Vol. 790
No. 128

Thursday
26 April 2018

PARLIAMENTARY DEBATES
(HANSARD)

HOUSE OF LORDS

OFFICIAL REPORT

ORDER OF BUSINESS

Questions
Short-Term Letting....1651
Brexit: Food Standards Agency....1654
Brexit: Galileo Space Project....1656
Employment Tribunal Hearings....1658

Unpaid Work Experience (Prohibition) Bill [HL]
Third Reading....1660

Family Relationships (Impact Assessment and Targets) Bill [HL]
Third Reading....1660

The Long-term Sustainability of the NHS and Adult Social Care
Motion to Take Note....1660

Artificial Intelligence
Statement....1690

Home Office Removal Targets
Statement....1700

The Long-term Sustainability of the NHS and Adult Social Care
Motion to Take Note (Continued)....1703

Lords wishing to be supplied with these Daily Reports should give notice to this effect to the Printed Paper Office.

No proofs of Daily Reports are provided. Corrections for the bound volume which Lords wish to suggest to the report of their speeches should be clearly indicated in a copy of the Daily Report, which, with the column numbers concerned shown on the front cover, should be sent to the Editor of Debates, House of Lords, within 14 days of the date of the Daily Report.

This issue of the Official Report is also available on the Internet at
https://hansard.parliament.uk/lords/2018-04-26

The first time a Member speaks to a new piece of parliamentary business, the following abbreviations are used to show their party affiliation:

Abbreviation	Party/Group
CB	Cross Bench
Con	Conservative
DUP	Democratic Unionist Party
GP	Green Party
Ind Lab	Independent Labour
Ind LD	Independent Liberal Democrat
Ind SD	Independent Social Democrat
Ind UU	Independent Ulster Unionist
Lab	Labour
LD	Liberal Democrat
LD Ind	Liberal Democrat Independent
Non-afl	Non-affiliated
PC	Plaid Cymru
UKIP	UK Independence Party
UUP	Ulster Unionist Party

No party affiliation is given for Members serving the House in a formal capacity, the Lords spiritual, Members on leave of absence or Members who are otherwise disqualified from sitting in the House.

House of Lords

Thursday 26 April 2018

11 am

Prayers—read by the Lord Bishop of Norwich.

Short-Term Letting
Question

11.06 am

Asked by ***Baroness Gardner of Parkes***

To ask Her Majesty's Government what steps they intend to take to ensure that HMRC share relevant information with local authorities to assist those authorities to identify landlords who are potentially in breach of the 90 day restriction on short term lets and to enforce those provisions.

Baroness Gardner of Parkes (Con): My Lords, I beg leave to ask the Question standing in my name on the Order Paper and remind the House of my interests as declared in the register.

Lord Young of Cookham (Con): My Lords, the process is for local authorities to initiate any request for information from HMRC. Any disclosures of HMRC information must be lawful and covered by the memorandum of understanding with the Local Government Association. While sharing of data could identify landlords who are letting property, this would not identify landlords who are in breach of the 90-night limit.

Baroness Gardner of Parkes: I thank the Minister for that Answer but, given the fact that the Tube now has a major promotion about how much more money you can get by letting your property for holidays, that the National Fire Chiefs Council has come out very strongly to say that it is worried about the fact that no one is responsible for checking these properties, and that reinstating the registration controls that were taken away would be very good—they operated most efficiently until removed by the Deregulation Act 2015 and most MPs were in favour of reinstating them, as I understand it—will the Minister put it to the Cabinet, or whoever he can put it to, to consider reintroducing the right of local authorities not only in London but throughout the country, if they wish, to have registers of these short-let properties?

Lord Young of Cookham: May I commend the vigour and tenacity that my noble friend applies to the subject, rivalling that of our noble friend Lord Naseby on retailers in the high street? The Government are in favour of the sharing economy; we believe that householders should have the right to rent out their rooms or their property when they do not need it, with the minimum of bureaucracy. Increasingly, visitors to London, whether from overseas or other parts of the country, expect to see a broader range of accommodation than traditional hotels, and we believe that London should respond to this changing market. Exceptionally, in London, this right is constrained and it can only happen for 90 nights per calendar year. Local authorities have powers to enforce that limit. We have no plans to extend the powers of local authorities beyond those which they already have to inspect properties, nor do we have any plans to introduce a register of the nature suggested by my noble friend.

Lord Campbell-Savours (Lab): My Lords, why do we not turn the question round and place a responsibility on local authorities to inform HMRC when properties are rented in their areas, particularly if we can build a register of landlords of properties? That would enable HMRC to pick up the huge amount of tax that is not paid by landlords who are avoiding tax in the United Kingdom.

Lord Young of Cookham: The noble Lord raises an important issue about the non-declaration of income from rented property. In 2013, HMRC launched an initiative to address the so-called tax gap. As a result, some 26,000 landlords came forward to self-correct undeclared income and £150 million had been collected by August 2017. Some 45,000 of what HMRC calls "nudge letters" have been sent out where there is third-party evidence of undeclared income. HMRC has a fairly sophisticated IT system to collect data from a variety of sources to track down income. Of course, it can approach local authorities for information on, for example, housing benefit or other information they may have in order to safeguard the revenue.

Lord Palmer of Childs Hill (LD): My Lords, the Minister seems to have focused the question on tax avoidance or tax evasion, when the focus of the Question from the noble Baroness, Lady Gardner, is on the 90-day limit and enforcement. Can the Minister tell your Lordships' House which local authorities are enforcing this in London and which are not? It is all very well discussing it, but if there is no enforcement, there is no use.

Lord Young of Cookham: Responsibility for enforcement rests, as the noble Lord recognises, with local authorities. They have quite wide powers of enforcement, and potentially there is a £20,000 fine for breach of the 90-day rule if people do not comply with the enforcement notice. Information would be made available to local authorities if, for example, neighbours or people in a block of flats felt that that 90-day limit was being extended. In addition, some of the platforms with which you register to rent out your property now have a 90-day cap on the number of days you can let out your property using that platform.

Lord Tebbit (Con): My Lords, can my noble friend tell me whether the Government will do anything to prevent persons who are fortunate enough to have tenancy of social housing in attractive areas, particularly in London, from sub-letting that tenancy to people who are not authorised to have such a tenancy?

Lord Young of Cookham: It is a breach of a tenancy agreement with a registered social landlord to sublet, and if anyone had any information that was happening,

[Lord Young of Cookham]
the local authorities would take tough enforcement action to make sure that people on the housing waiting list had access to that accommodation.

Lord Clark of Windermere (Lab): My Lords, until 2015, all landlords were able to charge all property cost against taxation. That was stopped, with the exception of holiday lets, the owners of which can charge everything, including mortgage repayment, against taxation. Are these London-focused lets subject to the general Act, whereby you cannot claim relief, or are they the same as holiday lets?

Lord Young of Cookham: I fear that that goes beyond my limited knowledge of the tax system. They would certainly have to declare the income; on whether they can set off against that income the related costs of letting it, I would have thought the answer was yes. Perhaps I can make some detailed inquiries of HMRC to see which of the regimes the noble Lord referred to—particularly regarding setting off interest—is applicable to holiday lets.

Baroness Couttie (Con): My Lords, I draw the House's attention to my interests as declared in the register. In Westminster, where I was the leader until January last year, short-term lets are a major problem, in some places pushing up property prices both for let and purchase, in an area where we have very short supply of housing. As a result of that, the Government have set up a pilot with Westminster Council. I would like to understand a bit about how that is working and the details of it.

Lord Young of Cookham: My noble friend is quite right. There is now an umbrella organisation for these platforms called the Short Term Accommodation Association, which has developed a range of measures, including a code of conduct. It has a relationship with Westminster City Council called a Considerate Nightly Letting Charter, which sets out the responsibilities of property owners, managing agents, freeholders and building managers and seeks to raise standards in the industry. I understand that the charter, which was launched on 5 March, is being distributed to Westminster residents, so some of us will get that. Updates will follow in due course, and the Government are working with Westminster City Council to see whether this pilot should be rolled out more broadly.

Baroness McIntosh of Hudnall (Lab): My Lords, may I take the noble Lord back to the question from the noble Lord, Lord Palmer? Does he have or can he get the information about how many local authorities in London are enforcing the 90-day limit, and can he confirm whether such enforcement is a duty or merely an option for those councils?

Lord Young of Cookham: As with all the powers under the planning Act, they have a discretion over whether to use enforcement powers—it is not mandatory. I do not have information on how many local authorities have used the powers they have, but I will endeavour to write to the noble Baroness and put a copy of the letter in the Library.

Brexit: Food Standards Agency

Question

11.14 am

Asked by ***Baroness Jones of Whitchurch***

To ask Her Majesty's Government what steps they are taking to enhance the role of the Food Standards Agency after Brexit.

The Parliamentary Under-Secretary of State, Department of Health and Social Care (Lord O'Shaughnessy) (Con): My Lords, the Government, including the Food Standards Agency, are committed to making sure that the high standards of food safety and consumer protection that we currently enjoy in this country are maintained as the UK leaves the European Union. From day one after Brexit, the FSA is committed to having in place a robust and effective regulatory regime, which will mean that business can continue as normal.

Baroness Jones of Whitchurch (Lab): I thank the Minister for that reply. However, given that a range of EU agencies, including the European Food Safety Authority, protect us from food scares, contaminated products, misleading labelling and so on, can we be sure that the FSA will have the resources, science and skills to fulfil the noble Lord's guarantee that UK food will be safe as from exit day? When will it receive clarification of its post-Brexit responsibilities? Finally, does he also agree that the 2 Sisters chicken scandal, which noble Lords will know came to light from an undercover investigation and not from an FSA check, illustrates the importance of regular and robust inspection on the ground in the future, rather than just a reliance on data-sharing and self-regulation by food companies?

Lord O'Shaughnessy: I can certainly reassure the noble Baroness that the Food Standards Agency is getting the resources it needs, as well as a stable funding settlement across the spending review period. The Chancellor announced £14 million more for it for 2018-19. That money will also beef up—excuse the pun—the National Food Crime Unit to make sure that it can investigate the kinds of cases that she has highlighted. As for the ongoing relationship with the EU, it is important to recognise that during the implementation period we will continue to access food information-sharing systems. We will continue to have food risk assessments carried out on our behalf by the European Food Standards Authority, and the Commission will make risk-management decisions that affect the UK. We will continue to be part of that system until the end of the implementation period. Naturally, what happens after that is a matter for negotiation.

Baroness McIntosh of Pickering (Con): Will my noble friend commit to setting out the timetable for all the implementation regulatory statutory instruments that are required to enhance the powers of the Food Standards Agency, given the role that it will be required to play not just in domestic food production but in relation to all imports from 29 March next year?

Lord O'Shaughnessy: I reassure my noble friend that not only are we taking 95% of legislation that derives from the EU regarding food standards and hygiene into UK law through the withdrawal Bill but we are also undertaking work to ensure that we have the right statutory instruments in place in a timely way so that we are prepared for all circumstances when we leave the European Union on 29 March.

Lord Rooker (Lab): If today is an average day, eight notices will be issued around Europe under the Rapid Alert System for Food and Feed. The only countries that get those notices are members of the EU and the European Economic Area. We will be outside those. This is an integral part of the single market and the customs union; the system did not exist before we joined the Common Market. How can the FSA operate on day one? If this area cannot be transferred over, how will we get those 3,000 notices a year warning of potential hazards? Collectively they provide security and safety for our population.

Lord O'Shaughnessy: The noble Lord is quite right to say that we get those alert systems now, and I can reassure him that we will continue to get them during the implementation period up to the end of December 2020. As all noble Lords will know, we are seeking to negotiate a deep and special relationship with the European Union when the implementation period ends—

Noble Lords: Oh!

Lord O'Shaughnessy: I do not think it is a laughing matter; it is a matter of the utmost seriousness concerning the security and safety of this country. It affects not only food safety but chemicals, medicines and aerospace. We have set out our plans for associate membership and others forms of relationship that will provide that information to our systems. Equally, information that makes a massive contribution to the safety of EU citizens is also fed back to the EU.

Lord Bird (CB): My Lords, is it possible that the Food Standards Agency will become so strong after Brexit that it will actually do something about the appalling poor-quality food that most poor people have to eat, which leads to our hospitals being filled up by people with all sorts of nutritional problems? Will the Food Standards Agency get behind addressing the problem of class-divided food?

Lord O'Shaughnessy: The noble Lord raises an important issue. However, it is important to distinguish what the Food Standards Agency is responsible for and what it is not. It is responsible for making sure that food is safe. Nutritional value is a different responsibility that accrues to the department and to Public Health England, and we have taken many significant actions, including reducing sugar content in drinks and food, to make sure that precisely the issues he is talking about are dealt with.

Baroness Bakewell of Hardington Mandeville (LD): My Lords, given the increased monitoring at slaughterhouses, both through CCTV and the presence of meat inspectors, is the Minister confident that the FSA has the capacity to train sufficient inspectors to ensure that the meat which arrives on supermarket and butchers' shelves is fit for human consumption so that we can avoid the CJD and salmonella outbreaks of the past?

Lord O'Shaughnessy: The Food Standards Agency has the resources, the expertise and the powers it needs to make sure that it can guarantee safety, as the noble Baroness has described.

The Countess of Mar (CB): My Lords, the Food Standards Agency is very reliant on local environmental health officers for enforcement. In the light of the poverty of local authorities and the cutting back in the number of environmental health officers, are the Government sure that enforcement can take place as it should?

Lord O'Shaughnessy: In preparing for the Question today, I looked at local authority spending on enforcement. It is stable at around £140 million a year and has been for a number of years, so local authorities are continuing to prioritise this, as indeed is their responsibility. We want to make sure that we bring new forms of assessment into the food standards regime so that we have an even more robust picture of the risks that are involved in food production.

Brexit: Galileo Space Project

Question

11.22 am

Asked by ***Lord Haskel***

To ask Her Majesty's Government what steps they are taking to continue United Kingdom participation in the Galileo space project after Brexit.

The Parliamentary Under-Secretary of State, Department for Business, Energy and Industrial Strategy (Lord Henley) (Con): My Lords, the United Kingdom has made clear to our European partners our desire to continue the United Kingdom's involvement in EU space programmes, including Galileo, provided that the UK and UK companies can continue to participate on a fair and open basis. The Government are engaging with the EU to this end.

Lord Haskel (Lab): My Lords, the Government have threatened to withdraw their support if we are not a fully participating member and not trusted with all the security arrangements. Does the Minister agree that that saying "If you do not trust us, we will go elsewhere and we want our money back" is an empty threat unless we have a practical alternative? What is that alternative and does it deal with the worrying lack of trust, which could extend to other matters relating to security, defence and our safety?

Lord Henley: My Lords, given our history, I find the lack of trust very confusing, but certainly we can look at other options. We have made it clear in a letter

[Lord Henley]
that my right honourable friend has sent to all appropriate Ministers in the other 27 countries that we wish to continue to participate in this programme. So far, we have had only a letter from the Commission itself setting out its view that we should not take part. In our view, that would be folly of the worst sort: it would increase costs for the whole programme by €1 billion and possibly delay it for three years.

Lord Hannay of Chiswick (CB): My Lords, have negotiations begun on the Prime Minister's proposals for a security treaty with the European Union? If they have begun or are about to begin, will they cover the security aspects of the Galileo programme and perhaps provide a way of avoiding what can be described only as mutually assured damage?

Lord Henley: My Lords, I am not aware of whether they have begun but certainly they would provide a way to deal with this matter. The noble Lord is right to stress that there would be mutually assured damage if the Commission was to continue with its suggestion that we should not participate in this programme.

Lord McNally (LD): My Lords, as with the FSA question, is this not a case of where Brexit bravado comes up against the brick wall of reality? If we leave the EU and then have an associate agreement with it of one kind or another, which the Minister cannot define at the moment, it will be weaker than full participation in the Galileo programme. Airbus has already taken its Galileo project out of this country in advance. We will be left for both security and space reasons either seeking such agreements with the United States or the European Union, or, we are now told, going it alone—with a minimum cost of £5 billion. They did not put that on the side of a bus.

Lord Henley: My Lords, if not anything else, it suggests the folly of the Commission in making this suggestion. Other countries have not said that they would not like us to participate. That is why my right honourable friend is engaging with other countries. There are benefits to the UK and to the whole EU with us continuing to participate. I repeat that if we do not participate—we are one of the lead players in this—the extra costs of this programme would be €1 billion and it would delay what is a good programme by up to three years.

Lord Soley (Lab): Following on from that question and answer, is the Minister aware that the digital security factor involved in this is crucial? The French are already making major efforts across the board to take work from British satellite and aerospace companies because we have a lead in such manufacturing. We will lose that lead to particularly France and Europe generally unless we can sign up to some digital security deal. That is vital and the Government need to say so, otherwise we will lose out massively.

Lord Henley: My Lords, the noble Lord makes a perfectly good point. My right honourable friend has made these points in his letter to the other Ministers involved in this country. That is why the other Ministers—certainly in my department, and in others—have already started engaging on this and will continue to do so. This is a proposal from the Commission but we want to see what the other countries feel about it as well.

Lord Wallace of Saltaire (LD): My Lords, the Minister referred to the Government investigating co-operation with other partners. If we are talking about other Governments with satellite programmes, I imagine it is a choice of China, Russia, India and the United States. Are the Government investigating all of those as options?

Lord Henley: My Lords, all I said—I am not going to go much further than this—is that we are looking at other options. I also stress that we have the capability to do quite a lot ourselves. I am not suggesting that we will engage with Russia and other similar countries.

Lord West of Spithead (Lab): My Lords, the Minister will be aware that we work closely with America in this field—most of the work is so sensitive we cannot talk about it—and that we were so far ahead of anyone else in the world in satellite coverage and intelligence that we used to help other countries. It is extraordinary that Europe is now playing silly games about the use of satellites when we have been so generous in the past in the giving of intelligence and working with it. It is also extraordinary, given the skills that we have in this area, that it is not keen to keep us fully involved.

Lord Henley: The noble Lord could hardly have put it better, particularly in stressing the capabilities that we have in this country. Only recently I visited an American company making micro-satellites in Glasgow. It could have invested anywhere in the world but it chose Glasgow because it knew Glasgow has the right people with the right skills here in the United Kingdom. We have a great capability and I am sure other people will recognise this.

Lord Howell of Guildford (Con): My Lords, just for the record, I say that we already co-operate with the Russians in the Soyuz and space station programme, in which Tim Peake flew and which is highly successful. Does the Minister agree that, if we can co-operate with the Russians despite everything, surely we should not have too many problems with the European Union?

Lord Henley: I am sure that the Commission will note my noble friend's point.

Employment Tribunal Hearings

Question

11.29 am

Asked by ***Lord Beecham***

To ask Her Majesty's Government what steps they will take to reduce the backlog of Employment Tribunal hearings that has arisen since the Supreme Court ruling in July 2017 that the high level of fees previously levied was unlawful.

The Advocate-General for Scotland (Lord Keen of Elie) (Con): My Lords, we wish to ensure that employment cases are dealt with swiftly and effectively. We are taking action to deal with the tribunals' increased case load. This includes setting aside extra days for judges to hear tribunal cases, as well as developing plans to recruit more tribunal judges. We continue to monitor the situation closely.

Lord Beecham (Lab): My Lords, this issue was drawn to my attention by a newspaper headline—in the *Times*, not the *Morning Star*—entitled "Tribunals gridlocked by surge in claims". Among the many cases cited by the trade union USDAW and Thompsons Solicitors was a case in London, which happened in November 2017 and will be heard in January 2019, and a case in Watford, listed for a three-day hearing in January 2018 but postponed until September due to "having overbooked and a lack of judicial resources". Is the Minister aware that ACAS conciliators have reported that they are overwhelmed by the increase in claims? For example, solicitors in Newcastle have been unable to get through to speak to anyone for two weeks. In detail, what steps do the Government intend to take, and within what timescale, to ensure that the maxim "justice delayed is justice denied" is no longer exemplified in the workings of the employment tribunal system as a result of what the Supreme Court ruled was its unlawful and unconstitutional imposition of fees of up to £1,200?

Lord Keen of Elie: On the last point, the Supreme Court determined that it was lawful to charge fees for the tribunal; it was the level of fees that was considered disproportionate. The time taken for tribunal cases was in the region of 26 to 28 weeks per case for resolution. That has increased to about 33 weeks because there was a significant increase in applications to the tribunals after the decision in July 2017. We have put in place a process for recruiting a further 54 tribunal judges for employment tribunals, which should increase capacity by about 44%. In addition, we are now taking steps to increase the number of fee-paid judges in the tribunal system; indeed, fee-paid judge sittings have increased by 180% since July 2017. We are also conscious of the need to employ additional staff in employment tribunals; that is being undertaken at the present time. I apologise for the length of my answer, but I felt I should give the noble Lord's question a full response.

Lord Marks of Henley-on-Thames (LD): My Lords, in the impact assessment supporting the 2013 fees order, the Government said that they were unable to predict how many employment tribunal claims would be deterred by the introduction of the fees but that they should deter unmeritorious claims. We now know that there was a 75% drop in claims following their introduction, with absolutely no effect on their success rate, and that this massive backlog has built up following their abolition. Will the noble and learned Lord accept that this is clear evidence that high tribunal and court fees deter meritorious claims and so reduce access to justice? Will he assure the House that any future impact assessments on this topic will have regard to such evidence?

Lord Keen of Elie: When the coalition Government introduced tribunal fees to employment tribunals, they did so in the belief that they were taking a proportionate step to meet the costs of our courts and tribunals. Indeed, the totality of fees income is still less than half the cost of our courts and tribunals. Going forward, we will be conscious of the need to ensure access to justice—a point made by Lord Reed in his judgment in the UNISON case.

Lord Howarth of Newport (Lab): My Lords, is the Minister aware that there is considerable sympathy for him having to keep returning to this House to defend the indefensible situation that the Treasury, being apparently unaware that justice delayed is justice denied and that access to justice is beyond price, has imposed on his department? What does he think of the Treasury's custom of hiding behind the skirts of the spending departments?

Lord Keen of Elie: My Lords, in what may be my last statement from the Dispatch Box, I observe that the Treasury has had to respond to the dramatic economic turnaround that occurred after 2008. That has had an impact on spending departments, but we require to maintain a coherent economic policy for the whole country.

Unpaid Work Experience (Prohibition) Bill [HL]

Third Reading

11.34 am

Bill passed and sent to the Commons.

Family Relationships (Impact Assessment and Targets) Bill [HL]

Third Reading

11.35 am

A privilege amendment was made.

Bill passed and sent to the Commons.

The Long-term Sustainability of the NHS and Adult Social Care

Motion to Take Note

11.35 am

Moved by ***Lord Patel***

That this House takes note of the Report from the Select Committee on the Long-term Sustainability of the NHS, *The Long-term Sustainability of the NHS and Adult Social Care* (Session 2016-17, HL Paper 151).

Lord Patel (CB): My Lords, it is a privilege to open this debate on the long-term sustainability of the NHS and adult social care as the chair of the committee that produced the report. I begin by thanking most sincerely all those who contributed to the report: our specialist advisers, Dr Anita Charlesworth, director of

[LORD PATEL]

research in economics at the Health Foundation, and Emma Norris, programme director at the Institute for Government; our committee staff, the clerk Patrick Milner, the policy analysts Emily Greenwood and Beth Hooper, and the committee assistants Thomas Cheminais and Vivienne Roach; and, of course, all the committee members, with their collective and individual wisdom and experience—a most agreeable and amiable group that it was my pleasure to work with. I think sometimes small lies are permitted.

Any difficulties that we had in our discussions were smoothed over with spiritual guidance from our resident Prelate, the right reverend Prelate the Bishop of Carlisle. We were sorry to miss the noble Lord, Lord Mawhinney, from most of our inquiry because of his illness, and I wish him well. The noble Lord, Lord Lipsey, is not happy that he will not be here today, but he is recovering from his illness. I wish him well and hope that he is back here soon. In the context of the debate, I am pleased to see the noble Lord, Lord Lansley, in his place. I wish him, too, a full recovery from his illness. We might have another time to discuss his reforms.

Now to the report. The inquiry started in July 2016 and lasted until December 2016—too short for us to cover all the issues in health and social care. Hence our call for evidence was targeted at the key challenges of the long-term sustainability of health and social care. We received more than 193 written submissions, amounting to 500,000 words. We took oral evidence from more than 100 key witnesses. We also received correspondence from more than 3,000 members of the public and hundreds of emails with personal experiences and heartfelt stories. I thank them all for writing to us. We also learned lessons as to how we might be able to engage with the public in future.

We published our report, which was 100 pages long plus annexes, with 34 key non-political recommendations, on 5 April 2017. The report was well received, with favourable comments from a wide spectrum of media—radio, local and national television and later professional journals and blogs—and equally positive comments from think tanks. The Institute for Government has recently expressed an interest in taking forward one of our key recommendations, and is exploring the possibilities related to establishing an independent body—possibly an OBR-style body—for health and social care.

I also thank the chair of the House of Commons Health Select Committee, Dr Sarah Wollaston, who took evidence from me and four other committee members in a full session lasting over three hours, and also—in different sessions—questioned the Secretary of State and the Prime Minister on aspects of our report. All this gave the committee the feeling that we had done a reasonable job on the task given to us.

The long-awaited government response came in late February 2018. It is 39 pages long, and detailed and informative on current initiatives and developments, but a little short on addressing the report's key recommendations. That is possibly because our important recommendations require a policy rethink and the Government need more time to consider them fully. Their subsequent response will—hopefully—be in actions. I am naturally kind and optimistic and I look forward to that.

This is an important year for the NHS. On 5 July 2018 it will be 70 years since its inception. Lots of celebrations are planned: services in Westminster Abbey and York Minster, features at the Chelsea flower show, celebrations at Wimbledon and much more. I have no doubt that many reviews will be carried out and published by various think tanks around the 70th birthday. As we rightly celebrate, however, concerns continue to be raised about the long-term sustainability of the NHS: its ability to deliver quality care in the face of rising costs, the ageing population and increasing comorbidities, and its ability to cope with developments in expensive medicines and technology, in particular in diagnostic and other areas, with its crumbling infrastructure. For the first time, 52% of the population think that the NHS is the biggest issue facing Britain today. Public confidence in the NHS, in social care and in primary care, is falling.

The weaknesses in the delivery structures of health and social care are made worse by winter pressures on services, as evidenced by daily headlines of bed blocking, queues at A&E, patients on trolleys in hospital corridors, cancellation of elective surgeries for months, and commissioning groups constantly rationing care.

Despite all this, the service, through its dedicated and hard-working workforce, tries to cope and to minimise hardship, and of course there are good initiatives and developments in the pipeline that will improve the service. What is needed, however, is a long-term fix.

A real celebration would be a political consensus, possibly delivered through an all-party commission—which has been asked for by many people, including politicians, political commentators and the media. Even our own Lord Speaker, in an article he wrote more than two years ago, asked for a commission to be established. The Government should initiate such a consensus. The Prime Minister's legacy would then be the delivery not just of Brexit but, importantly, sustainable health and social care.

I now come to the report itself. It has seven chapters, ending with proposals for building a lasting political consensus. The inquiry found a lack of long-term planning. We were unkind enough to suggest a culture of short-termism. Everyone, it seems, is so absorbed in struggling with day-to-day troubles and with the uncertainty of year-on-year funding settlements that a culture of "here and now" has developed. Our comments, which were not designed to cause upset or to name and shame, should be taken as constructive.

We found that the five-year forward view of the chief executive of NHS England, Simon Stevens, was the only example of strategic planning for the longer term. By the way, if I might digress, in Simon Stevens we have somebody who has, in my view, been given the freedom and authority to be the change needed to build a healthcare system based on outcomes. I am glad that the Secretary of State asked in a recent statement for a five-year or even a 10-year forward financial settlement for the health service. This was one of our key recommendations.

The evidence we received pointed strongly to the fact that, at the heart of securing a long-term future for health is the need for radical service transformation: a change that involves a model of primary care moving

away from the small business model to one of bigger group practices, properly resourced and able to deliver on diagnostics. GPs should have the power and authority to shape the delivery of primary and community care, linking with and, at times, being part of secondary care and even involved in hospital care—a model away from the overburdened, bureaucracy-driven current model that we heard about. The model should be attractive for young doctors to flourish in, which would make recruitment to primary care—as it was before—a problem of the past. Equally, it should be a transformation that involves reshaping secondary care, with specialist services consolidated.

Reform is also needed to reduce the bureaucracy and regulatory burdens that play little part in delivering better health outcomes. The current statutory framework frustrates this agenda, but change is needed. With the current focus on integrated, place-based commissioning, the need for two separate bodies, NHS England and NHS Improvement, has to be questioned.

Appropriate funding of the NHS remains the key issue. Years of cuts have led to the decline of services, demoralised the workforce and caused a crumbling infrastructure that in some cases needs the services of a bulldozer. No doubt we will hear of the extra funds given in the last Budget, and prior to that, but significant deficits in the majority of trusts continue. A settled funding plan, with a year-on-year increase linked to the rise in GDP, is our modest recommendation. A possible increase in funding to mark 70 years of the NHS was suggested by the Prime Minister, who mentioned it in her evidence to the House of Commons Liaison Committee. If true, this has to be welcomed: how much and what it will be used for will be the important question. We received clear evidence for maintaining a service free at the point of need.

The lack of any long-term planning for the workforce is the biggest internal threat to the sustainability of the NHS and adult social care. Much of the workforce planning is fragmented. Too much training of our clinical workforce is done through the old model, lacking flexibility and with poor opportunities to update skills. Lack of leadership leads all and sundry to believe that they are in charge of workforce planning and training. It is rather like a bus with too many conductors but no driver. We recommended a strong, independent, well-resourced role for Health Education England to plan for the long term and be accountable. Clear leadership is needed. I gather that our perceived criticism has been taken to heart and that change is on its way. All I can say is: good, and congratulations—may the force be with you.

Prevention of ill health was a key component of Simon Stevens's five-year forward view, but it has received little attention. There seems to be apathy, centrally driven, around planning for a co-ordinated prevention strategy. A service centred on illness is not sustainable. Much of cardiovascular disease, stroke, cancer—40% of cancers—diabetes, mental health, lung diseases and possibly even dementia has a preventative aspect. We need to learn from models in other countries. I am sure that if the noble Lord, Lord McColl of Dulwich, had been here, he would have had much to say about our obesity epidemic. He has another arrangement in Hong Kong so cannot be here today.

The report also identifies the NHS as a poor adopter of innovations, unable to drive increased productivity, cut waste, use data effectively, reduce variations in care and, above all, reduce variations in outcomes related to inequality and deprivation. The difference in the life expectancy of people in Hackney and the West End of London is the same as that between those in England and Guatemala—about eight years.

Let me now come briefly to social care. Despite extra funding, pressures on social care and the NHS continue. Analysis conducted by the Health Foundation, the Nuffield Trust and the King's Fund suggests a shortfall of £3.5 billion in social care by 2020. Our report makes a plea for a long-term settlement for social care. As the Government develop their Green Paper on social care for older people, I hope that they will look at all alternatives, apart from the cap, including models of funding that operate in Japan and Germany through a system of hypothecated social insurance, with a defined contribution based on age and income, paid for by all throughout life, with a small top-up contribution made by those who need it—a system that reinforces the principles of social justice, equality and social solidarity to which everyone contributes. Those principles are the bedrock of our much-loved NHS. This is not an ideological suggestion; it is a suggestion based on the one-nation principle.

Let me now turn to accountability. There is a clear need for parliamentary accountability based on transparent information. To this end, following much discussion and an in-depth audit of 16 independent and semi-independent bodies carried out by Emma Norris, programme director at the Institute for Government, we tested an idea with many witnesses and received broad support. We made three recommendations to establish an office for health and care sustainability with a clear and defined remit. The Government responded to this recommendation in 80 words and referred to two websites. The right reverend Prelate the Bishop of Carlisle may well take this further. It is an important recommendation, deserving greater debate and attention, and I hope we will have the opportunity for that at some time.

We are often told that our NHS is the best in the world. Why? Because the Commonwealth Fund, which is based in Massachusetts, places our NHS at number one. The fact is that the fund has its own agenda and uses a methodology to back it. Inconveniently, it also puts the NHS at number 10 for outcomes—and outcomes are what matter to patients. That is what they look for. On the other hand, the Legatum Institute, a London-based think tank, places the NHS 20th, Bloomberg places it 21st and the WHO places it 16th in the world. We need a service based on outcomes. Our outcomes in cardiovascular disease, stroke, cancers and lung diseases are not good compared with those of other, richer countries. A service that is considered accessible and low cost but is poor on outcomes is like having a coffee machine that is cheaper to buy but cannot make coffee.

Time has come for a political consensus to make our much-loved NHS a service that delivers the best care for all, is cost-effective and becomes the model of the best care in the world. We have been there before and we can be again. It is doable, as long as the NHS

[LORD PATEL]
does not continue to be a political football for those who hope to win votes. I hope that this debate is the start of that political consensus. I beg to move.

11.53 am

Lord Hunt of Kings Heath (Lab): My Lords, I applaud the noble Lord, Lord Patel, and his committee for this excellent report. It is a huge wake-up call to all concerned about the state of the NHS and social care, which has been given added weight by this morning's call by the noble Lords, Lord Darzi and Lord Prior, for substantial and long-term increases in funding.

The drivers of change—from demographic factors and changing disease patterns, to technological and medical advances and increasing healthcare costs—are intensifying at a relentless pace. The system, which was originally designed to treat short-term episodes of ill health, is now caring for a patient population with more long-term conditions, more co-morbidities and increasingly complex needs. With the share of the population aged 85 years and above set to increase from 2.4% now to 7.1% in 2066, this represents a formidable challenge for the NHS and social care. That is what makes funding so critical.

On average, spend on the NHS has risen by 3.7% in real terms since 1949-50. Yet at a time when pressures have never been so great, the Government and their coalition predecessor chose to cut adult social care and their spending on the NHS down to a miserable 0.2% per year average in real terms for the whole of the current decade. No wonder the NHS is reeling: targets have been abandoned; waiting times are growing; crude rationing is on the increase; doctors, nurses and other staff are demoralised; and there is huge unmet need in social care.

The Government's response, to which the noble Lord, Lord Patel, referred, has been what I shall describe as underwhelming. What is remarkable is how many months it took the department to come up with its response. However, it has emerged that the Secretary of State is canvassing support for a long-term funding settlement, potentially embracing a ring-fenced hypothecated tax. This is something the Select Committee gave attention to. I particularly look forward to the comments from the noble Lord, Lord Layard, on this because he has done a lot of work in this area. I can see the attraction. It would enable the public to see a direct link between taxes paid and benefits received in the shape of the NHS.

National insurance is often favoured as the most straightforward way of doing that. English health expenditure in 2015-16, at £119 billion, is remarkably close to NI contributions for the same year, at £114 billion. However, to get to a baseline health and social care figure for England you would have to add another £15 billion for social care. You would then need to add in more to get the kind of settlement that the noble Lords, Lord Patel and Lord Prior, are arguing for, and that would cover only England because the devolved nations, in one way or another, would also have to be factored in. A rise of 1% in national insurance would raise about £5 billion, so to get a reasonable baseline figure national insurance would have to rise considerably. It would also be a huge figure for any Chancellor to effectively lose control of in all the schemes that are being proposed. I am not an expert on national insurance—

Lord Forsyth of Drumlean (Con): Could the noble Lord indicate whether, when he talks about revenue from a rise in national insurance, he is talking about contributions from employees, or from employees and employers?

Lord Hunt of Kings Heath: It came from a paper from the Office for Budgetary Responsibility. I believe that it is to be a general rise of around 1% across the board, but I will check that out and place a copy of any letter that I send to the noble Lord in the Library.

The point is this: clearly considerations would need to be given if there were to be a rise in national insurance, such as to its impact on employees and employers. Would it be a tax on jobs? Would it be an increase in taxes on working people, when the main beneficiaries of the NHS are older people who do not pay national insurance? Although national insurance contributions are mostly progressive, they become much less so when you hit the upper earnings limit, where employee contributions decrease from 12% to 2% on incomes over £805 per week. I know some noble Lords believe passionately that this is the way forward, and it is an idea worth exploring, but we have to be realistic about some of the drawbacks.

Baroness McIntosh of Pickering (Con): If 1% were added to national insurance contributions, what would the cost be to the health service, being the largest employer in the land?

Lord Hunt of Kings Heath: I do not know the answer to that but clearly it is another point that has to be factored in, as it would in the care sector more generally. We have already seen this: clearly, it is welcome that the living wage has been introduced, but it has had a knock-on impact when the funding for those services has not gone up at the same time.

I also caution about the desire to create a cross-party approach, as the noble Lord, Lord Patel, asked. Last month, Dr Sarah Wollaston, chair of the Health Select Committee, wrote to the Prime Minister asking for a parliamentary commission on health and care to be established to report on the long-term future funding of the NHS. Today, my noble friend Lord Darzi announced his independent review.

All this is welcome. The more we can debate the pressing need to fund health and social care properly, the more likely it is that the public will support a rise in taxes, which is what I believe this debate is essentially about. But the decision cannot be offshored. In the end, you need a Government with the political will to make the investment necessary, put in place a plan to fix staffing and properly support people to manage their own health care and conditions for the long term. Labour did it. We increased the amount of money going into the health service, reduced waiting times dramatically and invested in the infrastructure. It can be done, but it takes a Government with the political will to do it.

Alongside the issue of funding, we surely have to get on with redesigning the current regulatory and structural mess that the Government have got the NHS into. As the Select Committee report said:

"A culture of short termism seems to prevail in the NHS and … social care",

with the department,

"unable or unwilling to think beyond the next few years",

so there is no long-term funding plan and no national long-term strategy on workforce planning. The NHS is seemingly incapable of driving up productivity, using data effectively or adopting new technology quickly, as the Select Committee concluded.

The Health and Social Care Act 2012 has much to answer for. Its conflicting threads have led to fragmentation, friction and confusion. The Act is dominated by obeisance to a competitive market, with economic regulation to the fore. It established lighter touch oversight from the Government, with NHS England created as an arms-length organisation, subject only to an annual mandate, and GPs were supposedly put at the heart of decision-making through their dominance of clinical commissioning groups.

What has been the reality? Competition has proved a very expensive foible. It reached its ultimate folly with the competition authorities intervening in a sensible reconfiguration of service proposals at a cost of millions of pounds. Large parts of the competition regime have now been ditched but, as the Act has not been repealed, NHS bodies are endlessly at risk of legal challenge. As for light-touch oversight, the reality is that NHS England behaves in the way of all state bureaucracies: heavy-handed and highly interventionist. As for GPs being in control, so frustrated have CCG leaders become at their impotence and unwanted role as rationers of services that many have gone back to their surgeries or even retired.

Ministers preside over this with glorious ambiguity, consistently washing their hands of the shambles and performance failures that they and their colleagues created. The Secretary of State humiliatingly calls in the bosses of the so-called independent NHS Improvement, NHS England and CQC for a weekly berating and demand that ever more chief executives be sacked.

When the Sainsbury chief, Roy Griffiths, was asked to look into NHS management in 1983, he said that if Florence Nightingale were to come back to inspect NHS hospitals, she would find no one in charge. I wonder, if that great man were asked to come back to do a report, what he would say about the current arrangement. Actually, I think we have a pretty good idea. The noble Lord, Lord Rose, was asked by the Secretary of State in 2014 to recommend how leadership in NHS trusts could be transformed. By the time he finished, I think the Secretary of State regretted asking the question, because in his report he talked about the level and pace of change being unsustainably high, with the administrative, bureaucratic and regulatory burden fast becoming unstoppable. He talked about a lack of stability and a deep-rooted concern over the many and varied messages sent from the centre of government. Indeed, not surprisingly, the report died the death. We continue with a huge system that is under huge pressure, underfunded, under-resourced with people, and yet it is having to cope with one of the most complex, conflicting administrative systems ever seen.

One thing I particularly welcome in the report of the noble Lord, Lord Patel, is that he did not confine himself just to funding. He talked about the culture and some of the other issues that need to be tackled. The report is excellent, and we have an excellent debate ahead of us. I hope that the Government will listen. It is a great pleasure to follow the noble Lord, Lord Patel, who has shown such leadership in chairing the Select Committee and presenting his report so well this morning.

12.05 pm

Lord Willis of Knaresborough (LD): My Lords, I begin by congratulating the noble Lord, Lord Patel, on his excellent introduction to this debate, his expert chairmanship of the inquiry, and his patience with committee members who sometimes resemble a herd of cats trying to be assembled into some order. Through his persistence in eventually getting a response from the Government, he has shown tremendous tenacity over the past 12 months. I am rather sorry that the spokesman from the Labour Benches immediately rejected the core thread of the report, which is: without consensus, we will go nowhere. Simply talking about the problems we have today, without being able to look ahead to 10 or 15 years, which is exactly what the report does, does a disservice to this House and the whole of the NHS and adult social care.

I am sorry that there was such a non-committal response from the Government, although it is gratifying that a number of the recommendations have already found their way into new policy initiatives. A department for health and social care is welcome, and we should celebrate it. The acceptance of a long-term funding settlement for health and social care is welcome and we should work on it. A return to a Dilnot-esque funding formula for adult social care again is back on the table, and a draft health and social care workforce survey is again extremely welcome. The latter is particularly welcome following an admission by the Secretary of State that,

"workforce planning is an area where we have failed, and successive governments have failed".

However the strength of this report, with its wealth of oral and written evidence, is its recognition that the health service and adult social care is a very complex organisation. If we are to develop a 21st century system, we need long-term bold political decisions. Frankly, simply raking over the coals of past mistakes will not get us there.

We added "adult social care" to the title of our report as we swiftly recognised the folly of treating NHS and adult social care as separate organisms within a future healthcare ecosystem. Despite the compelling case for substantially more resources to secure long-term sustainability, we did not become preoccupied with quantifying the amount needed. We emphasised that resource must follow function and that a far more pressing priority for sustainability was service transformation. That point was forcefully brought home when we examined the development of the STP programme, where transformation has been largely abandoned on the altar of sustainability simply to achieve budgetary targets.

[Lord Willis of Knaresborough]

Service transformation maintained by long-term funding stability must be the holy grail for all of us, but that will not happen if transformation has to meet early and often unrealistic financial targets. This is particularly true of workforce transformation, where often double funding is required as systems overlap and develop. HEE's recently published draft health and care workforce survey for England goes up to 2027 and commences with quote from the noble Lord, Lord Crisp, from an article in the *Lancet* in 2010, when he said:

"Health is all about people … the core space of every health care system is occupied by the unique encounter between one set of people who need services and another who have been entrusted to deliver them".

That has not been the case. All too often, those who deliver services, the workforce, are treated as a commodity rather than as a precious resource. The fact that this is the first time in 25 years that the health service in England has consulted on a comprehensive workforce survey is as damning an indictment of past policy as it is ambitious about the future.

The consultation is in direct response to recommendations 6, 8, 9 and 12 of our report and, in particular, the challenge to Health Education England to take a far bolder lead in co-ordinating workforce planning with other key partners. While I declare an interest as a consultant to HEE, I applaud HEE and its colleagues in NHS England, NHSI, Public Health England, the Care Quality Commission, NICE and the Department of Health and Social Care on coming together for this initiative—the first time that has happened since 2012 and, again, it should be celebrated.

However, transforming the workforce will not be possible without challenging what Gavin Larner, director of workforce at the DoH, said are,

"strong culturally conservative parts of our healthcare system, where the different professional tribes see particular ways of delivering services".

The committee recognised this challenge, despite the number of past presidents of royal colleges there, and recommendations 11 and 12 are directed at clinical hierarchies. The committee challenged the current length of medical training, the overreliance on traditional disciplines and early career specialisation, the difficulty in moving between disciplines, and the difficulty of the appellation of prior learning, even when postgraduate qualifications at doctoral level were reached in several appropriate subjects.

We challenged why, when 70% of patient episodes are dealt with in primary care, there is such an imbalance of postgraduate specialism in community-based practice. But we also applauded the initiative by HEE, supported by the NMC, to introduce nurse associate roles, recruiting and training some 5,000 additional colleagues this year, 50% of whom want to train as registered nurses. So we are growing our own nurses rather than depending on recruiting from abroad, adding to the skills mix on wards and in the community. Transformation means that many new roles will be introduced in traditional areas from surgery to midwifery, as well as nascent roles yet to emerge. The emphasis of royal colleges and other professional leadership groups as well as government and regulators should be on assessing their benefits to patients, not on fighting a rearguard action to protect past structures.

The future sustainability of the NHS and adult social care is not about more of the same but about developing a workforce that is flexible, ambitious and confident. As the report states, that will require continuous investment in healthcare's most valuable resource, its people.

12.12 pm

Lord Kakkar (CB): My Lords, I join in congratulating my noble friend Lord Patel on the extraordinary way in which he chaired the committee; I had the privilege of being one of its members. I also thank him for the remarkable leadership that he has provided in your Lordships' House when matters of health are debated, and to me personally—he was a supporter when I was introduced to your Lordships' House some eight years ago. He has been my mentor and has helped me understand how best to contribute to the work of this House.

I declare my interests as professor of surgery at University College London and chairman of University College London Partners. It is also a privilege to follow the noble Lord, Lord Willis of Knaresborough. He made the very important point that the NHS is about people—the people the NHS has the privilege to serve and those who ensure that the service can be delivered through their commitment and sacrifice.

As we move towards the 70th-year celebration of the NHS, it is very important for us to understand the contribution of those who have served in the NHS and have come from abroad to do so, particularly those from many Commonwealth nations. Their contribution has ensured that we are in a position today to have this debate to talk about the future sustainability of the NHS. Without those countless tens of thousands of contributions, frequently unrecognised, we would not have been in a position to establish a service that has had such a profound impact, not only on the health of our nation but on social cohesion. Will the Minister ensure that all those contributions, including of those who have come from overseas to serve our NHS, are properly recognised as part of the celebrations?

That is also an important point in understanding why the service is at times seen as demoralised. People need to be motivated. Regrettably, the NHS has become an organisation frequently defined by regulation and targets rather than by a commitment to a professional vocation—which was definitely a founding element of the NHS in 1948. Some way needs to be found to reinvigorate that professional vocational commitment so that it once again represents a foundation for the way care is delivered, while of course recognising that standards have to be met and quality must be at the heart of delivery of the National Health Service.

As we have heard, the committee considered the fundamental question of the long-term sustainability of health and care. In that regard, a need to develop consensus in three important areas was identified: on how a future NHS should be funded, on how a future NHS and care system should be delivered, and on what should be delivered as part of the nationally agreed consensus on health and care. It is vital for government and other leaders—political, professional and, more generally, public—to determine how a consensus is to

be achieved among those different constituencies and between them to ensure that a sustainable model can be adopted for the future.

On the first question, of a consensus around funding, the reality is that most public debate and discourse about the NHS and broader delivery of care focuses on funding. That is a principal topic of debate. The issues have been well described: how will we understand the impact of changing demographics on the need for the delivery of both healthcare and social care? How do we model the impact of changes brought about by the adoption of new working practices and technology as they offset the increased demands created by such change in demographic? How will that balance be understood and modelled over time? How will we create a political consensus that ensures that a funding strategy is secured and available over a prolonged period well beyond the life of a single Parliament and, potentially, a single Government?

A second area where consensus is needed is on how care is delivered. There is no question that the delivery of primary care, secondary hospital-based care and specialist care requires radical transformation to ensure the adoption of innovation and technology that will improve clinical outcomes—which, as we have heard from my noble friend, Lord Patel, patients rate above almost anything else. How will we achieve a consensus on the reform of primary care? How will we achieve a consensus in driving a strategy for true integrated care that understands the lifetime needs and broad chronic disease needs of individual patients, rather than looking specifically at institution-based care, be it in hospital or out of it? How will we achieve consensus on transforming the principal focus of the NHS from being on illness to being on preventing ill health so that it becomes fundamentally sustainable in the decades to come? These are complicated questions. Although we have seen since the royal commission of 1975 many subsequent commissions, reports, reviews and reorganisations, all well-meaning and making small steps towards longer-term sustainability for the NHS, none to date has delivered what was needed or ultimately expected to secure the fundamental base that will give us a sustainable NHS.

Thirdly, there is the very sensitive issue of what the NHS and social care should deliver. This has become an increasingly difficult political question. Frequently, decisions on what should be provided are taken on an ad hoc basis, with different decision-making in different parts of the country. Frequently, that is seen as unfair and unjust in a system designed principally as a national service there at the point of delivery for all our fellow citizens, with every citizen able to be confident that they will receive just as good care and access to innovation and to the potential to a clinical outcome, wherever they live and whatever their background.

Such challenges are not new to this Parliament. I had a very interesting conversation with the right honourable Member for Birkenhead in the other place, who brought to my attention a period in the 1830s with a similar national institution. On that occasion, the Church faced very serious problems, and a royal commission was established by Grey in 1832 to address the question of the Church and how it disposed of its funding, and the changing needs and demographics of the British people. In 1835, the Ecclesiastical Revenues Commission was established by Peel and, on that occasion, a commission with a slightly different remit, which had the ability to inquire and identify problems and suggest solutions but also to act and implement with the supervision of Parliament. I do not suggest that that is the solution at the moment, but it must be for Her Majesty's Government to identify a way at this important time—with these important challenges and on the basis of this detailed report—to find a method to achieve a consensus and move forward the national debate, addressing what is now becoming a critical problem.

12.22 pm

The Lord Bishop of Carlisle: My Lords, like other noble Lords who have already spoken and who will speak in this debate, I had the great privilege of serving on the Select Committee that produced the report of which we are, I hope, taking note today. Like them, I pay tribute to my colleagues, from whom I learned a great deal, and to our excellent chairman, the noble Lord, Lord Patel.

Since the report was published, more than a year ago, I found myself presenting its findings in various venues in Cumbria, where I live and work. On some occasions, local Members of Parliament and senior NHS staff have also been involved, but on every occasion the interest generated has been huge, which is a reminder, should we need it, of the importance of this topic to every citizen in every part of this country. At the same time, I have tried to emphasise again and again the underlying theme, the recurring refrain of the whole report—the serious lack of long-term vision and planning for the NHS, especially with regard to issues such as funding and workforce transformation, both of which have already been mentioned. Simon Stevens's five-year forward view is extremely encouraging and greatly to be welcomed, and I echo the positive comments made about it by the noble Lord, Lord Patel, in his introduction to this debate. But we need to look 15 or even 20 years ahead and, at present, that is simply not happening.

In attempting to summarise our 34 recommendations, the one that has consistently for me come out on top is number 33, which calls for the establishing of an office for health and care sustainability, rather like the Office for Budget Responsibility or the National Infrastructure Commission. The need for such a body was highlighted for us by the president of the Royal College of Physicians, Dr Jane Dacre, in her evidence to the committee. She said:

> "We are blighted by short-term planning that goes along with the electoral cycle. The health service is a very big and very expensive organisation that does fantastically well. But it is frequently the victim of short-term political decisions that make it less efficient".

We clearly need a co-ordinated, cross-governmental approach that requires an independent mechanism to scrutinise longer-term issues.

What would this look like? The audit of independent and semi-independent public bodies, in appendix 5 of our report, provides a basis for determining the remit for just such an office for health and care sustainability.

[The Lord Bishop of Carlisle]
We have suggested that it should focus on three key issues in particular: first, monitoring changing demographic trends, as mentioned by the noble Lord, Lord Kakkar, disease profiles and future service demand; secondly, thinking about the implications of future change for the NHS workforce and the skills mix; and, thirdly, looking at the stability and alignment of health and social care funding allocations relative to future demand, which, as we all know and as the noble Lords, Lord Patel and Lord Hunt of Kings Heath, have pointed out, is likely to grow hugely in the years to come. It should constantly look up to 20 years ahead and should play no part in the day-to-day operation of the NHS. It should report directly to Parliament, which I think addresses the cross-party hesitations expressed by the noble Lord, Lord Hunt. In fact, the value of such a body, which would not need to be very large, is blindingly obvious. That is why the Government's response to this recommendation is so deeply disappointing. They say:

"We believe that the functions of the proposed body would replicate existing mechanisms",

but existing mechanisms are not currently prompting or helping anyone to plan for the long-term sustainability of the NHS and adult social care. This dismissal of our fundamental recommendation is both perfunctory and inadequate.

As we have already been reminded, on 23 March this year the chair of the House of Commons Health and Social Care Committee, together with the chairs of several other parliamentary Select Committees, requested the Prime Minister to establish a parliamentary commission on health and social care across both Houses. I warmly support that request, I look forward to its approval and I hope very much that the commission's proposals will firmly include establishing an office for health and care sustainability.

12.28 pm

Lord Prior of Brampton (Con): My Lords, I first declare my interest as chairman of UCLH. The Select Committee has produced an outstanding report and I pay tribute to the noble Lord, Lord Patel—I was going to say my noble friend. He is a mentor to not only the noble Lord, Lord Kakkar; I regard him as a mentor to me as well in this place.

I make the obvious point: after 70 years, the NHS is still a remarkable institution. I do not think anyone in this House today is going to say that the NHS should be disbanded or that it is no longer fit for purpose. That is pretty remarkable after 70 years; there are very few organisations that have weathered so well. If you look around the world at other social insurance-funded systems or private insurance-funded systems, there is no doubt that the NHS—which pools the risks, whether genetic or social, of a whole nation—can deliver both fair and efficient healthcare. When Theresa May became Prime Minister she talked about social justice, and no institution better embodies those words than the National Health Service.

I will make four points, the first of which is on money. If we look back over the life of the NHS, there is a correlation between the amount of money that goes in and the productivity that comes out. It goes in fits and starts. One Government come in and put too much money in, and productivity goes down. The last Labour Government, whom the noble Lord, Lord Hunt, referred to, got the NHS to make huge progress, but during much of that time in the early 2000s a lot of waste and inefficiency went along with that extra money going into the system. We need a long-term settlement so that people in the NHS can plan for the future. It is not hard to create a long-term settlement, because the spending on the NHS is so determined by demography and technology that it is quite easy to predict. As some noble Lords will know, the IPPR has made a prediction of £50 billion extra by 2030. Whether it is £50 billion or £40 billion, surely that figure can be agreed on. If we are to have a cross-party view on this, exactly where we could have one is on what those requirements are for the NHS. However that is financed—whether through some form of hypothecation from general taxation, charging or productivity increases—that seems a perfectly legitimate area for proper political debate.

Secondly, on reform, by fragmenting the commissioning system into 212 clinical commissioning groups the Health and Social Care Act—my noble friend Lord Lansley, who was here a minute ago, was the architect of that—has made the process of integration more difficult. It also did not address the foundation trust issue, which was of course set up by the Labour Party when it was in government, and which has made integration much more difficult. If you are a foundation trust, you are solely interested in your own financial results and performance, and not in the performance of the system for the population as a whole which you service. We therefore not only have to address the consolidation of CCGs but have to look again at the regulation of foundation trusts. There is now evidence that where acute care and primary care work together in integrated systems, we reduce the number of emergency admissions into hospitals so that people are treated outside acute hospitals, which is all to the good.

The second area where the Health and Social Care Act was not helpful was in the split roles between NHS Improvement and NHS England, which has led to a fairly high degree of frustration and split responsibilities. To bring those two organisations together could well be part of the future. However, there is one caveat. Here I pay tribute to the noble Lord, Lord Carter of Coles, his team at NHS Improvement and their work on the Model Hospital and on the Getting It Right First Time initiative, led by Professor Briggs and Professor Evans. That "improvement" part of NHS Improvement should not be part of the regulator. You cannot be both a regulator with a big stick and a genuine improvement agency. However, the work the noble Lord has done in NHS Improvement should not be lost; it should be taken out of a combined NHS Improvement and NHS England organisation and treated separately.

The last part of any reform programme must be to emphasise prevention, as the noble Lord, Lord Patel, has already mentioned. We cannot regard the NHS purely as an organisation which cures the sick; it has to prevent people being sick in the first place. That has not received enough emphasis over the last six years.

I would like the Minister to address two other points in winding up. The first is that there should be a greater obligation on the NHS to support the life sciences industry in the UK. At the moment, it seeks to meet its own budgets and deliver care at the lowest possible cost but, for the economy and the country as a whole, the life sciences industry is absolutely essential. When it comes to developing cell and gene therapies and encouraging the convergence of data science and medical science in this country, for example, the NHS ought to have a greater obligation to support those initiatives and to become a test bed for British technology and science. However, the work that the NIHR has done under the leadership of Sally Davies and Chris Whitty in driving translational research in this country over the last five years has been terrific.

I should like to end on a point about Brexit. The Minister will know that my views and his on Brexit are very different but, whatever the outcome of the negotiations, there are three aspects of it which he may be able to give me some assurance on today: first, that we will remain part of any EU research programme such as Horizon 2020; secondly, that we will have a visa programme, not just for doctors and nurses but for the brightest and the best researchers, that is flexible and allows us to attract the best in the world to this country; and, finally, that we will remain part of the regulatory system in the European Union for medicines. If we do not, the chances of this country manufacturing these new advanced cell and gene therapies will disappear. We lost monoclonal antibodies from this country 10 or 15 years ago; we must be able to manufacture cell and gene therapies in this country. If we have to go through enormous compliance issues with customs at the borders, we will not be able to do so. I hope that we can have an assurance on that point.

12.36 pm

Lord Turnberg (Lab): My Lords, it was my pleasure too to sit on the Select Committee under the extremely wise chairmanship of the noble Lord, Lord Patel, and I congratulate him on introducing the debate today so well. Perhaps I may say how pleased I am to follow the noble Lord, Lord Prior. What he said very much resonated with me, as did what was said by the right reverend Prelate the Bishop of Carlisle.

Having heard from a huge number of witnesses, the committee came up with a very sensible and practical set of recommendations for the long term, but it was less than encouraging to have, after an extremely long gestation, the Government's rather anodyne response. Therefore, it was somewhat surprising to hear the Secretary of State on Robert Peston's programme a few Sundays ago saying some of the things that we had advocated. He spoke of the need for a 10-year plan and a ring-fenced funding system—a hypothecated tax, in other words—for health. I just hope that he was not so far off-piste that he will be given the boot. He had already persuaded the Prime Minister that he should be responsible for community services as well as health, if not for the funding of it. I never thought I would ever say this, but I just hope that he keeps his job.

I want to focus on just two aspects: integrated care and a hypothecated tax system. It seems trite now to say that any long-term solution to the problems of the NHS has to include care in the community. Draconian cuts have meant that social services are no longer coping with the increasing load of the elderly and infirm—everyone says that. The whole system is clogged up and we have been talking for ever, it seems, about integrating health and social care in a seamless system.

It is not as though we do not have models of how that can be achieved. The one that I know best and the one that seems to be working most successfully is that run by Sir David Dalton in Salford. I take some pride in that because I spent most of my clinical working life at Salford Royal Hospital, although I am well aware that it has taken considerable advantage of my having left and has done great things. As well as running the hospital extremely efficiently with a very enthusiastic team of doctors and nurses—which is somewhat rare in the health service at the moment—David Dalton has now been given the local authority's total budget for social services and community care. He employs the social workers, community nurses and two salaried general practices, and has now taken over mental health services too. He works very closely with the single CCG for Salford, as well as with the local authority, and he is now able to see the remarkable fruits of a completely seamless service for the 250,000 population of Salford. Dalton was asked to take over three local NHS trusts that were in financial trouble, and he is now busily turning them round very successfully. That shows what can be done if you have the right leadership, and if we can keep such leaders in their posts for the 17 years that it has taken Dalton to get to this point.

Those factors—excellent leadership that is not distracted by constant efforts to reach savings targets and not moving on every couple of years in some reorganisation or another—are both difficult to achieve. A change in culture requires sustained and persistent effort over a long period of time and is never a short-term possibility. Will the Minister consider ways in which the Government can provide the best conditions to allow this to happen, invest in long-term, high-quality leadership and give them the right incentives, and not get involved in any more reorganisations of the NHS? That does not mean that Salford and others do not need more money; they clearly do. We know that all NHS and social services have been starved of funds for so many years, despite the increasing demand. The question is how more money can be found.

I was one of those members of our committee who strongly favoured a hypothecated tax specifically ring-fenced for health and social care. I was bolstered in that belief by two distinguished economists: my noble friend Lord Layard, who will speak later in the debate, and the noble Lord, Lord Macpherson, neither of whom can be considered amateurs. It is noteworthy that the noble Lord, Lord Macpherson, was the Permanent Secretary in the Treasury, where you might expect some resistance to any form of hypothecation. Of course, there are all sorts of objections to hypothecation: it limits the flexibility of the Treasury to respond to the ups and downs of the economy, and, if it is based on national insurance payments, we know that the current sources of NI would not be sufficient by themselves to meet the costs of health and social care. Let me try to deal with each of those objections in turn.

[Lord Turnberg]

First, national insurance is currently paid only by those below retirement age, who, by and large, use the NHS much less than those over that age and who themselves do not pay. But why not? They pay tax on earned and other income, so why not national insurance? It may not go down terribly well in your Lordships' House, but national insurance paid by those over retirement age would go some way to evening out the intergenerational tax burden. Incidentally, polls show that it is true that the public at large would be willing to pay more tax, if it was earmarked for healthcare. We have a listening public prepared for hypothecation and—who knows?—perhaps the Treasury too could be persuaded if it recognised that it would not be under political pressure and bothered every year with bids for yet more resources for the NHS.

Secondly, how can we smooth out the impact of fluctuations in the economy and income? My noble friend Lord Layard—who will no doubt tell me if I have got this wrong—suggests that this could be achieved by a five-year agreed figure plus a 10-year estimated figure accepted by the Treasury, which would be able to take in the excess in good years and dole it out in the bad. I was delighted when, in his recent interview, Jeremy Hunt did not rule this out. I hope the Minister will follow this and be just as brave. Can he tell us anything about the Treasury's reaction to the Secretary of State's admission? Listening to the Chancellor recently does not give me much encouragement and so I will not be holding my breath, but at least the idea is out in the open. I await the Minister's response with interest.

12.43 pm

Lord Rodgers of Quarry Bank (LD): My Lords, I welcomed the decision to set up the committee in order to take a mature, carefully considered, all-round view of the NHS, more than simply the need for stable and predictable funding. I share the Government's response to the report: it is thorough and thoughtful, within the limits of time, and it raises most of the right questions.

I have played no significant part in health matters in the House except on stroke, which I shall mention later. But for many years, as a Member of Parliament, I dealt daily with the health problems of my constituents. In the 1960s my simple campaigning slogan was "Jobs, homes, schools and pensions" Then, in about the mid-1970s, I switched to "Jobs, homes, schools and health". Since then, the NHS—the national religion, as the committee calls it—has been full of pain as well as pleasure.

It may be pretentious to refer to a book, *The Politics of Change*, which I wrote 30 years ago but in a chapter entitled "Is Public Expenditure Enough?", I mentioned needs and means in health. It was not, I said, until 1976 that any attempt was made to establish rational and systematic priorities. Barbara Castle, then Secretary of State for Social Services, said:

"Demand will always outstrip our capacity … Choice is never easy but choose we must".

That was also broadly the message of the Cabinet Office central policy review committee at that time, as the noble Baroness, Lady Blackstone, may recall.

However, all too often over the years since then, politicians on both sides have ducked priorities and choice and delayed awkward decisions. That was the case with preventive medicine, and Aneurin Bevin himself said that,

"the victories won by preventive medicine are much the most important for mankind".

When death, disablement, injury and social distress could be avoided, even with a net saving of public expenditure over time, it seems extraordinary that a double bonus was ignored. I strongly support recommendation 30.

When I was Secretary of State for Transport in the late 1970s it was clear that a single, simple step of making seat belts compulsory could save 1,000 lives a year, prevent some permanent disablement and achieve substantial savings within the NHS. However, progress was slow because the Official Opposition and the Back Benches on both sides of the House claimed that seat belts were an unacceptable restriction of personal freedom. When I managed to get my seat belts on the Cabinet agenda, the Prime Minister was clearly half-hearted. Then, when I won in Cabinet, it took six months before I reached my Second Reading in the Commons. In carrying the Bill by 244 votes to 147, it was opposed by the Deputy Leader of the Labour Party and its Government's Chief Whip.

I welcome the report's call for more substantial and sustained action to achieve parity of esteem between mental and physical health. I endorse everything in the report about obesity and the failure by successive Governments to lead a robust campaign.

The report mentions stroke. It was in 1993 that the *Lancet* showed for the first time that stroke units saved lives and reduced disability. However, it took 14 years before the national stroke strategy was published. The Government in response to the report quotes the chief executive of the Stroke Association on what has been achieved by the reconfiguration of stroke services centralised in a fewer number of hospitals. I entirely share this view and applaud the London Hyper Acute Unit. As a victim of stroke, I am able to acknowledge the major strides in dealing with this illness over the past 15 years. The Government must maintain that momentum. It is good news that the new National Medical Director is now working toward a fully worked-out plan and the National Stroke Audit is being recommissioned. I ask the Minister only to say today, or in writing, what has happened to the reorganisation of acute stroke care in Greater Manchester and whether—or when—the changes in acute stroke services will be extended to elsewhere in the country.

Appropriate to a Select Committee, the report is wholly cross-party in tone. Quite apart from the closing paragraphs of the report, I greatly welcome that, but there is much more to be done to reconcile the spirit and purpose of the Bill and the willingness of Members of Parliament, local politicians and activists to accept change. They must work alongside CCGs and other NHS organisations to set priorities and make choices.

12.51 pm

Baroness Murphy (CB): My Lords, the report from the committee of the noble Lord, Lord Patel, is exemplary in its response to the evidence it received and in its

sensible recommendations. Sadly, we can almost guarantee that it will not be acted on. The response so far has been underwhelming, as other noble Lords have said. We do not need just a five-year plan or a 10-year one; as others have said, we need a 20-year plan, minimum. We have understood the demographics of our ageing population for 50 years—the trajectory is there before us—but heads have remained in the sand. My question is not how we can sustain the current system but why we would want to, given its sad state. I do not have any neat solutions, although I may echo some of the words of the noble Lord, Lord Turnberg.

I think that the situation is far worse than people believe. I have worked in the NHS all my working life, as a doctor, psychiatrist, academic and a manager; in fact, it was Roy Griffiths who persuaded me to become a manager when he did his report. I am now ashamed when I compare the healthcare here in England with what is available in other European countries. In particular, the primary care system of which we were so proud is now so poor at delivering access to people that, according to the OECD, we are the fourth-worst country for people being unable to access care and ending up in A&E as a result. Only three countries in Europe are worse than us: Slovenia, the Czech Republic and Slovakia. That is how bad access to primary care is here.

Our primary care system no longer provides a 24-hour service. Primary care and hospital systems have become even more fearsomely bureaucratic, strung up by regulation. Morale among doctors and nurses is as bad as I have ever witnessed. Last year, I went to a conference for young psychiatrists in Nottingham and I was shocked by their tales of the way the system impacts on their training experience and the way they are sent around and told what to do. It seemed a total anathema to the way I did my training. Our mental health system remains outrageously, chronically underfunded and the CCG system still allows money to be transferred sideways into other services that shout louder.

We smugly criticise the US for allowing the homicide by guns of 8,000 people every year. We tut about its gun laws. Yet, according to WHO statistics for 2015, we in the UK are five times more likely than Americans to die, once diagnosed, of mesothelioma, nearly three times as likely to die of oesophageal cancer, twice as likely to die of stomach cancer and nearly twice as likely to die of prostate and bladder cancer. Many more thousands of people in the UK die of poor treatment and inadequate follow-up. For example, prevention services would help diabetes not to become a crisis.

Why are we not scandalised by these figures? We should be. It is not that we have worse screening systems, but because our treatment, follow-up and aggressive care of people to provide better outcomes is simply not as good as many American and European systems.

Forty years ago I was really proud to be at the forefront of delivering dementia care services that I honestly believe were the best in the world. Forty years on we have fallen woefully behind. It has been demonstrated by research that it is now easier to get better care if you are impoverished in Texas than if you are a middling well-off person in the United Kingdom.

Yet the NHS is so beloved by the general population that when he was Chancellor, Nigel Lawson—now the noble Lord, Lord Lawson—said that the closest thing the English have to a religion is the NHS. How true that is. Because it is funded directly out of taxation, it is often starved of funds when tax revenues are inadequate or when the Government, as now, have a different approach to what should be funded and what should not. When we get these bursts of funding, as the noble Lord, Lord Prior, said, much of the money goes into increased staff salaries. Productivity, which is already appallingly low, goes down and the incentive is often to do less work rather than more. The investment must go into reshaping the system. We need a long-term settlement and political consensus about how to do it.

We have heard that perhaps one change that would make a huge difference is an integrated care system—by which I mean health and social care working together in clinical teams. We have known for many years that just having a joint budget, as they have in Northern Ireland, does not work adequately. We need proper care management systems working together—as we have heard happens well in Salford—but we really need case management working around clinical teams. That creates the elite feeling that people enjoy working in where they are really producing better outcomes for people. If I had one change to make, it would be to integrate funding and delivery of social and health care across the nation. I do not believe that that would fundamentally undermine the principles of the NHS.

My final point is that we need to look at how people understand where funds come from and where they go to. At the moment they see no relation between what they pay and what they get. It is time to ensure that the general public really understand that they are getting a cheap system that is poorly funded. They could have it so much better if they knew what they were putting into it and could see where it went from their own taxes. So I support hypothecated funding to help people understand where it is going.

12.58 pm

Baroness Redfern (Con): My Lords, I am pleased to take part in this long-awaited debate. I thank the committee's chairman, the noble Lord, Lord Patel, for his diligence and commitment. It was a privilege to serve as a member of the committee. I also thank the special advisers and clerks of the committee who ably supported us in producing this report.

Our main values may not have changed over the past 70 years, but what has changed, and is to be welcomed, is that we now see an average life expectancy for UK citizens of more than 80 years. To accommodate a growing population with its increasing expectations and demands, we have to have an NHS that is fit for the future. Clearly, just protecting the NHS budget will not address the financial challenges that lie ahead, but to survive it must change its aim to raise performance and deliver a safe, high-quality, as well as good value for money, service.

The overriding consensus throughout was a need for a future settlement far longer than the five-year forward view, rather than intermittent budgets being added on, however welcome. I do not wish to minimise that extra funding; it is welcome.

[Baroness Redfern]

From witnesses interviewed, there would appear to be a lack of a comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10, 15 or 20 years. It is therefore essential that workforce planning is based on predicted need rather than what budget is available at that place and time.

This report highlights the issue of there being a limited workforce strategy with too much reliance on overseas recruitment. With insufficient attention being paid to training the existing workforce, there will be a need for radical reform of many training courses for medical recruits to keep pace with change. Evidence submitted supported a need to be smarter at addressing the changing mix of skills required by a changing patient population. There needs to be attention on education and training to deliver efficiency and greater productivity, with good, clear career progression and opportunities to take on other career roles. We need to increase morale and bring back more enthusiasm.

The future of the health service relies on the NHS having the trained staff it needs to deliver services, in terms of both numbers and the appropriate staff to deliver care in a different way.

As witnesses stated, we must not again face the problem of a stop/go approach if, for example, we are to achieve world-class cancer outcomes. Staff shortages cannot be allowed to have an impact on the delivery of cancer diagnosis and care.

Before I go further it is important to have on record thanks to all the hardworking NHS staff, who perform above and beyond their remit, and to acknowledge the Government's long-awaited lifting of pay restraint.

Systems, too, have to change, beginning with the need to reduce bureaucracy. Given the amount of paperwork and pressure on the front line from all quarters, there is an urgent need to move to one single dataset to increase productivity, especially because unacceptable variations in patient outcomes are undermining the effectiveness and efficiency of the NHS. The NHS needs to show good performance throughout the UK.

The NHS has the potential to be a world leader in the use of data for research and service improvement but its digital infrastructure needs transforming as a matter of priority. Big data technologies have the potential to improve both NHS services and the research underpinning advances in healthcare.

It is critical for citizens to have confidence, when data is used in the public interest, that strong safeguards provide a firewall. Data-sharing needs to become a priority and not be left to remote national bodies. Evidence has shown that when people are involved, decisions are made better and quicker, health outcomes are improved and money is better targeted.

The UK is a leading force in medical innovation and has a history of research excellence, but the uptake of new medicines in the NHS is far too slow, with evaluations and financial approvals significantly reduced. Patient access, therefore, to new medicines is finally balanced on finances. We need to develop ways to improve that situation. Information we received showed that the key is to develop a culture in which innovation can be rapidly adopted and spread across the system, as solutions are found in the intellectual capital of people working in the healthcare system and the patients and citizens who use it.

More preventive care is needed, particularly around screening: screening tests are one of the best ways of engaging the general public. When diagnostic results are produced at an earlier stage people are more likely to survive cancer: the evidence is that more than nine in 10 people survive cancer when diagnosed at stage 1. That has been a great success.

I look forward, also, to the FIT bowel-screening test, which comes online this month. I hope the Minister will tell me that that is still on track. A bowel-screening target has been set of 70% uptake by 2020, compared to just 56% in 2016-17. We need good outcomes.

There are opportunities for improving the quality of services for patients while improving efficiency, lowering costs and providing more care outside hospitals. A strong, progressive capital strategy and investment in the maintenance backlog are also essential. If we accelerate this opportunity in the short term, it will deliver cost savings by using existing premises and in certain areas rationalising the estate to provide outcomes that are better for both patients and the public purse.

The need, therefore, is to develop a really strong, robust capital strategy to determine the investment required. Then we need to take swift action to accelerate change and build momentum in the system, in order to capitalise on short-term opportunities to save running costs and to cut waste through better utilisation of existing premises—even before rationalisation of the estate is initiated. Finally, funding needs to be more smartly targeted in the long term to help deliver a strong public service.

I have mentioned opportunities many times during my allotted few minutes, and I believe that there will be more. We have to act and deliver on those opportunities to provide a robust, safe, caring NHS that is fit for the 21st century—and, importantly, free at the point of need.

1.06 pm

Lord Carter of Coles (Lab): My Lords, I too congratulate the noble Lord, Lord Patel, on his introduction and his excellent chairing of the committee that produced this really authoritative report. We should not be surprised that it is so authoritative when we look at its members: there was clinical input, operational input and political input, all critical for navigating and producing a successful healthcare system. I refer to my interests in the register but will specifically mention a non-executive position on the board of NHS Improvement.

There is a high degree of consensus on the need for long-term funding and planning. Ministers are beginning to listen and the signs are good. We must get away from stop/go: it leads to all sorts of asset misappropriation and degrades the system over time.

I will touch on four points, starting with integrated care. Much has been made of this. Someone said to me the other day that the English system is so

fragmented—for many reasons—that it was like having a bad aeroplane journey: you have a bumpy take-off, a pretty smooth flight then a bumpy landing. Getting in and out of the system causes enormous difficulties. We have fragmented it, and we need, in bringing NHSI and NHS England much closer together, to do away with that fragmentation.

A key fault line in the system—as has been mentioned by other noble Lords—is the breakdown between acute care and long-term care for adults. It is a serious problem that is bedevilling the system. There are probably more than 10,000 people in our hospitals who should not be there. The effect is that we cannot perform the elective surgery and the system starts to spiral downwards. If the Government could do one thing quickly—this is about the long term but they need to do some things quickly—it should be to solve the problem of how to move patients out of the acute care system. Perhaps we should look at other healthcare economies, where central, rather than local, government funds the first 30, 60 or 90 days in the post-acute phase.

We need to look at other systems. The other day I was walking around a hospital in the United States with the lady who ran the trauma and orthopaedic department. I asked her what the average length of stay was for a total hip replacement. She looked really put out. She said that it was 56 hours. I said that sounded pretty good to me and asked what it should be. She said that it should be 52. We measure our length of stay in days: it is five and a half days, which is 130 hours. Other systems have developed because they have appropriate people in the care pathway. They have developed step-down care and homecare. In theory, people can move through the system and be cared for in the most appropriate place, both clinically and financially.

Integrated care is crucial, and the point was made earlier: we know how to do this. As someone said, the NHS has done everything right once. The challenge it faces is how to do things at scale: how to take its great skills—something that I will return to—and spread the productivity.

On integrated care and the issue of funding, whether that is a hypothecated tax or whatever, we must mutualise the risk. We do not want individuals bearing the risk and the fear that goes with it. We all agree on that but what form it will take, we will see. The critical point is: how do we involve citizens in the spending of that healthcare money and make them aware of what is spent? Do we take the French system and send them a statement every year saying, "This is what we spent to keep you in the state you are"? Or do we have a system like that of Singapore, where there are individual healthcare savings accounts and the citizen takes an active part in spending that money? Getting the total funding package is right but involving the citizen will be critical if we are to build a modern healthcare system.

I have worked on productivity for some years now in the NHS. It is inconsistent across the whole picture, in terms of not only money but care output and outcomes. Under the CQC ratings, there are 230 provider organisations in England. Of those, 12 are highly rated; 103 are good; 103 need improvement; and nine are obviously in serious difficulty. We have excellent hospitals—excellent community hospitals and mental health providers, and some of the great acute hospitals in the world—but we fail to take the learnings from them and spread them through the system. We are short on some degree of information-sharing and standardisation, although in fact we are quite rich on information. In many ways we do not use it properly or turn it into action, so it is quite critical.

People are beginning to think about this in NHSI. The noble Lord mentioned the work that Professor Briggs and Professor Evans are doing on standardising clinical pathways under the GIRFT programme. We are already gradually seeing the influence of people doing things in common. I think it was Benjamin Franklin who said, on the signing of the Declaration of Independence, "If we don't all hang together they'll certainly hang us separately". What has happened in the NHS is that we have been hanged separately by vendors or suppliers of materials, et cetera, so we need to hang together a little. Where we get that hanging together, we see savings. We have seen that this year in pharmaceuticals, where we have taken £300 million-odd out in the last year just by behaving collectively and switching purchasing in a proper manner.

That leads me finally to the issue of staff. People have talked about training and the need for it. All the time, we hear the praise for our dedicated NHS staff but perhaps we should turn to the annual staff survey and ask ourselves why 25% of the staff across the system feel harassed and bullied. I know of no other healthcare system in the world where that would work; in fact, for anybody involved in employing large numbers of people, anything above 10% is certainly a warning signal. In a good healthcare system, frankly, anything above low double digits is a crisis. We need to go back and understand this. Perhaps the Minister can say what is being done. The report talks about the effect of pay on morale but maybe we need to understand the effect of culture, management and pay on the critical issue, at this time of staff shortages, of how we use that scarce resource.

This report should shake our complacency. We seem to have a sort of schizophrenic attitude to the NHS. On the one hand, we are incredibly proud of it and think it is the greatest thing, yet when we look objectively we are failing. We are not as good as we should be, yet we have the perfect structure. What we need to do is to operate it better and we are beginning to work out how to do that. The question is: can we go at pace and move quickly enough? We need to convince the funders that as the money comes it will be spent wisely, and convince the public that we are spending it sensibly. We are on the edge of that but it will require an enormous push from government to get it there.

1.14 pm

Baroness Finlay of Llandaff (CB): My Lords, this important report is a 70th birthday gift to the NHS—a gift crafted and delivered expertly by my noble friend Lord Patel and his committee. Perhaps the Government's response reads a little more like a hesitant thank you letter.

[Baroness Finlay of Llandaff]

We must not forget that the NHS came into being following the Beveridge report and, as Aneurin Bevan entitled his book, it came *In Place of Fear*. To quote Bevan:

"The field in which the claims of individual commercialism come into most immediate conflict with reputable notions of social values is that of health".

We must not lose sight of that as we see an NHS in which fields of private endeavour have certainly developed improvements—but some aspects of commercialism, such as PFIs, have left the NHS deprived of its own funding. The recommendations on funding in this report now appear to have been taken up as government thinking, which is a fantastic compliment to the committee.

I would like to briefly address the issue of the workforce across several sectors and touch on opportunities for integration. As the noble Lord, Lord Willis, said, we depend on our workforce. A series of pressures, including Brexit, have compounded the strain felt everywhere. For doctors, particularly those in training, the events following the tragic death of six year-old Jack Adcock have shaken medicine to the core, because in many places the current system does not feel sustainable, with staff working at or beyond the limits of their capacity. This seismic effect has resulted in a loss of confidence in the system and has been felt in primary care. We need a workforce trained for today and for the future. The increased number of medical students is welcome but will probably not be anywhere near enough. We have been far too dependent for too long on importing staff at all levels for health and social care. In our changing world, we know there are predictions of shortfalls at every level.

For patients themselves, accurate diagnosis is essential. Reaching a diagnosis requires not only listening to the patients but picking up all the cues from around them and those who matter to them, as well as their environment. But diagnostic services underpin accurate diagnosis. Let me illustrate this with pathology. Pathologists are at the heart of cancer screening, diagnosis, monitoring and treatment. They diagnose tumours and determine the type of cancer, its grade and responsiveness. Blood cancers are treated by pathologists specialising in haematology. There has been a 4.5% growth in demand for pathology year on year, and longer survival thanks to treatment advances.

The tests to inform treatments are increasingly complex and, as has already been mentioned, screening will put a further demand on pathology—histopathology in particular. However, staffing levels have not risen in line with demand. Ten per cent of posts lie vacant and there is a predicted 25% workforce shortage by 2021 for both pathologists and reporting scientists, even allowing for information technology improvements. The *Cancer Workforce Plan* predicts that there will not be enough histopathologists in the NHS to deliver its ambitions.

Bevan had hoped that prevention would decrease the pressures of illness. We know perfectly well that it is not either/or but both. Prevention plus early diagnosis and rapid intervention are the challenges for the future. If we are to meet the challenges addressed in the report for better care in the community and freeing up hospital beds, the social care sector itself needs to address its recruitment and retention. Carers need to be registered, with a clear prospect of career progression. The Care Quality Commission has reported that a quarter of care homes require improvement. That cannot be ignored.

The pressure to move patients out of hospital beds into the community is so great that transformation and improvement at a local level is becoming a lower priority, yet it cannot happen without integrated systems. My noble friend Lady Murphy has already addressed this. More money alone will not solve the problem. People who go home early often do surprisingly well, yet our discharge services can be risk averse. People tell us what they need—but they need to be listened to.

Continuity of care is often provided by the social care workforce, who see someone day in and day out. They see the changes and the deterioration. But the problem of lack of integration means that, so often, people are bounced into emergency departments because that is where the lights are on 24/7 and the entrance door is there to other bits of healthcare. Emergency departments have seen an increase of almost 1.5 million attendances since 2010-11, equating to the workload of 10 medium-sized departments. Those pressures are still rising. They have been squeezed beyond the point at which the pips squeak. They know that safety is increasingly compromised. They are dealing with the sickest people, often in sudden crisis, across all disciplines, moving from one resuscitation to another—always calm, compassionate and competent, irrespective of the pressures and the severe distress they manage and the abuse sometimes hurled at them. How can you start a shift knowing that there are no ITU beds and that the hospital is full? The struggle is day in, day out. Some departments are putting in support such as positive reporting, mindfulness and the little things that recognise everybody's importance. That cup of tea is terribly important.

In my last few moments I shall address a missed opportunity. I declare my interest as vice-president of Hospice UK. Better integration of hospices and the NHS can certainly free beds and result in an up to 40% decrease in the use of hospital beds, with significant savings of more than £1,000 per patient. It can improve quality of life. Yet this is a missed opportunity. We still rely on the voluntary sector to look after the most vulnerable at their most vulnerable time. The silos have to go. This important report needs action and its recommendations must be taken forward, underpinned by a radical commitment to a National Health Service. The NHS reaches three score years and ten this year, but it is not near the end of its life. This can be the beginning of a new era, developing from Tredegar and Bevan's dream.

1.21 pm

Baroness Bloomfield of Hinton Waldrist (Con): My Lords, I, too, add my congratulations to those of other noble Lords to the noble Lord, Lord Patel, and his team on this excellent report and its thoughtful, challenging recommendations to Her Majesty's Government.

I have been exceptionally lucky in all my experiences with the NHS. An early diagnosis through a national screening programme and rapid follow-up led to successful

treatment at the Royal Marsden, and here I defend from my noble friend Lord Prior its record of working with private, transformational biotechnology firms, such as Immunocore. I received a humbling level of capable, compassionate and cheerful care from everyone—just what one would want from the NHS for everybody.

However, I recognise my experience is not matched by that of others around the country. In many regions, the service is creaking under the weight of demographic challenges, patchy social care provision leading to late discharges of the elderly and increasingly expensive treatments. This is combined with overwhelming expectations of what we should expect of the NHS in the 21st century, and as wonderful new treatments emerge for hitherto untreatable conditions this pressure is likely to increase.

I believe that, broadly, we all want the same thing: excellent care for all, free at the point of need. We may differ in the way we believe we can achieve it, but we are all motivated by the long-term vision of delivering better care more affordably, and I agree wholeheartedly with the noble Lords, Lord Patel and Lord Willis, that a long-term plan can be achieved only through political consensus.

The guiding principles of the NHS state that:

"the NHS seeks to improve the health and wellbeing of patients, communities and its staff through professionalism, innovation and excellence in care".

I want to focus my few comments on innovation, particularly technical innovation in the healthcare sector. This area comprised only eight pages of the report in a chapter that included productivity. Here I should declare my interest inasmuch as two of my children work in health tech, for eConsult and Lantum respectively. The former provides online GP services within the NHS, and the latter produces a workforce management tool connecting healthcare professionals with providers.

Heathcare is facing the kind of transformation not seen since the discovery of antibiotics and anaesthetics. Indeed, harnessing technology and digital innovation is critical to its long-term future. There is scarcely an area of medicine that cannot be improved upon by new technologies. Many of them can also have a transformative impact on disease prevention. In the energy market, which I know rather better, my view has always been that conserving energy is at least as important as energy generation in closing the energy gap, and so it must be that preventing illness will be a significant factor in narrowing the funding gap within the NHS.

Some £10 billion of the health service budget is currently spent on diabetes. NHS England's pilot of digital diabetes prevention programmes is a good example of a national focus on tech. There were 87 applications for the five places for the trial, and the successful bidders to be investigated and trialled include Buddi Nujjer, Oviva, Liva Healthcare, OurPath and Hitachi. If we could only diagnose diabetes earlier and educate people into healthier lifestyles, it would lead to a lighter burden for the NHS as well as a better quality of life for patients. Simon Stevens commented:

"So much else in our lives is now about online social connection and support, and that now needs to be true too for the modern NHS. This new programme is the latest example of how the NHS is now getting practical and getting serious about new ways of supporting people to stay healthy".

Depressingly though, both the chief executive of NHS Digital and Nicola Blackwood, in her report for PUBLIC, *The Promise of Healthtech*, talk of a silo mentality and technology inhibitor which discourages the uptake of new technology at scale. PUBLIC's survey last year commented that,

"If startups take twice as long as you expect, healthcare startups take five times as long".

Poor procurement practices are a major barrier to entry in certain parts of the country and in certain parts of the NHS. Many still rely on large IT vendors which fail to meet modern standards of interoperability. Cultural resistance, digital skills and the willingness to embrace technology also vary enormously across the NHS, so new companies need to understand issues of regulatory compliance and have evidence of clinical value in order to sell into the NHS successfully. Those that succeed will have focused their attention on areas where the NHS is most receptive to new technologies.

Primary care is an example. More care needs to be delivered through digital health solutions, giving GPs the time and ability to monitor and nudge behaviour remotely. Online consultations with GPs are now commonplace with companies such as eConsult. It was formed by a consortium of NHS GPs and helps to increase the capacity of GPs to see an ever-growing number of patients with increasingly complex health issues. Its remit includes spreading best practice throughout the country. Although there are still many sceptics within the profession who remain hostile to change, it is anticipated that by the end of this year many NHS patients in England will have digital access to their GP.

Dr Murray Ellender, writing in the *Times* earlier this week, stated that modern digital triage tools can now help to differentiate between serious conditions necessitating a face-to-face consultation and the more routine which can be dealt with remotely. Although he observes,

"if we use social media as a benchmark, digital consulting is still at the Friends Reunited … stage",

there are grounds for optimism. The current cohort of digitally savvy medical students and the recently qualified are sure to be rather quicker to embrace new technologies than their perhaps less digitally aware seniors. The changes that innovations such as cloud computing, VR, 3D printing, genomics and AI are bringing to the NHS could not have been imagined even five years ago and, frankly, cannot come a moment too soon.

1.27 pm

Lord Winston (Lab): My Lords, I thank the noble Lord, Lord Patel, for obtaining this debate and for his excellent report. I declare just one interest as a fellow of the Academy of Medical Sciences, and it is in that capacity that I want to speak in this debate to follow what the noble Baroness, Lady Bloomfield, said.

To extend the coverage of this report, we perhaps need to consider academic medicine a bit more carefully. Sir Robert Lechler, the president of the Academy of Medical Sciences, has written that the identification, training, development and retention of a new breed of clinical academic and research staff is essential for the NHS and UK science. They have to be digitally aware and properly trained in those things as well. He added

[Lord Winston]
that the academic health science centres, which were started some 12 years ago, have a clear role in the future of healthcare research and should be valued and should continue to be supported to be as effective as possible.

One of the issues is staff retention at those academic healthcare centres. This is a major problem. For example, in London, as I think I rather wryly pointed out to the noble Lord, Lord Prior, on one occasion when he was responding to a debate, after 12 years we are still looking for a professor of reproductive medicine to fill the chair that I left. We just cannot find anyone because of the expense of living in London and because, in this sector, the market has ensured that people are not working in academe or the NHS; they have gone private. I will come back to that point in a second. So this is critical, and we need to ensure new work practices and models for care delivery, and they have to be supported through research. In my view and that of the academy, that will require protected research time for medical professionals and the maintenance of funding. In particular, that must mean research for consultants, particularly in teaching hospitals.

We often boast about the advances that we have made in this country in medical care. The list is significant: organ transplantation, of course, thanks to Peter Medawar; antibody research, which has been mentioned; cancer research; and treatment for HIV. MRI and ultrasound were both started in this country. University College London is leading in some of the advances in neuroscience. In my own field, in vitro fertilisation and the screening of genetic disease were started in this country.

It is interesting to consider that we debated mitochondrial treatments for families with these diseases three years ago, in February 2015, and we agreed that that should be done. Three years later, as far as I am aware, there has not been a single treatment. Why should it take so long to get permission to do that when we have agreed in Parliament that it is essential? Think of those families who are waiting as a result of that research and those who have watched the child die of a horrible disease within the first two years of life. That seems wrong to me, and we should recognise that we need to implement our research in every field that we can.

One of the problems is something that I think was started by the Tory Party, although the Labour Government supported it: the internal market. Once we had the internal market, we could not centralise expertise in the way that we had before. We were able to develop very large patient bases, we could have better research and data, we could have much better trials and we could have training for people who could then go out to other parts of the country and improve what was going on in the health service.

A key issue is the need for young medical scientists. It is a major problem that lecturer posts, which are essential for research, are too few in this country and not fully supported, and often it is very difficult to make certain that you are going to get continued progression up to senior lecturer level. It used to be a huge advantage in medical research to have a PhD with an MD degree, but you could argue that it is now a disadvantage. We have young scientists who find that they cannot do clinical research in their hospitals because the NHS is just too difficult and too pressurised for them to do that at the moment. That is a massive problem.

As has been said repeatedly in this debate, we should also be looking at people as well as projects. It was interesting to read the article by the noble Viscount, Lord Ridley, in the *Times* this morning about the 100,000 Genomes Project. Of course it is a very interesting project and it may lead to important data, but as yet that has not been validated. We need to understand that we have to have investment in young people who are going to do the research. That is very important.

Time is short in this debate and I do not want to go on at great length, but I hope that, rather than just a complacent answer—I do not mean in any way to be discourteous—we can have an assurance from the Minister that we will see the academic health science centres, which have been such a success, continued. The one at Imperial College is a model for lots of reasons. It does many of the things that we have been saying in the report, such as collaboration: physicists, engineers, chemists, mathematicians and economists as well as medics work side by side to ensure that the research is promulgated and pushed in the best possible direction. However, those centres are fragile, and we need to ensure that the funding is secured and continued for the long term. If it is not, it is going to be very difficult to maintain the excellence in the health service, which I think will fall. The same must apply to the huge success of NIHR, which has been a massive advantage to research and is another form of collaboration. I hope the Minister will give us assurances on this point.

Artificial Intelligence

Statement

1.34 pm

The Parliamentary Under-Secretary of State, Department for Digital, Culture, Media and Sport (Lord Ashton of Hyde) (Con): My Lords, with the leave of the House, I will repeat a Statement made earlier today in the other place by my honourable friend the Minister of State for Digital and the Creative Industries. The Statement is as follows:

"The Government today publish our sector deal for artificial intelligence, a major collaboration with industry to secure the UK's global leadership in artificial intelligence and data. From how we travel to how we live and work, AI holds transformative implications for every aspect of our lives and for every sector of the economy.

For the UK, the economic prize is clear, potentially adding 10% to our GDP by 2030 if adoption is widespread, with a productivity boost of up to 30%. In pursuing that prize, we start with strong foundations. The UK was recently ranked first among OECD countries in Oxford Insights' AI government readiness index, and is home already to globally recognised AI companies including DeepMind, SwiftKey and Babylon Health. This success is supported by the UK's strong combination of world-leading universities that drive skills and R&D; a thriving venture capital market for AI that leads among economies of comparable scale;

and trusted universal public institutions such as our NHS that can pioneer data-driven innovation and connect the power of AI to the public good.

The sector deal that we have published today on GOV.UK therefore outlines how we are building on those foundations and on the independent review led by Professor Dame Wendy Hall and Jérôme Pesenti, reflecting that review's spirit of partnership and consultation between government, industry and academia. In skills, we have made it the UK's ambition to be home to the world's best and brightest minds in artificial intelligence. We will support the Alan Turing Institute's plans for expansion to become the national academic institute for AI and data science. We will create 200 additional PhDs in AI and related disciplines per annum by 2020-21, rising to at least 1,000 government-backed PhD places at any one time by 2025. We have set a target of 200 places for an industry-funded AI Masters programme, and will introduce an internationally competitive Turing Fellowship Programme in AI. We are also doubling the tier 1 exceptional talent visas to 2,000 a year to attract the brightest minds to the UK.

In infrastructure, we will ensure that the ambition of our AI sector is matched by the means of delivery in communications, in data and in supercomputer capacity. In telecommunications, we are investing over £1 billion to create a country with world-class digital capabilities, from 5G mobile networks to full-fibre broadband. In supercomputer capacity, we are delighted to announce as part of the sector deal that the University of Cambridge will make the UK's fastest academic supercomputer, capable of solving the largest scientific and industrial challenges at breakneck speed, available to AI technology companies. That complements the Government's support for start-ups' access to hardware via the Digital Catapult's Machine Intelligence Garage, and builds on Cambridge's existing track record as a hub for AI and technology.

We are investing in data, too, because data is infrastructure. Just as roads help us to reach a destination, data helps us to reach a decision. For AI systems, data is the experience that they learn from to be able to process information and interact usefully with the world and the people who live there. This Government have always valued the economic benefits of pioneers having access to high-quality public datasets, but some of the most useful datasets for AI are those that organisations are reluctant to share with others—for instance, because they have commercial value. The world's first centre for data ethics and innovation will therefore work to unlock the usefulness of that data while protecting its value for those organisations and, most importantly, keeping people's data secure.

We want AI-led growth to be both empowering and inclusive, and that applies to our approach to data. But it also informs our commitment that the benefits of AI should be felt across the whole country. The sector deal makes a commitment to establish clusters and regional tech hubs, designed to power AI growth, across the entire UK. We will invest £21 million in Tech City UK over four years so that it can expand into Tech Nation, thus transforming the UK from a series of stand-alone tech hubs into a powerful network that can place the nation firmly at the top of global tech rankings.

The message is made clear by the investment that industry has brought. In total, its investment with government forms an investment package of nearly £1 billion. That support sits alongside the £250 million already allocated for connected and autonomous vehicles and the £1.7 billion that has been announced under the cross-sectoral industrial strategy challenge fund so far. But please be clear: our ambition in AI will not stop at this sector deal. This is only the start of UK plans to seize the opportunities of modern technology and ensure that it follows the highest ethical standards. By doing so, we will ensure we continue to build a Britain that is fit for the future".

1.40 pm

Lord Stevenson of Balmacara (Lab): My Lords, I thank the Minister for repeating the Statement made earlier in the other place. We welcome it in its generality, although I have some comments about individual points. The most striking thing is that there is no reference in the Statement or the papers that accompany it to the excellent report recently published by your Lordships' Select Committee on Artificial Intelligence. It may just be a case of the Government getting their retaliation in first. I hope not; I hope that in time they will respond positively and carefully to the various recommendations made by that excellent report and look forward to returning to the topic then.

AI clearly presents huge opportunities for the UK, and it is important that the Government are taking it seriously, as I think they are in the Statement. Responsibilities go with that initiative, as is evident in some of the points made, but I shall probe further on them.

On R&D spend, which is at the heart of the Statement, as reflected in the press statement issued jointly by DCMS and BEIS, the ambition is to get to 2.5% of GDP, with an eventual target, although it is not quantified, of more than 3%. Sweden, Austria, Germany, Belgium and Finland all have R&D expenditure of more than 2.5%, and South Korea spends more than 4% of GDP on R&D. If the UK really seeks to be a leader in AI and technology innovation, as we hope it does, why is the target so modest?

My second point is about the link back to young people and the school curriculum. It was suggested that the Government discouraged the independent review led by Professor Wendy Hall and Jérôme Pesenti from looking at the curriculum in primary and secondary schools, which you would think would be part of the process of trying to get our country as a whole geared up to do more across AI. If they were told that they could not go there because looking at the curriculum is very thorny and difficult, what on earth are the Government going to do about it? There is good news in the extra funding for teachers, but teachers do not create curricula; curricula have to be created in the wider context of education. I should be grateful if the Minister would comment on whether there is to be movement on that.

Also in education, there is the rather curious phrase that the Government are going to "create" 200 PhDs, as if they are something that you just print or issue, like coinage. Further reading and looking in more

[Lord Stevenson of Balmacara]
detail at other parts of the Statement should reveal that this will be funding for a welcome increase in the number of people taking PhD programmes. Presumably they will be independently offered by universities, not simply created by government diktat. However, are we not in the middle of a crisis of funding for higher education? Where in the Statement—I could not find it—is any reference to how the students will live on the additional PhDs that are being created? To narrow my question down, will the PhDs mentioned be part of the independent review of higher education, which is looking primarily at undergraduate courses but needs to look also at masters and PhD students?

We have looked at digital infrastructure time and again in this House, and each time the Minister has come to the Dispatch Box and talked about what progress has been made he has been met by a torrent of scepticism and concern that the reality is rather different from what the Government think. At the heart of this must be a commitment from the Government to get ahead of the rather unaspirational USO that they are about to introduce and go to fibre to the premises. FTTP broadband is the only way we can take the benefit of the technology, invest and get the returns that we will need as a country. We are so far behind the EU average on FTTP, which is 24% penetration. We are at about 2.7% penetration. Countries such as Portugal, Latvia and Lithuania have coverages of 86%, 85% and 81% respectively. What are the Government going to do about that? This will not get us to where we need to be.

On visas, there is a welcome suggestion that tier 1 numbers will be doubled, although that takes us to only 2,000—presumably per year. Will the Government reflect on whether that will be sufficient to reach the ambitions set out in the Statement?

I have two final points. In the Data Protection Bill, we have been concerned about whether sufficient resources and powers are available for the Information Commissioner to carry out her very responsible job of trying to ensure that we have a proper data regulatory structure. I understand that amendments are to be tabled that will increase the powers of the ICO, and look forward to discussing them when they reach the House—perhaps next week or the week after—but the question of resources is still open-ended. It seems that the Government will back and expand our AI activity. If that is the case, can they assure us that the additional resources required by the Information Commissioner's Office will be provided at the appropriate time and that she will have the powers she needs?

Finally, on the very welcome news that the centre for data ethics and innovation is beginning to take shape and apparently has a budget of £9 million, what exactly is its current status? As I understand it, no legislative process has taken place, and I would be interested to know the timetable for that. Will the funding be limited to £9 million, or will other funds be available? More importantly, will it have a statutory position? The Government rightly pick up the need to ensure that all the work that is going on and is foreshadowed in the Statement will be effective for our economy, but it will be effective only if people trust that their data will not be abused and that there is appropriate understanding and a proper regulatory processes in place which engage with the ethical issues. We need a little more information on that. I should be grateful if the Minister could respond on when that will happen.

Lord Clement-Jones (LD): My Lords, having immersed myself in the subject of AI for the past year, I am absolutely clear that there is complete cross-party consensus on the potential for AI in the UK. I welcome today's sector deal, particularly the evidence of cross-departmental working, which underlies quite a lot of the work that is beginning to take place. I very much hope that today's sector deal is simply the tip of the iceberg of the Government's AI policy and ambition. I note that the Minister used the word "ambition", and I very much hope that this is but the first in a number of steps that need to be taken.

I hope we will have a much more extensive debate when the Government's response to our Select Committee report is issued in due course, because it covers so many aspects. As I see it, today's sector deal is essentially a nailing down of the commitments made in the industrial strategy, the proposals in the Hall-Pesenti review and the commitments made in the last Budget. I should be very interested if the Minister could unpack how much actual new money is involved in today's sector deal, because I see it essentially as a packaging up for the sector rather than a new, dramatic development.

There are many aspects of the sector deal to welcome, not least the role of the British Business Bank in helping finance AI developers, growth companies, and so on. I hope they will be given an even more important role in the future, and I hope they will not go the way of the Green Investment Bank, which is an absolute object lesson for the Government in this respect.

The Select Committee thought that the fundamentals of government policy were right but it was a question of scale, ambition, co-ordination and drive behind the policies of the new bodies involved. There are many examples of this. The noble Lord, Lord Stevenson, rightly mentioned infrastructure investment. When only 3% of the country is covered by ultra-fast broadband, a £1 billion investment is neither here nor there. It is a bit of encouragement but it will not move us very fast up the curve compared to our international competitors. Then again, the scale of the skills gap is absolutely huge. I know that there was some negotiation as part of the Hall-Pesenti review, but 200 new PhDs in AI, as mentioned by the noble Lord, Lord Stevenson—off-the-shelf or not—being initially financed is the absolute bare minimum required.

Then again, we are heavily dependent on skilled EU workers. A Brexit brain drain is already threatening the UK tech sector, which relies heavily on foreign talent from the EU. DeepMind is already setting up a laboratory in Paris because of that. We need overseas students to stay. Will the Government reinstate post-study work visas for graduates in STEM subjects who find suitable employment within six months of graduating? The noble Lord, Lord Stevenson, mentioned a doubling of tier 1 visas. That is very welcome but why do not the Government declare, as the Select Committee suggested, a shortage occupation in tier 2 for machine learning

and computer skills? That might make a huge difference. Collaborative research with EU countries is at risk as well. How will we fill the gap post 2020?

As virtually every Select Committee witness told us, creative skills will be crucial in the mix as well. What are the Government doing to emphasise not just STEM but STEAM in our schools? There is a dangerous dropping off of arts and creative subjects already. But, of course, it is not simply about the opportunities, of which there are many, but mitigating the risks as well, and making sure that we retain and build public trust in the new technologies involved. Inclusion is of crucial importance in this context. A strong inclusion and diversity agenda ran through our Select Committee report, which has been welcomed. In particular, we need more women in digital roles to help fill the skills gap. What are the Government doing to develop a culture that is inclusive, respectful and encourages women to pursue careers in AI?

Ethics must likewise be moved forward. I hope that the Government move forward quickly with this via the Centre for Data Ethics and Innovation by convening an international conference and other forms of international collaboration. I include the EU in this. Yesterday it published its report, *Artificial Intelligence for Europe*. In that, the role of the Charter of Fundamental Rights is highlighted as being the instrument by which one could incorporate a code of ethics. This makes the vote on Monday doubly valuable and I hope the Government will take due note. That is a very helpful way of making sure that we have an ethical framework that could cover most European countries.

I could raise many issues, not least data, which the noble Lord, Lord Stevenson, mentioned. I hope the Government will be talking to the Competition and Markets Authority about issues such as data monopolies. I hope that, as the Data Protection Bill goes through the Commons, they will look at whether we have real strength, and whether Article 22 of the GDPR really gives us sufficient rights of explainability for autonomous decision-making, as I raised in this House.

Finally, it is about ambition. If the UK wants to be seen as a world leader in any aspect of AI development, it needs to move as quickly as other countries, such as Canada and France. It must set its ambitions high to be a global player. It must welcome talent in growing its AI industry from start-ups to the next level.

Lord Ashton of Hyde: My Lords, I am grateful for the many questions that I have to answer from the two noble Lords. I obviously should start by paying tribute to the committee of the noble Lord, Lord Clement-Jones. There was no reference to it in today's Statement, and I take it as a compliment that the noble Lord, Lord Stevenson, thinks that DCMS works so quickly that we should include it in the sector deal a mere two or three weeks after it was published. I can say that we very much welcome the report. We thought it was a good piece of work and, in due course, we will provide a response. The report will help to inform actions going forward. It is important to understand that the sector deal today is only the beginning. When the noble Lord talks about the tip of the iceberg, that is very true. There are some things we intend to do, with facilities to make sure that they are monitored properly in the office of AI within the Government. I pay tribute to the noble Lord and his committee for that, and we will certainly look at that carefully.

Both noble Lords spoke of the skills gap. The noble Lord talked about Korea when referring to the 200 new PhDs, but we are not talking about North Korea; we are not just going to create 200 PhDs a year. They are proper PhDs that the Government will fund, leading to 1,000 government-funded extra PhDs by 2025. They are critical for the future but they are not the only areas in skills. The 200 have already been financed and there will be 450 by 2021 and 1,000 by 2025. They are starting in a phase-and-accelerating fashion in numbers per year.

Talking of skills and education, I accept, and have said before, that creativity is important. The Digital Catapult has identified the creative industries as one of the two high-profile potential areas for AI business growth in the UK. We understand that it is not simply a question of computer science, mathematics and such areas. To use the benefit of AI, we need creative minds. The businesses that already exist where we have a leading role in the world, have absolutely accepted that. One of the points of having the AI council is that it will bring together the Government, academia and the sectors to make sure that these points are raised at the highest level.

The noble Lord, Lord Stevenson, talked in particular about digital infrastructure and the commitment to fibre to the premises. We absolutely understand that we are behind many countries in fibre-optic connectivity. What he did not say is that we are ahead of Europe in superfast broadband by a long way, but we absolutely understand that we cannot be complacent. We are moving towards fibre to the premises. That is our goal and we absolutely accept that it needs to be done.

On visas, both noble Lords said that they welcomed the doubling of exceptional talent visas. They are for exceptionally talented people. We need to come to an understanding about the need for the new rules for immigration—luckily my noble friend from the Home Office is sitting here who will be very interested in this. The noble Lord, Lord Stevenson, talked about cross-government work on this, and the noble Lord, Lord Clement Jones, mentioned evidence. Our job is to make sure that the Home Office understands that when we come up with future Immigration Rules—we absolutely understand this is international business—we will need to have the best minds from around the world here. They will be attracted by our leading universities and the opportunities that will exist, and which this sector deal is trying to encourage.

The noble Lord, Lord Clement-Jones, talked about funding. When some of these things are mentioned, how much is actually new funding is a valid point. We have talked about just under £1 billion for this sector deal. Of this, about £600 million is new spending, and £342 million is existing spending that has either been repositioned or is in place already. Of that £600 million of new spending, about £300 million comes from the Government and, very encouragingly, £303 million from industry and the sector. For example, £35 million is from a Japanese venture capital company opening

[Lord Ashton of Hyde]
its first European HQ in the UK, £10 million is from Cambridge for the supercomputer, and there are others. About two-thirds is new money.

We absolutely accept that diversity is important, not only because it is the right thing to do, which it is, but because of all the talent we need to go forward. We have introduced the tech talent charter specifically to address that. Three weeks ago, I was at the G7 in Montreal talking about this and it resonated. In fact, we were held up in lights for it. We have 180 firms signed up and aim to have 500 by the end of the year. It is meaningful, and not just motherhood and apple pie about what we wish to do, because one of the things that firms sign up to is providing data centrally on the diversity aspects of their business so that we can compare and see that there is actual and meaningful progress. The charter will give organisations tangible actions and principles that they can adopt to become more gender-diverse.

I think that answers most of the questions. I am grateful for the broad welcome that both noble Lords have given.

2.02 pm

Lord Swinfen (Con): My Lords, the world of artificial intelligence is advancing rapidly and changing the whole time. Is my noble friend satisfied that our laws are up to date and can cope with the advances being made?

Lord Ashton of Hyde: My noble friend has the advantage of having been on the committee and probably knows more about this than I do. I do not think that one could ever say that one was satisfied that the laws were perfect in a fast-moving field such as AI and the new tech area. The Data Protection Bill, which is coming up for Report in the other place soon, is one way in which Europe and this country are bringing in data protection. In that context, I should mention the Information Commissioner, referred to by the noble Lords, Lord Stevenson and Lord Clement-Jones. We are looking carefully at what the Information Commissioner has asked for, especially in terms of powers. We are working on the legislation and trying to make it as future-proof as possible. Whether the Data Protection Act will last the 20 years that the last one did, I am not so sure.

Lord Haskel (Lab): Much of the outcome of all the work, which I very much welcome, is intangible. Who is going to own this intangible property? It is all right when it is used for the public good, but what happens when it is used for private profit? Surely this is the basis of the dispute over the work of Cambridge Analytica, and has to be settled before we put a lot of money into developing all this intangible property.

Lord Ashton of Hyde: That is exactly why we are setting up the centre for data ethics and innovation. It will be a world-leading institution. Artificial intelligence is a force for good and potentially a force for evil. We absolutely acknowledge what the noble Lord says, but we are specifically addressing that. I was also asked about the timetable for the centre. The chair is being recruited now and we hope to have it up and running by the end of this year. It will have a statutory basis in due course, but will be up and running before then because, as the noble Lord rightly says, we have to address some of these problems. For example, the report talked about data trusts, to make sure that public and private data are available in a sustainable way and benefit SMEs as well as the enormous organisations.

Lord Holmes of Richmond (Con): My Lords, the Germans will make smart cars; the United States and Canada will focus on the internet. We have a real opportunity in the United Kingdom to do ethical AI, not least when we consider the areas of finance, law, research and biotech. Does my noble friend agree that when it comes to AI in the UK, the only way is ethics?

Lord Ashton of Hyde: The only way to live your life is in ethics—not in Essex. As far as this is concerned, it is also important to collaborate internationally. The Prime Minister announced a new partnership with the World Economic Forum at Davos on developing a framework for the responsible procurement of AI in the public sector. That is one example of how we need to work with other organisations. We will continue to work with the EU while we remain a member and hope to negotiate a sensible arrangement on exiting for exactly that reason.

Lord Elystan-Morgan (CB): Have these matters been devolved to the various Administrations in Scotland, Wales and Northern Ireland and, if not, what discussions do the Government have in mind on these most impactive matters?

Lord Ashton of Hyde: As I have said, issues such as AI and data have to be dealt with internationally as well as in the UK. The sector deal includes the devolved Administrations. My department continues to have regular discussions about these issues with the devolved Administrations.

Lord Fox (LD): My Lords, the Select Committee report and the *Made Smarter* review made quite a lot of the opportunity of bringing smaller and medium companies into the AI revolution and using it to make themselves more productive and competitive. How does the sector deal help that?

Lord Ashton of Hyde: One example that I think I have already mentioned is data trusts. The review made the point that big companies have not a monopoly, but the advantage of having so much data. SMEs and small companies need access to that data in order to grow. That is the whole point of AI. If we can get a mechanism that allows big and small companies to work together on datasets to retain the value and to get some use of it, it would be a great advantage. We are committed to having pilots on data trusts in place by the end of this year.

Lord West of Spithead (Lab): My Lords, I apologise for not having been here at the beginning of the Statement. My question relates to a narrow field: the

issue of fully autonomous weapons systems which are using AI and learn as they go on. What is the Government's position on the development of fully autonomous weapons systems, bearing in mind that we know that at least two countries are working on what I think is an extremely dangerous thing?

Lord Ashton of Hyde: The development of weapons generally is a very dangerous thing. We consider that the existing provisions of international humanitarian law are sufficient to regulate the use of weapons systems which might be developed in the future as they have been flexible enough in the past to cope with the invention of new means of warfare such as submarines and aeroplanes, but we are obliged to determine whether new weapons or means comply with international law. We will continue to engage with the UN on this point. We bear it in mind; we understand the implications of it, and we will remain within international law as it stands.

Lord Giddens (Lab): My Lords, my noble friend stole my thunder a bit. In the way in which AI is described here, it sounds very benign. It is indeed important to innovation in the future, but it is stuffed with risks and dangers wherever you look, from labour markets to weaponry and all sorts of other areas. It is a huge mix of advantages and massive problems. I would like at least some comment on how the Government will deal with them.

The Statement repeated the idea that AI will inevitably increase productivity. I know where the statistics come from. I am deeply sceptical about them. The advance of the digital revolution so far has been associated with declining, rather than increasing, productivity. We have to be careful not to see some magic in all this which may not be there, which would then bring us back to the problems and dangers.

Lord Ashton of Hyde: The Statement said that AI had the potential to bring about a massive increase in productivity. In some areas, it will, as case studies show. For example, KLM doubled the number of text-based customer inquiries it handled during the past year while increasing the number of agents by 6%, so it is possible. I understand that there will be disruption in jobs because there will be probably be an increase in the number of high-value jobs. It will have implications. Overall, we think that it has the potential to raise productivity if it is handled properly, and by quite a lot. However, we accept that it has problems. We have to encourage such things as lifetime learning to enable people to transfer their skills so that they can contribute in a more modern way.

We accept that there are problems and dangers. That is one reason why we will have the centre for data ethics and innovation: so that we can bring in independent people to advise the Government on where regulation will be necessary and how regulations and laws should be developed. We are addressing that. The AI council will also inform government, because it will not just be government mandating from the centre; it will be a place where academia, the sector, industry and government can come together to drive the changes in the future.

Home Office Removal Targets

Statement

2.13 pm

The Minister of State, Home Office (Baroness Williams of Trafford) (Con): My Lords, with the leave of the House I shall repeat an Answer to an Urgent Question asked in the other place this morning. The Answer is as follows:

"Mr Speaker, yesterday I gave evidence about the Windrush generation at the Home Affairs Select Committee, about the people who contributed so much and who should never have experienced what they have. These people are here legally and should never have been subjected to any form of removal action.

As I told the committee, I have seen no evidence that this has happened. Everyone in this House agrees that this group were here legally but also that people who are here illegally should be treated differently from legal migrants. I am personally committed to tackling illegal migration because I have seen at first hand the terrible impact it has on the most vulnerable in society. Exploitation and abuse can come hand in hand with illegal migration. That is why my department has been working to increase the number of illegal migrants we remove. I have never agreed that there should be specific removal targets and I would never support a policy that puts targets ahead of people.

The immigration arm of the Home Office has been using local targets for internal performance management. These were not published targets against which performance was assessed, but if they were used inappropriately then I am clear that this will have to change. I have asked officials to provide me with a full picture of performance measurement tools that are used at all levels and will update the House and the Home Affairs Select Committee as soon as possible".

2.14 pm

Lord Kennedy of Southwark (Lab Co-op): My Lords, it is concerning that the Home Secretary had no idea that immigration targets were being used in the Home Office's "hostile environment" and then discovered that they were being used after all. It is not acceptable to suggest that this was just done locally. Who is setting the targets and how have they been set? Who is collating the information and where has it been reported to? How has it been used to direct policy, and why did the Home Secretary and other Ministers not know about this policy? This is another shocking example of the Home Secretary and her Ministers having created a culture and then lost control. The consequences are serious for innocent people who are lawfully here and who have been caught up in this scandal. For that reason, the Home Secretary should accept responsibility and resign.

Baroness Williams of Trafford: My Lords, Ministers have set out their ambition for increasing returns, but have not set the Home Office specific numerical targets. The idea of government setting removal targets goes back a number of decades. For example, in 2003 Tony Blair set a target of halving the number of asylum

[Baroness Williams of Trafford]
seekers within a year, while in 2007 Jacqui Smith made a commitment to remove 4,000 FNOs within a year. Senior managers in the Home Office have set targets in the past to drive performance locally, including last year, but have now moved away from doing so for this reporting year.

Lord Paddick (LD): My Lords, if the Home Secretary is to resign, I am not sure what she should resign over: the fact that targets for removal were set or that she did not know that such targets existed, even when they were displayed on posters on the walls of the Home Office. In addition, the BBC has reported today on an inspection report by the Chief Inspector of Borders and Immigration from December 2015 showing targets for voluntary departures of people regarded as having no right to stay in the UK. They are not local targets but overall Home Office targets for removal of illegal immigrants from the UK—contrary to what the Minister has just said.

Does the Minister accept that, if officials are given targets for the number of people they must deport, it will be very difficult for them to use their discretion and be compassionate? The current culture at the Home Office is rotten to the core and Ministers, not officials, need to take responsibility.

Baroness Williams of Trafford: I echo the noble Lord's point about discretion and compassion. I agree with him: I am not sure what the Home Secretary should resign over because she has done a wonderful job. She has made it quite clear that, if there is a culture such as the one which has been worried over, that culture will change. We want the Home Office to remove more people who are here illegally, but I repeat that Ministers have not set specific targets for this year. We are clear that we would like the number of removals to increase. Reducing the size of the illegal migrant population and the harm that it causes is a key component of an effective immigration system, and what the public would expect as a matter of fairness.

On the posters to which the noble Lord referred, local managers may use visual tools to heighten team activities, which could include but not be limited to staff movements, work activity and performance. But, as my right honourable friend the Home Secretary said this morning, she will look at the performance environment as a matter of urgency.

Lord Bassam of Brighton (Lab): My Lords, I have some sympathy for the noble Baroness, as I had her brief for a couple of years, between 1999 and 2001. So it is not the first time that we have visited the issue of problems with targets and migration. Can she tell the House whether targets for removals included Windrush generation UK citizens who have been able to provide curious Home Office officials with documents? Would she like to reflect on why, although the Home Secretary is very keen to see illegal migrants leave the UK, the Government have pursued a policy of reducing the number of people employed by the Border Force? I would have thought that ensuring that the force can do its job and has adequate staff to do it is an important first principle.

I am left to reflect that the crisis engulfing the Home Secretary is a product of the Prime Minister's hostile environment policy unravelling and her inability to control her department and its officials. One day she does not know that there is a target, the next day she seems to know that there is one. This is symptomatic of a Home Secretary who does not know exactly where her department is going.

Baroness Williams of Trafford: My Lords, as I said yesterday, there should be a hostile environment for people who have no lawful right to be here. In terms of the Windrush citizens, there is a very clear distinction between the Windrush generation, who are here lawfully, and illegal migrants, who by their very nature are not here lawfully. Immigration enforcement is focused on removing illegal migrants, and the Windrush generation clearly does not fall into that category. In addition, the Home Secretary stated yesterday or the day before that 8,000 records had been manually trawled through to ensure that nobody had been deported inadvertently. Thus far, there is no evidence that anyone has been removed who is a Windrush citizen and is lawfully here.

Earl Attlee (Con): My Lords, I have an interest to declare, because I helped to take the 2014 Act through your Lordships' House from the Government Front Bench. I do not recall the Windrush problem being raised, despite the fact that it has been a long-running problem—and I have asked the Library to research that in more detail. I agree with my noble friend the Minister that it is important to bear down on illegal immigration because it distorts the UK employment market but, more importantly, it leaves illegal migrants vulnerable, especially to modern slavery. Is not it the case that the party opposite was in power for 13 years and, although it had the opportunity, it never actually fixed the Windrush problem itself—that is, legal migrants and their children who came to the UK prior to 1973 and whose immigration status was never properly recorded? The party opposite could easily have taken the steps to avoid the problem years ago. Very regrettably, we—I use that word—did not solve that problem, and therefore we should all share in the blame for this disaster.

Baroness Williams of Trafford: My noble friend makes two incredibly articulate points. He is absolutely right: we should not be pointing the finger of blame at each other to try to pass the buck; we should accept that over decades and decades these people have been failed. He is also right to point out that illegal immigrants are vulnerable to exploitation and, as he says, to modern slavery. We should be bearing down on people who are not here legally and, absolutely, the Windrush generation does not fall into that category.

The Lord Bishop of Norwich: My Lords, yesterday there was a meeting here in Westminster of parliamentarians and representatives of the Church of England and of the black majority churches about the ongoing problems of the Windrush generation, some of which have been made more acute by the controversy over removal targets. From that meeting, one issue

that arose was that those contacting the helpline have not had a positive experience. What training has been given to those responding to people who call the helpline? Secondly, there is a hesitation among some to contact the helpline because they fear they will be targeted for removal if they do.

Thirdly, I should be very grateful if the Minister said what is being done to resource churches, which may well be the best place for information to reach those whom the Government want to reach. Many of the Windrush generation and of those who feel themselves to be targets are members of church congregations. I hope that the Government might welcome a partner in trying to reach some of those who are most affected by this.

Baroness Williams of Trafford: The right reverend Prelate makes a series of very good points. The Home Office has been very proactive in reaching out to the various organisations that we think might have a significant congregation of the Windrush generation—not only churches but other places.

As for people hesitating to make contact in case they are targeted for removal, I think the Home Secretary made it absolutely clear that the purpose of people contacting the helpline was not for immigration enforcement but so that Home Office officials could actually help them. On training, these people are incredibly experienced case workers; they are not out to take enforcement action—the Home Secretary has made that absolutely clear. However, if the right reverend Prelate has names of people who feel they have not had a positive reception or experience, I would be most grateful if they could be passed on to me.

The Long-term Sustainability of the NHS and Adult Social Care

Motion to Take Note (Continued)

2.26 pm

Baroness Tyler of Enfield (LD): My Lords, in its excellent report, the Select Committee chaired by the noble Lord, Lord Patel, makes it plain that very significant investment in the NHS and social care is needed to ensure its long-term sustainability and avoid further damage both to the quality of and the access to care. Indeed, it is no exaggeration to say that the current system is near breaking point. We cannot carry on patching a gaping wound with a sticking plaster.

The recent Nuffield Trust report said that public satisfaction with the NHS is falling. The main reasons cited included staff shortages, long waiting times, lack of funding and government reforms. Primary care is particularly underfunded and overstretched, placing far more pressures further downstream on hospitals. A recent *Daily Mail* survey found that one in seven patients had to wait longer than a fortnight for an appointment with their GP. In a report earlier this year, the King's Fund describes public health as dying from a thousand cuts. All the evidence shows that, to mitigate further costs, we must greatly ramp up our public health efforts to prevent disease. That was well addressed in the Select Committee report—but where is the response?

As the Select Committee report plainly stated, the issue of the workforce,

"represents the biggest internal threat to the sustainability of the NHS",

and I want to focus most of my remarks there. As we heard in our recent debate in this Chamber on Brexit and the NHS, there are roughly 40,000 vacancies in nursing. Yesterday, the *Guardian* reported three times more departures from nursing than before Brexit. I was struck by a piece on Monday's "Today" programme about GPs leaving because of the immense stress and pressure that they were under, which left patients in Plymouth regularly waiting two to three weeks for an appointment and one patient calling 93 times to be connected with her doctor. Britain has fewer GPs per person than other wealthy countries and, like nurses, they are leaving faster than they are coming. Those shortages increase the strains further down the system in the more expensive bits of the health service. A trip to the GP costs less than one-third of a visit to A&E. But nowhere is the situation more acute than in the mental health sector. Psychiatry is experiencing some of the highest vacancy rates—between 15% and 20%, with mental health nursing at 15%. In the current climate, it is salutary to note that some 40% of mental health staff come from overseas.

So what is being done about this? Health Education England's recent draft workforce strategy provided, frankly, precious few solutions. There is a distinct lack of detail, with no modelling for the future NHS workforce beyond 2020-21. A better plan must surely look beyond the culture of short-termism to staffing solutions that can meet long-term demand, address supply issues, promote innovative and technological change and consider—this is really critical—new roles for health professionals and new ways of working for doctors and nurses. This should include applying best practice from overseas and looking at radical reconfiguration of services.

In addition, we must ensure that the workforce operates within far more efficient systems that allow people to get on with their jobs and to spend the time they need with patients rather than dealing with regulation and bureaucracy. Some of our current systems are very unproductive compared with other countries, which other speakers in this debate have touched on. It is clear that the NHS has yet to get to grips with these critical and worsening workforce issues and the current—opaque, I feel—division of responsibility between NHS England and Health Education England is not helping. Can the Minister, when he concludes, say who is ultimately responsible for the long-term planning on these key issues, such as workforce planning and productivity?

Turning specifically to mental health, what should be read into the fact that the key recommendation relating to mental health regarding parity of esteem was totally ignored in the Government's response? To say it is not encouraging is something of an understatement. What does it say about the Government's commitment to integrated care? The mental health investment standard is the statutory requirement to increase mental health investment in line with other services. However, recent data from the Royal College of Psychiatrists shows that more than one in 10 CCGs

[Baroness Tyler of Enfield]
are failing to meet this standard. Can the Minister also say what action the Government intend to take in this area?

It sometimes feels as if we are engulfed in a veritable blizzard of new initiatives of the alphabet soup variety—we have STPs, ACOs and vanguards; I looked on the NHS website and there are a raft of others. I did not really understand what they even stood for and, frankly, it was impossible to understand how one related to another. We know the sustainability and transformation partnerships were set up to integrate health and social care across wide geographical areas, which is absolutely key to sustainability. But STPs have been told in no uncertain terms that they must prioritise cutting debt over everything else.

Achieving long-term sustainability will also need a far greater emphasis on integrated care. If I had more time—which I do not—I would give an excellent example in my own area, at the Whittington Hospital and the Highgate Hospital, of mental health and physical health having a really excellent physical health liaison service and working well together. From these small seeds longer-term change can grow, but it needs real political will and leadership.

On the big picture for future funding, I have been very interested to hear politicians of all stripes and other expert commentators talking about various ideas, including the Liberal Democrats' long-term funding solution for the NHS and social care, which is a progressive hypothecated tax. Cross-party consensus is important and I hope that a cross-party commission will be set up. I am very rarely disappointed in the noble Lord, Lord Hunt, but I was disappointed at the beginning of this debate when he said that he did not think that was a good way forward. I think it is. We await further details from the Prime Minister on the long-term funding settlement but, frankly, we cannot wait much longer. Unlike previous cash injections that have gone into the black holes of hospital trust debt, any new funding must go to radical reform and, particularly, more resources for primary, community and mental health care.

To conclude, the time is right for a national conversation on all this; it is long overdue, which is something that I think the noble Lord, Lord Turnberg, said. The time is right for it now. The general public have responded quite positively to ideas such as an earmarked tax, as long as it is tied to deliverable promises of real improvements in the health and social care that they receive and they know what they will be getting for their money. This is where we really need to focus moving forward.

2.34 pm

Lord Warner (CB): My Lords, finally we have a chance to debate a report that the Select Committee, of which I was a member, produced over a year ago under what I might call the benign and able chairmanship of my noble friend Lord Patel. The bland response from the Government could have been written, I would suggest, within a week or so of our report's publication and hardly seems worth discussing—so I will not. Its complacency contrasts dramatically with my noble friend Lord Patel's introduction and the leadership that he has shown. It is true that the Department of Health has become the Department of Health and Social Care, as the Select Committee recommended, but the hole in the funding of adult social care continues to grow, dragging more local authorities—many Conservative run—towards insolvency.

Our report raised many important issues, but I shall focus on just one: the key topic of funding. In today's world, a tax-funded, pooled-risk healthcare system such as the NHS, which is free at the point of clinical need, requires a more generous and reliable funding system than we currently provide or seem to be contemplating. We need to stop our feast or famine approach to NHS funding and relying so heavily on local authority funding for social care. We should face up to capping individual liability for social care costs, retain its means-tested basis, but find a more reliable national system for funding long-term care from taxation or social insurance, as they do in Germany and Japan.

Facing up to these rather inconvenient truths will be tough for everybody—politicians and public alike. It is much more comfortable to believe that everything will be okay if we just get a bit more efficient, use more technology, integrate health and social care and employ more doctors and nurses. Of course, we may well need to do these things. The updated NHS England *Five Year Forward View* and related initiatives are important steps in the right direction. We need to reduce the huge variation in the cost and quality of care around the country. Narrowing this variation would save somewhere in the region of £3 billion to £5 billion a year, as the noble Lord, Lord Carter, has demonstrated. But all these changes take time for a hard-pressed NHS to absorb and all require investment, both capital and revenue.

Improving efficiency and patient outcomes are important, but they are not a financial panacea for the tsunami of rising demand. That demand probably has an annual cost of at least a 2.5% to 3% increase in real terms year after year. This is considerably more than the less than 1% annual increase that has been provided to the NHS since 2010 and the 25% cut in real terms in adult social care budgets over the same period.

So, what to do? As our report showed, the funding of health and care has zigzagged all over the place over the past 25 years—I commend the graph on this, which is set out in the report. It has been inconsistent between health and social care, despite these services dealing with the same levels of demand. Periods of generous increases are followed by periods of great scarcity, irrespective of service demand. Lots of short-term handouts are provided, when what is needed is much more consistent funding allocated for longer periods ahead, so that people can plan better and make better use of the resources that are available.

This approach would not of course crack the issues of the level and method of funding, which are essentially matters that come down to political choice. What is clear is that, if the NHS is to be mainly funded from taxation, Governments need to be a lot more creative about how we raise the money. I am a great fan of the 1960s American radical, Abbie Hoffman, who memorably said in 1968:

"Sacred cows make the best hamburgers".

Why can we not ask the group who use the services most to pay more? They do not all need winter fuel allowances, free travel passes, free TV licences and suchlike. Why should older workers not pay national insurance? Why are there so many ways of avoiding paying inheritance tax? Why can we not collect more care costs from estates? Why can we not levy more tax on the sales revenues of the Amazons, Googles and Apples, and so on, rather than from their absurdly low declared profits? If it is politically easier to collect taxes for health and care by hypothecating the revenue for those purposes, as many have suggested, why can we not just overrule the Treasury's objections?

I know that the cry will go up that this is all pie in the sky and politically impossible. That is possibly true. But let us consider the alternative to more radical taxation action. Winter pressures become all-year pressures. Access to care deteriorates further and faster. Premature death rates among both young and old rise. We slide further down the international league tables in terms of healthcare performance. The trajectory towards care and treatment mediocrity continues and gains greater momentum. More staff leave the NHS and young people stop going into the UK health professions because the pressures, work conditions and pay get increasingly worse. EU health professionals stop working in the UK post Brexit, and the so-called Brexit financial dividend proves a mirage.

These things are already happening and will get worse. Our elected politicians need to get out of their trenches and lead a grown-up conversation about realistic funding for the NHS and social care. If they want to outsource the job to a time-limited independent commission, they should at least give an advance, approved parliamentary guarantee that its recommendations will be acted upon within a single Parliament. They would be helped if they set up an independent office for health and care sustainability, answerable to Parliament, as the Select Committee recommended, to oversee change and keep people focused on the longer term.

2.41 pm

Lord Layard (Lab): My Lords, I, too, congratulate the committee and, like many earlier speakers, think that something more radical is needed on funding. The fundamental problem with the present system is the complete disconnect between the Government's funding decisions and, on the other hand, what the public want and are willing to pay for. For example, in a recent MORI poll, people were asked to pick out their preferred option for the NHS, and no less than 66% of the public picked out the following option:

"I would be willing to pay more taxes in order to maintain the … spending needed",

in the NHS. However, the problem is that under the present system there is no mechanism by which they could implement their wish. Taxation and spending are totally separate issues in the way the system operates, and the public will get what they want only if we can find a way to bring the two together—and that is of course a hypothecated tax.

If you have a hypothecated tax and the public vote for a manifesto, they are voting simultaneously for the end and for the means. You have to bring the end and the means together into a single decision. So I am happy that our colleague, the noble Lord, Lord Macpherson, formerly of the Treasury, has asked me to say that he now favours hypothecation. The Treasury is the main obstacle to this proposal; it wants to make the spending decisions and thinks that it is best placed to do the trade-offs. But it is the Treasury that got us into the mess we are in now.

One obvious objection to hypothecation is that the health service needs certainty about its funding, while taxes are uncertain and depend on the business cycle. I discussed this issue in my evidence to the committee, and the following arrangement would work well. At the beginning of each Parliament, the Government would present a 10-year plan for the NHS, including services, workforce and expenditure. The second five years would be indicative, but the first five years would be a commitment. Associated with that commitment would be a preannounced rate for the health tax such that the forecast proceeds would equal the committed expenditure over the Parliament. If in the upshot because of the cycle there was some difference, year by year or even overall, between the proceeds of the tax and the committed expenditure, the Treasury would make up the deficit or collect the surplus.

As many people have said, we want a funding system that simultaneously covers health and the part of social care that is paid for by public funds. As some other noble Lords suggested, we would have to extend the insurance tax base to include all income at all ages. However, once this was put in place and we had converted the national insurance system into national health insurance and raised enough extra money for the health and social care system, which would be needed, to some extent we could cut other taxes which currently finance health and social care.

I will end on the issue of what scale of expenditure would be likely to emerge if we had such a system. First, over the last 40 years health expenditure has steadily risen as a share of the national income, except in the last decade, and that has been so in every advanced country, including in our own. We ought to expect that pattern to be ongoing, because it reflects people's preferences on how they want to spend their additional income. But in addition to that we need a rapid one-off upward adjustment to get us back on track, because we are off track. That is what people say they want, as I quoted, and I will also give your Lordships another research-based reason for a one-off adjustment.

This comes from happiness research—something I practise—which shows that physical health and, even more, mental health, have very large impacts on human happiness. These impacts are also very large when compared with the effect of variations in household disposable income after tax. In spite of the huge importance of health, health spending is now rationed by the NICE regulations, which require that you have to have at least one extra—this is jargon—quality-adjusted year of life for every £30,000 spent. It will not allow you to spend the £30,000 unless you have one extra quality-adjusted year of life as a result. But from happiness research we know that, when households collectively give up £30,000 in taxes, they lose only one-thirtieth of a quality-adjusted year of life. So spending

[LORD LAYARD]
more on health gives you a benefit-cost ratio of 30, which is a pretty good argument for spending more money.

So we need a hypothecated tax, and I see no reason why the British public would want to spend less than the average percentage of GDP that is spent on health in northern Europe. That would require an extra £40 billion a year as of now. That is the direction in which we should move, and we should move as fast as possible.

2.48 pm

Lord Rennard (LD): My Lords, I draw the attention of the House to my entry in the *Register of Lords' Interests*.

Some years ago, when I was advising my noble friend Lord Ashdown on what to say during elections, I asked him to avoid using the phrase "rationing" when it came to talking about the NHS because the phrase is perceived very negatively. But in reality, trying to meet ever-growing demands with resources that are not growing proportionately will always mean having to ration those resources in some way.

The noble Lord, Lord Patel, and his committee are to be congratulated on their report. It does much to address the issue of NHS sustainability—much more than the Government seem willing to admit is necessary, at least publicly. The problem results from both significant demographic changes and a reluctance in the past to ask people to pay higher levels of taxation to fund the consequences of people living far longer, needing pensions for far longer, and needing much more healthcare intervention, particularly to deal with long-term conditions.

Forty years ago, a man who had worked and paid taxes for 50 years retired at 65 and lived, on average, for just two years in retirement. The cost of his pension and his healthcare was therefore not very great. Today, a man is expected to live for 20 years in retirement. His state pension, therefore, has to be paid for 10 times as long as was the case 40 years ago. Women may live for longer, but both women and men on average will now expect to have 12 years of good health in retirement but eight years when more active health and care intervention will be required, some of it very expensive.

We have had great economic growth over the last 40 years, and this has financed far greater levels of taxpayer support for the NHS than might ever have been expected during most of the last 70 years. Even so, the increasing level of taxpayer funding for the NHS is not keeping pace with the growing demands on it, or with the demands for social care. So we need people to pay more for their health and social care, and to recognise that the most efficient way of doing so is via general taxation to pay for a national health service and to integrate this properly with social care.

The noble Lord, Lord Layard, referred a few moments ago to a MORI opinion poll. I draw the House's attention to the recent British Social Attitudes survey, which showed that most voters now back tax rises to fund the NHS if it needs more money—and, as the noble Lord, Lord Prior, indicated, it most certainly does. Options for paying more taxes found support in that survey from 61% of people. It showed that the alternatives—for example, charging for non-medical costs such as hospital food, or paying £10 to visit a GP—received just 21% support. The latter approaches are, I think, quite unacceptable.

The highest level of support in the survey was for people to pay more through a separate tax that would go directly to the NHS. A 1p increase in the basic rate of income tax, for example, would produce an additional £6 billion per year. However, it seems to me that a much more radical restructuring of the income tax and national insurance system is required to fund what is needed. I wish the Select Committee report had been less equivocal about hypothecating taxes for the NHS, because I believe that that is the only way forward by which people will agree to pay more taxation.

However, in my view the report was right to say that the long-term sustainability of the NHS requires more than an increase in taxpayer funding. For example, we need to do much more to reduce the demands on the NHS caused by factors such as the escalating rates of obesity and diabetes, and problems with alcohol misuse, and we still need to reduce further the prevalence of smoking tobacco.

In trying to tackle all these issues, we have to overcome the powerful lobbying interests of the food and drinks industry, as we have largely done with the tobacco industry's activities in this country. We need also to promote healthier lifestyles. At this point, I should declare my interest in having benefited from a GP referral programme that successfully encouraged me to take more physical exercise. The result of that may not be immediately self-evident—but your Lordships should have seen me 10 or 20 years ago.

We also need to make much more effective use of technology to improve the functioning of the NHS, which has been far too slow in replacing paper and fax-based correspondence with electronic communication. Much greater use must also be made of assistive technology, whether funded publicly or privately or through the increased use of personal health budgets. Providing specialist equipment to children that reduces the likelihood of surgery in later life, adapting people's homes, whether with grab rails, stairlifts or specially adapted kitchens, and ensuring that people have the most appropriate assistive technology to enable them to live their life to the fullest and most independent degree possible should become a much greater priority in the decades ahead.

That is all absolutely essential if we are to curb successfully the escalating demands on the NHS and, at the same time, enable more people with disabilities or long-term conditions to enjoy more gainful employment and contribute positively to society and to the economy.

2.54 pm

Baroness Emerton (CB): My Lords, I thank the noble Lord, Lord Patel, and the committee members for the report. It was like taking a breath of fresh air when I read it. With my experience over some years in the health service, it came alive straightaway. The report states that the,

"biggest internal threat to the sustainability of the NHS",

is the,

"absence of any comprehensive national long term strategy",

to secure for the health and care system a workforce which is skilled, well trained and committed.

My personal experience started as a St John Ambulance cadet two years before the NHS started. It was drummed into me as a volunteer and a cadet that the most important thing was the safety of the patient. I joined the NHS as a nursing student in 1952 and worked in the NHS until 2000. Since then, I have done other work concerned with both, all of which is listed in the register.

I would like to take up the point about the workforce. First, every employee and volunteer has an important part to play in the delivery of care, and it is important that they understand their role. That was brought home to me very clearly when I was put in charge of laundries because I complained about the linen being unsatisfactory, with a high incidence of bed-sores. I think that I have related this story before but it is worth repeating. When I talked to the laundry workers, none of them realised that their job had an effect on the patients. My point is that every volunteer and every employee needs a clear job description and a clear understanding of their job, and they should be monitored to see that they understand the importance of patient safety.

Secondly, there is an issue not just in hospitals but in social care. Those with a mental handicap or learning disability and those with a mental illness have to be examined every six or 12 months by a panel to see whether their support allowance can be continued. The panel has set questions but no background information on what caused the injury or on why the money might be taken away. The relation of a personal friend of mine had a brain injury before birth but his allowance was withdrawn. He had a parent who lived some distance away and was living on his own. The point is that social care needs monetary support, and every person involved in it, as well as in the health service, needs knowledge of what the job is about.

Thirdly, the correlation of theory to practice within the professions is very important and we need to ensure that it works well. It was particularly important when producing graduate nursing courses that adequate clinical teaching was linked with educational supply. We need to see a closer relationship between educational provision and the delivery of care. Correlation of theory to practice is vital, and, again, that is important for volunteers as well.

My last point is that, in delivering care, workforce planning is not just a question of numbers. It must include an understanding of the occupations that are being looked at. We must see it as a job not just for administrators but for all aspects of the health service: clinicians, volunteer charities and the users of services must be involved. During the history of the NHS we have had attempts where this has been attained, but recently we have not seen workforce planning being spread across the services and understood by all the clinicians, as was mentioned this morning. This is so important for the future of health and social care.

In summary, my introduction to the NHS was at a time when the Second World War had just ended. There was a fear that medical care was going to be too expensive and worries about how everyone was going to manage. It was a tremendous relief to the population when the NHS was introduced by the Labour Government for the United Kingdom. That relief is being sought now by the public, who fear that health and social care services are in danger. I hope the Government will take on the recommendations from the report and we will see some action. I hope the Minister will be able to confirm that we will see movement, not just in the short term but for the long-term future, as has been mentioned.

My only adverse comment on the report is this. This morning, I was reminded that the Griffiths report mentioned Florence Nightingale looking for the missing nurse. There were no nurses on this panel.

3.02 pm

Lord Farmer (Con): My Lords, I add my congratulations to those of others to the noble Lord, Lord Patel, and his committee on this report. I am particularly grateful that the committee took the opportunity to take a long, hard look at what the NHS is now and what we should be looking for in the future. I want to dwell on the report's emphasis on prevention and to talk about how family breakdown and dysfunctional family relationships contribute to the long-term unsustainability of the health service and the social care system.

We must not allow nanny state concerns to perpetuate the wilful neglect of this issue by successive Governments, including the current Administration, on whose Benches I sit. We have had strategies to address disability, diabetes and dementia—all of which are laudable and necessary. After all, disability affects one in six adults; diabetes around one in 10 adults; and dementia one in six adults over 80 years old. Yet, despite almost one in two 15 year-olds having experienced the breakdown of their parents' relationship, no UK Government have ever come close to developing a family strategy that acknowledges the repercussions of this and addresses the root causes.

The Select Committee report we are debating describes the short-sightedness of successive Governments and the culture of short-termism that seems to prevail in the NHS and adult social care. This sums up very well the policy approach over the last half century towards the growing trend of family breakdown, which drives need in both these areas. Moreover, the report highlights the false economy of neglecting public health, prevention and patient responsibility and gives short shrift to nanny state concerns.

The quality of people's relationships, particularly in their childhood, is a significant determinant of health as studies on loneliness and the effects of adverse childhood experiences, among others, make clear. Research from the International Centre for Lifecourse Studies—the ICLS—at University College London measured cortisol levels in thousands of 60 year-old adults to see whether there are long-term effects of psychological stress in childhood. It found that people who had been separated for more than one year from their mother had higher cortisol levels, which indicates a less healthy stress response several decades later, and therefore an increased risk of disease and early death. Other ICLS research

[Lord Farmer]
found that people who suffer stresses such as parental divorce in childhood are more likely to experience social and psychological problems later in their adult lives.

For children to flourish they need safe, stable and nurturing relationships, not just a good school place and a healthy diet. Nationwide, a million fathers have no meaningful contact with their children and, in some communities, father absence is the norm. This fuels the hunger for belonging, which leads many to join gangs and get caught up in the culture of violence, where life is cheap. Overstretched and understaffed accident and emergency departments then have to deal with high numbers of young men with stab and gunshot wounds.

Many other pressures on our health services can be traced directly back to broken and dysfunctional relationships. Prevention, in the form of family strengthening measures, should be available in every community. This and every previous Government have struggled to provide leadership in this area, yet they find themselves picking up the pieces at every turn. Curing is always more costly than preventing.

Many have gone beyond even being concerned about family breakdown. I met with a Minister this week whose official briefing included a graph showing that divorce levels had become stable and were even beginning to ease off. The implication was that "things aren't so bad after all". Yet this one simple set of descriptive statistics obscures the bigger picture: our high divorce rates are still almost at the top of the OECD league table and the growth area in parental splits is among those who are not married. Three-quarters of family breakdown among children under three involves unmarried parents. Three-fifths of parents who were closely involved but not living together when their children were born are no longer together by the time the children turn five, compared to fewer than one in 10 of parents who were married.

No Government have yet been courageous enough to put serious effort into communicating through policy and rhetoric that the best context for childbearing is within a committed relationship. A fear of stigmatising children born outside marriage has unintentionally penalised one generation after another by neglecting to encourage a culture where the norm is for parents, whether rich or poor, to be deeply intentional about bringing a child into the world and raising her together. Neutrality is not an option when the costs of family and relationship breakdown mount up inexorably in so many areas. These include, to touch on just a few: lower resilience among young people and greater susceptibility to them developing poor mental health; lower productivity, which leads to less cash for the NHS; fewer family members available to care for older relatives; and more people living alone in later life due to divorce, and therefore higher social care costs.

So often, and understandably, domestic abuse is a reason for reticence to talk about family stability. NHS Employers has estimated the cost to the NHS of repairing the physical damage to victims to be around £1.25 billion per annum, with the cost to mental health services related to domestic violence estimated at £176 million. A preventive approach is essential. People across the broad range of those impacted by domestic abuse need help to learn how to avoid or step out of unhealthy relationship patterns. That includes not just women victims but couples where abuse is mutual, couples who want the abuse to end but the relationship to be sustained, and male victims and female perpetrators.

On that point, I want to clarify some statistics I cited in the recent debate on domestic abuse led by the noble Baroness, Lady Lister. I mentioned SafeLives data showing that 95% of victims are women and 95% of perpetrators are men. This is based on the 4,500 people accessing independent domestic violence adviser services, and must be set alongside the Crime Survey for England and Wales. In the year to March 2017, the survey found that a little over one-third of victims of domestic abuse were men and slightly under two-thirds were women. For the purposes of this debate, health services—not the police—are often the first port of call. Indeed, the 2012-13 survey found that four out of five victims do not call the police.

The Government are beginning to take note of the damaging effect on children and young people's mental health of frequent, intense and unresolved conflict between their parents, even when violence is not a factor. In a sample of over 42,000 children attending children and young people's mental health services, family relationship difficulties were a presenting problem for over half—52%. Their Green Paper, *Transforming Children and Young People's Mental Health Provision*, published last December, acknowledges this in its chapter on wider action to support children and young people:

> "Children who are exposed to persistent and unresolved parental conflict are at a greater risk of early emotional and behavioural problems, anti-social behaviour as an adolescent and later mental health problems as they transition into adulthood".

I have one question for the Minister, who is I know is also exercised about the negative effects of relationship breakdown on children. The consultation process asked no questions about this wider action. What is the Department of Health's response to family breakdown?

3.11 pm

Baroness Pitkeathley (Lab): My Lords, in my 20-odd years in your Lordships' House I have lost count of the number of times I have spoken on health and social care issues and called attention to the challenges of maintaining and developing a system of health and care on which we all depend. Like many others in your Lordships' House I owe my life to the NHS, and in my professional life I spent 40 years campaigning for the rights of carers, on whom so much of that system depends.

The last few times I have made speeches here, as well as mentioning the problems in the NHS and care system—which we all know are legion and have been expertly detailed here today—I have said that I ventured to see a little more hope than I had hitherto, a ray of light at the end of the tunnel. If there have been rays of light—little chinks, perhaps—the report of the noble Lord, Lord Patel, was more like a search-light, a shaft of sunshine, perhaps even a new dawn. I congratulate

him and his colleagues on their excellent report dealing with the difficulties and, above all, suggesting practical solutions and emphasising that the time for action is now. The emphasis on integration of health and social care, on realistic and consistent funding, on public health and prevention are music to the ears of anyone who has ever worked in or with our systems.

The call towards a lasting political consensus is also to be welcomed. The official government response is, to say the least, pedestrian. However, the ideas and flexibility which I think we see coming from the Secretary of State now give us hope that this time we will see a long-term solution. This is the time for a new Beveridge, as some have termed it. Let us remember that our forebears managed to agree and implement those Beveridge reforms at a time of world war and when the country was bankrupt, so being preoccupied with Brexit and periods of austerity is really no excuse.

The report gives many details on how the much-needed reforms could be implemented. I support them all. I say to the Government three important things they should remember as they develop ideas for NHS reform and the Green Paper on social care. First, be bold. Adopt the bold and far-sighted recommendations this important committee has made. Try to put out of your minds the fact that bold proposals in the past have been labelled death tax or dementia tax, according to what various parties have said, and the resultant media furore. This has always resulted in those previous bold proposals being kicked into the longest possible grass. Have the courage to take a long view.

Secondly, be inclusive. You must take the views of those who know the areas of health and social care well and are familiar with trying to navigate around their problems to deliver services. Consult the directors of adult social services and the voluntary sector. Charities have the ear of consumers and are familiar with operating on tight budgets. Above all, take the views of the patients, users and carers. Do not let this be a top-down operation.

Thirdly, be honest. No Government of whatever colour or combination have ever made it crystal clear to the public that outside the NHS the responsibility for paying for care and arranging it rests with individuals and their families, with public funding available only to those with least money and the highest needs. As a consequence, no one ever prepares or plans for care. They scrabble around at the last minute when the crisis occurs and the truth dawns on them, so proposals in the report that new mechanisms should be introduced to make it easier for individuals to save for and plan for care are welcome.

In addition, the expectation has grown up that savings and property assets can be passed down to our children and grandchildren. We have to rethink this, which requires political honesty and courage. I endorse what the noble Lord, Lord Warner, said: we must tackle that other sacred cow, the protection of older people. Well-off older people should not be exempt from contributing. Why should they be exempt from national insurance? Why should they have all the freebies that we enjoy? How many noble Lords need the £200 the Government are generous enough to give them at Christmas?

The report of the noble Lord, Lord Patel, emphasises that patients too must take responsibility for their own health, a view which many of us will endorse. However, when we are thinking about responsibility, we cannot and must not ignore the role of the family and the informal carers. No proposals for reform or the future can ever ignore the contribution of those 6 million people, whom your Lordships have heard me mention on many occasions and whom any Government ignore at their peril. This contribution based on family obligation and duty is worth more than £132 billion and, however well we organise and fund health and care systems, it will remain the bedrock and must be supported to continue.

Two years ago we were promised a new carer's strategy, and much work was done on it. Thousands of carers were consulted and had their hopes raised about the new strategy. Then we were told it was going to be rolled up in the social care consultation. When that was first announced, the contribution of carers went totally unacknowledged. Perhaps by way of apology for that we were then promised in December a carer's action plan in the new year. I have asked the Minister before: where is the action plan? He told me he was writing to me. I have not yet received a letter and it is now almost May. Above all I want to ask him how the 9,000 responses that carers sent in in good faith about a new carer's strategy will be used and how those problems will be addressed. Every one of us will either be a carer or be cared for at some point in our lives—probably both. It is short-sighted to ignore their needs.

3.18 pm

Lord Colwyn (Con): My Lords, I declare an interest as a retired dental surgeon and a fellow of the British Dental Association. I am sorry I was not on this committee. It was well organised and the noble Lord, Lord Patel, deserves our congratulations. He assured me that it was his hope that the debate would provide an opportunity for Members to speak about the broader issues facing the health and social care systems in our country today. With this in mind, my noble colleagues will not be surprised to hear that I am keen to turn the attention of the House towards the question of where oral health and dentistry sit in the wider context of the NHS being able to meet its future demands.

More and more studies now confirm what dentists have always suspected—that a healthy mouth is a gateway to a healthy body, and that neglecting oral health can sabotage our long-term overall health. Tooth decay and gum disease are increasingly linked to heightened risk of serious health problems such as stroke, heart disease and diabetes, yet funding for NHS dentistry has fallen by 15% in real terms since 2010, while patient charges have gone up by an inflation-busting 5% in each of the past three years.

Underfunding NHS dentistry might seem tempting in a time of austerity, but such thinking is short-termist and wholly counterproductive. Patients who cannot find an NHS dentist or delay treatment due to its cost end up piling huge pressures on other parts of the NHS. Every year, hundreds of thousands of patients seek free help for dental pain from their GPs or at

[Lord Colwyn]
their local A&E, which is not equipped to cope with and help them. Add to that the cost to the economy of sleepless nights and lost working days caused by tooth pain, and it becomes even clearer that cutting dental services is not only bad for the patients but a false economy.

The number of children going to hospitals to have decayed teeth extracted under general anaesthetic is rising fast, with the latest figures released earlier this month showing that a child in England is admitted to hospital every 10 minutes for this almost entirely preventable condition. Public Health England estimates that around 60,000 school days a year are missed as a result, not to mention the wasted £36 million that these preventable procedures cost. All things considered, it is appalling that more than four in 10 children in England have not seen a dentist for over a year, even though they should ideally have a check-up every six months. We must make sure that we improve access to NHS dental services so that both children and adults can attend regular check-ups, get a timely diagnosis and get appropriate treatment for any problems early on.

The past few months have seen one local newspaper after another announce acute shortages of NHS dentists in their area, as practices struggling to make ends meet under the current dental contract have been quitting the NHS in large numbers. This brings into sharp focus the urgent need to deliver a reform of the dental contract. It is crucial that we introduce a new, more preventive contractual basis for NHS dentistry. This April sees the 12th anniversary of the introduction of the current dental contract, which is not only widely detested by dentists and discredited by health policy experts but, more importantly, is bad for patients because it rewards dentists for carrying out interventions rather than for keeping their patients healthy to avoid them. Shifting the focus to preventive treatment would not only yield long-term savings but improve the quality of life across the country. Dentists were promised a new, improved contract back in 2010 but, with Ministers recently announcing that pilots of the new arrangements will run for at least another two years, it looks like this badly needed reform is being kicked into the long grass.

With tooth and gum disease linked to many other costly health conditions, such as diabetes and heart disease, our health system cannot afford to wait much longer for NHS dentistry to be commissioned in a way that makes a decisive break from activity targets and puts prevention squarely in the centre. The British Dental Association tells me that dentists want to be paid for keeping their communities healthy, not for the number of treatments performed. That is what makes most sense for the long-term sustainability of our NHS too. We cannot achieve improvements in oral health with a system that continues to offer perverse incentives to treat instead of rewarding dentists for preventing disease.

Finally, much progress has been made in the field of oral health and dentistry over the past few decades, and that momentum cannot be allowed to falter. A new, improved contract, a focus on prevention rather than cure and making sure that dental services are properly integrated with the rest of the NHS are essential components not only in delivering cost-effective dentistry but in improving general health outcomes for the British people.

3.24 pm

Lord Bradley (Lab): My Lords, I first declare my health and university interests in the register. Secondly, I want to clearly record what a pleasure it was to be a member of the committee; I pay tribute to the diligence with which the noble Lord, Lord Patel, led the committee throughout our deliberations. I want to touch on three aspects of our report: the funding of and investment in the NHS and social care, particularly in respect of mental health; workforce planning; and the function of regulators and current governance arrangements. As a quick aside, I want to give some good news to my noble friend Lord Carter of Coles: I was discharged from the University Hospital of South Manchester 55 hours after my hip replacement operation and I pay tribute to the staff for achieving that outcome, although I am still hobbling slightly.

On funding investment in mental health, let me first put my comments in context. In 2015-16, NHS England's budget was around £116 billion. Of that, the mental health budget was just 13%, but it is known that one in four people suffer from mental health conditions. The *NHS Five Year Forward View* estimated that the cost to the economy of not tackling mental health is £100 billion a year—effectively the entire cost of the NHS budget. Furthermore, only 7% of the 13% is allocated to children and adolescent mental health services, and while the recent addition of a £1.4 billion investment in CAMHS is welcome, it represents, spread over four years, a mere £350 million a year for the whole of England. That is less than £2 million for each clinical commissioning group, which will set its own independent priorities.

The current funding is woefully inadequate for adults and children, and the ambition to achieve parity of esteem between physical and mental health clearly has a very long way to go. As our report concluded, this will be achieved only when properly addressed through a genuine, long-term strategy of financial investment to meet the needs of people suffering these conditions. The *Five Year Forward View for Mental Health* was published in 2016 and the *Future in Mind* report for children in 2015. Although both reports made good recommendations for service improvement, funding remains the key area of concern to make continued improvement and transformational change for genuine integration of services. An example of this is the funding in the *Future in Mind* report, which is due to last only until 2021, having been extended by one year. That is a mere three years away, but it is non-recurrent spending that is currently not intended to continue beyond that point. A long-term commitment to continuing to fund improvement to children's mental health care beyond 2021, for at least another 10 years, is essential if any early progress on better services for children and adults is to be sustained.

My second point concerns workforce planning. As our report made clear, the absence of any comprehensive national long-term strategy represents the biggest internal

threat to the sustainability of the NHS. Early indications show that the Government's reforms to undergraduate nursing education in England are failing to increase the number of nursing students required. Overall, applications to nursing courses have fallen by 33% since March 2016. Furthermore, applications from mature students have been disproportionately affected by the funding reforms, dropping by 28%, but it is mature students who are more likely to choose the shortage areas of mental health and learning disabilities. In addition, crucially, some courses may simply become financially unviable for universities to run, with a disastrous knock-on effect for local workforce planning. This must stop. The Government must urgently review their reforms to nursing training and develop a long-term strategy for the whole workforce in the NHS and social care.

My third point relates to governance and regulation. The committee stressed that the Health and Social Care Act 2012 has created, as we have heard, a fragmented system that is frustrating efforts to achieve further integration and the service transformation aims of the *Five Year Forward View*, which are crucial for the long-term sustainability of the NHS and social care. Too often, the independence of commissioners, particularly CCGs, on the one hand and the independence of providers, particularly NHS acute trusts, on the other creates silo working and barriers to stability of governance in delivering long-term transformation. This is exacerbated by the failure to implement long-term financial certainty.

Laudable attempts are being made for effective partnership working through a whole-system approach. The devolution of health and social care in Greater Manchester, my home area, is a prime example of this. We have also heard of the laudable efforts in Salford, which have achieved remarkable integrated results. But I do not believe that the benefits of such an approach can properly be realised until such partnership working has the crucial legislative back-up that is required.

Further, as we commented in our report, the regulatory framework might also not be fit for purpose. We recommended the merger of NHS England and NHS Improvement, but it would be helpful if the Government looked closely at the clear contradictions often displayed by NHS Improvement and the quality regulator, the Care Quality Commission. Strict financial limits are imposed on the NHS providers by NHSI through rigid financial control totals, while the CQC rightly identifies the need to invest in services to ensure quality of care and patient safety. This causes huge difficulties in practice. How on earth can this be addressed if provider bodies cannot invest beyond their strict control totals?

I would welcome the Minister's views on these points and an assurance that the Government are genuinely committed to their ambition to move to a long-term financial settlement for the NHS and social care, which our report shows is so desperately needed; that there is a relentless emphasis on general integration of mental and physical health; and that more resources will be moved upstream to underpin preventive and early intervention programmes to support the population's health and well-being, rather than just its ill health.

3.31 pm

Lord Taverne (LD): My Lords, like everyone else who has spoken in the debate, I was most impressed by this very important report. I shall confine myself to funding. I believe we should scrap national insurance contributions in their present form. NICs no longer fulfil the purpose for which they were designed. First, the public do not understand them. They believe NICs pay for the NHS, but in fact only 5.3% of NIC receipts go directly to the National Health Service. The rest goes into the general pool of tax receipts for a variety of welfare benefits. The NHS is overwhelmingly paid for out of general taxation. Next, NICs are now the biggest source of taxation after direct taxes. That too is not generally known. They are a very regressive and inefficient tax on jobs.

Thirdly, everyone now agrees that health and social care are interdependent and should be amalgamated, but a new integrated service desperately needs a new source of funding. Under the present system, while demand, for well-known reasons, rises inexorably faster than GDP, the projections are that the amount of GDP spent on health and social care is set to diminish. I quote paragraph 186 from the report:

> "The OBR projects, based on current spending plans, that UK spending on health and care as a percentage of GDP is due to drop from 7.4% in 2015-2016 to 6.8% in 2020-21".

That is unsustainable and intolerable. We already have the lowest spending of any country by GDP. We spend less than anybody else.

That is why I could not agree more strongly with the report's conclusion that we should have an independent body, such as an office for health and care sustainability. I, perhaps naively, contemplated such a body as having a rather more ambitious role: that it should have civic as well as professional representatives, and should produce a comprehensive budget, funded by the new system of health and social care contributions—a fair system based on ability to pay.

I discussed with the IFS the reasons for the Treasury's objections to hypothecation and to such an independent body. First, it limits the flexibility of the Government to allocate public spending most efficiently. This is not an objection to be lightly discarded or ignored because we have more and more hypothecation—for defence spending, overseas aid and many others. Flexibility in the Treasury's control of public spending is important. Next—this point has not yet been made—at times of recession demand will increase. The last thing needed is a decision by a commission or anyone else to raise contributions to meet rising demand. My answer was that the same problems face Governments. "Yes", I was told, "but Governments can borrow". My answer was, "Why not give the independent commission the power to borrow?" "Yes", was the answer again, "but this can lead to reckless borrowing by an unaccountable body". That is a function that perhaps only Governments should exercise. As a former Financial Secretary, I see the force of those objections.

There are two answers to this. The first was very strongly argued by a noble Lord. The overriding force is the fact that the public are prepared to pay if they believe proceeds go to a good cause. That is not a reason why they should be bamboozled, because Brown's extra penny on NICs was popular, but the public did

[Lord Taverne]
not realise that four-fifths of it did not go to the NHS but to the general pool of tax receipts. However, there is no doubt that a good cause will be strongly supported, if necessary by more taxation.

We also have something to learn from the Dutch experience. The Dutch, of course, have a very different system. They administer social and health care through private insurance companies, which provide a strictly regulated service. I would of course keep our National Health Service. What is relevant is that the Dutch insurance service is paid for by a compulsory national insurance premium based on ability to pay, which is in essence no different from the new hypothecated health and social care contributions I mentioned. As I understand the system, the premium is fixed by an independent body with wide representation, which is responsible for deciding an integrated total health and social care budget. I will have to look at the Dutch body again to see exactly what its powers are, but it seems to have successfully navigated the problems raised in my discussions with the IFS.

The Dutch system of health and social care is possibly the best in Europe. It is the most expensive, but it is popular because it is fair and money is seen to be spent on a good cause. In fact, the high taxation is a very good example of the dictum of the famous American judge, Oliver Wendell Holmes, who said that taxes are the price we pay for a civilised society.

3.39 pm

Baroness Masham of Ilton (CB): My Lords, I thank my noble friend for his persistence in securing this debate. I am sure that a great deal of time and work was put into the report.

The NHS is, without doubt, our most important insurance policy. Nobody knows when an accident or illness will strike them or their family. One minute you can be fit and well, the next minute paralysed from the neck down and unable to move. Or you may become critically ill with organ failure from sepsis if it is not diagnosed quickly and the correct treatment given.

The world seems very unstable at the moment. We need, as a top priority, sustainability in our NHS and social care. The NHS should not become a political pendulum. It faces so many problems: relentless needs and not enough GPs and hospital beds—especially intensive care beds—to care for the serious cases, which leads to the unfortunate cancellation of operations. Surely we cannot go on with ambulances piling up with patients waiting outside hospitals, and patients waiting in corridors for treatment and beds. We must do better in future.

As a member of the parliamentary group on alcohol harm, I want to mention the fact that cheap alcohol harms the health service in so many different ways. The liver units are full. Liver transplants are the last resort but they can be expensive and dangerous, given the increasing resistance to antibiotics. Far more should be done in the prevention of illness and accidents. This means, however, co-operation and collaboration between public health, NHS and social services.

Cutting public health funds is a retrograde step. Already, gonorrhoea is proving challenging because of drug resistance. There should be greater awareness of factors such as postural hypertension and autonomic impairment, which can cause "funny turns", faints and falls. These can, in turn, cause injury from bruising and fractures, which can be debilitating and sometimes life-threatening.

I have received a letter from the chair of the Harrogate Parkinson's UK group, who says that several older people who have been in hospital for a short time cannot be discharged to their homes because no care is available. They are, therefore, shunted off to care homes, causing great unhappiness. The letter goes on to say that this will become a much bigger issue as the elderly population grows in the coming years. Are the Government aware of this situation, and do they have any plans to deal with it? I need an answer to give them—they are waiting.

As I said earlier, Brexit is exacerbating the serious staff shortage problem, which must be solved if there is not to be a monumental catastrophe. I agree with this House of Lords report, which states:

> "We are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10-15 years. In our view this represents the biggest internal threat to the sustainability of the NHS".

There is concern that changes in procurement policy for wound care brought about by the Carter review could effectively restrict the availability of the most clinically appropriate wound care products. This could have serious results and add extra costs to the billions already spent by the NHS. Those with complex needs, such as leg ulcers, pressure sores and burns, could be most affected. I declare an interest in this regard, as for years I have been nursing a pressure sore in a very awkward place. As part of the NHS long-term sustainability strategy, the UK needs a national wound care strategy covering the complexity and variety of wounds, with improved diagnosis, prevention and timely treatment.

I end by saying that good health is so important to so many people. Access to rare disease medicines is paramount to those suffering from more than 6,000 rare diseases. I read last week that Brussels is cutting the UK out of the key role in approving new drugs. Nobody will benefit. We have brilliant researchers whose expertise, working with the European Medicines Agency, will be wasted. For the good of patients, everyone should be working together. Whatever happens, safety should come first.

3.46 pm

Lord Desai (Lab): My Lords, it is a privilege to follow the noble Baroness, who has done so much on the health front. I join everyone else in congratulating the noble Lord, Lord Patel, on an excellent report. We have had a very good debate. I think it is right to say that the NHS is a sort of religion in this country—the only religion that everybody has—but, for the same reason, we are always extremely dissatisfied with the state of the NHS. I have lived here for 52 years and not a day has gone by without the NHS being in crisis. We actually love it only if we can see it in crisis; if it ever became satisfactory, we would lose all faith.

I am going to concentrate on an issue that many others have talked about: the funding of the NHS. I have said before that our problem is that as longevity increases, it gives us a longer-living population with more medical needs. But we have also discovered that there are many more dimensions of health than we used to think there were, such as mental health. We are now discovering dementia not only in the elderly but in children. As we discover these problems, the demand for healthcare increases continuously and because we price it at zero, there will always be excess demand anyway. So how are we to fund it?

There has been a back-and-forth argument about national insurance contributions being hypothecated, or not. I asked the Library to do some research for me and it turns out that if we look at the total collection of NICs and the total budget for the National Health Service, for a long time we used to be able to collect more money in NICs than we spent on the National Health Service. Going back over the last 20 years, it found that during the first 10 years, from 1999 until about 2007, the difference between those two budgets was either a small amount of plus—that is, more revenue in NICs than NHS expenditure—or a small amount of minus. The difference was always under £10 billion, so it was possible once upon a time to think of NIC revenue as sufficient to finance the National Health Service. Whether that is done through a hypothecated rise is a separate problem.

What disrupted this happy relationship was of course the crisis of 2008. Once that happened, our NIC revenue stopped growing by as much as our NHS expenditure. We should remember that NHS expenditure had been increased from a slightly lower level to the European level of 8% by Tony Blair in 2003, so our expenditure went up sharply but our revenue from NICs were not adequate to service that. Now, the gap between what we collect in taxes and what we spend on the NHS has gone up to £20 billion. It is quite clear that whether we hypothecate or not, it would be good to keep track of that number. We have to see how we can get more money under NICs, because that happens to be the most convenient tax to play with.

I quite agree with people that there should be no exemption from NICs for people beyond a certain age, if they are earning money. Because we are already going beyond the standard retirement age of 65, anyone earning money in any capacity should pay NICs. I do not see why we should exempt anybody. I have also complained before in your Lordships' House that the category of self-employment is becoming more and more a category of tax avoidance from NICs. We all noticed how the BBC was advising its highly paid personnel to become companies, because then they would pay much less tax than the ordinary punter was paying. That is outrageous. We really ought to put a stop to this boondoggle and say that self-employment will get no concession. It is no good pretending that those people are really self-employed. Those two things may increase our collection under NICs.

It is not so much about whether we hypothecate, but when budgeting we ought to keep an eye on how those two numbers track each other and at what stage we may need supplementary revenue from other sources, or perhaps even some kind of borrowing programme so that over five or 10 years, the budgets would balance out. It is worth doing it from that longer perspective. We ought to think about funding the NHS in a five to 10-year cycle. That is one suggestion.

My other suggestion is that we have to do something about social care. On taxation, some people have asked why the people who are working and not using the health service very much should pay, while the people who go to the health service and are retired or elderly do not pay very much. The logic of this system is that while you are working, you pay. It is as if you are saving because you will use it when you are elderly—and when you are elderly, the corresponding younger generation will be working and saving. They will be financing your retirement expenses. In economics, that is called an overlapping generations model: in the first part of your life, you work, and in the second part of your life, you consume, but your savings in the first part finance your spending in the second. It is quite fair for working people to pay the tax that finances the medical needs of the elderly. In some sense, they are paying for their own retirement expenditure, as in a social insurance fund. We should be more positive about relying on national insurance contributions than we have been so far.

By the same logic, on social care costs, we ought to say that to the extent that people who have assets, mainly houses, are reluctant to sell them to finance care costs, we ought to rely on inheritance tax, increase it and hypothecate it to social care. I shall not go further because I do not have time.

3.54 pm

Baroness McIntosh of Pickering (Con): My Lords, it is a pleasure to follow the noble Lord. This is a wide-ranging debate and touches on a number of major issues. We are greatly indebted to the noble Lord, Lord Patel, and his committee, and I congratulate him on securing this debate. My father and my brother were country GPs and my uncle was a surgeon. They devoted their working lives to the health service. My father was one of the first NHS GPs in 1948. In the days when home visits were the norm, he worked on duty, on call every second night and every second weekend. Whatever the weather, Dr Mac would be there to look after the patient. I yield to no one in my admiration for those who work at every level in the health service.

I would like to look at ways of enhancing the long-term sustainability of the NHS, particularly in rural areas. I work with the board of the Dispensing Doctors' Association. Its national headquarters are in Kirkbymoorside in North Yorkshire. I recognise the great work that such doctors do dispensing in sparsely populated rural areas that are not well served by community pharmacies. Undoubtedly, providing all public services, not least healthcare, in rural areas is more challenging and more expensive, and it is not generally recognised in NHS funding.

There are further challenges, such as the lack of good access to rural broadband. It is important to acknowledge that it is very difficult for those practising in rural areas to access NHS Digital. I refer, for example,

[Baroness McIntosh of Pickering]
to the electronic prescription service, which is a particular challenge in rural areas. It seems bizarre that at the moment the health service seems to be putting more money into allowing patients to access wi-fi in the waiting room before a GP consultation than into beefing up the broadband available to rural GPs.

Historically, Conservatives in government have always emphasised rurality and sparsity factors in both funding and delivering healthcare. Given the vast areas that GP practices cover and the often long distances patients have to travel to general hospitals, community hospitals play a central role in delivering healthcare in rural areas. It is a matter of anger tinged with sadness that a decision was taken by the local clinical commissioning group to close the Lambert hospital temporarily, then permanently. More recently, NHS Property Services has decided to sell the site on which the hospital is situated. In terms of delivering healthcare locally, this is a retrograde step. To the local community, selling a facility that was gifted to the people of Thirsk and surrounding villages in perpetuity by the Lambert family is ethically and morally questionable. In my view, it is indefensible. It was a fantastic facility, offering step-up, step-down rehab after a fall, stroke or operation, making patients safe before they returned home. I take this opportunity to seek an assurance from the Minister that he will either intervene, block the sale of the site and permit the Lambert site to be converted into a health hub for the local community, which is what GPs in Thirsk are requesting, or ensure that the proceeds of the sale are returned and used for healthcare in Thirsk.

Primary care is currently the less-favoured arm in NHS funding compared with secondary care. This point was made by the noble Baroness, Lady Tyler. This imbalance needs to be addressed. The idea of hypothecating national insurance contributions to pay for the NHS has some merit but, as I mentioned in my earlier intervention, taking 1% out of the health service by increasing this charge is immediately to remove funding that would normally go to front-line care, so that potential gap in the finances has to be filled.

I welcome the idea of a royal commission to look at sustainable, long-term funding for the NHS, particularly if it were against a background of cross-party consensus. Such a commission would be a wonderful opportunity to review the balance of spending in favour of primary care, particularly in rural areas where costs are higher owing to rurality and the sparsity of the population, which I mentioned earlier.

I favour the model of GPs working in partnership, but we face a ticking time bomb. A number of GPs face retirement over the next five to seven years, and fewer GPs want the responsibility of being partners. It is not just that positions are difficult to fill in London, which the noble Lord, Lord Winston, referred to; they are difficult to fill in rural areas too.

My question to the Minister today is: where is the parliamentary scrutiny and accountability of NHS England and NHS Property Services? They operate independently of government and appear totally unaccountable to Parliament. I am aware of the mandate agreed between the Department of Health and Social Care and NHS England, but I question where the adequate parliamentary scrutiny is. For the sustainability of general practice and with a view to allocating more funds to delivering healthcare in rural areas, the balance between rural and urban areas should be addressed as a matter of urgency. Enabling GPs to treat patients swiftly after appointments at their surgery would prevent an increasing dependence on admissions to accident and emergency departments and prevent a troubling ailment becoming acute.

4 pm

Lord Rea (Lab): My Lords, I add my congratulations to those that have already been given to my noble and professional friend Lord Patel and his Select Committee for a very complete and relevant analysis. I declare an interest as a retired NHS GP and a fellow of the Royal College of General Practitioners who has also worked in epidemiology. I am also honorary president of the UK Health Forum, a think tank linking some 60 organisations interested in primary prevention. I am pleased that evidence from both these bodies is cited in the Select Committee's report.

I would like to say also that I have now joined the age group that gives the NHS the most trouble. I have had to use the NHS more in the past five years than I did in the whole of my life before that. Every time I have received care, I have been impressed by the courtesy, good humour and skill of the staff, even when they have been under very great pressure.

The report makes plain—as does most informed opinion—that greater resources are needed. I am repeating what nearly every other noble Lord has said. The Office for Budgetary Responsibility points out that the percentage of GDP spent on health in the UK, 7.4% in 2015-16, is low compared with other comparable countries, and projects that on present trends it will fall to 6.8% in 2020. As practically all other speakers have said, the NHS and social care have suffered for too long from short-termism and, recently, from serious underfunding, which makes intelligent planning difficult.

Our demographic problem of an ageing population with an increasing need for care is well documented but has not been acted upon adequately—if at all. Prevention in particular has been neglected. Despite the intention of the five-year forward view to step up preventive activities, progress has been slow and has not been made any easier by the Government's recent cutbacks to local authority funding for public health.

The history of public health includes many examples of products that are harmful to health but whose manufacturers resist calls to reduce or change their composition or their promotion. The tobacco industry is of course the prime example of powerful and dishonest but extremely skilled resistance to all measures—and it is still doing so. The alcohol and food industries are now doing much the same. Simon Stevens says that,

"obesity is the new smoking".

Voluntary agreements to make products less harmful have had only limited success. In the end, mandatory regulation will have to be brought in, as have most successful public health measures in the past, beginning with the water companies more than one and a half

centuries ago when cholera was rife. Governments initially shy away from regulation, such is the lobbying pressure that industry can exert. Recently, proposed robust restrictions on food promotion to children were delayed and toned down. Why?

Health education messages will have less effect when the harmful habit concerned is ingrained and there are strong social and commercial pressures to continue it. Some noble Lords may have seen Hugh Fearnley-Whittingstall's TV programme on fast food promotion last night—exactly this topic. Poor housing, depressing environments, unemployment and dead-end jobs make it more difficult to break habits that give temporary relief, such as smoking, alcohol, drugs or takeaway junk food, often sweet and containing too much sugar.

In such circumstances, to say that people need to change their lifestyle amounts to a form of victim blaming. More resources need to be directed to those living in deprived communities. To promote good housing and employment opportunities is part of the wider agenda of public health. The closer liaison of local authorities with public health, which was one of the better parts of the 2012 Act, has been frustrated by funding cuts.

Finally, I will say a word about the Select Committee's recommendation to set up a new high-level independent standing body on the lines of the Office for Budget Responsibility, with the power to advise on all matters relating to the long-term sustainability of health and social care, and which will report directly to Parliament. It should continually look forward for 10 or even 20 years. I agree with the right reverend Prelate the Bishop of Carlisle that this is an excellent plan which should lead to continuity and diminish short-term political pressures on health policy.

4.07 pm

Baroness Meacher (CB): My Lords I, too, thank my noble friend Lord Patel for his thoughtful report. I will focus on primary care and consider the compounding challenges of the primary care workload, the GP workforce, the nurse workforce, the budget and the blame culture.

First, the GP workload has increased by 16% over the past seven years as a result of the ageing population, the shift towards community care for certain illnesses and the dearth of capacity in hospitals. As noble Lords know, there are fully 1 million more people over the age of 65 than there were a mere five years ago. This means a more complex and time-consuming workload. The fact is that 10 minutes just does not do it for an awful lot of patients these days. The cut of 11% in the social services budget in five years just makes matters worse.

At the same time as the workload has increased so dramatically, GP numbers are under threat. The number of GPs taking early retirement has risen sharply following the clampdown on GP pension pots, bringing the retirement age down by two years to 58 and a half years. This means a huge and growing waste of expensive, highly trained GP resources. GP practice closures have been at record levels recently, and things can only get worse—considerably worse. An RCGP survey found that 39% of doctors in England said that they are unlikely to be working in general practice within the next five years. I find that terrifying. Doctors warn that a town without any GPs has become a real possibility. GPs talk about not wanting to be the last person standing when all their colleagues have left. The main reasons GPs give for their plan to leave general practice early are stress and excessive workload.

The Government say that the answer is to bring in more nurses. Absolutely, if only it were possible. A recent *Pulse* survey showed that one in eight practice nurse places in the UK is vacant. The shortage is expected to get worse if the Government go ahead with the plan to make nurses pay for their training. The nursing profession is anyway facing a demographic time bomb with mass retirements. The average age of practice nurses is 55. The GP nurse crisis is also linked to the historic failure to invest in primary care nurse training, and the long-standing neglect of community care nurse recruitment—a bundle of problems.

In this situation, an appalling fact has been the decline in the proportion of the NHS budget going to general practice, from 10.7% in 2005-06 to a record low of 8.4% in 2011-12. How can any Government justify that in the context of a major policy shift towards community care? Yes, the NHS England's *General Practice Forward View*, as others have mentioned, acknowledged at least some of the difficulties, and committed £200 million to some schemes. That is a small step in the right direction, but the need is for a serious assessment of the overall financial requirement of general practices to enable them to build the multi-disciplinary and multifunctional integrated organisations to meet the demand.

Another very significant problem in general practice, I have to say, is the blame culture. The sooner the GMC and the ombudsman adopt the airlines' approach of learning lessons from errors—yes, terribly important—rather than crucifying anyone who makes a mistake, the sooner we will reduce the very high level of stress among GPs, and reduce the trend towards early retirement and quitting really quite early on in their careers. If a GP sees anything between 60 and 100 patients a day, which they do, the chances of a mistake must be high. Of course legitimate complaints must be taken seriously, but a lot of patients would be very happy if they felt that their complaint would lead to some improvement. A complaint undermines morale and takes many hours of a GP's time—time that no GP has. Will the Minister agree to ensure that this issue of the blame culture is addressed?

I am very concerned that several witnesses to the committee talked about the anticipated drastic fall in GP and nurse numbers and the extraordinary fall in the general practice budget share, and came to the crazy conclusion that the general practice partnership model should be shaken up. Any top-down reorganisation of that kind would further undermine and demoralise general practice. No, general practice is transforming services, despite the pressures and lack of funding to facilitate change. These are the issues that need to be looked at.

The absolute priorities must be correcting the funding balance between primary and secondary care and increasing funding overall, as I think pretty well every

[Baroness Meacher]
contributor to the debate has said. The £50 billion figure is probably a useful guide, as mentioned by the noble Lord, Lord Prior. There also needs to be proper financial support to encourage the developments already under way in many areas—such as I have already mentioned, enlargement of practices, federation of practices, and crucially including psychological therapists, who could save GPs a great deal of time. That could be closely integrated with adequately funded social services. There are also innovations like the development of online services which I know the Minister supports. Then we have a chance of a sustainable primary care service. Can the Minister give an assurance that this is the approach that the department will take?

4.13 pm

Lord Cotter (LD): My Lords, we all know how serious the issue of mental health is for all ages. It is absolutely vital that we see increased funding for all the NHS but, in particular, for mental health. I ask the Minister to investigate one area of great concern—parity of mental health with physical health. This was announced as a future commitment by the Government. I quote the Select Committee:

"We welcome the greater prominence that mental health has received in recent years"—

that is most important—

"and we are encouraged by the Government's commitment to a five-year strategy for mental health … Notwithstanding the progress made, there is still a need for sustained and determined action to close the gap between the care received and outcomes achieved by people with mental and physical health issues. Achieving parity of esteem between the two must remain a top priority for service commissioners and regulators".

Mental health issues are still a major concern.

Local facilities which need local funding can fall down, as is happening in Weston-super-Mare, where I live. It has been announced that a very important facility for mental health called 1in4—it was previously called Friend—is going to be closed on 29 June this year. This is a disaster and I hope that the Minister will undertake to look into the closure of that facility. While I was an MP for the area, I found out how valuable it was. I was encouraged to see how vital it was as a drop-in centre for people with mental health problems. They were certainly made welcome and found opportunities to speak to the staff and to say to other people suffering from mental health problems that their particular concern was this, that or whatever. Time and again, I saw how this encouraged other people with mental health problems to say, "Ah, I thought I was the only person with this problem, but I now see that other people have the problem and I very much appreciate what is happening". This drop-in centre is one of the most important facilities in the West Country. I urge the Minister to look into this and see what can be done to maintain the service.

4.17 pm

Lord Ribeiro (Con): My Lords, as a member of the committee I join others who have expressed their thanks to the noble Lord, Lord Patel, for producing the report and getting us to where we are today. It is a landmark report and a wake-up call to government to take notice and to act.

When I introduced my Private Member's Bill on banning smoking in cars with children present, I was accused of invoking the nanny state. We have heard about that today. The Children and Families Act became law in 2014, and the regulations included penalties for the offence. The *Mirror* newspaper last year branded the ban an absolute failure because of only one conviction in two years. The DoH response was:

"The measure of success is the change of behaviour, not the number of convictions".

I agree with that.

Recommendation 29 of our report asks the Government to mount a nationwide campaign on obesity and to highlight the many complications that arise from it and its links to chronic disease. It should include the selling of food and drinks and the advertising of junk food before the 9 pm watershed to protect children and support parents.

I will focus on the public health and prevention aspects of our report. The WHO identifies the four most important risk factors for non-communicable diseases as tobacco use, physical activity, the harmful use of alcohol and unhealthy eating. My noble friend Lord McColl will have dealt with obesity, as he has been a champion of this cause for many years. I hope that in his absence I can say a little on obesity and the surgical treatment of the condition. I will also speak on the impact of smoking, despite its falling prevalence, which was estimated in 2015 to cost the NHS £2.6 billion and is a major cause of preventable premature death, with some 80,000 deaths a year. I will end with alcohol which, with obesity, causes significant liver disease.

The Government are to be congratulated on introducing the soft drinks industry levy, or sugar tax, this month. This is a success story that they should be proud to claim. It was estimated that £520 million in tax revenue would result. However, since its announcement in 2016, 50% of manufacturers have reformulated their products to avoid the levy and the current estimate is £240 million. No matter—it has had the desired effect and goaded industry into action to reduce sugar in its products. There can be only one winner, and that is our children and grandchildren. That is what I call a "nanny state" at work—and, ironically, a Conservative nanny state.

It is estimated that, in England alone, a third of our children are obese or overweight when they leave primary school, and it gets worse as they progress through senior school, where there is evidence that 80% of obese children will become obese adults. Obesity is associated with 10 types of cancer, of which breast and bowel cancer are top of the list. So it is not just about size but about the metabolic health problems that lie in store for obese children.

Soft drinks levies work: they have done so in France, Denmark, Finland and Hungary—even though people remain sceptical about its effects in Mexico, where it was introduced in 2014 and has not affected the poor there as much as was expected.

We have the second-largest obesity epidemic in Europe, and the sixth-largest globally. A Cochrane review of 22 randomised controlled trials of bariatric surgery found it to be more effective and cost effective for treating severe obesity than non-surgical methods

after two years. Long-term trials favour surgery. So why are others in Europe doing more as we do less? We are 13th out of 17 in EU countries and sixth in G8 countries for performing bariatric surgery. France, with a similar population to that of the UK, does 37,000 cases a year. Belgium, with a population of 11.3 million, does 12,000 per year. The UK does 5,000.

Surveys by the Royal College of Surgeons and the Metabolic Surgery Society suggest that some CCGs are not commissioning surgery unless a patient's BMI is more than 50. This is unsafe and puts patients at risk when they finally earn their surgery. About 2.6 million people in the UK meet the NICE criteria for bariatric surgery. We cannot operate on them all, so the NHS must target patients with high BMIs and those with type 2 diabetes. What are the Government doing to increase the rate of bariatric surgery and to reduce the variation in access across the UK?

Another area touched on earlier is the effect of the sugar tax on the nation's teeth and, in particular, on our children's teeth. I spoke in the debate on the Queen's Speech on the staggering amount of sugar—practically their own body weight—that children can consume in a year. It is time that something was done. To protect our children, the money from the sugar tax should go to nurseries, schools and breakfast clubs to help children brush their teeth and look after them. This is because Public Health England has shown that 141 children a day have their teeth removed in hospital due to dental decay. We should encourage schools to go sugar free, perhaps excluding special occasions such as birthdays.

On alcohol, policies should tackle affordability—hence the need for minimum unit pricing; availability, especially where minors are concerned; and marketing and distribution. A minimum unit price of 50p would have a major effect on white drinks—the cheapest alcohol products which cause the most harm, such as cider—without impacting on the price of drinks usually served in bars and restaurants. The health effects of alcohol abuse cost the NHS £3.5 billion per year. It is possible to exceed the guidance of 14 units per week for less than £2.50. There were 1.1 million alcohol-related admissions to hospitals in England in 2016.

This debate is limited in time. I had prepared something a little bit longer, so I will have to draw it to a close. With alcohol, it is important to focus on reducing demand rather than merely increasing NHS funding. This applies in areas that I have discussed, such as obesity, alcohol and smoking.

Finally, on the matter of public health and prevention, it is important to consider how future generations can take responsibility for their own health and contribute financially to their long-term care. The Prime Minister at PMQs in February 2017 said that,

"we do need to find a long-term, sustainable solution for social care in this country".—[*Official Report*, Commons, 8/2/17; col. 420-21.]

As the Secretary of State said in his evidence to us:

"The reality is that putting in place longer-term incentives so that people save more for their social care costs will not make a material difference for decades, but it is still the right thing to do".

I believe that he is right. Mention has been made of the Japanese and German schemes, and we referred to them in our recommendation 23. I passionately believe that those over the age of 40 should make some contribution to their long-term care.

As a colorectal surgeon, I relied on bowel cancer screening and colonoscopy to detect early colonic and rectal carcinomas. Sadly, far too many patients presented late, with evidence of disease in other organs, making surgery palliative at best. We need more cancer specialists, colonoscopists and pathologists to screen our growing elderly population. The noble Baroness, Lady Redfern, referred to faecal immunochemical testing for bowel cancer. When is that likely to be introduced UK-wide, as it was meant to be this month?

The Government are to be congratulated on introducing the sugar tax to deal with obesity and dental cavities, and the smoking regulations to protect our children from second-hand smoke. Now they must do more to tackle alcohol abuse and, in particular, cheap alcohol by introducing a minimum unit price.

4.26 pm

The Earl of Sandwich (CB): My Lords, I thank my noble friend not only for introducing this debate but for inviting me to join it. He knows that over the last few years I have brought up the subject of dependence on prescribed drugs, and I declare that I am a vice chair of the all-party group on that subject. This is a sad story, but today I am not going to describe the terrible effects of dependence on, and withdrawal from, medicines that have been recommended in good faith by doctors. Everyone here knows that most prescribed drugs are effective for most conditions but that many mistakes are made, and drugs are inappropriately prescribed for a variety of reasons. I have lived with the painful effects of withdrawal in my own family.

According to an authoritative article in the *Spectator* on 24 March, over 300,000 people leave their jobs every year because of mental illness. Paragraph 292 of the committee's report says that two out of three of them receive no appropriate treatment. Psychiatric drugs are dramatically increasing in number and availability, and the BMJ has reported a related high risk of suicide. Prescriptions for antidepressants in England rose to 64.7 million items in 2016, which is an all-time high, according to NHS Digital, representing a 108% increase over 10 years. Another 15.9 million prescriptions were issued for benzodiazepines and Z-drugs.

This debate is about the future and, therefore, gives us the opportunity to dream. But I am not interested in chimera, only in the possibility of change and the dynamic of that change. Many would like to see a radical transformation of mental health policy so that it takes in human beings more individually instead of consigning them to the conveyor-belt of medicine. Mental health patients, while they have come more into focus, are still not given a wide enough choice or more attention from psychiatrists or better alternatives to medicine. The pharmaceutical companies have a powerful hold. Big pharma cannot be blamed for responding to demand, but it can be reminded of its corporate responsibility when it comes to promotion, research or the sponsorship of trials and surveys, and they should be more sensitive to the effects of their products on increasing numbers of the public.

[The Earl of Sandwich]

I would also like to see more CCGs waking up to the reality of the consequences of mental ill health, and especially the perils of withdrawal. My noble friend Lady Murphy touched on this. There are very few services for those withdrawing from prescribed medicines, and most of them are voluntary and fragile. In fact, Mind in Camden is threatened with closure this summer because of Camden CCG's withdrawal of funding. Camden is the only London borough that offers this service through Mind, and it is available only to Camden residents. I understand that, perhaps because of negative publicity, the CCG is considering a new configuration of this service. There is even a risk that it will be merged with illegal drug addiction services, something that specialised charities avoid. But it raises a major question: should not the NHS be encouraging voluntary initiatives, especially at a time when prescriptions for antidepressants and dependence on them are rising? I know of another charity in Cardiff which closed for similar reasons. This is no national network; there are only a small number of these initiatives and their local CCGs should be backing them up, not swallowing them up.

The Minister may say that millions are being spent on mental health, but it is certainly not in this area of mental health. The support of voluntary agencies in every sector is surely an important, even vital, alternative to statutory funding at a time of austerity. One short-term solution would be a national helpline. We cannot leave this to the wish list of the future reorganised NHS or the recommendations of the review now being undertaken. It is viable and is needed now. I understand that it is being seriously considered behind the scenes, but I again urge the Minister to let us know whether it is actually going to happen.

Another important issue is the degree of public understanding of the effects of overprescription. On 24 February, the president of the Royal College of Psychiatrists and a colleague wrote in the *Times* that for,

"the vast majority of patients, any unpleasant symptoms experienced on discontinuing antidepressants have resolved within two weeks of stopping treatment".

This statement has appalled a large number of psychiatrists and patients who have lodged a complaint with the RCP, including some who have experienced withdrawal effects for between 11 months and 10 years. Even the Royal College's own survey of 800 users found that withdrawal symptoms generally lasted for up to six weeks, with a quarter reporting that anxiety lasted more than three months. If even one of our leading institutions can mislead *Times* readers on a matter of public safety, what hope do the Government have of explaining these things to the general public? It is well known that antidepressants are on the increase, and the NHS has to deal with the consequences. I know from a Question asked by the noble Lord, Lord Hunt, last month that the Minister is well aware of this issue and knows that Public Health England is conducting a year-long review of policy. He may argue that this is looking to the future, but he will also know that there have been reviews before, that the responsible Ministers have changed three or four times under the last two Governments and that the problem is happening now. Some immediate measures are essential before the end of that review. I much look forward to hearing his comments.

4.33 pm

Baroness Wheeler (Lab): My Lords, I, too, congratulate the noble Lord and his committee on this excellent report. The debates on the long-term future of the NHS and social care at this time, as we approach the 70th anniversary of the NHS, are invaluable, particularly as recognition of the need for long-term funding solutions is under the spotlight more than ever before. We also have the very welcome recent evidence from last year's social attitudes survey that shows that the majority of voters now back a tax rise to fund the NHS. The Government's response to the committee's report, a year after its publication, has been described as anodyne, pedestrian and underwhelming—and those are the kind descriptions. In truth, it contained very little that could not have been said three months after the report was published. The Minister has been very apologetic on many occasions about the delay, so perhaps we might be rewarded today with an actual explanation as to why it took so long to say so little.

Noble Lords have spoken on the key funding, structural and workforce issues arising from the report. I want to speak about these in the context of the future of stroke services. I know that the noble Lord, Lord Patel, will welcome this, as it is an issue close to his heart, and I commend the key role that he has played in this House in support of improved stroke care.

Stroke is the fourth-largest single cause of death in the UK. It occurs approximately 152,000 times a year in the UK, there are over 1.2 million stroke survivors, and it is the largest cause of disability. Over half of all stroke survivors have some form of disability. Every year, 80,000 people in England are admitted to hospital after having had a stroke. Stroke costs the health and social care system over £8 billion a year, but research by the Stroke Association shows that when informal care and lost productivity are factored in, this spirals to £26 billion. Without action, this is expected to at least double or triple by 2035. Indeed, the quality of stroke prevention and care in England is a strong barometer of how our health and care system is working, as it is both a medical emergency and a long-term condition. As the committee's report underlines, reorganising and centralising stroke services reduces disability and can save lives.

The 10-year National Stroke Strategy, brought in by the Labour Government in 2007, has led to major improvements in stroke prevention, treatment and outcomes. But progress has stalled as a result of funding cuts, CCGs not giving stroke reconfiguration the priority or support it needs, which results in huge variations in services across areas, and little attention being given to the whole stroke care pathway—and because of the Government's mistaken refusal to update the strategy forward into 2018 and beyond. However, the news that NHS England, along with the Stroke Association and others from across the health and social care system, are now working in partnership to develop a new national plan for stroke in England, is welcome. It is essential that this plan is prioritised and effectively

implemented to provide the leadership and direction needed to achieve better treatment, care and outcomes for those affected by stroke. Can the Minister update the House on progress on the national plan and on the timeframe for its development and publication?

While reconfiguration of services is planned or under way in many areas across the UK, progress is slow and patchy, with huge challenges in persuading local commissioners to prioritise these services, and persuading communities and patients that reorganisation works. In reality, much of the change is still small scale and limited in scope, such as shutting one unit and diverting ambulances to hospitals with better stroke facilities and staffing. Although 32 STPs have used the opportunity to review acute stroke services, most of these reviews have yet to be actioned and only four consider the whole stroke pathway. The committee's report makes it clear that the jury is still out on the current effectiveness of STPs, and this is certainly true of their likely impact on stroke reconfiguration and services. As both ADASS and the Local Government Association have pointed out, STPs' main focus is on NHS transformation, not on social care. The LGA sums it up, saying that,

"there has been little meaningful consideration of adult social care as a vital component of a resilient and sustainable health and care system".

Can the Minister say how this is being addressed as STPs are taken forward?

Sadly, for stroke survivors the care pathway is the area that has seen least progress in recent times. For comprehensive post-acute stroke care, such a pathway means early supported discharge, long-term neurological rehabilitation, vocational rehabilitation, exercise programmes, vascular risk reduction advice and support, and long-term follow-up and intervention for patients whose functional ability deteriorates. Nearly half of all stroke survivors who responded to the Stroke Association's recent survey say they felt "abandoned" after leaving hospital and lack confidence and information about how to navigate the post-acute pathway; two-thirds did not receive the vital six-month review of their care needs. Forty per cent of stroke patients are eligible for early supported discharge, which reduces the length of hospital stays and provides intensive multidisciplinary stroke-specific rehabilitation at home. But two out of 10 hospitals in England, Wales and Northern Ireland do not offer ESD, and it is not being commissioned by many CCGs despite national guidance. There are long waiting times in most areas for key post-stroke psychological and emotional support; on speech and communication, the average wait to start speech and language therapy is 22 days, varying from 8.5 days to two months between the best and worst-performing areas. These are precious lost days that can have a lifetime impact on the ability to communicate after a stroke.

On carer and family support, shockingly, one in three areas in England, Wales and Northern Ireland does not provide support for carers and families of stroke survivors. As a carer of my partner who is a stroke survivor of 10 years, I cannot stress enough how important being part of the local stroke community is to the well-being of stroke survivors, particularly those with severe disabilities.

In my area, we are lucky to have a stroke group just down the road, run and funded by the Stroke Association. We also have an amazing local charity called TALK, which provides support with speech, memory and communication difficulties. It is run by volunteers but against increasing odds. It was recently given one month's notice by the CCG that its small grant is to be stopped this month. When we talk about NHS and social care sustainability, surely these are exactly the sorts of services where local authorities need increased national funding so that they are able to provide support.

Many of your Lordships know that I always have lots to say about stroke but in the time left I shall make just a couple of points. I really welcome the committee's frank assessment and criticism of the current absence of coherent health and social care workforce planning. I hope that the Minister will today acknowledge this, look at the problems that are occurring and commit to a long-term workforce plan covering both health and social care. There are lots of examples of staff shortages in stroke services which I do not have time to go into. Again, I support what noble Lords have said about the need for increased social care funding.

Thirdly, straying a bit from the committee's report, the excellent "Children get dementia too" adverts on the Tube have prompted me to remind the House that children get strokes too, because the debates in this House have led to some progress being made. Childhood strokes affect around five out of every 100,000 children a year in the UK. People do not think that children have strokes, but they do, as the families of children who have had major strokes in the womb before birth or later in their teenage years know all too well. Awareness raising, more support for carers and families caring for children who have had a stroke, and much more research into childhood stroke, are needed.

Finally, I join other noble Lords in giving wholehearted support to the committee's recommendations on prevention and public health, and the need to move from an "illness" to a "wellness" service. For stroke, this is very important, and there is a need for better screening and diagnosis of atrial fibrillation.

In summary, stroke embodies the challenges of planning for population health and delivering integrated, accountable care, and it requires the joined-up health, social and voluntary sector support called for throughout the committee's report. I look forward to the Minister's response.

4.41 pm

Lord Sterling of Plaistow (Con): My Lords, it is with some trepidation that I take part in this debate. The professionalism of the report of the noble Lord, Lord Patel, together with everything that has been produced with all-party support, shows this House at its best.

Many years ago, I was at the Grosvenor Hotel attending a ball. The lady with me, who was beautiful and was wonderfully dressed in a long gown, was a senior nursing sister at St George's Hospital at Hyde Park Corner. The music was suddenly stopped and it was announced that an IRA bomb had just hit the Hilton Hotel. As noble Lords may remember, there were

[LORD STERLING OF PLAISTOW]
a very large number of casualties. My companion grabbed her bag and we rushed out. Everything had stopped. Police cars were all over the place. She ran into the middle of the road and stopped a police car. The bloke yelled out, "What the hell do you think you're doing?" She said, "I'm a nursing sister. Get me down there fast". I followed along. When we got inside, there were a couple of house doctors standing at the side. She said, "If you can't do anything better, get out of the way". As noble Lords can imagine, it was a pretty awful evening. At about 1 am, she came over to me with a white coat, covered in blood, over her gown, and said to me, "Jeffrey, I'm starving. Where can we eat?"

Another personal experience occurred at St George's Hospital, Tooting, 11 years ago. I was taken there from where I was in the country when I had a heart attack, and it was quite an experience, although it is something that you know can happen. It was the first time that I had ever been in an ambulance. I had seen many ambulances but had never been in one. Because the driver had taken the wrong route, the advice given by the doctors who were waiting was that I had better have a clot-buster. I said to the guy looking after me in the ambulance, "What the hell's that?" He said, "I've only done it once but I'm told that you had better have it. But you must read a form first because of the chance that you won't make it". So I had it and I made it, and my experience of the National Health Service on those two occasions is that its staff must be the most trusted people in our society and, if I may say so, the most loved.

Years ago, the late Lord Goodman, with whom I founded Motability, was asked by Barbara Castle to examine the funding position of the National Health Service. He carried out that report and I saw it at the time. At its conclusion, he said, "My strong advice is that you should charge £5 a night for every hospital bed". If you looked at the figures, you would have seen that that was meaningful. Sadly, it was turned down.

One of my companies built hospitals, and one knows, sadly, the way in which the management change the plans so many times so that the overruns and costs become extraordinary. It is my view that, on the management side, a great deal can be done.

Nearly 20 years ago, when Labour was in power, I was asked whether I would be prepared to look into the health service. I said that I would do it only if it was not a royal commission that would be kicked into the long grass but was done on an all-party basis and I could choose the members of the committee. Sadly, it was turned down and so I never had that experience.

The noble Baroness, Lady Meacher, mentioned the blame culture. Having wandered around the health profession and mixed with a lot of people there, I know that that culture is having a devastating adverse effect on morale and inhibits positive progress and action being taken by managers.

At the start of the debate, the noble Lord, Lord Patel, said that the National Health Service should be free at the point of need. I agree with that, but what I do not agree with is the misuse of the health service and it being taken for granted. Let me give an example. I have talked to people about the number of no-shows in out-patients and those wasting time by turning up at the emergency ward. I have spoken about this with senior registrars in three hospitals and my noble friend Lord Bridgeman will talk later about the views and role of GPs and doctors themselves. In practice, one-third of people who turn up have no need of any medical help and should have stayed at home and one-third should have been treated by a nurse or gone to a chemist. Others will go into this in much greater detail, but in my view the GP is the key factor for what will happen in the future.

My final point is on the NAO. I am not sure that the views of the NAO are right. Putting the care of the elderly under one umbrella may not be the right answer. I am particularly interested in what happens because I am heavily involved in this area and that of the mentally disabled. I find that people want time and they suffer from loneliness. It is not just about care: loneliness must come into the thinking on this.

I will finish by telling the Minister about one aspect of charging. When people get things totally for free—I have found this myself in the past—they do not value them in the same way as when they have put something into it themselves. You should pay £10 a visit to go to the doctor and if you do not turn up at out-patients you should pay £10. That would help enormously. The important point is that people need to value things, and they will do so if they have put in something themselves.

4.49 pm

Lord Parekh (Lab): My Lords, I too begin by congratulating the noble Lord, Lord Patel, and his committee on this report on the long-term sustainability of the NHS and adult social care.

When Lord Beveridge submitted his report, he told his 26 year-old research assistant, Harold Wilson, the following:

"From now on, Beveridge is not the name of a man; it is the name of a way of life".

It is important to bear that in mind. The NHS was supposed to embody a particular way of thinking and living. The way of living was based on three major values: first, wherever there is human suffering it needs to be redressed; secondly, it does not matter whose suffering it is; and, thirdly, redressal of the suffering is the responsibility of the entire society. In other words, relief of suffering, equality and solidarity are the three great values represented by the NHS.

In so far as these values are represented by the NHS, it is rightly loved by the country; it is almost a part of our religious practice. One hopes that the entire society will be based on these values but the NHS implies that, even if the rest of society is colonised by other values, it will be an island where these values are worshipped and cherished.

I want to explore what has happened to these values over the past 70 years. There was never an idyllic stage where everything was fine and dandy. I remember that in olden days there were all kinds of complaints about the NHS: for example, its hierarchical character, where consultants would behave like local potentates, and the way in which junior doctors were exploited—all

kinds of things happened. Over the years, in some respects these things have changed for the better and in other respects they have changed for the worse.

If we look at the situation now, we begin to see many problems, structural and functional. Morale is low—people are leaving the country or retiring early—and I am told there will be a shortage of about 10,000 GPs by 2020. There is also a wastage of medication and equipment; a wastage of time by asking people to fill in all kinds of forms; and a wastage of money by employing management consultants who contribute little to the working of a hospital. The NHS is also perceived as rather remote. The patient has no direct contact with the consultant, and the GP's contact with the consultant is intermittent.

With all these things going on, a radical rethinking is needed on how we should structure and fund the NHS and whether its role in a society like ours is consistent with the three values that it represents. It is in this context that one should look at the report of the noble Lord, Lord Patel. I am impressed by the amount of thinking that has gone into it and I wish to use the next two or three minutes that I have to contribute to that thinking and take it a little further.

I cannot do that at all levels but I shall try to do it at two levels. One concerns the financial side of it. In this country there are fewer hospital beds, doctors and nurses than the OECD averages. Obviously more money is needed. That money can come only from general taxation, for the kinds of reasons the report explains. However, there will never be enough. The demand is insatiable: the population will continue to age; new technology will continue to appear; and new medicines will emerge in the market. For all these reasons, there will never be enough money and we will have to find new ways of raising it.

Here I am reminded, having been a university professor, of the way in which universities were asked to diversify their sources of funding. Over the course of years they came up with various answers and perhaps some of them will be applied across the board. For example, there could be major endowments by individual donors. My university has recently been the beneficiary of a gentlemen donating about £2 million.

Secondly, the university has increasingly begun to wake up to the importance of cultivating the alumni culture. There is no reason why hospitals cannot similarly cultivate individual patients—those whose children have been born or those who have benefited from hospitals—and encourage them to contribute to the work of the hospital. In this way, one can give the local community a stake in the NHS. The NHS is not simply seen as a national tree, planted in the middle of an area; rather, it grows out of the area and has organic ties with the city in which it is located.

There is also a good deal to be said for research in the NHS, resulting in discoveries, inventions that will be patented. I have seen this happening in the United States; there is no reason why it could not happen here. For example, the NIHR receives money from the NHS, which could then support projects that would result in patents. Those patents could raise money for the NHS.

There is also the question of the amount of medicine wasted. A lot of patients forget to take their medicine. There is no reason why technology for this cannot be developed. In fact, technology is being developed where electronic tags could be attached to medicines so that, at a particular time, the patient is reminded that it is time to take their medicine. The pharmacist connected to the patient can also ring them and tell them that it is time for their medication. In this way, an enormous amount of money can be saved.

Although I do not think that this subject is worth exploring at this stage, I have often wondered about the whole business of merit awards. I cannot see any other profession where people can receive merit awards; certainly there is no chance of someone giving me, a university professor, £10,000 a year, even if I won a Nobel Prize. Doctors get this and I must ask the House to take a second look at why it was introduced, why it is deserved and whether it should be continued in the current climate.

My last point is simple. Ultimately, the report says that any medical institution, such as hospitals and GPs, depends on the good will of individual patients. Patients must therefore not make unreasonable demands on doctors. They should take care of their lives and take charge of their destiny, rather than expecting doctors to take care of them. That kind of individual responsibility must be cultivated and can come only if there is an organic bond between the individual and the hospital or GP. Once we begin to embed a local medical institution in the life of the community, giving the community a sense of responsibility for and ownership of the local health service, things can begin to produce miracles.

4.57 pm

Baroness Watkins of Tavistock (CB): I thank the noble Lord, Lord Patel, for securing this debate and for his work as the Select Committee chairman. I particularly congratulate the members of the committee on providing an excellent report, despite the fact that there was no nurse and five medical staff on the review team. The committee has produced a thoroughly excellent report that highlights the fundamental issues to consider if we are to preserve the notion of health-care that is free at the point of delivery, funded through the taxpayer, for future generations. Note that I do not say "the NHS" because, coming from a mental health background, I know that a tremendous amount of good care is provided by a range of charities and voluntary organisations as well as the mainstream NHS; however, it needs to be funded through the public purse.

I draw attention to my interests in the register, particularly as I am a nurse, as noble Lords know. With that in mind, I was initially intending to speak largely on nursing, but many noble Lords have done that so I have added one or two other issues to my speech.

Without doubt, we simply need enough appropriately skilled and motivated staff to provide care in the health service and social care—not just adult social care but children's social care. This has been highlighted by many noble Lords, particularly the noble Lord, Lord Willis, and my noble friend Lady Emerton.

[Baroness Watkins of Tavistock]

This requires a focus not just on recruitment and pre-registration training but on nurturing and developing the staff we already have. As Public Health England's report *Facing the Facts, Shaping the Future* distinctly put it:

"The most cost-effective way to ensure the health and care system has the staff we need is to keep the people we already employ"—

including those of the Windrush generation and their successors, many of whom I have worked with in my clinical experience.

Yet unprecedented numbers of nurses are leaving the NHS for reasons other than retirement—more than 5,000 more, in real terms, than five years ago. The Royal College of Nursing gave powerful evidence to the Commons Health Select Committee earlier this year about nurses feeling undervalued and not supported. Reasons for leaving cited included the pressure of the workload, with nurses often feeling that they are unable to undertake their full role in terms of care and kindness to their patients, but also a lack of flexibility, pay and career development. There have been significant cuts in CPD budgets, which have obviously prevented nurses and allied healthcare professionals in developing further competences to take over some of the roles traditionally undertaken by medical staff.

It is not merely that we need more money but how money is spent most effectively. At the most basic level, we need to support newly qualified staff of all types to ensure that they can undertake their roles safely and with confidence. However, at a time of transformation, with new models of care being introduced, a flexible, adaptable and resilient workforce is key to leading the NHS into the future. Upskilling the workforce to specialise in priority areas and to advance practice and leadership skills, so that people see working in the NHS as a career, not a job, will enhance productivity and facilitate change and improvements. These benefits would represent good value for money.

Much has been said on funding for health and social care. However, I will briefly mention how we might fund it in the future. The NHS is a source of national pride, with near universal support. There is much evidence to suggest that a large proportion of the public are willing to pay more to have a high-quality NHS. However, we need to be careful that whatever we do to increase funds for the NHS demonstrates intergenerational fairness. We cannot expect the younger generation to pay entirely for the older generation. I fail to understand why we could not undertake some of the other issues people have recommended here on older people paying more.

I have raised points about the workforce, but I will take one extra minute to talk about care. If we are to reduce expensive, prolonged stays in hospital that are harmful to patients' health and prevent unnecessary admissions, and allow ourselves to provide kinder care where people want it, in or near their homes, in a more cost-effective way, we need to think how we can do so. For example, I hear of children in mental health in-patient care being admitted 100 miles away from their homes and families, with essential components of their care and treatment, such as family therapy and liaison with social care, unable even to start until they can be moved closer to home. This is clearly not kind or cost-effective.

I have also just read a very poignant account of the provision of "comfort care" at the very end of life in the obituary of Barbara Bush, the former US First Lady. It noted that she rejected further treatment in hospital and selected a comfort care package at home for her last days. This illustrates how people with sufficient knowledge can plan the most comfortable care in a personalised way. I urge us to think how we might adopt the term "comfort care" rather than "end-of-life care", because it demedicalises the concept and may be particularly pertinent to people suffering from dementia.

I therefore support the concept that we should pool the risk for all people in terms of social care as well as healthcare. I very much hope that, as a result of this report, we will find a cross-party collaboration that will enable us to get not a 10-year funding plan but a 30-year vision for health and social care.

5.05 pm

Lord Saatchi (Con): My Lords, the noble Baroness, Lady Finlay, says that this report is a thank you gift to the NHS on its great anniversary. Perhaps my words could be a thank you to the noble Lord, Lord Patel, and his distinguished committee. I hope that this report and debate will be another proof, if any were needed, that your Lordships' House can change the course of history.

To that end, I will start with what the committee says in recommendation 24, on what it calls "the uptake of innovation" in the NHS. It says that there is no credible strategy. My noble friend the Minister will recall the passage through Parliament of the Bill that became the Access to Medical Treatments (Innovation) Act 2016, in which I had the privilege of playing a part, together with many other noble Lords here today. The Minister may recall that Section 2 of that Act confers a power on the Secretary of State to, in effect, use subordinate legislation to establish a database about the process and results of innovative medical treatments in the NHS.

Noble Lords will share my concern that, more than two years since that Act achieved cross-party support and received Royal Assent, not only has the database not been established but the section itself has not even been brought into force by commencement regulations under Section 4. So far as I have been able to establish in correspondence with the Minister's department, he has no definite plans to commence this section, to make the regulations or to establish the database.

As was noted in the two standing-ovation debates of the noble Baroness, Lady Jowell, in both Houses, data that can direct and fashion the future of medical treatment is absolutely crucial, and it was the clear will of Parliament, in enacting Section 2, that innovative treatment data would be used for that purpose. When the Minister replies to the debate I very much hope that he will give a firm assurance about the commencement of Section 2 of the 2016 Act and for the timetable for the making of regulations under it and the establishment of the new database.

My noble friend the Minister will note that my advice from parliamentary counsel is that two years should have been more than sufficient to enable the necessary pre-commencement consultations to be carried out. Although the courts will not force the exercise of a commencement power, given the other work being done on data in the NHS this could well be a situation—I am told—that engages the Fire Brigades Union case rules and the Court of Appeal judgment in that case, with which my noble friend will be familiar. I am sure that he will be anxious to give us a sufficiently clear assurance about his commencement plans to avoid any suggestion that it may become necessary to apply those rules.

The committee's report considers the organisational structure of the NHS, and here to help us we have the official government response, which other noble Lords have spoken about. When I first read it, I thought it was a spoof—not written by my noble friend the Minister but by someone auditioning for the next series of "Yes Minister." We learn that the STPs are working closely within the BCF, as are the GDEs. Meanwhile, the ACC and the AAC are developing the AAP in the TB, ITT and ITP programmes. The ACPs and the SCPs are also giving the AHPs the opportunity to work alongside the FFs to implement the ALBs following the NDG. Some say that these acronyms are harmless enough and just bureaucracy-speak. However, to make a serious point, as the Governor of the Bank of England said, such acronyms in the banking world—CDIs, CDOs, CDSs, SPVs et cetera—brought the world to its knees. Let us make sure that these acronyms do not bring the NHS to its knees.

I will come to the main point. Looking at the main conclusion of this outstanding report, the noble Lord, Lord Patel, and his committee want to see two separate things. They want a long-term approach; they also want a bipartisan, cross-party approach. The committee is nothing if not ambitious, but in those two ambitious aims it has a great friend—if I may say so, a powerful friend—that shares its conclusions. The Centre for Policy Studies, of which I am the chairman, has published two pamphlets on the subject of this report and debate. The first sets out why a royal commission on the NHS is now required—because, in the words once used when royal commissions were more fashionable, the NHS is,

"an issue of great national importance in which the tribal warfare between the parties is an impediment to the national interest".

That is much as the committee said. The CPS has also published the proposed remit for such a royal commission.

This came about because the researchers at the CPS, in their inquiries throughout the medical profession, Whitehall and Parliament, et cetera, found that there was no agreement on anything to do with the NHS—not on whether there is a problem with it; nor on whether, if there is a problem, that is the problem; nor what is the solution might be if that is the problem. The first of the many people to whom the CPS spoke said, "It's the money, it's the cuts—that's the problem". The next person said, "It's not the money, it's the organisation". The third said, "It's not the money and it's not the organisation, it's the culture that's the problem". The CPS published 69 of these alternative facts to portray the level of disagreement.

I will come to a happy ending now. Thanks to the gift granted to me to see ahead—I am looking at the right reverend Prelate for confirmation—I can bring your Lordships joyous news towards the end of this debate. On 5 July, it will be a beautiful summer's day for a great state occasion to celebrate the NHS, and the Prime Minister will confirm that she has been to Buckingham Palace to see the Queen. Addressing the nation on the steps outside No. 10, she will explain her decision to appoint a royal commission on the NHS. I will finish in one minute. Her reason will not be A&E waiting times, cancer mortality rates or anything to do with that. It will be because the trend in the NHS now contradicts her inaugural speech on the steps of No. 10, which was about attempting to remove injustice, inequality and unfairness.

A system in the NHS in which it is possible for people to be told, "If you have the money, the doctor will see you now; if you are poor, go to the back of the queue", which means one law for the rich and one for the poor, is the ultimate injustice. This is something that the Prime Minister cannot accept, and therefore she will capture the mood of the country about the NHS by saying, as she has just said about the EU, "Let's just get on with it". She will say, "I'm not prepared to go on kicking the can down the road", and that she wants a long-term view. She will agree with the noble Lord, Lord Patel, and his committee, and with the Centre for Policy Studies. She will want a cross-party approach to give us back our pride in the glory of the NHS. As she turns off the light on her bedside table—which I can also see ahead—the Prime Minister will say, "I will do it. If not me, who? If not now, when?".

5.15 pm

Lord Brooke of Alverthorpe (Lab): My Lords, like other noble Lords, I am grateful to the noble Lord, Lord Patel, and his Select Committee for producing their wide-ranging and influential report. Nye Bevan said that the NHS will last as long as there are folk with the faith to fight for it. Without doubt the noble Lord, Lord Patel, and the Select Committee have demonstrated that they have faith ,and they are ably supported by the right reverend Prelate the Bishop of Carlisle.

I shall confine myself to the Government's response to the part of the Select Committee's report headed "Public Health, Prevention and Patient Responsibility" and Recommendations 29 to 31. While longevity for both sexes has gone up, worrying evidence is now starting to emerge that in some locations it is not only stalling but possibly starting to reverse. Mental health illnesses are also greatly on the increase. There are social factors behind the causes, but a major problem, which we fail to address head on, is the unhealthy lifestyle habits that have developed in recent years in both adults and children.

As other noble Lords have said, 63% of adults and nearly one-third of children in England are classed as overweight or obese, rates of smoking are still at 17% and 10.5 million people are drinking at levels that pose some risk to their health, which has a knock-on effect with illnesses such as diabetes, cancer and heart disease. This in turn puts significant strain on NHS

[Lord Brooke of Alverthorpe]
resources. As the noble Lord, Lord Ribeiro, indicated, it is estimated that alcohol alone costs the NHS £3.5 billion a year, and obesity is going up and is now estimated to cost about £5.1 billion a year.

These costs and the related illnesses and diseases can be reduced. While the rate of smoking is still far too high, great changes have been achieved in a relatively short time through very effective public campaigning and by having Governments who have been prepared to take tough decisions on issues such as pricing, marketing and availability.

I turn to the Government's comments on obesity, where some very tough decisions need to be taken. I am pleased that they are being positive. In their response they set out a range of actions, all of which are to be applauded, but are they enough and sufficiently hard-hitting to achieve their objective?

The Government said that they will monitor change in the prevalence of childhood obesity through various schemes, including the national child measurement programme and the Health Survey for England. More detailed assessments will be carried out next year and in 2020, but when we check on this we find that we have been doing this since 2006. To my surprise, we have been weighing and measuring the height of 1 million children aged 4 and 11 every year since 2006 when the problem was first identified, and we are now talking about doing further assessments in 2019 and 2020. This review was set up with two key purposes. The first was,

"to provide robust public health surveillance data on child weight status: to understand and monitor obesity prevalence and trends at national and local levels, inform obesity planning".

This was back in 2006. The second was,

"to provide parents with feedback on their child's weight status: to help them understand their child's health status, support and encourage behaviour change where it will help a child achieve a healthy weight, and provide a mechanism for direct engagement with families".

What have we done with all this data that has been collected? This is not a mandated programme. Local authorities are only encouraged, they are not required. As we know, local authorities have suffered cuts to their income of close to 70% over recent years, so is it any surprise that after running this programme since 2006 we find obesity is now worse than it was when we commenced this exercise virtually at the turn of the century?

We now find ourselves in the position where overweight is becoming the norm with parents and even health professionals, and they are struggling to identify overweight children by sight. True, the Government have an obesity plan. The sugar tax is greatly welcome, as is the reformulation of food, which they are working on. I believe further changes are likely to come, restricting children's exposure to junk food and advertising, as reported in the *Times* earlier this week. We see Members from all parties coming together at last and recognising that the only way we can make a movement is by working together and not engaging in the usual feuding.

There are a number of initiatives, all with the best of intentions. Frankly, though, many of us believe there is a case for this all to be brought together with an overarching national campaign involving all schoolchildren. Here I look across at the noble Lord, Lord Saatchi; maybe this is an area where he could bring his particular expertise to bear. We should be endeavouring to engage 8 million children in this programme in the 24,000 schools around the country, not just a small element, as we have done since 2006. They need to be weighed and then, in turn, to be given the facts, full support and encouragement, with the involvement of their parents, to try to persuade them to lead healthier and more fulfilling lifestyles than they engage in at the moment.

I regret that the present obesity plan does not have a central focal point; it is a whole range of different small initiatives. We need some major pulling together of the threads with a strong lead being given. As I mentioned to the Minister last week, for some reason broadcasters are not involved in the plan or even mentioned in it, but they should be. Why are they not? The BBC, with its national and regional TV, radio and online facilities should be spearheading a flagship programme and related co-ordinated activities for the health not only of our youngsters; if we can run an anti-smoking campaign that affects parents, as that one did, we can do the same to see movement on obesity. Is it possible? Yes, it is. We need willingness, power and determination.

Even if the Government are not prepared to move on this, I hope that, in looking at the report, we can stand up and start to push people in a direction where we involve a massive number of them in tackling a major epidemic that cannot be left untackled any longer.

5.22 pm

Lord Loomba (CB): My Lords, I thank the noble Lord, Lord Patel, for initiating this debate on the report, which comes at a crucial time for the NHS and for adult social care. It is widely recognised by many that there is a need for immediate action to sort out the main difficulties that plague both the NHS and adult social care, and especially to look at better long-term sustainable funding so that the NHS can get on with its work in a more secure way than at present.

It is becoming increasingly clear that, as the report recommends, the NHS and adult social care should be brought together to tackle the problems in tandem so that the most apt solutions for both sides are put forward. The report recommended that the Department of Health should have budgetary responsibility at national level for adult social care and should be renamed the Department of Health and Care, and it appears that there has been some movement on this front as the department has now been renamed the Department of Health and Social Care. Confusingly, though, Jeremy Hunt said in his evidence to the House of Commons Health Committee in March that while he now has responsibility for adult social care, funding would continue to flow through local government, which delivers adult social care. Additionally, the Secretary of State for Health and Social Care now has responsibility for the proposed Green Paper on adult social care, but at the moment it will not cover the NHS.

Age UK's briefing for the debate highlights the interconnectedness of the problem. It should not be forgotten that problems with the care system in turn

create further pressure on the NHS. Delayed discharges are a good example of this, where older people are unable to be safely discharged from hospital because adequate social care plans are not in place.

Clearly, no business can run without an eye to the future, and an organisation as vital as the NHS needs a clear strategy of where we are, what the problems are, what needs to be achieved and the steps needed to achieve it. It is not insurmountable, but it will take willpower on all sides and agreements to be reached that allow for the patients who need assistance to be at the forefront of the change, so that they are given the best health and social care possible.

As the noble Baroness, Lady Pitkeathley, pointed out in this House last year, numerous commissions and consultations over many years have not resolved the issues. The bottom line is that while all this prevarication continues, the people who need help are suffering the most, as they are let down by a system that is not fit for purpose. With this comes low morale and a depleted workforce that needs uplifting, for without them it would be a much bleaker picture.

I am aware that waiting times in A&E are coming down. However, we need to reduce them further so that no one is forced to wait for more than four hours to be seen, and especially to improve matters so that there is not a repeat of this winter's acute problems, when ambulances at some hospitals were forced to wait outside and unable to deliver their patients due to lack of capacity.

What actions are the Government taking to increase the number of doctors and nurses working in the NHS, and how can immigration policies be amended to accommodate more doctors and nurses from overseas to help to fill the shortfall in staffing levels?

Finally, I am pleased to hear that the Government have committed extra funding to the NHS in the five-year forward view. Can the Minister identify how, when and where the extra money will be allocated?

5.27 pm

Viscount Bridgeman (Con): My Lords, I add my thanks to the noble Lord, Lord Patel, for the leadership he has given to produce this excellent committee report. It is a tribute to him and to the quality of the report that only a week ago, the date of this debate had to be changed, but he has still produced more than 50 contributors.

I shall confine my remarks to primary care and the role of general practice in England and, in particular, the primary medical services practices. I go back to 1998. In the revision of contracts at the time for GPs, they were offered two routes: the general medical service, which basically allowed them to continue as before, and the personal medical service. PMS doctors were paid a premium per patient for undertaking additional duties. This was a farsighted development instituted by the Conservative Government and put into action by the Labour Government, and it attracted a number of very forward-looking GPs. The arrangements worked well for 10 years. Patients benefited, and a significant contribution was made by many PMSs to reducing the workload of hospital A&E departments, of which I will speak further.

In 2014, NHS England reviewed the operation of PMSs, and concluded that the premium could not demonstrate value for money. As a result, it was to be withdrawn by the CCGs over four years and redistributed to all practices in the relevant health districts. Among the conditions handed down by NHS England were three significant ones to these other practices: to help reduce health inequalities; equality of opportunity to all GP practices; and support for fairer distribution of funding at a local level. Those are laudable intentions indeed, and I am sure that they will have the effect of bringing the standard of practices up, but I fear that that will be at the expense of the go-ahead PMS practices, which stand to lose a lot of money in resources.

Among the PMS practices, there is predicted an average fall in income in year four of 35%. How will those practices address this shortfall? Inevitably, it will involve a reduction of support staff, practice nurses, nurse practitioners, healthcare assistants and administrative staff. Perhaps some doctors will be unable to bring themselves to curtail some services, walk-in surgeries being an example. The shortfall will have to be made good out of partners' profits.

One of the main points I want to make, and have made, is the effect that this is likely to have on A&E and emergency admissions. In one practice, in central London, with which I am familiar, the emergency admissions are down by 60% from the national average. A&E attendances are reduced by 35%, and ambulatory care conditions, which I think is outpatients, by 73%. The key figure, by which a GP practice is measured, is the 65% reduction of antibiotic prescribed per 1,000 patients against the average practice.

I am lucky enough to be a patient of a central London PMS practice that has walk-in surgeries for two hours five days a week in the mornings, and for four days a week in the afternoon. I am assured by the senior partner in the practice that this was made possible by PMS premium funding and would not be possible without it. Let me mention briefly the financial aspects of practices against hospital admissions. A few years back, a PMS surgery was paid an annual fee per patient for an unlimited number of attendances at the surgery. As it happens, this was broadly equivalent to the cost to the NHS of just one basic admission to A&E before adding the cost of extra services, such as radiology. That is a clear reminder of the savings to the health service that the more go-ahead PMS practices have up to now been able to offer. I suggest that this move by NHS England, admittedly four years ago, was certainly unintended and unforeseen, but it has been adverse for patients, for the viability of the practices and an additional workload for the hospitals' A&E departments.

The British primary healthcare system has been described as the jewel in the crown of the NHS—I believe by Simon Stevens who is the head of NHS England. Both France and Germany, to take two examples, have fine healthcare structures, but I understand that primary care through general practice arrangements that we have in the United Kingdom are indeed the envy of both. The jewel in the crown the primary care sector may be, but it does not have the clout of the larger acute care trusts.

[Viscount Bridgeman]

This debate coincides three days ago with my right honourable friend the Secretary of State's letter to fellow Peers in which he outlined plans for health and now, newly under his jurisdiction, social care. This was to mark the 70th birthday of the NHS. Outlined in the letter are some quite radical plans for the reorganisation of the National Health Service, and I hope that he will bear in mind the fact that the PMS has been a huge success, contrary to the view of NHS England, and deserves further funding.

5.35 pm

Baroness Greengross (CB): My Lords, I welcome the Government's commitment in their response to the committee's valuable report to making sure that the NHS meets the needs of everyone, no matter who they are or where they live. I shall look mainly at the needs of older people, but also at the fact that intergenerational fairness is becoming more important and we must consider that.

I share the view of the British Geriatric Society. It is not as confident that the Government's response represents a genuinely strategic approach to ensuring sustainability. I am concerned that the range of positive initiatives either under way or being planned are less joined up and integrated than they could be. I endorse the British Geriatric Society's call for a new strategy for people living with frailty, dementia, complex needs and multiple long-term conditions, ensuring access to comprehensive assessment, personalised care plans for treatment and long-term follow-up for all older people with frailty, dementia and complex multiple long-term conditions.

Sadly, disability-free life expectancy is rising more slowly than life expectancy itself. Most people aged 75 and over have one or more health conditions and one in four people aged 85 and over is frail. Significant changes are needed in the workforce, flexibility in the place of care, and a more strategic and integrated approach for people living with those conditions. If we do not do that, the long-term sustainability of the NHS will not be achieved.

I agree with Care England that a well-funded, sustainable social care system underpins a sustainable NHS. Delayed discharges are a good example of this. Older people are unable to be safely discharged because adequate social care plans are not in place. This is even more important than it used to be and it must be properly addressed.

I am indebted to Age UK's report *Why Call it Care, When Nobody Cares?*, which looks at some key questions which remain to be resolved. For example, when the Green Paper is published, how will it ensure that older people in care are consulted, especially about their unmet care needs? In the interim, will the Government consider additional funding to support the system until the outcomes of the Green Paper can be implemented?

We know about the ignorance of the whole system. Many people are shocked by the cost of social care. There are huge misconceptions about how it is funded and how to access support and deal with the complexity of the system. Earlier this week, Sir Andrew Dilnot spoke at a parliamentary forum that I chair on intergenerational fairness. He reminded us that the increasing number of older people is not at all a surprise. Of the £150 billion spent on older people per year, only £7 billion is on social care. His proposed care cost cap, which would have ensured that people did not face catastrophic care costs, would have cost £2 billion, the same as the cost of the winter fuel allowance. It needs to be reconsidered.

We know that the main difficulty facing this and previous Governments is how to pay for all these things. On fairness grounds, the cost must be spread across all age cohorts, but especially this must now include older people themselves. It could be through an increase in national insurance, whereby older people would no longer be exempt from national insurance payments if they worked beyond retirement age. This would be fair: everybody in paid employment pays national insurance and you do not pay it if you are not in employment.

We know that self-funders of social care are subsidising people who are funded by local authorities. This is a hidden tax which is unfair. The extra funding that the Government have made available to adult social care to date is welcome, but the LGA, of which I am a vice-president, tells me that adult social care faces a funding gap of £2.2 billion by 2020. This must be addressed as an urgent priority. It should ensure that local partnerships with the NHS recognise the vital contribution of adult social care, public health and other key council functions, as well as suitable housing, to achieving improved health outcomes and sustainable services.

Good local public services are the bedrock of good mental and physical health, well-being and resilience. Despite the potential benefits of public health services, we know that local authorities face a £331 million reduction to their public health budget, on top of a £200 million reduction announced in 2015. Almost every service provided by councils has an impact on public health. Reducing health inequalities makes sense at a pragmatic as well as at a moral level, because it can prevent people becoming and remaining ill and reduce the associated costs to local government, the NHS and the rest of government.

Recent research modelling from the International Longevity Centre-UK, of which I am chief executive, explained that, between 2000 and 2015 across the OECD, even after controlling for other factors, health spending positively correlated with life expectancy. Therefore it is safe to assume that the increases in life expectancy seen in the UK in the past 40 years are similarly due to increased health spending. Indeed, between 1971 and 2012, average health spending per person increased by 3.7%, while GDP per person increased by just under 2%. Health spending is also increasing in terms of the total proportion of public spending, increasing its share of overall government expenditure by more than six percentage points over the same period

Last year, the ILC-UK published *Towards Affordable Healthcare: Why Effective Innovation is Key*, a report that concluded that while the UK is well placed to innovate to improve health outcomes and reduce costs, we are often not doing enough with the tools at

our disposal. As it is impossible to control the rate of growth in the economy, or the rate of population ageing, policymakers must concentrate on the residual costs that can be accounted for by policies and institutions, relative prices and technological change.

The ILC-UK report identified that targeted investment to implement and upscale seven systems already in operation in the UK or abroad could save the NHS £18.5 billion between 2015 and 2030. But funding mechanisms within the health system can often discourage targeted investment in innovations and there continues to be a slow uptake in the UK of new drugs and treatment. Speaking of costs, the Select Committee report raised a fundamental question: is it not time to stop increasing spending ad infinitum?

We must also learn from other systems and take them on. No social insurance system is wanted here, but we can learn from such systems because, through them, people know the value of what they get and what they pay for. We can borrow from those systems and learn.

I mentioned those who work paying national insurance, and everyone who puts in an annual tax return of earnings should declare all benefits, including free travel locally, TV benefits, fuel benefits and so on. Perhaps if we pushed that up a notch it would be fair; it would not bring in a lot of money, but it would be brilliant PR for the Government who introduced it and would contribute to free services for all.

Our health system is one of our most-valued services. Let us protect it at all costs and do something about the uncrossable divide between health and social care. These are services for everyone in times of need. Let us value them accordingly.

5.45 pm

Baroness Walmsley (LD): My Lords, as the brilliant Select Committee report makes clear, sustainability of health and social care is mainly achieved by a match between demand and available resources. Whatever funding solution the Government eventually propose, there is always likely to be pressure on money, so two approaches are necessary—to reduce demand and to work more cost-effectively. As my noble friend Lord Willis said, healthcare costs cannot be considered in isolation. Social care and the wider determinants of health, from public health, prevention, education and housing must be factored in. So the issue is much wider than the NHS, although its role in helping to reduce demand by prevention of ill health and developing new models of care is crucial.

The committee was quite right in its recommendation 19: it is essential that social care and health are properly integrated from top to bottom as they are interdependent —and Salford has proved that that works. Social care thresholds are rising but the need remains and is often displaced to the more expensive NHS. That is not clever. As the population ages, and as technology and infrastructure develop and appreciate, funding levels need to be adjusted accordingly. However, it is vital that we get a grip on rising demand, which is not caused just by our ageing population but by our failure to prevent preventable diseases. An eight year-old child wrote to me the other day about the link between child obesity and junk food; he said that we were not preventing preventable diseases, that it was not hard to prevent them and yet we were not doing so, and it was very sad. Well, indeed, it is very sad. The Select Committee was forced to write:

> "We are of the firm opinion that continued cuts to the public health budget are not only short-sighted but counter-productive".

Hear, hear. I strongly support its recommendation 30 that these funds should be restored.

Unless we put more effort into prevention of ill health, the burden of disease and demand for services will continue to rise. The committee pointed out that 89% of deaths in the UK are caused by cardiovascular disease, cancer, respiratory disease and diabetes. Many of these diseases are caused by lifestyle choices, such as poor diet and sedentary lifestyles, alcohol abuse and smoking. In recommendation 29, the committee proposes a nationwide campaign to highlight the problems caused by obesity, particularly among children. I hope that my speech on child obesity last week indicated how much I support that. I welcome the fact that the chef, Hugh Fearnley-Whittingstall, has already started that nationwide campaign with one city, Newcastle-upon-Tyne, as the noble Lord, Lord Rea, pointed out.

Many diseases are also caused by the social determinants of health, poverty, poor housing and poor air quality, which can shorten life in poor areas by as much as seven years, according to Professor Michael Marmot. This shocking health inequality is not social justice and must be addressed.

The five-year forward view called for a radical upgrade in prevention and public health and yet, in recent years, as many have said, we have seen a 30% cut in spending on these areas. Hard-pressed local authorities cannot subsidise public health. The Select Committee makes it very clear that this must change. What are the Government going to do about it?

People must take some responsibility for their own lifestyle choices, but we must not continue to rely on the NHS to fix it when we make the wrong choices. To make the right choices, we need information and help from public services that have now gone. However, people are not responsible for finding themselves in poverty or for living in areas with terrible air quality and poor access to healthy foods, as Hugh Fearnley-Whittingstall discovered.

The Government cannot rely on food retailers to take responsibility for this, but they do have a role to play. I welcome the recent initiative by Waitrose to introduce healthy eating specialist advisers in some stores—although it must be pointed out that Waitrose stores are not usually to be found in the poorest areas of the country. I congratulate those food manufacturers which have already reformulated their products to reduce sugar, salt and saturated fat and to reduce portion sizes but, as the noble Lord, Lord Rea, said, there is still a very long way to go. What plans do the Government have to learn from the response of sugary drink manufacturers to the threat of the mandatory sugar tax?

There is also enormous potential for technology and innovative treatments. The committee's recommendations 24 to 28 encourage this, which I support. Where I live in Wales, we do not have access to some of the new

[Baroness Walmsley]
tests and treatments available to noble Lords who live elsewhere in the country. It is a postcode lottery, which is the responsibility of the Welsh Labour Government. I say to the noble Baroness, Lady Meacher, that we are also about to lose the only GP practice in our large village of 4,000 people. Although I have often had to dial 50 times before getting through to make an appointment, I will miss it. I hope that my husband and I will not find ourselves sitting for over four hours in the A&E department of our local hospital as a result of the withdrawal of our valued primary care, so I agree with the committee's recommendation for a review of the business model of primary care.

5.51 pm

Lord Suri (Con): My Lords, this is a valuable and important report, which gets to the issues that we must start to grapple with if we want a decent National Health Service to hand over to future generations. The noble Lord, Lord Patel, and the committee he leads have done an excellent job and his vast experience in the NHS has clearly shaped the recommendations that it makes.

I have often been a critic of the way some departments are structured and how spending is delivered to priority areas. It often seems to me that government struggles with long-term funding for areas that are not specific projects with their own funding framework. This report picks up on an endemic culture of short-termism in the NHS. From adult social care to the public health budget, those responsible are sometimes more concerned about next year's figures than the overall picture over the medium term. This is not to disparage the excellent and valuable work of all our NHS staff, but is rather a reflection on the current NHS structure. I am therefore heartened to read about the five-year plan proposed for NHS funding.

In any business or service, planning year-by-year would be seen as inefficient practice, especially so when the recipient is being treated over a far longer period. In my view, the greatest current failing of the entire system is in adult social care. The fact that adult social care falls to local councils is a consequence of the Poor Laws and the end of workhouses, and seems outdated in the current context. Delayed discharges are one of the most significant factors that put pressure on the health service, but a lack of joined-up thinking and planning makes it harder for an effective policy solution to be found, although I welcome the additional £2 billion earmarked in the Spring Statement. Councils are not naturally suited to managing complex residential needs, and the obvious overlap between recipients of adult social care and NHS services suggests wide scope for efficiencies to be found. If not a full merge, some sort of shared responsibility must be a top priority, and I am glad the Minister has committed to such a policy.

One area that concerns me is the lack of engagement with the public for some of the new sustainability and transformation plans. Local communities deserve and ought to receive proper consultation on transformations to services in their areas. Failing to engage meaningfully is an own goal when communities are willing to help and can provide valued input or insight. STPs have no statutory footing, which is part of the problem. A statutory duty to engage local authorities at all stages of the planning process seems a sensible update to the existing framework. Do the Government have any plans to place the STPs on a statutory footing, and if so, will there be a duty to seek engagement from local stakeholders?

Finally, I am glad that the Greater Manchester agreement will allow for some experimentation in what works in social care. Devolution allows greater flexibility and allows us to see what works best. I hope that this new partnership finds some ways to make social care more efficient, and that any lessons learned are recognised at the national level.

5.57 pm

Baroness Hollins (CB): My Lords, unlike the noble Lord, Lord Saatchi, I cannot see into the future, but I remember the past. In 1980, when I was a senior trainee in psychiatry, the Reith lecture series was given by Sir Ian Kennedy, who addressed the fundamental problems with healthcare in this country at that time. High among the problems he identified was the value we place on acute hospitals. He argued that prevention was always better than cure but that, unfortunately, spending was always on cure, not on prevention. That was 38 years ago, and despite numerous transformations in the NHS, we are still having the same debate and reaching similar conclusions today. The noble Lord, Lord Prior, commented earlier that too little attention has been paid to prevention in the last six years. I suggest that it has been longer than that.

A consensus is forming today around the need for a more coherent and non-party political long-term strategy, with more robust community healthcare, social care alongside healthcare, and for the same value to be given to mental health as to physical health. In paragraph 34 of this game-changing report, the Royal College of Nursing is quoted as saying that we must consider health and care services and budgets as "fundamentally connected and interdependent". However, we also heard today about the gap between these aims and what is actually happening on the ground.

I worked as a psychiatrist in the NHS for over 30 years, and will focus my remarks on my own areas of expertise in mental health and learning disability. These services should be at the vanguard of a new sustainable health service. Most practitioners in mental health work in community settings rather than hospitals, and I recall from my own practice my team's endeavours to prevent the admission to hospital of people with learning disabilities who also have mental health problems, unless absolutely necessary for short-term specialist intervention. The services I developed and had the privilege of working in had close links to social care, with workers working alongside mental health and learning disability workers in community teams. They worked with some of the most vulnerable, isolated people in society who not only struggled with their mental health but had poor physical health outcomes and died much younger than their non-disabled peers. Such close working seems less possible today.

The learning disability Transforming Care programme is due to end in March next year without having changed the all-too-common factor of a one-way hospital

admission in crisis being the only option available. I left the debate briefly today to discuss the case of a young autistic man who has spent the last nine years in a private psychiatric unit. He was detained under the Mental Health Act on grounds of learning disability and aggressive behaviour. A recent attempt under the Transforming Care programme to discharge him unfortunately resulted in readmission after only three months. This was because of inadequate support in the community. Funding disputes were central to that failure. The social care support provider has still not been paid a penny, and the local NHS failed to take any responsibility for him. This local failure, still repeated around the country, is priming a boom in private hospital care, costing the NHS as much as £8,000 a week per person. Long-term admissions are good for business but not good for patients. I conclude from this that the barriers within the bureaucracy currently in place are making it well-nigh impossible to provide skilled, effective personalised care for people like the young man I have mentioned.

The Royal College of Psychiatrists highlights that, despite the Government reporting "record" levels of mental health spending, mental health NHS trust income is lower than it was in 2012 once inflation is taken into account. Referral numbers are going up, while the ability of trusts to provide services is going down—the exact opposite of a sustainable system, despite a more confident and competent discourse about mental health and the promised commitment to parity with physical healthcare. According to a freedom of information request reported in the *Independent*, nationally 50% of clinical commissioning groups say that they are planning to spend less of their total funding on mental health during the current year. How can this be right?

Funding is now so complex that it is difficult to track how national priorities are being translated locally. In any new long-term funding plan for the NHS, new money must not simply paper over the cracks in the current crisis, shifting the problems just five years further along into the next electoral cycle; nor must the money be sucked into acute hospitals, in keeping with practice over the last 40 years. Instead, it must be distributed with a focus on prevention. Funding for mental health services must be ring-fenced. Most importantly, social care should share in the benefit from any extra resources. The Association of Directors of Adult Social Services is calling for parity of esteem for the social care workforce. Its chair wrote that it is a source of shame that this is a minimum wage workforce and asks for serious consideration to be given to regulating the care workforce and to investing adequately in it.

I commend this important report. I also commend my noble friend Lord Patel for his leadership and, in particular, for his call for better health and care outcomes for everyone, including the young man whose shocking case I described earlier.

6.03 pm

Baroness Jolly (LD): My Lords, I join all Members in the House today in congratulating the noble Lord, Lord Patel, and his committee on an excellent report, which came with a list of three dozen recommendations. I also share the anxiety expressed by some Members of the House about the quality of the government response. To wind up this debate is difficult because it has been so rich. People have brought to it their personal experiences as clinicians, as experts and even as patients. That has made the debate very broad so I shall try to narrow my remarks to just a few areas.

When the NHS was formed, in 1948, no one could foresee a world in which people were living longer and much care was taking place outside of hospitals. To tackle the demands facing our health and social care sectors today we need still to innovate and change and to develop a patient-centred model of care. In recent years, the NHS has halved the number of hospital beds, and it is estimated that with more efficient care half of patients currently in hospital could be treated at home or within their community.

Much has been said about joint working and integrated care, and here technology can really help. I think the noble Baroness, Lady Redfern, was the first person to mention data. Having common datasets by which NHS computers can talk to social care computers was seen as part of the solution to this very problem of integration when I first became involved in the NHS, 20 years ago. As an aside, my noble friend Lord Rennard might wonder why the NHS uses a fax machine to talk to itself but apparently security is the issue: it is the most secure way of communicating between NHS establishments and regular telecoms are not up to the task. We need systems that work together to smooth the transition from primary care to hospital to social care services, and reduce cross-referrals and delays—the bumpy departures and landings to which the noble Lord, Lord Carter of Coles, referred. I hope the Minister will be able to give us some indication in his summing up of where we are with this particular piece of the integration jigsaw and other ground-breaking digital innovations.

To do all this, we need money. To have care that is oriented towards the future, we must have a properly funded and integrated framework for health and social care. This is to be seen not as government expenditure but as investment. There will be payback: in increased efficiency, better care and improved patient satisfaction. Both health and social care have suffered from ebbs and flows of funding depending on the direction of the political wind, and we must endeavour to change that. In the social care sector alone, real budgets have fallen by nearly a quarter and brought the sector to near collapse, while in the NHS hospitals are overstretched and underprepared to combat the annual winter crisis, which seems to be all year round. The noble Baroness, Lady Watkins of Tavistock, reminded us that social care involves not just old people. It includes people with a disability, whether it is a learning disability or a physical disability, and, as she mentioned, children. Both systems are in need of rescue and reform in order to serve future generations. Without proper funding levels, we cannot expect to effectively implement cost savings that would arise from the integration of care services, and we run the risk of seeing money targeted for innovation and changes to our services go towards merely keeping our NHS afloat.

At the local government level, council taxes are at the highest levels that could realistically be sustained, and the opportunity to add a discretionary amount for

[BARONESS JOLLY]
social care is now widely acknowledged as a flawed policy. The challenge at local government level is commissioning. A move to outcomes-based commissioning is slow to be embedded but would bring transformational change to service delivery. An example of that came in the debate today from the noble Lord, Lord Colwyn, who is a dentist. I did not expect such an example to come from the area of dentistry, but he made the point perfectly that if you commission for outcomes, you will get a better service.

Sustainability and transformation plans should prepare our system for the future and should be given the financial investment needed to see services change with the times and produce quality results for patients.

We on these Benches believe that proper NHS funding can be accomplished through bringing our health expenditure in line with other nations and by providing a ring-fenced integrated budget for health and social care that would be kept separate and defined for a 10-year period. This would allow the NHS, care providers and local communities to prepare for long-term needs, together with a plan that they can implement. It would remove short-term thinking on health and social care budgets and create a sector that is looking forward to the future instead of being occupied with daily crises.

The noble Lords, Lord Kakkar, Lord Willis, and Lord Carter, and the noble Baroness, Lady Finlay, and many others, mentioned the acute workforce shortage, which must be the single greatest threat to our health sector. To begin solving this we need to train new workers while protecting the immigration status of foreign-trained staff already here. As we come up to 70 years, we must also acknowledge our debt to the Windrush generation—the people who came from across the Commonwealth to help us set up the NHS to become what it is now.

In order to have a functional health and care service we must continue to support health and care workers, who will be absolutely critical to the way we work in any future model of care. I welcome the Government's shift on nursing pay, but in the current climate perhaps the Chancellor might consider a further uplift.

Health and care workers feel the pressure of caring for an ageing population and have remained committed to giving their services, even in the face of long hours and stagnant wages. In the long run, however, this will not be sustainable. The health and social care workforce is facing a tremendous gap in the number of workers, which we urgently need to address.

The noble Lord, Lord Willis, mentioned nursing associates. Before this debate I was speaking to members of a delegation from Kent. They were anxious about the nursing crisis in Kent. They mentioned nursing apprenticeships and asked me whether I was aware that there were no nursing apprenticeships at all in Kent. I confessed that I was not aware of that. Can the Minister give some indication of the uptake of nursing apprenticeships, and of the number of nursing associates, in England?

It is time to consider care work as a profession, which may well include regulation. For the most part, care workers work on the basic minimum wage. They often train in their own time and at their own expense and work unsocial hours with a difficult client group. They can always go to the supermarket and work for the same number of hours with less hassle—but they do not. They have a commitment and a love of the job and, as a society, we take advantage of that. So I hope that the Green Paper, in addressing the cost of care, will look at a model where their commitment and professionalism are recognised. We can then work to attract new care workers through providing regular performance-related pay rises and flexible working conditions to those who need them. Will the Minister tell the House how his department is involving partners in the preparation of this Green Paper and who represents the voice of the care workers? I would be grateful if he told me it is not care providers.

The picture with doctors is not hugely better than that for nurses. Yesterday, many of us received information from the Royal College of Paediatricians expressing alarm at the number of doctors on duty at any time. Nearly three-quarters of all medical specialties had unfilled training posts in 2016, with the number of applications to our British medical schools decreasing for the third year in a row, and by more than 13% since 2013. Fewer trainees are moving directly into speciality training, instead choosing to take a career break. Will the Minister give an indication of the attrition rate at this stage? What remedies are being considered to keep these hugely expensive to train professionals in the UK at the early stage of their careers?

This has been an excellent debate on an excellent report. I hope that as a House we will continue—I am sure we shall—through questions and debates to understand the Government's thinking and to influence their direction in this area.

6.15 pm

Baroness Thornton (Lab): My Lords, I first congratulate the noble Lord, Lord Patel, and his committee both for the excellent report we have been discussing and for persisting in pushing the Government to respond—a response, I think, which merits a C-plus perhaps, although my noble friend Lord Hunt thinks that is generous, and was late and could do better.

I declare an interest as a member of a CCG. In that part of my life, I am what noble Lords might call "up close and personal" with the results of the reforms of the noble Lord, Lord Lansley. I witness a great deal of great work, often in spite of the heavy hand of NHS England and our swingeing QIPP. In many ways, the report gladdens my heart.

I thank all noble Lords for their contributions, particularly my noble friends Lord Hunt and Lady Wheeler. As I said, the report is excellent and there is much that we can agree about in it. As the noble Baroness, Lady Finlay, said, it is a birthday present to the NHS from the noble Lord, Lord Patel, and the House of Lords—or perhaps it brings a new dawn to the NHS, as my noble friend Lady Pitkeathley put it.

I was struck by many excellent contributions today, such as that of the right reverend Prelate and his comments about an office for health and care sustainability. That idea is definitely worthy of consideration, and the recommendation did not deserve the dismissive response it received. I think that I would support it, but only if

we can get rid of some of the other bodies that this report suggests are not necessary. My noble friend Lord Turnberg and other noble Lords have urged the Minister to be bold and think the unthinkable. I definitely look forward to him doing so.

In his plea to integrate academic medicine into our hospitals, my noble friend Lord Winston told me something that I did not know, as he always does. It often shocks me when I realise that what he is saying is true. I look forward to the Minister's response to what he had to say.

The noble Baroness, Lady Finlay, and my noble friend Lord Carter made powerful contributions about the workforce in their different ways.

The noble Lords, Lord Kakkar, Lord Willis and Lord Saatchi, and the noble Baroness, Lady Tyler, talked about cross-party consensus. I need to respond to them. If I might put it like this—certainly to the noble Lord, Lord Kakkar—we could look at this in a different way. There is a great deal of agreement on many matters that we discuss. We all agree about the need for a preventative, not an illness-based, NHS. We all agree about patient safety, primary care and many other matters. Indeed, we in this House spend our lives finding agreement on how to proceed and what we might do.

The best way I can put it is that this problem is about trust. It is not only we on these Benches who struggle with trusting this Government. That lack of trust is based on solid experience of things such as the Dilnot report, but the state of the NHS is also the single biggest issue vexing Conservative voters, with more than seven out of 10 of them citing their concern in January this year. Notwithstanding my noble friend Lord Turnberg's support for the Secretary of State, fewer than four out of 10 Conservative voters thought that the Secretary of State should keep his job. The polling shows, as did the last election, that there is a problem with trusting this Government on the NHS.

The noble Lord, Lord Willis, should remember that his party was decimated in 2015, partly because of that trust. It is a problem that all political parties face in this country. It is to do with not just this issue, but the way we run our country. We need to contemplate and think about that issue, because it is obviously a very important one regarding how we proceed and build consensus about our National Health Service.

My intention is to speak about social care and the crucial issue of integration, which is so central to this report. As the report indicates, all the investment we might want to put into the health service will not work if we do not also deal with social care. I know from personal experience, both as a carer for my mother and as a CCG member, how complex it is to achieve integration, but there are, as many noble Lords said, examples of really great integration programmes going on at local level, with local leadership and innovation. My question to the Minister is: how can the system learn from that? Many of us have posed that question over many years. How can we replicate the systems that work?

Today, we see the announcement from the think tank the IPPR, which now seeks also to address the issues of the long-term future of our health and social care system, led by my former boss and noble friend Lord Darzi and the noble Lord, Lord Prior, also a former Minister, whose contribution about the fragmentation of the NHS I completely agree with. We should welcome this report and the consideration because it is being led by two very experienced former Ministers. I am sure it will look at the huge challenges that the health and social care system faces: the re-emergence of rationing and waiting times on the rise; deteriorating finances, with the zigzag that the noble Lord, Lord Warner, talked about on funding; demoralised staff, referred to by my noble friend Lord Carter; and all the issues that come with Brexit.

As many noble Lords have said, the future of the NHS and of social care are inextricably linked. A sustainable NHS is predicated on a sustainable social care system. My noble friend Lord Rea said that even better than I could. These are enormous questions about how the health and social care system can succeed in an age of rising demand and take advantage of new technology, and how to truly integrate health and social care systems.

How can we deliver parity of esteem for patients receiving support for mental health problems and join up health and care around those patients, as my noble friend Lord Bradley explained with great eloquence? If I have a particular criticism of the Government's response, it is that it was not robust enough at all on mental health.

Next year we will celebrate the 70th anniversary of the founding of the NHS. The health and social care system deserves a secure future that gives us confidence that it will celebrate its centenary in a little more than 30 years from now. The noble Baroness, Lady Watkins, is right: we need to take a 30-year perspective on this.

I need to comment on the idea of a royal commission. The Government have promised us a Green Paper. Since the royal commission on social care and long-term funding for older people first reported in 1999, we have seen 12 consultations and four independent reviews. With the Government undertaking yet another consultation and producing yet another Green Paper, the question is whether it will lead to action. Some £1 million was spent on the Dilnot review, only for the Government to delay the introduction of its recommended care cap before shelving it indefinitely. The Government are wasting time and public money on consultations. How can we have confidence that a royal commission will be any different? I do not think we can, or that we can wait for a royal commission to be established. I say to the noble Lord, Lord Saatchi, that we on these Benches would take some convincing that this is a sensible way forward.

We should be calling for social care to be placed on an equal footing with the NHS, rather than being an adjunct. We need care and health operating as one—locally led, focused on prevention and person-centred. It is social care that keeps people out of hospital in the first place and takes the pressure off the NHS. Delayed discharges are a good example of this, as was explained by the noble Baroness, Lady Greengross.

Are the Government going to give equal priority to social care and mental health? Will the Minister answer the questions, posed by many noble Lords, from the

[Baroness Thornton]
excellent Age UK briefing? It asks when the social care Green Paper will be published; how the Government will ensure that older people in care are consulted properly; and whether the Government will undertake—as my noble friend Lady Pitkeathley and other noble Lords outlined—to make sure that people understand what the cost of social care will be to their families.

In conclusion, the Government should return to this report and take a better look at it. This is one of those occasions where we should give them back their homework and say, "Have another go at this", because the report is full of great suggestions and recommendations and the response is not great. The long-term sustainability of the NHS and adult social care deserves a great response.

6.25 pm

The Parliamentary Under-Secretary of State, Department of Health and Social Care (Lord O'Shaughnessy) (Con): My Lords, I begin by congratulating all noble Lords on a debate that has been truly epic: in subject matter, in content, in form, in the heroic contributions—not just in this debate but also from those whom we laud in the health and care services—and in length. I am conscious of the need to give a fitting denouément to such a debate, and I hope I will do it justice.

Before dealing with the content of the report and the many excellent questions from noble Lords, I will say four things. First, I thank and congratulate the noble Lord, Lord Patel, and the entire committee on an excellent and far-sighted piece of work. My noble friend Lord Ribeiro called it a landmark. The noble Baroness, Lady Hollins, called it game-changing. It is a very far-sighted piece of work. Indeed, some of the very important recommendations in it—the addition of social care policy back into the department, the commitment to a long-term funding settlement, and a workforce strategy—are not small suggestions, but those have all been taken up by the Government since the publication of the report.

Secondly, I apologise yet again for the unacceptable delay in our response. It was not good enough. I apologise, too, to my noble friend Lord Saatchi for the jargon in it. It is a jargon-ridden industry, as he knows, although I do not think that his quote was a direct quote. I hope not. I would say only that he should have seen the first version.

Thirdly, I reaffirm the commitment of this Government to a world-class NHS free at the point of use, with access based on need. My noble friend called the NHS a remarkable institution, which indeed it is. The noble Baroness, Lady Masham, called it our most important insurance policy. We are also committed to a social care system that provides good-quality care and is based on a fair and mixed model of funding. I think that all noble Lords would agree with those commitments; we know that compassion is not the preserve of one political party or another.

The fourth, and in some ways most important, thing is to express my gratitude and admiration for those who work in the NHS and care services—among the most-loved people in our country, as my noble friend described them. I want to reassure the noble Lord, Lord Kakkar, that these people, who serve us through their lives wherever they were born, will be at the heart of the celebrations for the NHS's 70th birthday party. I also want to join the noble Baroness, Lady Jolly, and others in paying tribute to the many migrants—150,000, I believe, including the Windrush generation—who make such an important contribution to our national life.

As many noble Lords have pointed out, the NHS and adult social care systems face unprecedented challenges due to the ageing and growing population. These challenges are not unique to this country but common among developed economies. The noble Lord, Lord Warner, described it as tsunami of rising demand. It is worth pointing out, as did the noble Lord, Lord Patel, that the Commonwealth Fund has ranked the NHS as the overall best-performing health system for the second time in a row, but I accept his criticism, which is entirely fair, that we need to do better in achieving world-class outcomes.

I will deal now with the six main chapters in which the report is structured. The first is service transformation. The report says:

> "Service transformation is at the heart of securing the long-term future of the health and care systems"—

and we quite agree with that statement. At the heart of the integration of those two systems are, of course, the sustainability and transformation partnerships. I reassure the noble Lord, Lord Willis, and the noble Baroness, Lady Wheeler, that we have not abandoned these plans—quite the opposite. We are investing in them like never before, with more than £2.5 billion of capital. However, I take on board the comment of my noble friend Lord Suri about the importance of engaging with communities in these transformation programmes because, if we do not bring people with us, change will not be supported.

We are also trying to improve integration between the NHS and local authorities in social care through the better care fund, which is now pooling more than £5.5 billion into the provision of integrated care. Bringing those two subjects into departmental policy-making is critical for the future.

Several noble Lords pointed out the panoply of arm's-length bodies that exist in this space, but I can reassure the noble Lord, Lord Bradley, and others who asked about it that regulatory integration is going on. NHS England and NHS Improvement are working more closely than ever, and our mandate to the NHS and the remit letter to NHS Improvement were published together for the first time ever last month. I also assure noble Lords that we are able to achieve these changes without the need for primary legislation. The noble Baroness, Lady Thornton, the noble Lord, Lord Carter, and my noble friend Lord Prior asked about our commitment to integration. It is absolutely there in our strategy, along with a commitment to more integrated care systems. These are already demonstrating big improvements in the delivery of care in community settings, which is of course not only better for people's care but more cost-effective.

I also reiterate our commitment to publishing our social care Green Paper by this summer. It will set out our plans to tackle care and support for older people and the challenge of an ageing population, but we are

deeply conscious, as the Prime Minister and the Secretary of State have said, that changes to social care and the NHS need to go hand in hand.

The noble Lord, Lord Kakkar, wisely pointed out that consensus is needed not just on funding but on service transformation. It is incumbent on all parties to look to their own political tactics, particularly as we face the local elections next week, and ask honestly whether we are prepared to be part of that consensus. There are clear benefits to be derived from the rationalisation of services. The noble Lord, Lord Rodgers, and the noble Baroness, Lady Wheeler, talked about stroke services, where centralisation has helped. I think that 84% of stroke patients now spend the majority of their hospital stay in a specialist stroke unit, compared to 60% in 2010. There is clearly more to do and I will write to the noble Baroness with more detail on the stroke action panel.

We see fantastic examples of integration happening on the ground. The noble Lord, Lord Turnberg, and the noble Baroness, Lady Walmsley, talked about the work of Sir David Dalton and the Northern Care Alliance, which I have visited in Manchester. I have spent time with David and the alliance truly is a model for integration that we want to push, through the five-year forward view.

Many noble Lords, including the noble Baronesses, Lady Meacher, Lady Finlay, Lady Murphy and Lady Tyler, my noble friend Lady McIntosh, the noble Lord, Lord Rea, and my noble friend Lord Bridgeman all talked about the importance of primary care. The Government completely agree about the importance of good quality and good funding for primary care. Primary care funding is increasing in real terms over the spending review period. There are more nurse training places, as we discuss often in this House, more GP training places and a commitment for 5,000 extra staff in GP surgeries. This Christmas we saw, for the first time, GP services running 8 am till 8 pm seven days a week, to support people during winter. This is all about keeping people out of acute care wherever possible.

My noble friend Lady McIntosh asked in particular about rural coverage. I can tell her that a full review of the Carr-Hill funding formula, which affects allocations for surgeries across the country, will take place shortly. I believe that a review on that will be published next year.

I would like to take a moment to congratulate the noble Lord, Lord Carter, on his exemplary work in improving productivity and reducing variation. He is somewhat of a legend in the service, it has to be said —so much so that he even has a programme named after him. It is impossible to have a meeting without a reference to the Carter programme. I see that the noble Lord is smiling.

There are things such as the getting it right first time and model hospitals programmes, which my noble friend Lord Prior mentioned, and we are now applying some of these technologies to the better use of medicines as well. The noble Lord, Lord Carter, also talked about delayed transfers, as did the noble Lord, Lord Loomba, the noble Baroness, Lady Greengross, and my noble friend Lord Suri. Over what was a difficult winter we saw some improvement in delayed discharge, but we know there are still thousands of people who are medically fit to be discharged and should not be in hospital, and we need to get more of them into a social care setting.

Turning to the workforce, the report states:

"Those who work in the NHS and adult social care are the lifeblood of the organisations they serve".

We completely agree that these people are the best asset we have. The Secretary of State announced in March a three-year pay deal for those employed under the agenda for change pay contract, which we hope the unions will agree. It will help our plans for retention. We have recently carried out a public consultation on adult social care to gather greater evidence of how we can recruit to that workforce. That has to go hand in glove with recruiting into the NHS.

Following the committee's report, one of the great achievements has been Health Education England's draft strategy for a 10-year workforce plan. As the noble Lord, Lord Willis, said, it is probably 25 years overdue, but it is important in that it sets out for the first time the idea, particularly for the lower-skilled workforce, of having a career that spans social care and allied health professions. Bringing together those workforces is surely critical to delivering integrated care.

In order to retain our staff we need to make sure they are treated properly. The statistics about harassment have been mentioned. It is completely unacceptable. The noble Baroness, Lady Watkins, and the noble Lord, Lord Parekh, mentioned it. We are making some changes to try to improve the well-being of staff, including more flexible working, greater support through nursing associates, the new homes for nurses programme and tackling bullying.

As the noble Baroness, Lady Meacher, and my noble friend Lord Sterling pointed out, it is equally important to address the blame culture. We are trying to get away from it through the learning from deaths programme and rapid resolution and redresses processes so that we can create a culture of learning rather than blame from when things go wrong.

There is a chapter in the report on funding. I shall deal with funding in two ways: short-term funding, if you like, and longer-term funding issues. We of course agree with the committee about the need to provide further funding between now and 2020. Noble Lords will know that we have backed the NHS forward view with an extra £10 billion by 2020-21, and the NHS was given additional funds in the Autumn Budget and more in the Spring Budget. We have also announced more than £9.4 billion extra dedicated to social care funding over three years, so we recognise that there has been a short-term need, regardless of what happens in the long term, to put more money into the health service and social care—but I accept the challenge from all noble Lords that a long-term settlement is needed, and I will return to that subject.

The committee's report says:

"The Government should make it clear that the adoption of innovation and technology, after appropriate appraisal, across the NHS is a priority and it should decide who is ultimately responsible for this overall agenda".

The noble Lord, Lord Winston, pointed out that many of the most impactful health innovations have come from the United Kingdom, and we agree that

[LORD O'SHAUGHNESSY]
the NHS should be investing in and adopting new technologies. As my noble friends Lady Bloomfield, Lady Redfern and Lord Saatchi, said, uptake can be too slow. We are trying to address this through the life sciences industrial strategy and our response to the accelerated access review. We are investing in better digital and data infrastructure through things such as the global digital exemplars as well as providing support directly to SMEs to help them bring their innovations into the system. I now chair a new data strategy board, which is trying to bring our data infrastructure up to date. We plan to launch an NHS app at the end of this year to have more patient-focused digitisation and are creating the first local health and care records, which will provide across every health and care record dataset—believe me, there are a lot—the opportunity to link up data for direct care, which we will then build on through digital innovation hubs to provide that kind of dataset for research purposes. I hear over and over again that this is one of the unique opportunities that the NHS and Britain have because of the way our health and care services are set up.

My noble friend Lord Prior, who knows much more about these issues than I do, asked about the role of the NHS in supporting life sciences. He is quite right to say so. I would choose one example, the world-leading 100,000 Genomes Project. We are genuine world leaders in genomic medicine. It is now moving out of the research realm and this year we are setting up for the first time an NHS genomic medicine service, which is a great example of collaboration between the science base and the NHS. I was glad to hear my noble friend Lady Bloomfield's personal positive experience of this kind of partnership. However, it is worth saying, possibly in typical fashion, that we have too many programmes in this area that need to be rationalised. I asked my team to have a look at it about six months ago with the Office for Life Sciences, and there are 38 programmes supporting innovation across six agencies, possibly not adding up to the sum of their parts although spending £750 million. I am very focused on making sure that money is spent more rationally and with greater effect.

One of the ways that that will happen, as the noble Lord, Lord Winston, was quite right to highlight, is through the academic health science centres and academic health science networks. We have just recommissioned the academic health science networks. I intend to do the same for the AHSCs as well but I wanted to ensure that they are fully integrated into the innovation review we are carrying out internally. It is deeply important to me that Imperial does well because all my babies were born at the Queen Charlotte's and Chelsea, which I believe is a stone's throw away from the noble Lord's office.

My noble friend Lord Saatchi asked about the commencement of the provisions of his Act. He will know that it is something I am looking into at the moment and am not able to give him the commitments he is looking for. He knows I was not Minister at the time but I can tell him that this is something that is taking my attention, and I will write to him on that topic.

Many noble Lords emphasised, probably more than any topic other than funding, the importance for public health of prevention and patient responsibility. Indeed, the report called for the Government to be clear with the public that access to the NHS involves patient responsibilities as well as patient rights, a point emphasised by the noble Baroness, Lady Walmsley. It is undoubtedly the case that a healthy population is key to the sustainability of the NHS and many noble Lords, including the noble Lords, Lord Ribeiro, Lord Rea and Lord Rennard, have pointed out that tackling obesity is a great challenge. We have launched a childhood obesity plan. One of the major aspects of that, which has been commented on in this House today and on other days, is the impact of reducing sugar in soft drinks as well as a comprehensive sugar reduction programme. I am delighted that we will perhaps be able to relay to the young respondent of the noble Baroness, Lady Walmsley, that this is a preventable disease and we are trying to prevent it. It seems to be working, and there is cause for young people to have hope.

We are going to publish all the data and research that informs our plans, so that it is open for scrutiny. We are committed to considering whether sufficient progress has been made and whether additional policies are needed, whether in the form of advertising bans, statutory regulation or, as my noble friend Lord Ribeiro said, more bariatric surgery. We accept that we need to get a grip on this crisis, and we will take further steps if the ones we have taken so far have not worked.

It is worth addressing public health spending, which noble Lords have mentioned. We know that it came under pressure—there is no hiding that—as we made difficult decisions on coming into government in 2010. However, the 2015 spending review made £16 billion of funding available for local authorities over five years and, as the noble Baroness, Lady Masham, the noble Lord, Lord Rennard, and others have said, it is important that this public health funding, as well as other social care funding, must increasingly focus on keeping people independent in their own homes.

Many noble Lords—the noble Earl, Lord Sandwich, the noble Lord, Lord Rodgers, Lord Bradley and Lord Cotter, and the noble Baronesses, Lady Tyler, Lady Hollins and Lady Thornton—have talked about mental health and parity of esteem. We have legislated for that, of course, but that is not the only way in which we shall achieve our aim. There is increased funding. The mental health investment standard will be compulsory this year for CCGs. We are recruiting more staff and reducing out-of-area placements. We have the first waiting time standards and are extending those to receiving treatment. Making sure that those services join up around the sufferers of mental illness is critical, and we know that the Prime Minister has a deep commitment to that agenda. I accept that we need to do more and to go faster but, unfortunately and sadly, we are starting from a very low base.

The noble Baroness, Lady Finlay, raised the important issue of screening, diagnostics and staffing in radiology and pathology. This is one area where we can use technology. Indeed, the life sciences industrial strategy and sector deal committed us to use AI—another topic of conversation in the Chamber today—to transform radiology and pathology.

My noble friend Lord Farmer rightly highlighted the importance of family breakdown. He has been an ardent proponent of these issues. There is a focus on the role of families in the mental health Green Paper, but I always accept his pressure to do better. My noble friends Lord Colwyn and Lord Ribeiro talked about the importance of dental care and oral health. Actually, access to NHS dentistry is rising and the number of decay-free five year-olds is at its highest level, but I accept that this is something that we need to do more on, and I hope that our sugar reduction plans will help.

The noble Baroness, Lady Masham, my noble friend Lord Ribeiro and the noble Lord, Lord Brooke, talked about alcohol. I think we can take confidence from the benefits of the action taken to reduce smoking, and we are looking carefully at the minimum unit pricing scheme as it is implemented in Scotland, because we accept that there is powerful evidence in its favour.

I say to the noble Lord, Lord Cotter, that I will investigate the hospital closure he mentioned. My noble friends Lady Redfern and Lord Ribeiro asked about the bowel screening programme. The intention is to roll it out from this autumn.

The final section is headed "Towards a lasting political consensus"—leaving the best till last, perhaps. As the noble Lord, Lord Rodgers, reminded us, attempts at national consensus have eluded many Governments since the 1970s. The noble Baroness, Lady Pitkeathley, rightly encourages us to be bold. The Prime Minister is being bold. She recently announced a plan to come forward with a long-term funding settlement for the NHS, so that we can avoid what my noble friends Lady Redfern and Lord Prior called the feast and famine approach. I congratulate my noble friend Lord Prior on his work and that of the noble Lord, Lord Darzi, on the IPPR report published today. The Government have been working with NHS clinicians and experts, of course, but also with stakeholders—users, patients and carers—and I can tell the noble Baroness, Lady Pitkeathley, that my letter to her will be with her on Monday and we will publish our action plan on carers in the coming weeks.

I think the ultimate purpose of the report of the noble Lord, Lord Patel, is to build a political consensus. If there is one area where I share the concern of the noble Lord, Lord Hunt, and the noble Baroness, Lady Thornton, it is about a royal commission. I am not sure we need another one. As the noble Lord, Lord Hunt, said, what we need is leadership and consensus, but I thought we saw perhaps a glimmer of the future approach that the Labour Front Bench might take—I hope it is not true—of not wanting to be part of that consensus. I think the noble Baroness was keen to dispel that impression, and I hope that the Labour Party will join us in this process, but I accept that it needs political leadership from the Government of the day.

I have to deal with the proposal in the paper for an office of health and care responsibility, strongly pushed by the right reverend Prelate the Bishop of Carlisle, the noble Lords, Lord Taverne and Lord Rea, and the noble Baroness, Lady Thornton. The OBR, on which it is modelled, evolved from the Institute for Fiscal Studies, so perhaps the first stage to getting such an idea off the ground is to establish it as an independent health economic body outside government.

On funding and taxation, the noble Lord, Lord Layard, whom I know and admire, made a compelling argument for the benefits of a sophisticated form of hypothecation and the happiness that would come from such action. The noble Lord, Lord Desai, called for a softer version of such an approach.

Many noble Lords talked about what they felt was the willingness of older people—people over retirement age—to contribute, whether via national insurance or forgoing a winter fuel allowance. Many noble Lords used the phrase "intergenerational fairness". I tell them without, I think, overstepping my brief and getting into Treasury territory, that to someone in this perhaps younger corner of the House that seems quite appealing, and I shall make a very personal case to the Treasury to consider it. I think it is representative of older generations' willingness to contribute to the financial sustainability of the NHS. It is also important, as the noble Baroness, Lady Pitkeathley, and the noble Lord, Lord Desai, said, to make sure that we prepare people for the costs that will inevitably come their way in the social care system, which will continue to have a mixed-funding model.

To touch on Brexit, my noble friend Lord Prior asked about a research participation visa system for skilled workers and about remaining part of the European regulatory environment. I can say that on all those aspects, we have set out our intentions to be part of the research community and the regulatory environment. That is something that we hope to achieve through the negotiations.

To conclude, I thank the noble Lord, Lord Patel, and his committee again for a truly landmark report, which we continue to study hard. Our homework has been sent back to us by the noble Baroness, Lady Thornton, and I think it fair to say that since it was published I hope we have gone at least from a C+ to a B- with the actions we have taken. The Government have committed extra funding to the NHS since last November, but we are in no doubt about the pressures on the system because of the ageing and growing population, as well as the demands for improvements in areas such as mental health. A major review programme is under way through the five-year review, but there is no getting away from the fact that we need to move away from annual top-ups towards a sustainable long-term plan. The Prime Minister, with the support of the Chancellor, will provide a multi-year funding settlement in support of such a plan. Any such plan must turbocharge, as noble Lords have said, progress in spreading the excellence that exists in some parts of the system across the whole health and care service.

Alongside the development of this plan, we will have a new workforce strategy and a Green Paper and then there is social care. Our department and, indeed, No. 10 are particularly clear that the solutions to social care and the NHS must go hand in hand. As the NHS reaches its 70th birthday, this is what the Government are focused on delivering. We know that we can do that only with a broad consensus for change. This report is an excellent contribution to that process, and one that will stand the test of time.

6.52 pm

Lord Patel (CB): I truly say "Hear, hear" to the Minister, and thank him for his response. He has covered everybody's concerns and the points raised in the debate in great detail, for which I thank him.

I recognise that good progress is being made, but among that good progress is a need to do more to integrate the care and make the NHS a truly outcome-based service. I was always for a commission. We had a debate here three years ago, in which there were 22 speakers, three previous Secretaries of State, and only two dissenters. Both dissenters were on the Front Benches, so there is nothing new; nothing changes. As I said in my introduction, the reason is that election time comes, and the NHS is a good topic for trying to win votes.

However, I now see a chink of support towards a political consensus, and I hope that today's debate has contributed to that, and that there will be other times to help to do that. I also thank most sincerely each and every one of you who spoke today. It has been a tremendous effort. I recognise the great support that noble Lords have given to this report and to this debate today. There were many more: over 10 people had to drop out because the dates were changed, and I had more than 24 emails or notes from people saying that they would have liked to have taken part but could not. There is a great deal of interest in this House on the subject of the NHS and all the issues related to it, such as science, development, et cetera.

I see that there is no acceptance for an office for health and care sustainability, but its time will come. There will be a time when the public will demand it and some independent scrutiny of health and social care. I await the developments of the 70th-year celebration that the Minister mentioned. I await the Green Paper, and no doubt we will have an opportunity to discuss that. We await the report from the Institute for Government that is looking at bodies, like the OBR, that we suggested. It has been a great debate on which we have spent nearly seven hours, with fantastic contributions.

Motion agreed.

House adjourned at 6.54 pm.