

Vol. 733
No. 233



Thursday
1 December 2011

PARLIAMENTARY DEBATES
(HANSARD)

HOUSE OF LORDS
OFFICIAL REPORT

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Committee (9th Day) (continued)

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[Continuation of Official Report from col. 340, of Wednesday, 30 November 2011.]

Health and Social Care Bill Committee (9th Day) (continued)

Wednesday 30 November 2011

10.07 pm

Amendments 159A to 169 not moved.

Amendment 170 had been withdrawn from the Marshalled List.

Amendments 170A to 171A not moved.

Amendments 172 and 173

Moved by **Earl Howe**

172: Clause 22, page 33, line 44, at end insert “or (b)”

173: Clause 22, page 34, line 2, at end insert “or (b)”

Amendments 172 and 173 agreed.

Amendment 174 not moved.

Amendment 175

Moved by **Earl Howe**

175: Clause 22, page 34, line 16, leave out “function under section 14L(3)(a)” and insert “functions under section 14L(3)(a) and (b)”

Amendment 175 agreed.

Amendments 175A to 175CC not moved.

Clause 22, as amended, agreed.

Amendment 175D not moved.

Schedule 2 : Clinical commissioning groups

Amendment 175E

Moved by **Lord Marks of Henley-on-Thames**

175E: Schedule 2, page 280, line 34, at end insert “and shall apply the provisions of paragraphs 19A and 19C and the guidelines in paragraph 19C of this Schedule”

Lord Marks of Henley-on-Thames: We will withdraw this amendment but I am bound to say that on the question of conflicts of interest, we were really rather disappointed that my noble friend the Minister maintains the very clear view that he expressed. Of course we accept that there is power in the Bill to deal with conflicts of interest, but there is no assurance that that will be done. I stress that there can be no public confidence that it will be done unless there is something on the face of the Bill, so I hope he will depart from that clear view and take these amendments away with him for consideration for the next stage. I beg to move.

Earl Howe: My Lords, if I could just respond to my noble friend I will of course reflect, as I always do, on the debates that we have and the points put forward and I should be glad to discuss the matters that he raised outside the Committee if that would be helpful to him.

Lord Marks of Henley-on-Thames: I am very grateful. On that basis I beg leave to withdraw the amendment.

Amendment 175E withdrawn.

Amendments 176A to 176AD not moved.

Schedule 2 agreed.

Clause 23 : Clinical commissioning groups: general duties etc.

Amendment 176B

Moved by **Lord Hunt of Kings Heath**

176B: Clause 23, page 35, line 41, at end insert—

“() promote awareness of the NHS Constitution amongst providers of primary medical services within the clinical commissioning group”

Lord Hunt of Kings Heath: My Lords, we come to a second large group of amendments concerned with clinical commissioning groups and the way they do business. They also relate to responsibility for primary medical services and also relationships with the other healthcare professions. Amendment 176B adds to the responsibility stated in 14O(1)(b), page 35, lines 40-1, “to promote awareness of the NHS Constitution among patients, staff and members of the public”.

I would have thought a good basis for the promotion of awareness of the constitution might be to assure that GPs themselves were knowledgeable about the NHS Constitution and hence my amendment to promote awareness among GPs by clinical commissioning groups.

The noble Earl has got two answers to any issue raised as to how the Secretary of State will ensure that there is comprehensive provision. One is the mandate and the other is the NHS Constitution. Given that, and given that he puts so much store by the NHS Constitution, which is very welcome, it would be nice to know that general practitioners had some knowledge of it and some understanding of their responsibilities under it as commissioners.

One of the most important responsibilities laid upon clinical commissioning groups is to promote the involvement of each patient in decisions about the provision of health services to patients. However in 14T(2), on page 36, it is surprising that while the board may publish guidance to clinical commissioning groups on this, it is not required to. Equally surprising is in 14T(3) that the clinical commissioning group is only required to have regard to such guidance. My Amendments 194A and 194B require the board to publish guidance and require clinical commissioning groups to implement the guidance. I hope the noble

[LORD HUNT OF KINGS HEATH]

Earl will be able to accept that involvement of the public is of such importance that it ought to be a mandatory requirement.

10.15pm

Amendment 197ZA concerns patient choice. Clause 14U, page 36, line 40, states that each clinical commissioning group must act with a view to enabling patients to make choices with respect to aspects of health services provided to them. That, I am sure, is worthy of support by all noble Lords, but I take it that this applies to the commissioning of services. What about GP services themselves? The noble Earl will know that there has been a long-standing issue with patients often finding it difficult to change GP practices. It would have been sensible to have given clinical commissioning groups some remit to encourage choice within primary medical services. We have a situation where clinical commissioning groups can decide to place large contracts with themselves as GP providers. We have already discussed the issue of conflict of interest. One is looking for some comfort that somewhere in this system there is going to be some proper performance management of the quality of primary medical services. Again, I would be interested in the noble Earl's views on that.

On the same basis, my Amendment 207A returns us to public involvement and consultation by CCGs set out in clause 14Z(2) on page 38 of the Bill. I would just stress the importance of ensuring that if CCGs are consulting about commissioning decisions, why should they not also consult on the provision of primary medical services? The noble Earl may say that it is inappropriate for CCGs to do this, because of potential conflicts of interest, and the fact that they do not actually hold the contract of GPs. That is going to be held by the National Commissioning Board. I understand that, but I do say to him that if the Government propose to establish local field offices of the board to hold those GP contracts, it is a much more complicated picture which could well undermine the prospects of integration of primary medical services with commissioning.

My Amendment 208ZA concerns the voluntary sector. I know that on Monday your Lordships had a long debate at the end of the evening on issues about the voluntary sector and supporting it. I do not intend to say anything more about it at the moment, save that the much-maligned primary care trusts have given a lot of support to third sector organisations. I would particularly mention some of the support they have given to organisations in relation to public health, or to organisations that have perhaps provided support for patients in their own homes in the community enabling discharge of patients from hospital. Can we have some assurance that clinical commissioning groups will at the very least be encouraged to give support to these kinds of programmes in the future?

Amendment 197D continues with the theme of clinical commissioning groups' consultation, but particularly stressing the need for other professional groups, the non-GPs, to be consulted. I heard what the noble Earl said earlier about the reason why professions such as dentistry were not to be given equal status with

GPs. I think there will be issues about the relationship between GPs and the other contractor professions given that GPs are going to have so much commissioning responsibility. It will be very important to ensure that there is a confidence-building exercise among those professions, so they do not feel excluded from the work of clinical commissioning groups. He did not answer my question on rural dispensing and the conflicts and tension between the pharmacists and the GPs who dispense rurally. I do not really expect him to do so tonight, but I would just point out to him that he knows that there is a real tension here. It is something in rural clinical commissioning groups that will need to be watched carefully.

My Amendments 216ZZA and 216ZA continue the theme in relation to commissioning plans. They are intended to ensure that the agreement of all individuals for whom the CCG has responsibility for ensuring comprehensive service provision, and of the health and wellbeing board, should be required to agree to a commissioning plan or revision of a plan. My Amendment 216ZBA follows the same theme and also suggests if there is a disagreement between the clinical commissioning group and the health and wellbeing board, then the national commissioning board should decide how that will be dealt with.

I do not think this new system has any chance of working unless the health and wellbeing boards are seen to be a core focus for pulling together public health, commissioning and social care and the integration of services. How can we make it effective? It is not unreasonable actually to give the health and wellbeing board some right of veto over the commissioning plan of CCGs within the local authority area to ensure the two come together.

Amendment 216ZB is consequential to 216ZBA. My Amendment 220 concerns performance assessment. Currently, on page 44, line 38, the Bill says that the board must publish a summary of performance assessment of CCGs. I wonder why the board would not publish the whole assessment: again, there seems to be a disparity of treatment. The way the Department of Health is working is that it has very tight control of all elements of the health service, but suddenly GPs within CCGs are going to have this light-touch mechanism. It is a continuing puzzle to me what it is about GPs that they suddenly deserve such special treatment. Unless we sort out the issues to do with conflict of interest, I can assure the noble Earl that there is going to be trouble ahead. With all our experience of allowing great power to individuals without proper and effective corporate governance, we know that this is going to end up in big trouble.

Finally, I come to my Amendment 245A, which is of interest to the pharmaceutical profession. In the Bill, there is a reference on page 289, line 30, to a substitution of Section 2 of the NHS Act 2006 to say:

"The Secretary of State, the Board or a clinical commissioning group may do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any function conferred on that person by this Act".

This is a substitute for the general power in the current 2006 legislation, which says:

"(1) The Secretary of State may—

(a) provide such services as he considers appropriate for the purpose of discharging any duty imposed on him by this Act, and

(b) do anything else which is calculated to facilitate, or is conducive or incidental to, the discharge of such a duty.

(2) Subsection (1) does not affect—

(a) the Secretary of State's powers apart from this section, and

(b) Chapter 1 of Part 7 (pharmaceutical services)".

In the course of substituting Section 2, the safeguarding of pharmaceutical services in Chapter 1 of Part 7 of the NHS Act is removed by virtue of the removal of 2(2)(b). Perhaps the noble Earl would like to write to me about that, but there certainly seems to be a concern among the pharmaceutical service negotiating committee that a point may have been missed there. I beg to move.

Baroness Hollins: My Lords, I shall speak to three amendments in this group. The purpose of Amendment 203B is to ensure that any healthcare provider to which a commissioning group gives a contract allows its clinicians enough time to work for the benefit of the NHS and its patients. The work to improve patient care does not just take place in a clinician's own place of work. A great deal of background planning and preparation must be done in order for patients to see improvements in their care. Developments in service improvement, clinical standards, research, education and training only happen because clinicians and others are able to contribute their time and expertise to work outside their own organisations for the benefit of the wider NHS. There is always an understandable pressure to make service delivery the priority, but clinicians are increasingly finding it difficult to find the time from their employers to participate in activity outside their own organisation. This includes work such as developing clinical guidelines, setting standards, ensuring research ethics, developing and providing educational curricula and assessments, and providing expert clinical advice for a range of regional or national bodies, including the Department of Health itself. Most national bodies now report that they find it increasingly hard to secure clinician input to their work. Given the importance of their contribution, I do not think it unreasonable to ask all healthcare providers, including private providers who have won contracts with commissioning groups, to allow their clinicians reasonable time to help the NHS and its patients in this way.

The active engagement and leadership of clinicians underpins the Government's reforms. New structures, such as clinical senates and clinical commissioning groups, require the active involvement of clinicians, but this will not happen unless clinicians are supported and given the time to participate in this work for the benefit of the wider NHS. This is work to improve patient care, and patient care will suffer if it cannot be provided. The Academy of Medical Royal Colleges, of which I am a past member, would like to see the Bill contain a duty on employers to facilitate staff involvement in defined work on behalf of the wider NHS outside their own organisations.

I will now speak to Amendments 210 and 217. The purpose of Amendment 210 is to place on the NHS Commissioning Board a specific duty to issue guidance on the production of joint strategic needs assessments. Should that amendment be accepted, Amendment 217

places upon clinical commissioning groups a specific duty to demonstrate ways in which they have taken into account such guidance on production of JSNAs when presenting their commissioning plans. The Bill in its current form places a duty on the NHS Commissioning Board to publish guidance for commissioning consortia on the discharge of their commissioning functions. This is inadequate since it does not place upon the board a specific duty to produce guidance on the production of JSNAs. The transfer of commissioning from PCTs to clinical commissioning groups is arguably the most fundamental change in the Bill. Commissioning carried out by clinical commissioning groups must accurately identify and meet the needs of patients with mental illness and their carers. It is vital that the JSNAs that inform their commissioning decisions are of a high quality and capture as well as practically possible the prevalence of mental health problems within populations and the needs of people with mental health problems within those populations.

JSNAs are currently carried out by local authorities. Many local authorities acknowledge a lack of data available to them regarding the prevalence of mental health problems and learning disability in the populations they serve. For example, in 2008 the Cambridgeshire Joint Strategic Needs Assessment for mental health reported:

"There is a lack of good-quality local data on mental health prevalence and national data is used to calculate the estimated prevalence of mental ill health in the local population using the population statistics".

Or take Barking in Dagenham in 2010-11:

"The next JSNA needs to explore more specific data and actions for people with learning disabilities and people with autism. A recent self-assessment carried out by the trust highlighted this as a major gap".

Or take Southwark:

"There are limited data available about the prevalence of mental illness and the demographic profile of sufferers in Southwark".

Often, particularly in relation to moderate mental illness, there are little—if any—locally collected data, and estimates have to be used.

In Part 5, the Bill outlines the framework for joint strategic needs assessments and sets out a joint responsibility between local authorities and clinical commissioning groups. Commissioning plans are formulated on the basis of joint strategic needs assessments, and if we look at the organisations that will be involved with drawing up the commissioning plans, the problems are clear. Many local authorities acknowledge their difficulties with obtaining adequate and robust prevalence data on mental health issues and learning disability, while clinical commissioning groups will lack any experience of carrying out this kind of audit. As a result, patients with mental health problems and their carers may have little confidence that the commissioning plans produced with local authorities, under the Bill's provision as it currently stands, will reflect the true prevalence of mental health problems and learning disability in the population of which they form part.

[BARONESS HOLLINS]

There is some existing guidance on the construction of joint strategic needs assessments, produced in 2009 by the National Mental Health Development Unit. It said that,

“population level mental health needs assessment has not yet featured prominently in the joint strategic needs assessment process”.

The toolkit was designed to,

“allow a wider range of local partners to become more aware of how mental health needs and issues”,

should be addressed. It went on to say that it would hope to,

“facilitate more joint working at a local level to deliver better outcomes for the population”.

However, this organisation no longer exists and I do not think the Department of Health currently has any such guidance. It is dangerous to expect that clinical commissioning groups, which have no prior expertise in this area, will, in undertaking joint strategic needs assessments, stop the problems which local authorities have already encountered.

10.30 pm

Amendment 210 would ensure that the NHS Commissioning Board is required to produce annually revised, up-to-date guidance for clinical commissioning groups, including examples of good practice on how to conduct a JSNA so that it best captures the current and future needs of their entire population. Amendment 217 would ensure that clinical commissioning groups are required to demonstrate that they had taken this guidance into account when conducting their joint strategic needs assessments.

Lord Patel of Bradford: I shall speak in support of Amendments 210 and 217 which, as the noble Baroness, Lady Hollins, has just said, concern the quality and use of joint strategic needs assessments. These assessments are potentially vital to the work of CCGs and, more importantly, for the benefit of the populations they serve. The joint assessment is designed to lead to stronger partnership between communities, local government and the health service by providing a firm foundation for commissioning. This not only leads to improvements in health and social care provision, but also reduces health inequalities. It is an essential tool in the development of a truly integrated service across health and social care, which is why it is so important that the CCGs have adequate guidance on how to ensure that high-quality needs assessment is undertaken and used.

The benefits are clear—helping commissioners, especially CCGs, to specify the outcomes that they want to see, including those that encourage local innovation and, in so doing, helping providers to better shape services that address needs fully. However, the experience of joint assessments has not been uniform across the country and there are challenges in making these assessments as effective as they can be. A joint assessment inevitably involves complex sets of information and data from a wide range of sources, and this brings challenges in analysis and presentation which allow data to be intelligible and used for the intended purposes.

Joint needs assessments are a lot more than a technical exercise in data management. The most effective assessments involve local communities and use direct feedback and knowledge from those communities. I saw the power of this kind of assessment at first hand when I was fortunate enough to lead the Department of Health's black and minority-ethnic needs assessment programme on drug use across England. The strength and success of the approach undertaken in this programme was that local people were integral to its work. When it comes to identifying needs, there can be no greater source of information than that which comes directly from the people who are most affected by the issue. For example, in the case of drug use, it was important to recognise the experiences of a wide range of people who were affected, including women, young people, older people, people with disabilities, families, carers, and particularly drug users. The Department of Health programme demonstrated, however, that it is not an easy or simple process. It does not just happen, and it is vital to distinguish real engagement from mere consultative involvement.

Here in London, I have recently seen further evidence of the significance and impact of such effective community engagement in identifying and addressing needs. The Well London project, which is funded through the Big Lottery Fund, is an exciting £9.6 million programme that has been working with local people in 20 of the most deprived boroughs across the capital. Speaking about Well London, following a recent award for the project from the Royal Society of Public Health, Professor Sir Michael Marmot, director of the UCL Institute of Health Equity, said:

“If we are to reduce health inequities it is essential to take action on the social determinants of health—the ‘causes of the causes’ of ill health. That means working in partnership at local level to improve the social conditions in which we are born, live, grow, work and age. The Well London Alliance Partnership does just that. Empowering individuals and communities, and giving people a voice is integral to addressing health inequalities. I am delighted the Partnership has achieved well-deserved recognition for its work”.

Running over the past three years, Well London has transformed health through promoting health and well-being, improving healthy eating choices, promoting access to open spaces and increasing physical activity. The University of East London, which is a lead partner in the research phase of the project, is revealing some absolutely fascinating results and I will share a few of its findings with the House.

Results show that from a total of 10,843 participants, 8,400 reported an increase in healthy eating, 7,800 reported increased access to healthy food, 9,400 reported an increase in physical activity, 8,900 reported feeling more positive and 8,500 reported an increase in the understanding of mental well-being. The real key to success is having community engagement at heart. Professor Adrian Renton, the director of the Institute for Health and Human Development at UEL, said of this work:

“When we designed the project, we took account of the evidence that local social economic and physical environments provide strong barriers which prevent people from adopting healthier lifestyles and leading happier lives”.

This is an excellent example of how to undertake a strategic needs assessment across health and social

care that is driven by local communities and brings together commissioners, providers and the university sector to work alongside those communities in making a real difference to health and well-being. This is why it is essential to have adequate guidance on how to conduct such assessments, and that clinical commissioning groups should be required to demonstrate how they use such guidance. I hope that the noble Earl will see the benefit of these amendments and lend his support to making joint strategic needs assessments a truly effective tool in health improvement and service planning.

Baroness Whitaker: My Lords, I, too, support Amendments 210 and 217, for the reasons which the two noble Lords who have just spoken have given in respect of mental health and learning disabilities. There is another vulnerable group that I would like to draw attention to. The Minister told me in his extremely helpful answer to my Written Question:

“The Government are developing statutory guidance ... to support health and well-being boards in undertaking joint strategic needs assessments ... including the need to take full account of the needs of vulnerable groups”.—[*Official Report*, 17/10/11; col. WA 16.]

This is excellent. Will this be published for consultation and, if so, when? Commissioning boards also need guidance and I cannot see why, if it is statutory guidance, it is not in the Bill? There is one further reason why it should be. I shall briefly cite one of my colleagues who works with Gypsies and Travellers. She points out that currently, most local authorities and PCTs take their data about the ethnic breakdown of their population from health records. We know that not only are Travellers not included as a category in many of these data collecting tools, but many Gypsies and Travellers do not want to disclose their ethnicity for fear of discrimination, so they are wholly underestimated and consequently, based on the inadequate data they have, PCTs and local authorities do not see the need to do a thorough needs assessment. That is why there has to be an explicit provision in the Bill, so that authorities will look for the information. It is not going to be there to hand; they will have to look for it. Guidance is essential if we are to have the full picture.

Baroness Jolly: My Lords, I shall speak to Amendments 203D, 216ZAZA, and 216ZAZB. This is all about strengthening the relationship between health and well-being boards and clinical commissioning groups. These relationships will be key. Unless they are right and work properly, we will not get the system that patients deserve.

Partnership is key. Amendment 203D puts a new duty on clinical commissioning groups to ensure that their communication plans address the priorities of health and well-being board strategies. Amendments 216ZAZA and 216ZAZB work together, and are about strengthening language. We go from a fairly weak,

“The clinical commissioning group must involve each relevant Health and Wellbeing Board in preparing or revising the plan.”

to a stronger,

“Clinical commissioning groups must ensure each relevant Health and Wellbeing Board is a key partner in preparing or revising the plan.”

It puts the onus on clinical commissioning groups to ensure that health and well-being board plans are involved. The aim of the amendments is to give health and well-being boards more teeth in expecting commissioners, including councils, to do their bit to deliver the agreed priorities of the health and well-being board as expressed in the joint strategy.

Health and well-being boards are intended to bring a strong sense of place, local priorities, and democratic accountability. Advised by the director of public health, they will have population accountability for the whole area, and this is likely to be expressed as local priorities for action to address inequalities of outcome or access within the area.

As the Bill stands, the onus is on the commissioners to have regard to population outcomes and local priorities, consider joint commissioning, and to involve health and well-being boards throughout the preparation of their commissioning plans. This will, at best, create locally flavoured service accountability. There is no weight in the legislation.

Lord Hunt of Kings Heath: I am grateful to the noble Baroness for giving way, but I am very puzzled. I thought that Liberal Democrat policy was to give local authorities much greater involvement. Why does she not support my amendment, which would give much greater teeth to local authorities by giving them veto power over the commissioning plan? I fail to see why the Liberal Democrats are not supporting local government. In their manifesto they talked about much greater local government involvement. Why will they not support my amendment?

Baroness Jolly: I will explain to the noble Lord where this amendment came from. Certainly, as a group we were concerned that the relationship between health and well-being boards and clinical commissioning groups should be strengthened, so we spoke to the LGA. The LGA worked with us in producing these amendments. I would expect that the LGA, which clearly has a view about localism, would have given that priority.

Lord Hunt of Kings Heath: My Lords, we are not here merely to express the views of pressure groups.

Baroness Jolly: It is not a view of pressure groups. It was the view of our group when we were discussing what we wanted to pursue. We decided we wanted to look at how these links could be strengthened. Without the expertise among ourselves, we consulted with the LGA.

No weight is given in the Bill to the health and well-being boards' whole population planning for its area, and to the jointly agreed local priorities. If the health and well-being board judges them not to be adequately addressed in service commissioning plans, it should have the power to refer them back. This may be particularly important in relation to the NHS Commissioning Board and Public Health England's plans for the area.

[BARONESS JOLLY]

I hope that the Minister would agree that the need for these two organisations to work closely together, delivering local plans for local authorities, is taken as read. I wonder whether he would feel minded to make this more explicit at Report.

Baroness Finlay of Llandaff: My Lords, I shall speak to several amendments in this group. Some have already been spoken to. Some that have been led by my noble friend Baroness Hollins have already been addressed. I emphasise the importance of their benefit to the NHS as a whole—in fact, the whole of healthcare—by professionals being able to participate in the broader standard-setting and educational functions that she outlined in her speech.

It is also important that those from further afield are able to participate. It is quite easy for employees in the south-east to get to educational committees or colleges and participate in developing NICE guidance, but for those in rural areas, it may take hours to come down to committee. Even if they try to do video, links they do not necessarily work well. Those are the clinicians who will be the local leaders driving up the quality of services in their areas, so there is a direct benefit to the services in which they work, as well as to the broader NHS. However, their time has to be accounted for and unless it is recognised this is important national work, there is a real danger have some of these standards driven by those who happen to live and work in the London or Greater London area.

I turn to Amendments 208, 209, 212, and 214, which concern the importance of commissioning for less common conditions. Earlier this evening Lord McKenzie of Culkein already addressed the different population sizes that are ideal for different groups for commissioning. I emphasise that a lot of people in the country have rare and complex conditions, rare to the GP, but not rare in secondary care. Take, for example, cystic fibrosis, or patients with neurological disease who will need non-invasive positive pressure ventilation. This will be completely outside a GP's competence to establish and maintain. They need a highly specialized service within an area that they can access from where they live. Similarly with genetic services, the importance of good genetic advice at all stages, particularly when genetic conditions are diagnosed, is important. Sadly, many in primary care do not yet have a full understanding of the importance of such advice. Children with conditions such as diabetes may be seen quite commonly in a paediatric clinic, but insulin-dependent diabetic children under five will be a rarity for a GP who is likely to only ever have one on their list at any time. It will also be important that guidance is developed as to how commissioning for this broad range of conditions will occur. Otherwise, will have an increasing number of patients who cannot access the excellence that they know that they could—or even worse, they may just be excluded from it. It is not until they are running into major complications that they become aware of a service that should have had for many years.

These are all probing amendments. I draw the Minister's attention to Amendment 211, where we are trying to require an audit of the decisions taken and linking

back to HealthWatch England and the CQC itself to see whether the guidance is being followed and implemented in practice.

I hope that, when the Minister responds to this group of amendments, he will outline what will happen to the patient whose clinical commissioning group does not commission a service that that patient needs. I have already given the example of end-of-life care for patients in Southampton with motor neuron disease. Currently, those patients are moving house to go to Gloucester or they are just dying badly, never accessing the specialist care that they ought to get. Will the Minister respond by saying that it is up to the clinical commissioning group and therefore this inequity will continue, or is there a way that patients will be able to bypass their clinical commissioning groups and have a central point of appeal? Will it be through the Commissioning Board that they genuinely access the core clinical care that they should have? We have the skills in the country; we can provide it for people.

The same sort of situation arises for children with diabetes accessing insulin pumps. We know that they are under-utilised at the moment. There are a lot of children whose diabetes could be better controlled if they were accessing insulin pumps earlier and if the support services were in place for it. If the clinical commissioning group do not commission them because they do not understand that, in the very long-term, to avoid complications much later, it is a priority in this child's life, how will those people access the service? I look forward to the Minister's reply.

Baroness Masham of Ilton: My Lords, I have put my name to Amendment 209. Many GPs do not know about many less common conditions. Many surgeons do not know either. To give myself as an example, on several occasions when I have had a disaster I have had to explain that I do not feel from my lesion down, with all the dangers that that involves. Most of them cannot take it in. Amendment 209, to give guidance, might prevent mistakes. The expert patient has become useful with many conditions in helping in these matters.

Lord Patel: My Lords, I rise to speak to one amendment in particular. I will be very brief. I support some of the comments made by the noble Baronesses, Lady Hollins and Lady Finlay, about the clinicians' need to have time where they can contribute to the work of the wider NHS. I strongly support Amendment 210. The noble Lord, Lord Patel of Bradford, gave an excellent example of the value of the JSNA. I wish we could have a similar kind of needs assessment in the community for the care of people with chronic diseases. It might be good to use it to do so.

I speak briefly to Amendment 219 about the performance assessment of the clinical commissioning groups. Quite rightly it says that the local health and wellbeing board should be consulted. My amendment asked the question: why not go wider than that? Although I used only the provider as an example of going wider to consult the performance of CCGs, it equally applies to consulting Monitor or even CQC. I look forward to a reply from the Minister as to why it should not be wider than just the health and wellbeing board.

Lord MacKenzie of Culkein: My Lords, I rise to speak to Amendments 209 and 212, to which I have put my name. I spoke earlier about the issue of commissioning for less common conditions when I expressed my concern that CCGs governing small populations would not be able to deliver a service to patients in these categories. We heard from my noble friend Lord Warner earlier today and in earlier debates about the reduction of PCTs from 302 to something like 51. This would cover enough of the population to ensure effective commissioning. However, despite all his best efforts, there are many long-term conditions still falling between all stools. We heard from the noble Baroness, Lady Finlay, about the difficulties in different parts of the country; she referred to Southampton, for example.

Those with an interest in this matter will have been briefed by the neurological alliance about the paucity of the present Lincolnshire service. The PCT there has never implemented its own plan to address the problems for patients with less common conditions. A Lincolnshire neurological alliance tried to get the prototype CCGs engaged with that issue, but so far to no avail. When they called a meeting to try to bring the matter forward not one of the CCGs sent anyone to the meeting. This is what many of us feared and why we need these amendments or something like them on the face of the Bill. If we will deliver a better, more coherent and joined-up service, we cannot just rely on the promise that all will be all right when the Bill becomes law. The Commissioning Board must have the ability to see how CCGs plan to commission services for people with less common conditions, and be able to take a country-wide view of what is going on.

Services for patients are patchy in many parts of the country, and if this Bill becomes an Act there will need to be considerable improvement on that. I hope that the Minister can tell us tonight that the necessary steps will be taken to ensure that that patchiness will end, and that guidance is developed as set out in Amendment 209.

Earl Howe: My Lords, the broad theme of these amendments is to ensure the effectiveness of the commissioning process and the competence of commissioners, which includes the engagement with local authorities, patients and experts to ensure that clinical commissioning meets patient needs. Of course, that theme is entirely to the point.

In support of this, there is an extensive framework in the Bill to encourage CCGs to work with health and wellbeing boards in the exercise of their commissioning functions, and to seek expert advice. To my mind though, it is important that requirements in this regard remain proportionate and do not encumber CCGs with a duty to consult—as, for example, Amendment 197C would require—on the exercise of all of their functions. The health and wellbeing board is the forum for ensuring democratic legitimacy in the commissioning process.

Indeed, the health and wellbeing board is very much a key partner of the CCG, to use the good phrase used in Amendments 216ZAZA and 216ZAZB, but the partnership takes physical form in the jointly

agreed health and wellbeing strategy, which is based on the JSNA. It is a joint production, it captures an agreed outlook for commissioning, and it should inform the commissioning decisions of the local authority, and indeed the CCG.

I listened with care to the noble Lord, Lord Patel of Bradford, in this context. He spoke very convincingly about the need for evidence to support commissioning, but also, most importantly, that such evidence is used. We completely agree with him on that, and that is why we have created that link between the JSNA and the joint health and wellbeing strategy. The strategy here will play a key role in shaping service commissioning across the area.

Clause 189 of the Bill specifically refers to the “partner” CCGs of the health and wellbeing board. However, the CCG has to retain ultimate responsibility for the commissioning and spending decisions of the commissioning plan. That is important. The health and wellbeing board is not accountable for those decisions, and, of course, it does not have the same statutory responsibilities as CCGs, so we would not want to suggest that the plan is a joint one. It remains the CCG’s plan.

Noble Lords will find quite detailed procedures in the Bill in Sections 14Z9 to 14Z12 in Clause 23, on the process of drafting and revising commissioning plans. These include requirements in relation to consultation.

There are also direct requirements in the Bill in relation to ensuring that CCGs secure appropriate advice. We have also signalled the intention to facilitate the development of clinical senates and networks in order to provide a supportive matrix of expert opinion. However, I would not point to the particular duties or powers within the Bill or to contractual obligations in order to reassure noble Lords, or indeed to reassure the Royal College of Physicians, in relation to Amendment 203B. Rather, I would point to the tremendous potential in the new arrangements for bringing about a cultural change, and above all, to the key principle of clinicians leading the whole process of commissioning, from the assessment of need to the management of contracts. I believe that the system we are aiming to put in place will provide the right elements to stimulate the involvement of clinicians across sectors and organisations, with everything focused on that specific goal of delivering improved outcomes for patients.

The Bill institutes a framework for ensuring that clinicians are fully involved and supportive of commissioning, either as commissioners, or providing expert advice. Again, this is a duty that should not be amended so as to become a burden.

11 pm

I should like to highlight some of the ways in which we can ensure the competence of commissioners in relation to the amendments tabled by the noble Baroness, Lady Finlay. They aim to ensure the effectiveness of CCGs in commissioning for low-volume specialised conditions. I should like to reassure the noble Baroness that everything these amendments aim to achieve can be done within the existing provisions of the Bill. The board’s guidance on commissioning, which it must produce under new Section 14Z6, can cover

[EARL HOWE]

commissioning for less common conditions, and the board must be satisfied, before it establishes a CCG, that the area it would cover is appropriate to undertake effective commissioning and that the CCG has appropriate systems in place to do this.

The board possesses, under new Section 14Z19, the ability to intervene in a CCG where it considers that there is a significant risk that the CCG will fail to exercise a function. That would include commissioning effectively to meet the needs of its population. The actions that the board could require would include directing another CCG to undertake a function of a CCG, and CCG commissioning plans could cover arrangements for commissioning for less common conditions, but this should be something which CCGs have the flexibility and autonomy to approach as they see fit. In terms of recourse for the patient in the circumstances that the noble Baroness outlined, the patient could speak to a range of bodies such as the Commissioning Board in an extreme case, or they could go to judicial review. But I think a patient's first port of call, if they get no joy from the CCG, is the board. I can give a reassurance that CCGs will be under a statutory obligation to arrange for provision of care to meet the reasonable requirements of the people for whom they have responsibility, and the board must oversee that.

Baroness Finlay of Llandaff: Can the Minister define “reasonable requirements”? What is “reasonable” and in whose mind would something be reasonable or unreasonable? Some of us would say that the discrepancies we see emerging now are not reasonable, but they are decisions that are already being made in commissioning. This will become very important because of the financial climate in which the commissioning groups will operate. I would also appreciate knowing who the patient can actually appeal to. The noble Earl has just said in his response that patients can go to judicial review, but the terms of such reviews are tightly drawn and it is a difficult, adversarial process. You have to be a very motivated person to pursue it. But we are talking about patients who are ill, who often are vulnerable and do not have the financial resources needed to undertake such an activity.

Earl Howe: I appreciate what the noble Baroness says about judicial review, and of course she is right that it is a daunting process for the average citizen. As to her question of what is reasonable, I am sure she knows that that is not a question I can answer in general terms. It will depend on specific circumstances. I can only say that the board will have a duty to perform an annual assessment of how well each CCG has fulfilled its duties in the previous financial year. During the course of a year, matters may be drawn to its attention which it will take a view on, either that the CCG has taken a reasonable stance or an unreasonable one. I would have thought that if a patient insists on having a treatment that NICE has said is not cost-effective, that is not a reasonable request for an NHS patient. However, that is only one example, and it is not one that the noble Baroness cited. I had better write to the noble Baroness to set out further and better particulars of this issue, if that would be helpful to her.

We fully recognise the importance to effective commissioning of ensuring that allocations give CCGs the resources to meet the distinctive needs of their local population, and clearly we would expect the board to ensure that their methodology of allocation takes into account local factors, and inequalities would be one of those factors. Our preference, however, is not to place particular weight on one factor or a set of factors, however meritorious they may be, to which the board would be tied, but to give the board a free hand in setting the methodology for its allocations and the scope of its analysis of the needs of a CCG's population. I am really addressing Amendment 220 in that context.

In resisting the proposals that CCGs should be under a duty to agree their commissioning plans with the relevant health and well-being boards or an absolute requirement for plans to address the priorities of the health and well-being strategy, we are actually following the advice of the Future Forum. It said that to give health and well-being boards powers to sign off commissioning plans would create an unworkable dual accountability as boards could oppose decisions by CCGs which would have, after all, the statutory responsibility to arrange services to meet the needs of patients and responsibility for the budgets with which to do this. Commissioning competence will also be assured through the board's annual performance assessment of each CCG, which I referred to a minute ago and in which the board must have regard to commissioning guidance that it has published under new Section 14Z6. Clearly, the board would be exercising its function of assessment and report only if it provided all relevant information at its disposal. Giving the board the role of determining how it presents this information is a proportionate and appropriate level of responsibility. The Secretary of State may issue advice on annual performance assessments under the provision in new Section 14Z14(5)(a).

Amendment 245A places a limit on the general power of the Secretary of State, the NHS Commissioning Board and CCGs to take action to discharge their functions. While the amendment is no doubt well intentioned, it is unnecessary and would have the unintended consequence of preventing the NHS Commissioning Board from using its general power to support it in commissioning pharmaceutical services.

The only amendment that I have not specifically addressed is Amendment 176B, from the noble Lord, Lord Hunt of Kings Heath, which is about the NHS constitution. It would expand the duty in new Section 14O to promote the NHS constitution to require CCGs to promote awareness of the constitution among providers of primary medical services. CCGs are already under a duty to promote awareness of the constitution among patients, staff and members of the public, which would not exclude staff in primary care providers. CCG membership would have to be aware of the constitution to promote awareness of it among others.

I am conscious that I have not answered the question from the noble Baroness, Lady Whitaker, and I hope that she will allow me to write to her.

Lord Patel: My Lords, I do not think that the Minister answered the question that I asked about the performance assessment of CCGs; that it is to be done only by health and well-being boards and not by wider groups such as the providers, Monitor or the CQC.

Earl Howe: Well, my Lords, again that is a matter on which I will have to write to the noble Lord. The thinking is evolving on this—that is the truth of it—and it is probably best if I set out in a letter where our thoughts have reached.

Lord Patel: If the thinking is evolving, I hope that my question is helpful.

Lord Hunt of Kings Heath: My Lords, I am grateful to the Minister for that very comprehensive response. There are just two points to make. First, I thought that the noble Baroness, Lady Finlay, raised a very interesting question about the test of reasonableness. I come back to the issue of PCTs delaying treatment but keeping it within the 18-week wait, which the Secretary of State intervened on. CCGs may well do the same because it is a way of saving money but keeping within the target set, which no doubt will be reinforced by the mandate. I am not expecting him to answer, but it is an interesting question of whether that is reasonable or not.

On the question of the relationship between the health and well-being board and CCGs on their clinical commissioning plans, I realise that I caused great offence to the noble Baroness, Lady Eaton, and my noble friend Lord Beecham by describing the esteemed Local Government Association as a pressure group. I meant it in the context of tabling amendments here; although we are often helped by groups outside, we none the less stand on our own two feet. Now that my noble friend has given me the LGA evidence, I have to say that it was pretty weak and woeful stuff in relation to health and well-being boards. I have another document here from the Association of North East Councils which has produced an excellent paper on health and well-being boards that really gets to the heart of how these could be the engine room of change, collaboration and co-operation across public health, health and social care.

I understand the point the noble Earl has made about CCGs being accountable—I am not sure who they are accountable to, but they are accountable—for the commissioning plans, but my amendment allows for that. Essentially it says that the health and well-being board has the leverage to be able to call in the commissioning plans. In the end, if there is no agreement, although I suspect that normally there would be agreement, it will be up to the board to decide how to go forward, so there is a kind of mechanism for dealing with that. However, we underestimate the potential of health and well-being boards at our peril. I hope that I can persuade the Liberal Democrat Benches to have the courage of their convictions and support giving local authorities, through the health and well-being boards, much greater clout in this in the future. I beg leave to withdraw my amendment.

Amendment 176B withdrawn.

Amendments 177 to 178A not moved.

Amendment 178B had been withdrawn from the Marshalled List.

Amendments 179 to 184B not moved.

Amendment 185

Moved by Lord Kakkar

185: Clause 23, page 36, line 23, at end insert—

“() In particular, each clinical commissioning group must monitor the performance of primary care practitioners within its area and report its findings to the Board.”

Lord Kakkar: My Lords, Amendment 185, tabled in my name and that of my noble friend Lord Patel, proposes that each clinical commissioning group must monitor the performance of primary care practitioners within its area and report its findings to the NHS Commissioning Board. The purpose of this amendment is to try to explore with Her Majesty's Government their approach towards performance management and the assessment of outcomes in primary care.

In hospital practice we are all obliged to subject ourselves to very careful performance assessment. There is careful collection of data on clinical outcomes, patient safety and patient experience. Indeed, with the adoption of service line reporting in many acute trusts, there is also meaningful information on the utilisation of resources to be able to determine whether those resources are being appropriately used to achieve the best clinical outcomes for our patients. The availability of the collection of these data and their reporting is having an important impact on transforming clinical care in the acute secondary sector. For instance, only this week the report on data analysed by the Dr Foster organisation has demonstrated that in certain acute trusts at weekends, where staffing levels are potentially not appropriate, particularly for senior clinical staff, the management of acute stroke, myocardial infarction and other acute emergencies is associated with a less good clinical outcome.

To date, a similar approach to the collection of outcome data in primary care has not been achieved. As a result, it is not possible to speak with the same certainty about the performance of individual practitioners in primary care or indeed the performance and outcomes of primary care teams. This is a particularly important issue in the Bill. Rightly, the Bill recognises the importance of trying to change patterns and pathways of care to ensure that those with chronic conditions are more routinely managed in the primary care environment rather than being referred to the secondary care environment. However, if appropriate arrangements are not in place for the assessment of outcomes and performance in primary care, the transformation of clinical pathways of care to the primary care environment could result in a deterioration of standards and poorer outcomes for those patients because there will be no routine collection and reporting of the data on performance.

11.15 pm

It is argued that there will be certain measures and safeguards in place. For instance, all clinical practitioners will be subject to revalidation on a five-yearly basis.

[LORD KAKKAR]

The regulator—in this case the General Medical Council—will have responsibility for that. However, as things stand, the responsible officers who will have the obligation of supervising the revalidation process for primary care practitioners are based in PCTs. I would be interested to know what arrangements have been made with regard to describing the role and establishing the function of responsible officers with regard to future clinical commissioning groups.

Another issue is the current system of the quality outcomes framework and the additional points and therefore additional payments that can be achieved in primary care through meeting certain process measures that speak to quality in general practice. It is well recognised that the quality outcomes framework does not provide sufficient granularity to speak with the same confidence about the achievement of good clinical outcomes and the performance of primary care practitioners and groups. More needs to be done, potentially, with regard to the mandate that will be passed to the NHS Commissioning Board, and subsequently there must be instruction from the Commissioning Board to clinical commissioning groups on setting appropriate standards and ensuring that data are collected in a systematic and comprehensive fashion so as to be able to speak to performance in primary care.

Is any work ongoing in the department with regard to the development of potential standards, and objective and validated outcome measures that might be applied by clinical commissioning groups to the management and measurement of performance in primary care? I would like to understand the view of Her Majesty's Government with regard to this area, how it might be developed going forward and if any thought has been given to how or whether clinical commissioning groups need to report back information on outcomes in primary care to the NHS Commissioning Board. This is an important issue because it will be the Commissioning Board that holds contracts for individual primary care practices.

Perhaps I may remind the Minister of the interesting and informative report published by the King's Fund in March this year, entitled *Quality Improvement in General Practice*, which at the time the noble Earl warmly welcomed. I note a quotation from the *Health Service Journal* in March 2011 in which the noble Earl said:

“Practices will be monitored, supported and held to account by the consortia”—

now the clinical commissioning groups—

“What GPs have to realise is they are going to be held to account in a new way”.

How should noble Lords interpret that statement by the Minister with regard to the importance of assessing outcomes in primary care? I beg to move.

Lord Patel: My Lords, I support my noble friend Lord Kakkar's amendment on the performance of general practice and primary care physicians. I am a fellow of the Royal College of General Practitioners, although after I have said what I am going to say, maybe I will not be any more. I hope that that not will happen, because I say this wishing to help my primary care colleagues.

The noble Lord referred to the King's Fund report, published in April 2011, which was an inquiry into the quality of general practice. The inquiry was conducted by an independent panel of experts, chaired by Sir Ian Kennedy, and represents the most extensive review of quality across general practice undertaken in recent years, bringing together a wide range of evidence for the first time. The inquiry concluded that, while the majority of care provided in general practice is good—I emphasise that—there are widespread variations in performance and gaps in the quality of care delivered by some general practices. There are variations in the quality of diagnosis, particularly for cancers. There are disparities in the rate of referrals; for example, there is an eightfold variation in the rate at which practices urgently refer patients with suspected symptoms of cancer to a specialist. There is variation in the quality of prescribing. It is estimated that the NHS could save at least £200 million a year through more efficient prescribing of drugs such as statins.

The report also highlighted concerns that continuity of care is worsening, despite the evidence that this is what patients prefer and that they prefer to see the same general practitioner. Variations in the experience of patients and co-ordination of care highlighted by the report also included wide variations in admission rates for patients with conditions that could be treated outside the hospital. While we are promoting fewer patients going into the hospital, that is an important point. Only one in 10 patients with long-term conditions reports being told that they have a care plan, despite a policy commitment that all of them should have one.

There are a number of challenges facing general practitioners: demographic change, higher patient expectations, new technology and medicine, and the changing environment in which they operate. The challenges are therefore accelerating the trend for practices to work as multi-professional teams, with GPs working closely with specialists and other professionals within and outside their practice, delivering a new deal for patients that involves them much more closely in decisions about their care. GPs are moving from being gatekeepers—usually keeping the gate closed—to navigators, co-ordinating care for people with complex needs and helping and guiding patients to other public services, and being held accountable for the quality of care provided, which is accelerating the shift away from small practices working in isolation towards a more federated network of practices working more closely with one another and other professionals. Practices are looking beyond their surgery door by focusing on prevention and taking a more active role in public health issues such as obesity and reaching out to deprived communities.

CCGs will have a critical role to play in supporting quality improvement in general practice, monitoring the quality of individual practices and sharing their knowledge of this with the NHS Commissioning Board, which will hold the contracts of nearly 2,000 practice groups, and with the Care Quality Commission, which will be responsible for registering practices. It will also be important that the national contracts, the commissioning outcomes framework and the quality premium—no doubt we will discuss that in another group of amendments—are aligned to improve patient

outcomes. The experience of the quality outcome framework, QOF, has been that it is too narrowly focused. Research has shown that it has not actually delivered in improving outcomes and is insufficiently ambitious in the performance benchmarks that it has used. With most practices scoring over 90 per cent against QOF measures, the National Quality Board concluded that it,

“is not sufficiently able to discriminate between performance”.

In terms of measuring performance in primary care, and particularly in terms of measuring performance in relation to chronic diseases, the experience from the United States is quite interesting, and I shall quote it so that we can learn from it:

“All of the US groups in this study aimed to performance manage their doctors”—

this is in California—

“both specialists and primary care. For primary care physicians especially, where quality indicators were more prevalent, peer review of performance data on productivity and quality was relied upon as a valuable route to improved performance”.

The document also says:

“It was common for data to be reported back to individual physicians, usually with names attached”—

a practice that is carried out in some specialities in the United Kingdom—

“The leadership of medical groups was clear that intra-peer competition was a powerful tool for improvement”.

It states further,

“It is notable that the US medical group leaders were clear that the financial interests should never interfere with decisions about what was best for individual patients. In containing utilisation, they attempted to appeal primarily to doctors’ clinical professionalism”,

and that CCGs and the NHS Commissioning Board will,

“have to make a convincing clinical case to their rank-and-file GPs for efficiency, based on evidence about service quality. Without this, GPs are unlikely to cooperate with a consortium’s wider goal of achieving cost-effective care”.

My noble friend Lord Kakkar quoted the noble Earl being reported in the *Health Service Journal*. If I might tease him a bit more, he also said that CCGs and the NHS Commissioning Board would be better able to tackle performance than PCTs, and that the report that he approved of,

“makes clear we haven’t had sufficient levers in the system to expose substandard general practice in the past, and we do need to do that”.

He might, then, be able to say what the thinking is towards achieving this.

Baroness Finlay of Llandaff: My Lords, this group of amendments is complex. I declare an interest as I chaired the commission on medical generalism, whose report is currently being consulted across the general practice community in the UK. I am also a fellow of the Royal College of General Practitioners, having worked as a GP myself. Having said that, our report highlighted the wide variation in training of general practitioners, and the need for general practitioners to develop new pathways of working with secondary care, to be gate-openers at appropriate times, and not to keep the gate closed inappropriately.

I would also draw your Lordships’ attention to an article in this week’s *British Medical Journal* which asked whether general practitioners are being adequately monitored, and quotes a senior general practitioner as saying:

“If you asked me, ‘Do you know how safe general practice is?’, I would say, ‘I have no idea’”.

The article, sadly, highlights the fact that, in a snapshot of GPs referred to and subsequently disciplined by the General Medical Council, GPs are overrepresented in comparison to hospital doctors. That is partly because hospital doctors are employed in NHS trusts, working in teams where they are overseen by other people, whereas GPs are, typically, independent contractors, sometimes working in isolation, despite the recommendations from people like Dame Janet Smith. That makes it harder for those with responsibility for primary care to access the information that could alert them to poorly performing doctors.

That was the background to my amendment about NICE, which I unfortunately missed in the order—I realise that I can do nothing about that now; it was, anyway, a probing amendment—but it came out of evidence given to us in the commission. One of the pathfinder groups was clear that it did not feel under any obligation to adhere to or observe NICE guidance in the way in which it commissions services.

11.30 pm

I suggest that it will be very important to put in place adequate monitoring systems. It will be impossible for the Commissioning Board, at such a distance from individual general practitioners, to develop the intelligence to know what quality of care is being provided and how they are behaving and being monitored, given that the current structures will be disbanded. Against that background I suggest that the amendments around standards of primary care are particularly important.

It was also against that background that I tabled Amendment 248B in the group. It is intended to ensure that there is an overview of general practice. Again, it is a probing amendment that will apply to Part 4 of the Bill on medical services. I look forward to the Minister’s reply on how the quality of general practice will be driven up under the new arrangements.

Baroness Jolly: My Lords, I will speak to Amendments 213A and 213B, which are both probing amendments that concern the powers of the board with respect to clinical commissioning groups, and the all-round capacity-building of the clinical commissioning groups. Clearly, in their emerging, embryonic state they will need guidance, support and assistance. We hope that as they grow and improve, the need will decrease with time. However, when the need for growth and nurturing ends, the needs will change, new challenges will come along and there will be a constant need to ensure that clinical commissioning groups are able to draw on expertise in capacity-building. The amendments call on the board to offer this.

Proposed new Section 14Z8(2) states:

“The assistance that may be provided includes ... financial assistance”.

That is already there. We propose to add,

[BARONESS JOLLY]

“building and supporting capabilities”.

We anticipate that the board will do this, perhaps through the local field forces that will be best placed.

When the Bill was published, there was no provision. There was financial assistance and an undertaking to make available the services of the board to clinical commissioning groups, but it was not made absolutely clear what that meant and there was nothing specific about providing capacity-building. The amendment fills that gap. Will the Minister explain how it is anticipated that this could be provided? Is it expected that this should be commissioned by CCGs from the private sector?

Lord Hunt of Kings Heath: My Lords, the preceding speakers put their finger on a big issue, namely the quality of primary medical services and GPs. As noble Lords tactfully put it, the Government propose to give enormous power to GPs when the quality of their provision is variable, as we know. There is a fundamental question about why the Government consider that GPs are so well placed to exercise this huge commissioning responsibility. All Governments have struggled with this area. Out-of-hours services is an example of where GPs should have been in the driving seat, but it was not a great advert for their commissioning abilities. There is a genuine question, although it is probably a bit late for the noble Earl to answer it in depth, about the great ability that GPs are supposed to have in relation to commissioning. I am extremely puzzled by the logic of the government reforms. We have never been given an answer about why so much power will be given to general practitioners. It is extraordinary.

My Amendment 213 in this group concerns the power conferred in new Section 14Z7 on the board to exercise the functions of the clinical commissioning group at the request of a clinical commissioning group. I also have another probing amendment, Amendment 213ZA, concerning the power conferred in new Section 14Z8 for the board to “provide assistance or support” to clinical commissioning groups. Can the noble Earl clarify the kind of circumstances in which those powers can be used? Could he also say how this relates to the failure regime for clinical commissioning groups?

On a somewhat different tack, Amendment 220C concerns new Section 223G with regard to the financial allocations to clinical commissioning groups. The amendment requires the board to publish each year details of the methodology used to determine allocations to clinical commissioning groups. It is important that there is transparency in the allocation process, and the best way to ensure that is to publish full details of the methodology behind the allocation. For instance, will socio-economic factors influence the allocation? How much will health inequalities be taken into account? It would be helpful if the noble Earl could give an indication at some stage of the methodology and how transparent it will be.

Baroness Wilkins: My Lords, I speak to Amendment 239A tabled in my name. The Minister will remember the protracted debates surrounding the drug tariff and

the concerns of the thousands of people who use a wide range of incontinence products and services. As anyone who knows what life is like if you have to depend on the reliability of a stoma bag or a catheter, these products and services provide the bedrock of our dignity. Soiling ourselves in public is one of the deepest fears we all share, and despite the dry sound of the wording—I forgive the unintended pun there—this is what the amendment is about.

The months and years of negotiation around the drug tariff were finally resolved, but concerns have now been renewed with this Bill. Currently, it is the Secretary of State’s duty to set the drug tariff’s national framework. This sets the price and standards of prescription products such as stoma appliances, and the fees that pharmacies and appliance contractors can charge for their services, such as a home delivery service. But now the Explanatory Notes to the Bill suggest that, in the future, the drug tariff will be split. The NHS Commissioning Board will determine the level of fees and allowances paid for pharmaceutical services, while the Secretary of State will determine the reimbursement price for actual products. This amendment would require the NHS Commissioning Board to consult with appropriate representatives of patient groups and the industry before determining the payments. It is a probing amendment to get clarity on the relationship between the Secretary of State’s powers to set national frameworks and those of the NHS Commissioning Board in relation to pharmaceutical expenditure. There are concerns that changes to this system and any reduction in the Secretary of State’s powers to set national pharmaceutical reimbursement and remuneration will lead to the potential fragmentation of services across the country and deteriorating quality of care, with patients unable to get the products they need to ensure their well-being and independence.

There is particular concern about the implications for the services that pharmaceutical contractors provide to patients. These should be determined separately from the products that patients use. Obviously, being taught how to use an appliance properly is essential for its effective and safe use, but without that support in the community, there is a much greater likelihood of inappropriate usage, the increased risk of infection and higher rates of device wastage which will result in greater costs for the NHS and much more risk for patients. There is a need for greater clarity about what the changes to the Secretary of State’s powers would mean in practice and what the impact of these changes will be on the future stable supply of these products and services.

There are around 400,000 people in the UK who use urology and stoma products on a long-term or lifelong basis and, of these, around 150,000 who use a dispensing appliance contractor to deliver their products rather than a pharmacy. It is important that a wide range of products is available as people’s needs vary so much. It is essential that someone can continue to receive a product in which they have confidence. What is more, these are invasive products, so the clinical services offered by pharmacies and dispensing and compliance contractors are also critically important to being able to steer clear of hospital and maintain your ordinary life and work. At present, the existing

pharmaceutical service regulations provide patients with choice: choice of a clinically appropriate product and a delivery method that suits their needs as long-term users. It is vitally important that this security is protected in the new NHS architecture.

There are already concerns about the fragmentation of arrangements. Some PCTs have introduced restrictive formularies in an attempt to limit patient product choice, while others have tried to restrict choice of supplier by introducing a preferred provider. There is concern that the number of such developments could expand once the number of commissioning organisations increases, creating more and more postcode lotteries.

I would ask the Minister four questions about what is an essential service, despite the amount of talking that goes on in the Chamber. First of all, what powers will the Secretary of State have to determine reimbursement prices for products and remuneration fees and allowances for pharmaceutical contractors? Secondly, how will the changes to the Secretary of State's duty to determine pharmaceutical remuneration affect the drug tariff? Thirdly, what is the Government's position on the future of the drug tariff? Finally, how will the Government ensure that patients and industry are consulted before the NHS Commissioning Board and/or the Secretary of State determine pharmaceutical remuneration? I beg to move.

Baroness Masham of Ilton: My Lords, I want to support my noble friend. All I want to say is that these products are absolutely vital for people with long-term conditions. Will the Minister say why there is a split between remuneration and reimbursement? We would really like the answer to that question. It is even more worrying if the Minister does not know that there is a split, since that will cause fragmentation.

Baroness Finlay of Llandaff: My Lords, if I might intervene briefly, I think that this short debate has just illustrated that some people in our community are extremely vulnerable to small changes in commissioning, which may deny them a product that they need to maintain their independence and dignity and to be able to function fully in life and feel like a whole person. It is not appropriate for us to look only at some of the things that are easy to count—such as hip operations, major heart disease or whatever. Issues such as continence devices are difficult for people to talk about. It takes a lot of courage to raise them in a debate, as the noble Baronesses have done today, but they are incredibly important and there is a real concern out there that people will not get what they need to carry on functioning in the society in which we live.

Baroness Williams of Crosby: The point that I will raise with the Minister is far less important than the one just raised by the noble Baroness, Lady Finlay. I merely point to new Section 14Z19. Simply, I am puzzled about its heading, which refers to the "Power to give directions". My understanding was that we had already discussed at great length the fact that the only powers to give direction depended on the existence of a failure. Whether there is a mistake in the text, I do not know. Perhaps the Minister can explain why the power to intervene relating to the Secretary of State

suddenly creeps back into the Bill when I thought that we had established that it was elicited only by a significant failure.

11.45 pm

Earl Howe: My Lords, in responding to these amendments, I begin by highlighting one basic point. Our intention is that the relationship between the NHS Commissioning Board and CCGs should be mutually supportive. Of course, the board will have responsibility for overseeing the system of CCGs, authorising them and making any subsequent changes to their constitution, as well as for assessing their performance each year. In addition, the Bill gives the board clear powers of intervention. We should recognise, without the need to change the heading of new Section 14Z19, as Amendment 220ZA would do, that the intervention powers of the board are expressly designed for circumstances in which the CCG is at significant risk of failing, is failing, or has failed, to exercise its functions.

However, the board is also there to provide effective support to CCGs beyond the allocation to them of commissioning budgets. On this topic, while supportive of the principle behind Amendment 220C concerning transparency in how the board determines its allocations to CCGs, we should be cautious in our consideration of amendments on the specifics of how the board performs its functions, which would be better suited to the Secretary of State's mandate.

The Bill contains provisions to equip the board to act as a supportive partner to CCGs in the exercise of their functions. These provisions are flexible and proportionate, and I would urge that they stand unchanged. The board has the power to provide direct support to a CCG if it requests it, by taking on the specific commissioning function of a group. That is to say, if a CCG needed support in exercising its ability to commission care to meet the needs of its population, as set out in these proposed new sections, the board could, at its request, step in and undertake the commissioning function on a temporary basis. This is a sensible power to give to the board and CCGs, and it would be unwise to remove it. CCGs would only make such requests where they felt they needed the support of the board—that is obvious—and the use of this power would prevent deterioration in a CCG's ability to exercise a commissioning function, with its attendant threat to patient outcomes. It might be valuable, in particular, where a CCG or CCGs were finding it difficult to effectively commission for more specialised services across a much wider area than that covered by individual, or small groups of, CCGs.

There is no question of CCGs using this power to delegate their legal responsibilities for their patients. Even where the CCG requested that the board should support it by exercising a function on its behalf, the CCG would retain legal responsibility for the exercise of the function. That could not be delegated. The board, similarly, could not arrogate CCG functions. A CCG must expressly request that the board undertakes a function on its behalf. Noble Lords should also note that the power in new Section 14Z7 may be limited by the Secretary of State in regulations so as to ensure, should it be necessary, that certain functions of the CCG cannot be so delegated to the board.

[EARL HOWE]

Likewise, Amendment 213B is not necessary. I emphasise that the support or assistance that the board can supply would be in order to build CCG capability. This is unequivocally one of the reasons why the board would provide resources, or employees, or financial assistance to a CCG, so I fully support it. The amendment is slightly out of place as it adds to the list of ways in which the board would provide support, but is in fact an outcome of those inputs. I worry that it may lead the board to give undue weight to that outcome when we do not want to imply that board support should be limited to that objective. Clearly, without this amendment, the board has perfect freedom within the provisions of this section to support CCGs in building their capacity and capability. I hope, therefore, that this will be sufficient for the noble Baroness.

Some of these amendments would change the relationship between CCGs and providers of primary medical services and pharmaceutical services. CCGs must support the board in discharging its duty under Section 13E in relation to securing continuous improvement in the quality of primary medical services. It is right that this duty is expressed in terms of quality improvement. Amendment 185 would place a duty on CCGs to support the NHS Commissioning Board in securing continuous improvement in primary medical services by monitoring the performance of individual primary care practitioners in their area and reporting their findings to the board.

I support the concern of the noble Lord, Lord Kakkar, to ensure that CCGs are effective in supporting the board on the quality of primary care. As the noble Lord rightly said, quality in primary care is absolutely key to the success of the NHS, not least in managing chronic conditions. A great deal of work is currently going on in the Department of Health to construct meaningful quality metrics for primary care, including patient-reported outcomes, combined with plans to ensure the transparency of general practice performance. Our information strategy, which we will publish in a few months, will say a lot more about that. However, I fear that stipulating what activity CCGs should undertake in exercising this function would be to impose too specific a requirement on them in the performance of their duty under new Section 14R. The philosophy of the Bill is very much to limit processes and instead focus on outcomes.

The Commissioning Board will performance-manage contracts with providers of primary medical services, although it may ask CCGs to carry out on its behalf some aspects of the work involved. That could include promoting reviewing practice performance and ensuring clinical governance. However, it must be the board's decision as to how it wishes to performance-manage its contracts with providers, and how it should be supported in that by CCGs. The CCG will similarly want flexibility in its approach to how, as a peer group, it ensures the quality of the care provided by individual practitioners and practices. In this regard, the experiences of GPs as commissioners under practice-based commissioning will be invaluable in identifying ways to strengthen the relationship between practice

and commissioner. There have been a lot of very useful lessons learnt from practice-based commissioning, which must not go by the board.

In general, clinical commissioning groups will play a systematic role in helping to monitor, benchmark and improve the quality of primary medical services for the practices within their membership. This will include the use of clinical governance and clinical audit. Armed with the right information systems, clinical commissioning groups will be well placed to spot potential issues of poor performance at an early stage, to identify the root causes of the problems and to work with the board or the Care Quality Commission and other agencies as necessary to support practices and practitioners in improving performance. I see it as a mutually supportive arrangement. We have already had proof of this, as I say, in many practice-based commissioning consortia.

Local medical committees will also have a role to play here. I very much recognise the important role played by LMCs in relation to the local provision of primary medical services. We want this to continue, which is why the Health and Social Care Bill continues to provide a legal framework within which local medical committees may operate. The proposed amendments to Section 97 of the NHS Act 2006, which are set out in paragraph 42 of Schedule 4 to the Health and Social Care Bill, fully preserve the existing primary legislative provisions, with references to primary care trusts being replaced by references to the NHS Commissioning Board. This is a straightforward consequence of the proposal that the NHS Commissioning Board should take on statutory responsibility for the commissioning of primary medical services from PCTs.

Under the Bill, the NHS Commissioning Board will be able to arrange for clinical commissioning groups to undertake some of the board's functions relating to primary medical services. Where these functions include a duty on the board to take certain actions with regard to LMCs, the delegation of a function will not alter this duty. As well as protecting the existing legislative framework, I very much wish to encourage both the board and emerging clinical commissioning groups to identify ways in which they can work with LMCs for the greater good. I believe that this important task will be more successful if it is not constrained by further primary legislation. After all, local relationships have been shown to flourish within the existing primary legislative framework, which we are maintaining.

The noble Lord, Lord Hunt, asked, "Why GPs?", and contended that the Government had never explained why GPs should be given the responsibility for commissioning. I found that a rather extraordinary statement. He may recall that his right honourable friend Andy Burnham was very keen on GP commissioning—and I hope still is. In May 2006 in another place he said:

"We are introducing practice-based commissioning. That change will put power in the hands of local GPs to drive improvements in their area, so it should give more power to their elbow than they have at present".—[*Official Report*, Commons, 16/5/06; cols. 861-2.]

That is an endorsement of the principle if ever there was one.

Lord Hunt of Kings Heath: My Lords, I cannot let that pass. Of course, but that was within the context of a statutory framework that was a delegation from primary care trusts. The problem with the new system is that there is no accountability for what GPs do. There is simply no accountability whatever for GPs' commissioning decisions to the public and patients.

Earl Howe: I totally and utterly disagree. There is bags of accountability in the form of accountability to patients in the local area, accountability to the health and well-being board, and to the NHS Commissioning Board which we have debated at length. I do not understand why the noble Lord should doubt this. It permeates the Bill. Indeed, the whole thrust of our policy has been around two words: "autonomy" and "accountability". They are two sides of the same coin. You cannot have responsible autonomy without accountability, and we believe that we have built it into the system. The noble Lord may not have been in the Chamber when I answered my noble friend Lady Tonge a while ago, who asked me a similar question: why on earth are we doing this? We have published a White Paper and numerous documents to explain why we think this is the way to go and the philosophy behind what we are doing is that clinical commissioning about placing the financial power to change health services in the hands of those NHS professionals whom the public trust most. We know that the public trust them most and we believe that they are up to the task, and so do they.

The noble Baroness, Lady Wilkins, asked me about the drug tariff and appliances. I am the first to recognise how important this is. I myself, when in opposition, lobbied the department rather hard on the subject on a number of occasions because I well recognise all the issues to which she referred. Appliance contractors will be consulted about appliance services and remuneration, as they are now. As now, a full range of pharmaceutical services are expected to be commissioned in the future, including appliance services, but in view of the hour the best thing for me to do is to write her a letter. She raised a number of issues and it is probably appropriate that I should write to her and copy the letter to noble Lords.

I hope that I have at least illuminated these areas helpfully for noble Lords and that the amendment will be withdrawn.

Midnight

Lord Kakkar: I thank the Minister for his detailed and helpful response to Amendment 185 and to the amendments tabled by other noble Lords in this group. With regard to the question of securing the information and proceeding with some certainty on being able to understand that there will be an appropriate assessment of outcomes and performance in primary care, I think that more work needs to be done. It is clearly a very important area and this debate has highlighted ongoing concerns and anxieties; not so much about the principle—I think that all noble Lords have accepted the principle that it is important that there is appropriate assessment of outcomes and performance in primary care—but that mechanisms are going to be in place to ensure

that those data are collected, are made publicly available and can be acted upon to ensure that the very best healthcare is provided for the patients of our country. Recognising that there is more work to be done, I beg leave to withdraw the amendment.

Amendment 185 withdrawn.

Amendments 186 to 199ZA not moved.

Amendment 199ZB had been withdrawn from the Marshalled List.

Amendments 199A to 202 not moved.

Amendment 203

Moved by The Earl of Sandwich

203: Clause 23, page 38, line 2, at end insert—

"14Y1 Duty as to addiction to prescribed drugs

(1) Each clinical commissioning group shall have a duty to provide services to those suffering from addiction and withdrawal from prescribed drugs.

(2) In fulfilling this duty, clinical commissioning groups must co-operate with and take account of the work of non-governmental organisations."

The Earl of Sandwich: My Lords, the Minister already knows that, in moving the amendment, I use the example of the dangers of prescribed drugs and the urgent need to commission services for those suffering from addiction and withdrawal. This amendment follows the interesting amendment of the noble Lord, Lord Rooker, on Monday. I am sorry that I could not support him in his attempt at a Division because he said a lot of interesting things, although I know that this has become an historic occasion. That amendment pointed to the advantages of building on the work of voluntary organisations, especially those in the vanguard of meeting a particular need, as they are in this case. I know that the Minister has given an answer, that the board and clinical commissioning may want to find work that will assist in the effective commissioning of services:

"For instance, the board may provide funding to voluntary organisations with particular expertise in the provision of support to people with rare specialist conditions".—[*Official Report*, 28/11/2011; col. 119].

I have some experience of voluntary organisations, and I know that, on the whole, they provide a cost-effective service; the argument has already been well made in the debate. Using the example of prescribed drugs, research into current services has shown that, in a few cases, the NHS is already working alongside very frail NGOs. In some cases, the relationship is symbiotic. For example, in Belfast a very skilled NHS worker is leading the team. In Bristol, Oldham and Newcastle the PCTs are part-funding local services and providing care workers. However, in most areas of the UK PCTs are woefully unaware of the problem and the department is woefully unaware that the PCTs are unaware, and therefore no-one is able to provide the necessary training and meet the need. The noble Lord, Lord Warner, spoke earlier about the shortcomings of PCTs as commissioning groups in certain situations.

[THE EARL OF SANDWICH]

My first question is already answered: can the Minister assure me that he will do everything to support good practice in the voluntary sector for victims of prescribed drugs or for any other deserving category of patients? It would help if there was a duty to support NGOs in the Bill. I know that cannot be the case, and, as I say, the Minister has answered this.

Coming specifically to Amendment 203, I will briefly repeat my interest, because, as the Minister already knows, a relative of mine has been confined to his room for over a year in almost constant pain, unable to take part in everyday life or even in family life. I do not wish to ask for special pleading, because he is one of perhaps 1.5 million people who have taken sleeping pills or other benzodiazepines who are now at risk from drug addiction which in some cases is worse than illegal drug addiction. Most of this is at the hands of doctors. As I said at Second Reading, the NHS has created a problem and it is up to the NHS to solve it.

My research tells me that the Government are not solving it. They are confusing illegal with legal drugs and they are making polite noises about what they might do, but they are not doing it. They are making claims at a high level about services which are clearly not being provided at a lower level. While the voluntary sector is being forced to act on its own, the Government show little sign of supporting it and in the present climate are likely to resist anything new.

My amendment is about the CCGs commissioning services themselves. I know that we are going through a period of change and it is very hard to see what is now a PCT or an emerging CCG. I do know that a service confronting benzo-addiction withdrawal is not an easy service to set up. Voluntary activity so often stems from the experience of individuals who have had such experiences. Up and down the country, there are some people of high quality who have either been through the perils of addiction themselves or have been very close to someone who has been addicted. They are the people who can do the job. They are remarkable not only because they are able to apply their experience as carers and therapists without training, but because they have also had to teach themselves management, the ability to start an office, to raise funds, to advertise a service and most of all to balance time and money when there are so many other things to think about. It is like a health service in miniature. These are the people whom this Bill should support and to whom the CCGs should have a duty. I beg to move.

Baroness Masham of Ilton: My Lords, I support my noble friend's amendments. Addiction to over-the-counter drugs is an important issue. It can cause suicide. It ruins families. People cannot work. It needs all our support and I hope that the Minister will do something about this.

Lord Alderdice: My Lords, I support the noble Earl. He initiated a debate on this question some time ago. As I said at the time, one has to be careful. There are many patients who benefit considerably from some of these medications, when they are given responsibly

and monitored responsibly, but that does not always happen. One has to take this particularly seriously because, while those with alcohol and drug addiction often come to the health service for treatment—although perhaps they should come more often—this kind of addiction to prescribed drugs is effectively an iatrogenic disorder. Patients have come to have these medications, and they are not all over-the-counter medications. They are available properly only through doctors, so doctors and the health service have to take a particular responsibility. In that regard, I support the noble Earl in his concerns and I hope my noble friend the Minister will be able to give some reassurance that this is regarded seriously as an iatrogenic disorder that the health service is in some cases responsible for bringing into play through absence of proper monitoring and, in some cases, errant prescribing.

However, there is a second component, which is the involvement of NGOs and charities in treatment. When I was a young psychiatrist, I was very interested in alcohol and drug addiction and I worked in a unit. We did not have a specialised unit in Northern Ireland at that time to deal with drug addiction. I looked around in Ireland, North and South, and on this side of the water to find a service that would work. I found a voluntary organisation for addicts. I had myself admitted and went through the whole process as though I was an addict, removing myself from any contact with family and all my worldly goods, as it were, engaging in all the groups and the responsibilities that people undertook, the therapy sessions and so on. It was a very important experience for me because, like some other things that I did, it helped me to see things from the point of view of the patient and the kind of things that we were expecting patients to undertake.

However, I was doing it not only for my own interest, but to try to see what services would be possible in Northern Ireland. It became clear to me that, for all sorts of reasons, it was extremely difficult—well nigh impossible—to implement a service of that kind within the NHS, because we put all sorts of restrictions on the NHS. For example, one of the things that was very important was to go and do the washing and the cooking and be involved together in those kinds of things. If you tried to do that in the NHS, you immediately ran into all sorts of regulations, which we frequently discuss in a place like this. So it is not always that easy to do.

In a more general sense, sometimes charities and voluntary organisations can bring special things to services that it is very difficult to provide in the context of the NHS. Some of these are experimental and we should wait to see whether they are successful before the NHS takes them on board. That is very appropriate, but the burden of my plea in support of what the noble Earl says is that we should try to ensure that the contribution that is made by charities, particularly smaller charities, and voluntary organisations, which can experiment in these ways, continues to be valued. I have received a number of reports of some of the smaller charitable organisations, in the current climate—not after changes in legislation—finding it increasingly difficult to survive, because they only provide limited services. We have to take this seriously. I do not necessarily say that it has to go in the Bill, but even at

this late stage in the evening, the noble Earl deserves credit for raising this question, and I hope my noble friend can give some comfort on it.

Baroness Finlay of Llandaff: My Lords, I also support my noble friend Lord Sandwich on this terribly important topic. It links back to standards of primary care, which we have spoken about earlier this evening. I know that it is very late, but I hope that the Minister might take this away and consider it in terms of the standards of monitoring of primary and secondary care—as has been said, this is an iatrogenic disease for many people—and the importance that the third sector can play and fill a major gap that is not filled by any services that are formally commissioned. Without the third sector, these people will end up becoming ever-more needing of NHS services, but sadly they often get services that are not appropriate to their needs.

12.15 am

Baroness Hollins: My Lords, may I briefly speak in support of the amendment? I suggest that the duty to provide services to those suffering from addiction and withdrawal should also be a duty to ensure prevention of inappropriate prescription, which I think was implicit in what the noble Earl was saying. There are some very good NICE guidelines available. That refers back to an amendment of my noble friend Lady Finlay. It is important that commissioning groups require clinicians to take note of NICE guidelines, which might assist in preventing this kind of problem developing in the future.

Baroness Thornton: My Lords, I was very pleased to put my name to the amendment tabled by the noble Earl, Lord Sandwich. He and I have been discussing this for several years from various vantage points of my own, as a Minister and then supporting him in debates in the House. In a way, we lose sight of patients with conditions when we discuss this Bill. We talk about the theories of the clinical commissioning groups and how the relationships will work, the coterminosity of things and all of that, but at the end of the day it is about people who are ill, who have conditions or who are in very grave need of support. That is this group of people—those who have been prescribed drugs in a perfectly normal way by doctors and who then become addicted to them.

Several things happen here, which the noble Earl has very eloquently described. One of them is that the NHS seems to find it difficult to distinguish between the addiction of these people and drug addiction for illegal substances. That means that the treatment that is offered is often inappropriate.

In a way, this amendment is a test of the efficacy of the Bill. Can this new architecture deal with the problem that is being posed by this group of patients? In a way, I am looking for an answer from the Minister to address that. There is no question that some small progress has been made in support of voluntary organisations and in a few parts of the National Health Service through PCTs, which are of course being abolished, to address this issue, but it is not sufficient. I am worried that that progress is in jeopardy in the transition.

How will the transition ensure that what already exists is supported? This particular issue is a special and important one. It is not a huge issue in the framework of billions of pounds being spent by the NHS, but it is very important for those patients for whom it matters and for those in the future. So who will have responsibility for it? At what level will it be addressed? And how will the transition protect what exists at the moment?

Baroness Williams of Crosby: My Lords, the point raised by the noble Earl, Lord Sandwich, who has worked very closely in this field, should disturb all of us. It is a very late hour and I do not wish to detain the Committee any longer, except to say that one of the parts of the answer to this problem could be a much closer involvement of pharmacists in the whole issue of the drug regulation of individual patients. I know that my noble friend Lord Clement-Jones has raised before the question of how far qualified pharmacists can be brought more closely into very integrated working with CCGs. I simply suggest that this may be one of the ways to limit the terrible plight that the noble Earl, Lord Sandwich, was talking about—an individual pharmacist related directly to somebody who was closely dependent on a drug regime and the misuse of that drug regime in a way that leads to addiction.

Earl Howe: My Lords, I add my thanks to the noble Earl for his continued commitment to highlighting the needs of those suffering from addiction to prescribed drugs. It is one of the virtues of our House that it allows scope for noble Lords to highlight these issues in this kind of context. I am the first to recognise the pain and the plight of those whose lives have often been seriously damaged by such addiction, not to mention the damage done to families.

There are clear national guidelines for the usage of and withdrawal from prescribed drugs such as benzodiazepines, and GPs, pharmacists and specialist prescribers have those guidelines, but we know that what the noble Earl said is correct. There is access to support and treatment services for addiction to medicines in most local areas but some local areas are woefully short of such services. My department has commissioned evidence-gathering reports looking at the problem of addiction to prescription and over-the-counter medicines. We published a report on that in May which found that support is provided from a variety of services across primary care, community care and the voluntary sector. However, it also found such patchiness of provision.

I am sorry that the noble Earl said that he felt the Government showed little sign of supporting this group of patients or indeed taking the cause seriously. The national drugs strategy sets out an ambition to tackle all drugs of dependence, including dependence on prescription and over-the-counter medicines. My honourable friend the Minister for Public Health, Anne Milton, convened a round-table meeting of experts to discuss the future action required to prevent addiction to medicines and to improve support for people who develop problems. It included consideration of specific actions to support the commissioning services to respond to addiction to medicines, and a draft note of the

[EARL HOWE]

actions agreed at the meeting has been published. We will be convening that round-table meeting in four to six months to review the progress against the action points. I hope that the noble Earl will accept that this is an indication not only of good faith on the part of the Government but of our appreciation that this is a problem that we have to tackle.

We believe that local bodies, with their greater knowledge and understanding of local health needs, are best placed to assess the needs for services in general. That includes rehabilitation and support services. Under the arrangements set out in *Healthy Lives, Healthy People*, local public health bodies will be responsible for the commissioning of services in line with local need to support people recovering from dependence. This will provide local areas with an opportunity to better integrate the commissioning of drug and alcohol intervention and recovery services. Services will be contracted from a wide range of providers including the voluntary and community sectors.

We think that local areas have a wealth of data at their disposal and the ability to consider this group of people within their local commissioning plans. The noble Earl, both implicitly and explicitly, cast doubt on the ability of local health bodies to tackle this problem. I have to concede that in many areas, or at least in some, the local structures have not been fit for purpose, but I highlight my belief that those local structures are being immensely strengthened by the arrangements that we are putting in place. Here I have in mind the health and well-being boards, which will be a local hub in which the health needs of an area and the priorities for healthcare can be defined and built in to the joint health and well-being strategies on which commissioning decisions should be based. The whole idea of that is that no group should fall through the cracks. If there is a need for a service, it should be identified through that process.

We do think that the outcomes framework, which does not appear in this Bill but overarches everything that we are doing, will expose poor practice. It will expose those groups of the population that are not being well served, and the commissioners will be called to account for their actions or lack of actions. So I cannot promise jam tomorrow, but I do, I hope, hold out the prospect of significant improvement in this area. I would just emphasise to the noble Earl that, in the mean time, the Government are not going to take their foot off the accelerator. We do intend that his concerns should be addressed, and I hope that what I have said is of some help and comfort to him.

The Earl of Sandwich: Well, I certainly am not going to pick a quarrel with the Minister after midnight. I do not accept everything that he said. I do not think that I have convinced him, but at the same time I have heard some very encouraging sounds, and he is quite right that I have followed what the Minister's personal interest has produced so far, because that is important. His colleague, Anne Milton, is certainly seized of the problem. The question is: where do we go from here? I certainly will not prolong the discussion now, but I am grateful to have had the opportunity to raise it and thank everybody who took part in the short debate. I beg leave to withdraw the amendment.

Amendment 203 withdrawn.

Amendments 203A to 215A not moved.

Amendments 215B to 215D had been withdrawn from the Marshalled List.

Amendments 216 to 216ZAZB not moved.

Amendment 216ZAA had been withdrawn from the Marshalled List.

Amendments 216ZB and 216ZBA not moved.

Amendment 216ZBB had been withdrawn from the Marshalled List.

Amendments 216A to 220A not moved.

Clause 23 agreed.

Clause 24 : Financial arrangements for clinical commissioning groups

Amendments 220B and 220C not moved.

12.30 am

Amendment 221

Moved by Lord Hunt of Kings Heath

221: Clause 24, page 52, line 20, leave out from beginning to end of line 21 on page 53

Lord Hunt of Kings Heath: My Lords, as we come to our final group tonight, I shall be brief. This amendment relates to payments to clinical commissioning groups in respect of quality. Noble Lords may speak to other amendments in the group which focus on payments for improving health outcomes and the use of payments made to clinical commissioning groups. It would be helpful if the Minister could briefly explain the rationale for the payments, the potential size of the payments and the factors that will be taken into account. Can he provide reassurance that the payments will be used by clinical commissioning groups for commissioning services and not to make payments to general practitioners that they can then treat as personal income?

Will the Minister also comment on the potential for perverse incentives? The factors in new Section 22K(2) are very broadly defined. Could they be used in relation to a scheme to discourage patients from being treated? We know that the architecture of the Bill is built round the supposition that, as GPs are responsible for so much expenditure, if you give them the budget they will have an incentive to contain that expenditure, and I understand that. However, that might lead to commissioning groups seeking inappropriately to lessen the availability of treatment because of budgetary considerations. If there are quality incentives that could be interpreted as “demand management”—which is the term used in the health service—that is entirely understandable, but there could be concerns vis-à-vis the GP-patient relationship if patients felt that their GP was receiving personal payments in order to discourage treatment, and that that was inappropriate.

We have not yet discussed the impact on the doctor-patient relationship of these arrangements. This could be quite damaging and unless there are very strict safeguards about these quality payments there may be a lot of suspicion that essentially GPs are being given

money to put in their own pockets in order to reduce availability of services to patients. Some clarification on this would be appreciated. I beg to move.

Baroness Williams of Crosby: My Lords, the noble Lord, Lord Hunt, has raised an issue that has created concern in a great many quarters. The idea that an outstanding clinical group should be able to gain as a result of its outstanding performance but should then plough the money that came from that back into further improvements of the CCG is, I think, is broadly acceptable to the House. On the other hand, the possibility of such quality payments being used to benefit individual persons who are members of or partners in that CCG raises very large questions, not least about the relationship between patients and their providers within a CCG.

This issue deserves much longer consideration. It has caused quite a lot of concern in a number of quarters, some of which has been made available to us through e-mails and letters. I will not pursue the detail of the matter this late at night—I would be very unpopular if I did so—but this is not a trivial issue; it is a substantial issue and one that I hope that the Minister will feel able to answer briefly tonight, but, if not, perhaps he could return to it at a later stage.

Lord Patel: My Lords, my name is on Amendments 222, 223 and 223A, which relate to the same issue that both the noble Lord, Lord Hunt, and the noble Baroness, Lady Williams, have covered about the quality payments. It would be wrong if these quality payments were going to any persons, whether they be GPs or employees of the commissioning groups. If they are, my amendment says states we should specify in the Bill what they can be used for. It would be perfectly appropriate if they were used for improving patient care and better outcomes for patients—that is what they ought to be about.

Baroness Finlay of Llandaff: My Lords, this highlights clearly the difficulty we face when GPs are independent contractors. Improvements in patient care may result in increased capital investment, which is to the benefit of patients, but the capital investment is also essentially their practice pot, in some areas. If they then move on, we get into complicated areas as to what, at the end of the day, is the GP's personal funding and what is ploughed back into improvements. It is a major incentive to improve the premises in which you work, and everybody benefits from it. Systems have been in place until now for GPs to access funding to improve their premises. That has been necessary to drive up standards in primary care. When we are looking at this issue, the way that the Government tackle will to set a very important foundation for the whole direction of primary and community care services.

Earl Howe: My Lords, Amendments 221, 222, 223 and 223A refer to the incentive scheme for CCGs. This scheme will allow the board to reward CCGs for their performance in the light of at least one of the following factors: the quality of services provided; any improvement in the quality of those services compared with previous years; outcomes achieved for patients; and any improvements in outcomes as compared with previous years. The board may also consider the extent to

which the CCG has tackled inequalities. The purpose of the quality payment is to reward CCGs for these areas, and not, as some saw it, for saving money on their budgets. Unequivocally, the board can make a payment to a CCG only where the group has performed well on quality of services or outcomes achieved for patients. It is a well established principle of public health service reform to acknowledge and reward the provision of high quality services. Quite simply, we believe that commissioners should also be rewarded for commissioning high quality services for patients.

Amendment 222 amends the criteria which the board will take into account. The amendment would mean that the board would be able to consider only improvements in health outcomes identified during the particular year. Health outcomes will indeed be crucial, and will be measured through the commissioning outcomes framework, but we must not prevent the board from rewarding improvement in other outcomes which are of benefit to patients.

The Bill gives the Secretary of State the power to make regulations as to how CCGs may spend payments received in respect of quality. Amendments 223 and 223A would require any regulations made under this provision to limit CCGs to using any payment received under the scheme for the benefit of patients or to improve health outcomes. This risks blunting the scheme. There are a range of ways in which CCGs could potentially use the money that they have earned for quality of patient care, and we must not exclude the potential for the CCG to allow members to spend this money as they see fit, including rewarding the members for their work if that incentivises the membership. If the payment is required to go into the commissioning budget, it might well eventually be no incentive at all. To ensure transparency, CCGs must publish an explanation of how they have spent any quality payment which they receive. If we can get this right, it is money well spent, as it will incentivise the delivery of improved outcomes. If such performance is not apparent, then the payment will not be made.

As the Bill makes clear, the quality payment rewards outcomes for patients, not processes or targets. It is certainly not a reward for efficiency. Final decisions, however, on the design of the quality reward have not been made yet. We intend to discuss our proposals further with the profession. This is not about paying GPs extra. It is about rewarding CCGs for successful commissioning. We agree that there needs to be further debate about how CCGs use the reward, and that is why we have introduced a regulation-making power which will enable limitations to be placed on how it is used.

We do not want to rule out the possibility of clinical commissioning groups being able to reward their members. We would otherwise run the risk, as I said, of blunting the value of the quality payment as an incentive, but we agree that great care would be needed to devise any such payments so that they are fair and proportionate, and create the right incentives to deliver high-quality care for patients—hence the provision in the Bill to make regulations.

That is probably all the detail that I can give at the moment. The noble Lord, Lord Hunt, asked me about the size of payments. I am not in a position to commit

[EARL HOWE]

to an indicative figure at the moment. It will be up to the NHS Commissioning Board to determine the level of payments, and I am not in the business of tying its hands on that. There is quite a lot of thinking still to do about the design of this payment, as I indicated. I am sure we will return to the subject at a later date.

Lord Hunt of Kings Heath: My Lords, that was broadly reassuring. There are just two points I would make. First, there are plenty of examples where cost-improvement programmes have taken place and staff on the unit have received a certain percentage of that cost-improvement to spend on better services. I do not think that there has been any inhibition on their part because it has not gone into their personal pocket. I would have thought that most people in the health service, including GPs, would accept that if there were payments to be made, it would be right that they go to improve patient care one way or another. I hope the Minister might look at that again.

There is a real risk here. Let us look at outcomes, quality and improvement. I would have thought that an impact on demand management, where the commissioning group GPs were working together to ensure, for example, that there were not inappropriate admissions into hospital, would qualify as a quality improvement. However, we must accept that, for the public, demand management sometimes presents some really tough issues. Even when they instinctively think that they might be better off in hospital, they probably would not be, but in encouraging patients not to go

into hospital, GPs may find that the public query their motivation for doing so. Because of that, if there were any financial rewards, it would be much better if they were to go into the commissioning group as opposed to its members' own pockets. I am genuinely concerned about this impacting adversely on the doctor-patient relationship.

The noble Lord has said that this is work in progress. My aim has been to pass on comments to the noble Earl about what he might consider in the future. On that note, I beg leave to withdraw the amendment.

Amendment 221 withdrawn.

Amendments 222 to 223A not moved.

Clause 24 agreed.

Clause 25: Requirement for primary medical services provider to belong to clinical commissioning group

Amendment 224 not moved.

Clause 25 agreed.

Amendment 224A not moved.

Clause 26 agreed.

House resumed.

House adjourned at 12.44 am.

House of Lords

Thursday, 1 December 2011.

11 am

Prayers—read by the Lord Bishop of Ripon and Leeds.

Housing: Rented Homes

Question

11.06 am

Asked By Lord Kennedy of Southwark

To ask Her Majesty's Government what action they are taking to deal with the shortage of homes for rent.

The Parliamentary Under-Secretary of State, Department for Communities and Local Government

(Baroness Hanham): My Lords, the Government are committed to the provision of affordable housing and are investing nearly £4.5 billion to help deliver up to 170,000 new affordable homes, mainly for rent, by April 2015 in England. This is more than the 150,000 originally estimated and means that the Government will be able to deliver more affordable homes in that timescale than had originally been anticipated.

Lord Kennedy of Southwark: My Lords, we have the lamentable failure of the Government on new homes for rent. There is also the impact of 80 per cent of market rent, which means that a family of two adults and two children living in the London Borough of Newham needs an income of £48,000 a year to afford a home without claiming universal credit. Does the noble Baroness understand that, because of the lack of joined-up thinking across government and failed policies, hard-working families are paying the price?

Baroness Hanham: My Lords, that scoops up a whole lot of things, some of which are not entirely to do with me. The universal credit is not part of my department, although I recognise that the housing benefit goes towards the contribution of housing facilities. We are trying to provide, and will provide, affordable housing for as many people as we can. The universal credit and the amount of money paid in housing benefit is something that my noble friend Lord Freud will deal with in due course.

Lord Shipley: My Lords, does the Minister agree with me that the reason for the shortage of homes for rent is the failure of the previous Government, over 13 years, to build council houses? Given the pressure on the private rented sector, and the fact that 40 per cent of homes in that sector do not meet the decent homes standard, what consideration is being given to further regulation of the sector? Will the Minister consider the advice of the British Property Federation, the National Landlords Association and the Association of Residential Letting Agents that there should be a system of compulsory regulation of letting agents to ensure that professional and ethical standards are applied to private sector lettings?

Baroness Hanham: My Lords, with regard to the last point made by my noble friend, the Minister for Housing, Grant Shapps, has said that he is looking to see whether there is any requirement for letting agents to be registered. He is keeping that under review but there is no plan to do so at the moment. With regard to decent homes, yes, the decent homes money will still be there, and we expect to make a big contribution to that in the next few months and have done so already. Yes, the number of affordable homes was going down, rather than up, under the previous Government, and it is a matter that we are having to deal with.

Baroness Turner of Camden: My Lords, is the Minister aware that one of the problems is the size of the rents that are being charged, particularly in places such as London? For example, in my area of London a two-bedroom flat will cost £500 a week to rent. That is right out of the range of ordinary working people. Is the Minister aware that after the last war there was rent regulation that enabled at least some people to get into affordable homes? Some regulation is needed in this area at present.

Baroness Hanham: My Lords, young people on the waiting list who require affordable homes, or who are being asked to find private accommodation, will, like everybody else, have to see where they can find accommodation that they can afford. That is happening across London in particular. Housing benefit will support what it can, but I am afraid that people either have to pay the additional amount or find somewhere that falls within their capability. I do not think that anybody wants to go back to rent control. It was not helpful, did not leave properties in good condition and was not fair.

Lord Best: My Lords, will the Minister tell us what is happening about the real estate investment trusts, which are the intermediaries that allow insurance companies and the big pension funds to invest in residential property? They have been held up for a long time by the bureaucracy and complexity of the system but we badly need the finances that those big City institutions could put into residential housing. They would probably be rather good landlords. Will she tell us what is happening about those REITs?

Baroness Hanham: My Lords, I recognise entirely what the noble Lord has said. This is a very important aspect of getting money into residential accommodation. I think this matter is still being discussed with the Treasury. I hope that it will be able to say something about that in the not too distant future.

The Lord Bishop of Hereford: My Lords, we have heard questions about the rental prices in London. Will the Minister be kind enough to say something about what the Government are doing to try to ensure that there are more affordable rental homes in villages and the countryside as well?

Baroness Hanham: My Lords, the Government have a number of policies. The right reverend Prelate will know that a community right to build is one of the policies coming forward, which will enable communities to decide whether they can contribute in some way to

[BARONESS HANHAM]

getting affordable housing. Secondly, we are allowing decisions about the requirement for housing to be made locally so that local people have a bigger say in what is provided and where. We fully recognise the fact that affordable housing is needed in country villages but we also believe that if local people know where it is going to be, understand where it is going to be and are happy with that, there is far more likelihood that those properties will be built.

Lord McKenzie of Luton: My Lords, the Minister will be aware of provisions in the Welfare Reform Bill whereby housing benefit will be docked for those tenants deemed to underoccupy their house, even if there is no suitable available accommodation for them to move into. The noble Baroness will also be aware of the announcement on Tuesday about the so-called reinvigoration of the right to buy, with 50 per cent discounts. Will those tenants deemed to underoccupy their house be able to benefit from the right-to-buy provisions at the full 50 per cent discount?

Baroness Hanham: My Lords, I must be perfectly honest that I cannot answer that correctly. I will write to the noble Lord on that aspect. However, as regards the proposal on the right to buy, it is suggested that the discount will go up to 50 per cent, which means that there will be more opportunity for people to take advantage of the right to buy. The other side of that is that, unlike in the past where a substantial proportion of a deposit had to come back to central government, it will be retained locally so that it can be used to provide further affordable housing.

Lord Cormack: My Lords, will my noble friend recognise that although the right-to-buy policy was rightly and widely welcomed, and many of us welcome what the Chancellor said in outline, nevertheless it took a lot of houses out of the affordable bracket? It was a particular mistake to allow those occupying old persons' bungalows to buy their houses because it meant that their children bought them and then sold them on at a great profit, thereby depleting the stock of that sort of housing. Can we please not repeat that mistake?

Baroness Hanham: As I said in my previous answer, any money that comes from right to buy will be invested in new affordable housing. As for residential homes, they are slightly different to the mainstream right to buy, but I note what my noble friend says.

Pakistan Question

11.15 am

Asked By **Lord Ahmed**

To ask Her Majesty's Government what is their assessment of the contribution made by Pakistan as the front-line state in the "war on terror".

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): My Lords, Pakistan remains an important partner in the fight against terrorism. As my right honourable friend the Prime Minister stated following his meeting with President Zardari on 4 July last,

"working together to defeat terrorism in all its forms is very much top of our agenda".

The al-Qaeda core has been severely weakened over the last six months. It is important that the UK and Pakistan, together with other key international partners such as the United States, continue to work together to disrupt terrorist groups which threaten all our interests.

Lord Ahmed: I thank the Minister for his reply. Will he join me in sending condolences to the families of 26 Pakistani soldiers who were killed by a NATO air strike a few days ago? Is he aware that Pakistan has lost over 30,000 civilians and over 5,000 soldiers—more than any other country in the world—as well as \$75 billion to \$80 billion, and that Pakistan has hosted over 6 million refugees from Afghanistan? Separating the sacrifice made by the people of Pakistan from Ali Baba and his 40 companions, will the Minister assure the House that the British taxpayers' money allocated to DfID for education and training teachers will not end up in this individual's private accounts in Switzerland?

Lord Howell of Guildford: Yes, my Lords, as regards condolences, I certainly join the noble Lord. In fact, my right honourable friend the Foreign Secretary spoke to the Foreign Secretary of Pakistan only the other day to offer his deepest condolences. A full investigation of that really tragic and dreadful incident is, of course, under way. I hope Pakistan will participate fully in that investigation. The United States has expressed its regret at the loss of life.

As regards the suffering faced by Pakistan, I think we all acknowledge the colossal strain on Pakistan, its society and all its citizens, with the conditions they face not only on the terrorist side, but also through the visitations of floods and other challenges, all of which add great difficulty to Pakistan's administration. As for our aid, I can assure the noble Lord that all our aid is independently evaluated and scrutinised under our UK Aid Transparency Guarantee, and that certainly applies to all aid to Pakistan as well.

Lord Stirrup: My Lords, will the Minister agree that the most telling contribution Pakistan could make to global security would be to improve levels of effective governance, economic growth and employment within its own borders, and that the international community should not allow its frustration over other issues, however understandable, to divert it from this strategic focus in its engagement with Pakistan?

Lord Howell of Guildford: Yes, that is an extremely wise observation, and I think that Her Majesty's Government would totally agree with it.

Lord Avebury: My Lords, I add my condolences to the relatives of those who lost their lives in the tragic event last week. I ask the Minister whether consideration will be given to postponing the Bonn meeting to allow

Pakistan to participate. Could its agenda perhaps be extended to cover discussion of the findings of the NATO inquiry into this tragedy, including an investigation into the allegations made by Major General Ishfaq Nadeem, that it was impossible for NATO not to have known that it was attacking Pakistani posts, and that NATO had ignored mutually agreed communications procedures?

Lord Howell of Guildford: No, I do not think it would be right to seek postponement of the Bonn meeting which is coming up, and we urge Pakistan to join. I know that in its dismay at this whole event it has thought about not joining, and in a sense that is understandable. But one looks for second thoughts and hopes that Pakistan will join the meeting. It is not a meeting organised by or about NATO, it is about the whole future of Afghanistan. Pakistani involvement would be valuable and we strongly encourage it. We stick to the timetable that has been planned.

Lord West of Spithead: My Lords, while I was Minister for Security for three years, the country of gravest concern to me globally was Pakistan. Notwithstanding the huge efforts, huge sacrifices and so forth that have been made in Pakistan, does the Minister not agree that one of the greatest risks to that country is violent, extremist terrorism within and around its borders and not threats from India? The fact that India is being looked at by some people within the ISI and the army as the greatest threat has diverted its efforts.

Lord Howell of Guildford: The noble Lord makes an extremely good point. Pakistan has many problems but very high on the list are the terrorist threat and its borders with Afghanistan, as we all know. As to relations with India, we notice that India and Pakistan have recently been talking. We greatly welcome and encourage their dialogue, which we hope will lead to a less tense development on that side and therefore less distraction from the main aims that the noble Lord has rightly identified.

Lord Ahmad of Wimbledon: My Lords, accepting that Pakistan has been in the front line in the war on terror for the past 10 years, I seek our Government's assurance that strategically, militarily and tactically on the ground Pakistan's role will not be diminished and that it will continue to play an integrated role in the war against terror—not watching on the sidelines but being involved and engaged fully to prevent the kind of incidents that we saw recently with attacks on Pakistani forces within Pakistani sovereign territory. I join in extending condolences to the families who suffered loss as a result of that act.

Lord Howell of Guildford: I am sure that my noble friend's condolences will be appreciated. These horrific things do happen, and we await an investigation of what on earth went wrong for this to have occurred. Full integration in counterterrorism is very much our purpose. As the House knows, we have counterterrorist

discussions with Pakistan, although I cannot reveal the details, and we are determined to use its skills and intelligence availability in the united war against terror.

UK Border Agency: Prisoners *Question*

11.22 am

Asked By Lord Avebury

To ask Her Majesty's Government what is their response to the recommendations by the independent Chief Inspector of the UK Border Agency on how the agency manages foreign national prisoners.

The Minister of State, Home Office (Lord Henley): My Lords, this is an important report and the United Kingdom Border Agency has taken its recommendations seriously. Of the eight recommendations, four were accepted in full, three in part and only one was rejected. We have taken steps to implement and reinforce policy and procedures relating to the management of foreign national offenders. I have placed a copy of the full response in the Library.

Lord Avebury: My Lords, I thank my noble friend for that response, but does he not agree that the UKBA's lukewarm response to the Chief Inspector's recommendation that it should reduce the number of decisions that are overturned on appeal was disappointing? As the UKBA must have a good idea of the likely adverse decisions of the court in most of the one-third of appeals that it loses, is it not both perverse and costly to the public purse to continue acting on the presumption that, where the deportation threshold is met, only in exceptional cases will deportation breach Article 8? Secondly, what is the Government's strategy for reducing the number of foreign nationals who remain in prison after their sentences have expired, mainly because of non-co-operation by the prisoner or his embassy with the process of obtaining an emergency travel document?

Lord Henley: My Lords, I do not accept that our response to that particular recommendation was lukewarm. We accepted it in part and we accept that there is a need to improve the quality of our decision-making. We also accept that it is necessary to increase the number of those whom we manage to deport, as and when their sentences end. The number of those who have not been deported has come down steadily over the past few years.

Lord Hunt of Kings Heath: My Lords, is not the reason for the potentially muted response of the UKBA and the Government to this report because the core conclusion is that the quality of decision-making needs to be improved? The UKBA is faced with a 20 per cent cut in its budget and major new responsibilities. No wonder the Border Agency does not have that much confidence in improving the quality of the work that it is doing.

Lord Henley: My Lords, the UK Border Agency has confidence that it can improve these things and that it can do this within the perfectly manageable reductions that it is facing as a result of, as we have said on a number of occasions, the actions of the party opposite when in government. The agency will be able to improve its decision-making and it accepts that it needs to improve its quality.

Lord Ramsbotham: My Lords, the executive summary to this report mentions that,

“By January 2011, over 1,600 foreign national prisoners were detained under immigration powers at the end of their custodial sentence, pending deportation”.

I remember that, as Chief Inspector of Prisons in 1999, I recommended that the default position should be that prisoners sentenced to deportation should have that deportation processed while they were in prison, so that at the end of the sentence they went straight to the airport and out. Why were more than 1,600 still detained after the end of their custodial sentence?

Lord Henley: My Lords, there are frequently problems dealing with the country that the individual prisoner is going to and arranging travel documents. I remember the recommendations made by the noble Lord and that is something that we shall have to address in due course. Obviously, the best way of dealing with that would be to start the process somewhat earlier.

Riots Communities and Victims Panel

Question

11.26 am

Asked By Lord McKenzie of Luton

To ask Her Majesty's Government what is their response to the recommendations for immediate action contained in the interim report of the Riots Communities and Victims Panel published on 28 November.

The Minister of State, Home Office (Lord Henley): My Lords, we welcome the interim report from the independent Riots Communities and Victims Panel into the serious events of last summer and will study its findings carefully. There are a very large number of recommendations, which we shall consider in detail and with care.

Lord McKenzie of Luton: My Lords, I thank the Minister for his reply and for his welcome of the report. Does he agree that we are indebted to the panel that produced the report and for its work so far, including that of my noble friend Lady Sherlock? The report offers many challenges to government, local authorities, community organisations and faith communities, and cites positive examples of young people who are responsible, ambitious, determined and conscientious, despite having deprived backgrounds. It also says that for many there is a common theme of people needing hopes and dreams, and that a sense of

injustice, powerlessness and a lack of opportunity weighed heavily in their minds. They did not feel that they had a stake in society. Does the Minister agree that that should trouble us all? Notwithstanding difficult economic times, what assurance can he give the House on the Government's priority in tackling these matters?

Lord Henley: My Lords, as the noble Lord will be aware, the report came out only on Monday this week, so it is a bit early to make a very detailed response to all the recommendations. I have had a brief chance to look at the report but I have been engaged in other business in this House for most of the week. The report addresses itself not just to the Home Office but to other government departments and, as the noble Lord quite rightly said, to a whole host of other groups all of whom will need to consider what is in it.

Further, we await a report from HM Chief Inspector of Constabulary, the Met and the police in Manchester and Merseyside. The IPCC is also conducting a report, so a great deal will have to be looked at in due course. It would be wrong to announce too early how exactly we will respond to the very many recommendations in this report.

Lord Cotter: My Lords, on 11 August, I asked the Government,

“to ensure that measures”—

to assist businesses in riot areas—

“are taken very speedily, with minimum red tape and bureaucracy”.—
[*Official Report*, 11/8/11; col. 1526.]

In my Oral Question on 13 September, I asked the Business Minister to,

“continue to monitor the situation”.—[*Official Report*, 13/9/11; col. 617.]

On both occasions I received reassuring replies. I am shocked to learn from the report that many people have not yet had any compensation at all. Indeed, seven months after the riots in March the expectation from the report is that nearly nine out of 10 large claims and as many as half of small claims for business will not be met. It is likely that this situation will be answered—

Noble Lords: Too long!

Lord Cotter: I want to ask the Minister to ensure that we get a clear response now on behalf of business because I feel that it is inexcusable and that there is a sense of betrayal. Will the Minister give us a response quickly?

Lord Henley: My Lords, a number of the recommendations relate to the Riot (Damages) Act 1886, the Act that governs compensation for businesses that were affected by the events last summer. I will answer a Question on this subject in two weeks' time. The immediate recommendations from the interim report were that there should be an extension of the deadline for the submission of claims. I can confirm that we will look at that, just as we will look at the workings of the whole of the Riot (Damages) Act in due course.

Baroness Sherlock: My Lords, I thank the Minister for that comment in particular. As a member of the Riots Communities and Victims Panel, I had the privilege of meeting a great number of people and was very moved and shocked by stories of loss and trauma, so I welcome the fact that the Government will look at the Act.

Two things were raised most often with us. First, we did not meet a single person who had received a payout under the Riot (Damages) Act. Has anyone has had such a payment and, if not, will the Government move to overhaul the Act in some detail? Secondly, there was a sense that people in areas hit by riots felt that they had been abandoned by the police. I met some hugely brave police and PCSOs who had gone out there and risked their lives. Will the Minister comment on what the Government will do in response to make sure that police tactics are appropriate for the kind of disorder we now see? That means smart policing, not just tough policing.

Lord Henley: My Lords, I congratulate the noble Baroness on her contribution to this report as one of the four members of the panel. We are very grateful to her for all her work. We will review the Riot (Damages) Act. It is a fairly ancient bit of legislation and obviously needs looking at. We will also review police tactics and how they worked and we will look at the reports from the Met and other police authorities. We should also look at the areas where we had no riots because there are possibly lessons to be learnt from why there were riots in some places and not in others. There will be a great deal to consider and no doubt the noble Baroness and her panel will produce yet more for us as this was only an interim report. I look forward to that, and the Government will respond in due course.

The Lord Bishop of Ripon and Leeds: My Lords, one of the most heart-warming flip sides of the tragedy of the riots that comes out from the report was the way in which it brought out the best in so many people, including many young people. What can the Government do to recognise and honour those who supported communities during the riots, those who cleaned up afterwards and, indeed, those who, in many cases, prevented riots developing in the first place?

Lord Henley: My Lords, the right reverend Prelate is quite right to draw attention to all those who did such sterling work during and after the riots. We all owe an immense debt of gratitude to them. I think we should also learn what we can about how some communities came together and either prevented riots or cleaned up after them. Again, I believe that there are lessons to be learnt, and the Government will take note of that in due course.

Baroness Kingsmill: My Lords, in the light of the Minister's remarks on the riots and in the light of his obvious condemnation of the violence that was incurred by them, will he also add his voice to those condemning the remarks of Mr Jeremy Clarkson last night that strikers should be put up against a wall and shot in front of their families?

Lord Henley: My Lords, I am not, fortunately, responsible for the remarks of Mr Jeremy Clarkson and do not have to answer for him, but I think the noble Baroness can imagine what I think about his remarks.

Lord Elystan-Morgan: My Lords, will the Minister assure the House that in looking at the operation of the 1886 Act, consideration will be given not only to extending the time limit for a claim, which I think is a few weeks, but to the whole ethos of the Act: that is, the question of claiming against police authorities and the fact that the Act goes back a century and a quarter to a period when policing was much more formative in its development than it is nowadays?

Lord Henley: The noble Lord is right to draw attention, as I did earlier, to the age of the Act. It is possibly coming up to its sell-by or use-by date, which is one of the reasons why we want to review it. The recommendation in the report was that the submission of claims should be extended to 90 days. The Government had already extended it from 14 to 28 days. Extending it to 90 days is a very interesting suggestion and will be looked at as part of a wider review of the whole Act.

Baroness Symons of Vernham Dean: My Lords, will the Minister answer the specific question raised by my noble friend Lady Sherlock? Have any compensation payments been made so far?

Lord Henley: My Lords, I apologise for not answering that part of the question. My understanding is that some payments have been made but I confess that the number is very few. We would like to see more paid in due course, although we want to make sure that the right claims are paid. There have, in some areas, been rather a large number of claims and one suspects that not all of them are quite as valid as others.

Caravan Sites Bill [HL]

First Reading

11.36 am

A Bill to make provision to secure the establishment of caravan sites by local authorities in England for the use of Gypsies and Travellers

The Bill was introduced by Lord Avebury, read a first time and ordered to be printed.

Business of the House

Timing of Debates

11.36 am

Moved By Lord Strathclyde

That the debates on the Motions in the names of Baroness Emerton and the Earl of Sandwich set down for today shall each be limited to two and a half hours.

Motion agreed.

Procedure of the House Committee

Membership Motion

11.37 am

Moved By The Chairman of Committees

To move that Lord Campbell-Savours be appointed a member of the Select Committee in place of Lord Goldsmith.

Motion agreed.

Nursing

Debate

11.37 am

Moved By Baroness Emerton

That this House takes note of front-line nursing care.

Baroness Emerton: My Lords, I welcome the opportunity to introduce this debate to take note of first-line nursing care. The timing of this debate is opportune for several reasons, not least that the Health and Social Care Bill is currently in Committee, giving an opportunity for amendments to the Bill that are considered helpful to the implementation of the proposed Health and Social Care Act.

The professions of nursing, midwifery and health visiting—the largest single workforce in the NHS—plays an important part in delivering high-quality care to patients. The NHS is currently facing the Nicholson challenge of saving £20 billion within the next three years, not avoiding cuts in service provision. The scene is therefore one of challenge: meeting the forthcoming organisational changes while maintaining and developing new approaches to the delivery of high-quality care. That inevitably causes a mixture of anxiety and excitement: anxiety for job prospects, but excitement at the opportunities opening to the profession by moving to an all-graduate profession and by meeting the patient's needs holistically, with integrated patient pathways through primary, secondary and tertiary care, then back to primary care and care in the community, where the patient can be cared for in their home and supported by the NHS and social care with as much independence as possible for the individual and closeness to their family.

Where do the professions of nursing, midwifery and health visiting want to see themselves in the newly reorganised health and social care services so that they can deliver the high-quality care required and innovate in developing the new procedures that will result from research evidence, which will in turn result in best practice and be cost-effective? I declare my background in nursing. I am retired and not on the effective register of the NMC. I am a fellow of the Royal College of Nursing and president of the Florence Nightingale Foundation.

I should like to address concerns that have been raised in recent months about the move to degree-level registration for nurses. As my fellow commissioners

set out in the report *Front Line Care*, degree programmes equip nurses and midwives to work in many settings and roles and draw on a wider repertoire of knowledge and skills, including the capacity to make complex assessments and clinical decisions and deliver therapeutic interventions in situations that are often unpredictable and emotionally charged. I would emphasise that these skills include effective communication skills and, in particular, how to provide care in a compassionate way. Any nurse practising in the 21st century care setting must have all these skills. We must also remember that 50 percent of university-based education programmes, at both degree and sub-degree level, continue to be delivered in practice. In moving to a degree-level profession we are following what is already in position in Wales, Scotland, several countries in Europe and elsewhere, as well as in professions such as midwifery and physiotherapy. Recent changes to pre-registration nurse education, as set out in the Nursing and Midwifery Council standards, will equip nurses to lead and deliver care and will ensure that nurses of the future are equipped to work within a modern healthcare system, while ensuring that care continues to be delivered with compassion.

It is vital that the focus is not just on what education and training nurses and midwives should receive in their pre-registration courses. Equally important are the development of post-qualification training pathways for nursing, which are sadly not funded in the same way as our medical counterparts. The funding exists in the current education and training budget to fund junior doctors' salaries and postgraduate placements to training. We wish to see this extended to nurses and midwives so that they can continue to improve and develop throughout their careers and in particular, in the early years after registration. I would be very grateful if the Minister could confirm if the forthcoming publication of education and training will address the lack of central funding for post-qualification pathways for nursing, midwifery and health visiting.

The Royal College of Nursing, the Royal College of Midwives and the Queen's Nursing Institute have all recently published reports reflecting the staffing levels currently being experienced and the urgent need to address the whole issue of workforce planning, taking into account the recommendations in the current Bill. The increase in community care is going to require an increase in community nurses—that is, district nurses—to meet the nursing care needs of those transferred from secondary care following admission to hospital, those suffering from long-term conditions, the treatment of the elderly, frail and vulnerable who require care and support to live independently, and not forgetting those who choose, in increasing numbers, to have end-of-life care at home.

These demands from the community will require highly qualified nurses facing a very different setting, with support and mentoring to adjust if moving from secondary care into the community setting. This means that the workforce planning for the forthcoming changes in the community will need to include the training requirements, not only the professional qualifications, for an induction into health and social care spanning NHS and local government management systems, and third sector involvement in health and social care. The

specialist nurses for long-term care, for example Parkinson's, multiple sclerosis and cancer care, play an important part in maintaining the patient to stay in the community and will form part of the community team that supports these patients. The increase in demand on the mental health service will need community psychiatric nurses, not forgetting those with learning difficulties.

Working in the community places different demands on the community nurses than those working in secondary care and there is much to be learnt in regard to working with social services and voluntary organisations, and not least the families, carers and neighbours of those for whom they care.

Research evidence from the United States, Canada, Australia and here in the UK clearly demonstrates that a higher ratio of registered nurses to support workers results in lower mortality and morbidity. It shows that 26 percent of patients are more likely to die where nurses have the heaviest work load and 29 per cent are more likely to die after a complicated hospital stay. Seventy-two per cent of nurses with the heaviest workload showed negative job outcomes, burnout and job dissatisfaction and saw their hospitals' care standards deteriorating.

Aiken's study in the US demonstrated that every one patient added to the average, hospital-wide nurse workload increased the risk of death following common surgical procedures by 7 per cent. The UK evidence was recorded in 2007 by Anne Marie Rafferty. I ask that this research evidence be studied by the Government and that a cost-benefit analysis be worked on to see whether workforce numbers could be refined to take account of these findings in order not only to reduce morbidity and mortality but also to shorten length of stays, improve clinical outcomes and reduce infection, readmission rates and possibly the number of hospital beds. It should be recognised that community staff should be trained and in post in order to receive the increased workload.

Any reorganisation of services requires an in-depth analysis of the effects that the changes are going to cause and the means of solving the identified issues. As the nursing and midwifery professions and health visitors form the largest single part of the NHS workforce and play a vital part in delivering high-quality, safe care with compassion, respect and dignity, the implementation programme requires leadership from the profession nationally and at CCG level, as well as at the point of delivery of care, from ward sisters in secondary care and from nurse and midwife leaders in the community.

Nursing could best be described as the art and science of delivering high-quality, evidence-based care. The history of nursing demonstrates that nurse leaders effected changes in the development of the profession by exercising their powers of leadership through influence and persuasion, a leadership exemplar being Florence Nightingale, who influenced practice, education, research and public health and through evidence presented to politicians. Mrs Bedford Fenwick introduced the nursing register and regulation in 1919 after attempting to have six Private Member's Bills passed in Parliament and 30 years' struggle. Other examples are the Salmon

report, which many nurse leaders influenced, as they did with Halsbury, Platt, Briggs and the royal commission that led to the nurses and midwives Act 1979, the establishment of the UKCC and national boards and education moving into universities. Again, a time span of nearly 25 years was involved.

The involvement of politicians has been central to the implementation of these changes. One could describe politics as the science of government. Nurses, midwives and health visitors need to exercise their leadership skills by influencing and persuading government with evidence that will lead to changes in the profession, leading to higher-quality, evidence-based, safe and cost-effective care to the satisfaction of patients, relatives and the public. However, while it is recognised that implementation of research-based change takes time, can we wait 30 years to see a reduction in morbidity and mortality rates among patients?

Given the current economic situation and the recent negative reports on care delivery, there is a very important task to be achieved in regaining the public's and patients' confidence in the profession. There is no doubt that we have excellent nurses and midwives throughout the country, but sometimes there are failures, usually due to a systems failure in the organisation. It is therefore important that the status of the professions is raised in the eyes of the public and patients. This can be done only by addressing the professional issues as well as the organisational team, starting with the board, providing them with clear sets of values and objectives to which the whole organisation is committed, with clear lines of accountability and authority.

My passion is to see nursing care of world-class standard, but as well as attacking the issues within the profession there is the overriding need to address the culture within the NHS so that all professions and support staff are committed to ensuring that the part they play contributes to the change in culture—that is, compassionate care with dignity and respect throughout the workforce; and staff valued, which in turn is projected to all patients, relatives and the public, restoring the view that the NHS provides excellent compassionate care with dignity and respect to all. This would override the rather negative and critical view that pervades at the present time in some places. I beg to move.

11.51 am

Viscount Bridgeman: My Lords, I thank the noble Baroness, Lady Emerton, for her expert and sensitive treatment of this subject. I am afraid what follows now will be a slightly inadequate summary of what she began by saying and reverted to later in her speech—that is, the fundamental challenge to the training of nurses in the United Kingdom. As she reminded us, the trend over the past 10 years towards the requirement that nurses should be educated to degree standard is a desirable objective in itself. It makes nurses better equipped to address the ever increasing sophistication, both in treatment techniques and in equipment, and crucially it gives student nurses who are so motivated the chance to aspire to management positions within healthcare.

The downside of this, to which the noble Baroness has referred, is that during this period of nurse training a decreasing amount of time is spent on the ward with

[VISCOUNT BRIDGEMAN]

hands-on experience of dealing with patients. This is compounded by the fact that there is not the same opportunity for the junior nurse to learn from the ward sister—who I suppose one must now refer to as the ward manager—who can pass on his or her experience. These individuals so often find that the nursing teaching posts are more attractive than hands-on nursing and it is to these that many of them move. This is a problem which is not going to go away; frankly I see no immediate solution and I should welcome comforting words from the Minister.

I have some recent experience of the healthcare sector as a former chairman of an independent hospital in London, the Hospital of St John and St Elizabeth. On the whole, the independent hospitals have been able to retain the traditional system of the matron having total responsibility for the nursing staff, with the ward sister or manager looking after patients on the ward and, crucially, having responsibility for services such as cleaning. It would be both arrogant and unrealistic, coming from the independent angle, to say “If we can do it so can you”. There are so many differences between the environments of the National Health Service and the independent sector that it makes such a glib suggestion inappropriate, not least the organisational demands which a body the size of the National Health Service faces. Furthermore, on a personal note, I wish to place on record the great help and support the hospital with which I was associated receives from the NHS in many, many ways. There should be no misunderstanding about this—I am not referring to financial help. However, it is important that the two sectors have regard for each other, possibly to their mutual benefit.

Let me recount one experience I had which I think may be relevant to this debate. While the independent sector struggles to attract good nursing staff as much as the NHS, most are fortunate in having a satisfactory body of trained nursing staff. However, many of these hospitals, including my own, also operate a programme of giving work experience to trainee nurses in the NHS. Ours formerly involved an arrangement with one newish university in the London area. On more than one occasion, Matron was somewhat startled to come across the attitude “I am not interested in the nursing, I am only here to get something on my CV”. Subsequently—and understandably—the change was made to sourcing from one of the London teaching hospitals where we encountered a totally different type of student nurse—keen and committed, potentially a credit to the nursing profession.

The wastage of resources in the nursing training programmes of some institutions is self-evident and I would welcome an assurance from the Minister that his colleagues in the DoH are monitoring this, and particularly the suitability of candidates for these training schemes. My message to your Lordships—and, indeed, the Minister—is that I see no easy, quick-fix solution to the present less-than-perfect juxtaposition between academia and ward experience.

In conclusion, perhaps I may return briefly to the subject of ward cleaning. Many are the complaints one hears that the ward was dirty and that the ward manager was unable to do anything about it because

he or she was not in the reporting line for the contractor. I hope that arrangements can be made in future contracts for the contractor to be more visibly responsible to the ward manager. That would go some way towards allaying this problem, which seems too dependent on considerations of cost.

11.55 am

Baroness Warwick of Undercliffe: My Lords, I thank the noble Baroness, Lady Emerton, for providing this opportunity to highlight this crucial aspect of our national healthcare provision. Her distinguished leadership and experience in the nursing field give enormous weight to her observations today. She is a doughty advocate for the nursing profession.

There cannot be anyone in this House who has not at one time or another had cause to be grateful for excellent nursing care. However, we may also know of, or have experienced, less than compassionate care, or even neglect or indifference, from overstretched nursing staff. Like others, I am horrified by some of the stories that have appeared in the media, and we cannot ignore the shocking failings uncovered, for example, at the Mid-Staffordshire NHS Trust. Sadly, it would be wrong to suggest that the unfortunate cases that hit the headlines are entirely anomalous or isolated incidents. Indeed, it seems that not a week goes by without another story revealing a lack of care and compassion and arguing that standards are falling.

Some of those who claim this most vociferously blame the lack of compassion on the move to make nursing a degree-level profession. Like the noble Viscount, Lord Bridgeman, I want to focus my remarks on the area of nurse education. I want to challenge most strongly the line put forward in the media—and, indeed, on occasion in this House—that some of the recent instances of lack of care are because nurses are now all graduates and consider it beneath them to clean bedpans or clean after the vulnerable and sick in their care. The “too posh to wash” arguments favoured by newspaper columnists do not stand up.

Studies in England, Scotland and Northern Ireland have shown that graduate nurses spend longer hours working in clinical areas than their non-graduate counterparts. American studies have found that graduate nurses stay in the profession, on average, four years longer than non-graduates and, in addition, they tend to stay at the bedside more often, working with older people and those who are terminally ill. US research—it is a shame to quote only US research but there is very little research in this country on this area—has also noted that graduate nurses acted more independently and took more responsibility for their professional judgment.

The point I wish to make is that there is not, and should not be, a distinction between professional academic head on the one hand, and caring heart on the other. As the excellent report, *Front Line Care*, asserted last year:

“Truly compassionate care is skilled, competent, value-based care that respects individual dignity. Its delivery requires the highest levels of skill and professionalism”.

The core values of care and compassion do not change even as nursing becomes more demanding and complex. The challenges that nurse face today require

higher degrees of skill and a more well-rounded preparation. Indeed, *Front Line Care* urges:

“To ensure high quality, compassionate care, the move to degree-level registration for all newly qualified nurses must be implemented in full ... There must be greater investment in continuing professional development.”

I strongly support this position and I hope that the Minister, in replying, will confirm that the Government do too. Nurses practise in increasingly complex clinical and social environments.

The decision in 2009 that all new nurses must hold a degree-level qualification to enter the profession from 2013, was made with the aim of increasing skills, and training a medical workforce capable of operating in a more analytical and independent manner. I believe that making nursing a degree-level profession is the way to ensure high-quality front-line patient care. Currently, one in four nurses has a degree as their highest qualification, and I believe this must grow. As the noble Baroness, Lady Emerton, reminded us, this would merely enable us to catch up with Wales and Scotland and several countries in Europe and elsewhere—indeed, as well as with other professions.

I believe that it is a mistake to view being academically qualified and being a caring professional as somehow incongruous. This is not assumed in medicine or clinical psychology, so why should it be in nursing? Compassion is vital, but it is not enough; nurses must also be well educated to deliver safe, effective care. All nurses need to put quality care at the centre of what they do, but they also need extensive knowledge, analytical skills and experience to work in a variety of settings.

I know that universities strive to ensure that students entering the profession have the right blend of personal, caring attitudes along with the necessary knowledge and practical skills to deliver high-quality, evidenced-based nursing care for patients. This is why, as the noble Baroness reminded us, half of university-based education programmes at both degree and sub-degree level continue to be delivered on the ground, in health practice. Of course, there can always be improvements, and I know that universities and hospitals themselves are striving to make those improvements. But education and training must not stop at the point of registration. It must continue to consider post-qualification pathways for recently registered nurses, and recognise the importance of both multi-professional training and continued professional development.

Many noble Lords have raised the importance of education and training in a reformed NHS as the Health and Social Care Bill goes through Committee, and we have been reassured that the Government will give this area due weight and consideration on Report. Will the Minister reassure us today that, in its plans in the Bill for ensuring the continuation of appropriate education and training across the health professions, and developing a well educated and compassionate workforce, the new system will ensure continued professional development?

My final point is to echo some of the points made by the noble Baroness, Lady Emerton, that front-line nursing care is being severely threatened by the £20 billion efficiency savings target set by the NHS. The Royal College of Nursing's Frontline First campaign has been monitoring cuts in NHS services and posts since

July 2010. Its analysis of 41 trusts in England has highlighted the fact that registered nurses and healthcare assistants account for 34 per cent of the posts earmarked to be cut. On average across the 41 trusts, 8.3 per cent of qualified nursing jobs appear to be lost. The RCN cites these findings as evidence that trusts in England are making short-term cuts to meet the efficiency savings target. So, despite Government promises that there would be no cuts to front-line NHS care, clinical services and staffing levels are indeed being severely affected. At the same time, we know that English SHAs are cutting the number of pre-registration nursing places they fund. Last week, it was reported that nursing courses in London would be reduced from 2,000 to 1,580 after NHS London decided to withdraw funding. Estimates earlier this year suggested that course places in England for 2011-12 would be cut by 9.4 per cent compared to the previous year. These cuts to existing posts and to new entrants will have potentially disastrous consequences for patient care. So it is important for the Minister to address the issues of cuts and places in his reply.

The need to provide skilled care for people with many different conditions will continue to grow; we must have sufficient nurses, and our nurses must be properly equipped and supported to provide that skilled care.

12.05 pm

Baroness Jolly: My Lords, I thank the noble Baroness, Lady Emerton, for inspiring this debate. Hers is one of the most respected voices in your Lordships' House, and when she speaks on this subject we all listen and learn. I am also delighted to see here in the Public Gallery nurses who have come to listen to the debate.

What is the front line? All but a few of the 600,000-odd nurses are working right there, delivering world-class care to their patients. Some will be in key management positions in our trusts and a few are top civil servants advising the department and strategic health authorities. They are members of clinical networks, and I hope that in the new world they will be advising the NHS boards and should be on clinical senates.

If you were to talk to a focus group of the general public and ask them to close their eyes and think of a nurse, what would they say? In all probability they would think of a woman. Depending on their age, they might put that nurse in a frilly starched cap, and almost certainly in a hospital at the sharp end of acute medicine—including theatre, A&E, intensive care and neonatal nursing—although those with recent experience of the NHS might have a more modern, nuanced view. Of course, that picture is not accurate. Many nurses are men, and in the days of infection control frilly caps have gone. This focus group might be surprised that it is a graduate profession and that there are many specialist nurses with the equivalent of masters' degrees in their specialism. This situation is completely unrecognisable from that of 20 years ago. Let us be completely clear—here I totally agree with the noble Baroness, Lady Warwick—that, despite much red-top protestations to the contrary, all but a very few nurses do their jobs with utmost professionalism, as they fit into a multidisciplinary team based around patient care.

[BARONESS JOLLY]

I shall focus my remarks today on the nurses whose front line is the local community and who work in community settings, in the home and in community hospitals. They are largely unsung but play a vital role in patient care. They give the patients what they want—personal care at home or close to home. Their role is vital in keeping patients out of the acute setting wherever possible and in taking tasks from doctors, who are thus freed up for diagnostic work. We should be in no doubt that this is not only good news for the patient but, incidentally, delivers considerable savings to the NHS.

What roles might nurses take in community care? They are involved with cancer, continence, COPD, diabetes, district and community nursing, end-of-life care, learning disability, mental health, midwifery, minor injury nursing, multiple sclerosis, older people, practice nursing, prescribing, renal, school nursing, smoking cessation, stroke, and substance misuse. My list is not exhaustive, and I apologise unreservedly for any areas that I have omitted. These nurses are quietly innovative. The way that they work improves the care of their patients. They are collaborative and forge links with GPs, acute care, charitable sector providers and local authorities. They were designing informal packages of care and pathways before those terms were in common parlance. They act, while others plan and strategise.

In the history of community specialist nurses, midwives get the earliest mention in literature, in Exodus, delivering babies as the tribes of Israel fled from Egypt—if anyone can go back more than 6,000 years, I am happy to hear of it. This is a far cry from the world that my noble friend Lady Cumberlege spoke about on Monday in Committee on the Health and Social Care Bill. I should like to highlight two areas of outstanding care. Your Lordships will know that I worked for Macmillan Cancer Support, and I should like to explain its work in the community, and the role of minor injury nurses.

Last Sunday, I attended a service in Exeter cathedral to celebrate 100 years of Macmillan Cancer Support, which was established by Douglas Macmillan in response to his father's death from cancer. There are now thousands of Macmillan-trained nurses in the community, offering services such as chemotherapy at home, wherever possible, and helping the whole family deal with end of life, where necessary. At present, only a quarter of patients are able to die in their own beds, and 24/7 community nursing is critical to helping cancer patients die at home. These front-line nurses prevent crisis situations from occurring, so that patients are not transferred into hospital and hence reduce costs to the NHS in the longer term. However, half of PCTs are not providing this vital service. The palliative care funding review recognised that a relatively small investment in 24/7 community services would enable commissioners to deliver improved outcomes for patients and ensure that palliative and end-of-life care services are delivered in the most cost-effective way. The new draft end-of-life care quality standard also supports the need for 24/7 community nursing, and Macmillan would like to see the standard implemented effectively and as quickly as possible. Macmillan is also supporting those living beyond cancer. Macmillan nurses help families link

into specialist benefits advisers—either Macmillan's own or those trained by Macmillan and now working in CABs across the country—who work through and around the system for the patient and their carers. That is true personalisation.

On minor injury nurses, every week millions of people go to A&E or their own doctor for conditions that are minor—neither an accident nor an emergency. They go because A&E is easily accessible, but they waste the time of trauma teams. Two highly skilled specialist nurses in a community hospital or within an A&E department can run a minor injuries unit. They have access to advice from the A&E department as and when required. These units are able to treat a range of conditions: cuts, bruises, burns, simple fractures—even broken bones, as long as the skin has not been broken and the bone does not stick through—as well as sprains, strains and head injuries. Saturday afternoons see them full of sportsmen and women. In one year in Cornwall, 900,000 patients attended a Cornish minor injury unit. This prevented nearly 1 million attendances at A&E. By anyone's reckoning, that is an impressive record. If we visit their websites, praise for their service is fulsome. Holiday-makers visiting Cornwall, in Newquay, St Ives or Bude, leave messages on the websites to say how impressed they are by the services and asking why they are not offered locally.

I would like to move on to two general points about specialist nursing. Changes to the workforce need to be patient centred and must not be undertaken simply as a cost-cutting exercise. There is anecdotal evidence that, in some cases, services are downgrading roles simply to save money without analysing the needs of patients. Changes to the workforce need to be thought out and patient centred, mapping needs against skills. Macmillan is looking at how cancer patients can be given one-to-one support by a team of different professionals so that they receive support from the right person at the right time. In particular, Macmillan is looking at how support workers can be used to release capacity for specialists so that they can concentrate on tasks that make best use of and develop their skills, thereby improving the productivity and efficiency of teams.

I would like to echo remarks made by the noble Baroness, Lady Emerton, the noble Viscount, Lord Bridgeman, and the noble Baroness, Lady Warwick. I suspect that the speakers who follow might agree, although I dare not anticipate your Lordships' speeches. Education and training must be protected if we are to ensure a high-quality future nursing workforce. I am extremely concerned that under the current financial constraints, education and training budgets are being cut. In addition, there is not the capacity or funding to free up professionals to attend such training. Neglecting the continued education of professionals hampers their ability to advance their knowledge to meet the new and emerging needs of patients and threatens the future supply of specialist nurses. I would welcome assurance from the Minister on this subject.

This has been a very interesting and important debate. Its timing within the Committee stage of the Health and Social Care Bill is really useful. We must

do all we can to advance the nursing profession and in particular those specialist nurses who add so much to patient care.

12.15 pm

Baroness Masham of Ilton: My Lords, I thank my noble friend Lady Emerton for securing this debate on front-line nursing care. Whatever health Bill comes before us as new legislation, nothing will improve unless caring, compassion and dedication are put back into nursing. There is a lack of leadership and the lack of anyone taking responsibility on some wards, which are understaffed and badly managed. If there was a referendum on whether to bring back the old-type matron, who was in charge of nursing within the whole hospital and sisters who were hands-on and in charge of their wards—and the cleaning and helping of patients with their problems and discharge—wards would be better run.

Many of the tiers of nursing administration should be dropped; I am sure that the public would agree overwhelmingly. It is leadership and responsibility that is needed with front-line nurses. There is no doubt that hospitals are challenging places to run and that good administrators are vital but, again, there should not be overload and they should not be in conflict with clinical staff. The safety and well-being of patients should be the priority, and working in harmony is surely better. A consultant told me the other day that she had gone to the ward to see a patient and asked a nurse for the notes. The nurse retorted that the patient's nurse was not there that day, so I ask: was no one looking after her? This attitude is so unhelpful and the culture needs changing.

The other day, I was telephoned by a very popular GP who retired last year but still trains doctors. He told me that one of his trainees had a very rare condition that needed a life-saving operation, but the funding was not forthcoming. It is becoming a desperate situation. Knowing that his wife nursed part time in the local hospital, I asked how she was. The answer came back that she had become so concerned about patient care and nurses going off sick that she had not been sleeping at night, and had worried so much that she has now left. This nurse was Guy's trained and could not go along with the lack of staff and poor standards. It was one of the good days for patients when she was on duty. A culture of indifference to patients seems to have crept in with many nurses.

Having said that, I know that there are some excellent nurses and, for anyone who appreciates good nursing, they shine like bright stars. This being World Aids Day, there will be a debate on HIV and AIDS later today, and I have been so pleased to meet some very dedicated and kind nurses working on wards with AIDS patients. Perhaps this is because they have chosen this specialty and it is more than just a job. This is also the centenary year of Macmillan nursing—many congratulations to that splendid organisation, which has about 5,000 specialist nurses throughout the country, helping and advising people with cancer, while volunteers raise money by all sorts of ways. For many long-term conditions, specialist nurses are vital for illnesses such as diabetes, Parkinson's disease, stroke, epilepsy and so many other conditions. They teach patients and carers,

help patients from getting worse and keep them out of hospital. They are the vital link between primary and secondary care.

Most importantly, however, there are cuts to nurses, including those qualified in specialised neonatal care, and this cannot go on. There is a serious situation at the moment because the £20 billion Nicholson efficiency savings are causing cuts in important front-line nursing staff. For example, when nurses retire they are not being replaced. It has been brought to my attention that there is considerable anecdotal evidence that demonstrates how the district nursing service has been stretched to the point that it is providing a bare minimum service in many areas. District nurses are vital if patients who need nursing care in the community are to manage. The importance of district nurses should be recognised. Skills needed for nursing in the home are different from other forms of primary care nursing. I hope that the Minister will look into what is happening across the country.

With all the recent reports about the lack of care for the frail and elderly, and the horrific evidence shown in the "Panorama" programme of cruelty to people with learning difficulties in a care home, it seems that care assistants should be registered and regulated. I am among many people who feel that it is of great concern that nurses can be struck off their register and take unregistered jobs as care assistants. Patients are being put at risk, as it is unrealistic to think that the few nurses on a busy ward can supervise both care assistants and student nurses when there are vital jobs that only the nurse can do behind closed curtains. There should be training for all care assistants. They are often dressed up in uniforms which are indistinguishable from trained nurses, which is not open and honest to patients.

On a positive note, I would like to say what an excellent job nurses do in front-line nursing in Afghanistan. There seems to be real team co-operation while working under stressful conditions.

Prevention of infection has become more important than ever, given the increasing resistance to antibiotics. I would like your Lordships to realise the importance of infection control nurses working on the front line. There is much concern about moving the Health Protection Agency, which is vital in the fight against infections. Any dilution of its independence and ability to research will have an effect on front-line nurses in the long run. There are many infections, such as gram-negative bacteria, klebsiella and *E. coli* that affect urinary infections as well as PVL-SA—Panton-Valentine leukocidin positive staphylococcus aureus—which is an infection that can affect young, healthy people, causing necrotising pneumonia and can kill in a few days. There have been improvements in MRSA and *C. difficile* in hospitals, but controlling infections needs constant attention to detail. We should never get complacent.

I have great admiration for the front-line nurses who go out and find homeless and hard-to-reach people at risk of tuberculosis and work in prisons with a multitude of infections, including hepatitis B and C. Drug-resistant TB must be kept under control. These resistant infections, which are expensive and hard to

[BARONESS MASHAM OF ILTON]

treat, can be passed to anyone. Without doubt, front-line nurses are vital for our well-being and that of our children. They vaccinate the population and so often are the first people to stop a killer infection such as meningitis in an A&E department.

I hope that this debate will help to show our appreciation for front-line nurses, who need to have the highest standards to keep the NHS on top of the job.

12.25 pm

Lord Hunt of Kings Heath: My Lords, in thanking the noble Baroness, Lady Emerton, for her splendid opening to our debate, I declare an interest as chair of the Heart of England NHS Trust and as a consultant and trainer for Cumberlege Connections. I also acknowledge my noble friend Lord MacKenzie on the Front Bench. I suspect that what he does not know about nursing is not worth knowing; it is very good to see him there.

This is a very timely debate. We all agree that the quality of nursing care is fundamental to the quality of the patient experience. However, we are presented with a paradox. On the one hand there have been huge advances in the nursing profession over the past 20 years. There has been the move to it being a graduate profession. Nurses have taken on much greater responsibility. There is complex care and specialist nurses, in both hospital and the community, as the noble Baroness, Lady Jolly, so vividly informed us. I think also of midwifery. If the noble Baroness, Lady Cumberlege, were here, she would be able to talk about changing childbirth and how the profession was encouraged to take on a huge leadership role. The public have welcomed the increased responsibility that nurses have taken on.

At the same time there has been a mounting concern about basic standards of care and issues to do with hygiene, the feeding of patients, nutrition, dignity and even face-to-face contact. This has been reinforced by several reports from unannounced visits and the CQC over the past few years. There have been any number of investigations of concerns about what seems to be a falling off in basic values of care. What is the reason for that? My noble friend Lady Warwick convincingly demonstrated that the old canard about modern nurses being “too posh to wash” just does not stack up. However, there are a number of questions that one might ask. There is a real question about whether nurse training is too focused on academic performance rather than on practical nurse training.

I also wonder whether the drive for specialist nurses and modern matrons has removed too many experienced nurses from the ward or the equivalent within the community. Has the lack of regulation for healthcare assistants led to patchy and inadequate care in some places, despite the undoubted dedication of many of them? We need some serious thinking about how to enhance quality overall and the standards of basic care that nurses give. Certainly, in my own trust a lot of thinking has gone into the quality of nurses. I claim no credit for it. While we do not have matrons in starched caps, we certainly have visible chief nurses

in purple uniforms walking the wards as a visible demonstration of nurse leadership, which has been warmly welcomed. Anyone who wants to see nurses really dressed up should go to the Florence Nightingale service in Westminster Abbey once a year. I always hope that the chief nursing officer will come in uniform—alas not. To see the chief nurses of the Army, Navy and Air Force marching up the aisle is a wonder to behold. The reason why the public like to see it is that they want to see nurses in authority. They want them to have the confidence to be leaders in the ward, in the community and in the health service as a whole.

Another thing that we have done is to develop a robust measurement of nurse standards by polling 400 patients a month, looking at the results, reporting to the board and trying to identify any problems with nursing care. The third thing that we have done is to develop VITAL—virtual interactive teaching and learning. Essentially, it assesses all nurses online for their knowledge of best practice in fundamental care. This covers, for example, nutrition, falls, privacy and dignity and pain management. Since the summer, 60 per cent of our trust's workforce have achieved 100 per cent in that online examination. Our intention is that from next year all newly qualified nurses and midwives will have to achieve 100 per cent within six months or they will not get the substantive contract. We also expect our nurses and midwives to sign up to a code of values and behaviour. We are introducing a badge for our nurses which will be achieved only if they get 100 per cent in the online test, sign up to our values and have evidence that they are putting those values into action. The noble Baroness, Lady Emerton, will certainly remember the badge, which nurses wore with pride. It showed where they came from and who they were; for example, the Tommy's nurses. We need to get some of that ethos back into the health service.

We have done a lot but there are a lot of issues around the training and education of nurses. I do not disagree with the requirement for nurses to have a degree. I do not think there is any argument about that. However, we have thought about how a foundation trust could be much more involved in nurse education and supporting students in practical nurse training. We wanted to facilitate a practice-based model built around the trust which promoted our core values but adhered to national standards and the curriculum as laid down by the Nursing and Midwifery Council and with appropriate academic accreditation. It is fair to say that our proposal has not met with universal acclaim. Indeed, I feel that all the establishment bodies concerned with nurse training and education have put a real dampener on this. We have been accused of turning the clock back to the old schools of nursing. That is a bit unfair to some of the old schools of nursing because they were pretty good. However, we are not trying to do that. We seek to facilitate a more practical-based nurse education degree, which would have degree status but would be built much more around the hospital and its values. I do not think that this discussion is at an end. I believe that we will soon have a new chief nursing officer to follow on the excellent current CNO Christine Beasley, if one has not yet been appointed. This must be one of the main

focuses of the new chief nursing officer. What could be more important than sorting out the education and training of nurses?

The noble Viscount, Lord Bridgeman, and the noble Baronesses, Lady Jolly and Lady Masham, were right about the role of senior sisters, or their equivalent, in the community. We need to empower them to lead. That means they have to have control of the budget so that whoever is providing the cleaning or the food, whether it is directly employed people or contract cleaners, none the less when the senior sister wants something to happen there is no question but that it happens. We need to give our senior sisters much more confidence and support to take on a leadership role. We need to go back to the days when doctors were a bit scared of the senior sister because she is in charge and she is the person on whom the patients depend for the overall quality of care. Making our senior sisters supernumerary so that they can focus entirely on leadership and management will cost us £1.6 million. It is a challenge to find the resource to allow them to focus much more on leadership. The problem with being drawn back into being counted as one of the qualified nurses on wards is that they then get so focused on caring for patients that they just do not have the time to carry out the leadership role that is required.

I urge the noble Earl to take account of two further points. My noble friend Lady Warwick talked about the lack of UK research in relation to basic nursing standards. The noble Earl will not be surprised to hear that there is an issue with regard to the amount of money spent on research into nursing. I know of the efforts made by the department over the years to give a boost to the amount of money spent on research in relation to nursing but clearly we need to go somewhat further in that regard. We probably need to have more academics who can focus on research.

With regard to healthcare assistant regulation, the Government's response is to have a voluntary register. I suspect that there will be a halfway house and that it will not be long before some NHS organisations will say, "You can't be a healthcare assistant with us unless you register voluntarily". I hope that training programmes will be set up but, for the reasons that the noble Baroness, Lady Masham, has given in terms of safeguarding the public, the argument for regulation is becoming ever more persuasive.

I hope the noble Earl recognises that the number of nurse training places should be determined by Ministers. If he devolves that issue, he will find that in times of financial difficulty the number of training places will be cut. I would give much more discretion to the NHS locally to determine arrangements with universities regarding the provision of graduate education for nurses. However, history tells us that the moment the department relinquishes control of the number of training places, the health service does the wrong thing. I know that we are debating the tension between national leadership and local discretion, but national leadership is required in some areas, and this is one of them.

12.36 pm

Baroness Browning: My Lords, it is a great pleasure to follow the noble Lord, Lord Hunt of Kings Heath, with whom I have debated many issues in this Chamber.

I agreed with every single word that he said in this debate. I stand in awe of what he has done in his trust. He recounted the list of things that had been implemented, not all of which seemed to need an awful lot of money, although I understand what he said about education and training. You wonder why such practice cannot be rolled out around the country and why exemplars cannot be picked up rather than having trusts that try to reinvent the wheel, struggle or in some cases attract rather adverse headlines, as we have seen in recent years.

I had the great privilege to serve as a Member of Parliament for 18 years in another place. During that time I had the pleasure of working with and for nurses and midwives in my constituency, many of whom came to see me to discuss the problems that they encountered in their work. Sometimes they came individually and sometimes collectively. I pay tribute to the work that the profession does. There are people out there who go that extra mile. As patients or relatives of patients, we should all be extremely grateful to them for that. I know that I am.

However, as has been mentioned by other speakers, healthcare, which includes the nursing profession, has been the subject of some very worrying and adverse headlines, not just in recent weeks but for a long time. Some eight years ago in a debate in another place I raised concerns about nutrition and fluid intakes based on my personal experience of having an elderly relative in a hospital. It seems to me that these things have gone on for a very long time. Mencap still has concerns in this regard. Three years ago it published a report, *Death by Indifference*, which discussed people with learning disabilities who had died on hospital wards not through disease but through neglect. That is an indictment of us as politicians and of our nation. Members of the nursing profession and others involved in healthcare must feel that very keenly when they see and read about what is happening.

As I listened to the noble Lord, Lord Hunt of Kings Heath, I wondered how hard it would be to make best practice universal if there was a political will and a professional will in all parts of healthcare to look at what works and to implement best practice. I realise that budgets come into these things and that there are always differing opinions on how to do things. However, we are starting to see some common themes coming through, not least in the report *Front Line Care*, which the noble Baroness discussed. There is a common theme in this report. There is great confusion in the healthcare system, particularly in hospitals, and we as patients are also confused. It is quite possible to go into a general hospital ward and come away still not really knowing who was in charge. It is the uniforms, it is the way people conduct themselves. It is not that people are not doing their job, but you cannot always say who is in charge.

The heading on page 60 of the report says, "The Proliferation of Roles and Titles", and I would add uniforms to that. At one time I thought I understood

[BARONESS BROWNING]

all the uniforms on a ward, but I have to say that I do not now. Having been in hospital this year, all I can say is that the lady in the pale blue uniform did a jolly good job for me, but I still do not know what her job title was. The report says:

“especially doctors ... were often unclear about what skills and competencies they could expect from individual nurses and support workers, exacerbated by the plethora of job titles and role descriptions”.

It is bad enough that I as a patient was confused, but the fact that doctors are also confused tells us that something needs to be sorted out, and urgently.

Much more seriously, if doctors do not know what they can expect from these different job titles and uniforms, and if the nurses themselves have to delegate—I will come on to delegation in a moment—it is no wonder that there are problems and that some of them become systemic. I say to my noble friend, for whom I have great respect for the work he does on the Front Bench, that these problems are now systemic and need to be treated as a matter of urgency.

Frankly, we do not need another five years of reports and anecdotal evidence. It seems pretty obvious that some people are now overcoming these problems—the noble Lord, Lord Hunt, explained what happens in his trust—and this could now be rolled out. While I understand the need for localism and local decision-making, the Government have to take some leadership in making sure that this is rolled out and that they act as the catalyst to ensure we do not have the same debate in five years’ time.

I return to the subject of nurses and the nursing profession. I agree with noble Lords who have said that it does not necessarily follow that because someone has a degree in nursing, they lack compassion. That is a rather terrible thing to say. However, there is a question about the structure of nursing, which yet again is picked up very well in the report on page 87, under the part entitled “The Way Forward”. The report says:

“There was much comment on the style of leadership needed for the future. ‘It’s to do with whether we’re transactional (you will do this, that or the other—talking down to staff)’—

the Hattie Jacques scenario, I suspect, although a lot of people would quite like to see a few more Hattie Jacques on the ward—

“or transformational leaders (embracing staff and recognizing skills and contributions)”.

The report goes on to talk about mutual respect, not working in silos, and working as a team. Anyone who has worked in any large structure, whether in healthcare or elsewhere, will recognise those two different styles of management, although I have to say that it does not have to be one or the other. Leadership is about taking difficult decisions and about looking holistically across the whole. I quite agree with colleagues who have said today that those in charge of a ward should also have the authority to deal with nutrition and cleaning. I remember a debate in a German hospital, where the wards were absolutely spotless, about whether cleaning services should be contracted out. The question was asked, “How do you make sure that these wards are so absolutely spotless?”. The reply was that the

cleaning was contracted out but that the person in charge of the ward was able to stop the payment of the contract if they were unhappy with the results. That is the sort of authority and leadership that is needed on a ward, and it should be placed with an individual. This is not rocket science. If we had the collective will to implement that, it could be done tomorrow.

Nurses also have to delegate. I was very interested to hear Tony Hazell giving evidence on Tuesday to the Health Committee, which is holding an inquiry into education, training, and workforce planning. He said that there will be more training, both for nurses and for healthcare workers to whom nurses delegate. From this report, it is clearly rather important that everyone in the structure knows and understands their role, and that people are prepared to delegate so that they are not working in silos. In-service training is also important for nurses working in hospitals, out in the community and elsewhere, as well as for those are not nurses but who work in a supportive role. If such ongoing training were in place, we would not get the horrendous stories, which I have personally experienced on more than one occasion and with more than one person, of food being left at the end of the bed for someone who cannot access it. In-service training and education throughout is important, and it will also help nurses.

Finally, it is important that where there are serious problems, nurses should be able to report colleagues in a structured way. It is called whistle-blowing—a horrible term—but in my experience, where really good nurses experience this and hit the buffers in trying to report problems, too many of them leave the service. They find it just too difficult and too unpleasant. We have to build that into the structure when we come to reform these services.

12.47 pm

Lord Young of Norwood Green: My Lords, I, too, thank the noble Baroness, Lady Everton, for initiating this debate and congratulate her on a superb contribution. I enjoyed the history of nursing but must admit that I felt that one name was absent—especially as we are talking about front-line nurses—and that was Mary Seacole, who brought a different approach, though a very interesting one, about the same time as Florence Nightingale. I see that I have not transgressed because the noble Baroness is nodding. I am relieved that I have got my history right.

I enter this debate as a lay person, but I cannot help thinking that if Benjamin Franklin were alive today and living in the UK, he might be saying that there are three things that are certain: death, taxes and—whoever we are, at some point in our life—being impacted on by the National Health Service. Of course, the unfortunate fact is that as we gradually mature—I do not say get older; in the House of Lords we mature—we experience that impact. Last year I spent a week in an NHS hospital having a large lump of titanium inserted in to my hip. It was largely a very good experience. It was fascinating being in the ward, looking at the atmosphere there and the nature of the people who treated me. As has been said, some were absolutely superb: they had empathy, compassion and all the things that you want. Others, I could not help feeling, needed to be taken to

one side and told, "Look, part of working on a ward is to show care, empathy and compassion. If you're not doing that—it doesn't matter who you are, whether you are a doctor, nurse or care assistant—you are actually undermining the quality of care for people who are really at your mercy as patients".

When it is good, it is really good. I noticed this during that week. There were some ward sisters who came on and would do anything; never mind "too posh to work", they would do any job whatever. They were a brilliant example of leadership at its very best. There were others with whom I felt that it was not quite right. The worst example that I saw was when the elderly woman with suspected pneumonia in the bed next to me was getting in to that panicked breathing mode. In a plaintive voice, she said, "Help, nurse. Help", and a young nurse who was sitting at a computer turned round and said, "Someone will be along in a minute". I had difficulty in restraining myself at that point and fortunately someone did come along, but why did that nurse not get off her backside and do what she should have done, which was to respond to the woman while holding her hand? It is a matter of changing the culture—something that has already been referred to. I hesitate to bring up the worst examples but, if we do not have an honest and frank debate, we will not really address the issue.

However, as I said, I have seen some wonderful examples. My wife is currently being treated for a serious kidney condition and the renal ward at Hammersmith Hospital is absolutely brilliant. I reckon that the senior ward sister there—Sister Nicola—would be able to solve most of the problems in the National Health Service if only we could clone her. She is marvellous and empathetic, and the ward runs like clockwork, and so there are some absolutely brilliant examples.

My noble friend Lady Warwick rightly condemned the generalisation that takes place in the media by implying that, if you have a degree as a nurse, somehow you cannot undertake basic nursing tasks. I, too, reject that—it is clearly wrong. However, we have to make sure that the training for people who study for a nursing degree is right. As I understand it, they should spend 50 per cent of their time on the wards. I should be grateful if the noble Earl, Lord Howe, could confirm whether that is the case when he responds. Ward experience under the watchful eye of trained sisters is vital.

My noble friend Lord Hunt, who seems to have captured the ground in progressive approaches to the development of nursing, gave us some very useful pointers. Why do nurses not have something equivalent to the doctors' Hippocratic oath? My noble friend was absolutely right to talk about a code of values. That ought to be taken on board and be a part of the national scheme. Knowing who is in charge and has authority is important. Going back to one of the best examples that I had experienced, when I asked Sister Nicola what her qualifications were and whether she had been in the nursing profession for a long time, I discovered that she actually had only a diploma. I am not arguing against degrees but, with my passion and enthusiasm for apprenticeships, I argue that there should be a vocational route into nursing. Interestingly,

when I asked the consultant for her views on this, she said, "It's funny you should say that. We have a healthcare assistant who is a mother. She has returned to work recently and wants to go into nursing". There ought to be that vocational route for healthcare assistants. I am reminded of the old sandwich courses that you did if you wanted to get a degree in engineering. Again, when the noble Earl replies, I should be grateful if he could take up that point.

The noble Baroness, Lady Browning, said that there are a number of practical things that can be done—my noble friend Lord Hunt told us about some of them—and that we do not need another five years of research to encounter what we know to be proven good practice. I hope that the noble Earl, Lord Howe, will be able to assure us that spreading best practice will be one of the Secretary of State's key roles. It is not just about money; there is a real debate about staffing, although I do not want to go into that. Obviously if people feel under real pressure, that is going to create problems. I do not particularly want to explore that side of the issue but spreading best practice, as a key part of developing the health service, seems to be fundamental. Surely it would be a cost-effective, value-added method of improving the health service.

I have one or two points to make in conclusion. The noble Baroness, Lady Browning, touched many buttons when she talked about the confusion over uniforms. I absolutely echo that. You think, "That one's in blue, that one's got blue with spots on and that one's in pale blue". Sometimes it is also really difficult to distinguish healthcare assistants.

There is a question over whether healthcare assistants should be regulated. I tend to feel that, because they have become so important to hospitals and community care, the one thing that we should insist on is a requirement for basic training. That should not be an option. Perhaps a code of values, which my noble friend Lord Hunt suggested in relation to nurses, should also be adopted for care assistants.

A number of contributors said that it was important to make sure that those in charge of wards have authority. I have recently been in hospitals where the wards have been spotlessly clean. That is one part of the problem in wards but it is not the only one—noble Lords have also referred to the feeding of patients and so on.

I am conscious of the time but I should like to make a final point. I think that it was on the "Today" programme on Radio 4 this morning that I heard a former nurse speaking about whistleblowing. I do not like that phrase either, because it should not have to happen. The right management environment should encourage people, as part of working in a team, to explore the strengths and weaknesses of their work on a ward. They should be able to say, "How can we work together? If there are problems, I should be able to feel that I can go to my immediate manager and have a frank discussion". It is important to ensure that the right processes are in place to enable nurses to feel confident enough to do that.

In conclusion, I feel privileged to have had the opportunity to take part in this debate and I look forward to hearing the noble Earl's response.

12.57 pm

Lord Patel: My Lords, I note that I am the only doctor speaking in this debate. Noble Lords are right: doctors do as matrons tell them. Therefore, when my noble friend Lady Emerton—the matron—said to me, “You will speak”, I did not argue, but I am very pleased to be able to do so and I thank her for the opportunity.

As most noble Lords know, during my fruitful life my specialty was maternal foetal medicine. I worked in a team that looked after mothers whose pregnancies were complicated by other medical conditions or who developed serious complications during pregnancy or labour. I pay tribute to the most dedicated nursing workforce with whom I had the privilege to work—midwives and specialist neonatal nurses. They were the key members of the team and prevented not only deaths but handicaps among the babies who were born either prematurely or with difficulties, or whose mothers had a difficult labour. They are the most skilful nurses with whom I have ever worked. I still go to my hospital occasionally. I walk through the labour and delivery room and get the usual comment: “Have you come here to work or to drink our coffee?”. I have the coffee, as I do not think that I would be allowed to work. I am going to talk mostly about the current state of affairs in midwifery and neonatal nursing.

We currently have a shortfall in England of between 4,500 and 5,000 midwives. This is partly because of a fall in recruitment but it is also related to an increase of 22 per cent in the number of live births over the past two years. There are now 690,000 births per year in England. Another problem is that the midwifery workforce is ageing. Half the workforce is aged between 45 and 55, and therefore recruiting a younger workforce is extremely important. Not only that, there is a change in the way in which midwives work. Their work has become more complex because of older mothers. There has been a 71 per cent increase in 40 year-old mothers and a 24 per cent incidence of obesity in pregnancy, both of which lead to higher rates of complications in antenatal care and in labour.

There is also a reduction in the overall budget. In 1997-98, the maternity services budget was 3.1 per cent of the total NHS budget. Although the sum might have gone up in total, it was 2.46 per cent in 2010. There is a serious issue of recruitment of midwives and an increase in maternity services. I know that the Government recognise the problem. Even before the election the Prime Minister, as Leader of the Opposition, writing in the *Sun* pointed out that midwives were, “stretched to breaking point ... overworked and demoralised”.

He promised that when in power, the Government would increase the number of midwives by 3,000. Unfortunately, that has not happened.

I congratulate the Government on the issue of training. They have committed to maintaining the same number of places for student midwives in the 2011-12 academic year as there were in 2010-11, which was a record high. This is welcome as it will help to address the two issues of the midwifery shortfall and the ageing midwifery profession, provided that there are jobs at the other end of the process. Recruitment ought to be part of it.

Last week the Royal College of Midwives published its *State of Maternity Services Report 2011*, which makes several good points. The key ones suggest steps to address the problem. One is to increase the choice of place of birth—I know that the Government are keen to allow mothers to have a choice—such as midwifery-led units and home births. Births in these settings require less midwife time, and in low-risk pregnancies outcomes are not affected. Other suggestions include: the appropriate deployment of properly trained and supervised maternity support workers to do non-midwifery tasks; a guarantee not to cut midwife training places; and encouraging the health service to increase recruitment and meet the target of 4,000 more midwives.

There is clear support for more midwives. A recent public e-petition to Parliament calling for the Government to recruit an extra 5,000 midwives has already been backed by 20,000 people. I hope that after today's debate it might increase to 2 million. I hope that I have made my point that there is a need to address the midwife shortage if we are to deliver quality care to pregnant mothers and newborns.

I turn briefly to the issue of neonatal nursing. As highlighted in the report published on 9 November by Bliss, a special-care baby charity, one-third of neonatal units in England are cutting their nursing workforce, stopping recruitment or downgrading posts. Referenced against the Department of Health's toolkit for neonatal services, there is a shortage of nearly 1,200 neonatal nurses. Care of the neonates, both premature and following neonatal surgery, is highly skilled, intensive work, and outcomes for those vulnerable babies, including mortality rates, are directly related to skilled nursing care around the clock. Cuts in training and education budgets have led to a shortage of qualified specialist neonatal nurses. We need commissioners and providers to implement NICE specialist neonatal care quality standards. In future we will rely a lot more on NICE quality standards to drive up quality and outcomes in the health service. If they are not implemented—as they clearly are not, in specialist neonatal care—improvements will not come about.

The Government want a reduction in perinatal and infant mortality. Delivering care to neonatal quality standards will go a long way to achieving that. I look forward to the Minister's comments on both maternity and neonatal services.

1.06 pm

Lord Ribeiro: My Lords, I apologise for speaking in the gap without giving notice, but I could not let the noble Lord, Lord Patel, give the impression that he was the only doctor here who was prepared to speak. I thought that I would share some thoughts on my view of nursing, which I have to limit to my own special interests of surgery as they are the only group of nurses I know anything about.

It is interesting that reference was made to the Salmon report, which I think was produced in 1968 when I was a fairly young junior doctor in the Middlesex hospital, which sadly no longer exists. We had a matron, wing sisters and ward sisters, and there was no question about who was in charge. There was leadership right down to the ward level, and the important thing about

nurses at that time—there are still quite a few of them out there today—was that they knew they were in charge. They had responsibility for the ward and I totally agree that we should not wait for the hospital manager to say that a sister of a ward cannot tell the cleaning staff that they have to stop. I well remember doing ward rounds at Basildon hospital when the sister would put a notice on the door saying, “Ward round in progress. Consultant present. Quiet please”. If the cleaning staff tried to come in she would tell them to go away until the ward round was finished. Latterly we would not dare tell the cleaning staff to go away because their response would be, “If I don’t clean this ward now I’m not coming back”. There has to be proper leadership. It does not have to come from Richmond House; it has to come from within the organisation, seeing its responsibility to ensure that leadership is delivered. Leadership is the key—knowing who is in charge.

One of the things that has been said about doctors is that they have treated nurses as their handmaidens. It may be said that doctors have been resistant to seeing nurses progress, and we have had a long debate about training, education and diplomas, which I shall not go into. But the opportunities that opened up for nurses after Salmon provided nurses with a way to move into management and other areas. The advantage for nurses is that their opinion and advice has influenced medical care over the past 40 years that I have been in medicine, and much of it to the good. The downside has been that we have created another pathway for nurses to go other than the ward. Therefore, talented nurses may have wanted to stay on the ward but if they wished to progress and improve their salary status, they had to go sideways into management. That is where some of the problem has emanated from. We must look at ways of remunerating and keeping nurses who want to stay on the wards to do so.

I shall not speak for long but I want also to make a point about teamwork—nurses and their contribution to the team function. As a surgeon, like the noble Lord, Lord Patel, I know that we work in a close team. Our main team is the ward staff and ward sister who look after our patients. In my case the ward sister would tell me through the grapevine when my junior doctors were not doing all that they should. There is a big function for the ward sister, other than just looking after patients. In theatre, you have a close-knit team. Another thing that I regret is was that in the old days many nurses would come along and observe what was going on in theatre and say that they would like to become theatre sisters. They were encouraged to go into it. Latterly in my time as a consultant, I found that fewer and fewer nurses were being directed to go to work in theatre. I think this is a great shame because we live in a world of multidisciplinary working, and it is important that nurses should be encouraged to specialise if they wish to.

Finally, I came back from Afghanistan recently, and in answer to the noble Baroness, Lady Masham, I have to say that the nursing teams in Camp Bastian are superb. Many of them are volunteers from this country, and their contribution to the war effort in Afghanistan has to be noted and applauded.

1.10 pm

Lord MacKenzie of Culkein: My, Lords, we all owe a great debt of gratitude to the noble Baroness, Lady Emerton, for securing this important debate on front-line nursing today. It has been a very well informed debate. It is not very often that we have the opportunity to debate nursing in this House, so the debate is to be doubly welcomed. It comes at a time when the nursing profession is, to coin a phrase, getting it in the neck. As my noble friend Lady Warwick of Undercliffe said, not a week goes by but there are reports of poor care with a lot of armchair analysis of where it is all going wrong. There are justifiable concerns which have to be addressed, and I will come to them shortly.

Like the noble Baroness, Lady Emerton, I am a nurse who is no longer on the effective register, and I have not been for the past 10 years to so, but because of that I want to start from this side of the House by saying something in defence of the nursing profession. The vast majority of nurses, and midwives too, are good and safe practitioners. They provide good quality and safe care. They are highly skilled. They are involved in research and all sorts of things that could have been only dreamt of in my early days as a nurse. Good work does not get publicity. The noble Baroness, Lady Jolly, reminded us of the good work done by Macmillan nurses and hospice nurses, and the noble Baroness, Lady Masham, and the noble Lord, Lord Ribeiro, referred to nurses who join the military reserves, spend six months in Camp Bastion, then come back and continue their remarkable work in the National Health Service. Good work is done by specialist nurses, such as stroke nurses or community psychiatric nurses, to highlight just a very few. Good things do not get publicity; bad things do. The image of the nursing profession is suffering as a result of recent publicity, some of it rather damning, about the quality of care in a number of settings.

In my experience, morale has its ups and downs, and now it is on the way down but at least until now the image of nursing had always been good. Morale is now being hit from a number of areas including the growing public perception that nurses are not capable of compassionate care, the two-year pay freeze and pension issue, the downgrading of posts and the actual and forecast staffing reductions coming from the Royal College of Nursing and UNISON. As we have heard today, that is not just hyperbole from staff organisations. The noble Lord, Lord Patel, told us stories about special care baby units and the number of neonatal nurses who are being downgraded while in post. We are getting the same story from the Multiple Sclerosis Society that a significant number of posts are being cut.

It became really too much when a leader in last week’s *Sunday Times* said:

“One reason for the government’s tough austerity programme is that ... Labour poured more money into the National Health Service ... and the number of nurses increased by a fifth”.

That is going too far. Poor morale is not conducive to happy nurses, and no Government can ignore it for very long. I think a match may have been put to a slow-burning fuse with the prospect of even heavier cuts, 1 per cent pay maxima and possibly different

[LORD MACKENZIE OF CULKEIN]

salaries for nurses doing the same job, for example, in Stockton-on-Tees and in Guildford. Bad morale has an effect on staff. It cannot be overlooked, but neither can or should it be used to justify bad delivery of nursing care. I hope that we can get some broad measure of agreement on the way forward, which means dealing with some of the reasons for the apparent decline in some aspects of care.

The report of the Prime Minister's commission on front-line nursing, set up by my right honourable friend Gordon Brown, has much to commend it. The noble Baroness, Lady Emerton, was, as she reminded us, a commissioner. The recommendations of that commission, if implemented, point the way forward on many of the issues that need to be addressed for the future. The present Government welcomed the report. They say that it does not go far enough but, at the same time, they say that it has to be looked at in the light of the present economic climate. That might be a contradictory position.

Staffing levels are always an issue in nursing. We heard about them yesterday in the debate on mandated levels and ratios, and we know from research that inappropriate staffing leads to poorer care and higher mortality. In response to amendments yesterday, the Minister told us about the safeguards that will be in place, but most of them are already in place yet have not prevented the problems, for example, in Mid Staffordshire, and when the CQC gets involved, it is, as was highlighted yesterday, usually too late.

There is much mythology about the so-called good old days. The press are forever hankering after matron, but know nothing about the science and art of nursing. What is not a myth is the fact that basic or essential care was better. I speak as a fascinated observer and recipient during a recent six months' hospitalisation. I should have been in for one night, but ended up staying for six months. My experience was that most technical skills were excellent, although staffing levels and ratios outside intensive care and high dependency were not always good enough. Essential care was not always as good as it could or should have been. The care that used to be delivered by enrolled nurses, student nurses and pupil nurses is now delegated to some 303,000, I understand, healthcare assistants or support workers who fulfil many different nursing and midwifery roles. I am told that there are some 120 different job titles for support workers throughout the National Health Service. If that is true, find it astonishing. As was said yesterday, there is too much variation in the quantity and quality of training available for support workers. That needs to be improved and to be done to a national standard agreed with stakeholders. Scotland has already done this, and Wales and Northern Ireland are looking to follow.

Much of the care that is delegated to healthcare assistants is hydration, nutrition, pressure area care, intimate care, oral hygiene and keeping the patient clean and dry. We used to call that nursing care but, to my regret, it is often now dismissed as social care. It is nothing else but essential nursing care, and if it is not done, and done properly, then we have lost sight of what we are about as a profession. Healthcare assistants increasingly do more than essential care. They do

temperature, pulse, respiration and oximetry observations. In the community, they are dressing leg ulcers and undertaking catheterisations and tube feeding, which were once the sole prerogative of the district nurse. I understand that healthcare assistants can, in some hospitals, undertake procedures such as cannulation. I wonder whether patients know that the person putting a needle into their vein is unregulated and not professionally accountable. I suspect they would be surprised.

Can we rid of the confusing titles? Patients are entitled to know who is looking after them. The noble Baronesses, Lady Masham and Lady Browning, and my noble friend Lord Young mentioned uniforms. They are confusing. Patients have no idea who is looking after them. The whole of the profession is suffering because the basics are not always being attended to. This is, I am convinced, due to incorrect staffing levels and training, education and organisational cultural issues. It is also to do with societal attitudes to the elderly, which is not peculiar to the National Health Service. The National Health Service cannot cure society's ills, but it needs to get a grip and sort this matter out internally.

There are more changes to come. Nursing in England is to become a wholly degree-based profession, which is right. But perhaps I may pick up on the point made by my noble friend Lord Young that there needs to be a wider entry gate. There is always the fear that when a profession becomes wholly degree-based, it cuts out the possibility of a number of people who would make excellent nurses getting entry to that profession.

Good selection of potential students is essential. Recently, we have heard quite a bit about nurses not being fit to practice when they emerge from universities. I do not know whether enough nursing input goes into that selection but, if not, it should do. We also need to deal with clinical practice and relate it to theoretical content, and we need to get it right. My noble friend Lord Hunt of Kings Heath has spoken at length on this point and I agree with him entirely. I do not think that there is anything wrong with a practise-based model and I hope that those discussions are not at an end.

Protection of the public should be effective, all the more so given the cost-driven trend for employers to substitute trained nurses with support workers. That brings me back to regulation, at least of those who are delegated duties by trained nurses. The Nursing and Midwifery Council, the Royal College of Nursing, UNISON, the Queen's Nursing Institute, the health committee in another place and, not least, healthcare assistants themselves want statutory regulation. The Government do not agree. They want assured voluntary registration. Some regard this as a small step in the right direction. It is small step but we do not think that it goes far enough. However, we will come back to that debate in the near future under the Health and Social Care Act.

Perhaps I may return to the Prime Minister's commission on front-line care. I hope that the Minister will give us some detail on what the Government plan to do with each of the recommendations. I appreciate that that is a tall order, so perhaps he could write to us.

There are four very important first principles. On the pledge for nurses and midwives, my noble friend Lord Young spoke about the Hippocratic oath and having an equivalent, which could be developed.

We have heard a lot in this debate about the responsibility of senior nurses. I agree entirely that they need to be given back the authority that they had. On corporate responsibility, as we have heard, recently Sir David Nicholson told a conference of senior NHS staff that many of its employers had no idea of how many nurses they have in the hospital or on a ward at any one time. A hobbyhorse of mine is the return of the ward sister. That responsibility must be restored and properly defined. Like the noble Baroness, Lady Emerton, I am passionate about nursing. I look forward to what the Minister has to say. Again, I thank the noble Baroness for giving us the opportunity for this debate.

1.22 pm

The Parliamentary Under-Secretary of State, Department of Health (Earl Howe): My Lords, on occasions like this, I reflect on how lucky we are in this House to have the noble Baroness, Lady Emerton, in our midst. She has allowed us to appreciate once again why she is such an unquestioned authority on this crucial subject of nursing care. I, for one, am very grateful to her.

The wording of her Motion is of course carefully chosen. Front-line nursing—in acute settings, in the community, in schools and in people's homes—is a part of all our lives and has always been an essential element of patient care in the National Health Service. Patients are clear about what good nursing care should look like. They want to be confident that their nurses are knowledgeable, safe and competent. They expect their nurses to be caring and compassionate. They want to be treated with respect by nurses who genuinely care for them and about them.

We in Government are also clear about what we expect from a front-line nursing workforce. I cannot better the description offered by the noble Baroness, Lady Warwick. We expect high-quality, safe and knowledgeable care for all; we expect dignity and compassion for all; and we expect nurses to make the most of each and every interaction they have with patients to improve their health and well-being, and their experiences of care.

What makes a good nurse? The first requirement is a point raised by my noble friend Lord Bridgeman. We should attract people into the profession who not only have academic ability, but also have the right values, attitudes and behaviours. Education commissioners expect universities to demonstrate that their recruitment processes embrace this approach. Employers will also look for this as part of their selection and recruitment processes when they are helping to interview potential students and are appointing registered nurses. Getting this right at the start will help to reduce attrition and maximise the resources that we put into nurses.

The second requirement, as our debates on the Health and Social Care Bill have amply demonstrated, is that we educate and train our nurses well. The Nursing and Midwifery Council undertook a comprehensive review of pre-registration education and published new standards

for pre-registration education in 2010, following extensive and wide public consultation. Importantly, fundamental care is specifically reflected in these new standards. I would say to my noble friend Lord Bridgeman that student nurses spend as much time gaining practical, hands-on experience with patients as they spend in the classroom. In fact, I believe that that ratio has not changed over the past 30 years. I completely agree with the excellent points made by the noble Baroness, Lady Warwick, about degree-level nursing. The first of the new educational programmes began only this year and it will be about three years before the first students emerge from these new programmes. The NMC will evaluate these changes and I look forward to seeing this work.

The next requirement is to enable nurses to nurse. That means doing what the noble Baroness, Lady Masham, talked about so compellingly: finding ways to make sure that we keep senior, experienced nurses beside patients delivering hands-on care and not filling in endless piles of paperwork, which are sometimes of marginal usefulness. That is why we are committed to reducing bureaucracy and empowering our nurses as clinical leaders. The NHS institute's productive series is helping nurses to reduce unnecessary and wasteful practice at the point of care, which is freeing up nursing time to be spent on essential tasks, such as providing assistance with mealtimes and carrying out interventions to prevent pressure ulcers and falls. Any good nurse will tell you that spending more time with the patient facilitates a better and more timely patient assessment, thus enabling the nurse to spot signs of deterioration or to pick up on small but significant things that a patient often will not think to mention. That is why my officials are working with the NHS institute to explore ways in which areas that are not yet embracing the productive series can be identified and supported with implementation, thus allowing the spread of best practice, about which the noble Lord, Lord Young of Norwood Green, spoke.

A phrase that I have learned recently is "essential rounding", a system that sees nurses doing planned rounds every one to two hours to check on patients and to deal with any concerns. We are pleased to see nurses embracing that concept. Feedback about it from patients and nurses is very positive, with some studies seeing a reduction in falls and improvement in patient experience since implementation. In fact, a plethora of best-practice guidance is available. But central initiatives can take us only so far, which is why effective nursing leadership at the front line is so important. Matrons and senior nurses are role models and they are pivotal in developing the culture of care in their clinical areas. Through the standards they set for others to follow, to monitoring the performance of individual nurses, they ultimately make the difference between good and bad care.

I welcome the work of the NHS institute in developing a clinical leadership competency framework which will help develop patient-centred nursing leadership. The noble Lord, Lord MacKenzie, whom I welcome to the Front Bench, was right that the vast majority of nurses are extremely professional, care deeply about their patients and do a tremendous job, often under very difficult circumstances. But, at the same time, the

[EARL HOWE]

noble Lords, Lord Young and Lord Hunt, were right to be honest that this is not always the case. The CQC's report on its 100 unannounced nurse-led inspections showed how the quality of care—in this case, for older people—can fall far short of what we would want. That problem is far more widespread than we would expect. About half of hospitals visited gave cause for concern. Twenty hospitals were not delivering care that met the essential standards that the law says people should expect. I was alarmed to see that in 14 hospital trusts fewer than half the staff said that they would be happy to see a friend or relative treated in their own hospital.

However, I would say to the noble Lord, Lord MacKenzie, that I do not think that it is right simply to say that this is because of poor staffing. The CQC dignity and nutrition inspections found many examples of excellent practice where staffing was not ideal and cases of poor nursing care where there was a full staffing complement. We are hearing more and more concern from patients and nurses themselves about inadequate staffing levels and inappropriate use of support workers. As I said in our debate yesterday, setting safe staffing levels is not an exact science. These decisions are complex and they are best made by local clinicians and managers on the ground, who understand the needs of their patients. As noble Lords are aware, there is guidance available from the RCN and others to assist clinicians and managers in setting safe staffing establishments.

This same guidance is used by the CQC when determining whether providers have enough suitably qualified, skilled and experienced staff. The CQC can take tough and independent action when an organisation is not taking appropriate steps to ensure that there are sufficient numbers of suitable staff at all times. The noble Baroness, Lady Emerton, mentioned Anne Marie Rafferty's research. I would be pleased to look at that research in detail and I will ask the Nursing and Midwifery Professional Advisory Board to consider it and report back to me early in the new year.

Much of the concern around nursing in acute settings has been related to inappropriate delegation by nurses to healthcare support workers. Wherever there is a multidisciplinary team of regulated professionals and unregulated healthcare workers, appropriate delegation and supervision is vitally important. This is an area ripe for formal review. We very much welcome the NMC's plans to update its guidance on delegation so that nursing staff know how to do this safely and are clear that they retain responsibility for their actions. We have also asked Skills for Health and Skills for Care to accelerate production of a code of conduct and recommended core training for healthcare support workers and adult social care workers in England. We expect work to begin by April 2012, with the aim of delivering outputs ahead of the establishment of an assured voluntary register, which could be operational from 2013 onwards.

Nurse leaders, managers and trust boards must take staffing concerns seriously and, where staffing is found to be an issue, they must take immediate action. In the new world of the NHS, there will be two watch words for commissioners: outcomes and quality. This

carries the basic point that clinical commissioning groups will want to satisfy themselves that the services they commission have safe and effective staffing profiles. Nurses will have an increasing role in commissioning and in developing the shape of local services—that is exciting.

Safe and effective care has several strands to it, all in the direct gift of nurses. Noble Lords may be aware of the QIPP safe care work stream quality improvement programme—the safety thermometer—which aims to focus nursing attention on four areas of harm: falls, blood clots, pressure ulcers and catheter-related urinary tract infections. We have published the 2012-13 operating framework with strong messages about reducing harm in these areas, making sure that these are firmly on trusts and commissioners' agendas.

My noble friend Lady Browning spoke of the need for government leadership and she is right. We are making sure that the nursing contribution to quality is being championed at the very centre of government. The SHA chief nurses are leading the nursing contribution to quality improvement at the front line through the energising for excellence quality framework. Much of the success of the quality framework will depend on transparency and, as part of our transparency agenda, NHS North is working towards local publication of nurse-sensitive metrics in areas such as falls and pressure ulcers and is also exploring how best to include patient and staff experience data. The patient experience is absolutely centre stage as we set about measuring the quality of nursing care. Ensuring that patients have a positive experience of care is reflected in the NHS outcomes framework that the new NHS Commissioning Board will use to hold the NHS to account for what it delivers. Everyone who works in the NHS has a role to play in ensuring that patients have a good experience. It is not optional, and it is not "someone else's job". The task is to make listening, understanding and responding to patients' views as commonplace as acting upon clinical audit data, patient safety data or financial data.

Nurse training has, unsurprisingly, featured prominently in this debate. The noble Baroness, Lady Warwick, raised the issue of continuous professional development. Later this month, the Government are publishing our detailed proposals on education and training that will describe the arrangements for continuing professional development, which we recognise is of great importance. My noble friend Lady Jolly spoke about the role of specialist nurses and her concern about downgrading roles without due regard to patients' needs. I agree that service planning has to put patients firmly at the centre. The Government acknowledges the important role of specialist nurses in improving health outcomes and patient experience. In the end, local organisations must have the freedom to determine the skill mix of their clinical teams. Commissioners, clinicians and trust boards have to work together to ensure that the workforce is capable of meeting the needs of patients and that they have access to continuing professional development.

My noble friend also spoke about the introduction of end-of-life care standards, and I am happy to assure her that we will continue to work towards implementing the end-of-life care strategy.

The noble Baroness, Lady Masham, spoke with her customary force about bringing back old-style matron. That resonated throughout your Lordships' Chamber, and there is no doubt that strong nursing leadership is essential at all levels for high-quality care. The noble Lord, Lord Hunt, was quite right about that. Directors of nursing and trust boards must set the culture for a hospital, and that includes a leadership style that challenges poor standards and creates an environment for high standards.

My noble friend Lady Browning raised the subject of whistle-blowing. It is very important that the culture of a hospital is right to enable whistle-blowing to happen. Leadership from boards has to set the tone for that. To whistle-blow does require great confidence and support. I believe that more of this will come because of the increase in graduate nurses.

All this has a direct bearing on the point made by my noble friends Lord Bridgeman, Lady Browning and Lord Ribeiro about cleaning. Nurses have a key role to play in ensuring that hospitals are kept clean. The infection control nurse, the ward sister and matron who set and enforce local standards are particularly important. The code of practice for the prevention and control of infections ensures that nurses are involved in all aspects of cleaning standards. The code provides that directors of nursing are involved in all cleaning contract negotiations, which is very important. Matrons have personal responsibility and accountability for delivering a clean safe environment for care.

The noble Lord, Lord Hunt, mentioned supernumerary sisters. The RCN has just published guidance on developing business cases to fund the supervisory status of the sister so she can exercise her leadership role effectively. The guidance is helpful, timely and above all very practical.

The noble Baroness, Lady Masham, spoke of the importance of district nurses—again, absolutely to the point. We acknowledge the enormous contribution of district nurses in helping people manage long-term conditions, keeping people out of hospital and ensuring people are able to access the resources they need, when they need them. We want to make sure that people go to hospital only when they need what a hospital can do. We see a much greater role for district nurses in the future, not a diminishing one.

The noble Baroness, Lady Warwick, and others mentioned the RCN *Frontline First* report. I do not want to dwell too long on this, but I have to voice some serious criticism about that report. The RCN's numbers are mainly based on an analysis of just 41 trusts. The trusts identified in the report have disputed the RCN's figures. The RCN has not offered commentary on the fact that some of these plans are about moving services out into the community to provide better care for people when and where they need it. We are not disputing that some trusts have reduced the number of staff—some have—although many of these are support staff and often it is being done through natural turnover. We do emphatically reject the conflated numbers that the RCN is claiming. I have got some chapter and verse in my brief, but all I would say is that it is up to local trusts to determine their workforce needs. We have made it clear that any reduction in clinical posts

must not have an adverse impact on the quality and safety of patient care. We have introduced a quality assurance process for SHAs to complete with trusts.

The noble Lord, Lord Patel, spoke about midwifery. The Government are not reducing the number of midwifery trainees. In 2010-11, 2,488 midwives training places were planned. A further 2,507 training places are available this year—that is a record high. The Government are committed to ensuring that we have the right number of trained midwives, especially given the increased number and complexity of births in recent years. This includes ways of supporting midwifery recruitment and retention to help local organisations which are able to commission the number of training places that they need. We have asked the Centre for Workforce Intelligence to undertake an in-depth study of the maternity workforce starting this year. This will inform the future commissioning of training places, including for midwives.

On specialist neonatal nurses, I took the points that the noble Lord made. The National Institute for Health and Clinical Excellence quality standard and the toolkit for high-quality neonatal services are valuable tools to assist NHS commissioners and providers in the provision of high-quality care for babies and their families. However, I shall take away the points that the noble Lord raised.

We have heard today from my noble friend Lady Jolly, among many others, about the opportunities for front-line nursing. Technology moves on, medical knowledge is constantly advancing and the members of our nursing workforce will need to keep abreast of these changes. But one thing that we know will not change is the importance of the care that nurses deliver; and the key role that nurses can and do play in improving quality of care, patient outcomes and their experiences of care.

Lord Young of Norwood Green: Will the noble Earl comment on my point about a vocational route into nursing?

Earl Howe: In the time available, I shall do so very briefly. Access to nursing is, as the noble Lord will know, already through quite a wide entry gate—through progression from apprenticeships, NVQs and access courses. Universities set the entry standards and do not always rely on A-level qualifications. However, it is important that students must be able to cope with degree-level study—it would be wrong to set them up to fail. However, we are aware that the entry gate about which the noble Lord, Lord MacKenzie, spoke needs to be as wide as reasonably possible.

It is patients who matter most. As a Government, we are committed to bringing about the improvements in front-line nursing care that patients want.

1.43 pm

Baroness Emerton: My Lords, I thank every single person who has contributed to this debate, which has covered a very wide area. Everything said was neither good nor bad, but was to be noted—as the title of the debate invited us to do. The debate has given us an

[BARONESS EMERTON]

opportunity, particularly as we are in the middle of the Health and Social Care Bill, to ponder on some of the things that have been raised today. It has been particularly open and honest, and I congratulate and thank everyone who has participated. It has been an especial pleasure to me to have in the noble Lord, Lord MacKenzie, a nurse on the Front Bench and I thank him for it. I thank also the Minister for going through in such detail all the points that have been raised and for agreeing to take some of them forward.

Motion agreed.

International Development Policy Debate

1.44 pm

Moved By The Earl of Sandwich

That this House takes note of Her Majesty's Government's proposals for international development policy, including proposals on the situation of Dalits.

The Earl of Sandwich: My Lords, I am delighted to open this debate on international development. It is nice to see a few old friends present. There may be other preoccupations nearer home, such as the eurozone crisis or the recession, but I am asking noble Lords to look at the drama going on every day in countries suffering from poverty and injustice. I much look forward to the maiden speech of my noble friend Lord Singh, who knows a lot about this subject. I declare an interest having been associated for nearly 40 years with Christian Aid, mainly as a staff member and a board member, and having also worked closely with Save the Children, CARE and Anti-Slavery International.

The current director of Christian Aid, Loretta Minghella, said in a conference last week that,

"The scandal and outrage of 21st century poverty is wrong".

More than 1 billion people suffer from hunger or injustice, and the two often go together. According to Save the Children, chronic malnutrition affects 178 million children—one-third of all children under five in developing countries. Of these, 7.6 million died from malnutrition, ill health or other effects of dire poverty last year. The world's population continues to grow, being above 7 billion, and could grow by perhaps half as much again in this century. Yet the rate is slowing down with economic growth, and I believe that this planet has the resources to grow enough food and defeat hunger. We will further reduce the number of malnourished people provided we beef up support for small farmers in the poorest countries, and production and distribution are properly managed.

We in Britain are in the forefront of this campaign. It is my starting point that, largely due to the work of our voluntary organisations, the British public in their many forms have become much more aware of needs around the world. Thanks to our NGOs and church networks working overseas, aid today has enormous popular support, expressed in the manifestos of all the parties and leading to our ring-fenced aid budget, which is not surprisingly envied by other departments.

Both Conservative and Labour Governments have a good record in maintaining this country's reputation in development, even in conflict countries such as Iraq and Afghanistan where at times we have become unstuck militarily. The problem in Iraq was that huge sums of mainly US aid was wasted through foreign contracting firms and consultants. In Afghanistan, too much of our aid programme was skewed towards military objectives in Helmand. Nevertheless, through such projects as the national solidarity programme and the Afghan NGOs, we have undoubtedly made an important, long-term contribution. Child mortality has come down by 26 per cent since 2001.

Our official aid agency, DfID, has shown that it is second to none among OECD agencies, at least level with the Scandinavians, who have always had the highest reputation. I am certain that DfID will be able to spend its increased allocation up to the 0.7 per cent target, although there are real concerns that other government departments may poach some of the budget. No doubt the FCO and the BBC will find legitimate ways of using some of it for diplomacy and broadcasting because there is much common ground between them.

Yet despite DfID's successes, I doubt that the public can be satisfied with the progress of the UN and our aid agencies in meeting the millennium development goals, or that our successive Governments have done enough to eradicate poverty. Everyone knows that government money is wasted, especially those who have worked in non-government agencies. This is why the coalition has decided to review the aid programme and test its accountability, to make sure that every project is value for money. Later, I shall ask the Minister whether that is achievable.

I am glad that my noble and right reverend friend Lord Harries will speak about the situation of the Dalits, since he also served on Christian Aid's board. We are both well aware that a large proportion of India's poor, about 170 million, are from that community. Atrocities are committed against them every day. I have described previously the appalling inhumanity of many caste Hindus, some in senior positions, and the urgent need for India and Nepal to implement the laws that they have already made. FCO and DfID have entered a dialogue with New Delhi and some of the active NGOs. I hope that the Minister will update us on that dialogue.

I shall not deal with multilateral agencies or the European Union today, but I hope that someone will. They were well covered by the noble Lord, Lord Hunt, in his debate last week, when the noble Lord, Lord Judd, demonstrated how essential they are in monitoring themes such as gender equality, human rights and trafficking. I can confirm this from my own work with ASI and Christian Aid.

During a stay in South Sudan in February and an IPU visit to Kosovo two weeks ago—two post-conflict states at different stages of development—I realised, not for the first time, that international development can mean very different things. South Sudan is one of the poorest states on earth and we are engaged with its new Government, not always successfully, on designing better systems for delivering education, health and clean water. The World Bank trust fund, as in Afghanistan,

ensures that the money sits in an offshore account and is not spent until it has been through an arduous process of accounting, which can mean that it is not spent at all. Large sums have gone astray in the process and it is widely assumed that this explains the lifestyle of many senior members of government. The existence of excellent NGOs in South Sudan, however, has ensured that funds have reached the people directly as well as through the machinery of government.

In Kosovo, capacity building is much more formal and official. DfID has been a key actor in the building of confidence in institutions, and I was personally impressed by the advice it is giving to the Kosovo Assembly through Select Committees on issues such as finance, the constitution and the electoral system. In the main it is governance and the rule of law which receive UK funding. Kosovo has been a special concern of this country since NATO's intervention in 1999, yet DfID has decided to close its aid programme at the end of next year and this could prove very damaging. I must ask the Minister what provision there will be for the embassy—or perhaps the EU or one of the German agencies—to take over the programme.

Incidentally on the theme of governance, the CPA is holding an important conference here this week which is benefitting parliamentarians from all over the world. Kosovo is one of 16 bilateral programmes that DfID has decided to close down by 2016 so as to focus its bilateral spending on 27 priority countries. I am sure that the Minister will explain how they became priorities and whether it was the focus on the poorest rather than on post-conflict countries.

The question is: do we have enough confidence in DfID? Do its projects represent value for money? Will they make a real difference to the lives of the poor? Evidently the coalition is not satisfied with DfID's performance because it has commissioned a whole series of reforms and reports to make aid more effective and accountable. New Governments always do this to show up their predecessors and PR plays a role, but I know that the Secretary of State is personally committed to a strong humanitarian response, and his ministerial visits to Sudan and the Somali border testify to this. I am sure that he will encourage the excellence in DfID's programme.

I was pleased that the bilateral review has led to a new focus on the conflict states and an emphasis on tackling the two scourges of the poor: maternal mortality and malaria. In this context we should note on World Aids Day the real progress made against that appalling condition, and I also welcome the new all-party group of my noble friend Lord Crisp, which will deal with global health and the vital question of health workers. UCL and *The Lancet* are also continuing their valuable joint research on global health.

Last week saw the first four reports from a new watchdog, the Independent Commission for Aid Impact, which is to report to Parliament on whether the UK aid programme is making a difference and achieving value for money. This is a tall order judging from what I have read of the initial recommendations for Bangladesh and Zimbabwe. The commission will have to delve into many of our overseas programmes in detail and while it claims independence it will rely heavily on the

experience of DfID itself to steer it through. While I am impressed by the Government's efforts to achieve greater accountability, I doubt they will have the energy and resources to follow up every project. Halving administration costs to only 2 per cent is surely too ambitious and I wonder if the Minister really thinks that it is achievable.

Corruption is endemic in the poorest societies and has to be targeted within our aid programme. It can be eliminated. I have always been impressed by what the Crown Agents have done with the customs and port rehabilitation programme in Mozambique, which still has a big UK training component. However, the Public Accounts Committee report on 12 October found that DfID did not estimate levels of fraud and corruption. It said that its increased budget was bound to lead to higher spending on multilateral projects which would be easier to manage and reduce the need for monitoring and assessment. Perhaps the Minister could confirm whether this is true.

Aid effectiveness is the international buzz word and the Fourth High-Level Forum on Aid Effectiveness is taking place this week in Busan in Korea. This forum follows the Accra agenda for action designed to promote deeper partnerships in development which respect the diversity of aid and acknowledge the ownership of the country concerned. This is an important principle, well known to NGOs, that rich countries have no right to make decisions for poor countries, although in practice they do it all the time. I would like to think that DfID is pursuing the agenda, but in international development when the donor agencies interfere they always say that they are doing it in the name of good governance, accountability and transparency. In reality hypocrisy wins and conditionality remains a powerful weapon of aid.

I have mentioned India, which is having a fierce public/private argument about its services at the moment. I am glad the Government have kept it in the portfolio, although replaced by Ethiopia as the largest UK programme. The role of China deserves a debate all on its own. China has taken a prominent position in Africa, not least through its gift of the impressive new African Union headquarters in Addis Ababa which will open with great ceremony next month. It is a significant investor in east Africa. Earlier suspicions that Chinese workers were replacing African ones were unfounded and China has a good reputation for major infrastructural schemes, such as road building and agricultural development. DfID has already looked at ways of working more closely with China on rural projects; I trust it will do so again. Investment in agriculture is vital, especially seen in the context of the effects of climate change now being discussed in Durban which hit the rural poor most of all. Is DfID doing enough to help these small producers, men and women, with agricultural extension schemes and to encourage the private sector to help finance transport and rural roads and so improve trade and food distribution?

There have been growing criticisms of land grabbing in South Sudan, Uganda and elsewhere by farms and forestry schemes some of which are based in the UK. Multinationals are adept at evading codes of conduct and corporate responsibility although there are exceptions.

[THE EARL OF SANDWICH]

Can DfID do anything to safeguard against these negative developments if they stem from British companies?

For many years I have admired the effectiveness of the International Development Association, which has done a lot for small farmers. However, I understand that even IDA is in the business of promoting private enterprise well out of reach of these farmers and perhaps at their expense. One of its loans to Mali, for example, covers the salary of a Malian investment promotion agency. Will the Minister say whether the coalition should be supporting this kind of profit-led promotion?

In conclusion, I take my noble Lords back to my original statement about public opinion. The Government have a mandate to use a very generous budget not only to bring relief from suffering but to enable the poorest farmers and many other communities to achieve a sustainable livelihood and thereby bring down the numbers suffering from hunger and the price of food as a matter of urgency. Will the Minister confirm that the Government are fulfilling this mandate? I beg to move.

1.59 pm

Lord Judd: My Lords, I am sure that the whole House will applaud the noble Earl, Lord Sandwich, for having secured the debate and for having opened it so effectively. His commitment on these issues is steadfast. Like him, I greatly look forward to the maiden speech of the noble Lord, Lord Singh of Wimbledon, with all his background and experience.

I am, naturally, glad that the Government remain firm in their objective of securing 0.7 per cent of gross national income for the aid programme by 2013. However, apart from its diminishing value in real terms in the context of global financial realities, it is important to know what exactly is the Government's definition of aid. It seems it is being repeatedly stretched to make up for cuts at the Foreign and Commonwealth Office and elsewhere.

It is interesting that the noble Baroness, Lady Northover, is to reply to the debate. She has a long-standing reputation, established in opposition, not only for advocating 0.7 per cent but of constantly underlining the importance of the quality of the aid and development provided within that objective and, very significantly, of supporting the central related policies in the sphere of international rights, finance and trade.

I pay tribute to the many NGOs, whose work on international aid and development has been a bedrock of increased political commitment by all the principal political parties. Their advocacy is of a high standard, based as it is on real front-line experience. In preparing for this debate, I have, yet again, found invaluable the insight, analyses and challenges provided by Oxfam, of which I am glad to have been a previous director, Saferworld, of which I am a trustee, and the World Development Movement.

The debate is well timed. The High Level Forum on Aid, effectively, is reaching its conclusions in Busan, South Korea, as we deliberate here today. Can we be

assured that the commitments of the 2005 Paris declaration will not be sidelined in Busan and that those commitments will be strongly reaffirmed? It is surely disappointing that, as the OECD has confirmed, while the developing countries have made significant progress on delivering the commitments of the Paris declaration, particularly in improving their planning and financial management, donor countries have made significant progress on only one of their 13 targets—that of improving co-ordination between themselves.

DfID has announced its intention to reduce the amount of UK aid spent on budget support around the world by 43 per cent. Can the noble Baroness tell us more of the real rationale for this? While aid given directly to the budgets of developing countries may, of course, sometimes cause difficulties in measuring instant results, it can surely be an excellent means of achieving sustained positive outcomes. It allows developing countries to make long-term investment in the core services, such as the health and education systems. Is there not a danger that, in overstressing aid for specific targeted projects compared with demands for measurable short-term outcomes, the sustainable development process will be distorted and undermined? Is DfID, in its plans, and with its preoccupation—some might say obsession—with targets, getting that balance right? How will the indispensable long-term funding to establish essential supporting systems be ensured? Frequently the real sustained effect of aid can be measured only in the long term. That is certainly my experience of years of involvement.

Seven million people are already facing acute food shortages in Niger, Chad, Mali, Mauritania, Nigeria and Burkina Faso. This indicates that next year there will be a massive problem of food availability and the danger of widespread famine will become acute. The danger is all the greater because people have not yet had the opportunity to rebuild their assets and increase their resilience after the severe crisis of 2009-10. If in a so-called normal year 300,000 children die in the region from malnutrition-related causes, any small addition, whatever form it may take, can push these catastrophic figures disastrously higher still.

Greatly to their credit, the Governments of Niger and Burkina Faso have already signalled they will need assistance. In the light of these indications and clear warnings, and taking into account DfID's commitments made in response to the challenging *Humanitarian Emergency Response Review* of the noble Lord, Lord Ashdown, to strengthen anticipation and early action in disasters and to build resilience to disasters, what exactly are the Government doing convincingly to apply these commitments in the grim realities once more accumulating in the Sahel?

Meanwhile, climate change poses a grave threat to food production and to the livelihoods of the poorest communities around the world, most especially of women, who rely on being able to grow their own food to survive. Changing rainfall patterns, longer and more severe droughts, floods and rising temperatures all present acute challenges to farmers and make it difficult for them to know when best to sow, cultivate and harvest their crops. This will inevitably eventually lead to vast movements of people, aggravating the pressures of migration and provoking instability.

This makes the events at Durban all the more relevant and urgently demanding. An effective global agreement to tackle climate change can no longer be delayed. Obviously this must include provision to assist the poorest countries and the most vulnerable people within those countries. The green climate fund is an imperative. What exactly are the Government doing to pursue innovative sources of finance to fund it—for example, a levy on global shipping or a tax on international financial transactions? As we listen to the Chancellor it seems very little, if anything. Indeed, there seems to be an entrenched ideological opposition to some of these proposals. This is inexcusable. How does the noble Baroness, with her past advocacy of precisely such measures, feel about that as the position of the Government? Do not all negative arguments about taxes on financial transactions, for example, fall into insignificance against the developing human nightmare? A minute rate of tax on financial transactions could produce very large resources for the battle for humanity.

One of the greatest obstacles to the implementation of the millennium goals on schedule is certainly the 1.5 billion people who live in states affected by conflict and fragility. I understand that, in response to this, a new deal has been proposed at the High Level Forum this week. Can the noble Baroness confirm that this is indeed the case and that the UK is meaningfully and not just rhetorically behind it? I gather it has five objectives: fostering inclusive and legitimate politics; establishing and strengthening people's security and justice; promoting employment and livelihoods; ensuring fairer social services delivery; and better financial management. I, for one, would be cheered if all this can be confirmed. If it is agreed that aid in more fragile states should focus on achieving peace, it will mean that ensuring that conflict, security and justice issues, which have been absent from the current NDG agenda, are brought fully into the discussions also about what follows NDG in 2015.

Success in moving forward will depend upon the new deal becoming not only a deal between national governments and international donors but a deal between them and the people living in conflict-affected communities, ensuring that these people themselves have genuine ownership of development and peace-building processes. If countries are to make a successful transition to peace, it will be essential that dialogue processes are genuinely inclusive and sufficiently independent to bring in a meaningful range of differing perspectives and to keep the most sensitive issues on the table. The new deal must on no account limit itself to legitimising the use of aid for "train and equip"-style security and justice programmes. If it is to support sustainable peace, it must focus on not only the capacity of state institutions but on their culture and professionalism and how they behave. It is vital that they also focus on what matters to the people living in conflict-affected countries—less exposure to violence, greater confidence in their safety, access to justice, services and livelihoods, and political freedom and inclusiveness.

If I have become convinced of anything in a lifetime of work in these spheres, both in Parliament and outside it, it is that sustainable peace cannot be imposed or manipulated. It has to be built from the community

upwards; building in widespread inclusiveness in the process and a real sense of ownership of that process and its outcomes by the parties to the conflict is absolutely essential. After all, the process began to move in Northern Ireland when the political wing of the IRA became part of it.

2.11 pm

Lord Roberts of Llandudno: My Lords, I appreciate the opportunity given us by the noble Earl, Lord Sandwich, to discuss once again this crucial issue. I was reading recently about the potato famine 150 years ago in Ireland and how 1 million people starved to death there and 1 million more emigrated. There was such poverty in some of the south Wales valleys, and then there was the cotton famine in Lancashire and its horrendous consequences. In many other places, such as the Highlands with its crafting problems, we realise that we ourselves have in the past been touched by such poverty. Possibly it is comparable to the worst poverty that we can see in the world today.

We have people who are humane and want to move in and help those in need. Sometimes the need arises because of the scourge of diseases, as in Africa at present, or the failure of the crop year after year, as has happened with the potato crop in Ireland—or else you have the greed of mine owners or mill owners or others who are the masters of their communities. There are so many reasons and often it is those reasons, some of which are very presentable, that cause such hardship for millions and millions of people. In the mid-1930s, the Duke of Windsor, then the Prince of Wales, visited Merthyr Tydfil and other places in south Wales and saw the devastation and said, "Something must be done". It is easy to say. Today we see the Horn of Africa and the devastation in parts of Asia and the tremendous need in other parts of the world. Something must be done. In the south Wales valleys that something was done by intervention from outside. Often the people who are weakened and have no more motivation left—people who do not even have the energy to think of their futures—rely on outside aid.

I welcomed the other day the autumn Statement, which really confirmed this 0.7 per cent for international aid. We need it and it must be used, but we can also remember our tremendous debt to voluntary giving—and the noble Lord, Lord Judd, was part of that great movement. CAFOD, Oxfam, Save the Children, UNICEF and Christian Aid have done tremendous work, as have countless smaller charities that we may not know anything about, in parishes and communities—people who see the concern. I remember being involved about 20 years ago in the Ethiopian famine, when we had to thank the press and television for the way in which exposure at that level made people want to give. I remember standing with a milk churn in Llangollen after one such programme had shown the great need from some area in the world, and people queued up to donate.

I remember also how we tried to get pure and safe drinking water for children in Rwanda. We had the appeal and there was some individual sacrifice. I wish I had a copy of the letter with me now from one lady from south Wales, who said:

[LORD ROBERTS OF LLANDUDNO]

"All my wedding presents have gone. I am living in one-room accommodation and all I have is the vase that my husband gave me on my wedding day. I am selling that vase because the need of the children of Rwanda is greater than my need".

That is sacrificial giving. We should always say "Thank you" not only to the big organisations but to those whose hearts are, to use a Methodist phrase, strangely warmed when they see the need and want to respond to that need.

While some people are giving and giving most generously, this week I have heard of one or two examples that I dare not mention in this Chamber, which show how people respond to the needs and suffering of other people. Some are giving but others are taking and are trying to make a profit from the most vulnerable people and the poorest nations in the world. I am grateful to the *Guardian* newspaper for showing last weekend how venture capitalism had become vulture capitalism and how certain organisations and finance organisations are trying to milk the situation for their own benefit and the profit of their own people.

I have a reference to the Democratic Republic of Congo and the demand by venture capitalists for the repayment of £100 million debt, which is equal to giving 500,000 children schooling or giving 8 million people safe drinking water. The choice is there, but somehow the compassion of ordinary people is often not shared by these organisations.

I am grateful to a Methodist colleague of mine, Dr Mike Long, in Llandudno, who recently researched the situation in Zambia. I will not go into the details, and most noble Lords know it in any case. In 1979, Zambia was given credit by Romania for \$15 million to buy agricultural machinery and vehicles. Zambia was unable to repay. We should remember that life expectancy in Zambia is 39.8 years. This debt mounted and in the end the demand was for \$53 million by one of these venture capitalist organisations. It has been reduced to \$15 million in a court case. But the people of Zambia find it so difficult.

In Lusaka, a declaration by the Christian churches of all denominations stated that:

"Zambia cannot pay back because the debt burden is economically exhausting. It blocks future development. Zambia will not pay back because the debt burden is politically destabilising. It threatens social harmony. Zambia should not pay back because the debt burden is ethically unacceptable. It hurts the poorest in our midst".

We—the majority—give, and others are ready to reap the benefit from the most vulnerable and poorest people and nations of the world.

I thank the Labour Government of 2010 for their Debt Relief (Developing Countries) Act 2010, which might clear the debts of 40 of the poorest nations in the world. However, there are loopholes, one of which is Jersey. I hope that the Minister, who is a noble friend of mine of long standing, can give me some assurance that Her Majesty's Government will somehow or other try to bring the courts of Jersey into the embrace of that Act.

With those few words, I therefore say that we are joining other nations to give the poorest countries in

the world a fresh start by breaking the chain of poverty. For many, it will be a beginning that they never dreamt was possible.

2.20 pm

Lord Harries of Pentregarth: Like other noble Lords, I am grateful to the noble Earl for initiating this debate on such an important subject. It will be a particular pleasure to be able to listen to the noble Lord, Lord Singh.

I strongly agree with many of the points made by previous speakers, but I shall focus exclusively on the second part of the Motion regarding the proposals on the situation of the Dalits. Everyone is aware in general terms of the situation of the Dalits—the former untouchables—but it is difficult for us fully to take on board the extent and seriousness of their plight. To take, for example, the extent, more than 260 million people in the world continue to suffer from practices linked to caste, and of those, 170 million are Dalits living in India. As to the seriousness of their situation, more than 200 years ago William Wilberforce described what he referred to as "the cruel shackles" of the caste system as,

"a detestable expedient ... a system at war with truth and nature".

Since Wilberforce's time, one form of slavery has been abolished, as we know, but not that associated with caste. It is properly described as a form of slavery. As the Prime Minister of India, Dr Manmohan Singh, said in 2008,

"caste is a blot on humanity".

He described it as being parallel to apartheid. Manual scavenging, of which all noble Lords have heard, is just one of the many forms of degradation to which Dalits are subject.

In the light of this, it is obvious that it is not possible to consider issues of education, health and poverty reduction in India or other countries such as Bangladesh or Nepal where the caste system operates without highlighting and prioritising in policy terms the issue of caste and its terrible effect on the most vulnerable. Studies show that Dalits suffer quite disproportionately in education at every level, in health at every stage of their lives, and in access to benefits. There is absolutely no hope of achieving the millennium development goals without ensuring that every aspect of development policy takes fully into account the dire effects of caste without an appropriate focus on those suffering most as a result. DfID is of course aware of this, but does that awareness drive every aspect of policy in a concerted and consistent way and is the effect of this monitored?

More specifically, does DfID explicitly address caste exclusion across all the civil society programmes that it funds, developing clear benchmarks and indicators to monitor this? Furthermore, does DfID integrate social exclusion into all its programmes, beyond those of civil society? Does DfID support excluded groups in their advocacy and help them increase the accountability of Governments to the most excluded? In order that we might be clear that we are practising what we are preaching, does DfID ensure that in its own employment practices it has a team that is fully inclusive and representative? Following on from that, does DfID,

throughout its India office, build understanding of social exclusion? Without positive answers to these and other questions, all attempts at poverty reduction will be undermined, as a growing body of research increasingly shows.

DfID also has a key role to play in influencing other donors, such as the Asian Development Bank, the European Community, the World Bank, the UNDP, and so on, better to understand and address these issues. DfID has a key role in ensuring that all UK NGOs and foreign investors adopt best employment practices in their policies. There is evidence in the past of some employment agencies used by NGOs excluding certain Dalit and Muslim names before passing on selected candidates.

I have mentioned that there are at least three key areas—education, health and access to benefits. I know that the noble Lord, Lord Avebury, will address education in particular and how Dalits are heavily disadvantaged in every aspect of education. I shall not therefore deal with that. However, I will briefly mention another area—children's health. A recent study of children under 12 being treated showed that Dalit children were discriminated against in a variety of ways. By every indicator, this discrimination was shown to affect between 80 per cent and 90 per cent of encounters between Dalit children and those charged with providing them with some kind of medical help. I shall give some small examples. Medicine was placed in the hand without the person giving it actually touching the hand; or the medicine would be put on the floor or window sill; they were given less time with doctors and nurses; and the children were called names and treated roughly. It is not surprising that infant mortality—high in India as a whole—is particularly high among Dalits.

There is another particular area that the noble Baroness, Lady Cox, would have highlighted if she had been able to speak in the debate. I refer to the human trafficking and slavery of India's Dalits. For example, there may be as many as 20 million people in India in bonded labour, of whom between 80 per cent and 98 per cent are Dalits. In addition, children, particularly Dalit children, are being trafficked into domestic servitude and prostitution, with 40 per cent of India's sex workers being children. Then there is ritualised prostitution and bride trafficking. In all these areas, it is Dalits who are most at risk and find it almost impossible to obtain redress. Often they do not have identity papers, they have difficulty being believed, and—believe it or not—a third of rural police stations do not even allow Dalits to cross the threshold. DfID has done well to institute the human trafficking in south Asia programme, but at the moment its resources are too small to make the impact that is needed—not just in cross-border trafficking but in India itself.

My point is therefore very simple. It is impossible to tackle the subject of poverty, particularly in India, Nepal and Bangladesh, without highlighting and prioritising the issue of Dalits and expressing those priorities in real policy terms. DfID is aware of this, but is that awareness driving every aspect of policy in a concerted and consistent way? Is the effect of this policy on the Dalits being properly monitored?

2.29 pm

The Lord Bishop of Ripon and Leeds: My Lords, I, too, am deeply grateful to the noble Earl, Lord Sandwich, for achieving this debate and for his powerful opening speech emphasising the positive contribution that aid can make to breaking the “chains of poverty”, to use the phrase of the noble Lord, Lord Roberts. Yet, we heard from the noble and right reverend Lord, Lord Harries, of that continuing failure to tackle discrimination based on work, descent and caste. I therefore welcome the renewed emphasis on the situation of Dalits in south Asia, and look to ways in which international development policy can be used to affirm and develop human rights for those who are so savagely damaged by descent and caste.

I hope that we will not be lulled, if that is the right word, into thinking that this is a problem for India and south Asia alone. We need to watch the ways in which such discrimination exists in other societies, including our own, and I therefore welcome the determination of the UN Decade of Dalit Rights to identify and connect with the diaspora of those affected by discrimination based on descent and caste.

Like others, I want specifically to welcome the Government's defence of their international aid budget of 0.7 per cent of GDP even though that involves some diminution in the actual amount of aid. But to defend that figure through tough economic times is a major tribute to the work of the Minister and of the Government as a whole. I hope that she and they will hear our congratulations on achieving that continued figure. I hope that in her reply the Minister will report on what she expects of the high-level forum on aid effectiveness in Bhutan, to which others have already referred.

I also welcome the establishment of the department's faith working group, which recognises the importance of faith in many communities around the world and the need to explore how faith can contribute to the success of policies tackling discrimination—not just the work of faith bodies in this country, which I acknowledge and am very grateful for, but the contribution made by religious organisations and faiths throughout the world. In that context it is particularly good to be able to be part of a debate in which the noble Lord, Lord Singh of Wimbledon, is taking part, someone from whom I and many others have learnt much of the place of faith in societies all over the world. I should be grateful for comment on what progress the faith working group has made and whether any concrete steps have been taken as a result of its work.

The UK has a strong record on seeking an international aid policy which will have real impact. In particular, I want to both stress and encourage the new moves being made, not just here but throughout Europe, for greater transparency in the extractives sector. Tearfund's recent report, *Unearth the Truth*, gives examples of the need to use natural resources for the real benefit of our poorest communities across the world. Exports from extractive industries are worth something like nine times the value of aid to Africa. Tearfund cites Sierra Leone and also Colombia as countries where conditions could be transformed if the revenue from the

[THE LORD BISHOP OF RIPON AND LEEDS]

extractives sector was reinvested in meeting millennium development goals and in providing basic services such as health, water and sanitation.

I hope that the Minister will be able to comment on how we can have a more transparent picture of the way in which the extractives industry affects relationships with some of the poorest countries of the world and ways in which aid can be directed so that it can provide support and encouragement in the development of those countries.

The condition of the Dalits and of others discriminated against by work or descent must be a wake-up call for all those who believe in fundamental human rights. I am grateful for the stance of successive Governments in the crucial use of international aid to promote the care of the poorest in our world and I look forward to a renewed expression of the Government's commitment to the breaking of those chains which bind not just those who are themselves in a situation of poverty but all of us in the worldwide culture in which we share.

2.36 pm

Lord Singh of Wimbledon: My Lords, it is with a feeling of humility and trepidation that I rise to speak for the first time in this House, particularly after having listened to the earlier words and speeches that were put so movingly.

I shall say a few words on where I am coming from, and what I hope to bring to the House. I started life as a mining engineer, but not long after qualifying, was told by the then National Coal Board that British miners would never accept a Sikh mine manager. I was offered a job in the scientific department but politely declined, seeing it as an opportunity to go and see a bit of India, a country that I left as an infant. Surely people there would welcome me. They did not. I was seen as a Punjabi, and not welcome in the mines of West Bengal, but I stubbornly dug my heels in and gradually became accepted.

I returned to England to take up a post in a civil engineering management consultancy, and though there was some initial hostility, I was soon respected and valued and even assisted in taking a year off to do an MBA. It was while I was with this company that I noticed a strange end-of-day ritual that made me see the lighter side of our attitude to those we see as different.

We were on the fifth and sixth floors of an eight-storey building. Above us were the overseas civil engineers, who clearly thought themselves superior. They would go about with briefcases carrying labels of exotic places visited. At the end of the day they would get into the lift to go home. When the lift got to our floors, a curious thing would happen; those inside would unconsciously stick out their stomachs to give the impression that the lift was a little fuller than it actually was. We would barge in none the less; the stomachs would gradually recede and we all became fellow work colleagues.

The lift would then move to the floors below, occupied by the Department of Health and Social Security. We all joined in in sticking out our stomachs to deter what, in our bigotry, we saw as a lower form of life

entering our lift. However, again, they took no notice and got in; the stomachs would grudgingly recede and we all got to the ground floor as fellow human beings—until the next day.

This strengthening of common identity by looking negatively at others is all too common. We see it all too often with a group of people who have been speaking together on a street corner. If one goes away, you can be sure that those remaining will often make some negative comment about the person who has just left, to strengthen their newfound sense of unity. We see it in the behaviour of football crowds. In its most serious form, it can lead to the active persecution of those we call different.

Guru Nanak, the founder of the Sikh faith, saw it in the India of his day some 500 years ago. He reminded us that we are all, men and women, equal members of the same human family and he criticised all notions and distinctions of race, caste or gender. These are 21st-century values being put forward in the 15th century. This theme has been central to my own life: from campaigning against apartheid in South Africa when it was unfashionable to do so, to supporting dissidents in the former Soviet Union and working with Amnesty International, and others, for greater social and political justice for all members of our human family. In this context, I fully endorse all the comments of the noble and right reverend Lord, Lord Harries, about Dalits, and the other remarks made by other speakers.

Some of us are quick to criticise some aspects of life in the United Kingdom but when we go abroad, even to our countries of origin, we see that this country is way ahead of much of the rest of the world—light years ahead in its freedoms, and its understanding and respect of different cultures and ways of life. Our country can take justifiable pride in the way that it has welcomed many from other lands and the lead it has taken in extending human rights, social justice and economic well-being to other parts of the world.

Moving to the central theme of today's debate, some 10 years ago I was invited to join a working group of DfID. I went as a cynic but was soon converted by the passion and genuine commitment of all those involved including, as has been mentioned, many voluntary organisations. I persuaded Sikhs to buy bonds of the GAVI alliance for the mass vaccination of 500 million people and urged the community to support the humanitarian work of DfID with its characteristic generosity. We also established Khalsa Aid, a Sikh charity.

At this time of economic recession, it is tempting to look to our need and ignore the suffering of others; in biblical terms, to cross to the other side of the street. Yet, as the continuing success of Children in Need showed, this is not the way of the British people. The euro crisis, economic difficulties in the United States and the emergence of new, major competitors also remind us that our economic future is inextricably linked to that of other nations, including the very poor. Britain is unique in the way it has led on many issues of justice and in the fight against poverty. It is a tribute to Britain that we are continuing to give assistance, with international development the highest priority. In

the past year, Britain's development budget of just short of 0.6 per cent of GDP helped to train more than 95,000 teachers, build or refurbish 10,000 classrooms, train more than 65,000 health professionals and provide clean drinking water to more than 1.5 million people.

In addition to the ethical arguments, there are strong economic and geopolitical imperatives for helping the poor climb out of poverty. These include the development of soft power and influence in key areas. By 2050, Africa will be a key trading partner, rich in resources with a population of over 2 billion. Understandable reservations about the misuse of aid should be tackled by more stringent checks and never be used as an excuse for doing less or doing nothing.

I could go on, but I am conscious that a maiden speech should be brief. Before I finish, I would like to thank your Lordships for your extraordinary kindness in making me feel so welcome, with particular thanks to the noble and right reverend Lord, Lord Carey, and the noble Baroness, Lady Kennedy, in introducing me to your Lordships.

2.45 pm

Lord Avebury: My Lords, I am particularly delighted to be the first to congratulate the noble Lord, Lord Singh, on his thoughtful and practical maiden speech, graced as it was with touches of humour. The noble Lord and I are old friends from years back, so it gives me particular pleasure to welcome him to this House today. He has had a very distinguished career, not only as a chartered engineer and management consultant—backgrounds that I share with him—but as an effective promoter of interfaith understanding, for which he received the Templeton Prize in 1989. The noble Lord was also awarded the interfaith medallion for services to religious broadcasting in 1991.

The field of work in which I have known him best is in his services to the prisons. He was the Sikh representative on the Chaplain-General's consultation with other faiths back in the mid-1990s. When that was developed into the present Chaplaincy Council he continued to serve on it as the Sikh adviser to NOMS, in which capacity I know he has made a significant contribution—not always on the side of the establishment. The noble Lord has been the editor of the *Sikh Messenger* since 1984 and director of the Network of Sikh Organisations since 1995. He brings wisdom and the insights of the Sikh faith to our deliberations based, among other principles, on sharing with others whose needs are greatest and the equality of all human beings, as he mentioned. We look forward with eager anticipation to hearing from the noble Lord often in the future.

The noble Earl, Lord Sandwich, has given us a welcome opportunity of looking at DfID's policy on aid to India and what we are doing to help the Government of India in promoting equality, particularly for the most severely disadvantaged communities. Even though untouchability was formally prohibited by the Constitution of India in 1950, it is so firmly embedded in the culture that 60 years on, the 170 million Dalits still endure extreme forms of social and economic exclusion and discrimination, as we heard from the noble and right reverend Lord, Lord Harries. We need to consider whether, and if so how, DfID's policies

could be geared towards helping India to eliminate the severe handicaps that Dalits have to endure, perhaps bearing in mind the saying of the Guru Nanak, the founder of the Sikh religion that, in his mother's womb no man knows his caste.

We would agree that DfID's work should be refocused on the poorest, and that concentrating aid on state partnerships in Bihar, Madhya Pradesh and Orissa, but with some elements stretching to five other states, is a simple if rather crude way of achieving that objective. The Dalit Solidarity Network-UK and the National Campaign on Dalit Human Rights in Delhi urge that we review our policies from a human rights perspective, in light of the fact that Dalits are not benefiting proportionally in the remarkable economic advance being made by India as a whole. We should therefore address caste-based exclusion and deprivation across the whole of the civil society programmes that we fund, developing clear benchmarks and indicators to monitor progress and ensure that we are getting value for money, as the noble and right reverend Lord, Lord Harries, has also said.

I doubt that there can be, as the Government response to the Select Committee report implies, an abrupt transition from a level £280 million yearly aid programme from now until 2015 to a partnership based on critical global issues. I would be grateful for an assurance that projects specifically geared towards alleviating caste discrimination will continue to be supported. UNICEF, for instance, has a knowledge partnership with the Indian Institute of Dalit Studies to unpack policy concerns of relevance to children. It is looking at the barriers that limit access by Dalit children to healthcare, which were also mentioned by the noble and right reverend Lord, Lord Harries, leading to high levels of morbidity and mortality in these communities.

The Select Committee says that DfID's new Indian programme should have a strong focus on reducing child and neonatal deaths, and the Government agree with them—although they also agree that resources should be switched from health, which now absorbs 40 per cent of the budget, to sanitation, to which only 1 per cent is allocated.

Although India has reduced the under-five mortality rate from 118 to 66 per thousand births between 1990 and 2009, it is not on track to achieving the reduction by two thirds of this rate by 2015, called for in the millennium development goals. In the UN's 2010 report on the MDGs, it says that revitalising efforts against pneumonia and diarrhoea, while bolstering nutrition, could save millions of children's lives. The Global Alliance for Vaccination and Immunisation, GAVI, referred to by the noble Lord, Lord Singh, and to which the UK is the largest contributor in the world, is funding the adoption of vaccines against these diseases in an increasing number of countries. We promised \$485 million out of the total of \$1.5 billion subscribed at the pledging conference in London last June, believing, as we do, on solid evidence that this is one of the most cost-effective ways of spending aid money to help attain MDG4.

Paradoxically India still has the largest number of unimmunised children globally—7.2 million in 2010—even though it is the world's largest manufacturer of vaccines. It has introduced measles vaccine in about half the

[LORD AVEBURY]

states and is making some good progress with Pentavalent, but only in two states as compared with the original plan for 10; while as yet it has no plans for rolling out vaccination against pneumococcal disease and rotavirus, which are the two biggest killers of children worldwide.

A delegation from the APPG Against Childhood Pneumonia, of which I have the honour to be co-chair, visited Bangladesh in November and was told it was on course to roll out all three of these vaccines nationally over the next few years. Penta is already being delivered, as the delegation saw on a visit to a village 50 kilometres from Dhaka. GAVI estimates that the second measles vaccine will start in 2012, followed by pneumococcal conjugate vaccine in 2013 and rotavirus in 2014.

It is not therefore altogether clear to me why India lags behind on saving children's lives when the potential is so clearly there. Will my noble friend say whether the plan for Pentavalent has been scaled back because GAVI had yet to be satisfied that vaccines could be effectively delivered and administered in India? Will she also say whether DfID can help India to solve any of the logistical problems that are delaying these programmes? I gather that more than 25,000 cold chain points have been established, but that active management of their proper functioning and timely repair is critical. If this is blocking approval by GAVI of the programmes, is it something on which DfID could offer technical assistance, bearing in mind our very substantial investment in GAVI itself?

I would be grateful if my noble friend could also say what monitoring there is of the existing immunisation programmes in Bihar and Madhya Pradesh where less than 50 per cent of children were covered in a 2009 survey, and in Orissa where the coverage was under 60 per cent, to ensure that Dalit children were being protected, at least in proportion to their numbers. If, as one might suspect from the UNICEF study already referred to, discrimination and the fear of discrimination inhibits access to healthcare generally for Dalits, the probability is that the existing programmes are not reaching these deprived people. In Bihar, for instance, the reason given for the partial information of a third of those missed was an awareness and information gap, which was far more likely to affect Dalits than the rest of the population. Would DfID be able to help to design local awareness-raising campaigns in our three target states, possibly with the help of experts in communication from the Dalit diaspora?

The Select Committee recommended that DfID should fund the collection of data on caste, tribal and religious affiliation of those who access maternal services or have institutional deliveries, but the Government's response was that adequate disaggregated data were available without further studies. Are they equally confident that disaggregated data exist for access to vaccination and immunisation programmes and if not, will they consider funding a pilot study in the three target states?

On education, the Select Committee had nothing to say about Dalits except indirectly, where it particularly welcomed DfID's new focus on girls' education. In their reply, the Government said they would use the opportunity of India's request to support their flagship secondary education initiative to look at,

"ways to help get more Dalit girls into secondary school and ensure they can afford to stay there".

According to a UNICEF study from 2006, the dropout rate of Indian Dalit children from primary education was 44 per cent, and the National Commission for Scheduled Castes and Scheduled Tribes says that for girls this rises to an astonishing 75 per cent. There is no doubt that Dalit girls suffer even more extreme discrimination, prejudice and persecution than boys. Stories about the rape, violent assault and murder of Dalit girls appear regularly in the media. To mention one: when five boys were frustrated in their attempt to rape a 17 year-old Dalit girl in Lucknow last August, they poured kerosene over her and set her on fire. AsiaNews reported the comment of Anulraj Anthony of the Justice and Peace Commission of the Catholic Bishops Conference. He said that two aspects revealed the vulnerability of the victim: "She is a girl and a Dalit". So it hardly surprising that vulnerable girls from these communities have an uphill struggle to get anywhere in the educational system.

The UN Special Rapporteur on the Right to Education has made special reference in his 2006 report to the needs of girls from communities that experience discrimination, and says that literacy is as low as 9 per cent for the Mushahar women of Bihar state. Surely one way of improving Dalit girls' access to secondary education is to reduce their dropout rates from primary education and to promote MDG2A, to ensure that girls as well as boys complete a full course of primary education. The empowerment of women everywhere starts with literacy, and this is an absolute imperative in a society where there are ancient cultural barriers to the equality of particular communities.

We have our own problems here with deprivation of children from Gypsy and Traveller communities, and I am often struck by the parallels with the caste system. So it is not in a spirit of criticism that I want DfID to do more to help India to address the acute disadvantage suffered by the Dalits in health, education and, indeed, access to public services in general. It would be presumptuous to say that we can make more than a minor contribution to helping them to eliminate dysfunctional cultural norms that have persisted for millennia, but I hope that our aid to India can be concentrated on helping it to meet its own objectives.

2.58 pm

Viscount Craigavon: My Lords, I am grateful to my noble friend Lord Sandwich for obtaining this Cross Bench day debate on this subject and allowing our noble friend Lord Singh to participate. Some of us are more familiar with him on the morning "Today" programme, when we are not entirely awake, hearing his few words of wisdom. Now I am fully awake, I realise that his words are even more wise. I believe we should be grateful to the present Government for the direction of progress by this department since the election. That obviously includes the funding commitments, even with the latest adjustments.

The structure of the millennium development goals allows us to make international comparisons, and I am aware that the Commonwealth representatives are currently discussing MDGs in a conference at Westminster.

One of their concerns is the fast-approaching deadline of 2015, and what happens after that. In this large area, I would like to focus particularly on the importance of MDG5, and mainly on 5B, which is about achieving universal access to reproductive health by 2015. We should be grateful that the Minister, Andrew Mitchell, even in his shadow role before the election, appreciated the importance of this field of reproductive health; and we are very fortunate now to have as a spokesperson in this House, the noble Baroness, Lady Northover, whom we know—as the noble Lord, Lord Judd, said—is an expert in the whole field of international development as well reproductive health. I also welcome the noble Baroness, Lady Kinnock, to these debates from her Front Bench.

As I am sure the noble Baroness, Lady Northover, will confirm, we had good news on Tuesday from her Under-Secretary of State, Stephen O'Brien, at a family planning conference in Senegal, where DfID has committed £35 million of new money for contraception in an area of the world that is particularly able to benefit from it. It is helping to save thousands of women's lives. He is quoted as saying:

"Family planning is a smart, simple and extremely cost effective investment of aid. It is at the centre of all our development work and we are going to ensure more women are given the choices they want and deserve".

That statement is very encouraging, and I hope that it leads to further such initiatives, as well as informing the practice of the other parts of the department. That is a very good instance of one of the main concerns, which is meeting the unmet global need of an estimated 215 million women who want to avoid or delay pregnancy, but who have no access to any effective methods.

To return to the department as a whole, we have recently had the opportunity to read the financial management reports of the Auditor General, the Commons Public Accounts Committee following that, and the reports and recommendations of the Independent Commission for Aid Impact, which was initiated by the department. Parts of these examined such things as effectiveness, value for money, leakage through fraud or corruption, running costs, delivery chains and suchlike. This is not the place to follow up those considerations in detail, but it is useful to have an independent opinion on such things.

Even on a cursory reading, one realises the full complexity and problems of successful and effective delivery, especially into other less developed countries, of the services required. One of the issues raised, partly in the context of bilateral versus multilateral spending, was the rather unusual,

"pressure to spend increased resources",

which was mentioned by the noble Earl, Lord Sandwich. When money might be available, but the skills, facilities and manpower to deliver bilateral aid programmes effectively are not there, it might be easier to support multilateral programmes instead, when effectiveness and value for money would be more difficult to assess.

The large proportion of money that is required to be donated through EU channels can also suffer from a lack of accountability. I understand that a new agreement is up for negotiation, and I hope that we

can take the lead among our European partners in helping to frame new uses for that money, over which we can have more oversight. Maybe the noble Lord, Lord Hannay, who will follow me, will be able to add to that,

I mentioned MDG5 at the beginning. That is, by common consent, the most off-target of the MDGs and, given that the target year is 2015, the hope now is that these aims will continue to be pursued beyond that year. Some progress in that MDG has recently been reported. The recent figure of 500,000 maternal pregnancy-related deaths, has now been reduced to 360,000. According to the Guttmacher Institute, 30 per cent of such deaths can be reduced by the provision of good family planning.

Normally in addressing this subject I try to avoid what one might call the numbers game. However, recently we have had the rather stark reminder of the world population reaching 7 billion, with attendant future upward projections. That has resulted in journalistic and more learned diagnoses of how serious or otherwise that milestone is. As we invoke population numbers as a contributing factor to climate change, we must always be aware that our western environmental footprint is many times that of most of the developing world. For example, one figure is that our footprint is 20 times more damaging to the environment than an Indian's. The Indian Health Minister said that the birth of the 7 billionth child was a great worry and told the *Times of India* that all celebrations should be put on hold until the population stabilises. As we know, that is some way off for India.

I am always astonished when people casually mention, quite commonly, the inevitability of wars being caused by the shortage of water. There are many other essential commodities in danger of becoming scarce, particularly with the increasing demand from countries such as China, which understandably want to raise their standard of living. Last weekend, the *Times* had an article with the headline:

"Standing between the world and starvation".

It was about the increasing price of and demand for phosphorous fertiliser being produced in China and its inevitable exhaustion, which is, admittedly, some years away. However, that is the basis of what might be unsustainable agriculture in many parts of the world, which often includes GM crops.

I am afraid that it might be human nature to hope for some magic solution to all these problems—that is, until are palpably upon us. It is similar, but even more so, with the population numbers. If there is any magic solution there, it is simply the offer of choice, mainly to women, rather than any talk of coercion, as there might have been in the past. This is part of the sustainability debate, and I hope that the department can take it as its task to lead us in anticipating such crisis situations in the future.

When earlier I said that I normally avoided talking about numbers in this field, it was partly because of my belief that, even more importantly, we should focus on the quality of life, rather than quantity. In marking the 7-billion milestone in debates in the UN in New York, the rather unfortunate phrase "the bottom billion" seemed to emerge. It refers to the poorest, who

[VISCOUNT CRAIGAVON]

have little or no access to basic needs. While not wishing to give currency to that phrase, maybe we should be as concerned about them as we are about the increasing numbers. It is encouraging that the department now seems to be targeting a reduced number of poorer states, as well as identifying fragile states for special attention.

I referred earlier to people expecting magic solutions to save us from ourselves. Sometimes that takes the form of comforting myths as to why we need not address population growth seriously. As a member of the All-Party Group on Population, Development and Reproductive Health, I hope I may recommend a recent publication, which was co-authored by one of its vice-chairs, Richard Ottaway MP, who is also chair of the Foreign Affairs Committee in the House of Commons. It is a highly readable and attractive publication, called *Sex, Ideology, Religion: 10 Myths about World Population Growth*. This was published about a month ago and will shortly be available online on the group's website, which is on the All-Party Group's list. It deals more concisely and eloquently than I can now with why we should continue to take population growth seriously. I am sure that the department will continue to do that, along with its many other responsibilities, which we have heard about today.

3.08 pm

Lord Hannay of Chiswick: My Lords, I warmly congratulate my noble friend Lord Sandwich on obtaining this debate on international development policy. I sometimes feel that we devote too little time to foreign affairs and development as we apply ourselves to our primary task of scrutinising and improving the Government's legislative proposals. I never felt that more strongly than yesterday, when the Foreign Secretary's Statement on relations with Iran was not repeated in this House. I have no intention of diverting this debate on to that ground, other than to say that it was a lamentable decision. If we want to be regarded as a mere superfluous appendage to the other place, that is the surest way to go about it.

I should also like to congratulate my noble friend Lord Singh on his extremely graceful maiden speech. Ten years ago I chose to make my maiden speech in a debate on international development, so I cannot but congratulate him on his choice of subject matter.

The coalition Government's decision to ring-fence our overseas aid from the spending cuts was a courageous one when it was first made and is all the more so now that they are sticking to it in the face of much discouraging economic news. Through all the cacophony of press criticism of that decision, I have yet to hear one respectable argument for making developing countries far poorer than we are suffer because of an economic crisis for which they have absolutely no responsibility. In any case, they are already suffering from the slowing of the global economy.

I am certainly not going to cheer the decision of two days ago to reduce the sums earmarked for aid in the latter part of the current spending period. However we are—and this I do welcome—sticking to our Gleneagles and UN commitments. That 0.7 per

cent of our gross national income is going to be a good deal less than was earlier anticipated is, I fear, an ineluctable fact. I hope that the Minister replying to the debate will be able to say what we are doing to hold other developed countries to their Gleneagles and UN commitments, which some of them are missing by a very wide margin indeed. We should not spare their blushes, however much they would like us to do so. What plans do we have to use next year's G8 and G20 meetings to get those commitments back on track?

I was encouraged to hear that the Secretary of State for International Development had recently been to China to discuss the scope for co-operation between us in helping developing countries. Can the Minister say something about the outcome of that visit? Did the Chinese respond positively? What sort of programmes and projects could we work on together? I hope, too, that we are working on similar bilateral co-operation with countries such as India and Brazil, which are just beginning to mount serious aid programmes. Some time back I suggested that co-operation over aid could be one of the best ways of thickening up our relations with those emerging powers. Are we doing that now in a systematic way? Brazil in particular has many links with African countries, both cultural and economic, and it has devised imaginative and effective programmes for bringing its own poorer citizens out of the abject conditions in which many of them lived, so it would surely be an ideal partner if we could agree to work together. Have we got anywhere down that road?

I return briefly to a question that I put to the Minister recently: namely, the plight of UNESCO following the lamentable US decision to withdraw all its support from that organisation when Palestine was admitted as a member. I hope that we have not concealed our disagreement with that deplorable move. Why on earth should developing countries around the world be punished for giving the Palestinians a status that is no different from that which we all, including the US Administration, believe is our right? That sort of behaviour is a throwback to the worse mistakes of the previous Administration. I know that it is mandated under US law, but that is an explanation not an excuse.

Be that as it may, I hope that when we come to consider our own future support for UNESCO we will take all that into account. I very much support the broad thrust of our policy of holding UN agencies to account for the quality and effectiveness of their development work, but no organisation can take a cut such as UNESCO has had to take overnight without a lot of disruption and some damage to its overall performance. Can the Minister say how we are planning to respond? With some sympathy, I hope.

I am sorry to disappoint my noble friend Lord Craigavon but I am not going to say anything about EU aid. Having taken the afternoon off from the festivities in the Moses Room and chosen to participate in your Lordships' debate on this aid programme, I thought that I might as well go the whole hog. Therefore, I will not refer to the EU's programme but I will follow my noble friend by drawing attention to the 2015 deadline for achieving the millennium development goals—a deadline that is now well above the horizon.

A lot has been achieved and more certainly will be in the next three years, but it is already clear as daylight that we will fall short, and by a substantial margin. Moreover, too many of the successes have been concentrated in too few of the developing countries, so it is surely high time for us to clear our own minds about what we will aim to achieve after the 2015 deadline. I suggest that we will need a better focused, less broad-brush approach and that it should concentrate on what Professor Paul Collier has so eloquently called the “bottom billion”. I am sorry if the phrase offended my noble friend. Our decision to ring-fence our aid puts us surely in pole position to lead the search for an improved MDG mark 2. I hope that the Minister can tell us that we are already at work with that in mind. If so, can she give us some idea of where we think the main emphasis of those future programmes should be?

One other point I would like to raise is the question of failing or failed states. Last July DfID produced an excellent paper on this tricky subject which I could not fault, partly because it followed so closely the path set out in a number of preceding reports, not least that of the UN reform panel on which I had the honour to serve. Prevention is better than waiting for countries to go over a cliff and then trying to catch them in mid-air or, more often, picking up the pieces in the aftermath of the disaster. It not only costs less but saves many lives that would otherwise be lost.

Is this a proper task for development agencies or should they, as some critics suggest, concentrate exclusively on the alleviation of poverty? I suspect that this is in any case something of a false choice. The poverty of failing or failed states is in many cases dire. One of the characteristics of those states is that for purely political reasons their poverty cannot be alleviated by classic developmental policies. Are we just to let them stew? I would say not. Moreover, it is essential to demonstrate that the international community’s responsibility to protect—R2P, as it is called—is not just a recipe for military intervention but a call in the first instance for strengthened policies of prevention. Therefore, I argue that helping those states to avoid failure is very much a proper object of our development policy. I hope that the Minister will say something about how the department is following up and implementing that first-class paper of last July.

In conclusion, I very much welcome the recent decision by DfID to put more resources into the BBC’s World Service Trust. The fact that much of the World Service’s output has genuine developmental value is surely not in doubt and has been quantified. It is high time to recognise this potential as another facet of our development policy. It should have happened a good time ago, as some of us in this House urged last winter, but better late than never. Back-Benchers are supposed to get more pleasure out of criticism than praise, but I am truly pleased to speak so positively about the coalition Government’s development policies—more positively, I suspect, than some of their supporters in another place would have done. I hope that that will be some small encouragement to the Government to stick to the path they have chosen to follow.

3.17 pm

Baroness Kinnock of Holyhead: My Lords, I also add my thanks to the noble Earl, Lord Sandwich, for initiating this debate, and indeed for his lifelong, strong commitment to international development. I also congratulate the noble Lord, Lord Singh of Wimbledon. He clearly brings great wisdom and experience to the work of this House, and as his maiden speech has shown today, we can look forward to many more interventions of that calibre from the noble Lord.

This is a timely opportunity to consider how best to implement international development objectives in what is, as many noble Lords have intimated, a rapidly changing and deteriorating international environment. Today, we are discussing these issues against the backdrop of faltering progress towards meeting the MDGs and in the knowledge that most of the world’s poorest countries will not meet the 2015 targets, as well as knowledge of the emerging and growing threats linked to climate change, food security, and a very disappointing record on aid.

One particular statistic has called into question whether the MDGs are actually able to reach the most marginalised, disadvantaged and hard-to-reach poor. We now know that 75 per cent of the world’s 1.3 billion poor people actually live in middle-income countries, and that in fact 20 years ago, 93 per cent of poor people lived in lower-income countries. We have seen a huge shift in that period. Does this evidence not then dictate that we need to focus more on poor people, not just on poor countries? We can tick the boxes when we use MDGs as our benchmarks, but social exclusion, environmental sustainability, and governance are just not factored in to the MDGs. The MDGs are formulated in terms of average progress, and fail to assess whether progress has been broad-based or indeed equitable. MDGs’ assessment processes tend to obscure what is happening within countries.

All the evidence shows that the most disadvantaged people—who have been referred to by many noble Lords today—are being left further and further behind. Social disparities are seriously holding back progress. With that MDG focus on aggregate progress, we will not deal with those intersecting inequalities which are so resistant to change, and when such uneven progress is being disguised by the process used by the MDGs. Meanwhile, as Ban Ki-Moon said recently, “inequality eats away at social cohesion”.

All of this sits very well with both aspects of the debate: international development and the Dalits. The work of the Institute of Development Studies in Sussex and the Overseas Development Institute is very clear and very good indeed, and I recommend it.

In Latin America, for example, extreme poverty is much higher among indigenous and Afro-descendent populations compared with the white Latino population. The region’s poor earn only 3 per cent of the total regional income, and make up 25 per cent of the population. Remarkable progress has been made, however, by Governments in Brazil, Chile, and Malaysia.

Noble Lords have drawn attention to the plight of the Dalits, who are denied fundamental rights and opportunities. This evidence clearly makes the case for

[BARONESS KINNOCK OF HOLYHEAD]

challenging discrimination which leads to entrenched poverty and indeed to terrible suffering. In Nigeria, only 4 per cent of mothers in the predominantly Muslim north-west are delivered in a health facility, compared with 73.9 per cent in the predominantly Christian south-east. In Kenya, minority ethnic groups have lower immunisation levels and higher under-fives mortality rates. A poor indigenous woman in Guatemala has one year of education compared with the national average of almost six years.

In every country and in every region, people are being denied their right to play their part in social and economic developments. This is on the basis of gender, race, ethnicity, religion, and often location—if people live far away from the capital, it is much easier for their needs to be ignored. This is systematic social, economic, and political discrimination, and leaves people literally and metaphorically at the end of the road. This calls for an expansion in developing countries of, for instance, social protection, access to decent work, minimum wages, and many other opportunities which people need if they are to see real progress.

In 2000, the millennium summit identified the need for social justice. Does the Minister agree that dealing with inequalities is the key to realising that aspiration, of which we have somehow lost sight?

Global aid budgets are critical to the achievement of the MDGs. We are obviously very clear that the achievements of this Government in getting agreement across the whole party on overseas development are extremely important, but we want some clarity on the reduction in overseas development aid. A reduction of something like £1.17 billion seems to be on the cards. That is enough to vaccinate millions of children against deadly diseases and, for example, to cover the training of midwives, who would be able to save many lives. Will the Minister give some detail on which budget lines will be affected by this reduction in funding? Bilateral programmes depend on long-term sustainable financing. Incidentally, this is a core effectiveness principle which the Government have signed up to in Busan. Will the Minister give an assurance that bilateral funding for country programmes will not be reduced?

Will the Minister perhaps also indicate whether the World Bank allocation will be reduced? In the context of the Durban conference, will he clarify whether it is the intention to take money for climate change adaptation and mitigation? Will the Government give an assurance that this will be additional money and that it is not the intention to take the necessary resources from the DfID budget? Of course, the Labour Government made a very strong commitment to 90 per cent of funding for climate change being additional funding, with 10 per cent being not additional but focused on poverty reduction. Are the Government also prepared to agree to that arrangement?

My final point is on the prospect of a commitment to the financial transaction tax—referred to by my noble friend Lord Judd—which I think it has been proven does not have to be global. The FTT is seen increasingly as not only desirable but feasible. It has been endorsed by Bill Gates, by a clutch of Nobel peace laureates, by UNICEF and the UNDP, and by many other economists and others, as well as, as the

Minister knows, the Liberal Democrat manifesto before the last election. Robert Peston has recently said that an FTT,

“would improve the functioning of capitalism”.

Does the Minister agree with this view? I look forward to her response.

3.27 pm

Baroness Northover: My Lords, I, too, thank the noble Earl, Lord Sandwich, for securing this debate and for introducing it, as ever, so cogently. As others have also said, he has an outstanding record of work in this area. Once again, the depth of experience among noble Lords has shone through. I was struck by the very wise maiden speech of the noble Lord, Lord Singh of Wimbledon, which I thoroughly enjoyed. I am sure that we all look forward very much indeed to his future contributions.

This debate—in its title, at least—spans all that the Department for International Development does and has an especial and additional focus on Dalits. In some ways, their plight serves to show up all that we should be doing: if we are not addressing the needs of the most marginal people, then what is our purpose? Underlying all this is fairness. Across the world, too many people live in conditions that are anything but fair. In sub-Saharan Africa, one child in seven does not live to see their fifth birthday simply because of unsanitary conditions and dirty water. Every year, more than 1 million children lose their mothers simply because those women did not receive adequate care during pregnancy and childbirth. Each day, 69 million children do not have the chance to go to school.

As the right reverend Prelate the Bishop of Ripon and Leeds said, we know that what we are doing to help people out of poverty is right, but we also know that it is in everyone's interest. The noble Lord, Lord Hannay, played his part in the UN high-level panel, which made very clear that particular link. If we fail to tackle the root causes of the global challenges that face us, whether they be economic instability, conflict and insecurity, climate change or migration, then we will all suffer the consequences. That is why I am very pleased that, despite our economic situation, the coalition has kept to its commitment to spend 0.7 per cent of GNI on aid from 2013. I thank noble Lords for the welcome that they have given to that commitment, as well as for the very kind words that have been expressed to me by noble Lords.

I can also assure noble Lords that, as well as meeting their promise on the quantity of British aid, the Government are determined to ensure the quality of British aid. We are doing what we can to encourage other countries to meet their promises. It is in extremely difficult circumstances that this is the case, as noble Lords will appreciate, and we are also, as referred to by the noble Lord, Lord Hannay, trying to bring in the BRIC countries. My right honourable friend the Secretary of State received a positive response when he was in China and I look forward to hearing more from him on this issue.

On the quality of aid, the coalition Government undertook the bilateral and multilateral reviews referred to by noble Lords. The noble Earl, Lord Sandwich, in particular, asked about specifics, particularly in relation

to the bilateral review. All DfID's programmes were assessed against need, effectiveness and other factors, including what was being done by other donors. DfID concluded that British aid should in future be focused on 27 countries, which together account for three-quarters of global maternal mortality, nearly three-quarters of global malaria deaths and almost two-thirds of children out of school. This tighter focus will ensure that we concentrate our efforts where the need is the greatest, increase our impact on fragile or conflict-affected states and deliver in the places where most poor people live. Aid to Russia and China has been stopped, while another 14 countries will see their existing aid programmes closed by 2016.

The noble Earl, Lord Sandwich, asked about Kosovo. I can assure him that DfID's graduation from Kosovo will be a phased process, honouring existing commitments and exiting responsibly. After 2012, the British embassy will continue to support Kosovo and UK funding will continue through the EU and other multilateral agencies. The noble Earl will no doubt note how well the EU came out of the multilateral review, and we are very glad that the UK can continue its strong funding through that, which will support Kosovo.

In the multilateral aid review, DfID assessed 43 international funds and organisations to which the UK contributes. Nine organisations, including UNICEF and GAVI, were assessed as providing very good value for money and therefore we are increasing their funding. The noble Earl asked whether there was a particular proportion that would go between bilateral and multilateral countries. There is not a fixed proportion. In the multilateral review, four organisations were deemed to be underperforming and have been placed on special measures. We are pressing for UNESCO, the Food and Agriculture Organisation, the Commonwealth Secretariat and the International Organisation for Migration to improve their performance. Should we see no improvement when these organisations are re-assessed in 2013, the UK will reconsider its support.

I hear very much what the noble Lord, Lord Hannay, said about UNESCO, which we did indeed discuss at Question Time the other day. I have written to him on that subject and I hope that he will receive that letter shortly. We bear in mind the balance between the challenges facing UNESCO in this regard and its need to make sure that it delivers more effectively than thus far.

These are extremely difficult times for the United Kingdom. Therefore, it is even more important that people can see that the aid that they are supporting through their taxes is targeted, focused on the poorest, and makes a difference. The noble Earl is quite right that there is great public support for aid.

The noble Lord, Lord Judd, is right to flag up whether the emphasis on results puts the longer-term programmes under some question. The answer is that we are acutely aware that development is a long-term process. We are fully committed to that. The concentration on education, health, girls' education and so on underlies that commitment, but it is also important that people can see the end-result of their aid giving so that we can ensure that we can maintain the percentage to which we have committed this Government.

No other Government thus far have managed to achieve that. I bear in mind what the noble Baroness, Lady Kinnock, said about there not being as much money available, even when we meet the 0.7 per cent, as if we had a really flourishing economy. That is enormously to be regretted, but I note what other noble Lords said about the achievement of reaching even 0.7 per cent. I pay tribute to the previous Government for helping us on that way, but this coalition Government are committed to that.

Just as DfID has scrutinised multilateral donors, it is offering itself for scrutiny because that is very important in people understanding where this money is going—hence the new Independent Commission for Aid Impact, ICAI, which published its reports recently, and DfID's new aid transparency guarantee. The focus on results does not mean that we do not understand how development is a long-term effort.

We also know that the concentration on fragile states will not easily produce instant results, but we are acutely aware that conflict breeds poverty. No low-income, fragile country has yet achieved a single millennium development goal. I hope that I can assure the noble Baroness, Lady Kinnock, that we are making plans for after 2015. Although at the moment there is tremendous focus on trying to ensure that as many elements of those MDGs as possible can be delivered, we are looking beyond that.

We are increasing the level of funding for fragile states to 30 per cent of development aid by 2014-15, while the building stability overseas unit, which is based jointly with DfID, the Foreign Office and the Ministry of Defence, is focusing on upstream prevention. Some of the lessons learnt from the lack of development awareness in the early days in Afghanistan, for example, must surely be applied in the future, as well as some of the lessons from Iraq. For example, not destroying the infrastructure needed to support the civilian population once the initial conflict was over is one lesson that was carried through, with the building stability overseas unit emphasising that that was to be the way that things were approached in Libya.

I know that noble Lords will understand and commend DfID's focus on women and girls, recognising that daughters, mothers and wives tend to reinvest gains in their own families and communities, completing a virtuous cycle of development. We will also invest in girls' education. One extra year of schooling can increase a girl's wages by 10 to 20 per cent, helping to end the transition of poverty from one generation to the next. We will maintain a particular focus on maternal health, saving the lives of 50,000 women in pregnancy and childbirth.

I hope that the noble Viscount, Lord Craigavon, will welcome the fact, as he seems to have done, that we will also give at least 10 million more girls and women access to family planning. Contraception costs less than £1 a year. The noble Viscount noted that the global population figure now stands at 7 billion, which shows how important the policy is. That cannot be overstated.

More generally, we are seeking to provide people with the means to pull themselves out of poverty. Wealth creation is the engine of long-term growth, as

[BARONESS NORTHOVER]

we have seen in parts of Asia, and so we are putting in place the conditions—land reform, better transport links, fairer legal systems and improved internet access—that we hope will encourage that development. Within DfID, a new private sector department is helping to promote this. We will redouble our efforts to open global market opportunities to developing countries, pressing the EU to do all that it can to make sure that poor countries benefit. We will continue to lobby G20 countries to provide 100 per cent duty free, quota free, market access for the least developed countries.

Where British companies invest in developing countries we will make sure that they do so in an open, transparent and accountable manner. The new Bribery Act helps to reinforce that. We strongly encourage businesses to respect human rights and the environment and we provide support for international standards, such as the OECD guidelines for multinational enterprises.

I was asked about the extractive industries. UK support for that has contributed to 11 countries reaching compliance status and 22 other candidate countries going through the validation process by September 2011. The right reverend Prelate is absolutely right that it is extremely important to look at the economic development of these countries and to make sure that that is occurring in a way that assists the population at every level, down to the bottom billion to which reference has been made, and not simply to those at the top, and that we do not concentrate simply on aid.

Good health is a basic starting point for people who are trying to lift themselves out of poverty. That, too, is an area on which we very much focus. At the moment, there is a strong emphasis on malaria in all our country programmes with a view to helping halve malaria deaths in the 10 worst affected countries. On this World AIDS Day, the British Government remain at the forefront of global efforts to tackle HIV/AIDS, on which I note that I have another debate immediately after this. Although we have made huge progress, there are still more than 34 million people living each day with HIV. Our main focus is on women and Africa where there is the highest incidence and the greatest vulnerability.

Alongside all our proactive work on governance, health, education and economic growth, we will continue to respond to humanitarian emergencies. As noble Lords know, more than 13 million people are experiencing the worst effects of the drought that has spread across the Horn of Africa. UK aid is providing much-needed support, including food, vaccinations and clear water and sanitation. Our response to humanitarian crises has also been reviewed by my noble friend Lord Ashdown—a review that has been widely welcomed internationally. The incidence and severity of natural disasters is likely to increase due to climate change. We know that the poorest and most marginal will be hit the hardest and worst. The noble Lord, Lord Judd, is absolutely right about that and it is a major focus of DfID.

Time is running short, and I want turn now to the Dalits. Noble Lords have rightly made the point that members of the Dalit caste suffer from the most severe forms of poverty, deprivation and exclusion. Often

living apart from the rest of society they routinely face discrimination in accessing basic services and are barred from undertaking certain occupations. The case of the Dalit girl mentioned by my noble friend Lord Avebury brings that graphically home to us. We have heard much about their plight from noble Lords—in particular, the noble and right reverend Prelate, Lord Harries of Pentregarth, and my noble friend Lord Avebury, who have been doughty champions of Dalits in this House in terms of those overseas and those in the United Kingdom.

Britain is committed to helping India to eradicate caste discrimination. Indeed, as noble Lords know, discrimination on the grounds of caste was abolished by the constitution of India in 1950, but we recognise that there is a long way to go. The UK regularly raises such issues with the Government of India, about which the noble Earl, Lord Sandwich, asked. It was last discussed in September on a ministerial visit by my noble friend Lady Warsi.

DfID's development programme is specifically designed to benefit the poorest and most excluded, included Dalit women and girls. We are seeking to increase the number of Dalit children, especially girls, enrolled in school. My right honourable friend the Secretary of State for International Development is due to visit India shortly and plans to meet Dalit girls while he is there and seek to address how we can ensure that more of them are in school and able to see school through.

At a strategic level we are supporting civil society programmes, such as the poorest areas civil society programme and the international partnerships programme. Both are aimed at tackling discrimination, and together the two programmes should help more than 25 million excluded people.

DfID is also working with Dalit groups in Bangladesh and Nepal to help them access basic services, such as health and education. DfID Nepal is working with the Dalit NGO Federation and my honourable friend in the other place, Lynne Featherstone, visited Nepal in June this year in her capacity as champion on violence against women, and engaged with Dalit women there. The noble Earl, Lord Sandwich will remember that when we were in Nepal a few years ago through DfID, we also met Dalit groups and I certainly found that extremely informative.

I am aware that I am running out of time and have numerous questions from right across the House. My best strategy is to write to noble Lords in answer to the numerous questions raised. To conclude, as ever this has been an extremely stimulating, wide-ranging and constructive debate, which has amply demonstrated the House's understanding of the many complex challenges which we face in our efforts to alleviate poverty and suffering across the world. We know there are major challenges facing all of us, we know we are all inter-linked and the noble Lord, Lord Singh, put that beautifully. Something happening in one area of the world will have an impact elsewhere. We know it is a challenge maintaining aid when we are in the midst of our own economic problems. We also know that, whatever those problems are, those who are the most

vulnerable are those who are already at the margins—the poorest and especially the women and children among them. I know that view is shared right across the House.

3.47 pm

The Earl of Sandwich: My Lords, I do not want to stand in the way of another important debate, on HIV/AIDS—a very relevant and connected debate, albeit in the United Kingdom—so I will be brief.

This has been a very heartening debate because it is encouraging to know about programmes that are really working and to hear people who are sympathetic and instrumentally involved in seeing policy through. I was very encouraged by that.

It is a Cross-Bench day so I thank all the Cross-Benchers, if not for electing me, for electing the subject of the debate and also the subject of the Dalits, raised by the noble and right reverend Lord, Lord Harries, which I think strengthened the content of the debate. It is a very wide canvas and it is almost impossible to fill in all the areas. I hope that he will be recruiting from Members of the House for his new all-party group on Dalits; it will have a lot of impact on legislation here, where the Dalits are also discriminated against.

I thank the Minister for her stamina, not least because she was up late last night, as was I, and saw what was happening. She now has another debate to respond to. The 0.7 per cent target is still there. I was hoping for a fuller answer on the multilateral agencies. I am slightly alarmed to think that the IOM as well as UNESCO, mentioned by the noble Lord, Lord Hannay, are on trial in some way in the aid programme, because they have such a reputation, and as he said, they need support day by day.

I must thank my noble friend Lord Singh for his maiden speech. I was a student in India years ago and the gurdwara was the place to go when you were really down and out—I remember that so well. We think in our childhood culture of the bearded as being wise. I am sure that he has always been told that he is wise, but, more than that, he is a mining engineer. We need those to give real strength to our debates.

I thank the noble Lord, Lord Avebury, who always brings up interesting subjects, and the noble Lord, Lord Judd, whom I have known for many years. I thank all your Lordships.

Motion agreed.

HIV and AIDS in the UK

Debate

3.51 pm

Moved By Lord Fowler

That this House takes note of the report of the Select Committee on HIV and AIDS in the United Kingdom (HL Paper 188).

Lord Fowler: My Lords, I am grateful to the authorities for finding room for this debate on World AIDS Day. Perhaps I may first offer some thanks. I thank the committee, which was a mixture of old campaigners—

I must be careful how I say that these days, but the noble Baroness, Lady Trumpington, is not here—and Members who were very much new to the area but who made a major contribution. I am delighted to see so many of the committee here, late on a Thursday afternoon, including my noble friend Lady Ritchie. I thank the clerks, Mark Davies and Matt Smith, for their invaluable work and tremendous effort. I also thank all those people who were witnesses, many of whom are the heroes of the struggle against HIV and AIDS—the clinicians, the Health Protection Agency, the department and voluntary organisations, without which, frankly, we would not be able to manage in this country.

It is 25 years almost to the week that we had our first debate on HIV and AIDS in Parliament. It was on Friday 21 November 1986. Reading that debate, I see that, as Health Secretary, I had the support of Michael Meacher for Labour and of Archy Kirkwood for the Liberal Democrats. I even had the support of Bill Cash—I have not often been able to say that in my political career. All the parties combined to make it an entirely non-partisan debate, and so it has remained—as, too, have many of the issues raised in it; public education, treatment and research are still the issues today.

However, there is of course one enormous difference between now and then. At that stage, AIDS was a death sentence. We had neither drugs nor vaccines. In the hospital wards, we found young men dying as doctors and nurses looked on helplessly. That was why we took the decision then to mount a very high-profile public education campaign using television, radio and press, while sending leaflets to every household in the country. If we wanted the public to know of the dangers, it was the only course open to us.

Of course, not everyone at that time agreed. They said that it would offend the public—there was little evidence afterwards that it had done that—and that the Government should stand well clear of such a controversial and, to them, distasteful error. My view and that of my colleagues on the special Cabinet committee that we had set up under the brilliant chairmanship of Willie Whitelaw was that that was not the case. Disease was disease, suffering was suffering, and we had a moral and human obligation to treat sexual disease just like any other and, above all, to try to prevent its spread.

The aim of our Select Committee has been to examine the progress that has been made in the 25 years that have intervened. The greatest change in every meaning of that word is the availability of effective drugs. Antiretroviral drugs have transformed the life expectancy of those with HIV. Provided that people are treated early, there is no reason why they cannot live long lives. In this country we are fortunate that such drugs are freely available, a position that even today after more than 25 million deaths worldwide is still not the case in many parts of the world. In Britain the drugs are there and the death toll has been drastically reduced. Perhaps that is why one of the most common questions that I get asked today is, “Is it still a problem?”. The answer is an unequivocal yes. It is not only a problem, it is a growing problem. The evidence that the Select Committee received on this was utterly

[LORD FOWLER]

clear. Today almost 100,000 people in this country are living with HIV, the number of HIV patients has trebled in the past 10 years, a quarter of those with HIV do not know that they are infected and continue to spread the disease, and although we have drugs to prolong life there is still no cure and no vaccine.

This point should be emphasised; those with HIV, despite the drugs, face a lifetime of treatment and, even worse, the threat of discrimination in jobs and normal social life. The stigma has not been removed. It is not consequence free. A few months ago I received a letter from a man who had just been diagnosed with HIV. He said: "Last year I was diagnosed with the disease and it almost drove me to suicide. I would not want someone else to go through the pain I have. I am now seeing a psychiatrist and talking through how to deal with the disease". More happily he went on to say that he had now started the medication and his viral level was almost undetectable. That gives some indication of the kind of pressure and suffering that can be caused, even today, to those with HIV.

The real tragedy is that HIV is entirely preventable. Thanks to medical advance, very few babies in this country are now born with the condition. It is not like asthma or epilepsy. To be blunt, we have seen in the past decade a failure in our efforts to reduce the spread. One reason for that failure is clear enough; as a nation we spend more than £750 million a year on drugs to treat HIV, and in contrast the Government spend a miserable £2.9 million trying to prevent it. That is the failure of the policy and the direct and unavoidable challenge to this Government.

The basis of our report is that priority should be given to preventing HIV and AIDS in the United Kingdom. So far, the effort has been wholly inadequate over the past decade and a new priority must now be given to prevention policies if the epidemic is to be stemmed. Our belief is that HIV and AIDS remain one of the most serious public health issues confronting the Government at the start of the 21st century.

In principle I am encouraged by the Government's proposals to set up a new public health body with a ring-fenced budget; it is an excellent idea, although we will obviously have to ensure that the detail of the proposal lives up to the promise. However, I say to them that it is essential that much greater priority is given to prevention in areas such as HIV. At the moment we have a health system that is financed to treat the casualties but is simply not resourced to prevent those casualties coming about. Before Ministers say that this is simply a plea for money, let me remind them what can be saved by successful prevention policy. It is estimated that a lifetime's treatment costs is between £280,000 and £360,000 for every patient. If we can prevent just 1,000 new infections, we are talking about savings of around £300 million. That is good news for the NHS budget, and it is exceptional news for the people spared a lifetime of treatment.

In entirely practical terms, I refer Ministers to paragraph 229 of our report, where we challenge the local procurement policies at present being pursued inside the health service and propose that antiretroviral drugs should be purchased on a national scale using the purchasing clout of the health service. The

Government should reconsider their position and, in so doing, they would do well to read the debate in this House last Thursday, particularly the speech of the noble Lord, Lord Sugar, who made exactly that point about purchasing generally.

Of course, not everything costs vast amounts of new money. One of the undoubted reasons why HIV is spreading is that too many people are not tested; a quarter of the 100,000 with HIV do not know that that is their condition. That is obviously bad for the people who do not test, because the longer it goes on undiagnosed the worse the outcome for the individual. It is certainly bad for the country, because every undiagnosed person represents a public health hazard. It is a sure way of spreading the virus.

We have a series of proposals, but I shall pick out only three. Home testing kits are already available on the internet, but it is a trade that is unregulated and unchecked. The committee took the view that home testing was a sensible extension of testing generally, provided that such tests were accurate and under a licensing system. I am glad that the Government agree with that and I congratulate them on accepting it.

The second proposal concerns general practitioner testing. We should involve general practitioners much more and certainly ensure that people who sign up with GPs for the first time are tested. That point was made this week also by the Health Protection Agency, which points out that of the 680 people with HIV who died in 2010, two-thirds were diagnosed late.

The third area concerns prisons. I am less sure, to be frank, what the Government's attitude is here, having read their response. We know that the incidence of HIV in prisons is above the average. It would seem almost an automatic step for prisoners to be tested for their own sake so that treatment can be given, and certainly for the health of other prisoners. I will welcome the Minister's guidance on this. Overall, the aim of policy should be that HIV testing should be a normal part of medical care.

Let me return to 1986 and make a comparison between one feature that has improved markedly and another that has not improved to anything like the same extent. The good news comes from drugs. It was not entirely unanimous inside the Thatcher Government that we should introduce clean needle exchanges for injecting drug users. I could put it more strongly than that. There were fears that it might be seen as condoning criminality and that drug crime would rise. Nevertheless, we went ahead and the result has been consistently successful. Only about 2 per cent of HIV cases in the United Kingdom come from injecting drugs and we have received no evidence from the police that it has led to any increase in criminality.

I add this; we were set up certainly to look at HIV/AIDS in the United Kingdom, but we cannot ignore what is happening in the rest of the world—not only in sub-Saharan Africa but in countries such as Russia and Ukraine. There the HIV epidemic is driven by injecting drug users and is at an alarming level. In Russia, more than one-third of drug users are living with HIV; in Ukraine the position is even worse. Conceivably, our experience here might be of help. Can the Minister say what efforts we are making to make our experience available overseas?

The part of our experience that is less encouraging is that the stigma and discrimination that surrounds HIV testing has not remotely disappeared. We were told of examples in employment and even of graffiti being daubed on homes and people being forced to move away. I do not say that this is general but I do say that it occurs too often. Noble Lords will know, of course, the teaching of the Christian Church—and, indeed, of every other religion—of love thy neighbour. In that context, it is interesting to look at the Ipsos MORI poll carried out in 2010 for the National AIDS Trust. Respondents were asked whether they agreed with the statement, “If I found my neighbour was HIV positive it would not damage my relationship with them”. Thirty-three per cent strongly agreed with that, while 30 per cent tended to agree, but 23 per cent either disagreed or strongly disagreed. That position had actually got worse since 2007.

The stigma surrounding HIV is one further reason why the whole issue should be tackled early, and we should take relationship education seriously and not be dictated to by the bigots who say that it is all a plot to force explicit sex education down the throats of four year-olds. People who campaign on that sort of falsehood should hang their heads in shame.

It is interesting to see from the same survey that young people in particular are interested in hearing more about the reality of HIV and that many confess to ignorance in this area. In 1986, the campaign was “AIDS: Don’t Die of Ignorance”. Of course, the challenge today is different, but no one can dispute that there is a challenge or that ignorance of HIV remains an issue. Frankly, I do not agree with the Government that no new campaign in this area is worth while. There is a real danger that we drift into worse problems by our complacency. Of course, I understand the restraints on spending. It may come as a surprise to the Front Bench that in Margaret Thatcher’s Government we also had restraints on public spending. What we did not have was a budget of £120 billion. Prevention, either against HIV or in any other area, is not one of the most costly programmes for the health service. We need a new prevention initiative. That is good financial investment for the health service, but above all it is a good human investment in that it can avoid so much avoidable suffering and distress.

4.06 pm

Baroness Gould of Potternewton: My Lords, I start by thanking the noble Lord, Lord Fowler, for making the meetings enjoyable, friendly and determined. We were absolutely sure that we were going to come to the right conclusions. The people out there who work in the field have welcomed the report. I have not heard one negative remark about the report and that says an awful lot, in many ways, about how the noble Lord, Lord Fowler, guided us through those many days. I support the noble Lord in his thanks for the staff. Sometimes we overburdened them but nevertheless they were absolutely wonderful with us. It was certainly a very concerted effort—every Tuesday morning for eight months. As one noble Lord said to me when it was over, he was suffering from Tuesday morning withdrawal symptoms—I am looking straight at him.

I think that that applied to many others. If I raise any criticism of the response, this is in no way a criticism of the officials in the Department of Health, with whom I have worked for many years, and all of whom are fully committed to building the sexual health services, including for HIV, from the Cinderella service that it was to the improved service that we have today. Even the response goes in the right direction of travel. At this point, I declare an interest, among many, as chair of the Sexual Health Forum and as chair of the All-Party Parliamentary Group on Sexual and Reproductive Health.

I reiterate what the noble Lord, Lord Fowler, said—that the Select Committee was right to focus on prevention as a theme of the report, whether relating it to raising awareness, education, testing or treatment. It cannot be said too often that HIV remains the most serious infectious disease affecting the UK and prevention is the only way we will make that change. We had an interesting short debate during the passage of the Health and Social Care Bill on the need for national sponsored awareness-raising campaigns. But as with the response to the Select Committee report, I did not get any real assurance that national campaigns were on the agenda. While accepting the need in some instances for targeted campaigns—£2.9 million has been spent on those campaigns—there appeared to be a complete rejection of the idea of campaigns directed at the general public. That is a serious mistake as it does not take into account the rising number of UK-acquired infections among people not in the high-risk groups, who now account for more than 25 per cent of newly diagnosed infections each year. However, I was pleased to see the welcome given to the National Aids Trust website, HIV Aware, which directs its messages of prevention and awareness specifically to the general public. This is a classic example of the important role that the third sector plays in the alleviation of HIV and support for those affected. Has thought been given by the department or the Government as to how we could nationally disseminate the themes of the HIV Aware campaign more locally so that there is uniformity of message throughout the country? It would cover high prevalence groups as well as the wider audience. It would raise awareness and provide information and advice at very little cost. I do not think the argument against that can relate to cost.

Also in terms of awareness-raising, I was pleased to note the work taking place among faith leaders. As our visit to Leeds highlighted, it was possible to have dialogue with some faiths, but in other instances it proved to be very difficult. It is terribly important that this work is expanded for us to influence what is happening among some of the groups who find it difficult to accept HIV.

Overall, the public have become less aware of HIV and that has created widespread public ignorance. As the noble Lord, Lord Fowler, said, the lack of awareness by the public is one of the reasons why stigma persists and why there are so many mistaken beliefs on the supposed dangers of HIV. This creates a negative and judgmental attitude towards people with HIV. Stigma is still a daily reality for many people living with HIV. As in the instance given by the noble Lord, Lord Fowler, it can have a devastating effect on the life of

[BARONESS GOULD OF POTTERNEWTON]

someone with HIV and can often be compounded by profound health inequalities—for HIV is also about health inequalities.

Most importantly and crucially, stigma can deter someone from being tested. Ignorance makes people very frightened of being tested in case they then have to face the consequences that go with it. Preventing the spread of HIV has to involve the promotion of early testing and the widening of the scope of venues where testing can take place in order dramatically to reduce the estimated 22,000 people who have HIV but do not know it—the 25 per cent who are undiagnosed but might be furthering transmission.

As the Select Committee Report states, HIV testing must become normalised. An offer should be made to newly registered patients in general practice and as well as to general and acute medical admissions. The Department of Health's important screening pilots have shown that staff and patients welcome more HIV testing in hospitals and in primary care and community settings. However, for the future, it will be for healthcare professionals and local authorities, when they take over in 2013, to follow that work through. I am putting a positive slant on the Government's response that they will consider favourably the *Time to Test* report. Perhaps the Minister can confirm that I am right to be optimistic.

The evidence of success of this approach is made forcibly by the success rate of antenatal clinics where an offer is automatically made and, as a consequence, mother-to-child transmission is at a very low level. I heard this morning at a meeting of how, when the fathers turn up at the clinics, staff can try to persuade them to have an HIV test. Many have previously been resistant to that. They are examples to learn from. The high level of acceptance of an offered test makes economic as well as medical sense and that message needs to be repeated. Prevention of half those undiagnosed cases would save the country £1.2 billion in healthcare costs. More than half the people are diagnosed late and some are already very ill, which again leads to far higher annual treatment costs. If we could have early testing, we could have early treatment and reduced costs.

The work being undertaken by MedFlash, referred to in the Government's response, will, I am sure, be invaluable in providing an interactive tool to support GPs and primary care staff in offering HIV testing as it will enable those staff, among whom there is great nervousness about making an offer, to do so. That barrier needs to be looked at much earlier and we must think about having discussion of HIV in medical schools and nurse training, so that when staff are faced with such questions, they know the answers. Instead, they are finding it very difficult.

It is also very important that we look for a positive outcome to the public health outcomes framework indicator on late diagnosis. I appreciate that many are being considered in the public health field and I know that the Minister cannot give me an answer. However, I am hoping that she will say that I can be optimistic.

One of my concerns about the new structure—although I am a strong advocate of public health moving into local government—is the design of the new commissioning

structure and the inter-relationship between the different elements that make up that structure. This is particularly important for HIV because of the expected split between treatment and care and between prevention and testing. The split of functions may be inevitable, or it may not be; it might still be changed. I understand the case made by the Government in relation to other infectious diseases. I welcome the commitment that prevention work will not become isolated from treatment services. However, I would like to hear a little more about how that will happen in practice. Perhaps the Minister can elaborate on the mechanisms that will ensure that that prevention work does not become isolated from treatment services.

In conclusion, I should like to make three short points. On standards, the response indicates that the provisions set out in the Health and Social Care Bill allow for the development of quality standards for social care and public health, opening up the possibility of quality standards that fully support integrated care pathways. The question that follows, however, is whether comprehensive guidelines will be produced to make that system consistent and effective or will it be left to each locality to determine how that works. In some it might and in others it might not.

The committee recommended that NICE be commissioned to develop treatment and care standards for HIV specifically. While there are excellent standards produced by BHIVA, they do not address the need to co-ordinate specialist health HIV services with other services. I hope that the Government might reconsider and take up the recommendation that was in our report.

My next point relates to charging for HIV treatment and care and the recommendation that HIV should be added to the list of conditions in the NHS (Charges to Overseas Visitors) Regulations 1989. This is a matter which the noble Lord, Lord Fowler, the noble Baroness, Lady Masham, and myself will be raising during the passage of the Health and Social Care Bill. I am not asking for an answer to that today. However, I understand that a review is being undertaken and it might be helpful if we could know when the review is to be concluded.

Finally, I want to say a few words about tariffs. The response indicates that funding methods such as block contracts provide no incentive for organisations to improve patient care. In the light of that clear and positive statement in the response, can the Minister clarify the decision in the Health and Social Care Bill not to allow national tariffs for public health, including sexual health? Not to allow a level of flexibility of tariffs will almost inevitably mean a return to block contracts and therefore, as the response says, diminished patient care. There is a clear contradiction here and I think that it needs clarification.

Much has been achieved in the past. However, if we are to maintain momentum and respond effectively to the challenges of a growing epidemic, we need a national, holistic strategy on HIV, a view endorsed by the HPA in its report earlier this week. We need a strategy that encompasses the findings of the Select Committee report: early diagnosis, effective treatment

and social care, HIV prevention and testing in a wide range of settings, laws and policies to eliminate stigma and discrimination, a well-trained workforce and the reduction of health inequalities. That is the approach that I hope we will see in the planned sexual health policy framework, which gets a number of mentions in the response to the report. Only then can we be assured that the momentum that has been achieved can and will be maintained.

4.19 pm

Baroness Tonge: My Lords, I begin by congratulating the noble Lord, Lord Fowler, and the committee, of which I was a member, on this report. I consider it to be a very important piece of work and I would have hoped that the Government would have accepted all of our recommendations. Perhaps that was a bit too much to ask for; sadly, we have a little more persuading to do. I want to talk about two or three aspects of the report and I make no apology for repeating some figures that we have already heard, because they are very important and need to be engrained on everyone's mind.

HIV infection is growing in the United Kingdom. By next year, there will be more than 100,000 people living with the disease in this country and in AIDS treatment, one of the great medical successes in recent years—a quite fantastic medical success—the costs are now approaching £1 billion a year. Yet we still have to remember the title of the committee's report: *No Vaccine, No Cure*. It is not curable but for the fortunate people who are diagnosed early, this disease has become a rather nasty long-term condition, which can be controlled with the right treatment, so that people can go on to live a relatively normal lifespan. We have already heard about early testing being desirable. Unfortunately, this has led to a young generation growing up now who think that AIDS can be cured, like any other STD. It is, "No worries, then"—you go to the doctor.

It was 25 years ago that the noble Lord, Lord Fowler, as Secretary of State for Health, launched the never-to-be-forgotten "Don't Die of Ignorance" campaign, with its collapsing tombstones. My children trembled in front of the television set during that campaign. It had impact. They have never forgotten it, and it certainly slowed the spread of that disease in the UK. The noble Lord should always be remembered for his courage in pushing through that campaign, against what I know was some pretty tough opposition.

I do not know how much that campaign cost, but I know how inadequate spending on prevention is today. We have heard that £2.9 million is being spent on prevention—the cost of a house in my old constituency—despite the Government using "prevention" 35 times in their response to the report. I counted each mention because I am a pretty sad person sometimes. Despite those 35 times, only £2.9 million has been spent on prevention yet, as we have heard, nearly £1 billion is spent on treatment in one year. On another preventable statistic, as we have heard, a lifetime of treatment is estimated to cost between £250,000 and £350,000. For the individual and for the Treasury, prevention has to be and is better than cure.

I want to emphasise a few more aspects of prevention, which may not have occurred to some people. AIDS is one of many sexually transmitted diseases and in my view we should not single out one disease for a campaign, as we did recently with chlamydia. That was a wasted opportunity. AIDS is a very serious disease, but I repeat that we have a sexually active population. Sexual images are everywhere and much advertising uses them. Heterosexual and homosexual activity is on our TV screens, in the cinema, and on the internet and YouTube. I do not watch YouTube but I know that young people watch it a lot. That activity is everywhere and young people are immersed in it, but whoever has seen an actor talk about condoms or sexually transmitted disease before hopping into bed with the leading lady? I never have in my lifetime.

I do not want to sound like an old prude but we have to accept that this is the way people behave. They must have the freedom to live their lives, heterosexual or homosexual, as they wish—so long as their actions do not affect others, which sexually transmitted disease does. That is good John Stuart Mill stuff: they are limiting the freedom of people to enjoy their lives. Therefore, people must be given the right warnings and information, and they must be given to all sections of the population, not just the target groups. I have talked to some AIDS campaigning groups about this, and I can say that a spin-off from this more generalised approach to the whole population may help to diminish the stigma which AIDS sufferers have to contend with. I repeat: it is a sexually transmitted disease like gonorrhoea, syphilis, trichomonas, chlamydia and even warts. Are your Lordships feeling uneasy yet, sitting on your red Benches? They are all sexually transmitted diseases and can be prevented. Let us be open about them all and push preventive messages for all of them, especially AIDS.

In their response to the report, the Government said at page 8 that they do,

"not support the Committee's recommendations on the need for a national campaign aimed at the general public, as there is little evidence that this would be effective".

Where is the evidence? I do not think we saw that evidence and we should if it exists. There should be no ifs and buts from the Government. We must massively increase preventive campaigns or face huge bills and destroyed lives. We must also have statutory sex-and-relationships education in our schools, covering all aspects of sexual activity. Stop caving in to the religious lobbies—state education must provide this.

We have another problem however—I hope on a lighter note—even if we got the Government to agree on these issues. It is the reorganisation of the health service which, as noble Lords probably know, is not one of my favourite topics. The Health and Social Care Bill will have a huge impact on the treatment, care and prevention of AIDS and every other sexually transmitted disease, because everything is being broken up. Treatment of the disease is to be commissioned by the national Commissioning Board and provided nationally. HIV prevention will be commissioned by Public Health England, I think either via or with local authorities. Sexual health promotion generally will become the responsibility of local authorities. Genito-urinary clinics, many of which treat AIDS patients too

[BARONESS TONGE]

at the moment, will be the responsibility of local authorities, but the AIDS bit will somehow have to be funded by the national Commissioning Board.

AIDS testing will be done by local authorities. GPs will be encouraged to monitor and maintain AIDS patients already being treated, but the cost of their drugs will be commissioned nationally. Failed asylum seekers with AIDS, still sexually active in the population, are currently denied free treatment. Who will be responsible for them? Do noble Lords get my drift? Said quickly, it all begins to sound like a Gilbert and Sullivan patter song. During the Christmas holidays, I am going to work on the NHS reorganisation plans to make a nice little ditty out of all those various quangos and the way in which they will connect with one another.

For example, why should cash-strapped local authorities—I have been a member of one—or Public Health England get excited about testing for AIDS or prevention of AIDS if the budget for treatment lies with another body? In reality, they will be one phase removed. Arguments about savings “in the long term” in my experience in management, fall on deaf ears because all budgets are short term and even Governments seldom look beyond the next election. Ah, but I hear you cry, we shall encourage integration and co-operation. This, I suppose, is where the health and well-being boards come in, but without representation on those boards from the national Commissioning Board responsible for AIDS treatment, how will they integrate? What about a local authority which has a particular religious majority, or just plain old-fashioned stigma, prejudice, ideology or disapproval. What about that authority? This may severely restrict the choices made and the services it provides.

As well as the health and well-being boards, health services require full staffing and plenty of resources for those staff to find the time to contact colleagues in other services to integrate and co-operate with. Call me an old cynic but I was in the thick of it for many years in the NHS and I know the reality. These words and phrases are pushed out so easily but are so difficult to implement in practice. Noble Lords will have gathered that I am disappointed by the Government's response, but I am prepared to accept that it may be different once they get to grips with the consequences of their own health reforms.

4.30 pm

Baroness Masham of Ilton: My Lords, I should like to congratulate the noble Lord, Lord Fowler, on securing the Select Committee on HIV and AIDS in the UK. Now we have the Government's response to the committee's report and this debate on 1 December. I think the noble Lord is Lord Fix-it. I was pleased to be a member of the Select Committee and thank the staff for their very hard work.

I have been a member of the All-Party Group on HIV/AIDS since its formation in 1987. In the early days of HIV/AIDS, the noble Lord, Lord Fowler, was Secretary of State for Health and instigated the campaign to warn people against the dangers of HIV/AIDS. To this day, many of us remember the lilies and the

tombstones. Some of us, who were in at the beginning of this serious virus, know that there is no vaccine and no cure, and that great effort should be put into prevention and research. The USA undertakes a huge amount of research but there is still no vaccine.

Spending on prevention is seriously inadequate. HIV is entirely preventable but the latest figures show that the Government spent only £2.9 million on national prevention programmes, compared with £762 million on treatment. In a number of cases, general sex or health campaigns have made no mention of HIV, so the public think that it is not a problem. There has been little in the press that confirms their idea that the virus has gone away. This disparity of spending persists despite the fact that preventing one infection avoids a lifetime of treatment, estimated to cost between £280,000 and £360,000. We recommend that a new national campaign should be mounted to tackle the ignorance and misunderstanding that still exist.

As I said, many members of the public think that HIV/AIDS is no longer a problem; they are wrong. There are many people living in the community who are HIV positive and do not know it. They may be infecting others unknowingly. Late diagnosis is a huge problem. People are diagnosed when they are seriously ill and often die within a year or are very expensive to treat. Our Select Committee suggested that there should be wider testing facilities, for example in GPs' surgeries.

A few years ago the very good GP surgery Lambeth Walk, which I visited, conducted a pilot scheme in testing for HIV. It was ideally suited because the surgery is close to St Thomas's Hospital, which has an HIV/AIDS unit for secondary care. I have heard that the pilot scheme ended and the testing did not continue. Will the Minister please look into why this project did not continue? Perhaps she would write to me.

We took evidence from many people who work for organisations that are involved with HIV/AIDS. One such body was the Health Protection Agency, which does an excellent job, working with infections. There is concern because in the Health and Social Care Bill now before your Lordships' House nobody seems to know what is happening to this independent body, which advises the Government and is well thought of throughout the world. I think the HPA falls into the category of, “If it ain't broke, don't fix it”. Could the Minister please tell the House what will happen to the HPA? We have the very difficult situation of drug resistance and the very problematical HIV virus which mutates. Research is so important and should be shared with the rest of the world in order to find a vaccine.

The HPA, or whatever it becomes, should still be able to do research and receive grants. There was concern that if it is absorbed into the Department of Health or Public Health England its independence may be lost. People with HIV can be very susceptible to tuberculosis and again there are strains of TB which are resistant to antibiotics. This is an increasing danger. Our report says that data on HIV in prisons must be improved. The Health Protection Agency should utilise surveillance and profile HIV within the prison population. At the same time a review exercise

into offender health services in public prisons is under way. The Government should supplement this with a review of the extent and nature of HIV prevention, testing and treatment services within the public prisons to determine the levels of provision across the country.

The Government's answer is that the Department of Health has worked with the Health Protection Agency to improve disease surveillance in prisons and provide prison-specific data on STIs, including HIV. The department and the HPA are aiming to disaggregate data on prison diagnoses next year. What will happen if the HPA is disbanded? I need an answer, being a member of the All-Party Parliamentary Group on Prison Health.

Throughout the process of taking evidence we found that stigma kept on coming up. HIV stigma is still a daily reality for many people living with HIV. A recent National AIDS Trust survey revealed that 69 per cent of people agree that there is still a great deal of HIV stigma in the UK. In a large-scale east London study, one in three people living with HIV had experienced discrimination. Half of all discrimination was in healthcare. The Department of Health must take a lead on this and develop training resources aimed at stopping such discrimination to be used by all current and new NHS and professional bodies.

One of our recommendations is that the Government, local authorities and health commissioners build on work already taking place within faith groups to enlist their support for the effective and truthful communication of HIV prevention messages. The Government agree but I read in the *Evening Standard* of 25 November that the London Church has been putting lives at risk by telling HIV-positive worshippers to stop taking their medication because God had cured them. After a healing process in which the pastor sprayed water in their faces and shouted over them, asking for the devil to come out, the patients were told that they could discard their medication. This is a death sentence but illustrates that there are many problems still to be overcome.

We found some excellent services and dedicated staff and volunteers when we visited Leeds, the Chelsea and Westminster Hospital, the Homerton Hospital and Brighton. I want to mention a gem that some of us visited in Brighton. High up on a hill overlooking the city, with a wonderful view, is the Beacon: a splendid, beautifully adapted house where people with HIV/AIDS can stay after they have been in hospital for a short time to rehabilitate before they go home. There should be more Beacons across the country for all sorts of long-term conditions. One finds good ideas often come out of HIV/AIDS treatment, and there are many aspects that would have been good for us to look at, such as children's facilities—children can become HIV positive from mothers giving breast milk—and end-of-life resources, but time did not allow for this.

I hope the report will be of use. There is something special about HIV/AIDS, as the virus and drugs are complicated. The priority aim should always be prevention. We must not forget that last year there were an estimated 3,800 UK-acquired HIV cases diagnosed.

4.41 pm

The Lord Bishop of Wakefield: My Lords, I am particularly nervous to follow the comments on the particular church background that the noble Baroness mentioned a moment ago. I would like to start with an example of where the church and church agencies have been rather more positive. Almost 20 years ago when I was in Rome for a series of meetings, I was taken to two or three projects in Trastevere, in the heart of the city. These included a language school for illegal immigrants, a soup kitchen and a hostel for children born with HIV/AIDS. It was a powerful experience, meeting the children and their mothers. The unit had been opened about a year before by Desmond Tutu and was entirely the initiative of the Community of Sant'Egidio, a lay community which now works throughout the world on the same sort of projects.

This commitment to HIV and AIDS was mirrored in this country by the churches in the early days of the Mildmay Hospital, the London Lighthouse and other early AIDS projects. Of course, there was some element of enlightened self-interest in this work. The churches, not least through their priests, have been affected by these diseases just as much as other organisations and agencies. Looking back to my experience in Rome, I was stimulated to think further about the complexity of this task and the way that that agency had found itself dealing with illegal immigrants at the same time as HIV/AIDS, and so on. Migration and the spread of the disease and other viruses have been a key part of all this, as indeed has the enormous growth in international travel. This automatically presents us with issues about the treatment of all people with HIV, regardless of where they come from or indeed their present resident status. Humanitarian concern places an imperative on us to make sure that all who are living with HIV/AIDS receive proper care and treatment. This point has already been made by noble Lords in this debate. Again, there is, of course, an element of enlightened self-interest in this. If we are selective in the way we face this continuing issue, we may indeed be storing up further trouble for our own society in the coming years. Disease and infection know no boundaries, either morally or internationally.

Just two months ago I welcomed representatives from across the Anglican communion, and especially from Africa, to a day consultation at Lambeth Palace on this very subject. I had been well briefed having spent two weeks in Tanzania only a month earlier, where I was introduced to projects. The focus at this consultation at Lambeth was particularly on sub-Saharan Africa, to which the noble Lord, Lord Fowler, referred earlier. It struck me at the time that in what I was saying to that consultation, I could equally well have been speaking to myself and to our own situation here in the UK. The situation is not something that we can take for granted, and that seems to have been made perfectly clear in all the speeches that we have heard so far in this debate. The situation here is as serious as it ever was. The figure of 100,000 that we heard at the beginning is terrifying, and it is increasing.

The Church of England is committed to the fight against HIV/AIDS through its community work in many places. In my own neck of the woods in the

[THE LORD BISHOP OF WAKEFIELD]
diocese of Wakefield, the St Augustine's project in Halifax provides help for asylum seekers, refugees and EU migrants, and to all those resident in the local community who need assistance. HIV and AIDS is, of course, an integral part of this, so we do work from first-hand knowledge in each locality.

In 2004, the Church of England produced a report which we called simply *Telling the Story: Being Positive about HIV/AIDS*. In a useful and concise manner it focused on many of the problems that we still face—for example, the question of openness about the crisis. It read:

“At the heart of the AIDS crisis lies the sin of stigmatization. Unless and until we address this central issue, whether it is manifested in our communities, expressed in our personal or national attitudes or, as in the case of Africa, is directed towards an entire continent, stigmatization will remain the single most resistant defence against any fulfilment of our promise to future generations”.

What the report said remains just as true now as it was then. It went on to say:

“If the Church's response is to be effective ... then we will need to understand that the only way that we can work for an AIDS-free world is to work for stigma-free hearts, individually, nationally and globally”.

Any one of us who has encountered people living with HIV/AIDS will know only too well of the difficulties that they have in finding the courage to be open about what has afflicted them and is threatening their lives.

Earlier, I noted that our attitudes to AIDS are related not simply to stigmatisation but to enlightened self-interest. This means that there are at least three practical ways in which we must respond to be effective. First, with regard to public health, new evidence shows that effective HIV treatment results in a 96 per cent reduction in onward transmission. Therefore, ensuring that everyone who needs treatment receives it is the key to tackling the UK HIV epidemic. Charging for such treatment deters people both from being tested for HIV and from seeking treatment.

Secondly, ending charging for HIV will, in the end, save the NHS money by preventing new infections and identifying HIV early, as the noble Lord, Lord Fowler, noted in his introductory speech. Then it can be effectively treated. This will reduce hospital costs and, indeed, expensive hi-tech treatment. Thirdly, there is no evidence to support the claim that there is a market in HIV “health tourism”, or indeed to suggest that the ending of charging in this country would lead in that direction.

I have mentioned once or twice issues of enlightened self-interest but ultimately the issues behind this debate take us to a far deeper level—to what is essential to our common humanity. Universally we owe it to each other to offer free and effective care in response to an epidemic which has wiped out whole populations in sub-Saharan Africa but which has also been, and remains, critical within our own society. Such fear still exists, so people are unprepared to talk about their condition and others are too frightened to face it when dealing with people pastorally or medically.

I remember, as I am sure do many other noble Lords, that some 25 years ago people whispered about the terrifying implications of the growth of AIDS.

Such whispering began on the boundaries of some of the homosexual communities in North America. Now, a generation on, this is no matter for whispering about, nor indeed is it the rumour of an impending crisis. The crisis is already upon us and it is also no longer an issue for homosexuals alone; it affects all parts of our community. The crisis is upon us and we owe it to each other as a society to respond with all the resources that we can effectively muster.

4.50 pm

Baroness Healy of Primrose Hill: First, I congratulate the noble Lord, Lord Fowler, on securing this important debate on World Aids Day and must say how privileged I was to have served on the Select Committee that was so expertly chaired by him.

The report calls for urgent action by the Government and I wish to highlight two recommendations in particular. Recommendation 72 states:

“HIV awareness should be incorporated into wider national sexual health campaigns, both to promote public health and to prevent stigmatisation of groups at highest risk of infection. We recommend that there should be a presumption in favour of including HIV prevention in all sexual health campaigns commissioned by the Department of Health”.

Recommendation 139 states:

“Ensuring that as many young people as possible can access good quality SRE”—

sex and relationship education—

“is crucial. We recommend that the Government's internal review of PSHE”—

personal, social, health and economic education—

“considers the issue of access to SRE as a central theme. Teaching on the biological and social aspects of HIV and AIDS should be integrated into SRE”.

The report makes it clear that although there is a widespread assumption that the danger has gone away, nothing could be further from the truth. Thousands of people are still being infected every year and the number of those diagnosed with HIV continues to grow relentlessly. Next year it is estimated that there will be 100,000 people with HIV in the UK. Although medical advances have ensured much better treatment and enabled those diagnosed with the illness to live much longer thankfully, serious medical and mental health problems remain for many with HIV.

As the report states:

“Patients can now live with HIV, but all those infected would prefer to be without a disease, which can still cut short life and cast a shadow over their everyday living”.

I highlight those two recommendations as part of the way forward to help prevent the disease and to increase understanding and tolerance by the public for those who have contracted the virus. The problem of stigma has already been raised by the noble Lord, Lord Fowler. It leads to isolation and fear of getting treatment and possibly prevents people seeking a test in case they are found positive and excluded by their community. Our report argues that the awareness of responsibility and risk must extend to the population as a whole, and general campaigns may be necessary to educate the wider population. Evidence from charities noted by the Select Committee suggests that a general HIV prevention campaign would be valuable. As the report says in paragraph 100:

"Discrimination against those affected by HIV is based, at best, on ignorance and, at worst, on prejudice, and we unreservedly condemn it. This underlines the need for a general public awareness campaign on HIV".

I am particularly disappointed that the Government have responded to this by saying:

"We do not support the Committee's recommendations on the need for a national campaign aimed at the general public as there is little evidence that this would be effective".

I hope they will think further on this and that with the publication of their new sexual health policy framework planned for 2012 they will have reassessed,

"where further work is needed to ensure a strong and sustained response to tackling HIV".

Complacency is not an option when looking at the scale of infection in the UK. As the report states:

"There has also been a dramatic increase in the yearly number of new HIV diagnoses since the late 1990s. This peaked in 2005, with more than 7,800 new diagnoses ... In 2010, there was a year-on-year increase for the first time since then, with an estimated 6,750 people diagnosed".

By next year, the report states, and I repeat, that the figure for people living with HIV is likely to be above 100,000.

The need to increase awareness remains, and so does the need to ensure that young people are taught about the illness and how to guard against it. The committee heard evidence of the increase in numbers of young people contracting the virus. The Health Protection Agency report of 6 June 2011 states that,

"a quarter of MSM"—

—men who have sex with men—

"newly diagnosed in 2010 probably acquired their infection 4-5 months prior to diagnosis, with higher recent rates in younger ages".

According to the HPA, in 2009 10 per cent of diagnoses for HIV were among those aged between 15 and 24 years-old. The National AIDS Trust has highlighted that since 2000 new HIV diagnoses among 15 to 24 year-olds have risen by nearly 70 per cent and among young gay men they have more than doubled. As a generation grows up without memories of the widespread health promotion messages of the 1980s, spearheaded by the then Secretary of State, now our formidable chairman of this Select Committee, the noble Lord, Lord Fowler, reliable HIV information for young people remains essential.

Given the lack of either a vaccine or a cure, then,

"prevention is better than cure when there is no cure",

as Dr John Middleton, vice-president of the UK Faculty of Public Health said. One of the best means of prevention lies in education. Present teaching looks at HIV and AIDS within the science curriculum. However, the separate subject of SRE, with its focus on broader social issues, which can increase levels of safe sexual behaviour according to the Sex Education Forum, should also be considered as part of HIV and AIDS prevention methods. While the report calls for the mandatory teaching of SRE in schools, the Government have indicated that that was,

"not the approach we are taking to education policy",

and that it was,

"imperative that parents will maintain a right to withdraw their children from SRE lessons".

Yet a recent survey commissioned by Brook, the charity, found that 43 per cent of young people said that their SRE was unsatisfactory or non-existent. More alarming is the recent Sex Education Forum research, which found that one in four young people did not learn about HIV in school, which was described by a government Minister, Nick Gibb, as "unforgivable".

The Select Committee report states that,

"ensuring that as many young people as possible can access good quality SRE is crucial",

and recommends that the internal government review of PSHE considers access to SRE as a central theme. In a report in 2010, Ofsted highlighted SRE as an area for improvement, finding that in a third of schools visited students' knowledge of SRE was no better than satisfactory. In a previous report, Ofsted expressed concerns about teaching around HIV and stated specifically:

"In particular, schools gave insufficient emphasis to teaching about HIV/AIDS. Despite the fact that it remains a significant health problem, pupils appear to be less concerned about HIV/AIDS than in the past".

I am pleased to see that the government response to this report states:

"The reviews of the National Curriculum and of PSHE by the Department for Education will take account of the Committee's recommendation",

but where compulsion is not appropriate I return to the report's call for a national sexual health campaign. We cannot afford to let public awareness of HIV and AIDS fade away, and young people must be given the information either through such a campaign or by better education in schools or preferably both. It will help young people to learn to look after themselves and their health better and to increase their understanding and tolerance of those who live with the illness. The success of the "Don't Die of Ignorance" campaign in the 1980s should serve as a lesson to the Government to ensure that young people do not live in ignorance today.

4.59 pm

Lord Lexden: My Lords, I join other noble Lords in congratulating my noble friend Lord Fowler most fervently on the excellent work of the Select Committee that he has chaired and on securing this debate on World AIDS Day. I approach any event involving my noble friend with trepidation. To my shame, I did not always have the answers to the perfectly straightforward questions that he asked me at Conservative Central Office, where I worked when he was party chairman nearly 20 years ago, yet with his customary kindness he always seemed to forgive me.

This is an immensely important occasion that should be noted by people and organisations that share the deep concerns that have been expressed so movingly in this House today. The Motion before us refers to the whole United Kingdom. The matters that we are considering affect all parts of our country. I am above all conscious of their impact on Northern Ireland, the place that has been closest to my heart since the 1960s when I began to study its history and went on to teach, along with British history, at Queen's University Belfast. Political responsibility for all health services rests of

[LORD LEXDEN]

course with the devolved Northern Ireland Executive, but on this day above all the interests of those suffering as a result of HIV/AIDS in the Province should surely form part of our general UK deliberations.

Northern Ireland has just one laboratory dealing with the results of tests carried out throughout the Province. It therefore enjoys a high degree of accuracy in its data. Equally importantly, the lab can gather evidence of rates of testing from all sources, enabling it to pinpoint areas where the most rapid improvement can be made. Over the years, Northern Ireland has enjoyed a relatively low prevalence of diagnosed HIV, but recent trends suggest that this may well be changing. The Health Protection Agency recorded 79 new diagnoses of HIV in Northern Ireland in 2010, which is a 316 per cent increase on new diagnoses in 2001. The increase for the United Kingdom as a whole over the same period was around 20 per cent. Rates of testing in Northern Ireland are not increasing in response to the state of affairs as rapidly as they should. Less than 10 per cent of all HIV tests are being performed in primary care settings. The vast majority are being done in clinics or in hospital.

As our Select Committee's report has made clear in comments endorsed so firmly by noble Lords speaking in this debate, the stigma and discrimination that continues to surround HIV must be eliminated. That is absolutely crucial in Northern Ireland if the number of tests performed in GP surgeries is to increase significantly. As my noble friend Lord Fowler stressed, and as other noble Lords have said, early diagnosis improves the chances of more effective management of this disease. Too many deaths of HIV positive adults are due to the diagnosis coming too late for effective treatment. As has also been pointed out, early diagnosis of a patient is also of major importance in preventing the spread of infection to others.

How might earlier diagnosis be promoted in Northern Ireland? First, there is a strong case for the increased availability and accessibility of testing in areas where people might otherwise go untested. Almost one-fifth of GP practices in Northern Ireland did not perform a single HIV test last year. Of those that did, half performed three or fewer. In some places, the story is more encouraging. Northern Ireland's south-eastern trust has made particularly good progress in increasing primary care testing, with a new clinic being established to serve the local community. It will be instructive to take note of the successes of the south-eastern trust and to consider how its innovations might best be extended to the rest of the Province.

There is also a strong case for the advocacy of point-of-care testing among targeted groups. Point-of-care tests such as the well known "determine" are easy to perform and can offer results within 15 minutes, which can be life-saving where time is of the essence. At-risk groups, such as the homeless, are not easy to contact and help if longer tests are employed, but we will not get the major increases in testing and early diagnosis that are needed in Northern Ireland without increased awareness among clinicians and staff of the issues surrounding HIV and AIDS, which often include the difference between them and the dispelling of misinformation.

Here too, there is some good news in the Province. The in-service HIV awareness training project began in Belfast during the hard-hitting campaigns of the 1980s initiated by noble friend when he was Secretary of State for Health. The project has made steady progress ever since. Around 60 HIV awareness trainers help staff and practitioners to understand the basic issues surrounding HIV and AIDS. They promote methods of early detection and diagnosis and address the changing character of the virus.

Since the project began, more than 40,000 staff have received training and the project has expanded to take in the south-eastern and southern trusts. The Belfast trust hopes that by 2013 the entire Province will be able to benefit from the training, which is devised in consultation with a wide range of organisations. In areas such as healthcare, which can have a high turnover of staff, projects such as this are vital in securing the quality and, importantly, the continuity of care that patients faced with an HIV diagnosis need.

In Northern Ireland, as in the rest of the United Kingdom, the advances that we have seen in medicines that help people to cope with HIV and AIDS must be accompanied by similar advances in the public understanding of the disease. If that does not happen, the disgraceful social stigmas that surround the issue will persist. The social aspects of HIV and AIDS are central if the goals advocated by this widely applauded report are to be met.

Public understanding, as we have heard, has certainly increased, but many of the stigmas that campaigns during the 1980s highlighted still persist for those with a positive diagnosis. Research carried out by the HIV support centre in Belfast on 40 of its clients reveals that over half have been verbally assaulted, harassed or threatened in the past 12 months as a result of their HIV status, and over 25 per cent had felt suicidal. One respondent to the 2010 people living with HIV stigma index said, "We are all afraid of rejection. The moment you tell someone you are HIV positive they just run a mile and never look back".

These are the attitudes that we must change. Not only are they hurtful and harmful to people with a diagnosis, they are also likely to deter people from seeking a test in the first place. It is shocking to think that someone might prefer to wait until a test is carried out in an intensive care unit than come forward at an early point because of the risk of being stigmatised and rejected by those around them, including their families and friends. Sadly in Northern Ireland this remains all too common.

If only we could create new antiretroviral medicines overnight. Sadly, as we have heard in this debate, it could be many years before the next great leap forward in helping people to live with HIV and AIDS. What we can begin overnight is a redoubled commitment to increasing public education on HIV and AIDS, a commitment to reducing the stigmas that HIV positive people face, and a commitment to preventative messages and projects such as needle exchanges as highlighted in this report.

We must continue to press for three things. First, more accessible testing is needed in places where people are unlikely to go to a clinic or hospital until it is too

late for effective treatment. Secondly, more training is needed for staff and professionals in order to increase the level of testing that is being performed outside hospitals or clinics. Finally, unequivocal support must be given to organisations, voluntary or publicly funded, that are helping to break down the barriers associated with HIV and AIDS today, and helping those struggling with the condition to lead happier lives. We must end the situation in which people considering being tested must perform some kind of social versus medical cost-benefit analysis. Only then will people with HIV receive all the benefits of early diagnosis. Only then will the public at large become fully aware of the true nature of HIV in the United Kingdom and the great steps forward that have been taken. Only then will those who follow us in the next generation be adequately equipped to protect themselves against its threat.

Keats's beautiful poem, *To Hope*, contains the following poignant lines, which seem particularly apt today, and I conclude with them:

"Whene'er the fate of those I hold most dear
Tells to my fearful breast a tale of sorrow,
O bright-eyed Hope, our morbidfancy cheer;
Let me awhile thy sweetest comforts borrow".

5.09 pm

Lord Rea: I thank the noble Lord, Lord Lexden, for his contribution and congratulate him on it. It was very refreshing to have someone who was not on the committee bring us some fresh insights and information from a part of the world which we did not visit.

Like all speakers, I congratulate the noble Lord, Lord Fowler, not only on his excellent introductory speech and on securing this debate on this day, but, more than this, on his dogged persistence with this issue over the past quarter of a century and his courage and correct judgment in putting HIV/AIDS so startlingly on the map in the mid- 1980s. As my noble professional friend Lady Tonge said, he faced strong disapproval and opposition from powerful members of the establishment, despite getting all-party support. He wisely persisted with the tombstone public education campaign as well as the controversial but highly successful needle exchange scheme which he has told us about. As result, the UK became the most successful country in the world in curbing the epidemic. In the developing world and some developed countries, the epidemic has continued to spread and, in sub-Saharan Africa, has resulted in the expectation of life for the whole population being reduced by 10 to 15 years with serious socioeconomic effects. But that is another debate, although a highly important one.

It was a privilege to serve on the Select Committee. I thank not only our chairman and our specialist adviser, Professor Anne Johnson, but also our two brilliant, dedicated clerks and, last but not least, our highly efficient secretary Deborah Bonfante, who handled the mountains of printed paper which passed before our eyes smoothly and effectively. Our witnesses, whether scientists, clinicians, voluntary sector workers or patients, were always knowledgeable and helpful.

I shall concentrate on some clinical and epidemiological aspects of the epidemic, emphasising, as all speakers have done, the imperative need for better prevention.

This was the common thread which drew all our witnesses together and is the theme of the report. It is often said that the persistence of HIV in the developed world is at least partly due, as the noble Baroness, Lady Tonge, said, to the availability since the mid-1990s of antiretroviral treatment that prevents HIV developing into AIDS, and that this has resulted in greater risks being taken by some sections of the sexually active population now that HIV is no longer a death sentence. Even if this was only partly true, it indicates widespread ignorance of the burden that living with HIV can cause, as several noble Lords have most vividly described, even when ARV treatment is being correctly given. Though some of them will live a full lifespan, others will not be so fortunate. There are often unpleasant side-effects, though they are now less common since combination antiretrovirals have become more refined.

The future health and lifespan of HIV-infected people receiving ARV depends very much on the stage that the infection has reached when treatment is started. Early diagnosis after infection is thus extremely important. ARV drugs are much less effective when there is a high viral load, so that full blown AIDS symptoms which are difficult and expensive to treat can develop, even when the subject is on ARV treatment. Fifty per cent of newly diagnosed cases in the UK are classified by the HPA as being at a late stage of infection, with a CD4 cell count of less than 350 per cubic millimetre, just over half of which are severely immunocompromised, with a CD4 count of less than 200. The late diagnosis rate varies from group to group, being highest among heterosexual men—63 per cent of them. It is estimated by the HPA that 22,200 people are living with HIV infection in the UK who are undiagnosed. Most of them are unaware of their condition; some of them are developing high viral loads which means that they will respond less well eventually to treatment as well as acting as a reservoir of infection.

HIV carriers who are being successfully treated, on the other hand, have a very low infectivity of 1 per cent or 2 per cent but even this low rate means that they must still use a condom or take other steps to reduce the chance of passing on their infection. So while acquiring HIV infection is no longer an automatic death sentence it is still a life sentence—it means a lifetime of medication and the other serious drawbacks I have described—a much worse fate than that of other sexually transmitted diseases which can now mostly be treated and cured.

In addition, as the noble Lord pointed out so vividly, people living with HIV are subject to a number of social consequences. We heard from several of our HIV-positive witnesses examples of stigma against people with HIV in employment and in social settings, despite successful ongoing treatment. Frequently there are psychological symptoms, sometimes very severe, including suicide. Life insurance policies and mortgages are difficult or impossible to obtain by HIV-positive people, according to the Terrence Higgins Trust. If after perseverance a policy is agreed, the premium is highly loaded and no cover will be given for illness or death from an HIV-related condition. That puts people at a huge disadvantage when attempting to live a full life, and buying a house, for instance.

[LORD REA]

The noble Lord, Lord Fowler, and others have described the increasing financial burden caused by HIV infection, particularly the cost of drugs. This cost is increased if HIV is detected late and complications have to be treated in hospital. But the main cost of HIV comes from the persistence and spread of the epidemic through sexual contact with HIV carriers who are not aware of their HIV status. As other noble Lords have pointed out, this is why one of the main messages from our witnesses and the report is the need to widen the screening net by testing in more settings than previously. In fact I suggest testing wherever a blood test is being carried out for any reason and on certain other occasions, for instance when a patient is having a health assessment or being registered at a general practice, for hospital out-patients or in-patients and in STD clinics even when a blood test was not originally planned.

The case for this policy is very well argued in the *Time to Test for HIV* report, mentioned by the noble Baroness, Lady Gould, published this year—or was it last year?—by the HPA. We visited a group practice in Brighton where routine HIV testing was done as well as the carrying out of general healthcare of HIV patients being followed for their HIV and treated by at the HIV unit at Royal Sussex County Hospital. When a positive test result meant that someone had a fatal disease there was a policy of only testing when suitable counselling for this eventuality was made available. Now that a positive test does not have quite such a dramatic meaning, it is acceptable for the test to be carried out by any suitably trained professional, providing of course that the consent of the patient is first obtained; an opt-out possibility must always be offered.

I have not covered our recommendations at all systematically. There are 53 of them; each has been covered by the Government's response and many of the report's recommendations have been accepted. I am particularly pleased that the recommendation to make home testing legal and quality controlled has been accepted. This was the suggestion of many of our witnesses. Also welcome is the lifting of the requirement for all overseas visitors to have to pay for HIV treatment. Lifting this charge makes good public health sense.

I was, however, disappointed in the Government's response—other noble Lords have mentioned this—to paragraphs 236 and 237 of the report, which called for the integration of HIV and sexually transmitted disease services. This is particularly relevant in the light of the changes envisaged in the Health and Social Care Bill now in Committee in your Lordships' House. I hope that the noble Baroness who is replying to this debate will be able to raise in Committee some of the issues that I am about to describe.

We heard justifiable concerns about the split between HIV treatment services to be commissioned by the National Commissioning Board, and the provision of prevention services for HIV and other STIs in genitourinary medicine clinics to be provided by local authorities—through their ring-fenced public health budgets, presumably. The proposed changes claim to enable integration between the services, but in this case it seems that the reverse is being proposed. Many

PCTs have increasingly brought HIV and STI services together under the same roof, as they logically should be. In this case the opposite seems most likely to occur. Perhaps the noble Baroness can tell us the department's latest thinking on this particular problem.

I was going to speak also about the future of the HPA, but that has been covered extremely well by the noble Baroness, Lady Masham, and, as I have now been speaking for 12 minutes, I shall end on that point.

5.21 pm

Lord May of Oxford: My Lords, I begin by paying tribute to the noble Lord, Lord Fowler, with sincerity undiminished by the repetition. He did a superb job of chairing an excellent committee. I thought I would be unique in paying tribute to our special adviser, but the noble Lord, Lord Rea, anticipated me. In choosing Anne Johnson, with whom I have had the privilege of working and publishing, for that job, she was not merely the best person in Europe but the best person, arguably, in the world. She was absolutely superb. She has a connection with this House that is not widely appreciated. If my memory is correct, she is the niece of a very distinguished late Member of the House.

I think the Government's response to our report was basically a good one. That must be borne in mind as I now go on to air the respects in which I found it disappointing. My speech will be perhaps a little different in that it will be more academic. However, it will be no less impassioned.

I have on a previous occasion drawn a graph with my hand and scattered my papers down the aisle and I risk doing it again. It is worth reminding the House what has happened not only with HIV but with sexually transmitted diseases. When HIV first appeared it was mainly among men who had sex with men and among drug users, and its incidence rapidly went down in this country, Australia and New Zealand because of effective measures such as those we have heard about. It then, for about 15 years, ticked along at a low level, slowly further declining among drug users and men who have sex with men and slowly increasing among heterosexuals to keep it at a roughly constant low level. However, over the past six, seven, eight years it has begun an upswing that shows no sign of diminishing. The question before us, which we have heard a lot about, is: why is this?

It is a fact that many studies of people—particularly young people—reveal that they are less well informed and less concerned about sexual health than was the case 20 years ago. As our report says, this is possibly because diagnosed early the majority of people with HIV can expect a near normal life expectancy. That is true and good and it needs emphasis, not least because it has a complicated and curious association with the stigmatisation initially that HIV was a death sentence. While that is true and good at the moment, it is not quite as simple as it is presented. We do not yet have clear sight of a vaccine. I declare an interest in this subject as I am co-author of the first and contentious prediction of the demographic impact of HIV on sub-Saharan Africa that was grossly pessimistically at odds with the World Health Organisation and

others, whose models were much more elaborate but epidemiologically stupid. To my great regret, we were right.

I have a continuing interest in a fact not commonly appreciated in debates such as this. Although our almost magical understanding of the interaction between an individual virus and the immune system cells can enable us to design a drug or sequence of drugs that suppresses viral replication, we still do not have an agreed understanding of the pathogenesis—of how the initial infection is handled. Escape mutants appear and at first they are handled, then finally the immune system goes down. My view is that it will be difficult to have a vaccine before we have an understanding that matches the brilliant descriptive molecular biology with a more complex sense of the incredibly complex dynamics of the immune system and the many escape variants that it is trying to handle.

At first, we could not handle the resistance that quickly evolved to the first antiretrovirals. My research group, among others, was involved in that in the 1990s. We now have a mixture of a richer panoply of drugs, combined with a better understanding of how to use them, and we can keep people alive—but how long that is going to last is not something that anyone can sign off on. It is not a question of whether eventually, as with any set of such agents, we will finally run into a barrier; it is not a question of whether but of when, in relation to the timescale of when we have a vaccine. One thing that we sought in our discussions was an estimate of that. I am pleased to say that very good people working on this are of the view—which I share—that we probably will have a vaccine before we run into the wall. But we do not have a guarantee.

We have a very good reason, well beyond that of simple compassion or the financial details that we have heard about, not to take our foot off the pedal but to keep emphasising the need to slow down and reverse the increase in the incidence. This is a three-pronged thing. We need uninfected people to appreciate the need to be more careful; we need infected people to be diagnosed earlier so that they can be treated earlier, which will make them less infectious to a degree; but to do that, the third prong, we need infected people to know that they are infected. That brings us to some of the key recommendations that did not get the in-your-face affirmation that I would have wished.

The first recommendation is that:

“HIV testing should be routinely offered and recommended, on an opt-out”—

not an opt-in—

“basis, to newly registering patients in general practice, and to general and acute medical admissions”.

I realise that that will not be popular with some groups, but that is what we recommended. We also said that routine and opt-out testing should be offered in other circumstances that are related to the trend in the upward rise of sexually transmitted infections—hepatitis is one, or associated things such as TB. The Government’s response to this was broadly welcoming, but speaking from my five years’ experience as Chief Scientific Adviser first to Major and then to Blair as a permanent secretary embedded as a kind of

anthropological tourist in a strange culture. I recognise, I am afraid, in the response to that recommendation, the caution and elevation of process over product that is characteristic of our well meaning and excellent Civil Service. I would like there to be a much more positive and unambiguous affirmation of the need to do that. I have resisted expressing that thought with colourful Australian adjectives.

Another of our recommendations is that we repeal the ban on home testing kits, with appropriate caveats. The Government supported us, but with subtle nuances of language they did not accept the recommendation, and said that they would review the policy. They will think about thinking about it. That is not good enough.

What is totally indefensible on ethical and common-sense grounds is our current policy that visitors or others without the right to live here can be freely diagnosed as having HIV but cannot be treated. This is ridiculous simply on common-sense financial grounds, much less unambiguous ethical grounds, because it demotivates people from even being tested. The government response did not agree with or even support us. It used the dread words “review policy”. That is not good enough.

In general, we also recommended,

“that the Department of Health undertake a new national HIV prevention campaign aimed at the general public”.

Here I shall go off-piste to offer a personal opinion on how best to do this. I am strongly of the view that wherever possible this sort of activity should be delivered though the NGOs, not the NHS. That is because some 10 years ago £400 million was put into a campaign on sexual health by the Department of Health. In the event, only 31 of 191 primary care trusts spent a penny of the money on sexual health, and none spent any of it on awareness campaigns. What fraction of that £400 million was given to NGOs? It was 1 per cent. It would have been much more effective if 1 per cent had been given to the primary care trusts and 99 per cent to the NGOs.

In summary, despite the negative tone of some of the things I have said, the Government have given us a welcoming response and they have a proud record in this, as we have heard. I was living in the United States when the committee of the noble Lord, Lord Fowler, was acting, and we watched in despair and distress as the same recommendations coming out of the US National Academy of Sciences to Ronald Reagan were seen as the kind of immorality you expect of a bunch of academics. I end by emphasising again that we have done well but we are not doing as well now. We have to put our foot back on the pedal and we have to be focused on effective prompt action, not on endless review.

5.34 pm

Lord Black of Brentwood: My Lords, like other noble Lords who have spoken, I warmly welcome the publication of this first-class and comprehensive report from the Select Committee, and I am delighted that we have an opportunity to debate it on such an important day.

If I may, I start with a personal tribute to my noble friend Lord Fowler. For nearly a quarter of a century, his name has been inextricably linked with this issue

[LORD BLACK OF BRENTWOOD]

and he has courageously trod an often lonely path. The Don't Die of Ignorance campaign was a phenomenally bold move. Looking back on it 25 years later, we can see that it was a seminal moment in the history of HIV and AIDS that without any shadow of doubt saved countless thousands of lives. I say to my noble friend that I was just over 20 when the campaign was launched and was therefore part of a generation of gay men who, without the very stark warnings the campaign contained, could have fallen victim to what was then an untreatable disease. My generation owes an enormous debt to the foresight and courage of my noble friend, those who worked with him and the pressure groups that so assiduously supported him. They gave us the gift of life.

I wholeheartedly endorse the conclusions of this compelling report, in particular the emphasis on early and better testing. There is no doubt, as we have heard so often during this excellent debate, that the issue of late diagnosis is now the greatest challenge in dealing with HIV/AIDS. As the report makes clear, delays in dispensing antiretroviral therapy have grave health implications for the person diagnosed, as well as the risk of onward transmission. As the noble Lord, Lord Rea, touched upon, the figure in the report that 52 per cent of adults diagnosed with HIV in 2009 were diagnosed late is shocking. The problem is even higher among those aged over 50, at over 65 per cent. This is becoming not so much a problem of the young but a problem of the middle-aged.

When treatment of HIV is so effective and easily accessed, with rarely any of the problems of unpleasant side effects that once occurred, there can be no excuse for this. We need, therefore, above all else, to get to the roots of this issue. That is what I would like to concentrate upon, drawing heavily on the report.

There are undoubtedly many causes—after all, this is a very personal issue—but I would like to highlight three. One is certainly education. I do not just mean what is taught in schools, where the report has valuable recommendations on incorporating sex and relationships education into the national curriculum to ensure that children are taught about security in intimate relationships; it is more the importance of education throughout life. As the problem of late diagnosis among those aged over 50 is real and pressing, perhaps we need to find, for instance, novel ways to educate older audiences too, by deploying information through the media and the opinion-forming channels which influence those in middle age.

The second is the role of GPs and health professionals. The report rightly highlights how,

“a major obstacle to more widespread testing seems to be with those who could offer the test”.

In other words, some GPs avoid recommending a test to those who might have HIV because of misconceptions about the need for counselling, time constraints and, above all, stigma.

When I was preparing for this debate I visited the excellent Bloomsbury Clinic within the Mortimer Market Centre in Camden a few weeks ago. I heard a dreadful story there of someone who made his way to the clinic after having been ill for two years with a variety of

conditions that should have shouted to his GP “HIV” from the rooftops. This person had never been given a test by his GP; by the time it was discovered, when he found his way to the clinic, full-blown AIDS had set in and the person involved lived barely a few weeks.

That sort of situation, rare though it is, is completely unacceptable. I hope that the recommendations in the report on the need for practitioners to become more confident in identifying those at risk of HIV are acted on without delay.

However, perhaps the single most significant problem remains that of stigma, as many noble Lords have said, most movingly, perhaps, in the examples given by my noble friend Lord Lexden. Of course, there have been remarkable strides in addressing the fear and misunderstanding of HIV, which are the wellsprings of stigma. Enormous credit must go to those many organisations—we have heard about the National AIDS Trust and the Terence Higgins Trust, which do remarkable work—which have fought tirelessly to combat HIV, as well as to the wonderful clinicians who work with patients and give them the confidence to deal with it.

However, there is much more to do and it is absolutely central to the issue of diagnosis, because fear of stigma and fear of testing are inextricably linked. Consider this: in the 2009 *People Living with HIV Stigma Index*, as we have heard, one in eight HIV-positive people living in the UK reported being physically harassed in relation to their HIV status in the previous 12 months. More than one in five had been verbally assaulted or threatened.

My noble friend Lord Fowler quoted from the survey on public knowledge and attitudes undertaken last year by the National AIDS Trust, which does such fantastic work in this area, about how people would regard a neighbour who was diagnosed with HIV, quoting, quite rightly, “Love thy neighbour”. There is an even more shocking figure in that survey that 20 per cent of respondents disagreed with the proposition that,

“if someone in my own family told me they were HIV positive, it wouldn't damage my relationship with them”.

Therefore one in five would have a more negative view of someone in their own family who was diagnosed.

Four areas of action need to be taken to tackle stigma, and the report very helpfully points the way in some of them. The first relates to healthcare professionals; sadly, as the noble Baroness, Lady Masham of Ilton, said, half of all discrimination reported by people with HIV is in healthcare, particularly in the case of dentists and GPs. Yet those are the very people who should be encouraging testing then, when somebody is diagnosed HIV positive, ensuring that they get swift and effective treatment from experts at the brilliant HIV centres around the country. NHS staff need consistent, high-quality and, above all, continual training about not just the basic facts regarding HIV but the unacceptability—indeed, the unlawfulness—of HIV discrimination, and about the actions that need to be taken to ensure that patients with HIV have the respect and support they deserve. Here, the new NHS Commissioning Board has a vital role to play in requiring anti-stigma training, especially in primary care.

The second area relates to general public information. Undoubtedly, “Awareness of HIV”, in the opening words of the report, is “below the public radar”. What that means is that public understanding of HIV transmission has also decreased significantly in the past decade. The Ipsos MORI surveys commissioned by NAT, which we have heard mentioned today, have over the past few years shown an increase in the number of people believing HIV can be transmitted through kissing. Less than half those questioned cite sharing needles as a possible route, although that is actually the second most common transmission method. These misunderstandings foster stigma because of the link between poor understanding of how the disease is transmitted and a judgmental attitude towards people living with it. Education in schools is obviously vital here, but so are local sexual health campaigns and information to ensure that, at the local level, people have accurate information on how HIV is and is not transmitted.

The third area relates to the media; here, I must declare my interest as executive director of the Telegraph Media Group. Undoubtedly, HIV scare stories in some small parts of the media still foster the fear that is the basis of stigma. While HIV and its ramifications are complex issues to report, not least because they can often become entwined with other emotive subjects such as immigration, there is never an excuse for inaccurate reporting when it can have a terrible human cost. Some progress has been made. The National AIDS Trust, working with the help of the Press Complaints Commission, has produced excellent guidelines for reporting HIV which have started to make an impact. They cover the law, the myths, the vocabulary and issues about testing. They are extremely important in tackling stigma and I encourage their wide dissemination in newsrooms across the media.

My fourth point relates to public policy. The Government’s recent mental health strategy has, as one of its six objectives:

“Fewer people will experience stigma and discrimination”.

The Government are, rightly, backing this with significant funding. HIV is in many ways comparable to mental health in terms of conditions that arouse fear and foster stigma: yet there is no strategy or funding in place specifically to tackle HIV stigma and its resulting harms to public health. As the noble Baroness, Lady Gould, said earlier, such a strategic policy could work across departments and disciplines, involving education and teachers, the police, social workers, the media and, above all, healthcare professionals to tackle stigma at its roots.

Of course, money is tight but investment in a strategy of this sort would be perhaps the most cost-effective money the Government could ever spend. Various noble Lords have quite rightly pointed out the simple maths, which I am afraid were never a strong point of mine. I would look at it this way: £1 million spent on an HIV stigma strategy would be recouped by preventing just four of the 2,656 confirmed UK-acquired infections diagnosed in 2010. It is just four; once we get to the fifth, we have started saving. If it were successful, the long-term savings to the public purse could be considerable. Taken together, these four steps could

significantly help tackle the stigma, encourage more people to get tested early, help prevent onward transmission of the virus, and ensure a better quality of life for the 100,000 people who will soon be living with HIV.

In my closing comments, I want to mention those 100,000 people. Thanks to effective treatment, there is no reason that they should not lead long and healthy lives. However, we have to recognise that HIV is now a chronic illness, that our understanding is relatively new, and that we do not know what its long-term consequences might be, or the long-term effects of the drug therapies, particularly in terms of other conditions that those living with HIV might contract. If you have HIV, every illness that you get could potentially impact on your treatment regime. As people live longer, this is going to become a much more complex issue to deal with and the model of care, as the report notes, will need to change accordingly. That means a holistic approach to treatment, with regular access to specialists in the field for all those with HIV.

For a number of reasons, some of which I mentioned earlier, GPs may not be the best suited to this task. I am cautious of any moves to give them primary responsibility in this area when it is specialist care which is going to be increasingly vital as the health service copes with an increasingly elderly population living with HIV. Ideally under the new commissioning arrangements, designated centres of excellence for HIV treatment and care should be the ones responsible for ensuring the most effective, convenient, continuous and flexible therapy for all HIV patients. I believe this would be likely to offer better longer-term results in quality of care than the strategy of giving GPs shared responsibility with specialists.

In my remarks today, I have tried to touch on a wide range of subjects. I could go into nearly as much detail as the brilliant report that we are considering. That is a point that underlines how complex this issue is in public policy terms. We are fortunate indeed that this report has given us the opportunity for such an important debate. I hope that in its way it can be as effective as the original campaign 25 years ago—this time not just so much about saving lives, but improving the quality of those lives. That is the great and noble task ahead.

5.47 pm

Baroness Massey of Darwen: My Lords, I, too, thank the noble Lord, Lord Fowler, for securing this debate and I thank the Select Committee for producing such a timely and thorough report. I was not a member of that committee, but I want to make some general comments about prevention campaigns, then focus on prisons and schools and ask the Minister about the Department of Health’s new sexual health policy framework. It is an honour to follow so many well-informed, even poetic, speeches. I know that all those noble Lords who have spoken today have a long-standing commitment to HIV/AIDS prevention and treatment. In thanking Lord Fowler, I have to say that he is one of my public health heroes.

At a time when HIV/AIDS was emerging as a health threat, when the public response was one of fear, confusion and prejudice which sought to stigmatise

[BARONESS MASSEY OF DARWEN]

certain groups, the noble Lord remained calm and reminded us that this was a health issue that needed to be tackled firmly. I know this because I was working in public health at the time, and how glad we were that he was in post. Yes, there were, I believe, icebergs and tombstones—sometimes misinterpreted by the general public—and maybe we would do some things differently now. However, the noble Lord, Lord Fowler, certainly had a great impact on those campaigns of public awareness.

The rampant and unthinking prejudice which emerged then still has echoes in the ignorance and dangerous attitudes of some people who oppose sex education and sexual health promotion today. It is interesting that other public health issues, such as vaccination, smoking, wearing seat belts and so on, are not connected to sex, or are perhaps only marginally, and so are not fraught with the connotations attributed to HIV and AIDS. In the government response, the high cost of treatment is described as a compelling investment. In 2010, prevention could have saved over £32 million annually. I was pleased that the committee recommends both targeted, intensive campaigns and, very importantly, that awareness should be incorporated into wider national sexual health campaigns, with evaluation commissioned by the Department of Health.

There should certainly be a new national HIV prevention campaign targeted at the general public. Let me say briefly why this is important. There has not been such a campaign for a long time. The high profile of HIV/AIDS has decreased and the problem of HIV infection and other sexually transmitted infections is increasing. We are in a new era of communications. We now have the internet, social networking of many kinds and highly sophisticated mobile phone applications. All are wonderful but they can also be misused, as we have seen in grooming and internet and mobile phone bullying. I have sympathy with the support of the noble Lord, Lord May, for NGO involvement in such campaigns.

Apart from HIV and AIDS, there are other dangers, some rather curious. I was in Nottingham last week, discussing substance misuse and public health. I must declare an interest as chair of the National Treatment Agency. As I learnt in Nottingham, there is concern about the injection of steroids in relation not just to bodybuilding but to the desire for the body beautiful. There is also concern about the injection of a substance that will give a body tan that also enhances libido. In Nottingham, people were found who have contracted HIV/AIDS and hepatitis B through these practices. It is very worrying and a call to renew our look at how we campaign.

Prevention campaigns have to be part of general health campaigns, using ever more sophisticated and subtle means of communication with adults and young people. I am also glad that the committee has shown concern for future structures in public health. Such concerns were highlighted by the noble Baroness, Lady Tonge, and many others. As the report points out, sexual health has often been the poor relation of the health service. The voluntary sector has done an enormous and valuable amount to tackle HIV and AIDS. We all wait to see how drug, alcohol and sexual health services

will fare in future public health services with a ring-fenced budget. They must not be lost among other demands. I know how ring-fencing has in the past enabled drug treatment to improve the numbers in treatment and waiting times. Health and well-being boards and other local monitoring groups must be vigilant about keeping HIV on the agenda.

The public health White Paper, *Healthy Lives, Healthy People*, spoke of working,

“towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services”.

It points out that testing should be a priority of any prevention policy. Prevention has been spoken about a great deal today. The testing of pregnant women has been a success. Other testing, such as by GPs and home testing, could be effective, as many others have pointed out.

I now want to talk about schools, which were referred to by others, including my noble friend Lady Healy. Schools should be considered part of the community and, therefore, connected to community services. There have been good examples of older pupils in schools visiting Brook Advisory Centres as part of the PSHE programme. This encouraged them to seek advice, perhaps after leaving school. Schools should also teach about public health issues. The danger of HIV infection should be taught as a specific issue, not just in sex education—if it exists. I should like to see secondary schools teaching compulsory modules on public health. This would go alongside teaching about respect for oneself and others, decision-making, self-esteem and communication skills. All these skills can reinforce the ability to behave responsibly in relation to sex and substance misuse. I am not talking here about explicit sex education for five year-olds and I do not believe that schools are either. Those who rant about sex and five year-olds should visit some schools and inform themselves about the responsibility of school governors, some of whom are parents, for the curriculum.

We have suffered recently from a barrage of misinformation and prejudice about teaching sex education. Such misinformation is an insult to teachers, parents and school governors and it should have a health warning on it. Primary schools, including five year-olds, can discuss relationships with family, friends and the community. Children have rights and responsibilities. They can learn about keeping themselves and others safe. Later, this foundation of rights and responsibilities can be used to teach about drugs, alcohol and sex. Lack of information and misinformation are highly dangerous.

I turn briefly to offender health. People in prisons are a high-risk group in many ways. Among them there are significant levels of illiteracy and mental health problems. We know that some prisoners use drugs and have sex. But, significantly, prisoners leave prison and may spread infections. The recent report on prisons and drugs chaired by my noble friend Lord Patel of Bradford recommended: a cross-government strategy; a streamlined commissioning system; a framework for service delivery; user and carer involvement—that is very important; and links to the wider criminal justice and health and social care systems.

For HIV we need all those things. We need guidance to prison governors and clarity on best practice in managing HIV in prisons, to include provision for prevention, testing and treatment and data collection. I hope that clinical commissioning groups will address, monitor and evaluate the outcomes of interventions in prisons. There must be continuity of care. The programmes to identify substance misuse and provide individual key workers to help with employment, housing and other social issues have proved highly successful.

The report on prisons highlights many significant issues for HIV and AIDS prevention and management of services. I very much look forward to following what happens in the new structures for public health. I hope that the Minister can give us a preview of the sexual health policy framework. I also hope that, perhaps in two years' time, the noble Lord, Lord Fowler, will reconvene a committee to look at the outcomes of these new structures and the impact of the sexual health policy framework. As usual he has done a great favour to those concerned for public health. I again congratulate him and the committee on this debate.

5.57 pm

Lord Gardiner of Kimble: My Lords, it has been a great privilege to serve on the Select Committee under the chairmanship of my noble friend Lord Fowler. It has been a particular privilege to serve with colleagues across your Lordships' House, our professional adviser and clerks, who all know so much more than I do about this devastating and serious virus.

I fear that I may have asked some all too obvious questions. My first was because I failed to understand—and still do—why antiretroviral drug prices need to vary across the country. I am a supporter of localism but surely it is desirable to procure nationally if this means that more competitive prices can be achieved across the country and significant savings can then be utilised on the front line of treatments or, indeed, on prevention measures. In the Government's response to the committee's report, it is acknowledged that beyond London regional procurements have been less successful. However, I do not see that rectifying this has been viewed as a priority. I hope that I am wrong. Predominantly, it has been a privilege to hear directly from exceptional professionals, dedicated volunteers and courageous and inspirational people who live with HIV.

Your Lordships have already heard that in this country the stark facts are that the number of people living with HIV is increasing—it is now more than 100,000—with treatment costing £1 billion a year. In the world some 34 million are now living with HIV/AIDS. The rate of infections in the world is thankfully slowing yet in the UK the rate is increasing, so now is the time for the UK to tackle this virus with renewed determination. With early diagnosis we can enable the majority of people with HIV to have as normal a life as possible. The drugs have transformed the prospects for so many. However, we must now concentrate even more tenaciously on prevention. This is the key to all our aspirations to defeat HIV/AIDS and eventually eradicate it.

Some prevention measures in the UK have been outstanding successes. Many noble Lords have already referred to the clean needle programmes and routine antenatal testing of pregnant women. More generally, however, our financial commitment to prevention campaigns for too long has been disproportionately low. The lifetime cost of treatment of a single patient is nearly £360,000. Yet £2.9 million, as has already been referred to, is all we will spend on national prevention programmes in 2011-12. The Government in their response recognise the benefits that investment in prevention would offer. We need to do more than that. We need action. There must be a far more robust attitude, a sense of mission on prevention, which my noble friend Lord Fowler so admirably galvanised and led in the 1980s.

We must be bold about prevention programmes. Is the UK rate of infection increasing because we have not been? Of course our efforts should be focused on the parts of the community most at risk. But should not HIV also be seen as part of the overall sexual health campaign? The more we place it in that context, the wider the message reaches. I do not understand why the Government are so adamant that a national campaign aimed at the general public, which the committee recommended, would not be effective. I apologise to the Minister, but when the national campaign led by my noble friend Lord Fowler is universally acknowledged as having been extremely effective, I do not understand the Government's initial response. At the same time, the Government quite rightly accept that more needs to be done by all to address behaviour that increases the risk of HIV infection. I urge the department to look at this with urgency as it formulates the new sexual health policy framework. I am sure the department will be widely supported in being robust in considering all the options when prevention contracts end in March next year. I also hope that upon gaining new responsibilities, local authorities will prioritise prevention.

No responsible person underestimates the financial pressures we face in this country; new money is more than hard to find. However, we will fail to be cost effective if we do not direct scarce resources towards prevention. Even with the success of antenatal testing, last year over 70 babies were born HIV positive; that is, 70 children with the prospect of medication all their lives. It is a sobering and distressing thought and we must do better.

One element of serving on the committee which most affected me was learning about the consequences of late diagnosis in terms of quality and expectancy of life. Some 52 per cent of adults in 2009 were deemed as diagnosed late: heterosexual women at 59 per cent and heterosexual men at 66 per cent. Two-thirds of those over 50 were diagnosed late. That may be a profile that is not what many would have expected. Going further, 30 per cent of new diagnoses are in the very late diagnosis category. This is a frightening percentage with many adverse health implications.

In committee we discussed testing at some considerable length and received much evidence. The current situation surely warrants that we should look at the whole issue of testing and its expansion. Antenatal testing is now

[LORD GARDINER OF KIMBLE]

seen as a routine and uncontroversial procedure. Is this not the route we should now take? As part of tackling stigma and discrimination, should we not be looking to normalise as much as possible our approach to testing? Why cannot HIV testing on an opt-out basis—as the noble Lord, Lord May of Oxford, has already highlighted and as is recommended in our report—be routinely offered and recommended to new registered patients, to general and acute medical admissions and on entry to prisons? The wider we test, the more we can break down stigma. The more we do so, the more likely that people will come forward, be tested and, if necessary, receive medication. Therefore, I endorse the Government's comments that HIV testing should be within the competence of all doctors and nurses, and I welcome the department's review of the policy which bans the sale of home-testing kits. Echoing the noble Lord, Lord May of Oxford, I hope that the review will, in turn, move to action.

I came to the deliberations of the committee with a fresh mind. I can see, alas, that we in the UK have been faltering in our national efforts to conquer this dreadful virus despite the supreme dedication of superb professionals and volunteers. We need renewed vigour and courage to seize this moment. Every new infection of a baby, a young person, a man or a woman takes its toll on the patient and on their family and friends. Medical advances since the 1980s have been dramatic, yet no cure is in sight. It is on our watch now that we must be innovative and bold on prevention and compassionate to the all too many people who live with HIV.

6.06 pm

Lord Collins of Highbury: My Lords, I, too, congratulate the noble Lord, Lord Fowler, on initiating this excellent debate. I have huge respect for the work that he has done and continues to do in raising awareness of HIV and AIDS.

I also pay tribute to all the members of the Select Committee for producing such an excellent and timely study. I say "timely" because only this week the Health Protection Agency warns that the virus is on the rise again in the UK. As we have heard in today's debate, more than 100,000 people will be living with HIV in the UK by the end of the year, and, as the noble Lord, Lord Fowler, said, more than a quarter of HIV infections remain undiagnosed—that is, in people who have not yet had a test and do not know that they are infected.

The HPA reported that new diagnoses of HIV in men who have sex with men have hit a record high, with around 3,000 men diagnosed in one year. That is the largest annual figure ever recorded. It was 1,820 in 2001, 2,660 in 2005, and 2,790 in 2009. As many noble Lords have said, it is time to break the silence and stigma around HIV, and this report is a very welcome step in helping us to do that.

Early diagnoses and the excellent treatments now available from the NHS mean that many have a chance of avoiding the worst consequences of this virus. As the noble Lord, Lord Fowler, reminded us, when the epidemic began 30 years ago, people with HIV swiftly became sick, developed AIDS and died of infections,

such as pneumonia, which their bodies could not fight off. Today, combinations of antiretroviral drugs keep people alive and healthy, and can give them a relatively normal lifespan as long as they stay on the medication. This means, too, that the number living with the virus continues to rise.

Early preventive action not only saves lives but saves money. This is where I also want to amplify the conclusion in the report that a new priority must be given to prevention. As many noble Lords have said, spending on preventing infection is seriously inadequate—just £2.9 million compared with the £762 million treatment bill. I very much regret that the Government dismiss out of hand the committee's recommendation for an advisory committee for HIV prevention research. Such a committee might give us a clearer indication of the effectiveness of some of the public campaigns.

An area that I want to stress in particular, evidenced in the committee report, is the link between prevention strategies and treatment. As my noble friend Lady Gould and others have said, that link is tested. As I have said, more than a quarter of those with HIV in the UK do not know that they have it, which means that they may be unwittingly passing it on to others and may not be diagnosed until they are ill and treatment is more difficult.

As my noble friend Lord Rea said, in 2010, 50 per cent of all new diagnoses were made late—in other words when the CD4 cell count falls below the level at which treatment is recommended. The proportion diagnosed late is higher in heterosexual men—63 per cent—and heterosexual women—58 per cent—than among gay and bisexual men—39 per cent. Black African and Black Caribbean people are more likely to be diagnosed late than white people. People diagnosed over the age of 50 are more likely to be diagnosed late than younger people. While progress is being made, it is being made very, very slowly. At the current rate it could take 50 years to eradicate the late diagnosis and start treatment on time.

As the noble Lord, Lord Fowler, reminded us, of the 680 people with HIV who died in 2010, two-thirds were people who had been diagnosed late. On the other hand, the outlook for people who are diagnosed promptly is excellent, with life expectancy just a few years shorter than that of people without HIV. Will the Government do more, as the Select Committee and the HPA ask, to increase access to HIV testing? For example, the report advocates that such testing is routinely offered to new patients of GPs and at hospital general admissions in areas of the country where rates of HIV infection are high. While I welcome the Government's positive comments, including reviewing the ban on the sale of home testing equipment, I believe, as the noble Lord, Lord May, said so effectively, that more needs to be done to incentivise public health commissioners to prioritise HIV testing. With responsibility for HIV prevention moving to local authorities, it is vital to look for ways to ensure they are prioritising this issue and to invest in effective targeted prevention work. It must be a key performance indicator. Like others, I very much hope that it remains in the final public health outcomes framework. However,

there are currently no plans to include a specific public health outcome measure on HIV prevention or sexual behaviour. I should like the Minister to respond to that.

This lack of emphasis from central government is exacerbated, as we have heard today, by distribution of budgets and responsibilities in the new health structure proposed in the Health and Social Care Bill. As local authorities will not be paying for HIV treatment out of their budgets—this will be funded by the NHS Commissioning Board—like others, I am concerned that there is no cost-saving incentive to prevent further transmission. The Bill proposes significantly to increase the power of local authorities through health and well-being boards. While I am not opposed to greater local power in principle, I am concerned that the new structure opens the door for an ever-increasing politicisation of public health, which could have a severe impact on less socially acceptable health conditions, such as HIV. There are still considerable negative associations and stigma attached to HIV and a severe lack of knowledge about HIV among the general public, as the National AIDS Trust's recent Ipsos MORI research study report showed. This makes it particularly vulnerable to prejudice and can silence local voices of people with HIV. Stigma, prejudice, ideology or disapproval can threaten evidence-based interventions which meet the health needs of groups most at risk of HIV. There is potential for the increased role for elected officials to pose a threat to the continuation of the high-quality services needed to tackle the HIV epidemic in the UK. Indeed, in some places, HIV organisations have already begun to experience barriers when working with local politicians. Therefore, I urge the Minister to acknowledge how important it is for the Government to understand this and to build suitable protections into their reforms package. This should be through HIV-related outcomes in the NHS public health and social care outcomes frameworks. There should also, in relation to HIV and sexual health, be a detailed mandate from Public Health England to local authorities which sets out the essential elements of a comprehensive sexual health service, as my noble friend Lady Gould urged. It is vital that the Government ensure that stigmatising views of HIV, and around sexual health more broadly, do not affect decisions about local public health services.

As the Select Committee report said, stigma and lack of understanding can undermine HIV prevention efforts. Misinformation circulated about HIV, suggesting that it is a judgment or that it can be cured through non-medical methods, poses a threat to public health messaging. This is especially the case when such statements are made in faith-based settings, given the significant influence of faith leaders in some communities. As someone who still finds leaflets from local churches in Finsbury Park offering cures for AIDS, I know how important such work is, as the noble Baroness, Lady Masham, reminded us. I am therefore pleased that the Government agree with the Select Committee's recommendation about the valuable contribution that faith leaders and faith groups can make to HIV prevention and care services. When linked to projects such as the African Health Policy Network's Ffena programme, which has trained more than 100 people living with

HIV to become advocates for understanding of the condition, we know the policy can make a real difference in our communities. These sorts of projects involving HIV-positive people as advocates and confident service users are a vital tool in addressing stigma through publicising the condition and encouraging dialogue. It is really important that the Government ensure continued support for this work, especially in these difficult economic times.

After recent research that showed that drugs can protect against the transmission of the virus, I also welcome the report's call for immediate reviews into the possibility of putting people on medication sooner and offering it to their uninfected partners. However, I fully accept that such a policy should be considered after detailed research into the particular circumstances pertaining in this country.

Finally, I want to turn to the Health and Social Care Bill's proposals on health and well-being boards. Many noble Lords have mentioned them in the debate. They will be central to the integration of services. However, I share the concerns expressed by many HIV/AIDS charities that the NHS Commissioning Board will not be routinely represented at all health and well-being board meetings. Without the presence at health and well-being board meetings of those commissioning HIV services, there is a real risk that the importance of HIV prevention, as well as the concerns of people living with HIV, will be sidelined in favour of areas where there is a direct financial benefit, and which, perhaps, are not as potentially controversial. I ask the Government to do more to ensure the presence of representatives from the NHS Commissioning Board at health and well-being board meetings and to guarantee that voices representing the needs of people with HIV are heard in the deliberations of those boards.

6.20 pm

Baroness Northover: My Lords, I congratulate my noble friend Lord Fowler on securing this important debate today, World AIDS Day. He has an outstanding record as the person who very much shocked us into an awareness of AIDS. He also deserves plaudits for his continuing interest in HIV and AIDS nationally and internationally, an interest that has done much to raise awareness inside and outside Parliament. As we know all too well, in issues such as this awareness is a significant part of the battle.

The report by the House of Lords Select Committee on HIV and AIDS in the United Kingdom, *No vaccine, No Cure: HIV and AIDS in the United Kingdom*, was most timely, given that it was 25 years ago when my noble friend led the Government's response to HIV and AIDS. I commend the outstanding membership of this Select Committee, many of whom have a long record of work in this area, as I know from when I was an officer of the All-Party Parliamentary Group on HIV and AIDS. This report will help to inform the Department of Health's new sexual health policy framework planned for next year.

In October, we published the Government's response to the report and made clear that we agreed with many of the Committee's recommendations on combating HIV and AIDS. World AIDS Day provides an excellent

[BARONESS NORTHOVER]

opportunity to reflect on the progress that we have made. Globally, there has been progress. The epidemic has stabilised in many regions. New infections have fallen by 21 per cent since 1997. Nearly 7 million people are on antiretroviral treatment—a more than tenfold increase over five years.

Today is also an opportunity to recognise the continuing challenges presented by HIV, both globally and at home. More than 34 million people are living with HIV and, as noble Lords have noted, there is no cure or vaccine in sight. Around 10 million people in need of treatment are not getting it. There are more than 7,400 new HIV infections every day, which is two for every person who begins receiving treatment. To compound the problem, HIV funding is flatlining, about which we can read more in today's papers.

While the scale of the epidemic is very different in countries such as the UK, as my noble friend Lord Fowler pointed out, we are not unaffected by the global picture. Effective treatment from the NHS can transform the lives of those living with HIV or AIDS, but there is no cure or sign of a vaccine and HIV still attracts considerable stigma, which is a huge challenge.

The Government's early response all those years back, led by my noble friend Lord Fowler, has helped to make sure that the UK has remained a relatively low prevalence country for HIV, particularly compared with some of our European neighbours. The early introduction of needle exchange and harm minimisation programmes, for example, has meant that we have very low rates of HIV in drug users who inject, unlike in other countries, as my noble friend pointed out.

Earlier this week, the Health Protection Agency published its annual HIV report for 2010. There are now around 91,500 people living with HIV, of whom around a quarter are unaware of their infection. This means that they are unable to benefit from highly effective treatment and risk unwittingly transmitting HIV infection to others. The HPA also reported that in 2010, new diagnoses in men who have sex with men—MSM—reached a peak of 3,000, and MSM remain the group most at risk of HIV transmission in the UK.

That is why I very much welcome the report's focus on the importance of HIV prevention. The Government agree that we need to be more effective in supporting responsible sexual behaviour. HIV prevention makes good economic sense too, as noble Lords have pointed out. The HPA estimated that preventing the estimated 3,800 HIV infections acquired in the UK in 2010 would have saved over £32 million annually, or £1.2 billion over a lifetime, in costs.

This year, the department has invested £2.9 million in a national programme of HIV prevention for men who have sex with men and for African communities, delivered by the Terrence Higgins Trust and African Health Policy Network. On top of that, the NHS provides many HIV prevention services, some funded separately and some funded as part of mainstream services such as testing and distributing information and condoms. The Department of Health is currently considering how national HIV prevention programmes

might be taken forward when the current programmes end. The Committee's comments will help to inform what happens.

Of course, effective prevention requires effective testing. Late diagnosis is the most important factor associated with HIV-related morbidity and mortality in the UK. We agree with the Committee that HIV testing should be offered more widely and in various healthcare settings, particularly in areas of high prevalence. In September 2011, the HPA published its final report on pilots which the department funded in 2009-10 to help to reduce late diagnoses of HIV. The findings were encouraging and patients responded to being offered HIV tests. We are also funding the Medical Foundation for AIDS and Sexual Health to develop ways of helping GPs and primary care staff to offer HIV tests more routinely.

It is vital that the public health system is versatile and proactive enough to deal with HIV and AIDS. Reference has been made to how this is going to be structured in the future. Ring-fenced public health funding is central to our NHS and public health plans. This will allow us to plan spending on prevention without the money being raided for other projects. In today's restrictive financial climate, this is a very noteworthy commitment in this area.

Finally, I turn to the concerns raised by noble Lords about the current policy to charge some people for HIV treatment. As we made clear in our formal response to the Committee, we are concluding an internal review of our current policy—I know that review does not please the noble Lord, Lord May, but I hope he will be encouraged in the end—and expect this review to be completed by the new year, including any discussions with the other government departments that have an interest. The review is considering many of the issues raised today. These include the increasing evidence on the public health benefits of early diagnosis and the significant role of HIV treatment in reducing the onward transmission of HIV.

Promoting HIV testing to reduce undiagnosed HIV and late diagnosis remain important priorities for HIV prevention. We would be very concerned if our current policy was to deter people from being tested for HIV, even though testing has always remained free of charge to all. I acknowledge that a small number of vulnerable people will not be covered by the current exemptions and that they may be deterred from accessing HIV testing services because they cannot afford treatment or are confused about the entitlement to free NHS treatment. In considering any changes to our current policy we must avoid creating an incentive for people to come to the UK for the purpose of free HIV treatment, without compromising our overriding responsibility for public health. I hear the powerful case made by the right reverend Prelate the Bishop of Wakefield in this regard. The department's review has considered many of the issues raised today and we will conclude it by the new year.

I turn to some of the questions that noble Lords have put to me. The noble Lord, Lord Fowler, asked about supporting more HIV testing in general practice. I have made reference to the funding that we have provided to the Medical Foundation for AIDS and

Sexual Health, which is working on a three-year project to try to support GPs and primary care staff in offering HIV testing. The noble Baroness, Lady Gould, also referred to that.

The noble Lord, Lord Fowler, and the noble Baroness, Lady Masham, asked about prisoner health. As they know, we do not routinely screen people in prison for HIV just because they are prisoners—rather, we have an active case-finding programme which encourages both prisoners and staff to consider whether their behaviour, current or previous, may have put them at risk of infection with HIV and provides them with an opportunity for testing. We respect the rights of prisoners to accept or refuse testing if they so choose, which reflects normal practice in the wider community.

The Department of Health offender health team has worked with the HPA to improve disease surveillance in prisons. We aim in the new year to disaggregate data on diagnosis made on people in prison. Condoms are routinely provided in prisons to prevent the transmission of STIs. NICE evaluated the evidence of effectiveness of needle-exchange programmes in prisons and stated that there was a need for more research on the added value. It felt that the condom programme was useful.

The noble Lord, Lord Fowler, and other noble Lords, including the noble Baroness, Lady Healy, spoke of the need for a new prevention campaign. The awareness campaigns of the 1980s, which targeted the whole population, were effective in raising the public's awareness of a serious public health threat at a time when we did not know how HIV would develop or the main routes of transmission. By the mid-1990s, it was clear that men who have sex with men and people from sub-Saharan African countries were disproportionately affected by HIV. That is why, since 1996-97, the Department of Health funded programmes that focused on those communities. This approach is supported by community organisations and others including the HPA. The previous Government also subscribed to this. I hear what noble Lords have said and this will no doubt continue to be assessed on an evidence-based approach.

The noble Lord, Lord Fowler, asked about home-testing kits, to which I think I made reference in my speech. We are reviewing our policy on banning the sale of home HIV tests. We recognise anyway that the current ban is probably not sustainable given that home-testing kits are already available from overseas on the internet. It is essential if there is any change that home-testing kits are quality-assured, including the provision of clear patient information on following up positive or unclear results. It is extremely important that those kits are reliable if they are going to be used at home.

The noble Lord, Lord Fowler, asked about national procurement of ARV drugs, as did others. The Department of Health is keeping this under wider review. We are very keen to ensure that we have clinical collaboration in ensuring there is leverage on price and that experience from procurements on a local and regional basis will be used in evaluating the ability to take this forward on a multi-regional or national basis. It will be under review.

Various noble Lords, including the noble Lords, Lord Lexden and Lord Black, and the noble Baroness, Lady Gould, spoke about stigma. It is of course very much the case still that stigma is an enemy to progress. TB was a stigma in the 19th century and cancer in the 20th century and we have a problem here also when people are unwilling to come forward because HIV has the power to define a person in a way that an illness simply should not. Too many people with HIV still experience shame and isolation because of their diagnosis and that can manifest itself, as we have heard, in discrimination in all sorts of places.

The Department of Health's new sexual health policy framework planned for next year will consider how key partners involved in HIV care work and others can work together to reduce and challenge HIV stigma. The national HIV prevention programme for African communities, funded by the Department of Health, has contributed to toolkits for faith leaders and communities in this area and we want to develop this further; that is a very important message that comes out of this report.

The noble Baroness, Lady Gould, asked whether the Department of Health would consider the HPA's *Time to Test for HIV* report. The answer is yes and this will help to inform our forthcoming sexual health policy framework. She also asked about the public outcomes framework; we are considering responses to this, including a proposal on an indicator on late HIV diagnoses and we will publish that framework very soon. The noble Baroness also asked about tariffs on sexual health; as she probably knows there is ongoing work on tariffs and I will write to her in more detail about this.

My noble friend Lady Tonge expressed her reservations about our plans in general and this issue in particular. I can reassure her, at least in one or two areas. The £2.9 million on prevention that was flagged up as being inadequate excludes work done on prevention by the NHS, for example testing, condom distribution and local health promotion. There is more there than she might have felt. I will no doubt address many of her concerns on the health Bill more widely outside this Chamber, otherwise I am sure we will be here again until at least midnight.

My noble friend Lady Tonge, and the noble Baronesses, Lady Healy and Lady Massey, spoke about PSHE in school; I assure noble Lords that we recognise that children benefit enormously from high-quality PSHE education which helps them make safe and informed choices. There is a slimming down of the statutory curriculum to give schools more freedom and space to teach a curriculum which engages pupils; however, we have launched a review of PSHE to identify the core body of knowledge pupils need and ways of improving the quality of teaching. I emphasise that we welcome representations, including evidence and examples of good practice, and I strongly urge noble Lords to feed into that process. As a result of the review we will be drawing up proposals, based on the evidence, and consulting on them.

The noble Baroness, Lady Masham, asked about the future of the HPA; we will be having further discussions about this in the health Bill. In fact, we

[BARONESS NORTHOVER]

almost came to it last night but I think it will now be discussed on Monday. As she knows, the HPA, along with a number of other organisations, will be brought together into Public Health England, which will be free to carry out research; it is an executive agency of the Department of Health that will be established in April 2013—always assuming your Lordships pass the health Bill. It can carry out research, it must give advice to the Government—it has that independence; those working will be able to apply for grants and so on. We will work to maintain the excellent quality of HPA's current HIV surveillance programme when it transfers to Public Health England.

The noble Lord, Lord Lexden, referred to Northern Ireland, and it was extraordinary to hear of the difficulties that he perceived there. It shows how in many areas, not only geographically but by community, some communities can be particularly difficult and harder to reach than others. Nevertheless, I assure him that the Department of Health works with the devolved Administrations to discuss issues that are common across the UK, such as increased testing, and to share good practice on prevention and care.

There was some concern about possible fragmentation because of local authorities being much more involved now in public health and also the NHS Commissioning Board. Again, we will no doubt return to these issues in the Bill, but the Department of Health is already working, and will be working over the coming year, with key stakeholders to map out the integrated sexual health pathway that will address the concerns raised today. This debate will no doubt feed into those concerns to ensure that work on the issue is joined up.

I have referred to the HIV home testing kits, which the noble Lord, Lord May, flagged up. The noble Lord, Lord Black, and other noble Lords spoke about HIV awareness in the general population being very low. Although we wish to seek improvement in all kinds of areas, it is quite interesting to note that, according to NAT's Ipsos MORI poll, four out of five adults in the communities that are most at risk were aware that HIV can be passed on by having sex without a condom. In other words, the targeting of information, at least to those groups, is having an effect. I am pleased that that is the case.

The noble Baroness, Lady Massey, the noble Lord, Lord Gardiner, and others asked about the sexual health policy framework. We are seeking to take a life course approach—that sounds like a course that we are offering through PSHE—to sexual health needs, for young people through to old people, including people aging with HIV, and we are working with the Sexual Health Forum to agree this framework. That work is being undertaken at the moment.

The noble Lord, Lord Gardiner, asked about introducing HIV testing and learning from antenatal HIV testing. We have asked the UK National Screening Committee to consider the evidence on making HIV testing more routine. We await its response.

I hope that I have covered most of the points raised. If there are points that I have not answered, I will write to noble Lords. Clearly we have a tremendous amount to think about as a result of this report and there is still more to do. We all have a part to play in

keeping HIV high on the agenda, and debates such as this and the coverage today in the media all help to raise the profile of the disease. I welcome the report and the extremely important cajoling from noble Lords today. I am aware that we shall return to some of these areas in the discussions on the health Bill. I look forward to being further cajoled and I hope that we can make progress in at least some of the areas that have been flagged up in this important debate.

6.44 pm

Lord Fowler: My Lords, it has been an excellent debate and I thank everyone for taking part in it. I repair one omission and give thanks to our special adviser, Anne Johnson, who was absolutely first class in her advice.

I said at the beginning that we had the first debate on HIV/AIDS 25 years ago this month in the Commons, and today's debate was very much in that tradition, with outstanding contributions. There was general agreement on the serious increase in HIV, the central importance of early testing and the importance of combating the stigma.

I thank the two Front-Benchers—the Minister and her shadow—for their contributions. On the Minister's reply, to use the famous words of the noble Lord, Lord May, there were quite a lot of reviews in what she was saying, but I agree with her that a ring-fenced budget is infinitely preferable to one that can be raided and which we have had in the past. I am encouraged by what she says about charges for people from overseas and on home testing. I am not quite so encouraged by what she says about prisons, which we will have to revisit. As for what she says about a general campaign in getting this message over, I will say only that, as I count it, the noble Baroness, Lady Massey, called for one, as did the noble Baroness, Lady Gould, with all her experience, and as did the noble Baroness, Lady Tonge. The noble Lord, Lord Gardiner, agreed that there should be one, as did the noble Baronesses, Lady Masham and Lady Healy. For what it is worth, I think that there should be one as well, so I think she might find herself in a slight minority in this House.

The right reverend Prelate the Bishop of Wakefield made a quite outstanding speech on the work of the Church of England, to which I pay tribute. I also pay tribute to Bob Runcie, who was archbishop at the time of the 1986 campaign. I agreed with everything he said about charging for HIV treatment.

The noble Lord, Lord Lexden, made an important speech and rightly reminded us of the importance of Northern Ireland and the challenge there. The noble Lord, Lord Rea, talked about HIV not being a death sentence any more but certainly being a lifetime of medication. The noble Lord, Lord May, in a masterclass on the background, history and origins of HIV, made an outstanding contribution. I hope he is right in his predictions on the development of a vaccine. Above all, I think his message was that there is no reason to take the foot off the pedal at this point, which I hope that the Minister heard very clearly.

The noble Lord, Lord Gardiner, made a crucial point in passing about purchasing policy on drug costs. The noble Lord, Lord Black, underlined the

vast importance of involving general practitioners in the work, which, as his example showed only too well, has not always been the case.

There will be future opportunities for talking about these things. If I could put in a commercial for the right reverend Prelate and the noble Lord, Lord May, we have an amendment down on testing for overseas visitors and we might conceivably put the Minister under rather more pressure than she was under this

afternoon. I thank her and indeed everyone for an important debate on World Aids Day. I hope that we can renew our efforts to combat HIV, which seems to be the message that has come through from the whole debate.

Motion agreed.

House adjourned at 6.49 pm.

Grand Committee

Thursday, 1 December 2011.

Eurozone Crisis

Considered in Grand Committee

2.03 pm

Moved By Lord Lamont of Lerwick

That the Grand Committee do consider the economic situation of the United Kingdom, including the impact of the eurozone crisis on the United Kingdom and other non-eurozone members.

The Deputy Chairman of Committees (Lord Brougham and Vaux): Good afternoon, my Lords. I am sorry about the delay, but we had to have a sound engineer so that *Hansard* could report.

The House yesterday agreed a Motion to limit the debate in today's Grand Committee in the name of the noble Lord, Lord Lamont of Lerwick, to four hours.

2.03 pm

Lord Lamont of Lerwick: My Lords, I am very delighted to have the opportunity to introduce this debate. I ought to explain that this debate originated as a question put down by myself and the noble Lord, Lord Flight, intended for the dinner break, and was to be a debate entirely and only on the euro crisis. Somehow the Motion has metamorphosed into something wider, and the debate that was originally intended to be in the Chamber has now been relegated to the Moses Room. In view of the attendance here today and the importance of the subject, which can hardly be underestimated, perhaps it would have been more appropriate had it been in the Chamber in the first place.

I hope that noble Lords will forgive me if, despite the widening of the Motion, I confine my remarks almost entirely to the issue of the eurozone. Of course, I will listen extremely carefully to the points made by other noble Lords—notably, the noble Lord, Lord Eatwell, from the Front Bench, the noble Lord, Lord Myners, its other spokesman, and, of course, my noble friend Lord Wolfson of Apsley Guise, who is going to make his maiden speech during this debate. He is notable for many things, but one other notable thing that he has done has been to offer a very large prize—I shall not mention the exact sum of money—for anyone who can give him the solution as to how to dissolve a monetary union. During the course of my speech, I hope to name at least one candidate for the prize.

I will say just one brief word on the Autumn Statement and the position of the British economy. The critics of the Autumn Statement criticised the Chancellor and the Government yesterday for not having achieved their borrowing targets and for having increased borrowing, yet these were the same people who were urging them the day before to increase borrowing further. They seemed to believe that if we

had borrowed more money last year, we would be borrowing less money this year. If only life were as simple as that.

As the Chancellor of the Exchequer said the day before yesterday, you have only to turn on your television to see that everywhere in Europe other countries are reducing their budget deficits and taking drastic action to do so. Indeed, we are probably doing so less quickly than many other countries in the eurozone. The Government's starting point was the situation that our annual deficit as a proportion of GDP was equal to that of Greece, around 12 per cent. Of course, as is fairly, rightly and frequently pointed out, we had the advantage of a low stock of debt, but if you are adding to that at the rate of 12 per cent per annum, that advantage will quickly disappear. In today's world, the Chancellor was absolutely right to embark on the programme of fiscal consolidation that he has.

One reason for having a debate on the eurozone crisis by itself is that I believe it represents a large threat to our economy and that of the world. One commentator yesterday compared the Chancellor's task to that of a doctor treating a patient on board the "Titanic", and the approaching iceberg was the eurozone. If anyone doubts the seriousness of the situation, just look at the front pages of the newspaper, with Mr Van Rompuy and Mr Barroso sitting opposite the President of the United States in the White House; they were not invited there just to have a cup of tea. Indeed, the action by central banks yesterday to increase dollar liquidity and the liquidity of banks in other currencies via swaps was expressly done, according to the spokesman of the United States Government, to offset the effects of the eurozone crisis and the threat to the banking system.

Denial has been a theme of the eurozone crisis. Outstanding examples of denial have been the constant assertions that eurozone banks have adequate capital, a debt default within the eurozone could never happen and the break-up of the eurozone was unthinkable. We have had extraordinary suggestions from Commissioner Barnier—the noble Lord, Lord Myners, had some observations about him the other day—who went out of his way to suggest that credit agencies should be banned from expressing opinions on the economies of member states that had received financial assistance. It seems extraordinary that, in a European Union where we have Charter of Fundamental Rights that enshrines the freedom of speech, this should not extend to credit agencies expressing an opinion about the state of different European economies. We have had many hobgoblins, not just credit agencies. We have had short sellers, credit default swaps, hedge funds and derivative traders—all have been blamed for the increasing and exacerbating crisis within the eurozone.

This crisis has also been characterised by drift. Perhaps that is inevitable because of the nature of the eurozone. When the eurozone was first set up, many people argued that having a currency without a government was a strength; but, in fact, being a currency without a government has turned out to be one of its fatal weaknesses. Thus we have had a whole plethora of attempted solutions at the crisis. First, we had the Irish bailout, then the first Greek bailout, then the

[LORD LAMONT OF LERWICK]

Portuguese bailout and then the second Greek bailout. We had the European stability facility, which, as the director of the IMF said, was probably introduced illegally. We then had the European Financial Stability Facility, the EFSF, and we have the proposed ESM in 2013.

We have had lots of different versions of the EFSF. First, it was going to be leveraged; nothing much seems to have happened on that. Then we were going to have co-investment by other countries in it. Then, despite the extreme criticism of credit default swaps, it was going to be made into some sort of insurance mechanism doing exactly what credit default swaps do. Finally, *de haut en bas*, it was decided that the bailout should be funded by the Chinese—the richest countries in the world were going to ask some of the poorest countries in the world to bail them out. I think that there is an average income of \$24,000 per annum in the eurozone compared with \$5,000 per annum in China.

It is not just the policies of the eurozone that are the problem. One of the anxieties has been about the ability of the eurozone to execute any solution. Many weeks have passed since the first proposed 50 per cent haircut on Greek bonds was announced. The terms have still not been agreed by private holders, full interest is still being paid on Greek bonds, and the eurozone still wants to deny that there has been a Greek default because, of course, it wishes to maintain the myth that sovereign bonds in the eurozone are risk-free.

We all have different views about the euro and the eurozone and how it was set up, but there seem to me two fatal flaws in the eurozone that have received inadequate attention. The first was the German insistence on the no-bailout rule. That, of course, has been breached not once but several times, but it is still very dear to the German heart for reasons perhaps to do with their own experience of monetary union. It is something that they have surrendered very reluctantly, and it is, I believe, one reason why the German reaction at each stage of the crisis has been to do the minimum necessary in order to keep the euro afloat. For them, there will not be a big bazooka.

The second flaw, which has been pointed out by the economist Andrew Smithers and which again, I think, has received inadequate attention, is the misconception of having one central bank coexisting with 17 sovereign Governments. Normally, of course, a central bank must be able to print money. The Bank of England and the Federal Reserve board are owned by their Governments, whose bonds they buy and sell with no credit risk in their daily operations with the banking system. In a currency area, there should, of course, be local governments, but their borrowing should be tightly controlled from the centre, as it is in the UK, or they should be able to default, as is the situation in the United States. In Europe, the pretence is that the debts of the member states are without credit risk; so the European Central Bank is unable to avoid putting risks on its balance sheets in its day-to-day operations with the banking system. It is hardly surprising, therefore, that the Germans are so opposed to the European Central Bank being forced to buy more bonds. It is

one thing for the European Central Bank to be the lender of last resort to the banking system, but one can understand the Germans thinking why should it be the lender of last resort to Governments that have overspent and overborrowed?

Until recently, talk of restructuring the eurozone, or of the departure of some members, or of the break-up of the eurozone, was unthinkable. That all changed, of course, at the Cannes summit, when some Greeks made it clear that they did not want to accept the terms of the write-down but wanted to remain within the eurozone. They were then threatened with expulsion from the eurozone—what was unthinkable suddenly became possible. We know that the Financial Services Authority and indeed the Treasury have been drawing up contingency plans. The FSA has been putting questions to companies about a change in the structure of the eurozone. I am not advocating or supporting a change in the eurozone's structure or saying that a country should depart, but it would be foolish not to recognise that this is now on the agenda and requires thinking about. It is not inconceivable that in a couple of years' time the shape of the eurozone could be different from how it is today.

We have seen currency unions that have been broken up before: the currency union between Britain and Ireland; that of Czechoslovakia; and indeed—often ignored—that of the rouble-zone, where one currency became five, six or seven currencies. It is clear that, in the currency union of the eurozone, financial integration has been very deep, and has accelerated exponentially in recent years. However, the issues that would arise if one country departed are clear. Some of those were outlined in a paper by Philipp Bagus of King Juan Carlos University in Madrid. My noble friend Lord Wolfson might care to 'both study his report and to bear it in mind for the award of his prize for someone studying how monetary unions might be adapted. He identified the issues of redenomination, the importance of keeping payment systems going if one country departs, derivative contracts, cross-border loans and the capital banks.

I entirely accept that, in the eurozone, the departure of one or several members would be highly complex and could be extremely expensive. However, while we hear a lot about the costs of breaking up or altering the shape of the euro, the costs of the euro remaining as it is are becoming astronomical and potentially disastrous. Let us start with the bailouts. The two bailouts of Greece cost, respectively, €109 billion and €110 billion. The Irish bailout cost €95 billion. The Portuguese bailout cost €75 billion. These come to a total of nearly €400 billion. If the EFSF reached €750 billion, Germany's part in that would be €211 billion. Where other countries get into difficulty and are unable to meet their obligations, Germany's share of that would rise. For this reason the EFSF looks a little like a pack of cards or, as one distinguished central banker called it, a gigantic Ponzi scheme. If it increased to €1.45 trillion—and given that the guarantee of Italy and some other countries in that situation would be worthless—Germany would have to guarantee nearly €800 billion, or 32 per cent of German GDP. If France were to lose its AAA status, the German share would rise to €1.385 trillion, or 56 per cent of German

GDP. These may be contingencies; they may be theoretical. However, merely to examine the numbers is to understand why Germany recoils from ploughing more and more money into the EFSF and recoils from the big bazooka.

The European Central Bank has accepted Governments of the peripheral countries as collateral from the banks. If any of the eurozone Governments were to default, they would probably bring down with them part of their domestic banking system. The banks in that situation would be unable to repay the loans to the European Central Bank, which would be left with the collateral. Open Europe calculated Greece's 50 per cent haircut alone would cost the ECB between €44.5 billion and €65 billion—and that is just one country. Again, one can see why the Germans are reluctant to put more into the EFSF and reluctant also to let the ECB do what so many people have urged it to do: buy more and more bonds.

Which direction will the Germans go in? They talk of fiscal union, but do not mean what we in our debates mean by a fiscal union. We tend to mean a common treasury and tax system. The Germans mean simply more peer pressure and more supervision of national budgets. That is unlikely to work. So what is the German solution? It seems to be to do the minimum possible at each stage. Each country that is in difficulties is expected to deflate for long enough to become competitive with Germany and to put its public finances on a sound footing. However, given the dire state that some of these countries are in, I question whether that is a sustainable solution. The eurozone threatens to asphyxiate its members.

If there were a real fiscal union requiring treaty changes, it would of course be vital to protect our national interests. I would have no objection to the Government agreeing treaty changes that did not affect us, but it is vital that our national interests should be protected. I hope that the Minister will give us some assurance on that. However, I do not think that that is the route Germany will go down. I have said what I think it will try to do. With this minimalist approach, we can look forward—alas—to recurring crises. They could come every few months. They could go on, possibly for years. I think that it was Adam Smith who said,

“there is a lot of ruin in a nation”.

There is probably a lot of ruin in several nations put together. Such a continuing crisis would be extremely damaging to confidence. It would sap it continuously and would mean that the already bleak outlook for growth would become even grimmer.

Such an approach may keep the eurozone and the currency afloat. However, the great risk is the possibility of an accident occurring in the mean time while adjustments take place. It could happen somewhere else in the financial system; for example, in the marking to market of sovereign bonds. We could see a major crisis in a major bank or in another financial institution. It is far better now to look at restructuring the eurozone and not to take it as a given that it must continue in its present form. The effect of delay will be simply that in the longer run the costs of adjustment will become greater. There is no painless solution, but let us hope that somewhere in Brussels, someone is working secretly

to prevent this crisis turning into complete chaos.

2.24 pm

Lord Monks: My Lords, I am grateful to the noble Lord, Lord Lamont, for initiating this timely and important debate. Its title is rather wide; as has been said, it is about the UK and the euro, and my angle is going to be a little bit different from the one that the noble Lord opened the debate with. In the week of the Chancellor's Autumn Statement, there have been yet more make-or-break meetings in Brussels. Yesterday there was a substantial public sector strike, just to underline the timeliness of what we are going to debate today.

No one should doubt that in the present economic crisis there are also the seeds of a considerable political one. The way that the international markets set strict rules for countries makes it fairly clear that many democracies are struggling to live within those rules, and to some extent that includes us.

When the banks were in trouble, everyone agreed that that moral hazard did not apply. Governments sprang to their defence and transferred the banks' huge debts on to their nations' balance sheets, splashing copious amounts of red ink over the national accounts. Yet when the individual countries were subsequently hit, moral hazard came in with the vengeance. The terms of the so-called rescue packages are very harsh—less Marshall Plan, more reparations.

It should now be clear, and I hope that it is clear in Brussels and in the IMF, that this is a road to depression and political crisis in the countries worst affected, not a road to recovery. The single way to cut deficits is to get people back to work. Then there are more tax revenues to be collected and more disposable income to spend. Looking after the deficit while hoping that unemployment looks after itself is self-flagellation or, worse, economic suicide, as Joseph Stiglitz has regularly termed it.

How did we get into this mess? There are many reasons for that, but one is that the world economy has changed fundamentally since the financial deregulation of the 1980s. This was carried through in the UK largely on the watch of the Treasury of the noble Lord, Lord Lawson, who inadvertently is leaving at the very moment that I have referred to him.

Lord Lawson of Blaby: No, I am here.

Lord Monks: Apologies for that. One effect of this, although there were others, is that the traditional constraints in financial services largely disappeared. Banks increased their leveraging and invented a bewildering range of new products, most of which in hindsight appear to have been more dangerous than beneficial, described as “socially useless” by the noble Lord, Lord Turner, currently chairman of the FSA or, to use another memorable phrase used by Warren Buffett about credit derivative swaps, “financial weapons of mass destruction” that we turned in on ourselves. Wall Street and the City nevertheless claimed to have developed sophisticated forms of risk management, a claim that we can now see was wholly fatuous. By the

[LORD MONKS]

way, very few people anywhere saw the crash coming, and the economic crisis is now also a crisis of economics. The economists have quite a lot to answer for.

To return to deregulation, though, the effect was to increase private indebtedness to unsustainable levels, leading to rising inequality with totally unjustifiable rewards for people at the top—especially, but not only, in financial services. Even in this crisis, in the period of flat growth that we are going through, average executive pay of directors in the FTSE top 100 increased by 49 per cent last year. And just wait for the forthcoming Christmas bonus season in the City; on past form it will be an orgy of Bourbon-like self-indulgence and a two-fingered salute to the Prime Minister's claim that we are "all in this together".

In a debate here last Friday, it was suggested that Europe and the euro were to blame for the crisis by the constraints imposed on national economies. In fact, in my view it is not Europe that threatens national sovereignty. Properly led, though I accept that that is a fairly big qualification, it offers a chance at European level to enhance national sovereignty by creating an economic bloc large enough to influence markets and not be cowed by them.

As for the UK, the crisis has exposed the long-running problem that we have not been fully competitive for a long time with our neighbours across the North Sea: especially Germany, but also the Netherlands and the Nordic countries. We have not benchmarked our performance on a consistent basis against those countries in a way that others do—countries like Belgium and, to a degree, France. We have tended to muddle along using periodic devaluations of sterling, bolstered for periods by the bonanzas of North Sea oil and later by the boom in financial services. Now there are no more bonanzas in view, and the national task must be to move our economy in the same direction as our North Sea neighbours. We must be more long-termist. We must promote more investment, more manufacturing, social markets, greater equality and more multi-stakeholder governance on boards, including worker influence, as well as strong public services. That is the way those countries do it, and theirs are among the most successful economies around, not just for this year but for many years.

The noble Lord, Lord Heseltine, recently said that he had favoured the UK joining the euro because it would make us more like Germany. I believe that he was right, and he could still be right if the euro survives the present crisis. Soon Germany has a very big decision to make. In fact, I think Mrs Merkel is the only one who can win the prize of the noble Lord, Lord Wolfson, because she is the only one whose decision is going to matter. One of the interesting things about this debate is how marginal it feels to the debate about the future of the euro.

While we are talking about the German influence, I think that the reasons of the noble Lords, Lord Lawson and Lord Howe, for pushing in the 1980s for the UK to join the exchange rate mechanism also rested on a

wish to make the fundamentals of the British economy move in a more northern European or Germanic direction. I believe fundamentally that that remains the challenge today for the British Government of whatever hue, for employers—unions included—and for all sections of British society. Our North Sea neighbours have had continuous success, and we should resume our efforts to match them.

2.32 pm

Lord Ashdown of Norton-sub-Hamdon: My Lords, I am grateful to the noble Lord, Lord Monks, for introducing this issue. Although it is perfectly reasonable to be discussing the economics of this country, it seems to me completely bizarre that we should be discussing, outside the circle around the fire, this 650-pound gorilla of what happens to the euro. For us not to have addressed or discussed that seems bizarre. Indeed, for us to be doing it in this Room today rather than in the main Chamber seems odd as well, and I am grateful to the noble Lord for mentioning that.

It is a privilege to follow the noble Lord, Lord Monks. I agree with so much of what he said, and I will come on to that in a moment. Although we talk about the economic crisis, I think that the real crisis is a deep political one, and perhaps we do not recognise that at our peril. Of course we must look forward, but it behoves those of us who argued, as I did, that this country should join the euro in 1997 to say a little word about the past and perhaps to justify that position.

I start by saying that I do not resile one iota from my belief that it would have been right for this country to have joined the euro at some time between 1997 and 1999, for reasons that I shall seek to explain. Those who argue to the contrary, that not joining the euro was the best thing that we ever did, seem to miss a number of points. First, they presume that the euro would have been the same as it is today had we joined; of course, it would not have been. We would have added substantially to those voices within the eurozone in favour of liberalised markets and greater competition, and the balance of the euro would have been different. Even those of us who argued, as I did, that it was illogical to create an economic giant controlled by a political pygmy might even have begun to win the argument within the eurozone that we had to create the instruments to ensure that the position we have now arrived at in the euro was at least less likely.

The second proposition is that somehow or other, if we had joined the euro, we would have been like Greece, Portugal, Ireland and Italy. I do not think that that is true. We are not a small southern economy without a manufacturing tradition but with a certain cavalier attitude to the rules. We are a northern economy, large and with a strong manufacturing tradition, and we respect those rules.

Those rules would have been very good for us. I reflect on the fact that by not joining the euro we left ourselves open to do what we have always done whenever we hit a problem: we do not tackle the fundamental problem, which is that Britain does not produce enough goods at competitive prices that the world wants to buy. Instead, we devalue our way out of trouble. It is what Harold Wilson did, for which he was excoriated, and it

is what we have done. Even Conservative newspapers have said, "Thank God we can devalue". Harold Wilson, thou should be alive this day.

Instead of doing what we needed to do—produce competitive goods that the world wanted to buy—we devalued our way out of difficulty. Instead of acting like Germany, we decided to act as we always have done. Sooner or later this country must tackle its fundamental problem and produce goods that the world wants to buy at a competitive rate. However, not only did we take advantage of the ability to devalue and dodge the issue, but we decided that it was easier and more fun to behave like Italians and build up a massive amount of debt—in fact, not like the Italians, because their debt was 97 per cent of GDP in 1999 and is about 104 per cent now, while our net government debt is now two and a half times what it was.

We are now faced with the worst of all propositions. We have to make ourselves competitive because at last we must, and we must deal with a huge burden of debt as well. Is the position better than it would have been if we had been subject to the disciplines inside the euro? I do not think so. Let us compare our position to that of Germany or those of the other northern economies that are most like us. I take the position of Germany in particular, but one could find the same examples in Benelux, Austria, Finland and other countries. Between 1999 and now, Germany increased its debt by 20 per cent but doubled its growth. We increased our debt by 250 per cent and halved our growth. In which position would one prefer to be?

Of course, Germany has the problems of the euro to cope with. However, as an economy it has nothing like the problems that we now have to cope with and nothing like the difficulties that are ahead of us. I know which of the two positions I would much prefer to be in. It was a great pity that this country did not grasp the nettle and submit itself to those disciplines. I am very confident that if we had done, today we would not be in the economic position in which we find ourselves.

I will address the future in the three or four minutes that I have left. Here I find myself more in agreement with the noble Lord, Lord Lamont, than I had thought I would be. There are three options available to the eurozone. Option one is that the whole thing collapses. Of course, that would be a disaster and a catastrophe. I am very confident that it will not happen because the countries that run the eurozone have too much invested in it; they will not allow it to happen. For all that the noble Lord, Lord Lamont, told us of the costs of trying to save it, the costs of not doing so are even greater.

The second option is that somehow the euro of 17 survives. If I was asked to make a judgment on that, I fear I would say that it is unlikely for two reasons. First, I am not sure that the people of the nations that will have to face these austerities will all agree to do so. It may be unwise not to, because conditions for them will be far harsher outside than inside. However, with a frightened population it is unlikely that all of them will accede to the austerity measures necessary to maintain their position inside the euro of 17. Secondly—here the noble Lord, Lord Lamont, is right—the markets

cannot yet be made to believe that the euro of 17 can be sustained. We would probably need a bail-out fund not of €1 trillion but of €2 trillion or even €3 trillion to do that. I doubt if the markets can be made to believe that. Therefore I believe and have always believed that the most likely circumstance is that we will fall back to a core euro. Sooner or later, that is the most likely outcome.

I do not predict it as a certainty. However, on the balance of probability the most likely outcome is a eurozone made up of Germany, Austria, Finland and Benelux. My guess is that Sweden would join under those circumstances. So might Denmark, which is tracking the euro. France, of course, would be in—perhaps not for economic reasons, but for political ones it could not be left out. The big question is whether Italy would be in. Again, it seems almost impossible to imagine that it would be, because I doubt that the German people would bail out Italy. However, if Italy is not, Germany will have to find a huge sum to bail out the banks—to recapitalise German and French banks—as a consequence. Somehow or other, that seems to be the position that we come to.

The question is: what should Britain do in these circumstances? If we had a core euro of that sort, the eurozone would be strong—in surplus, perhaps—and it would be deeply in our interests to join. Do I say that we should from this position? No, I do not. But being the only one of the outs, the only one of those not in the current eurozone that wants to go further out, while all the rest of them want to get back in would be disastrous. If we do not show a willingness to join if it is in our country's interests, then we immediately diminish our influence and our effect in the Councils of Europe. It is inevitable that the eurozone countries, whether a core eurozone or one of 17, will caucus together and work together to their advantage and, ultimately, our disadvantage. If we are outside that circle, we diminish the influence and voice of Britain catastrophically.

My position is very simple. Let me see if I may differentiate it from what I suspect is the position of the noble Lord, Lord Lamont. My position is very practical. Should it become in Britain's interests to join the euro we should do so. His position is likely to be that even if it were to be in Britain's interests to join the euro, we should not. A position driven by pragmatism seems to me to be the best position for our country. I believe that this will come sooner than we think. If this thing can be made to survive—and I believe in the end that it will survive—then, sooner than we think, we will have to address the question of whether or not it is in our interests to join. If it is, I say we should, whereas I think that many people, especially in the Conservative Party, still take the view that even if it was in Britain's interests to join we should not. A position driven by pragmatism is wise for this country; a position driven by prejudice is not.

2.41 pm

Lord Williamson of Horton: My Lords, I declare an interest, as I spent a good part of my career in the United Kingdom in public service dealing with European affairs, and a smaller part of my career in the European Commission.

[LORD WILLIAMSON OF HORTON]

I am very glad, like earlier speakers, that this debate has been arranged, because the serious difficulty that at least five eurozone members are having with the sale of state bonds to finance their public expenditure is already clearly having an effect on our economy, and, if events continue to deteriorate in the eurozone, it could have a much more serious effect. Despite some of the gloom around the Autumn Statement, the present Government are handling our economic problems well, with the consequent low interest rate on UK bond issues, at or about the level of German Bunds. But we must not be complacent. I do not accuse the Government of this, but complacency is implicit in some comment in the United Kingdom on the eurozone's problems. It is not just the eurozone's problem.

I wish to speak briefly on two issues. First, what are the eurozone countries likely to do—all of us here are speculating on it, but it is important—by way of treaty change or other economic or financial measures? Secondly, and most importantly, how should we best protect our national interests as the drama continues to unfold?

First, then, what are the eurozone countries likely to do in order to respond to the absence of a central bank or financial institution of last resort? The European Central Bank has recently purchased a very large amount of national debt from some eurozone countries, but it is under the eagle eye of the German constitutional court. I doubt that it could issue euro debt bonds of its own without breaking the Maastricht treaty. Such bonds could be only a partial substitution of national bonds, and the guarantee need not necessarily be full—it also could be partial. Stability bonds would be a valuable aid to the correction of eurozone problems.

Almost every day the *Financial Times* tells us that the European Central Bank must be more like the Federal Reserve, and sometimes the *Financial Times* is right. It seems almost certain that new powers will be taken in the eurozone, either by way of enhanced co-operation or by treaty change.

The United Kingdom has already made it clear—correctly, in my view—that it is benevolent but will not participate. So far, there has been a treaty change in March this year to put the European stability fund on a permanent footing, as well as other measures short of a treaty change in October. In September the Dutch proposed a new budgetary commission with the power to intervene in eurozone countries with excessive deficits, with potential sanctions. In October the Commission proposed closer monitoring of eurozone countries' budgets, including the right to ask a country to look again at its budgetary proposals, and envisaged developing options for eurobonds. The Commission believes that that could be done by an enhanced co-operation procedure with treaty change later. That is questionable. Currently, the position of the eurozone countries is that they are considering changes to strengthen monetary union, including possible treaty change, with an interim report this month and a final report in March 2012.

So it is all go, but, unfortunately, not many of the problems have gone away—rather the contrary. It goes without saying that other methods of increasing the resources available to the European stability fund or a

greater use of finite resources could combat some present difficulties. The recent decision by a number of central banks to cut the cost of dollar swap lines is useful in the short term.

However, I would like to say a word or two about the possible enhanced co-operation or treaty change that is under discussion in the eurozone. The Minister has an outstanding knowledge of finance, but it is possible that even he may have found the institutional issues somewhat labyrinthine—not, of course, a traditional Greek labyrinth but a grade one European labyrinth. If the eurozone countries wish to move quickly, as the markets clearly want, the procedure of enhanced co-operation under Article 20 of the treaty and the detailed arrangements in Articles 326 and 334 of the Treaty on the Functioning of the European Union is the quickest. Changes made in this way would, of course, apply only to those countries that agreed them, would not form part of the *acquis* and could not affect the single market. The Treaty on the Functioning of the European Union is extremely explicit on that point, stating that enhanced co-operation shall not undermine the internal market, that it shall not distort competition between member states and that it should not constitute a barrier to all discrimination in trade between member states.

In my view, eurozone countries could not legally introduce a financial transaction tax by this method, but that view may be contested—that is a point of importance for the United Kingdom. If action were not taken by enhanced co-operation of the eurozone countries, the treaty would have to be amended or we would just drift along. For a treaty amendment, there are three methods: there is the ordinary revision of procedure—more accurately described as the complicated revision procedure, including a convention, an intergovernmental conference and unanimity of all member states. I think that that is one possibility which can be excluded. Or there is the simplified revision procedure under Part 4 of the Treaty on the Functioning of the European Union, without a convention or an intergovernmental conference but requiring unanimity and ratification by member states. We would need to ensure that if the treaty changes applied only to the eurozone, our national interests within the European Union as a whole were not damaged. In my view, maintaining and strengthening our financial services should be the prime object of our attention.

If, as I assume, there were no transfer of powers or competencies from the United Kingdom to the European Union, a referendum would not be required in the United Kingdom. The highly important European Union Act, passed in the current Session but which seems to have had little public impact, embodies the principle of “so far and no further” by requiring referendums in the United Kingdom if there were any transfer of powers or competencies but not otherwise.

The most effective response to the eurozone difficulties might well be stability bonds, with partial substitution of national bonds and some element of guarantee. But of course in order to pass the “no bail-out” hurdle currently in the treaty, a simplified treaty revision for the eurozone members would be needed in that case.

2.49 pm

Lord Lawson of Blaby: My Lords, I join others in commending my noble friend Lord Lamont for having, by a somewhat circuitous route, initiated this debate and for his outstanding opening speech. I echo him too—he was perhaps slightly understated—as in my judgment it is an absolute disgrace that this debate is for only four hours and has been shunted off to the Moses Room rather than being on the Floor of the House. Much as I love the government Chief Whip—and it is not just her—on this occasion the House has been badly let down by the usual channels.

We have so little time that, like my noble friend Lord Lamont, I will confine myself entirely to the eurozone disaster. It was predictable and predicted. I was not alone in predicting it, but I think that I was the first Minister to explain the fatal flaw at the heart of this misconceived venture. I shall quote a speech that I made as Chancellor of the Exchequer at Chatham House on 25 January 1989, before European monetary union had come into being. It was even before the Delors report, the blueprint for monetary union and the eurozone, had been published, but by that time we knew what it was going to say. I said:

“Nor would individual countries be able to retain responsibility for fiscal policy. With a single European monetary policy there would need to be central control over the size of budget deficits and, particularly, over their financing. New European institutions would be required, to determine overall Community fiscal policy and agree the distribution of deficits between individual Member States. These are not technical issues.

The setting up of a European Central Bank or a new European institution to determine Community fiscal policies go to the very heart of nationhood. What organisation would really be the government? It is clear that Economic and Monetary Union implies nothing less than European Government—albeit a federal one—and political union: the United States of Europe. That is simply not on the agenda now, nor will it be for the foreseeable future”.

That is what I said more than 20 years ago, and it was as true then as it is today. It was not meant to be a case for Britain not joining; in my opinion, there was no way Britain would join anyway. I was trying to persuade my European friends and colleagues that they would be ill advised to go down this calamitous route.

You might ask, “Why did it happen?”. It happened partly because there are always ignorant worshippers in the church of Europe who believe that anything that is “more Europe” must ipso facto be a good thing—you do not have to work out the details, because if it is “more Europe” it is good. Of course, the main promoters were much more sophisticated than that. They knew that it could not work without full political union, and it was full political union that they wanted. This was never an economic venture; it was entirely political. It was a means to achieve a full blooded political union—a united states of Europe.

The motives of those who wished for that may have been commendable or noble, but they committed two unforgivable errors—and I could use a worse word than error. First, they showed complete contempt for democracy. That has always been one of the least attractive aspects of the European movement during my time. It was quite clear that you could not have a political union unless you could convince the people

of these democracies that they should have it. You had to carry the people with you. But the people do not want it; and it is not just the British who do not want it. As some noble Lords know, my main home nowadays is in France. I can assure noble Lords that French people do not want it either. None of the peoples of Europe, save perhaps those of Luxembourg, want it. But they have been shown a complete contempt for democracy.

The other disgrace, which made this venture the most irresponsible gamble that any senior group of politicians has ever taken in the post-war era, is that it was quite clear that if the gamble did not come off, there would be a disaster, and that is what we have now. In fact, we have a doomsday machine. It is quite extraordinary that we are not asking how to dismantle this doomsday machine, but how to keep it going. “How do we go from bad to worse? Let us keep the doomsday machine going”. It is nonsense. When you have a doomsday machine, you try to dismantle it, but they say, “No. How can we perpetuate it?”.

So where do we go from here? This has both an economic and a political dimension. As I said, the economic dimension has to be the dissolution of the eurozone and a return to national currencies. It has to be done in as orderly a manner as it can. As my noble friend Lord Lamont said, there have been a number of cases in history where monetary unions have been dissolved. Incidentally, history also shows that, as with German monetary union in the 19th century, you have to have political union first, which Bismarck in Prussia imposed, before you can have monetary union. They had to solve the question of the political union first, and they could have monetary union only after achieving political union. I admit that it is not easy, but it is clear that it is the least bad solution. To continue with the doomsday machine would be very much the worst step—not just for us, but for the whole of Europe.

The other aspect of the economic way out is how we deal with a potential—and burgeoning—banking crisis. The consequences of impaired sovereign debt in the eurozone mean that we have a new banking crisis superimposed on banks that are already enfeebled by the banking crisis of 2008 to 2010. This is where the economic threat is coming from. There is no economic threat posed by the break-up of the eurozone because that would be a good thing. The economic threat—it is serious and I do not wish to belittle it—comes from the problem of a serious banking meltdown. But there ways in which this can be addressed. I believe that the IMF has a key role to play, and as members of the IMF, obviously we will be contributors. The heart of the problem is impaired sovereign debt on banks’ books and so on. I have some experience of this because the first thing I had to deal with when I became Chancellor of the Exchequer in 1983, along with my opposite numbers in what was then the G5—it had not grown to seven in those days—was the Latin American sovereign debt crisis. It was not quite as big as this one, but at the time people felt that there was a real threat to the world economy. It was handled pretty well by the IMF with the support of the finance Ministers and Governments of the G5 countries. I do not have time to go into it now, but it can be done.

[LORD LAWSON OF BLABY]

Countries are then able to buy time, and that means that to some extents banks are able to do so as well. Banks need time to strengthen their balance sheets. Some banks may still need official assistance as well—assistance from the taxpayer, as it were—in order to prevent a serious banking crisis, but that is the responsibility of national Governments and Treasuries. It is absurd to think that there can or should be a European solution to that. The German Government will have to support German banks if they need support, the French Government will have to support French banks if they need support and so on, just as the noble Lord, Lord Myners—whom I see in his place—tried to support them. Perhaps he was too generous to them; the terms were not very good, and he did not strike a very good bargain. Nevertheless, he was absolutely right that there needed to be some taxpayer support for British banks in difficulty at that time. This is the responsibility of the national Governments around Europe. The idea that there should be eurozone bonds, as if the eurozone were a Government, is ridiculous. The idea that you put the European Central Bank, which is probably already technically insolvent, into an even worse state is absurd.

That is the economic way through. Politically, later on—

Lord De Mauley: My Lords, I do apologise to my noble friend. I respectfully draw his attention, and that of other noble Lords, to the fact that this is a time-limited debate. There is a confusion of clocks around the Chamber, but the one to keep an eye on is the one in front of each of us.

Lord Lawson of Blaby: I am most grateful to my noble friend for reminding me of that. It underlines what an outrage it is that we are being cribbed and confined in this way.

Noble Lords: Hear, hear!

Lord Lawson of Blaby: However, I conclude by saying that, later on, we will have to address the politics, which means that we have to get our European partners to sit down around the table and say, “Look, the existing way that Europe works is disastrous”. It has led to this. We have to have a proper constitution; not the Lisbon anti-constitution, but a proper constitution in which it is quite clear which are the competences of the centre and which are the competences of the member states, and to have them properly entrenched, as any self-respecting constitution does.

Finally—this is finally, I tell my noble friend—meanwhile, because we cannot wait for that, there is a threat to the City of London and to Britain as the great financial centre of Europe and the world from misguided European regulation, whether it is the Tobin tax or other things.

I cannot possibly give way. Please, I cannot because of the time. Blame the Whips on both sides.

We have to say clearly that we will invoke the Luxembourg compromise. There is no way that we will allow ourselves to accept a majority vote on regulations that will be damaging to the City of London,

when the City of London is far more important—indeed, far more important to Europe—than all of the rest of the financial centres of the European Union put together. We must be absolutely firm in invoking the Luxembourg compromise in saying, “No way”.

Lord Myners: My Lords, before my noble friend speaks, I ask the Whip representing the Government whether we will all now be allowed, if required, 13 minutes. The Whip made very little effort to restrict the noble Lord, Lord Lawson. I personally would have liked the noble Lord to have had more time to speak because he has such rich and informed experience. The Whip allowed that to run for 13 minutes, and I hope that he will extend the same courtesy to people from the other side of the House if they so wish.

Lord De Mauley: My Lords, the noble Lord knows perfectly well that we are a self-regulating House. We have all agreed to time-limited debates.

3.04 pm

Lord Desai: My Lords, first I thank the noble Lord, Lord Lamont, for giving us this opportunity. I shall also heed what my noble friend Lord Monks said: this is not just an economic crisis, but a crisis of economics. I guess, as the first paid-up academic economist to speak in this debate, I had better take that seriously.

I want to talk simultaneously about the UK economy and the European zone, but I also want to include the USA. I see this as a crisis of the developed economies. I see this as an historic moment when the tectonic plates are shifting, and we are now landed with a geriatric capitalism. The young and dynamic capitalism has moved eastwards and southwards—indeed anywhere but to the old, developed economies.

It is not just that the eurozone is in crisis—and it not just an exchange rate crisis, it is a sovereign debt crisis. The United States is in a crisis of debt and deficit, and so are we. The question we have to ask is this: why is no one practising good old-fashioned Keynesian economics? We told the world for many years that we had the answer and that this would never happen again. Perfectly sane people—I presume they are sane—across many countries are finding that they are restricted by debt and they have to tackle deficits, but they cannot use the fiscal spending instrument that they thought they could always use. One answer is that we are all cowards, but I shall resist that.

There are a couple of things that are worth saying. A long-running cycle started in the 1970s, at which stage manufacturing began to leave the developed economies and migrate eastwards. That came about partly as the result of globalisation and partly through a profitability crisis in western countries. Our labour costs were too high and capital went in search of cheaper labour elsewhere. This happened not just in the UK, but by and large a group of developed countries had the same experience. There are one or two exceptions, but I will stick to this argument. We tried to find substitutes in the services sector, both in public services and in financial services. At the end of 40 years, we have finally come to the crunch. They are no longer a viable solution to our problems.

In the mean time, especially during the long boom from 1992 to 2007, probably the longest boom in the history of capitalism, we compensated for our lack of wealth-creating capacity by finding debt instruments. Both households and Governments were in debt before the recession hit. It is important to remember that both Germany and France broke the growth and stability pact not while there was unemployment but when there was full employment. Our debts started to go up while we still had full employment, as did our household debt. When we entered this recession, unlike any previous recession, we were already in a highly indebted position for both households and Governments. It is this which makes the application of the Keynesian solution somewhat difficult. First, there are large leakages due to imports since we do not make very many things. If you do spend money, there is bound to be import leakage. But it is also the fact that households, especially in the latest crash, feel compelled to deleverage because they have acquired debt and they now feel that they have to get out of it.

There is money in the private non-financial corporations. They are sitting on large surpluses. The puzzle is this: why is it that when interest rates are at historically low levels, private non-financial corporations are not investing? One obvious answer is that there is no demand. But if investment has to be for the long run, surely no one believes that demand is going to stay low for ever. There is an obstacle to private investment spending in the economy, and that is one of the things we need to tackle.

I shall now read out a headline from yesterday's *Financial Times*. It states:

"Europe squeeze makes Osborne look soft"—

we are all in this together; all countries are tackling it. In the UK, it was quite clear before the election in 2010 that the problem of our debt levels had somehow to be tackled. There was almost an all-party consensus; the difference was on at what rate we should try to eliminate the deficit. My party took the view that within the Parliament we would eliminate half the deficit, and of course the coalition Government took the view that all the deficit should be eliminated. Now, if we are to believe the OBR, it will not be possible to do it within a single Parliament and will take longer. I reserve my judgment on that; it may be much too pessimistic a view but, for the time being, let us leave it.

Could something else have been done? That is the real question. Could a slower cutting of deficit have led to less of a drop in demand and employment? If so, would we still be suffering from the extra shock of the eurozone crisis—the inflation and all that has derailed the Osborne policy? There are two problems, and I am sure that the noble Lord, Lord Skidelsky, will speak on them. First, I am sceptical that the half-deficit elimination strategy could have been sustainable, especially when markets all around were going hysterical about sovereign debt. That is a matter of judgment and people will disagree. Secondly, even if it was possible to do it, the eurozone crisis and the inflation shock caused by the quantitative easing policy of the Federal Reserve and the Bank of England would have been there anyway.

The room we have for manoeuvre is quite limited. I only have half a minute. We need to develop a very different economy in which households restore the habit of saving and Governments restore the habit of balanced budgets. If we can do that—perhaps not by 2015 but in another decade or so—we might be able to restore western economies to a healthy state.

3.12 pm

Lord Alderdice: My Lords, I start from the position of one who has been for many years, and still is, very committed to the European project, not just for reasons of political principle and doctrine but because of my experience in my part of the United Kingdom. It was the European project approach that inspired us as traditional enemies—unionists and nationalists—to meet each other across the table rather than across trenches, virtual or otherwise. It was that model of the institutions—cross-border and council of Ministers—that enabled us to find our way forward into practical political ways of co-operating east-west, north-south and within Northern Ireland. It was the European context that brought the United Kingdom and the Republic of Ireland together and produced a framework of relationships in which political leaders and civil servants were able to work together. However, I confess to having been profoundly disappointed by two approaches and three attitudes within the European project that have been profoundly damaging in recent times.

From the start, I wanted to see the development of a Europe of the regions, because it seemed the way for us to move beyond the nationalism that had been so damaging in the last century and towards a federal Europe. However, as time went on it became increasingly clear that political leaders were not terribly prepared to give up the national power of Governments and pool sovereignty sufficiently to make a Europe of the regions a serious possibility. That to me was finally made clear by the appointment, late in 2009, of Herman Von Rompuy and the noble Baroness, Lady Ashton—very fine people in themselves—which was a mark of the lack of preparedness of European leaders to appoint those who would really drive Europe forward. For many of those leaders, and for many of their people, the European project had become a vehicle for the accumulation of power and wealth, not the management of conflict.

The second was the debate between deepening and enlargement. It seemed that one had to choose one or the other. Many of my colleagues, particularly in the rest of Europe, disagreed. They said, "No, no. That is very old thinking. It is wholly possible to have deepening and enlargement at the same time". I always begged to differ. I could see value in both, but I could not see the possibility of both being done at the same time. That struck me again at Copenhagen in 2002, for example, when a number of new members were brought in who did not necessarily abide by the rules. I think particularly of the admission of Cyprus when it was quite clear that the Cypriot problem had not been resolved and that this would ensure that it would be impossible to resolve the problems not only of Cyprus but of our relationship with Turkey. Tragically, so it proved.

[LORD ALDERDICE]

Those were not the only rules that were broken. Here I move on to the three attitudes. The attitude to the rules was defective, as the noble Lord, Lord Desai, mentioned. The stability pact was already being broken long before we ran into the recent economic problems. It seemed as though the project itself and its political dynamic were so important that one could afford to close one's eyes to the breaking of rules both by southern and northern countries for their own short-term purposes.

There was a second attitude that disturbed me. I wholly realised that the appointment of the Commission as an institution that could drive things forward when national interests would sometimes have held them back, was a necessary thing for the starting and development of the European Union. However, if it continued for too long, a tendency would develop in which European elites and bureaucrats felt that it was not really necessary to bring all the people along all of the time. Again, while I see the short-term requirement for the new Governments of Greece and Italy not to be properly democratically anchored, it is a very dangerous development that thoroughly undermines our capacity to turn to autocrats in other parts of the world and recommend the European project.

Finally, as time went on, the fundamental purposes of the project became lost and submerged. Increasingly, countries wanted to join the European Union not for the political reason of preventing a return to political instability and war in Europe but because they thought that it was a short-cut to wealth and comfort. Many countries joined without any real intention of finding a way to measure up to the kinds of requirements that were in place. At the same time, politicians saw the European project as a way of gaining a platform on the world stage, where they could compete with the United States, China and the developing powers. However, while that may have been their ambition, it was not the purpose of the project and was frankly not what Europeans themselves wanted. They were not interested in that kind of competition. They wanted peace, stability, reconciliation and economic progress in Europe.

As we move down this road, it has been extremely damaging to us within the European Union. Of course, the noble Lord, Lord Desai, is absolutely right. The economic problems we face are not solely problems for Europe; they are much wider. However, today we are concentrating on Europe. In appreciation of the noble Lord, Lord Lamont, I hope that this debate is the first instalment of a wider consideration of issues that are absolutely critical for our country and need further, longer discussion in your Lordships' House.

Noble Lords will not be surprised that, as a doctor, I will focus on diagnosis before coming to treatment. There are serious questions about whether the diagnosis of the economic dilemmas that we face has been correct. We were told from the start that it was a liquidity crisis. Then it was a problem of bank capitalisation. Then it was a recession, perhaps even a depression. All these things may be around but, fundamentally, what we face is a differential and massive correction. Some countries have simply been living within Europe way beyond not only their current means but any means that they are likely to be able to

acquire. That is a very serious matter because, when we come to the resolution of the problem, some of those countries will not be able to return to the way of living that they had three, four or six years ago. As my noble friend Lord Ashdown said, we could be among those countries; there have been indications of that in recent times.

A solution was put forward by some of our colleagues. I heard Guy Verhofstadt, the former Belgian Prime Minister and a good liberal in many ways, make a diagnosis and treatment proposal that I had heard from him before. He said last week in Palermo that a state without a currency was possible but that a currency was not possible without a state to back it up—therefore, we need more Europe and a European federal state. My difficulty is not in thinking how we can find rules for such a thing to happen. As I said, the problem is in persuading people to live by the rules. Although I can understand that a fiscal union could be developed on a German model, I remain to be convinced that even if it is applied to Greece, the culture of Greek society would accept a German-style implementation of those kinds of rules. So I have difficulty in seeing not the theory but the political practicality of making it work. We need to go back to where we made some earlier mistakes.

If it is not possible for all the countries to maintain the requirements of staying within the euro, as seems to be the case, it may be unhelpful for us to insist that Europe moves forward with all those countries within the euro—unhelpful for them and for Europe. The interests of this country economically and politically require us to have a sensitive and nuanced approach to our European colleagues, not to try to press them in a direction that they cannot sustain. There are rules and debts have to be paid, either by the debtors, the creditors or the whole society through inflation or something else. However, if we do not find a new way in which to run Europe with a more variable geometry that allows all of us to remain together in peace and with variable but significant economic and political prosperity for all of us, I fear that, tragically, questions over the fundamental purpose of the European project—to maintain economic and political stability—may move back into view. That prospect should make all of us shudder.

3.21 pm

Lord Flight: My Lords, it is nearly six months ago that the noble Lord, Lord Lamont, and I at the same time asked for a debate on the eurozone's problems. It is interesting that they have been allowed to worsen since, whereas if measures had been taken a little earlier, perhaps the crisis would not be as grave. But I would like to congratulate the noble Lord, Lord Lamont, on his speech and the noble Lord, Lord Lawson, on his. It was a great pity that we could not hear all that he had to say; here we have two ex-Chancellors of the Exchequer who were in the eye of the needle at key times in recent history and who knew at first hand a lot of what went wrong at the time.

My very modest contribution is a great one for insomniacs. I wrote a book in 1988 called *All You Need to Know About Exchange Rates*. It focused on

what was going on in Europe, and there are references to the wisdom of the noble Lord, Lord Lawson. The point it made even then—a pretty obvious point—was that if countries are very disparate in their economies and some have a real Germanic hard-working ethic and others like to enjoy life you cannot share a currency. It will fall apart. People forget that Europe tried a common currency from 1863 to 1893 everywhere excepting the German states, including Switzerland as well as the other countries—the silver franc. That fell apart because France became massively uncompetitive. There are a lot of other issues but, at the heart of the problem as to why the euro is in such trouble, is because southern Europe has become 35 per cent to 40 per cent uncompetitive against efficient, northern, Germanic Europe. Who wants to buy the bonds of a country where you can see staring you in the face, one way or t'other, that there is going to be a big devaluation sooner or later? That is really at the absolute heart of the problem. You cannot share a currency when those are the characteristics.

Kohl said to Mitterrand that you cannot really embark on a common currency until you have political unification. Mitterrand said to Kohl that that would take forever to achieve, but that if there was a common currency it would force political integration and unification. Much is said about that as a potential solution to our problems. However, I do not see the reality of that. An exercise was done that demonstrated that Germany would need every year to give something like 35 per cent of its GDP to the southern economies to keep them afloat. People forget that in America 30 per cent of federal taxes still go to keeping afloat the unsuccessful regions. Even in little UK, about £80 billion per annum is transferred from the more prosperous to the less prosperous parts. If you share a common currency where there are significant economic differentials, you need substantial transfer payments to keep the less successful economies afloat. However, the sort of long-term transfer payments that would be needed for Germany, Italy, Spain and Greece to share a currency are simply not realistic.

The German solution has been to say, "Come on, you economies, have an internal devaluation and be like us". Is it realistic to think that Italy would have a 35 to 40 per cent internal devaluation? There would be blood on the streets; it would be hardly practical to achieve. I cannot remember which noble Lord made the point but he was quite right; we do not want Versailles but perhaps a bit of the Marshall Plan. I read just the other day to my amazement that Germany only finished making its Versailles reparations a year or so ago. The total payment was the equivalent of about €350 billion—and look what that did to Europe in the 1930s.

A federated Europe is not the answer to the euro's problems. I cannot see that forcing massive internal devaluations is a solution, either. Hong Kong managed to effect a successful internal currency devaluation after the Asian currency crisis, but that was one of the few successful cases.

So where are we with the various proposals? The noble Lord, Lord Lawson, made the important point that you can perfectly well change currencies if you organise it well and in time. The risk is to the banking

system. It is interesting to note not only what the Fed and other central banks organised yesterday, but that, quietly, the Bundesbank over the past six weeks has lent nearly €500 billion to the central banks of southern Europe. Not just individuals but businesses and anyone owing money had been getting their money the hell out of those countries and parking it in euros in Germany and elsewhere. In those countries, the banks are being squeezed like fury and have become forced sellers of government bonds in order to manage their balance sheets. Mercifully this has not been written up too much in the newspapers, but there is an acute banking crisis already in those economies. Yesterday was almost a rescue day before the whole thing collapsed. I note that the IMF said yesterday that the euro was within 11 days of collapse.

Contrary to what some on my side of the argument said, I support the concept of the ECB being able at least in the short term to buy government bonds, because there is a need to buy some time to work out arrangements for orderly currency reordering in the eurozone. I do not think I will win the noble Lord's competition, but it seems to me that the only other option to everyone going back to their historic currencies would be to have a soft currency for southern Europe and a hard currency for northern Europe. One could achieve that either by leaving the euro as the soft currency and bringing in a new, hard currency, or by doing it the other way round. From what one hears, there is a possibility that that may come to fruition because Germany is seriously looking by itself at bringing back the deutschmark. If that happened, Holland, several Benelux countries and probably France would endeavour to join the currency bloc. That is one solution. It is less painful than everyone going back to their individual currencies. It could be done, as occurred in 1893. It needs planning. Banks have to be closed and one has to work out who will bear what liabilities, but it is not impossible.

Keeping the banking system afloat is absolutely fundamental and again I am relieved that the US has come to the rescue. It seems to me that the management by the leaders of the eurozone over the last year has been pitiful. These problems were staring us in the face a year ago; people were writing articles and letters to the paper about them. It is not something that has just come and hit us from nowhere. The whole underlying problem has been understood as well. I just hope that it will get sorted in an orderly fashion and will not collapse in a chaotic fashion. Our economy is clearly in a precarious situation and chaotic collapse would be very bad news for this country. I am still in the camp that thinks that a hard/soft currency would work and I hope Germany will use its initiative to achieve that.

3.30 pm

Baroness Valentine: I declare that I am chief executive of London First, a not-for-profit membership organisation that seeks to make London the best city in the world in which to do business.

I will not presume to predict the denouement of the crisis in Europe. However, whatever path to stability is eventually taken, it is likely to take until at least 2020

[BARONESS VALENTINE]

for Europe to find any sort of new “normal”. With our primary trading partner in a state of flux at best, and paralysis at worst, we in the UK must carefully consider how best we can avoid contagion and the steps we can take to return to growth.

Given the likely period over which we can expect to see reduced growth elsewhere in Europe, it is clear that our own path out of recession is likely to be more challenging and slower than we had previously predicted. To use a hill-walking analogy, before the eurozone crisis we had hoped that we would be gently, if challengingly, climbing our way to the sunlit uplands in the next year or two—a pleasant hike up the South Downs, if you will. We are in a different reality now. Perhaps a better analogy might be a trudge up Ben Nevis—longer, tougher and exposed in places.

Just as there are several routes up Ben Nevis, there are numerous, sometimes competing, approaches proposed for returning to growth. The one I would like to focus most on today is investment in infrastructure. In this context I welcome the Chancellor’s announcement of £6.3 billion in additional investment in infrastructure over this spending period, although this increment is modest compared with the cut in spending from the previous Parliament. The reduction in direct public investment makes it all the more important that the new approaches to funding infrastructure that he announced, such as the memorandum of understanding with pension funds, bear fruit. Investment in economically productive infrastructure shores the UK up for the long term, gives business the confidence to invest, and provides jobs.

I also welcome the review of the PFI model that Infrastructure UK begins this week. However, I would urge the Government to bring it to a prompt conclusion. Private investment will be essential to delivering the Government’s new swathe of infrastructure projects as set out in the national infrastructure plan. However, each investment must be carefully thought through so that it delivers sustainable growth rather than quick fixes or botched jobs. We must be clear about the objectives of any project and the part played by the Government in achieving them. In this context I welcome the new Cabinet committee to be chaired by the Chief Secretary.

If we look at schemes introduced under the old PFI process, a key lesson is that you need an experienced and accountable client for them to deliver well. In practice, this means government clients must resist the temptation to overspecify or constantly tinker. It means standardisation of projects like schools and hospitals and it means being prepared to employ expertise that is not present within government. I appreciate that this runs against the grain of current thinking but there is a real risk of the Government being penny-smart and pound-foolish. Investors need certainty about what will follow from PFI and the Government need to be absolutely clear where accountability sits for the whole of any project, resolving planning issues, funding and financing, and getting the best possible deal for the public sector, otherwise we are in effect setting off without a map.

There will, of course, be many competing demands for infrastructure investment. Typically, investment in London’s infrastructure shows a higher economic return than elsewhere in the country and the capital is some 30 per cent more productive than the rest of the UK. There is therefore a strong argument for supporting projects that will help London to lead the UK through the difficult times ahead. Some of these are within the City itself, such as desperately needed river crossings in east London or the extension of the Northern line to Battersea. These would have a rapid and positive economic impact. While I welcome the government support, I should like to see it accompanied by details of proposed user charges, clarity on sources of public funding and a timetable.

There will also be difficult decisions to be taken. Almost inevitably, given the nature of infrastructure projects, there is an inherent tension between economically productive investment and political antipathy. For example, it is becoming widely accepted that the UK needs an international hub airport with greater capacity than can currently be achieved at Heathrow; the Chancellor noted as much in his speech. The lack of hub capacity is stopping the UK from having the range of direct flights to BRIC and other growing countries enjoyed by European competitors, thus undermining growth and commerce. There is an obvious solution: build a third runway, where the planning application is ready, the financing is in place and services could be up and running within a decade. Ironically, that is the one conclusion that the Government have ruled out. Perhaps the chill winds of economic circumstance have yet fully to penetrate Downing Street.

Beyond infrastructure, and as the rest of Europe works its way back to stability, the competitive position of London will increasingly be challenged. Indeed, we are already seeing this in some of the financial regulation emanating from Brussels such as the proposed financial transactions tax, which has the potential to have a disproportionately damaging effect on London as Europe’s financial capital. Likewise, when I look at the way in which some of our European competitors are forging transport links with emerging markets, I see a risk that we will be left quite literally waiting at the gate.

At the moment, the capital probably has the most successful and international professional and business services sector in the world. A recent report indicates that almost two-thirds of major international companies have an office presence in London. People come here to do deals because they know that the talent and structures are here. London is the natural launch pad for American businesses looking for a European base and vice versa, as well as a toehold for Far Eastern businesses.

Retaining those businesses and attracting more is vital for our future. As Europe is stagnating, so it is imperative that we raise our game in trading terms with the rest of the world. International businesses must see London as a strong and competitive place to do business, and that relies both on their perception of current policy and on their confidence in the Government’s future plans. Above all, the UK must be—and be seen to be—open for business. Immigration policy needs to welcome productive workers and genuine students,

employment law needs to create the conditions for more jobs, not fewer, and our regulatory approach needs the flexibility to accommodate these global players. Our corporate and personal taxes need to be seen to be competitive and consistent. At one end, I urge the Government to act on their ambition to lower the top rate of tax. Equally, I would like to see the personal allowance increased as speedily as possible, a measure that is fair and puts more money back in everyone's pockets.

I began by observing that the eurozone's path to stability was still uncertain. That being the case, it is all the more important that our own leaders demonstrate clarity of vision, certainty of direction and consistency of approach in how they address the challenges that this crisis has brought for our own country. That way, perhaps climbing the mountain ahead may feel a little more like a hike in the hills.

3.38 pm

Lord Wolfson of Aspley Guise: My Lords, it is with great pleasure that I speak for the first time in your Lordships' House. I thank your Lordships for the extraordinarily warm welcome that I have received from everyone I have come into contact with here. It is a genuine inspiration and privilege to hear the quality of debates and observations in this House. I also thank the officials and staff for their never-ending patience, helpfulness and professionalism, which are such a great asset to this institution.

I thank my supporters: my noble friend Lord Leach of Fairford, who has been something of a political mentor to me, and my father, my noble friend Lord Wolfson of Sunningdale. I realise that not so long ago it would have been a contradiction in terms for a father to introduce his son. For me it was an unusual pleasure and an apt one. My father's incisive mind, his deep work ethic, his moral courage in both business and his political life and his philanthropic convictions have been an inspiration to me. I hope that they will remain so and that they will guide me. I am not just saying that because I am his heir, by the way, in case anyone was thinking that I was just creeping.

My father's qualities reflect some of the character of his uncle, the son of a Jewish eastern European refugee who founded a great business empire and went on to do charitable works. Those have been conscientiously carried on by his son. Indeed, it is his charitable works that are more of an inspiration. It is a lesson in capitalism that it is not necessarily the making of the money but the wise spending of it that is a testament to greatness in a capitalist society. It is also a remarkable testament to this country that my great-grandfather was able to count among his descendants within three generations, three Members of this House and a Baronet. It is an extraordinary reflection of the tolerance, openness and opportunities afforded by this great nation, and it is an honour, to serve in this House which, over the centuries, has done so much to shape and protect the laws and liberties of this land.

Today, we are talking not about protecting our laws and liberties, but protecting our finances. I worry about all the hard work that is going into propping up the eurozone at the moment. To use an analogy, it is

like a group of men standing around a fire on a freezing cold night. The fire is beginning to dwindle, and slowly but surely they decide that the best thing they can do to keep it going is to take their coats off and burn them. At some point I worry that we will run out of coats. The German standing by the fire does not have an infinite supply of clothes to burn on the fire. If nations are to behave responsibly at this time, we must face up to the possibility that the eurozone may well collapse. The noble Lord, Lord Ashdown, instructively pointed out that the euro may survive, but that it is likely to do so in a lesser form.

The turmoil and problems caused by a collapse would be enormous, but I do not believe ultimately that the reason for it is anything to do with the financial markets; it is to do with the labour markets. It is to do with the structural problems that have caused these financial problems. The fact is that over the past 10 years, Greek wages have risen by around 30 per cent relative to German wages. Wages in Spain and Portugal have risen by 20 per cent more relative to German wages. That has locked them into a structural lack of competitiveness. Internal devaluation is simply not an option, because people have mortgages and debts. If they take a pay cut, they cannot take a debt cut. If they take a debt cut, that is a real devaluation; that would mean leaving the eurozone. What happens when countries leave the eurozone is the challenge I am most worried about.

The noble Lord, Lord Lamont, was kind enough to refer to a prize that I have initiated. I am hoping that, having heard this debate, there will be a Lords entry and we can pool our resources, although obviously I would not be part of the team myself. The big problem for me is not what happens to trade, because I think that it will sort itself out. I am a trader and I am used to dealing with big swings in the valuation of currencies. The major problem is the banks. The position that we in this country must worry about is the position of the British banks with subsidiaries in southern European countries, particularly where they have more loans and mortgages outstanding than they have deposits. I would be interested to hear the Minister's view on this. Do the Government have a clear view of what the exposure of British banks would be in the event that certain countries leave the eurozone? British banks could be left with an enormous exposure to debt that would have to be written off. The problem is that whatever view we have at this time of the size of that exposure, it can change. That was pointed out by my noble friend Lord Flight. It can change overnight, and indeed some £500 billion-worth of those deposits have already moved from the weaker countries to the stronger ones.

It is my belief that unless something is done urgently to control this flight of capital, the crisis that will eventually emerge will be far worse. We are facing a Catch-22 of enormous proportions. If the Governments of Europe begin to impose anything that looks like capital controls, that in itself will precipitate the end of the eurozone. If they do nothing, the end of the eurozone will be that much worse.

I finish by saying that, in my view, it is a far better approach to take the bolder of these two choices, and address the issue of capital flight now, before it is too

[LORD WOLFSON OF ASPLEY GUISE]

late, with all the risks associated with it. In a case where you have to choose between making a bad decision and making a very bad decision, it is always best to make the bad one.

I thank your Lordships for hearing my maiden speech with such silence and respect and even with apparent interest. I, too, am disappointed that I was not able to make it in the Chamber.

Noble Lords: Hear, hear.

Lord Wolfson of Aspley Guise: However, I am at least able to say that I made it in front of a full house, so I thank your Lordships very much.

3.45 pm

Lord Hollick: It is a great pleasure to follow the maiden speech of the noble Lord, Lord Wolfson. He showed great humanity and insight, with a nice, witty touch. He is a man of considerable distinction in the business world and, as we have heard today, comes from a family of great distinction. He was the youngest CEO in the FTSE 100 when he was appointed as CEO of Next. He showed, as has been mentioned on a number of occasions, a great flair for promoting some of the causes close to his heart when he announced his £250,000 prize—no mean prize, that. Perhaps he might like to consider a more modest prize for Peers who can come up with an exit strategy from the current economic turmoil that we find ourselves in. Sadly, as he has pointed out, he will be unable to participate in that, as House rules would probably prevent him under a conflict of interests. I congratulate him on his speech, and we very much look forward to his contributions.

I am very grateful to the noble Lord, Lord Lamont. There are two debates here, one about Europe and one about the United Kingdom. I intend to talk about the United Kingdom, but obviously against the background of all that has been said on Europe. The OBR report was a truly sobering document. There has been an alarming deterioration in the public sector finances, with borrowing set to rise by more than £150 billion above last year's forecast. Growth has stalled for at least another 18 months, with all the risks on the downside. Household budgets, down by 2.3 per cent this year, are under intense pressure, particularly for the less well-off. This takes place against the existential threat of the disintegration of the eurozone, with all the consequences that have been colourfully and accurately made plain in this debate.

The Chancellor's key economic judgment in 2010 was that fiscal consolidation would promote growth, that private sector growth would replace the jobs lost in the public sector and that private sector investment would make up for the shortfall in public sector investment. That judgment has been shown to be wrong. If you peel away the rhetoric, the Chancellor is now admitting as much. He is now being urged by both the IMF and the OECD to consider a more flexible approach, with a staged approach to cuts combined with temporary tax cuts. The Chancellor, like his predecessor, has worked hard and successfully to maintain credibility in the financial markets. As we

have seen in the eurozone over the past few months, once credibility is lost, it is hard and very painful to regain: borrowing costs increase to quite unsupportable levels. Financial markets want to see a clear plan, effectively implemented; but they are also well aware that fiscal consolidation without economic growth is a dead end. The risk in today's very volatile world economy is that our current recession will turn into a depression.

In March, the Government published *The Plan for Growth*, with 137 measures. They have just published a scorecard on how they are getting on with these measures. The OBR judged at the time that the measures would have no significant impact on growth. So how does the latest package shape up? Is this apparently long list of rather hurriedly assembled growth measures likely to make any measurable difference? It will not, according to the OBR, until 2014-15. I would be grateful if the Minister could confirm that the Treasury also agrees that the measures will have no discernible effect over the next three years, when growth is most needed.

In our debate on growth in March, noble Lords on all sides of the House urged the Government to focus on infrastructure and SME financing. The Government listened and acted. The noble Lord, Lord Skidelsky, has long advocated an infrastructure bank, which I enthusiastically support. An independent specialist bank that can evaluate risk, access and finance projects and possibly take advantage of the Government's ability to borrow at ultra-low interest rates will be essential if we are to encourage pension funds to invest in infrastructure. Pension funds are indeed hungry for safe, long-term, inflation-proof returns. However, all the evidence suggests that they prefer to invest in established projects with proven cash flows, not in risky greenfield projects.

SMEs create jobs and bring competition to established players, to the benefit of productivity and the consumer. SMEs are now coming to the centre of the political debate. On the supply side, more rigorous competition needs to be stimulated in sectors such as banking, utilities and energy supply if new entrants are to be encouraged to enter the market. Of course, funding must be more readily accessible. Credit-easing initiatives are welcome, particularly after the poor experience of Project Merlin. However, the Treasury is still far too fixated on debt finance. Many of our SMEs are undercapitalised by international standards, in part because the tax system treats debt finance more favourably than equity finance. With insufficient equity, the SME owner pays a very steep price to the bank and has to pledge all his assets to raise a loan.

Instead of tinkering with minuscule tax reliefs for EIS or VCT schemes, why do we not tap into the considerable cash resources of entrepreneurs and the wealthy in our society and encourage them to invest risk capital in SMEs by allowing equity subscription to be written off against the marginal rate of tax? This would not only bring in much needed equity to SMEs but would make available the experience and knowledge of the investors. I can testify that the smart-investor model works well in the venture capital industry here and in Europe, and it is one of the key ingredients behind the successful level of business formation in the United States.

Why SMEs are not borrowing is apparently a mystery to the Treasury. The reason is simple: why should they take on more borrowing to increase capacity if there is no sign of an increase in demand? When Bob Diamond appeared recently before the Economic Affairs Committee of this House, he noted that since the start of the year more than 40 per cent of Barclays business customers had increased the level of their cash deposits with his bank because they saw no merit in investing at a time of weak demand.

If the Government are to deliver growth, they must stimulate demand. Now that the Chancellor is embracing a more flexible and interventionist approach, he needs to be bolder. He should borrow to finance infrastructure projects that generate cash returns, and should stimulate demand by lowering taxes such as VAT and the basic rate of income tax, which will feed directly through to consumption. He should provide much bigger tax incentives to invest in SMEs and to encourage employment and training. He has already identified a number of areas where taxes can be raised without damaging growth. I suggest that he should now bear down even harder on loopholes such as the stamp duty avoidance scheme on expensive properties and on the regressive structure of community charges. Now that he has at last embraced a new approach, he needs to turn this week's mish-mash of measures into a bold and coherent plan to promote growth through investment and demand management.

3.53 pm

Lord MacLennan of Rogart: My Lords, it is a very great pleasure to follow the maiden speech of the noble Lord, Lord Wolfson of Aspley Guise. In Glasgow, where I was brought up, his family was regarded not only as distinguished but as one that aspiring young people ought to emulate. I had the privilege of meeting some of his family in that great city rather a long time ago. I enjoyed what he had to say, as I believe the whole Committee did, and we look forward very much to his future participation in our debates.

The euro crisis has been repeatedly cited as the external factor that has blighted Britain's economic recovery prospects. It therefore seems to follow that this country ought to do all that is within its power to assist in the resolution of that crisis. The attitude of the responsible Ministers has, I fear, been insufficiently supportive of the efforts being made by the other European Governments to avert the risk of sovereign default and spreading contagious bank collapses.

In the somewhat bullish report that the Chancellor of the Exchequer, Mr Osborne, gave to the House of Commons after the European summit of 26-27 October, he indicated that, although the IMF could use,

"its expertise and advice to help the eurozone to create the special purpose vehicle that it is considering",

he emphasised not only that the IMF,

"cannot put its own resources in"—

as he put it—but that Britain would not put its resources in either. Having stood back, the Chancellor then saw fit to call for the eurozone countries to produce their plans,

"to increase their firewalls and sort out Greek debt".—[*Official Report*, House of Commons, 27/10/11; col. 471.]

While it is clear that our Government recognise that it is in Britain's interest that the euro operates more effectively, it is rather obscure how the Government are working to bring that about.

The situation has deteriorated in the past few weeks. Risk premiums on the bonds of the AAA-rated Austria and France rose to record levels. It was pointed out this week, on 28 November, that two decisions were made at the summit with damaging consequences that were not intended. I quote a report from Reuters Breakingviews:

"First, banks underwent a stress test that marked their sovereign bond exposures to market whereas previously regulators maintained the fiction that these positions were risk-free. This meant that lenders suddenly had to start holding capital to back their sovereign debt investments. Not surprisingly, they have become more reluctant to buy bonds. This, in turn, has made it harder for governments to fund themselves. Second, the summit decided to strong-arm the banks into agreeing to",

what was described as,

"a 'voluntary' debt restructuring for Greece. Because the deal is supposedly voluntary, credit default swaps (CDS)—a type of insurance policy that pays out if an entity goes bust—won't be triggered. This arm-twisting has convinced lenders that CDSs are a useless way of hedging the risk of investing in euro zone government bonds. Without a hedge, many prefer not to hold the bonds at all—again making it harder for states to fund themselves".

Despite these political problems, it does seem that there has been some good political news. The new Prime Ministers of Greece, Italy and Spain have all indicated their determination to cut debt and make their economies much fitter. None the less, they will have an impossible task if investors cannot be convinced that the euro is here to stay. Perhaps the central hope of restoring confidence lies with the European Central Bank. If it can devise support for Governments who are intent on restructuring their economies, that should be backed. It does not necessarily mean that it has to become a lender of last resort; however, that prospect has definitely been advocated by many in this country and elsewhere, although reluctantly considered by Germany. Germany should certainly consider ways and means by which the central bank could go further, to assist the problem of facilitating its greater involvement. Of course, Germany is afraid of the lack of adherence to the terms of the stability and growth pact in some of the peripheral countries—perhaps overlooking what it did itself in the earlier days, which has already been referred to in this debate.

This country should also back the central bank, although we are not part of the eurozone. It was rather surprising that the Government indicated that they would not contribute money to the IMF that might be contributed to Europe. That seems to me to be a bizarre position and certainly makes it more difficult to give credence to the thought that the present Government are actually trying to help the eurozone. The EFSF might be the recipient of loans from the European Central Bank to bring its firewall into effect. Given that the ECB is not at present committed directly to fund Governments, perhaps it could itself lend to the IMF, which in turn could lend to Italy and Spain.

The German recognition and requirement of fiscal discipline is rational and should certainly be embodied in the revised treaty, but perhaps that might be extended to form a debt union, with the mutualisation of debt

[LORD MACLENNAN OF ROGART]
jointly and severally guaranteed. However, such moves cannot be made overnight and will not deal with the immediate problem. The threatened countries must now pool their thinking on what are acceptable debt targets and the timing of their implementation, and that will not be a uniform scenario; it will have to take recognition of the different platforms from which countries are starting.

Before Britain loses its reputation altogether as a concerned member of the European Union, it should seek to use its position to indicate ways in which the situation can be taken forward. Showing good faith rather than Euroscepticism can have a catalytic effect.

[For the continuation of today's proceedings, see Official Report, 5 December 2011.]

Written Statements

Thursday 1 December 2011

Benefits: Disability *Statement*

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

The Government are today announcing that the mobility component of disability living allowance will not be removed from people living in residential care homes and that the mobility component of personal independence payment, which will replace disability living allowance, will also be payable at both the standard or enhanced rate to people in residential care homes provided they satisfy the entitlement conditions.

In the spending review 2010 it was announced that, from October 2012, the disability living allowance mobility component would be withdrawn from people in residential care homes after 28 days. Our aims have always been to ensure not only protection of public funds but also that disabled people who live in residential care homes retain their independence and are not prevented from getting out and about.

In response to concerns raised about this proposal, the Government announced that it would not remove the mobility component from people in residential care homes from October 2012 and that it would look again at the underlying evidence and gather more, before reaching a final decision on the way forward for the new personal independence payment. We have now gathered and reviewed further evidence, including the helpful contribution provided by Lord Low's review. Although this does show that the issue of mobility needs for people in residential care homes presents a complex and varied picture there was insufficient evidence of overlaps in funding provision to justify the withdrawal of the mobility component.

Having listened to the concerns raised and carefully considered the evidence the Government will now table an amendment to the Welfare Reform Bill for consideration at Lords Report stage to remove the provision which allows for withdrawal of the mobility component of personal independence payment from residential care home residents

Child Maintenance *Statement*

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

I am today publishing a consultation document on the calculation methodology for the new statutory child maintenance scheme, to be launched next year.

The Government want to encourage and support parents to make their own family-based arrangements, but are committed to providing a statutory service for those separated parents who are unable to co-operate.

As part of our programme of reforms, the existing Child Support Agency schemes will be replaced over time with a new, efficient scheme for those parents who are unable to make their own arrangements.

The aim of the new scheme is to produce a faster, more accurate and transparent process for assessing child maintenance payments. Payments will usually be based on the non-resident parent's latest tax year gross income, sourced directly from HM Revenue and Customs. This will make the scheme less dependent on information from non-resident parents and so make it harder for non-resident parents to avoid their responsibilities by not disclosing their full income.

Annual reviews will ensure that cases are kept up to date in a way they are not on the current CSA schemes.

I am also announcing two proposals today which would provide particular benefit to parents with care, who are generally mothers with children.

The Child Maintenance and Other Payments Act 2008 provided for the flat rate paid by non-resident parents on benefit and low income to be increased from the current £5 to £7. I am today consulting on whether this should be increased further to help ensure more children receive the financial support they need.

I am also consulting on achieving a fairer situation for children to get closer to equalising the financial support for children living with, and those living apart from, the non-resident parent.

The consultation document, the impact assessments and draft regulations will be available on the Child Maintenance and Enforcement Commission (CMEC) and Department for Work and Pensions websites later today. A link to the CMEC website is attached below.

Copies of the consultation document and the impact assessment will be placed in the Libraries of both Houses.

<http://www.childmaintenance.org/en/publications/consultations.html>.

Department for Work and Pensions: Contingencies Fund *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 Department of Work and Pensions has obtained approval for an advance from the Contingencies Fund of £800,000 to allow for the development of IT. This amount is part of the proposed investment in conditionality and sanctions changes of £3 million agreed at the time of the spending review

In October 2012, the conditionality and sanctions project will introduce a claimant commitment, designed to give greater clarity to claimants about the consequences of failing to comply with their job seeking or work preparation requirements. This will be underpinned

by a more robust sanctions regime with tougher sanctions for repeated non-compliance, and a revised hardship regime. These changes will align current key benefits with the proposed policy for universal credit, which will simplify the migration of existing claims on to universal credit from 2013.

The advance from the Contingencies Fund will allow essential work to commence on detailed process design and IT changes, to enable the implementation of the new conditionality and sanctions regime in advance of universal credit.

Parliamentary approval for additional resource and capital of £3 million for this new service will be sought in the supplementary estimate for the Department for Work and Pensions. Pending that approval, urgent expenditure estimated at £800,000 will be met by a repayable cash advance from the Contingencies Fund.

Disabled People

Statement

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

I am pleased to announce that today the discussion document, *Fulfilling Potential*, was published. This sets out the Government's vision of enabling disabled people to fulfil their potential and have opportunities to play a full role in society.

Fulfilling Potential invites disabled people and their organisations to help shape future policy and develop a cohesive new cross-government disability strategy. This will be a key part of our commitment to breaking down the barriers to social mobility and equal opportunities faced by disabled people in Britain today.

Fulfilling Potential outlines three main areas for discussion: realising aspirations, increasing individual control and changing attitudes and behaviours. It seeks practical ways of making a real difference to disabled people's lives, even in these difficult economic times.

The Government inherited a wide range of relevant strategic thinking including the Life Chances report, the Independent Living Strategy, and the Roadmap 2025. We will build on this and on the UK's commitment to the UN Convention on the Rights of Disabled People. We will work closely with the devolved Administrations to share best practice and strategic approaches.

Following a three-month engagement period, we will publish our new strategy in spring next year.

Employment: Migrant Workers

Statement

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

The Government are committed to the free movement of workers within the European Economic Area, and also to protecting the sustainability and affordability of our welfare systems. As part of that commitment we want to ensure that non-active migrants from outside the EU cannot gain access to welfare if they have never worked or paid contributions in the United Kingdom.

In considering proposals to amend the social security provisions of the EEA agreement, we took the view that the proposals would have the effect of extending social security co-ordination to non-active persons moving between the EU and EEA. Furthermore, the proposal was based on treaty powers for the co-ordination of social security schemes in relation to the free movement of workers within the EU (Article 48 of the Treaty on the Functioning of the European Union), whereas the provisions related to free movement between the EU and the EEA states.

In focusing on the nature and content of the proposal rather than the cited legal base, the Government came to the conclusion that the appropriate legal base was Article 79(2)(b) TFEU, which allows the EU to adopt measures concerning the free movement rights (including social security rights) of third country nationals. Article 79(2)(b) lies within Title V of Part III of the TFEU, and so the Government considered whether they wanted to opt in to the measures; and we concluded that we did not want to opt in.

In negotiations we continued to argue for a change to a Title V legal base, and that the UK's position be reflected in the text, but were unsuccessful. The decision on the position to be adopted by the EU was put to the Employment, Social Policy, Health and Consumer Affairs Council in June 2011. The Government expressed our serious concerns over the legal base for the proposal, and noted our right to take further action. The council decision was none the less adopted, and a further decision giving effect to the measures was adopted in the EEA Joint Committee on 1 July 2011.

In parallel with these processes, we considered across government the options, including legal action, open to us and we have decided to take direct action in the European Court on the basis that the Article 48 legal base is incorrect and that the council decision is therefore invalid. That action was initiated on 16 August by submitting an application on behalf of the UK to the Court of Justice of the European Union.

I believe this action demonstrates how seriously the Government take our obligation to protect our rights under the Treaty on the Functioning of the European Union.

Energy: Carbon Reduction

Statement

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

The Government are today publishing the Carbon Plan, setting out the Government's long-term plans to meet their carbon targets, including the fourth carbon

budget set earlier this year. The plan shows how doing so will set us on a plausible pathway to our 2050 target to reduce emissions by at least 80 per cent from 1990 levels. The plan will help drive new high-value economic sectors and save billions through energy efficiency.

The Carbon Plan shows that UK emissions have already been cut by more than 25 per cent on 1990 levels. With the policies already in place the economy will easily exceed the 34 per cent target set for the first 15 years under the Climate Change Act, and would have done so even if the recession had not occurred. Meeting the fourth carbon budget of a 50 per cent cut in emissions by the mid-2020s will not have any additional cost implications during this Parliament, but beyond that will galvanise jobs and investment during a decade of mass deployment of key technologies.

In the next decade, the UK will complete the cost-effective measures begun in the previous decade, in particular focusing on energy efficiency. We will also need to prepare for the future by demonstrating and deploying the key technologies needed to entirely decarbonise power, buildings and road transport in the 2020s and beyond. Rather than picking winners, the Government will support the development of a portfolio of technologies for each sector in order to drive innovation and lower costs. As part of the Carbon Plan, we are publishing the updated list of the key actions that each government department and the devolved Administrations are taking in each sector during the lifetime of this Parliament, to provide further transparency and accountability.

In the 2020s, these key technologies will move towards mass rollout. Developing options now will not only reduce the costs of deployment in the 2020s, but it will also enable the UK to gain a long-term competitive advantage.

Up to 2030 and beyond, emissions from the hard-to-treat sectors, such as industry, shipping and agriculture, will need to be tackled. This will require a range of solutions to be tested in the 2020s at the latest, such as more efficient practices in agriculture; switching from oil and gas to bioenergy or low-carbon electricity in industrial processes; and deploying carbon capture and storage.

Today's package represents a significant step forward in our commitment of moving to a low carbon economy. To the negotiators in Durban working this week and next to make progress on a global agreement on climate change, the Carbon Plan shows the UK is walking the walk, demonstrating that even in tough times it can be done and living up to our promise to show climate leadership.

To the public and businesses at home, rightly worried about the cost of living and state of the economy, the Carbon Plan shows that the gradual rebalancing of our economy away from carbon is achievable and, in the long run, highly desirable.

Our national economic interest is to be found in a cost-effective transition to low carbon. Every bit of progress we make is one more step away from import dependency, away from the emissions that are likely to lead to savage weather impacts, and towards an economy that wastes less and saves more.

Energy: Nuclear Power 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.

The Department of Energy and Climate Change (DECC) will today publish two documents that further demonstrate the Government's commitment to managing our existing nuclear legacy and sites in a responsible manner.

the conclusions of its consultation on the long-term management of UK-owned separated civil plutonium and:

our response to the recommendations for Government contained in the chief nuclear inspector's final report on events at the Fukushima nuclear site in Japan that was published on 11 October 2011.

Management of the UK's plutonium stocks

The consultation was published in February and set out for public scrutiny Government's preliminary view on the long-term management of the UK's plutonium. In particular, the consultation covered the security and proliferation sensitivities associated with continued storage of plutonium, and how these could best be managed in the interests of future generations.

The consultation document made it clear that, although there remain many issues to be resolved before any policy could be implemented, the UK Government believed that there was sufficient information available to make a high-level judgment as to the right strategic policy option for plutonium management. The Government therefore proposed a preliminary policy view to pursue reuse of plutonium as mixed oxide fuel (MOX); converting the vast majority of UK civil-separated plutonium into fuel for use in civil nuclear reactors. Any remaining plutonium whose condition is such that it cannot be converted into MOX, will be immobilised and treated as a waste for disposal.

Having considered all responses received during the consultation period the UK Government have concluded that they have identified the right preliminary view. Accordingly, the Government confirm this as the preferred policy. While the UK Government believe they have sufficient information to set out a direction, it is not yet sufficient to make a specific decision to proceed with procuring a new MOX plant. Only when the Government are confident that their preferred option could be implemented safely and securely, that is affordable, deliverable, and offers value for money, will they be in a position to proceed with a new MOX plant. If we cannot establish a means of implementation that satisfies these conditions then the way forward may need to be revised.

The Government are now commencing the next phase of work, which will provide the information required to make such a decision. The next steps towards will see further information being gathered by the Government and NDA through detailed commercial discussions on the market for MOX fuel and the availability of reactors in which it can be burned.

Other discussions will focus on detailing the costs and timescales for procuring services or facilities, including a suitable MOX plant, which can be delivered at minimum risk to Government.

Further work streams will take forward the requirements for the justification of the whole MOX path from fabrication, through use to disposal, which will be required before UK Government can commit to spending significant capital on procuring a new MOX fabrication plant.

In addition the Government have concluded that overseas owners of plutonium stored in the UK could, subject to commercial terms that are acceptable to UK Government, have their plutonium managed alongside UK plutonium, in line with a reuse policy. Where appropriate and subject to compliance with intergovernmental agreements and commercial arrangements that again, are acceptable to Government, the UK would be prepared to take ownership of overseas plutonium stored in the UK after which it would be managed alongside UK plutonium, again in line with a reuse policy.

While converting the plutonium into MOX is the most credible and technologically mature option, the Government remain open to any alternative proposals for plutonium management that offer better value to the taxpayer, and will seek to gather more data on all options.

Copies of the consultation response have been placed in Libraries of the House or can be obtained from the DECC website: <http://www.decc.gov.uk/consultations/Default.aspx?status=28&area=0>

Weightman report on events at the Fukushima nuclear site.

I welcome the findings and recommendations in Dr Weightman's report and commend him and his team on the important work that they have undertaken in pulling together information and lessons from the events in Japan.

In the response the Government set out work we have done or intend to do in implementing Dr Weightman's recommendations, including:

continuing to work with our international partners on nuclear safety, particularly through the development of the IAEA director-general's action plan;

taking forward work from the Nuclear Emergency Planning Liaison Group review of the UK's national nuclear emergency arrangements in light of the experience of dealing with the prolonged Japanese event; and

ensuring that openness and transparency are enshrined in the work we are taking forward to create the ONR as a statutory body.

Copies of the Government response have been placed in Libraries of the House or can be obtained from the DECC website: http://www.decc.gov.uk/en/content/cms/meeting_energy/nuclear/safety_and_sec/weightman/weightman.aspx.

EU: Competitiveness Council Statement

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): The EU Competitiveness Council will take place in Brussels on 5 and 6 December 2011. I shall represent the UK on internal market and industry issues on 5 December, and my right honourable friend the Minister of State for Universities and Science (David Willetts) will represent the UK on research issues on 6 December.

The internal market and industry substantive agenda items on 5 December will be: a policy debate on enhanced co-operation in the area of the creation of unitary patent protection; a policy debate on unitary patent protection with regard to the applicable translation arrangements; agreement of general approach for proposals for a directive regarding interconnection of central, commercial and companies registers; a presentation by the Commission regarding business competitiveness and SME programme; a policy debate on a unified patent court and draft statute; adoption of council conclusions for the industrial policy flagship initiative; adoption of council conclusions on impact assessment in the council; an exchange of views on results from the Single Market Forum; and adoption of council conclusions regarding customs co-operation with eastern neighbouring countries.

A number of other items will be discussed under AoB. This will comprise Commission presentations and updates on the following:

European shipbuilding;

proposal for a regulation on European standardisation; proposal to align product harmonisation directives to Decision 768/2008 (NLF);

results of the European Tourism Forum and Informal Ministerial Meeting;

results of the conference on the Implementation of Lead Markets Initiative and the European Innovation Partnerships (Warsaw, 26 and 27 October 2011);

Single Market Act implementation;

services directive: state of implementation;

consumer market scoreboard;

proposal for a regulation on a European observatory on counterfeiting and piracy;

proposal for a directive on the protection of orphan works;

proposal for a regulation of the European Parliament and of the Council concerning customs enforcement of intellectual property rights;

proposal for a directive on alternative dispute resolution (ADR) and proposal for a regulation on on-line dispute resolution (ODR);

proposal for a regulation of the European Parliament and of the Council on a consumer programme (2014-20);

cohesion policy;

REACH: report and review in the light of EU Competitiveness;

REACH and the candidate list of substances of very high concern; and

work programme of the incoming Danish presidency.

The research substantive agenda items on 6 December will be: a presentation and exchange of views of the Framework Programme for Research and Innovation (Horizon 2020); a Commission overview on progress towards agreeing the Euratom Framework Programme for 2012-3; adoption of council conclusions regarding launching of joint programming initiatives on “Healthy and Productive Seas and Oceans”; “The microbial challenge—An emerging threat to human health”; “Connecting Climate Knowledge for Europe (Clik’EU)”; “Urban Europe—Global Challenges, Local Solutions”; “Water Challenges for a Changing World”; and adoption of council conclusions on partnering in research and innovation. There will also be an adoption of space council orientations on the value of space for the security of European citizens.

The research, space and any other business items will comprise: information from the Commission regarding active and healthy ageing; a presentation by the Commission on the European earth monitoring programme (GMES); information from the Hungarian delegation regarding the Budapest declaration on agricultural research; and information from the presidency regarding the report on the high-level ministerial group on simplification.

The Government’s objectives for the council are:

to contribute to a debate on political aspects of the patents package (the patent regulation, languages regulation and the Unified Patent Court);

confirm agreement with council conclusions or general approaches with respect to companies registers, industrial policy and customs co-operation;

further progress on impact assessment in council; express the UK’s initial views on the Horizon 2020 proposals; and

agree new joint programming initiatives and conclusions on partnering in research and innovation.

European Parliament *Statement*

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): My honourable friend the Minister of State (David Lidington) has made the following Written Ministerial Statement.

Following ratification by all 27 member states of the European Union, the protocol amending Protocol No. 36 to the EU treaties on transitional provisions, which made amendments to the composition of the European Parliament, entered into force on 1 December 2011. The protocol was approved for the purposes of Section 5 of the European Union (Amendment) Act 2008 by Section 15 of the European Union Act 2011.

The protocol allotted to the United Kingdom one additional seat in the European Parliament. As the statement on 26 October 2010 by the Parliamentary Secretary to the Cabinet Office set out, the Electoral Commission undertook an independent analysis to determine which European electoral region in the

United Kingdom the new MEP should be assigned to. As a result of its analysis the Electoral Commission, in compliance with its obligations under the European Parliament (Representation) Act 2003, decided that the West Midlands should be the recipient region. The Government accepted this recommendation.

The returning officer for the West Midlands region referred to the results of the 2009 European elections, as if the extra seat had been available in the West Midlands electoral region in those elections. This method of filling the seat is in accordance with the terms of the protocol and is in line with the practice of most of the other member states which gain additional MEPs under the protocol. In accordance with the procedure set out in Schedule 2 to the European Union Act 2011, the returning officer has declared Anthea McIntyre to be returned as the additional MEP for the West Midlands.

This is an interim measure until the next elections to the European Parliament take place in June 2014. At those elections all UK MEPs, including the MEP for this extra seat, will then be elected in compliance with the normal procedure.

Further Education *Statement*

The Parliamentary Under-Secretary of State, Department for Business, Innovation and Skills (Baroness Wilcox): My honourable friend the Minister for Further Education, Skills and Lifelong Learning (John Hayes) has today made the following Statement.

The Government are today publishing *New Challenges, New Chances: Further Education, Skills System Reform Plan: Building a World Class Skills System* and the underpinning Skills Investment Statement for 2011-14, copies of which are being sent to all honourable Members and placed in the Library.

Our vision is for a further education and skills system in England freed as far as possible from central bureaucratic burdens, thus able to respond more effectively to the needs of local learners and employers and so make the maximum possible contribution to renewed growth.

Our plan is based on 10 key policy commitments:

we will empower learners—from basic through to higher level skills—to shape the system through their participation. First class information will inform their choices, with government funding focused on supporting students where it can have most impact;

we will launch a National Careers Service in April 2012 to provide information, advice and guidance which both informs and stimulates demand for further education, work-based training and higher education. Lifelong learning accounts will equip learners with the information they need to make the most of their learning opportunities;

we will create a vocational pathway as navigable, rigorous and attractive as the academic route, so recalibrating the character of higher learning;

we will develop and promote excellent teaching, by establishing an independent commission on adult education and vocational pedagogy to develop a

sector-owned strategy and delivery programme. We will also facilitate an independent review of professionalism in the FE and skills workforce;

we will take further action to ensure that qualifications are of high quality and comprehensible, by improving awareness of the Qualifications and Credit Framework—consulting employers on their engagement in qualification development—and by consulting on the character and function of National Occupational Standards; we will take action to remove restrictions and controls on college corporations, creating new roles for governors, working closely with other educational providers in post-14 learning, with local stakeholders taking the lead in developing delivery models to meet the needs of their communities;

we will continue our programme to free the FE system from central control, building upon the successes already achieved, including further work by the Skills Funding Agency with colleges to remove bureaucratic burdens;

we will provide £3.8 billion a year of public funding to the sector and we will create a simple transparent funding system that is both robust in ensuring funding enables high quality provision that delivers good value for money, and which responds to local needs; we will empower students by providing better access to quality information to make informed choices, determined by a better understanding of opportunities for further learning and employment destinations. Simultaneously, to assure quality, we will take swift action in relation to failing provision, providing intensive support and, if necessary, intervening to ensure that alternative and innovative delivery approaches are secured for the future; and

we will build on the growing international demand for practical, technical and higher level vocational skills. Inspired by the legacy of our achievements at WorldSkills 2011, we will stimulate and support the sector to take advantage of opportunities in the global market.

Housing *Statement*

The Parliamentary Under-Secretary of State, Department for Communities and Local Government (Baroness Hanham): My right honourable friend the Minister of State for Housing and Local Government (Grant Shapps) has made the following Written Ministerial Statement.

Today, I am pleased to announce the delivery of 159,000 more homes over the last year, and £431 million of government funding to local authorities.

The new homes bonus is a powerful, simple and transparent incentive for housing growth. It is a key part of the housing growth focus of our national housing strategy, which we published on 21 November. Commenced in April 2011, the bonus is based on the council tax of additional homes and those brought back into use, with an additional amount for affordable homes, for the following six years. It ensures that those local authorities which promote and welcome growth can share in its economic benefits, and build the communities in which people want to live and work.

The bonus will be paid in respect of 159,000 homes from October 2010 to October 2011 including 137,000 extra homes and 22,000 long-term empty properties brought back into use. The allocations also include the first affordable homes enhancement, which totals £21 million in respect of 61,000 new affordable homes.

This means we will pay councils £431 million of provisional new homes bonus for local authorities in England. This includes the second instalment of £199 million in respect of year one and £232 million for housing growth in year two.

We are committed to ensuring that the bonus remains a flexible, non-ringfenced fund, for local communities to spend as they see fit—from reinvesting it in housing or infrastructure, support local services or local facilities, or using the funds to keep council tax down. Local authorities are best placed to understand the barriers to growth in their areas, the needs of their local communities and lead a mature debate about the benefits that growth can bring. There are already good examples of local authorities using the bonus in a variety of ways. For example Wychavon is returning up to 40 per cent to the community where growth is taking place. Liverpool is reinvesting in a commitment to deliver 2,000 new homes. The Vale of White Horse is investing in business growth by making the car parks free in the three local market towns of Abingdon, Wantage and Faringdon.

The new homes bonus is a key part of our ambition, set out in the local growth White Paper, to create a fairer and more balanced economy through encouraging growth. It will sit alongside the Government's proposals to allow local authorities to benefit from economic growth by the local retention of business rates. Our reformed community infrastructure levy allows local authorities to ensure development contributes to the infrastructure needed to support growth and will give people a real say in spending to deal with the impacts of growth on their neighbourhoods.

On top of these provisional allocations, we will address any loss of new homes bonus in areas affected by last summer's riots through riot recovery funds

Local authorities will have until 30 December to make representations on their provisional allocations. The department has written to local authorities with details for making representations on their authority's provisional allocations and I have also written to all Members of Parliament in England.

A full list of the provisional allocations is being placed in the Library of the House. Further information on the bonus, including the first *New Homes Bonus Bulletin—Unlocking the Bonus* can be found at: www.communities.gov.uk/housing/housingsupply/newhomesbonus.

A copy of the Bulletin is also in the Library of the House.

Legal Aid *Statement*

The Minister of State, Ministry of Justice (Lord McNally): My right honourable friend the Lord Chancellor and Secretary of State for Justice (Kenneth Clarke) has made the following Written Ministerial Statement.

The Government set out their intention to introduce competition for the procurement of legally aided services in *Proposals for the Reform of Legal Aid in England and Wales* (November 2010). The consultation paper stated that the immediate focus would be on criminal legal aid, with civil and family legal aid to be addressed over a longer period. The response to the consultation (June 2011) stated that proposals for criminal legal aid competition would be published in a separate consultation paper during 2011. This Statement provides an update on the Government's position in relation to competition and criminal legal aid services, and a timetable for future activity.

The Government believe that competitive tendering is likely to be the best way to ensure long-term sustainability and value for money in the legal aid market. Pressure on legal aid expenditure is likely to continue, increasing the need for further reform of the current arrangements for administratively set remuneration rates in the absence of competition.

The Government believe that tendering criminal defence work for competition, alongside regulatory changes, has the potential to significantly modernise legal aid provision, improve the service provided to legal aid clients, streamline the procurement process and deliver value for money for the taxpayer.

Clearly the development of a competition strategy will be likely to have a substantial impact on the market for legally aided services, as will a number of other current developments. These changes will require significant levels of engagement between the Government and the profession. We plan to begin these discussions in early 2013 once the key components of our legal aid reform package, the regulatory changes allowing alternative business structures, and the introduction of the quality assurance scheme for advocates have had time to bed down. We will publish a full formal consultation document on the competition strategy towards the end of that year. The indicative timetable for the development of our competition strategy is therefore as follows:

- consultation paper published—autumn 2013;
- response to consultation paper—spring 2014;
- tender opens in first competition areas—autumn 2014; and
- first contracts go live—summer 2015.

I would also like to inform the House that we intend, subject to parliamentary approval of the Legal Aid, Sentencing and Punishment of Offenders Bill, to implement all of the legal aid reforms in April 2013. This will include the abolition of the Legal Services Commission under the Bill and the creation of the new agency in its place.

Libya *Statement*

The Chancellor of the Duchy of Lancaster (Lord Strathclyde): My right honourable friend the Prime Minister has made the following Statement.

I am today publishing in full the national security adviser's review of how the Whitehall machine operated during the Libya conflict and what lessons we can learn, in keeping with the commitment I made to the House on 5 September.

I told the House on 21 March that I believed that military intervention was necessary, legal and right to protect the people of Libya from the brutality of Qadhafi's regime, and I pay tribute to the courage and professionalism of our Armed Forces during this conflict. There remains much to do to secure a successful transition to a peaceful and prosperous democracy, and we will continue to assist the interim Libyan Government. But our Armed Forces, our diplomats and development experts who re-established the British presence in Benghazi and Tripoli, and all those in the UK who contributed to the success of the international effort, can be proud of the part they have already played.

The National Security Council proved its worth in ensuring effective co-ordination of this country's contribution throughout the crisis in Libya. But it is always right to learn the lessons after any conflict. In addition to the areas where things went well, Sir Peter Ricketts' review has also highlighted a number of lessons for future conflicts, including the importance of swift evacuation of UK nationals; integrating better economic analysis and policy more prominently at the early stages of conflict planning; and establishing a clearer cross-government process for the negotiation of United Nations Security Council Resolutions.

Copies of the review of lessons learnt from Libya have been placed in the Libraries of both Houses. The review is also available on the No. 10 website.

Schools: Admissions *Statement*

The Parliamentary Under-Secretary of State for Schools (Lord Hill of Oareford): My honourable friend the Minister of State for Schools (Nick Gibb) has made the following Written Ministerial Statement.

I am today laying the revised School Admissions and School Admission Appeals Codes (the codes) before Parliament as required under Section 85 of the School Standards and Framework Act 1998. Subject to the views of Parliament, these codes will come into force on 1 February 2012. A copy of these codes has also been published on the departmental website, so that schools and local authorities can take account of the technical changes that have been made to the codes since their publication on 2 November.

The White Paper, *The Importance of Teaching*, outlined the intention to "simplify the code so that it is easier for schools and parents to understand and act upon, while maintaining fairness as the guiding principle". As part of the consultation process we consulted on a number of key policy changes that are set out below, all of which are intended to deal with issues which we believe create unfairness in the system, or which frustrate or confuse parents.

The current codes have evolved over a number of years with successive versions adding further regulations in a chaotic and unplanned fashion. As a result, the admissions system has grown unnecessarily complex and bureaucratic, comprising some 130 pages of densely worded text, with more than 650 mandatory requirements. These revised codes are less than half the size of the

previous codes and are simpler, fairer and easier to understand. We have removed much of the repetition and unnecessary material, while retaining the key safeguards to ensure that school places can be allocated in a clear and transparent manner.

The department consulted extensively on the codes from 27 May to 19 August and received more than 1,330 responses with 700 from parents, as well as a wide range of interested parties, including local authorities, dioceses and head teachers. Overall, respondents broadly welcomed the proposals to slim down the codes.

These codes make a number of changes to the current codes:

giving greater freedom to schools to increase the number of places they are able to offer by removing the duty to consult locally and the ability to object when a school increases its admission numbers;

ensuring that any child who leaves public care through adoption, a residence order or special guardianship order, will continue to be given the same priority although they are no longer looked after by the state;

making the co-ordination of admissions to primary schools administratively simpler through a single date, 16 April, each year when offers of school places are made from 2014 onwards;

allowing schools to prioritise the children of staff either employed at the school for at least two years, or who will meet a clear skills shortage;

allowing infant classes to exceed the statutory limit to avoid separating children from a multiple-birth, and for children of Armed Forces personnel admitted outside of the normal admission round;

allowing schools to take direct applications from parents for in-year applications;

prohibiting the use of random allocation as the principal method of allocating places across a local authority area;

requiring admission authorities to consult on unchanged arrangements only every seven years, rather than three;

reflecting changes in the Education Act 2011, allowing anyone to object to the schools adjudicator about admission arrangements, and enabling objections about academies' admission arrangements to be referred to the schools adjudicator; and

greater clarity on decision-making and related processes for appeals, to ensure greater uniformity and to reduce costs across the system.

In addition, as highlighted in the code, but achieved through individual funding agreements, we will be allowing academies and free schools to prioritise pupils eligible for the pupil premium.

Written Answers

Thursday 1 December 2011

Arab Partnership Fund Question

Asked by **Lord Hylton**

To ask Her Majesty's Government whether they will assist the Center for Mediterranean Integration in increasing trade and foreign direct investment in North Africa and the Middle East. [HL13688]

Baroness Northover: There are no current plans to assist the Center for Mediterranean Integration.

The UK has established a dedicated Arab Partnership Fund to support political and economic reform and transition in the Middle East and North Africa over the next four years. This comprises a £40 million Arab Partnership Participation Fund to support political reform managed by the FCO, and a £70 million Arab Partnership Economic Facility (APEF) managed by this department. The APEF will support job creation, economic growth and effective and accountable financial institutions. Programming of this funding is currently under way.

Benefits Question

Asked by **Lord Laird**

To ask Her Majesty's Government what types and levels of pensions and benefits and other state entitlements are payable to single or widowed old age pensioners; whether they are means-tested; and what is the minimum state-supported income such a pensioner can obtain. [HL13640]

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud): The minimum state support would be the single person's standard minimum guarantee in pension credit of £137.35 per week for those with no other income plus, in most circumstances, £200 annual winter fuel payment.

Most pensioners, however, receive a state pension based on their national insurance record. Those with a full record of contributions or credits receive a basic state pension of £102.15 plus, in most circumstances, £200 annual winter fuel payment. They may also receive some additional state pension. Those bereaved may be able to use their late spouses' or civil partners' national insurance contributions to improve their own state pension. If necessary the state pension may be topped up by pension credit.

The main benefits available as at November 2011 are in the table below.

<i>Benefit</i>	<i>Rate</i>	<i>Income-related</i>
Attendance Allowance	Higher rate £73.60	No
	Lower rate £49.30	

<i>Benefit</i>	<i>Rate</i>	<i>Income-related</i>
Carer's Allowance	£55.55	No
Christmas Bonus	Annual payment £10.00	No
Council Tax Benefit	Variable according to Council Tax liability	Yes
Disability Living Allowance (Care component)	Highest rate £73.60	No
	Middle rate £49.30	
	Lowest rate £19.55	
Disability Living Allowance (Mobility component)	Higher rate £51.40	No
	Lower rate £19.55	
Housing Benefit	Variable according to rent liability	Yes
Industrial Injuries Disablement Benefit	Variable	No
Over 75 TV Licence	Free	No
Pension Credit Guarantee Credit	£137.35	Yes
Pension Credit Savings Credit	Up to a maximum of £20.52	Yes
Social Fund	Variable	See note 6
Basic State Pension	£102.15	No
Additional State Pension and/or Graduated Retirement Benefit	Variable	No
Winter Fuel Payment	Annual Payment (winter 2011-12) Anyone who has reached women's State Pension age up to age 79 £200.00 Aged 80 or over 300.00	No

Notes:

1) Rates shown are maximum weekly rates for a single person from April 2011 unless stated otherwise.

2) Receipt of benefits is subject to entitlement conditions being met.

3) The weekly amount a person can receive will depend on entitlement and individual circumstances.

4) Income related benefits have higher rates available in certain circumstances for those with severe disabilities, caring responsibilities and certain housing costs.

5) Disability living allowance is payable to severely disabled people who claim before age 65 but payment can continue after age 65 as long as entitlement conditions are met.

6) Most Social Fund payments and loans, which include cold weather payments, are dependent on the person receiving certain benefits.

7) Where there is entitlement to two benefits which cover the same contingency only the highest amount will be paid. For example, both state pension and carer's allowance are considered to be income-replacement benefits so no one will receive both in full. As the law provides that the contributory benefit takes precedence, the state pension will always be paid but would be topped up to the level of the carer's allowance if the latter is the higher amount.

8) Benefits with fewer than 100,000 recipients are not included in the table.

9) Benefits in cash or kind provided by other government departments, local authorities, the National Health Service and others are not included.

Children: Playgrounds

Question

Asked by **Baroness Jones of Whitchurch**

To ask Her Majesty's Government what is their policy on children being charged to use local playground facilities. [HL13604]

The Parliamentary Under-Secretary of State, Department for Communities and Local Government (Baroness Hanham):

The Government do not expect local authorities to address their financial challenges simply by increasing fees and charges. We have given local authorities much greater financial autonomy and flexibility to manage their budgets and have encouraged them to share back-office services, join forces to get better value from their buying power, cutting out excessive chief executive pay and rooting out overspending and waste. I would note that in some local authorities, such as the London Borough of Islington, playgrounds levy charges for extra services, such as providing supervised care.

Committee on Standards in Public Life

Question

Asked by **Lord Ashcroft**

To ask Her Majesty's Government, following the publication of the report on *Political Party Finance* by the Committee on Standards in Public Life, whether the estimated cost of that inquiry of £445,000 represents good value for money. [HL13663]

The Minister of State, Ministry of Justice (Lord McNally): The Government welcome the Committee on Standards in Public Life's thirteenth report. It is a valuable contribution to the debate. We remain committed to limiting donations and reforming party funding, and to that end we plan to continue cross-party discussions based on the principles identified by the committee and the Government's reform commitments.

Cyclists

Questions

Asked by **Lord Wills**

To ask Her Majesty's Government what consideration they have given to introducing a licensing regime for cyclists. [HL13754]

Earl Attlee: The Government recognise that there is value in training cyclists to ride safely and confidently on the road. That is why we supported the development of the National Standard for Cycling and the related Bikeability training scheme. We have made a firm commitment to support Bikeability for the lifetime of the current Parliament and are providing £11 million this year to local authorities and School Games Organisers to train up to 275,000 children.

However, the Government consider that the costs of a formal testing and licensing system for cyclists would outweigh the benefits. The safety case for a

testing/licensing system is not as strong as that for drivers since, by contrast with motorised vehicles, bicycles involved in collisions on the highway are highly unlikely to cause serious injury to other road users. Furthermore, cycling has clear benefits for cyclists themselves (particularly in terms of health) and for wider society (tackling congestion, reducing CO₂ emissions and improved air quality) and the introduction of a licensing system would significantly reduce these benefits, especially over the short term. Over the long term, it would prohibit children and young adults from enjoying the mobility and health benefits cycling brings until they were old enough to pass a formal test.

Asked by **Lord Wills**

To ask Her Majesty's Government what consideration they have given to introducing a national system of bicycle lanes. [HL13755]

Earl Attlee: The National Cycle Network, managed by Sustrans, is a network of cycle routes across the UK. It currently runs within two miles of 75 per cent of the UK population and covers 12,600 miles of walking and cycling routes.

However, cycling is best suited to local journeys, and most cycling provision is provided by local authorities. We therefore support local authorities in England in providing local transport infrastructure through the formula grant, Integrated Transport Block settlement (from DfT) and the £560 million Local Sustainable Transport Fund (also from DfT).

The Government are currently providing funding to Sustrans to improve walking and cycling links to schools, and in many cases this will connect schools to the National Cycle Network. In addition, a number of local authorities have successfully bid to the Local Sustainable Transport Fund with schemes that will also link up to the National Cycle Network.

Asked by **Lord Laird**

To ask Her Majesty's Government what proposals they have to discourage cyclists from travelling past red traffic lights. [HL13811]

Earl Attlee: The Highway Code has a specific section on cycling which details the legal responsibilities for cyclists. Rule 69 states that cyclists, "Must obey all traffic signs and traffic light signals" (Section 36 of the Road Traffic Act 1988 and Regulation 10(1) of the Traffic Signs Regulations & General Directions 2002).

The enforcement of cycling offences is, of course, an operational matter for the police. We support any action taken by the police to deter and reduce the number of cycling offences.

Cyclists: Deaths

Questions

Asked by **Lord Wills**

To ask Her Majesty's Government how many pedestrians have been (1) killed, (2) seriously injured, and (3) injured, by cyclists in each of the past 10 years. [HL13756]

To ask Her Majesty's Government how many cyclists have been (1) killed, (2) seriously injured, and (3) injured, on the road in each of the past 10 years.

[HL13757]

Earl Attlee: Information regarding reported pedestrian casualties, killed or injured by pedal cyclists, in road accidents: Great Britain, 2001-10 is given below.

	2001	2002	2003	2004	2005	2006	2007	2008	2009	<i>Pedestrians</i> 2010
Killed	0	4	4	1	3	3	4	1	0	4
Seriously injured	60	47	45	49	61	47	48	52	66	77
Slightly injured	198	158	210	186	215	176	177	208	226	260
Total	258	209	259	236	279	226	229	261	292	341

¹ Figures refer to accidents occurring on the public highway (including footways).

The information requested regarding pedal cycle casualties killed or injured is available on the department's website at the link below: <http://www.dft.gov.uk/statistics/tables/ras30065>.

These statistics are based on personal injury road accidents that are reported to the police. It is known that a considerable number of personal injury road accidents are unreported; in particular it is known that less serious accidents involving pedal cycles are particularly reliable to underreporting. Further information is available from: <http://assets.dft.gov.uk/statistics/releases/road-accidents-and-safety-annual-report-2010/rrcgb2010-06.pdf>.

Cyclists: Helmets

Question

Asked by **Lord Laird**

To ask Her Majesty's Government, further to the Written Answer by Earl Attlee on 21 November (WA 184) concerning the wearing of cycle helmets, whether they consider that such helmets save lives and prevent injuries.

[HL13724]

Earl Attlee: In certain circumstances (eg low speed collisions and where no other vehicle is involved), helmets can be effective in reducing the likelihood of death or the seriousness of the injury suffered by a cyclist. However, most cyclist fatalities occur as a result of collision with a motorised vehicle, and therefore, helmets cannot be seen as a panacea for reducing cyclist fatalities. We do, however, encourage cyclists—especially children—to wear helmets to protect them if they have a crash. However, we believe this should remain a matter of individual choice.

Disabled People: Grants

Questions

Asked by **Baroness Thomas of Winchester**

To ask Her Majesty's Government whether the results of the pilots undertaken in 2008–09 by Cumbria County Council, Oldham Council, Sheffield Council and Westminster City Council on the impact of removing the ring-fencing of the disabled facilities grant were taken into account in the decision in

the 2010 Comprehensive Spending Review to remove the ring-fencing of the disabled facilities grant.

[HL13633]

To ask Her Majesty's Government what assessment they have made of the impact of the removal of the ring-fencing of the disabled facilities grant in the 2010 Comprehensive Spending Review upon (1) the number of housing adaptations in each local authority in the United Kingdom, and (2) spending by each local authority on housing adaptations in 2010–11 compared to 2009–10.

[HL13634]

The Parliamentary Under-Secretary of State, Department for Communities and Local Government (Baroness Hanham):

Despite the need to tackle the budget deficit that we inherited from the last Administration, we are increasing spending on disabled facilities grant over the spending review period, from £169 million in 2010–11 to £180 million in 2011–12, rising to £185 million in 2014–15. This reflects the priority this Government attaches to protecting the vulnerable, and the value of this scheme in helping disabled people to live as comfortably and independently as possible in their homes.

The coalition Government are also committed to decentralisation and greater freedoms for local government, which is why we have freed funding from Whitehall ring-fencing.

This decentralisation will give local authorities the ability to commission services innovatively, for example by linking up with other related funding streams and programmes to produce better outcomes from the available resources.

Education: Sixth-form

Question

Asked by **Lord Ashcroft**

To ask Her Majesty's Government how many students, broken down by subject, continued their education at sixth-form level in (a) 2010, and (b) 2011.

[HL13512]

The Parliamentary Under-Secretary of State for Schools (Lord Hill of Oareford): The closest data we have to monitor numbers in sixth-form education are the number of GCE A-level entries. Students can of course enter more than one A-level.

The number of entries for each GCE A-level subject group for 2009-10 and 2010-11 is provided in the table below. This information was provided in the recent publication *GCE/Applied GCE A/AS and Equivalent Examination Results in England, 2010-11 (Provisional)*.

GCE A-level entries in each subject group for 2009-10 (final) and 2010-11 (provisional)¹

	2010 (final) ¹	2011 (provisional) ¹
Biological Sciences	52,728	54,734
Chemistry	40,379	43,256
Physics	27,786	29,216
Other Science	4,283	4,229
Mathematics	69,803	75,492
Further Mathematics	10,813	11,400
Design and Technology	15,244	14,871
Computer Studies	3,683	3,518
ICT	9,359	8,830
Home Economics	358	368
Accounting and Finance	3,808	3,496
Business Studies	30,971	28,764
Economics	20,314	20,826
Geography	29,225	28,192
Government and Politics	12,629	13,303
History	45,146	45,319
Law	14,261	13,129
Psychology	53,080	52,947
Sociology	27,177	27,500
Other Social Studies	4,267	4,134
Art and Design	42,784	42,617
Drama	15,262	14,589
English	84,037	83,072
Media/Film/Television Studies	24,228	24,213
Other Communication Studies	10,022	9,874
French	12,324	11,475
German	5,055	4,550
Spanish	6,564	6,390
Other Modern Languages	5,912	6,802
Classical Studies	5,919	5,754
Religious Studies	17,895	18,536
Music	8,841	8,706
Physical Education	21,304	19,614
General Studies	47,886	42,868
Total	783,347	782,584

1. 2011 provisional data are currently in the process of being checked by schools and colleges. Revised figures will be published in January 2012 accounting for amendments made by schools.

Coverage: Students aged 16-18 at the beginning of the academic year in Schools and FE Sector Colleges in England.

Coverage: GCE A level examinations taken in each academic year.

Source: *GCE/Applied GCE A/AS and Equivalent Examination Results in England, 2010-11 (Provisional)*.

Finance: Virgin Money Questions

Asked by **Lord Myners**

To ask Her Majesty's Government whether the commitments made by Virgin Money to Her Majesty's Treasury in connection with the purchase of Northern Rock plc that there will be no more compulsory redundancies and that Newcastle will become the operational headquarters for Virgin Money are supported by sanctions for non-compliance. [HL13550]

The Commercial Secretary to the Treasury (Lord Sassoon): Virgin Money has made a number of commitments in its announcement about Northern Rock plc on 17 November 2011. These are public commitments which are made in writing by Virgin Money.

Asked by **Lord Myners**

To ask Her Majesty's Government what is the ownership structure of Virgin Money and what assurance they have sought from shareholders, in connection with the sale of Northern Rock plc, about their commitment to support the company with more capital if necessary. [HL13551]

Lord Sassoon: As part of the Financial Services Authority's (FSA) approval of the transaction, the FSA is undertaking a change in controller process which includes appropriate assessment of shareholders in the Virgin consortium, the new proposed controller of Northern Rock Plc.

Asked by **Lord Myners**

To ask Her Majesty's Government what capital instrument is to be paid to Her Majesty's Treasury by Virgin Money in connection with the sale of Northern Rock plc and in what circumstances this instrument could be (a) repaid, or (b) not paid out, in full. [HL13552]

Lord Sassoon: Virgin Money will issue to HM Treasury, on completion of the sale, tier 1 capital notes with a par value of £150 million and an annual coupon of 10.5 per cent.

Virgin Money has indicated that it intends the notes would be exchanged, or purchased by the acquirer, upon an initial public offering or sale, without reducing the amount and quality of the firm's capital resources, which would allow HM Treasury to exit its investment.

Asked by **Lord Myners**

To ask Her Majesty's Government whether the Financial Services Authority has approved the acquisition of Northern Rock plc by Virgin Money. [HL13553]

Lord Sassoon: The transaction remains subject to approval by the Financial Services Authority and receiving European Commission merger clearance.

Asked by Lord Myners

To ask Her Majesty's Government whether Sir Richard Branson is a director or shareholder of (1) Virgin Money, (2) the company acquiring Northern Rock plc, or (3) any of the companies or trusts owning, controlling or benefiting from any part of Virgin Money or the companies or trusts in its ownership structure; and whether Sir Richard Branson has ever applied to be an approved person by the Financial Services Authority and has (a) had that request rejected, or (b) been asked to withdraw his application. [HL13555]

Lord Sassoon: This is a matter for the parties to whom you refer, namely Sir Richard Branson and the Financial Services Authority.

Fire Safety*Questions**Asked by Lord Harrison*

To ask Her Majesty's Government what assessment they have made of the likely impact on fire risk of an ageing population. [HL13647]

To ask Her Majesty's Government what assessment they have made of the possible impact on fire risk of an increase in vulnerable adults with (1) mental health, and (2) physical, disabilities living independently in domestic settings. [HL13648]

The Parliamentary Under-Secretary of State, Department for Communities and Local Government (Baroness Hanham): None. But my department is currently considering a number of research proposals.

Government Departments: Buildings*Questions**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 Scotland Office. [HL13609]

The Advocate-General for Scotland (Lord Wallace of Tankerness): The Scotland Office occupies one building in Edinburgh and one in London. There are no plans to install photovoltaic solar systems, however the office keeps the energy efficiency of the buildings under constant review, in the light of the Green Government Commitments, and have introduced a range of energy efficiency measures consistent with value for money.

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 Foreign and Commonwealth Office. [HL13612]

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): Within the UK, the Foreign and Commonwealth Office is considering a trial solar photovoltaic project, with a view to assessing if it is effective and cost-efficient. Where this is the case, we will look to roll it out as a standard feature in a number of properties across our estate.

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 Ministry of Defence. [HL13613]

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Haver): Some solar photovoltaic (PV) schemes have already been installed on the defence estate. The Ministry of Defence will continue to exploit opportunities to install solar PV panels and other low carbon energy generation technologies where compatible with defence activities, environmental constraints and value for money in terms of cost and carbon emissions reduction.

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 Ministry of Justice. [HL13657]

The Minister of State, Ministry of Justice (Lord McNally): There are currently no plans for photovoltaic installation on buildings owned or occupied by the Ministry of Justice.

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 Department for Culture, Media and Sport. [HL13660]

Baroness Rawlings: The department has no plans to install photovoltaic solar systems.

Gypsies and Travellers: Dale Farm*Question**Asked by Baroness Smith of Basildon*

To ask Her Majesty's Government, further to the Written Answer by Baroness Hanham on 21 October (WA 108), what is her definition of "clear-up costs" in respect of the Dale Farm site; and whether this includes the costs of eviction and the costs of clear-up after the eviction. [HL13695]

The Parliamentary Under-Secretary of State, Department for Communities and Local Government (Baroness Hanham): In its offer of grant to Basildon Council, the Department for Communities and Local Government made clear that the grant was a one-off payment for costs incurred by the council in relation to the clearance of the unauthorised traveller site at Dale Farm and would be paid once the clearance had been completed given the exceptional nature of this site. It did not further define the words "clear-up costs".

Housing Question

Asked by **Lord Myners**

To ask Her Majesty's Government what assessment they have made of the impact on the value of existing housing stock of the proposed support for new builds, particularly in areas where new building is likely to be concentrated. [HL13681]

The Parliamentary Under-Secretary of State, Department for Communities and Local Government (Baroness Hanham): The Government's recently published housing strategy is underpinned by a thorough assessment of the problems it seeks to address. This includes the failure of housing supply to keep pace with demand over the past 15 years, which contributed to volatile and rising house prices. Median house prices are now seven times median earnings, compared with three and a half times in the mid-1990s.

The long-term pressures are such that house prices (and the value of the housing stock) look set to increase. The Government's housing strategy includes a package of measures which will help to boost supply and moderate house price rises to more sustainable levels. In the short run this will provide a much needed boost to the construction industry and help enable conditions whereby more households can meet their aspirations to buy a home.

Irish Language and Ulster Scots Language Question

Asked by **Lord Laird**

To ask Her Majesty's Government, further to the Written Answer by Lord Shutt of Greetland on 15 November (*WA 134*), whether the Ulster Scots language and culture is being treated equally in the United Kingdom. [HL13521]

Lord Shutt of Greetland: As stated previously, the Government recognise the importance of respect, understanding and tolerance in relation to linguistic diversity, including in relation to Irish and Ulster-Scots.

Legislation Questions

Asked by **Lord Kennedy of Southwark**

To ask Her Majesty's Government what legislation, passed during the 2005–10 Parliament, is the responsibility of the Department for Work and Pensions and has yet to be brought into force, either in full or in part. [HL13737]

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud): The table annexed provides details of primary legislation which received Royal Assent in the period in question, which is the responsibility of DWP, and which has yet to be brought into force, either in full or in part. The table includes details of primary legislation which has

been prospectively commenced. DWP has joint responsibility with other government departments for parts of the Equality Act 2010, and the table summarises the position for the whole Act.

Within the period of 2005-10 over 700 statutory instruments were signed by Ministers of the department. We can not provide details of all provisions of secondary legislation which have yet to be brought into force as this would require detailed checking of each statutory instrument which would incur disproportionate cost.

Primary Legislation		
Title	Respective sections	Future commencement?
Pensions Act 2007	Section 15(1)	06 Apr 2012 (SI 2011/1267)
	Schedule 4 (Part 2);	SI 2011/1267 brings some of the paras in Part 2 into force in April 2012 and 2015, but paras 44, 45, 48, 50-53, 56-58 remain uncommenced.
	Schedule 7 (Part 7)	06 Apr 2012 (SI 2011/1267)
Welfare Reform Act 2007	Sections 29, 37, 40 56-57, 61(1)(a), 63, 67	
	Schedule 3 (paras 5, 7(2)-(6), 9(5), (12), 21);	
	Schedule 4 (paras 3(a), 4-6, 9);	
	Schedule 5 (para. 13);	
	Schedule 7 (para. 1)	
Child Maintenance and Other Payments Act 2008	Schedule 8 repeals relating to: Vaccine Damage Payments Act 1979, Income and Corporation Taxes Act 1988, Criminal Justice Act 1991, Social Security Administration Act 1992, ss 2A, 2AA, 130, 132, 150 Social Security Contributions and Benefits Act 1992, ss 20, 21, 30A-30E, 40-42, 44, 47, 61, 61A, 84, 86A, 87, 89, 93, 150, 171ZP, 171A-171G, 176, Schs 3, 4, 11, 12, 13 Disability (Grants) Act 1993, Pension Schemes Act 1993, Social Security (Incapacity for Work) Act 1994, Jobseekers Act 1995, Sch 2, paras 19(5), 25, 26 Pensions Act 1995, Social Security Act 1998, ss 31, 77, Sch 7, paras 73, 103 Welfare Reform and Pensions Act 1999, ss 61-64, Sch 8 State Pension Credit Act 2002, National Insurance Contributions Act 2002, Tax Credits Act 2002, Sch 3, paras 25, 30 Income Tax (Earnings and Pensions) Act 2003, Civil Partnership Act 2004, Sch 24, paras 14, 15	
	Sections 16-19, 21, 25-30, 32-34, 37, 39-42, 60(2)	
	Schedules 4;	
	Schedule 5;	
	Schedule 7 (paras 1(1)-(6), (8), (11)-(18), (22)(b), (23) - (24), (25), (27)-(31), 5-6)	
Payments Act	Schedule 8 repeals relating to: Debtors (Scotland) Act 1987, Child Support Act 1991, ss 32-34, 36(1), 37, 39A, 40A, 40B, 47, Schs 1, 5 Child Support Act 1995, Sch 3, para 10 Child Support, Pensions and Social Security Act 2000, ss 16, 28, Sch 3, para 11(17) Employment Act 2002 Civil Partnership Act 2004, Welfare Reform Act 2007, Tribunals, Courts and Enforcement Act 2007	

Primary Legislation

Title	Respective sections	Future commencement?
Pensions Act 2008	Sections 1, 6, 19, 30-31, 33-36, 39, 42, 44-51, 53, 55-57, 59, 61, 66, 87-95, 102 - 104, 122, 124(4) - (5), 127, 129, 137, Schedule 3, Schedule 4, Schedule 8 (paras. 10-12, 15), Schedule 10 (paras. 1 3, 6-9), Schedule 11 Parts 1 and 5 and some of the repeals listed in Part 6. Sections 2-5, 7-18, 20-29, 32, 37 38, 40-41, 43, 52, 54, 58, 60, 77, 96-98, 107, 109-112, 114-119, 121, 124(2) - (6), Schedule 5 Part 3 para. 11 are in force for regulation-making powers only but not in force for other purposes. s. 106, Schedule 11 Part 3	06 Apr 2012 (SI 2011/1266)
Welfare Reform Act 2009	Sections 3(1) and (4), 4-7, 9, 12(5), 13(5), 16-22, 25, 29-32, 36, 51-54, 55(1) and (2), 56, Schedule 1, Schedule 2, Schedule 5, Schedule 6, Schedule 7 Parts 1 and 5	
Equality Act 2010	Sections 1-3, 14, 28-31, 36(1)(d), (5) and (6), 78, 100-107, 160-165, 167(1)-(5) and (7), 191, 196-201, 211, Schedule 2, Schedule 3, Schedule 4 paras 5-8, Schedule 13 paras 2 and 5, Schedule 16, Schedule 20, Schedule 22, Schedule 23	

Asked by Lord Kennedy of Southwark

To ask Her Majesty's Government what legislation, passed during the 2005–10 Parliament, is the responsibility of the Wales Office and has yet to be brought into force, either in full or in part.[HL13795]

The Advocate-General for Scotland (Lord Wallace of Tankerness): None.

Migrant Workers: Bulgarians and Romanians

Question

Asked by Lord Laird

To ask Her Majesty's Government, further to the Written Answer by Lord Henley on 2 November (WA 269), what is their assessment of the discrepancy between the 174,577 Bulgarian and Romanian nationals issued with work permit variants between 1 January 2007 and 31 December 2010 and the 135,740 issued with national insurance numbers; and whether those without a national insurance number have paid no income tax or national insurance contributions. [HL13728]

The Minister of State, Home Office (Lord Henley): The difference between the two figures does not necessarily mean that a proportion of those given authorisation to work have not paid tax. The number of national insurance numbers issued to Bulgarian and Romanian nationals will, because the same number is kept for life, correspond to the number of Bulgarian and Romanian nationals allocated such a number. By contrast, the figure of 174,577 includes both work authorisations and registration certificates issued to Bulgarian and Romanian and it is possible that any individual Bulgarian and Romanian national may have been issued more than one such document over the period in question.

Organophosphates

Question

Asked by The Countess of Mar

To ask Her Majesty's Government, further to the Written Answer by Lord Astor of Haver on 16 November (WA 165), which independent bodies the Ministry of Defence would consult on organophosphate poisoning if appropriate; and why they were not listed in the Answer. [HL13630]

The Parliamentary Under-Secretary of State, Ministry of Defence (Lord Astor of Haver): As I explained in my Answer of 16 November (WA 165), the Ministry of Defence (MoD)'s understanding of the adverse health effects of exposure to organophosphate (OP) compounds is informed by the published peer-reviewed literature including reports by independent scientific advisory bodies. The short and longer-term effects of acute high-dose exposure to OP compounds are established but this is not so for low-dose exposure.

In 2002 the report by the Department of Health's Committee on Toxicity of Chemicals in Food Consumer Products and the Environment (COT) reviewed the evidence on possible links between exposure to OP compounds, in doses insufficient to cause overt toxicity and adverse health effects. They concluded that the substantial body of evidence that had by then accumulated gave little support to the hypothesis. They recommended further research and a second report, reflecting contemporary evidence including the outcomes of the research programme, is awaited. If appropriate, the MoD would consult the COT on OP effects.

Railways: High Speed 2

Question

Asked by Lord Brooke of Alverthorpe

To ask Her Majesty's Government whether they will respond to HM Opposition's proposal for a cross-party agreement and approach on building the High Speed Railway 2; and, if so, when. [HL13783]

Earl Attlee: As the Secretary of State for Transport and her predecessor have both made clear, the Government welcome the strong cross-party consensus that exists on our plans for high speed rail. The Secretary of State intends to announce the Government's response to the recent public consultation shortly, and look forward to working constructively with HM Opposition on these matters in the future.

Surveillance: Telecommunications

Question

Asked by Lord Alton of Liverpool

To ask Her Majesty's Government whether they have taken steps to establish whether the British company, Utimaco, the Italian company, Area, and the French company, Qosmos, have equipped the Government of Syria with the power to intercept, scan and catalogue Syria's communications data and internet activity. [HL13572]

The Minister of State, Foreign and Commonwealth Office (Lord Howell of Guildford): We are seeking to gather further information on recent allegations made in the media and I will write to the noble Lord in due course.

The Government look into all credible allegations of breaches of sanctions involving UK companies. However, in this case, the equipment in question is not currently prohibited by sanctions or export control legislation. But given the recent allegations of such equipment being used for internal repression or human rights abuses by repressive regimes including Syria, the UK firmly supports action being taken by the European Union to restrict the export of such goods to Syria.

Transport: Certificates of Professional Competence *Question*

Asked by Lord Willoughby de Broke

To ask Her Majesty's Government what effect the recently introduced European Union Regulation 1071/2009, which requires operators of vehicles of over 3.5 tonnes to obtain an international certificate of professional competence, will have on small independent road transport businesses. [HL13661]

Earl Attlee: This requirement will have no effect on any current holders of operator licences. All existing certificates of professional competence, national and international, remain valid after the 4 December.

From 4 December this year, the current examination for the national-only certificate will be abolished, from that date all examinations for new certificates of professional competence will be at the international standard.

Visas *Question*

Asked by Lord Laird

To ask Her Majesty's Government how many Croatian nationals have received visas and work permits in each year since 2002, broken down by each category of entry document; which of those categories will continue to have effect after Croatia joins the European Union; and for how long.

[HL13727]

The Minister of State, Home Office (Lord Henley): The requested information is in the table below. Statistical information is not available before 2004. Work permits were replaced by the points-based system (PBS) from 2008.

<i>Visa Category</i>	<i>Year</i>							
	2004	2005	2006	2007	2008	2009	2010	2011 to September
PBS Tier 1					4	29	15	17
PBS Tier 2					0	58	53	32
PBS Tier 5					0	28	38	32
Work permit	140	143	113	123	100	26	6	2

These data are based on management information. They are provisional and subject to change.

The Government have committed to applying transitional controls on labour market access as a matter of course for all new member states. Croatia's accession to the EU is not anticipated until July 2013.

Under the terms of Croatia's accession negotiations, member states are able to apply the same type and length of restrictions to Croatian workers as those that apply to Romanian and Bulgarian workers. The controls the UK will apply for Croatia have not yet been determined. They will be informed by an assessment of the UK's labour market conditions and the likely volume and impact of migration from Croatia post-accession. We will announce our decision on transitional controls closer to Croatia's date of accession.

War Memorials *Question*

Asked by Lord Morris of Manchester

To ask Her Majesty's Government, further to the Written Answer by Baroness Rawlings on 2 November (WA 274), how many charities are currently in

receipt of funding from the Memorial Grant Scheme; and what is the largest grant that has been awarded.

[HL13593]

Baroness Rawlings: Since the start of the scheme in 2005, the Memorial Grant Scheme has paid out grants to 85 charities. This figure includes the faith groups that have supplied a charity number in their application. The highest single grant paid out to a charity is £162,967.71 to the Armed Forces Memorial Trust (charity number 1100521). This charity has also received the highest total grant of any charity with £1,129,687.30 being paid through the scheme to date.

Winter Fuel Payments *Questions*

Asked by Lord Bradley

To ask Her Majesty's Government how many households in each parliamentary constituency in Greater Manchester are eligible for a winter fuel payment. [HL13748]

To ask Her Majesty's Government how many households in each parliamentary constituency in

Greater Manchester are in receipt of a winter fuel payment. [HL13749]

The Parliamentary Under-Secretary of State, Department for Work and Pensions (Lord Freud): The information requested on eligibility is not available. The department can only assess eligibility for those people whose circumstances are known. The vast majority of winter fuel payments are made automatically without the need to claim. But those people whose circumstances we are not already aware of, for instance because they

are not on state pension or other benefits administered by DWP, need to make a claim so that their eligibility can be assessed.

Information on the number of households which received a winter fuel payment in winter 2010-11 (the latest winter for which information is available) is provided in the document *Winter Fuel Payment Recipients (number of households) 2010-11 by Parliamentary Constituencies and Gender (All)*. This is available in the Commons Library and on the internet at <http://research.dwp.gov.uk/asd/index.php?page=wfp>.

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