangements in place to ensure adherence to relevant principles of good governance. The CCG's governing body will have responsibility for ensuring that the CCG adheres to relevant principles of good governance. The Secretary of State can also make regulations for CCGs under Clause 71 of the Bill, which are designed to ensure that in commissioning, CCGs adhere to good procurement practice. These regulations may impose requirements relating to,

"the management of conflicts between the interests involved in commissioning services and the interests involved in providing them".

These regulations can also confer on Monitor powers to investigate suspected non-compliance. These are the safeguards that the Bill puts in place. My view is that it is unnecessary and indeed undesirable to go further.

Requiring CCGs to adhere to examples of good practice in managing conflicts of interest, such as declarations of interest; or maintaining a register of interests; or the monitoring or registration of hospitality received by members is a temptation, but one that should be resisted. We have got to be very careful about encumbering the Bill and CCGs with inflexible prescriptions as to how CCGs should operate within the statutory framework, or procedure about how they

[Earl Howe]
specifically manage potential conflicts of interest. This does not mean that these are not reasonable safeguards. Requiring the governing body to discuss in public choices between potential providers, or publish any decisions made in camera, for example, would remove a necessary discretion around ensuring that sensitive issues, either relating to contract values or performance, or staff matters, were given the appropriate level of confidentiality. I would urge in particular that we do not—as proposed in Amendment 175CC—put restrictions on those from whom a CCG can commission services. Given the importance we attach to ensuring that services are delivered in an integrated way, we cannot afford to cut CCGs off from being able to commission services from local GPs with a special interest, for example, who could deliver secondary care services in a community-based setting.

Baroness Thornton: Will the noble Earl acknowledge that there is a conflict of interest there? There must be a potential conflict of interest there. How does the Bill mitigate that? How does the Bill deal with that? I cannot see from what the noble Earl has said so far that that is going to happen.

9.15 pm

Baroness Finlay of Llandaff: Before the Minister responds, I wonder if he could also explain why clinical commissioning groups would not necessarily have to have a register of hospitality, conflicts of interest and so on? Those of us who work for NHS trusts certainly have to complete a register, and if we receive hospitality above a minimum amount or major gifts, not only do we have to declare them, but we actually have to decline them. I think we would be subject to severe discipline if we breached that code.

Earl Howe: I do not disagree with any of these principles, but I am not sure whether the noble Baroness understood what I said earlier: there have to be arrangements for securing transparency about the decisions of CCGs, and governing bodies have to ensure that CCGs adhere to relevant principles of good governance—think of the Nolan principles, for example, and many other ways in which good governance can take place—but there is no need to specify all this in the way these amendments suggest because the arrangements provided for in the Bill will cover these things. As the noble Lord, Lord Warner, said we are not in new territory here. There are very well established procedures for tackling conflicts of interest when they arise. There might very well be a conflict of interest in the kind of situation to which the noble Baroness, Lady Thornton, has alluded, but there are ways of addressing and coping with that.

The key to this is to have in place a rigorous framework of requirements, approved by the board as part of the CCG establishment process, to ensure absolute transparency and to manage conflicts of interest, subject to oversight—the oversight must be proportionate, but it has to be there. We can put on the face of the Bill, as Amendment 176AD would have us do, a detailed list of behaviours that we would expect members of CCGs to observe. Obviously I cannot disagree, as I say, with the stipulations on this list, but they are already provided for in the Nolan principles and indeed the GMC code *Good Medical Practice*, to which the noble Baroness, Lady Finlay, referred—and adherence to that is a condition of registration for medical professionals. The noble Lord, Lord Warner, was absolutely right: this code is what GPs and doctors in general fear to transgress. Of course, if one looks at that set of behavioural requirements, they are actually only an ideal and they have no specific system in place to ensure that they are met. The sanction on doctors is the threat that they will be referred to their regulator.

The NHS Confederation was very clear about this, and I have to say I agree with it. The Bill has to allow flexibility for the way that conflicts of interest are handled and developed over time, rather than being rigidly set in law. What the NHS Confederation told us was that conflicts of interest need to be managed effectively otherwise,

"confidence in the probity of commissioning decisions and the integrity of the clinicians involved could be seriously undermined. However, with good planning and governance, CCGs should be able to avoid these risks".

I agree with that. There is a balance to be reached, and we believe the system that the Bill would introduce for managing conflicts of interest—the key points of which I hope I have described—provides that.

Baroness Thornton: My Lords, I thank the Minister. He will know, as will all those who have been Ministers, that when we are first appointed, we are told—the noble Baroness, Lady Williams, will remember this—that not only must we declare all our interests and have probity about the way we conduct ourselves, but we have to be seen to be doing it. A lot of these amendments are about being seen to do the right thing, and in terms of the relationship between GPs and their patients that becomes even more important. I agree with the noble Baroness, Lady Williams, and the noble Lord, Lord Marks, about their amendments and the need to have proper safeguards and remedies on this.

I think that if we co-operate, the noble Baroness, Lady Finlay, and I can probably crystallise these into something on the face of the Bill. I was disappointed that the noble Earl feels that this is satisfactory in the Bill at the moment, because I think the noise outside this Chamber and the comments from GPs tell us that people are very concerned about it. We need to address that in the Bill. I am happy to withdraw this amendment, but we may need to return to this at a later stage.

Amendment 156 withdrawn.

Amendments 157 and 158 not moved.

Amendment 159

Moved by ***Lord Warner***

159: Clause 22, page 29, line 33, at end insert "providing that it can demonstrate that it can meet the requirements of commissioning competence specified by the Board"

Lord Warner: In moving Amendment 159 I shall also speak to Amendments 160 and 164 in my name. I start by emphasising that this is a package of amendments that relates to many concerns that have been expressed to me and others—namely, that we need to make very sure that we ensure the assessment of competence of CCGs is sound and open before they undertake the commissioning of services that this Bill will enable them to do.

My earlier Amendment 157 enabled us to debate the number and population size of clinical commissioning groups, both of which considerations have a considerable bearing on the issue of competence of CCGs. I will not rehearse those arguments again except to emphasise that if the Government go ahead with such a large number of clinical commissioning groups, as it seems may well happen, then it is even more necessary to tighten up the Bill's provisions on proof of competence and the ability of the National Commissioning Board to reject applications where competence is in doubt. It is for those applicants to take on the role of a clinical commissioning group to prove that they are competent to take on this task and to safeguard the public money that will be entrusted to them.

Amendment 159 makes it clear that in submitting an application to the board, the clinical commissioning group applicant must demonstrate that it can meet the requirements of commissioning competence specified by the board. If its application does not do so then the board should be able to reject it out of hand. The onus is on that group to show that it is competent to undertake the commissioning. It seems to me that clinical commissioning groups will have had plenty of time to assemble their case and to prepare for their application. The Bill should make it absolutely clear that a demonstration of competence should be mandatory in submitting an application. If I can put it crudely, we do not want to see people taking a punt. They have to be able to demonstrate that they can actually do the job, otherwise public money and safety will be put at risk.

Amendment 160 is linked to Amendment 159. It requires that when the board publishes information for applicants, that information document must specify the competencies required to commission health services. This problem of specifying competencies in commissioning has bedevilled the whole movement towards commissioning over several decades. Mark Britnell's attempts at world-class commissioning ran into the same problem—we were not sufficiently clear about what competencies would deliver good quality health services from commissioners. So this competency issue is at the heart of making clinical commissioning groups work. It is vital that the board is left in no doubt of its responsibility for doing this and that applicants are in no doubt that the competency hurdle that they have to clear is put very clearly to them before their application can be accepted. What we do not want to see, if I may put it this way, is a load well meaning waffle coming out of the board about commissioning. We want to have articulated the competencies that have to be met before applicants can be successful. Amendment 164 rounds the whole process off in terms of applicants showing that they can discharge clinical commissioning group functions "competently", which is the word which it adds to the Bill.

These amendments make it clear that Parliament regards competence in commissioning as the yardstick by which the success or failure of applications to become clinical commissioning groups will be judged. This issue should be uppermost in the mind of the board when it makes decisions, and wording that makes this clear should be on the face of the Bill. Competence in commissioning has been missing in the past and we are in danger of repeating the mistakes of the past by not making it absolutely clear in this Bill what is required of the applicants to be clinical commissioning groups. I beg to move.

Lord Hunt of Kings Heath: My Lords, I have a number of amendments in this group. I will start with Amendment 159A which questions why, on page 9, line 36, it is possible for non-providers of primary medical services to be eligible to apply to establish a clinical commissioning group. Particularly in the light of my noble friend's comments on Amendment 159, one would surely only want applicants who had experience of providing GP services to be able to apply to form a clinical commissioning group.

Amendment 160A requires the board, before considering an application to form a clinical commissioning group, to consult with the general public, the relevant local authority, the relevant health and wellbeing board, and patients receiving primary medical services from providers within the clinical commissioning group. The noble Lord, Lord Greaves, raised some pertinent questions about transparency in the formation of clinical commissioning groups. It is extraordinary that there seems to be no process by which putative CCGs consult with their patients before they make an application. The decision is, essentially, being made by bureaucrats within the National Health Service system—who put constraints on CCGs,—and the GPs themselves. Where on earth are the public in all of this?

Lord Greaves: The noble Lord very kindly referred to what I said. Is it not also the case that a group of GPs could go ahead and put forward proposals without even consulting all the GPs in their area?

Lord Hunt of Kings Heath: From the reading the Bill, it is only when two or more are gathered together that they can make such an application. So the noble Lord is quite right. The amendment is seeking assurance that there will be public consultation and consultation with patients. We are told this is all about patients. Can patients therefore be consulted before GPs commit themselves to forming a clinical commissioning group? Or are we just to be told at some stage, "That's it, you are in that clinical commissioning group because you are in that practice and you have no choice". It is remarkably high-handed for it all to be done with no public involvement whatever. It is remarkable how many changes are already being made without any statutory authority given by this legislation.

[Lord Hunt of Kings Heath]

I want to continue the theme of consultation, because I have a number of amendments in this group which come back to the same point: Amendment 164A in relation to the board's determination of applications; Amendment 166 in relation to variations in the constitution of clinical commissioning groups; Amendment 166B in respect of variations made in the area covered by a clinical commissioning group, as specified in the constitution; Amendment 167A in respect of mergers, and Amendment 167B as regards the dissolution of clinical commissioning groups.

If I as a patient am part of the clinical commissioning group, one would have thought that I would have a role in deciding whether it is appropriate for that clinical commissioning group to be dissolved, or is that again just for the GPs to decide? What about Amendment 216ZZA as regards commissioning plans? Perhaps I have misread the Bill and there are crucial points which would envisage members of the public and patients within a CCG area being consulted on all these matters.

9.30 pm

On the question of parliamentary scrutiny, many of the rules concerning the application to become a clinical commissioning group are to be covered by regulations. I would have thought that, in view of their importance, these ought to be affirmative. Amendments 164B, 166A, 166C and 167C provide for that.

Over and above matters to do with application of parliamentary scrutiny are questions as to what CCGs are actually going to do and how we can ensure that they understand that their responsibility is to provide comprehensive provision to their patients covered by clinical commissioning groups. My Amendment 163 seeks to cover that. Under proposed new Section 14C to be inserted in the 2006 Act, the board must grant an application if it is satisfied as to a series of matters set out in proposed new Section 14C(2). In proposed new Section 14C(2)(e), the board has to be satisfied that a CCG is able to discharge its functions. What functions are these? This takes us back to Clause 10, whose functions on CCGs are dissipated from the functions set out in Section 3 of the NHS Act 2006, which encompass comprehensive revision.

This is vitally important. What are we entitled to as patients from our local clinical commissioning group? This is very important when it comes to any potential rationing by those CCGs in terms of treatments that we can receive. I, for one, prefer the safeguard that is contained in Section 3 of the 2006 Act, unamended, as opposed to the proposals in this Bill.

Amendment 166ZA is concerned with applications to vary the constitution of a clinical commissioning group and asks for the board to determine and publish, after consultation, criteria which Government are granting as a variation to the constitution. It is not unreasonable for us to know under what criteria such a variation may be granted.

My Amendment 167BA makes the same point in respect of the dissolution of a clinical commissioning group. My Amendment 220ZC will also provide for patients covered by a clinical commissioning group to be consulted in any proposed dissolution. Amendment 167D relates to property transfers in the event of a dissolution or variation of the constitution of a CCG and again requires the board to consult before a property transfer can take place. Finally, my Amendment 165 provides that when a clinical commissioning group is granted an application, it is wholly committed to assume the duties under Section 3 of the NHS Act 2006.

Baroness Williams of Crosby: My Lords, I congratulate the noble Lord, Lord Hunt, particularly on Amendment 160A. The idea that patients whose GPs are serving on the Commissioning Board, or are part of a commissioning group which represents that board, should be consulted and we should hear what their own experiences have been, is innovative and interesting. He should be congratulated on putting it forward. It means involving patients as individuals in their own assessment of the service that they have had. Time and again the Bill reflects the demand that that should happen—no decision without me, and so on. This actually makes that real. It gives the words flesh, and I congratulate him on that. It is quite an exciting idea and I hope that it is one that will commend itself to the Government, given the Government's wish to involve patients.

I am not so happy about Amendment 163B. I fear that the opposition Front Bench has not taken on board as much as I hoped that it might the idea that regulations should not go straight to Parliament, even if they are affirmative, but should go by way of the Health Select Committee. The noble Lord will be familiar with the argument—that the Health Select Committee has a huge range of expertise and knowledge. As a former Minister he will know—as well as I or the noble Baroness, Lady Thornton, knows—that the regime of regulatory scrutiny is not very effective. If there is an individual Member of Parliament in another place who knows a great deal about it and is concerned about it, you can have a real debate and that real debate can affect the outcome with regard to regulation. However, nine times out of 10, there is no great debate. In the case of the negative resolution procedure, there is often no debate at all.

I fear that this is a very weak safeguard for the huge amount of regulation that is built into the Bill. I therefore hope that I might commend to the House, and not least to the opposition Front Bench, the idea of looking again at the proposal, which is also radical and new. It is an idea that really ought to commend itself to those of us who believe strongly in accountability to Parliament and in the need to strengthen Parliament's power vis-à-vis the Executive across the whole world.

Lord Hunt of Kings Heath: My Lords, perhaps I can come back to that. On Amendment 160A, I am grateful to the noble Baroness for her support. I am not even sure that I got it right. I am also trying to get at the fact that so much is happening now without any consultation. The CCGs are essentially being decided by the system and then at some stage there will be a formal application process. I am long enough in the tooth in the health service to know about NHS consultation. Frankly, we all know that the traditional NHS consultations make the decision and then consult. I fear that, with CCGs, this is what is happening.

While I welcome the support for the involvement of the public in a formal application, I find it perplexing that so much is now being decided and that the public are not involved at all.

I listened to the noble Earl before supper talking about this being bottom up. That is not what is happening. I do not think that he understands quite how much this is being driven by the centre. It is quite extraordinary. You can call it guidance, but putative CCGs are being given such clear steers about what will be acceptable. I feel that we will reach a situation where, at some point, it will all be a done deal and the consultation will simply not be realistic.

On the noble Baroness's comments about making the regulations affirmative, I accept that, even if they are affirmative, there is a limit to what parliamentary scrutiny can provide—although that does provide some safeguards. I would be interested in debating the idea of giving the Health Select Committee a role, although excluding your Lordships' House from it would be a problem. I say to the noble Baroness that I think it a pity that the House did not adopt my suggestion about a mandate for a kind of national policy statement approach. There is an argument for having a more interactive debate, if you like, about some of these matters. I very much take to heart her constructive comments on this and the Select Committee role. It could be a very useful debate for the future.

Lord Alderdice: My Lords, lest it be thought that we were all wholly of one mind on these Benches in regard to some of these proposals, let me say that I am much more cautious about the propositions. My noble friend Lady Williams of Crosby has described the propositions for consultation with patients as novel. She is quite right. When the noble Lord, Lord Hunt, says that he recognises NHS consultations from the past as decisions first and consultation afterwards, he recognises how the previous Government carried out their business. As somebody who was in the health service at the time, I was very familiar with it.

We must be realistic about some of the propositions that come forward for consultation. Think through what is actually involved in doctors coming forward with proposals to fulfil the requirements set down in legislation in all its various aspects passed by Parliament, and then being asked to consult with the patients as to what exactly they think. Think through what exactly that might look like for general practitioners and their patients—those patients who would choose to back the general practitioner in his application to go along with the proposals, or would start to run a campaign against their GP. Is there really a thought that this will be something that serves the interests of helping general practitioners and their patients to move forward together? It is an interesting and novel proposal from the point of view of debate in your Lordships' House. However, I am not at all convinced that it has been thought through in terms of how one might actually implement such a thing, and in terms of working with patients and patients working with their general practitioners.

In psychiatry, for example, I think of how much discussion and consultation there has been with patients about who their sector psychiatrist might be, never mind all sorts of other important decisions about them. The fact is that it is not a way in which one can possibly run these things. It is important to have consultation with the public in general, but to try to divide it up so that patients are consulted on whether their GP should follow decisions taken in line with decisions that Parliament set down is wholly another matter. My noble friend was right to describe it as "novel", but I am much more cautious about the proposal than she is.

Lord Hunt of Kings Heath: I thought that what the noble Lord said about the last Government was a cheap shot. I was talking about the NHS consultation in my experience over 40 years. It has not been a wholly satisfactory situation. It is quite remarkable what the noble Lord seems to be saying. The health service has strong corporate governance and strong processes for consultation, but suddenly we are bunging £80 million to GPs and they do not have to consult. Are they in such a mystical position that they do not need strong corporate governance; that we can trust them, even though some of that money will be spent with the GPs instead of on other parts of the health service? Suddenly we think that they are jolly good chaps and we can trust them. We can trust them simply to form these clinical commissioning groups, in which in theory they will have great power, and there is no consultation whatever. It is quite remarkable what the noble Lord is saying.

Lord Alderdice: My Lords, let us be clear. It was no cheap shot. It was a comment on how the previous Government carried through their policies. He will know very well that I sat on those Benches and asked the questions of him. I am very much aware of it. What I said had nothing to do with corporate governance. It was the specific proposal that GPs' patients should be asked to express a view on the proposition that their general practitioner be part of a clinical commissioning group. As though there was some serious alternative to it, and that it was something that could be carried through willy-nilly without any potential disadvantage in the GPs' conduct of the practice.

What I pointed out was that this is not something that has any kind of precedent; it was, as my noble friend said, "novel". What I said about it was quite clear. It has not been tried and I am not persuaded that it is something that has been well thought through. It could be very divisive within a practice. That is not at all to say that other elements of corporate governance are not appropriate. I wholly support them and the proposal. I was addressing a specific issue and I notice that it was the one issue that the noble Lord did not respond to.

Lord Hunt of Kings Heath: So I as a patient have no right to say or comment on which clinical commissioning group my GP wants to join? It is nothing to do with me and just up to the GPs to decide? That is what he said. On the question of general consultation, let me remind him of the NHS plan. If this Government had done this properly, they would have published a Green Paper. They would have gone through a process of working with the health service, they might have spent six to nine months doing it and they would have got

[Lord Hunt of Kings Heath]
much greater by it. It shows that they have dealt with these reforms in a high-handed manner. The result is that there is no buy-in whatever and that is why the Government are in the trouble they are. I pray in aid the way that the NHS plan was dealt with and the fact that 500 people came together on a number of bases to work on the plan. That is why it had so much greater ownership.

9.45 pm

Lord Alderdice: My Lords, I addressed one specific proposal, not the whole world and the whole conduct of the Bill. I addressed one specific proposal, and the noble Lord comes back and tells me, "Has a patient no right to express a view?". Of course the patient has a right to express a view. There will be public consultation. That is not the issue. The issue is that the noble Lord produced a specific proposal. One of my colleagues found it novel and interesting. I find it novel, but I am not at all persuaded that it has been well thought through, and I am interested that the noble Lord jumped so immediately to defend not the proposal but his posture.

Lord Patel: My Lords, I thought that I might get up to say one sentence to stop this conversation from going further. My name is on several amendments, particularly those proposed by the noble Lord, Lord Warner, about competency. I have a simple question, which I am sure the Minister will be able to answer easily. What competencies do the commissioners have to demonstrate before they are authorised to become commissioners? I know that there will be guidance, but what competencies will be looked at that demonstrate that they can be commissioners? I am being very brief today because of being chastised for talking too long; but now I have evidence that suggests that I was not the worst, so I will carry on another time.

Lord Greaves: My Lords, I want to say one or two things about the consultation and go back to what I was saying before dinner. The question of patients is a bit of a red herring. To that extent, I think that the noble Lord, Lord Hunt of Kings Heath, was asking to be tripped up over it. Everybody is a patient to some extent, but the important thing is that the residents of an area, or citizens—whatever they are called nowadays—should know what is going on and that there should be an opportunity for a public debate to take place in the normal places—local newspapers, local radio, public meetings—about the future, structure and organisation of the health services in their area.

The noble Lord, Lord Hunt, was absolutely right when he said that there is a huge amount going on at the moment. It is not going on in complete secrecy; people involved in it know what is happening and are telling other people, and people in local authorities and others are having some discussions. However, by and large, there is not a proper process for providing people with open and full—or even partial—information about the proposals that are taking place. I do not think that it is a question of patients being able to tell their doctors which CCG they want to be part of, because the CCGs will be area-based, as we all know, and the doctors will be part of the CCG in their area. The questions are: what area is that going to cover, where is the CCG going to be, and how is it going to fit in to the health service? That is a fundamental question. So to that extent the noble Lord, Lord Hunt, is absolutely right. I think that the question of patients is a red herring.

Whenever I go to see my doctor, I consult him about what is happening in the health service, he consults me about that and all sorts of other things, and occasionally we get around to talking about my health; but I do not suppose that I am a very typical patient. That is a fact of life. However, it is a fundamental problem, and the source of a huge amount of the mistrust about what is going on at the moment is that people simply cannot find out what is going on. That is not in the amendments to this Bill. The Minister and his colleagues simply need to tell the health service to be a lot more open and transparent about what is going on and allow local debate on it.

Earl Howe: My Lords, these amendments are all concerned with the process of the establishment of CCGs or changes to the established organisation. The Bill lays the groundwork for the NHS Commissioning Board to establish CCGs. Ensuring the competence of an applicant group to exercise the functions of a CCG is a key part of that process.

In the first instance, the board may publish guidance on the making of applications and this may include details of how it will assess the fitness of CCGs for establishment and therefore their suitability to assume responsibility for exercising their commissioning functions. That is really what Amendment 159 is trying to get at. The whole process is intended to ensure that the CCG has made appropriate arrangements to discharge its functions competently. If the board is not satisfied about that, it will not grant the CCG's application, or else it will grant it subject to conditions under the transitional arrangements.

I can confirm that we intend to make provision in regulations to require the NHS Commissioning Board to take the views of the shadow health and well-being board into account when they consider the establishment of a CCG. Health and well-being boards will be able to provide insight into the willingness and ability of a prospective CCG to be involved in partnership working and engaging with the local population. That is the theme of Amendments 160A and 162.

However, in my view, wider mandatory consultation with the public, either by a prospective CCG or by the board on receipt of an application to be established, would be completely disproportionate and add unwarranted delay to the establishment of new arrangements. We already have intelligence that early implementer health and well-being boards are engaging in constructive dialogue with CCG pathfinders about the right size, area and configuration to best meet local patient needs. That is fine, but problems arise when you start to mandate it. I am very uncomfortable about that. Consultation with the public has its rightful place but I was completely unconvinced by the argument of the noble Lord, Lord Hunt. For my money he simply has not made the case.

We also need to ensure that we do not have a cumbersome process for agreeing changes to CCGs, which may evolve over time as organisations and may choose to merge formally or to adapt their constitutions, which of course would need to be agreed with the board. A number of amendments in this group seek to require consultation, with the public, the relevant local authority, the relevant health and well-being board and patients receiving primary medical services from providers within the CCG, for different processes: establishment, variation, merger or dissolution of CCGs. The Bill as it stands would set clear duties for patient and public engagement in new Section 14Z. CCGs would have to engage the public in their planning of the commissioning arrangements; in the development and consideration of commissioning proposals, which would have an impact on the manner in which the services are delivered to the individuals; and in the range of health services available. They would also have to engage on decisions of the CCG affecting the operation of the commissioning arrangements where implementation of the arrangements would impact on individuals or the range of services available. The CCG would also have to consult the patients it is responsible for on its commissioning plan. That is quite right and proper and I hope that, in that area at least, there will be some agreement across the House.

As regards local authorities and health and well-being boards, these boards will include representation from the local authority and CCGs. I suggest that is the ideal forum for CCGs to discuss proposals such as mergers with their fellow members. However, it would not be appropriate to impose an explicit requirement for CCGs to consult the board on such matters.

Turning to Amendments 164B, 166A, 166C and 167C, tabled by the noble Lord, Lord Hunt of Kings Heath, I commend the report of the Delegated Powers and Regulatory Reform Committee of your Lordships' House. These amendments would make the resolution procedure for certain regulation-making powers relating to applications between CCGs and the board affirmative. This approach was rejected by the DPRRC, which found that the negative resolution procedure would give noble Lords ample opportunity to consider regulations laid before the House covering determination of applications for establishment of a CCG, for variation of CCG constitutions and on dissolution of CCGs.

The noble Lord, Lord Patel, asked me about competencies. In September the department published *Developing Clinical Commissioning Groups: Towards Authorisation*, which sets out our current thinking on the domains that the Commissioning Board may wish to use as indicators to judge the competencies of prospective CCG commissions.

While I know that there will not be a meeting of minds over this, I hope that I have at least fleshed out what the Government's intentions are. There will, obviously, be opportunity for further reflection on these matters.

Lord Warner: My Lords, I was not convinced by the noble Earl's views on the number of clinical commissioning groups in our earlier debate. I was even less convinced by what he had to say about competencies. There was a lot of talk about, "The board may wish to do this", and, "The board may wish to do that", on competencies. The problem of healthcare commissioning in this country has actually been the lack of competency. That has been the problem for 10 to 20 years, under successive Governments. If we miss the boat again on this issue, we are making a great blunder.

I do not want to go over the ground about consultation with the public at all. I am interested in having in the Bill that the critical requirement of becoming a clinical commissioning group is competency to do the job, and that the board is required to specify what those competencies are, before people make an application. My noble friend Lord Hunt has made the perfectly sensible observation that while we are sitting, chatting about this Bill, people out there are doing the business about who will be clinical commissioning groups. That is what is actually happening. We need to make sure that they are under no illusions that competency is the yardstick by which they will be judged. I am not satisfied with the Government's response and wish to test the opinion of the House.

9.57 pm

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Written Statements

Wednesday 30 November 2011

EU: Agriculture and Fisheries Council

Statement

The Parliamentary Under-Secretary of State, Department for Environment, Food and Rural Affairs (Lord Taylor of Holbeach): My right honourable friend the Secretary of State for Environment, Food and Rural Affairs (Caroline Spelman) has made the following Written Ministerial Statement.

I and my right honourable friend the Minister of State for Agriculture and Food (Jim Paice) represented the UK on agriculture matters at the Agricultural and Fisheries Council on Monday 14 November. My honourable friend the Parliamentary Under-Secretary for Natural Environment and Fisheries (Richard Benyon) represented the United Kingdom on the fisheries items. Richard Lochhead MSP, Michelle O'Neil MLA and Alun Davies AM were also in attendance.

The first item for discussion was the communication from the Commission to the European Parliament and the council on the external dimension of the Common Fisheries Policy. The Commission emphasised the twin objectives of ensuring sustainable management of fisheries resources whilst maintaining a level playing field across member states and third countries in order to ensure a viable EU fishing fleet. There was general support for common principles such as the need to fish sustainably, the desire for EU vessels to only use what is surplus to local requirements, ensuring coherence of the CFP with EU development policy and the need for transparency from third countries about fishing activities in their waters.

On specific issues, a number of member states expressed concern about the effect on economic viability of increasing the vessel owners' contributions towards paying the costs of access rights; while others, including the UK could support an increase in owners' contributions, or owners coving the full costs.

In order to ensure a level playing field a number of member states called for third country producers to be liable to the same social and environmental obligations as EU producers. The UK, along with France, Germany, Belgium and Ireland expressed support for trade measures being taken against those countries that were not fishing sustainably.

The Danish presidency will take this forward as part of the CFP reform package in 2012.

The main agricultural item on the agenda was further discussion of the Commission's proposals for reform of direct payments under pillar 1 of the Common Agricultural Policy. Member states were asked for views on the proposed structure of pillar 1, and on the Commission's plans for convergence of payment rates within and between member states. There appeared to be a developing consensus that the overall structure of the Commission's proposals was too complex and that greater national flexibility was required for member states to respond to specific needs within their own territory.

On the detail of the proposal, a number of items were raised by member states. On greening of direct payments, even those member states that did generally accept the principle questioned the bureaucratic burden it would place on farmers and national administrations. On support for young or small farmers, many member states called for the provisions to be voluntary for member states.

When considering the move to a single payment rate within individual member states (or regions), the UK and France were in a group of member states that accepted the end goal, but thought the Commission's proposals moved too quickly, particularly in the first year. However, some member states remain opposed. On the issue of the convergence of payment rates between member states, Ministers were split between those that will lose and those that will gain.

There were five any other business items. The first was information from the Commission on implementation of the conventional cage ban as set down in the laying hens directive. The Commission announced that it would be writing to member states to seek confirmation of compliance with the ban, which comes into force on 1 January 2012 or to ascertain how compliance will be reached. This letter will be the first step towards infraction proceedings against non-compliant member states. The Commission noted progress at a meeting of officials on 28 October considering a workable, non-legally binding, agreement to tackle the issue of large-scale non-compliance with the conventional cage ban across the EU. For the UK, Minister Paice intervened to state that such an agreement would need to include, as a minimum, a list of compliant and non-compliant producers from member states, action plans for compliance spanning no longer than six months (which would also prevent member states from placing new hens into conventional cages), clear marks to identify non-compliant eggs, and restriction of trade for these egg and egg products to the country of production. The majority of member states that have complied with the rules were against any form of compromise agreement. In conclusion, the Commission reiterated its commitment to start infringement proceedings from 1 January 2012 but considered progress on an informal agreement as the best and quickest way to ensure full compliance from member states.

The next AOB item was a report from France on the food for deprived persons scheme. France stated that they had agreed a joint declaration with Germany agreeing continuation of the food for deprived persons scheme until the end of 2013. The declaration also stated that neither country believed that the conditions were in place for a similar scheme to be supported from the EU budget beyond 2013. The presidency concluded that there was now a qualified majority in favour of the proposal, and would aim for formal legal agreement at the December Agriculture Council.

Hungary presented the next AOB item, a paper, supported by France, Lithuania, Austria and Romania, arguing for an extension to the sugar quota system beyond 2015. Six other member states supported this

call, arguing that it would provide stability of production and to allow expansion to meet demand. The UK led the counter-argument against a continuation of quotas, supported by Slovenia, Ireland and Latvia.

The presidency presented a paper on the Ryn "Forestry for climate and biodiversity" conference, and noted forthcoming international negotiations on a legally binding agreement on forests in Europe.

The final AOB item was another presidency paper reporting on the 30th conference of the directors of paying agencies of the EU; the key conclusion of the conference had been the need for further progress on simplification.

EU: Employment, Social Policy, Health and Consumer Affairs Council

Statement

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud): My right honourable friend the Minister of State, Department for Work and Pensions (Chris Grayling) has made the following Written Ministerial Statement.

The Employment, Social Policy, Health and Consumer Affairs Council will be held on 1 December 2011 in Brussels. I will represent the United Kingdom on all agenda items.

There will be two ongoing negotiations at this council. In the first negotiation the presidency is seeking a political agreement to the extensions of the crisis derogations to the European Globalisation Adjustment Fund. I will stress that the UK does not believe that the EGF is an effective or efficient instrument for managing large redundancies. Whilst at this stage it is not possible to know how discussions will evolve, I will be seeking to protect UK taxpayers by reducing disbursements from this fund, in accordance with the position agreed with the parliamentary scrutiny committees.

In the second negotiation, the presidency is seeking a general approach to a proposal amending Regulation (EC) No 883/2004 on the co-ordination of social security systems and Regulation (EC) No 987/2009 laying down the procedure for implementing Regulation (EC) No 883/2004. In this negotiation I will seek to support the presidency in achieving a general approach. I will reiterate that a broader debate is needed on social security for migrants. I will also support the Commission's suggested broader review of the co-ordination of unemployment benefits.

There will also be a policy debate on the implementation of the Europe 2020 strategy in the field of employment and social policy. The debate will be informed by three papers: the Commission's annual growth survey (including the joint employment report); a set of conclusions on the European semester; and an opinion of the Social Protection Committee on the social impact of the crisis. I will welcome the annual growth survey and emphasise the need for all member states to have a credible and determined approach to structural reform, including through credible fiscal consolidation measures, opening up of markets and deeper growth-friendly labour market reforms.

There will be a progress report on three topics: minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (electromagnetic fields), the pregnant workers directive and the equal treatment of persons irrespective of religion or belief, disability, age or sexual orientation.

In addition, Ministers will consider two sets of council conclusions, covering ageing as an opportunity for the labour market and the development of social services and community activities, and the review of the implementation of the Beijing platform for action.

The Commission will also present a report on the functioning of the transitional arrangements on the free movement of workers from Bulgaria and Romania.

Under any other business the presidency and Commission will provide the key messages from the first annual convention of the European platform against poverty and social exclusion. The presidency will provide information on the legislative proposals in the area of migration (single permit, intra-corporate transfers and seasonal workers) and will report on the informal meeting of Ministers for Family and Gender Equality. The Commission will also provide an update on the review of the working time directive, the posting of workers directive and the state of play on the European debate on women on company boards.

EU: Energy Council

Statement

The Parliamentary Under-Secretary of State, Department of Energy and Climate Change (Lord Marland): My honourable friend the Minister of State for Energy (Charles Hendry) has made the following Written Ministerial Statement.

I represented the UK at the Energy Council in Brussels on 24 November. Fergus Ewing, Scottish Minister for Industry, Tourism and Energy, also attended.

The council began with a report by the presidency on the progress of discussions of the energy efficiency draft directive. Denmark noted that the directive would be a high priority for their presidency from January 2012.

There was a debate on the draft regulation on infrastructure. I expressed the UK's support for the proposal and noted the need for better cross-border permitting procedures to create a fully integrated EU market, as well as the importance of regional groupings such as the North Sea countries' offshore grid initiative. A number of member states also registered their support for the proposal while noting the need for it to respect other areas of EU legislation, such as environmental rules and member state competence.

The council agreed conclusions on external energy relations, following interventions by a number of member states. The Commission reported on a number of international relations items, including providing a brief summary of the latest situation on the southern corridor, negotiations with Turkmenistan and Azerbaijan and with Russia.

The Commission gave a presentation of the draft regulation on offshore oil and gas activities. I welcomed the overall intention of the proposal to increase safety but expressed concern over the use of a regulation. Other member states expressed concerns.

Over lunch, Ministers discussed the effects of changes in member states' domestic energy policies on their neighbours, continuing a similar discussion at the informal Energy Council in Wroclaw in September.

Denmark briefly outlined its plans for its presidency. Its energy priorities will be the energy efficiency directive and the 2050 energy road map.

Schools: Industrial Action

Statement

The Parliamentary Under-Secretary of State for Schools (Lord Hill of Oareford): My right honourable friend the Secretary of State for Education (Michael Gove) has made the following Written Ministerial Statement.

Industrial action, today, has had a severe impact on schools across the country and has caused disruption to children's schooling and to parents and employers. At the same time, we know that many dedicated professionals have worked hard to keep schools open where they could.

The Department for Education has collected data about school closure from local authorities, academies and free schools to assess the impact of today's industrial action.

There are 21,476 state-funded schools in England (maintained schools, academies, free schools, university technical colleges and studio schools). 13,349 (62 per cent) were reported to be closed. 2,951 (14 per cent) were reported to be partially open and 3,351 (16 per cent) were reported to be fully open. The situation with a further 1,825 (8 per cent) has not been reported to us or the local authority did not know.

Of the 20,027 maintained schools, 12,526 (63 per cent) were reported to be closed, 2,536 (13 per cent) were reported to be partially open and 3,140 (16 per cent) were reported to be fully open. The situation with a further 1,825 (9 per cent) was not reported or was reported as unknown.

Of the 1,449 academies (including free schools, university technical colleges and studio schools) 823 (57 per cent) were reported to be closed, 415 (29 per cent) were reported to be partially open and 211 (15 per cent) reported to be fully open. There are 24 free schools, of which four were reported closed, one was reported partially open and 19 were reported to be fully open.

Written Answers

Wednesday 30 November 2011

Armed Forces: Pensions

Question

Asked by ***The Countess of Mar***

To ask Her Majesty's Government, further to the Written Answer by Lord Astor of Hever on 16 November (*WA 148–9*), what information they hold about the reasons why 4,930 Gulf War veterans are in receipt of war pensions; what criteria they are defined by; why they do not know how many suffer from organophosphate (OP) poisoning; and what would be the cost of identifying which Gulf War veterans have OP poisoning. [HL13629]

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Hever): The war pensions computer system (WPCS) benefits programme is used to record information regarding war pension scheme (WPS) claims, and awards to be administered and paid. It does not hold specific details relating to the cause of conditions, illnesses, death, or the location of the causal incidents as this information is not required to process the benefit claims.

To answer the question tabled would require the department to locate the 4,930 individual war disablement pension files relating to personnel known to have served in Gulf War 1, identify whether these individuals' war pensions were awarded specifically as a result of their service during that campaign, and determine the causal incident of the award. It is estimated that the cost of this exercise would be some £44,000 and therefore, could only be provided at disproportionate cost.

Asylum Seekers

Question

Asked by ***Lord Avebury***

To ask Her Majesty's Government how many asylum cases are under consideration by the Criminal Cases Directorate; of these, how many relate to persons arrested on entry to the United Kingdom; and how many of those in turn relate to persons convicted under Section 2 of the Asylum and Immigration (Treatment of Claims etc.) Act 2004 for not having a travel document at the time an application for leave or asylum was made. [HL13713]

The Minister of State, Home Office (Lord Henley): There are 323 asylum cases under consideration by the Criminal Casework Directorate as of 24 November 2011. It would incur a disproportionate cost to obtain a breakdown relating to persons arrested on entry and convicted for the lack of a travel document.

BBC: World Service

Question

Asked by ***Viscount Waverley***

To ask Her Majesty's Government what criteria they and the BBC World Service use in determining regional broadcasting priorities. [HL13746]

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): The BBC World Service decide their language service priorities based on: market significance (including such factors as population); market need (which takes into account elements including press freedom, human rights, political freedom), and market impact (for example the strength of local broadcasters). The BBC World Service has editorial and operational independence, but there is a continuing discussion with the Foreign and Commonwealth Office about the Government's foreign policy priorities.

Care Services: Social Work

Question

Asked by ***Lord Judd***

To ask Her Majesty's Government what plans they have to establish a college of social work to champion excellence in the profession and to enhance the profession's role in society. [HL13592]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): The college of social work will play a key role in the emerging landscape for social work in the light of reforms to regulatory arrangements, the work of the Social Work Reform Board and Professor Munro's recommendations. The college will provide the social work profession with clear leadership and a single, authoritative voice.

To this end, Government have provided the Social Care Institute for Excellence with £5 million to develop the college of social work over two years. It is planned that the college will become a legal entity in January 2012.

Economy: Growth

Question

Asked by ***Lord Myners***

To ask Her Majesty's Government why the United Kingdom's rate of economic growth during the 12 months to the end of September 2011 was lower than that achieved by any other European Union country with the exception of Cyprus, Greece and Portugal; and what action they are taking to improve this relative performance. [HL13510]

The Commercial Secretary to the Treasury (Lord Sassoon): This is a time of real international uncertainty and instability. It is clear that the UK is not immune to the crisis in the euro area, its biggest export market. The action being taken by the Government to tackle the deficit and rebalance the economy is helping to

protect the UK economy. A decisive resolution of the euro area crisis would provide the single biggest boost to the British economy.

The Office for Budget Responsibility's central economic forecast, published today, shows UK GDP growing faster than euro area GDP in each year from 2012 to 2016.

Embryology

Questions

Asked by ***Lord Alton of Liverpool***

To ask Her Majesty's Government, further to the Written Answers by Earl Howe on 22 November (*WA 222*), what steps the Human Fertilisation and Embryology Authority will take in future to ensure that gamete providers are promptly notified when it becomes evident that any resulting embryos had been used in research without their consent. [HL13721]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): The Human Fertilisation and Embryology Authority has advised that the steps it would take would be within the scope of the authority's compliance and enforcement policy, which can be found on its website at: www.hfea.gov.uk/docs/2011-10-01_Compliance_and_Enforcement_Policy_(2011).pdf.

Asked by ***Lord Alton of Liverpool***

To ask Her Majesty's Government, further to the Written Answers by Earl Howe on 22 November (*WA 222*), whether the Human Fertilisation and Embryology Authority (HFEA) followed its stated policy of not commenting on persons responsible and nominal licensees with respect to Dr Mohamed Taranissi; and whether the HFEA will clarify the circumstances under which someone who had been both the person responsible for research licence R0075 and the nominal licensee for research licence R0133 at a time when concerns over properly informed consent were raised had previously or subsequently worked for the authority. [HL13722]

Earl Howe: As I advised the noble Lord in my answer of 22 November 2011 (*Official Report*, col. *WA 222*) the Human Fertilisation and Embryology Authority has advised that it is its policy not to comment on its relationship with any persons responsible or nominal licensee.

As regards the issue raised by the research licences cited, the authority has also advised that it is confident that it has adequate governance arrangements in place.

EU: Credit Rating Agencies

Question

Asked by ***Lord Myners***

To ask Her Majesty's Government whether they have the power to stop efforts in the European Union to harmonise and increase the scope of credit rating agency liability. [HL13509]

The Commercial Secretary to the Treasury (Lord Sassoon): As stated in our response to the European Commission's consultation on credit rating agency regulation and in our written and oral responses to the House of Lords EU Subcommittee's report on sovereign debt ratings, the Government do not believe that harmonising or increasing the scope of credit rating agency (CRA) liability will improve ratings accuracy. The UK already has a civil liability regime in place which is sufficiently flexible and robust to hold CRAs liable, where appropriate.

All of the measures included in the Commission's proposed package on CRAs, which was released on 15 November, will be negotiated in the Council of the European Union and the European Parliament, in line with the standard legislative procedure.

EU: Parliamentary Scrutiny

Question

Asked by ***Baroness Nicholson of Winterbourne***

To ask Her Majesty's Government what progress they have made in their review, announced in January 2011, of current arrangements for parliamentary engagement in European Union issues. [HL13504]

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): Making Government more transparent and accountable is an important priority for this Government. Effective scrutiny of European business is an integral part of this. This was the subject of discussion during the passage of the European Union Act 2011. It is for Parliament to decide whether and how it wishes to revise the current system of scrutiny. Relevant committees of both Houses have responded positively to our initial discussions with them. In addition, a number of parliamentarians have made proposals to reform scrutiny. The Government are keen to continue both to discuss these matters with all interested parties and to work further with the committees to produce realistic proposals in the near future.

On justice and home affairs issues specifically, the commitments made in January for enhanced scrutiny of the justice and home affairs opt-in are being implemented and have resulted in a number of debates in the House of Commons on the UK's participation in proposed European Union legislation in that field. These arrangements are to be embedded in a code of practice which will draw from experience to date. This will be done through appropriate consultations with interested parties in Parliament and will enable measures of strong parliamentary interest to be debated.

Food: Nutrition

Question

Asked by ***Lord Gordon of Strathblane***

To ask Her Majesty's Government what assessment they have made of the legal arguments submitted to the Department of Health by the Health Food Manufacturers' Association in relation to the Nutrition and Health Claims Regulation, its interpretation and its implementation. [HL13685]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): Departmental officials have considered the legal arguments submitted to it by the Health Food Manufacturers' Association in relation to the Nutrition and Health Claims Regulation.

Government Departments: Buildings

Question

Asked by ***Lord Kennedy of Southwark***

To ask Her Majesty's Government what plans they have to install photovoltaic solar systems on buildings owned or occupied by the Home Office. [HL13568]

The Minister of State, Home Office (Lord Henley): We have installed photovoltaic panels at a property owned by the National Policing Improvement Agency but we have no current plans to install further photovoltaic panels on other Home Office buildings. With our facilities managers, we are constantly reviewing the latest technologies against the potential of our assets to install low-carbon technologies.

As part of the sustainable operations on the Government estate targets we reported 53 per cent of purchased electricity on the Home Office estate came from low or zero carbon renewable sources. We have already implemented a programme of energy efficiency measures to reduce carbon dioxide emissions as part of the Prime Minister's target to cut carbon emissions by 10 per cent across central government in 12 months, including introducing a payment by results mechanism as an incentive for our facilities managers' suppliers to deliver energy and carbon savings.

Health: Assessors

Question

Asked by ***The Countess of Mar***

To ask Her Majesty's Government whether, in the light of the holding of Commissioner Williams in tribunal case CIB/664/2005, the Department for Work and Pensions will make available to all appeal tribunals, claimants and representatives the Logic Integrated Medical Treatment (LIMA) Technical Manual 2011; and whether they will place a copy in the Library of the House together with a copy of the LIMA software questionnaire used for assessment of claimants by healthcare professionals. [HL13524]

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud): Commercial Management of Medical Services will arrange for a copy of the Logic Integrated Medical Assessment Technical Manual 2011 and the LIMA software questionnaires which are contained in appendices 3 & 4 of the Employment and Support Allowance Handbook to be placed in the Library of the House.

The Logic Integrated Medical Assessment Technical Manual 2011 and the LIMA software questionnaire (ESA 85) are currently available to tribunals, claimants and representatives through the submission of a written request under the Freedom of Information Act to Commercial Management of Medical Services, Room 306, Block 3, Norcross, FY5 3TA or by email @ DWP.MEDICALSERVICESCORRESPONDENCE@DWP.GSI.GOV.UK

Health: Cancer

Question

Asked by ***Lord Sharkey***

To ask Her Majesty's Government what is the current average period between a patient's first reporting of symptoms relating to lung cancer to a general practitioner and diagnosis of lung cancer; how this period has changed over the past five years; how it compares with averages of such periods for other serious diseases; and whether they have a target for a reduction in this average period. [HL13580]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): The department does not collect statistics regarding average time taken from the onset of symptoms of lung cancer to its diagnosis. However, the National Report of the 2010 Cancer Patient Experience Survey, published in December 2010, included a series of questions about general practitioner (GP) presentation and referrals.

The views of 67,713 cancer patients were included in the survey results and of these 3,758 had lung cancer. The following table shows the responses of patients with lung cancer to questions concerning GP presentation and referral, presented alongside the score for all cancers.

	Lung	*All Cancers*
Saw GP no more than twice about cancer related problem before being referred to a hospital doctor	66%	75%
Waited no more than 4 weeks before being referred to hospital doctor	95%	90%
Thought first appointment with hospital doctor was as soon as necessary	84%	81%

Both national and Trust level reports can be found at the following link: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_122516.

Health: Low Priority Procedures

Questions

Asked by ***Baroness Morgan of Drefelin***

To ask Her Majesty's Government what health care interventions and procedures are classified as low priority by primary care trusts or clusters in England. [HL13766]

To ask Her Majesty's Government what criteria each primary care trust or cluster uses to decide on access to low priority procedures for patients. [HL13767]

To ask Her Majesty's Government what information is made available to the public and patients about the use of low priority procedures lists by primary care trusts or clusters. [HL13768]

To ask Her Majesty's Government what processes are in place in primary care trusts to allow patients to appeal decisions about access to treatments included on low priority lists. [HL13769]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): As the Government have made clear, we do not believe that there are medical or surgical interventions, routinely offered by the National Health Service, that are consistently of low value. There is however significant evidence that a number of procedures or interventions, which are of a high value if carried out on the correct patient at the correct time, have been offered to or carried out on patients who will either not benefit fully from them, or who would have experienced greater benefit and less risk from an alternative.

It is for primary care trusts (PCTs) to decide what services they commission in order to meet the needs of local populations. There are numerous mechanisms and pieces of guidance in place to assist in making those decisions. For example PCTs are required to fund drugs and treatments recommended by the National Institute for Health and Clinical Excellence (NICE) in technology appraisals, and other NICE guidance provides valuable advice for commissioners.

As set out in Professor Bruce Keogh's letter to strategic health authority medical directors, in developing procedures to help ensure the appropriateness of referrals we have been clear that local processes:

must not introduce outright bans for interventions or treatments;

must be sensitive to individual circumstances and take account of those circumstances in any decisions;

must have systems in place to enable exceptional case reviews; and

must have robust policies in place which can support clear and defensible decisions on whether access to services will or will not be possible.

A copy of the letter has been placed in the Library.

We would expect all PCTs to make public their criteria for fair access to services. Under the NHS Constitution patients can expect local decisions on funding of drugs and treatments not covered by NICE technology appraisals to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment which a patient and their doctor feel would be appropriate for that individual, the patient has a right to have that decision explained to them.

The department does not hold a comprehensive central list of procedures and interventions for which PCTs have additional referral requirements or prior approval processes, nor does it hold the details of the criteria used. Previous discussions with PCTs regarding local processes and 'lists' have helped inform ongoing discussions with surgical associations.

Higher Education

Questions

Asked by ***Baroness Brinton***

To ask Her Majesty's Government, using the latest available figures, how many 19–24 year olds were on full-time further education courses funded by the Skills Funding Agency in England; and what proportion were (a) in employment, (b) unemployed, and (1) in receipt of jobseeker's allowance, (2) not in receipt of jobseeker's allowance, and (c) economically inactive. [HL13515]

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): Based on information in the Individualised Learner Record (ILR), there were 316,400 government-funded learners aged 19–24 participating in further education (learner responsive only) in 2009-10, the latest year for which final data are available. Of these, 100,800 were full-time. Participation in other forms of further education provision, for example apprenticeships, is not included.

The ILR does not provide information on economic activity. However, we can estimate this using the Labour Force Survey. In the first quarter of 2011, it is estimated that of those aged 19–24 studying full-time at a further education college (excluding apprenticeships) (a) 43.0 per cent were in employment, (b) 5.4 per cent were ILO unemployed and (c) 51.7 per cent were economically inactive. The Labour Force Survey does not provide robust estimates of jobseeker's allowance claimants. We do not directly record in the ILR information on the type of benefits people are receiving when they take up training. We do, however, collect information in the ILR on why a learner has received fee remission for a particular learning aim they undertake. From these data we can provide information on the number of enrolments by learners who received full fee remission through being in receipt of jobseeker's allowance. This should be used with caution given it does not provide a full picture of the range of entitlements that a person has.

As the reason for fee remission is recorded at the learning aim level and mode of attendance (full-time or part-time) is recorded at the learner level it is not directly possible to analyse the number of enrolments where fee remission has been applied by the full-time or part-time status of the learner. We are, however, able to measure the total number of enrolments (includes both part-time and full-time) by fee remission.

In 2009-10, the latest year for which final data are available, there were 685,400 learner responsive enrolments by adults aged 19–24. Of these, based on the "fees waived" field, 45,300 (7 per cent) received fee remission through being in receipt of jobseeker's allowance. Note that the number of enrolments is greater than the number of learners participating because a learner can enrol on more than one course.

Enrolments in other forms of further education provision, for example apprenticeships, are not included.

Information on further education participation, enrolments and achievements is published in a quarterly Statistical First Release (SFR). The latest SFR was published on 27 October 2011: http://www.thedataservice.org.uk/statistics/statisticalfirstrelease/sfr_current.

Asked by ***Baroness Brinton***

To ask Her Majesty's Government, using the latest available figures, what proportion of adults aged 24 and over studying full-time who completed (a) a level three course, and (b) a level four course, took longer than (1) three years, (2) four years, and (3) five years. [HL13516]

To ask Her Majesty's Government, using the latest available figures, what proportion of adults aged 24 and over studying part-time who completed (a) a level three course, and (b) a level four course, took longer than (1) three years, (2) four years, and (3) five years. [HL13517]

Baroness Wilcox: In 2009-10, the latest year for which final data are available, less than 1 per cent of adults aged 24 and over who completed a level 3 or level 4 course (full-time or part-time) in government funded further education (learner responsive) took longer than three years to complete it and the proportion taking longer than four or five years is even smaller.

Information on further education and skills participation, enrolments and achievements is published in a quarterly Statistical First Release (SFR). The latest SFR was published on 27 October 2011: http://www.thedataservice.org.uk/statistics/statisticalfirstrelease/sfr_current.

Human Rights

Question

Asked by ***Lord Laird***

To ask Her Majesty's Government, further to the Written Answer by Lord Howell of Guildford on 13 November (*WA 130*), whether they will place a copy of the relevant information on the European Court of Human Rights' website in the Library of the House. [HL13523]

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): This information is not held centrally by the Foreign and Commonwealth Office in the form requested but can be obtained from the European Court of Human Rights in Strasbourg.

Israel

Question

Asked by ***Lord Stoddart of Swindon***

To ask Her Majesty's Government whether they are aware of any constraints on Israel's possible ability to deploy nuclear weapons unilaterally. [HL13642]

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): There is a widespread assumption that Israel possesses nuclear weapons. We continue to call on Israel to become a party to the non-proliferation treaty. We are fully committed to seeing a Middle East entirely free from all weapons of mass destruction.

Israel and Palestine: West Bank

Question

Asked by ***Lord Hylton***

To ask Her Majesty's Government what representations they have made to the government of Israel about whether compensation has been paid to Palestinian owners, who lost land or are severed from their land, by the construction of the separation wall and barrier and associated roads on the West Bank. [HL13653]

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): We have not specifically raised with the Israeli authorities the prospect of compensation for Palestinian owners who have lost land. We remain concerned about evictions and demolitions of Palestinian property in the West Bank. The UK has a good record of lobbying hard on issues relating to house demolitions and settlement building.

We view any attempts to change the facts on the ground as a serious provocation likely to raise tensions and cause unnecessary suffering to ordinary Palestinians, as well as being harmful to the peace process and in contravention of international law.

Migration Advisory Committee

Question

Asked by ***Lord Laird***

To ask Her Majesty's Government whether the independent economists on the Migration Advisory Committee are able to take up party political appointments; and, if not, whether they will change that rule. [HL13600]

The Minister of State, Home Office (Lord Henley): The Migration Advisory Committee (MAC)'s code of conduct states that members must not hold any paid or high-profile unpaid posts in a political party, or engage in specific political activities on matters directly affecting the work of the MAC. The Government have no plans to change this.

Organ Transplantation

Questions

Asked by ***Baroness Tonge***

To ask Her Majesty's Government what safeguards are in place (1) in the European Union, and (2) in the United Kingdom, to prevent organ trafficking. [HL13623]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): In the United Kingdom we have a robust legal framework and regulatory oversight to combat any commercialisation or trafficking in this area. Sections 32 and 33 of the Human Tissue Act 2004 covering Wales, England and Northern Ireland prohibits commercial dealings in human material for transplantation and sets out the penalties for trafficking. The legislation in Scotland is separate but similar and is set out in the Human Tissue (Scotland) Act 2006.

It is a legal requirement in the UK that all organ removal and organ transplantation must be reported and recorded and the allocation of donated deceased organs must be to agreed criteria overseen by NHS Blood and Transplant. All living donations are regulated in line with legislation, and no live donation will proceed without an interview with the potential donor by an independent assessor to ensure that the donor is not receiving financial inducements to donate nor is he/she being coerced emotionally or physically.

In the European Union, all member states must implement Directive 2010/53/EU by 27 August 2012. This requires that all organ donations from living and deceased donors are voluntary and unpaid and that procurement should only proceed after all necessary requirements relating to consent in force in the member state have been met.

The UK has also participated in the development of the World Health Organization guiding principles to ensure that human material removed from deceased and living donors for the purpose of transplantation only takes place according to agreed principles. The declaration of Istanbul encourages all countries to draw up legal and professional frameworks to govern organ donation and transplantation activities.

Asked by ***Baroness Tonge***

To ask Her Majesty's Government what progress has been made in the United Kingdom to encourage organ donation. [HL13624]

Earl Howe: Since the publication of the report by the Organ Donation Taskforce in 2008, work has taken place to strengthen the donation programme and increase the number of organs available for patients. There are now over 200 highly trained specialist nurses for organ donation based in hospitals across the country and NHS Blood and Transplant is continuing to train and recruit more staff into this vital role. Clinical leads for organ donation have been appointed in every acute hospital working closely with hospital organ donation committees to increase donation rates. This means that we are on track to meet the 50 per cent improvement in deceased donor rates by 2013 anticipated by the taskforce, with latest available figures showing that deceased donor numbers have increased by 31.4 per cent against the 2007-8 baseline.

A Transitional Steering Group (TSG), chaired by Chris Rudge, has been established to help maintain the momentum achieved pending the introduction of the NHS Commissioning Board. During the transitional period the TSG will be focusing on the six big wins—optimising deceased donation rates through undertaking brainstem death testing and considering donation after cardiac death in all appropriate circumstances, increasing consent rates, increasing donation from emergency medicine, timely referral of donors and better donor management.

Overseas Aid

Questions

Asked by ***Baroness Tonge***

To ask Her Majesty's Government what proportion of the Department for International Development's expenditure on human resources for health in 2010–11 has been allocated specifically to meet the sexual and reproductive health needs of the poorest and most marginalised groups. [HL13535]

To ask Her Majesty's Government what proportion of the Department for International Development's expenditure on human resources for health in 2010–11 has been allocated to youth-friendly sexual and reproductive health services. [HL13536]

To ask Her Majesty's Government what proportion of the Department for International Development's expenditure on human resources for health in 2010–11 has been allocated to strengthening sexual and reproductive health community services. [HL13537]

Baroness Northover: Throughout our development programmes the Department for International Development's (DfID's) top priority is our commitment to achieving results. Our vision is a developing world where all women are able to exercise choice over the size and timing of their families. We will double our efforts to enable at least 10 million more women to use modern methods of family planning by 2015, and prevent more than 5 million unintended pregnancies.

We do not track inputs and expenditure according to the categories requested.

Details of expenditure against individual input sector codes including health, reproductive health, family planning, can be found on our annual publication of Statistics on International Development available at www.dfid.gov.uk. The UK's codes are based on the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) codes, which as used for reporting overseas development assistance and as a DAC member, the UK is committed to transparent reporting of development assistance in a way that permits international comparisons.

All spending over £500 is published, as per the UK Transparency Guarantee.

Recent analysis has estimated that 25 per cent of DfID's expenditure on health supports Human Resources for Health.

Passports

Question

Asked by ***Lord Laird***

To ask Her Majesty's Government how many passports have been issued by the British embassy to the Holy See in each year since 2005. [HL13636]

The Minister of State, Home Office (Lord Henley): The embassy to the Holy See does not issue passports.

Police and Social Responsibility Act 2011

Question

Asked by ***Baroness Trumpington***

To ask Her Majesty's Government what action they will take regarding the use of powers conferred by Part 3 of the Police and Social Responsibility Act 2011 (Parliament Square and surrounding area); and when they will take such action. [HL13498]

The Minister of State, Home Office (Lord Henley): The Government have issued a commencement order for the relevant provisions of the Police Reform and Social Responsibility Act 2011 to be brought into force from 19 December 2011.

Police: Discipline

Question

Asked by ***Lord Maginnis of Drumglass***

To ask Her Majesty's Government, further to the Written Answer by Lord Henley on 10 November (*WA 93*), when the Home Office ceased to keep records of the disciplinary record of individual police officers and service records pertaining to constabularies overall. [HL13558]

The Minister of State, Home Office (Lord Henley): The Home Office held aggregate data on police officer complaints and misconduct until 2004.

Prisons: Foreign Nationals

Question

Asked by ***The Earl of Listowel***

To ask Her Majesty's Government how many foreign nationals less than 18 years old were held in custody beyond the expiration of their sentences in the past 12 months; and for how long they were detained beyond the expiration of their sentences. [HL13549]

The Minister of State, Home Office (Lord Henley): In the past 12 months there have been two foreign nationals under the age of 18 who were detained beyond the end of their custodial sentence. The first was detained for 12 days due to discrepancies over their age and the other was detained for 118 days under ministerial authority.

This information is taken from internal management information and is subject to change.

Regional Growth Fund

Question

Asked by ***Lord Moonie***

To ask Her Majesty's Government how much money has reached companies and organisations granted funds in the first round of regional growth fund awards; how many offers have been withdrawn since the principal announcement; and what was their value. [HL13675]

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): Claims for £95.4 million have been received by companies and organisations granted funds in the first round of the regional growth fund awards. All monies are expected to be transferred by 1 December 2011. Two offers have been withdrawn since the conditional allocation of funding. The value of these awards will not be released in order not to prejudice the commercial interests of bidders.

Overall, more than half of those bids approved in April, are underway, with RGF funding expected to be called upon as the projects progress.

Responsibility Deal Alcohol Network

Questions

Asked by ***Baroness Hayter of Kentish Town***

To ask Her Majesty's Government how many meetings of the Responsibility Deal Alcohol Network have been held since it was formed. [HL13581]

To ask Her Majesty's Government when the Responsibility Deal Alcohol Network next plans to meet. [HL13582]

To ask Her Majesty's Government who are the current members of the Responsibility Deal Alcohol Network. [HL13583]

To ask Her Majesty's Government what progress has been made on each of the seven responsibility deal pledges on alcohol made by members of the Alcohol Network. [HL13584]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): Since its formation in November 2010 the Responsibility Deal Alcohol Network has met five times, with the last meeting on 23 November. The Responsibility Deal Alcohol Network plans to meet next on 26 January 2012.

The current members of the Responsibility Deal Alcohol Network are:

Jeremy Beadles	Chief Executive, Wine and Spirit Trade Association
Mark Bellis	Faculty of Public Health
Paul Edmonson-Jones	Director of Public Health Portsmouth City Council
Seymour Fortescue	Chairman, The Portman Group
Alan Hopley	Addaction
Liam Hughes	National Advisor, Local Government Association
Paul Kelly	Director of Corporate Affairs, ASDA
Paul Lincoln	Chief Executive, National Heart Forum
Prof. Martin Lombard	National Clinical Director for Liver Disease
Guy Mason	Head of Public Affairs, Morrisons Plc
Vicki Nobles	Director of Corporate Affairs, Diageo GB
Andrew Opie	Director of Food Policy, British Retail Consortium
Bruce Ray	Director of External Affairs, Bacardi Brown Foreman
Prof. Jonathan Shepherd	University of Cardiff

Nick Sheron	University of Southampton
Brigid Simmonds	Chief Executive, British Beer and Pub Association
Keiran Simpson	Corporate Relations Director, Heineken UK
Chief Constable Jon Stoddart	Association of Chief Police Officers
Paul Tuohy	Mentor UK
Kay Wheelton	Head of Commercial Non Food, Fuel and Drinks, The Co-operative
Scott Wilson	Director of Communications, Molson Coors
Kristen Wolfe	Head of Alcohol Policy, SAB Miller
Sarah Woolnough	Senior Policy Researcher, Cancer Research UK

All public health responsibility deal partners will be required to set out what they plan to do to meet the pledges they have signed up to. These pledge delivery plans will be published online by the end of the year. Partners will also be required to report annually on their progress on delivering against these plans, using a set of defined quantitative measures. Annual updates from the first year of the responsibility deal should be available on the department's website in the summer.

Asked by ***Baroness Hayter of Kentish Town***

To ask Her Majesty's Government what contribution members of the Responsibility Deal Alcohol Network have made to the development of the alcohol strategy; and when the strategy will be published. [HL13585]

Earl Howe: Some individuals, who are Responsibility Deal Alcohol Network members, have provided input to the strategy via stakeholder events over the summer. The remit of the Responsibility Deal Alcohol Network is not to develop strategy or policy.

We expect to publish the strategy in the first months of the new year.

Retail: Online Retailers

Question

Asked by ***Lord Lucas***

To ask Her Majesty's Government whether they will require online retailers such as Amazon.co.uk to publish on their websites the full name, business address, contact telephone number, email address, and VAT number of their third-party sellers so that customers can satisfy themselves that no VAT fraud is involved. [HL13491]

The Commercial Secretary to the Treasury (Lord Sassoon): A business that advertises or sells goods or services online must provide customers with its full name, its address and its contact details, including an email address. If the business's activities are subject to VAT, it must also provide the VAT registration number.

In June, Her Majesty's Revenue and Customs announced a series of campaigns to improve tax compliance by businesses, including one planned for spring 2012 which will focus on those using e-marketplaces to buy and sell goods.

Smoking

Question

Asked by ***Lord Laird***

To ask Her Majesty's Government whether they have conducted an inquiry into the dangers of passive smoking caused by groups of smokers located at the entrances of public buildings; if they have, what was the result; and, if they have not, whether they will do so. [HL13725]

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): The Government have not conducted an inquiry into the dangers of passive smoking caused by smokers at the entrances to buildings and have no current plans to do so.

Surveillance: Telecommunications

Question

Asked by ***Lord Alton of Liverpool***

To ask Her Majesty's Government, further to the Written Answer by Baroness Wilcox on 22 November (HL13224), in deciding not to prevent the sale of surveillance equipment to Iran what account they took of Article 4(2) of Council Regulation (EC) No 428/2009 of 5 May 2009, and of Article 1(c) of Council Decision 2007/140/CFSP, Chapter 1 of 26 July 2010, concerning restrictive measures against Iran, which relates to "equipment which might be used for internal repression". [HL13628]

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): Article 4(2) of Council Regulation (EC) 428/2009 states that a licence will be required for the export of items not listed in Annex I to the regulation if the destination is subject to an embargo imposed by a decision of the Council of the EU, the Organisation for Security and Co-operation in Europe, or a binding resolution of the Security Council of the UN, and the exporter has been informed that the items are or may be intended for use as components in military items, for the development, production or maintenance of military items, or as unfinished products in a plant for the production of military items. In this case, we understand the software is to be used to analyse data from the public mobile telephone network and not as a component in, or for the development, production or maintenance of, military items and therefore Article 4(2) does not apply.

Article 1(c) of Council Decision 2010/410/CFSP of 26 July 2010, which repealed Council Decision 2007/140/CFSP, is given effect throughout the European Union by Article 2.1(b) of Council Regulation (EU) 961/2010 of 25 October 2010. This states that it is prohibited to sell, supply, transfer or export equipment which might be used for internal repression as listed in Annex III of the regulation. The software in question is not listed in Annex III and therefore the prohibition in Article 2.1(b) does not apply.

Unemployment: Under 25s

Question

Asked by ***Lord Warner***

To ask Her Majesty's Government what measures to reduce unemployment among people aged under 25 (a) they have taken in the past 12 months, and (b) they are planning for the future. [HL13485]

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): On 12 May, the coalition Government announced a £60 million package of measures to help reduce youth unemployment. This included:

a new innovation fund, providing £10 million per year to fund organisations working with young people not in education, employment or training (NEET);

10,000 access to apprenticeship places to help 16 to 24 year-olds who need extra help to become an apprentice;

employer commitments to offer more apprenticeship places;

an increase in the number of work experience places young unemployed people a period of work experience between two and eight weeks in length to create 100,000 places by March 2012;

a new sector-based work academy route providing 50,000 unemployed people aged 18 and over in the next two years with training, work experience and a guaranteed interview;

additional support for 16 to 17 year-old JSA claimants, including more input from Jobcentre Plus advisers, access to work clubs and work experience and early entry to the Work Programme at age 18 for those already unemployed for six months or more; and

the continuation of the graduate talent pool brokerage service for 2011 graduates.

The new Work Programme began on 10 June 2011. This offers unemployed people targeted, personalised help, delivered through the best of private and voluntary sector providers. We are giving 18 to 24 year-olds priority access from the nine month point of their claim to jobseeker's allowance—with earlier entry from three months for the most vulnerable groups like young people age 18 who have already been NEET for six months and care leavers.

We are expanding the apprenticeships programme and will fund up to 250,000 more apprenticeships over the next four years compared to the previous Government's plans. In the 2011 Budget we announced a £180 million package of funding for 50,000 additional adult apprenticeships (19+) over the spending review period. This includes funding for training up to 40,000 additional apprenticeship places providing additional capacity to support young unemployed people, in particular through progression from the DWP work experience programme. The other 10,000 places will help to provide an increase in the number of advanced and higher apprenticeships offered by small and medium sized enterprises.

On 16 November, we announced new measures that will make it easier for companies to take on apprentices, and ensure that the quality of apprenticeships is continually improved. This includes providing £30 million of funding to support up to 20,000 additional jobs for young people in small firms by offering employers with up to 50 employees an incentive payment of £1,500 to take on apprentices aged 16 to 24.

We have been working across government to set out how we can maximise participation of 16 to 24 year-olds in education, training and work and tackle the consequences of young people being NEET for an extended period. We are due to publish a cross-government participation strategy shortly.

Visas

Questions

Asked by ***Lord Laird***

To ask Her Majesty's Government, further to the Written Answer by Lord Henley on 16 November (*WA 168–70*), how many confirmations of acceptance for studies each of the 88 tier 4 B rated general educational providers assigned in the past 12 months. [HL13703]

The Minister of State, Home Office (Lord Henley): From 5 September 2011, sponsors cannot be awarded a B rated (sponsor) licence. All new sponsors must now hold either an A rated (trusted) or highly trusted sponsor status.

At the time of my response of 16 November, there were 88 B rated sponsors on the tier four sponsor register. As at today's date there are currently 82 B rated sponsors on the register. This number has decreased due to a number of factors including sponsors being re-rated to an A rating or being suspended from the register.

The current B rated sponsors have assigned a total of 8,865 confirmations of acceptance for studies (CAS) in the past 12 months.

Asked by ***Lord Laird***

To ask Her Majesty's Government, further to the Written Answer by Lord Henley on 1 November (*WA 258*), whether Rayat London College and Lampton College London are A or B rated tier 4 student sponsors; and from which of the listed public bodies they obtained educational oversight. [HL13704]

Lord Henley: Rayat London College and Lampton College London are currently suspended from the sponsor register and, therefore, are not currently either A or B rated sponsors.

Rayat London College has applied to the Quality Assurance Agency for educational oversight.

Lampton College London has applied to the Independent Schools Inspectorate for educational oversight.

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