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PARLIAMENTARY DEBATES
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HOUSE OF LORDS
OFFICIAL REPORT

ORDER OF BUSINESS

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The following abbreviations are used to show a Member's party affiliation:

Abbreviation	Party/Group
CB	Cross Bench
Con	Conservative
DUP	Democratic Unionist Party
GP	Green Party
Ind Lab	Independent Labour
Ind SD	Independent Social Democrat
Ind UU	Independent Ulster Unionist
Lab	Labour
Lab Co-op	Labour and Co-operative Party
LD	Liberal Democrat
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 or for the Lords spiritual.

House of Lords

Tuesday 7 December 2021

2.30 pm

Prayers—read by the Lord Bishop of Carlisle.

Small Business Commissioner: Late Payments

Question

2.38 pm

Asked by ***Viscount Colville of Culross***

To ask Her Majesty's Government what plans they have to extend the powers of the Small Business Commissioner to deal with late payments for small businesses and freelancers by (1) allowing the Commissioner to deal with complaints against companies with fewer than 50 employees, and (2) requiring the chief executive officers and chairs of offending companies to respond to the Commissioner.

The Parliamentary Under-Secretary of State, Department for Business, Energy and Industrial Strategy (Lord Callanan) (Con): My Lords, we have consulted on extending the scope and powers of the Small Business Commissioner, including extending their scope to deal with complaints against a small business by a small business, and the power for the commissioner to compel information from a business in relation to a complaint. We are working through the impact of any changes with the new commissioner to better understand the resourcing implications of each option and the likely impact on businesses.

Viscount Colville of Culross (CB): My Lords, three-quarters of self-employed people suffer from late payments; many of them do not get paid at all and the situation is getting worse. It adversely affects their business and a lot of their valuable time is taken up with chasing unpaid invoices. Why, on such an urgent issue, when the consultation finished last December, have the Government still not come forward with proposals? When will proposals be forthcoming?

Lord Callanan (Con): The noble Lord makes a good point, and I very much sympathise with his concern. However, we received a lot of replies to the consultation and are currently working through the options. He will be aware that any proposals in this area will require primary legislation and have resourcing implications for the Small Business Commissioner, so we are currently working through all the options.

Lord Flight (Con): My Lords, the tidying up of late payment problems without hurting trade still needs to be addressed by both larger and smaller companies. What does the noble Viscount envisage the Small Business Commissioner needing to help to deal with the problem of requiring senior company officers to explain their position to them? How does he envisage that those arrangements will improve the situation?

Lord Callanan (Con): I apologise to my noble friend, but I did not quite catch all of his question. This is a serious problem. The Small Business Commissioner is newly appointed, and she is still getting to grips with her role. To be fair to the previous commissioner, since December 2017, the commissioner has recovered more than £7.8 million owed to small businesses. A lot is happening in this area, but I totally accept that we need to do more.

Lord Palmer of Childs Hill (LD): My Lords, will the Minister please say whether, in the trade agreements on which the Government are embarked, there will be some provision so that overseas companies pay their UK customers promptly?

Lord Callanan (Con): These things are all extremely important. I do not know whether there are any specific provisions in trade agreements on prompt payment, but I shall certainly have a look and write to the noble Lord about it.

The Earl of Clancarty (CB): My Lords, does the Minister agree that the key problem for many freelancers, including creative professionals, is that they are caught between what sometimes feels like an ingrained culture of late payment and not being able to challenge for fear of losing work? Ultimately, we need a system that automatically penalises late payers without the aggrieved party having to raise its hand.

Lord Callanan (Con): The noble Earl makes a good point. I remind him that UK legislation already establishes a 60-day maximum payment term for contracts for the supply of goods and services between businesses, although those terms can be varied if they are not grossly unfair to the supplier. We also have the prompt payment code. We have received more than 50,000 reports from businesses that they are abiding by the prompt payment code, but there is always more to do on this.

Lord Cunningham of Felling (Lab): My Lords, I have been in Parliament for a long time—perhaps people would say for too long. For all that time, late payment has been a problem under Governments of both major parties and the coalition Government. Why is it such an elusive problem? Why is it so difficult to find a solution to what is damaging to small and medium-sized businesses?

Lord Callanan (Con): I would never say that the noble Lord has been in Parliament too long. We need more representatives from the north-east in Parliament, for as long as possible—says he in a self-congratulatory way. The noble Lord is right. It is a difficult and complicated problem which Governments of all persuasions have grappled with. It is different in different industries, with different suppliers for small businesses and large businesses, but there was a commitment in the Conservative manifesto to crack down on late payment. That is why we launched the consultation. We are currently working through the responses. We will need primary legislation to implement it. The noble Lord will know, from his time in government, how tricky it is to work through those problems.

Lord Sherbourne of Didsbury (Con): Can my noble friend ask his department to look at what happens in other countries, to see which countries do better than we do and what lessons we can learn?

Lord Callanan (Con): That is a very good suggestion. I certainly will do that.

Lord Aberdare (CB): My Lords, the Small Business Commissioner's role is limited in relation to construction companies. For example, she can deal with complaints from small construction firms about payment disputes only with larger firms which are signatories to the prompt payment code. Why then can she not deal with the same complaints when the bigger firm is not a code signatory? Will the Minister look at extending the commissioner's role to provide full support to small construction businesses?

Lord Callanan (Con): I have had this discussion with the noble Lord before. The construction industry is different; there are adjudication processes already set up for it and we are also looking at the issue of payment retention, as the noble Lord knows well. It is a complicated issue. The legislation already precludes the application to the construction industry, because there is an adjudication code process already there.

Lord Bassam of Brighton (Lab): My Lords, I appreciate the Minister's candour in this but remind him that, earlier in the year, he said:

"Late payments damage the cashflow of small businesses, which can hold back investment or job creation and, in the worst cases, lead to job losses and business closures. Action to stop the damaging practice of late payments remains a key priority for Government."

But is it, given that it has taken the Government over a year to consider the consultation and we are yet to see any response? Will the Government now commit to providing SMEs with greater protections from insolvencies, including by giving statutory powers to the Small Business Commissioner to chase late payments? This is a very urgent issue.

Lord Callanan (Con): This is a priority for the Government —there are lots of priorities for the Government at the moment. The new powers that we consulted on include compelling the disclosure of information, including in relation to payment terms and practices, and imposing financial penalties or binding payment terms on businesses. These are important issues that need to be considered properly. We need to go through the consultation responses properly, and we will respond as soon as we can.

Lord Fox (LD): My Lords, there is a danger that the Minister's response might be interpreted as kicking the can down the road and waiting some time for legislation to possibly come in the future. In the meantime, small businesses of the type described by your Lordships are suffering. Will the Minister recognise that the current situation is not as it should be and use current powers and levers to improve it?

Lord Callanan (Con): We have a newly appointed Small Business Commissioner who is cracking on with the job. She is currently in discussion with my department about the resourcing that she requires. As I said, so far almost £8 million-worth of debts have been recovered for small businesses, so there is a lot of good work going on, but I totally accept that we need to do more.

Lord Cormack (Con): My Lords, it is two years since the election manifesto, and a year since the review. Can we not inject some urgency into this? Can my noble friend perhaps define his own interpretation of the word "urgency"?

Lord Callanan (Con): My noble friend is tempting me to get into dictionary definitions and semantics. As he well knows, I cannot give a precise timescale for the processes of government, but we are working on the issues and we will respond as soon as we can.

Lord Watts (Lab): My Lords, it seems that, if the Government do not want to do something, they set up a review body and then forget about it for a year or two. Would it not be a good idea to set a timescale for any review, so that we can have some accountability in this House?

Lord Callanan (Con): We do not just set up a review body; we have a consultation, as we are obliged to for all legislative proposals. It is important to get responses from all concerned. I have had many debates in this House where people have criticised us for lack of, or inappropriate lengths of, consultation, so I make no apologies for going through the consultation process. It is important to gain a range of views on this subject. We need to take the time to respond to it properly and correctly, and we will do so.

Lord Lexden (Con): Are the Government setting a fine example by settling their own payments promptly?

Lord Callanan (Con): The answer is yes. We have already established a formal payment period for contracts for public authorities.

Baroness McIntosh of Hudnall (Lab): My Lords, in an earlier response, the Minister suggested that the Government had many priorities, and I am sure they do, but can he say where he thinks this matter sits in the list of government priorities?

Lord Callanan (Con): It is at the top of our broad range of priorities.

Smuggling: Kittens and Puppies

Question

2.48 pm

Asked by ***Lord Black of Brentwood***

To ask Her Majesty's Government what steps they are taking to prevent the smuggling of kittens and puppies into the United Kingdom.

The Minister of State, Department for the Environment, Food and Rural Affairs and Foreign, Commonwealth and Development Office (Lord Goldsmith of Richmond Park) (Con): My Lords, the Animal Welfare (Kept Animals) Bill outlines how the Government will fulfil their manifesto commitment to, among other things, crack down on puppy smuggling and address the low-welfare movement of pets, including by reducing the number of pets that can travel in one non-commercial movement. We have also consulted on further proposed restrictions to the commercial and non-commercial movement of pets into Great Britain, and we will publish a summary of responses in due course.

Lord Black of Brentwood (Con): I thank my noble friend for that Answer and for the action the Government are taking on the microchipping of owned cats. The Government's proposals to clamp down on puppy smuggling through new pet travel regulations governing the movement of puppies into the UK are very welcome, but should not the same protections apply to kittens? Otherwise, there is a real risk of unscrupulous sellers bringing in increasing numbers of defenceless kittens under the age of six months, with real damage to their welfare. Would he also agree that measures to tackle illegal imports of both puppies and kittens need to be accompanied by improved enforcement provision and pet checks at UK ports?

Lord Goldsmith of Richmond Park (Con): My Lords, enforcement is clearly key, but we did not propose increasing the minimum age of imported kittens to six months or banning the import of heavily pregnant cats because there is very limited evidence that there is a significant illegal trade in cats or significant numbers of low-welfare movements. Similarly, we are not aware of evidence to suggest that there is a significant trade in declawed cats. However, having said that, the consultation sought views on whether this is the right approach, and we will be led by the outcome.

Baroness Ritchie of Downpatrick (Lab): My Lords, as an animal welfare measure—and the Minister has already referred to the need for enforcement—will the Government bring forward a complete ban on the commercial movement into Britain of dogs that are pregnant?

Lord Goldsmith of Richmond Park (Con): My Lords, the proposal that we have put forward involves banning the import of heavily pregnant dogs for welfare reasons. We do not think that that needs to extend to pregnant dogs as a whole.

Lord Trees (CB): My Lords, the smuggling from abroad is driven by the high demand for puppies unmet by conventional breeding establishments in the UK. While I support the Government's efforts to clamp down on illicit importations, should we not be addressing the root cause of this problem and, recognising that dogs are social animals, encourage large-scale, high-health, high-welfare dog breeding in the UK? This would end the serious animal welfare and biosecurity problems caused by criminal smuggling.

Lord Goldsmith of Richmond Park (Con): My Lords, an unacceptable number of low-welfare establishments provide puppies and dogs for the UK market from overseas. In taking the measures that we are taking, there is undoubtedly going to be at least one effect, which is that we will see an increase in high-quality breeding programmes here in the UK. The market will undoubtedly respond to that demand without compromising welfare.

Lord Addington (LD): My Lords, does the Minister agree that the old saying, "A dog is for life, not just for Christmas", should be expanded? If you get a pet, it is going to be for at least a decade. Will the Government make sure that there is greater awareness of the responsibility that one is taking on and of how long it will go on? The message at the moment seems to have become the victim of fashion.

Lord Goldsmith of Richmond Park (Con): My Lords, there is no doubt that, during the Covid pandemic, we saw a spike in the acquisition of pets of all sorts, particularly dogs. As the pandemic has come—we hope—to an end, we see that people are often coming to regret those decisions, so there is a glut of unwanted pets right now. I encourage anyone looking for a pet to seek out the nearest rehoming centre and adopt.

Baroness Hayman of Ullock (Lab): My Lords, the noble Lord, Lord Black of Brentwood, talked about enforcement, as did my noble friend Lady Ritchie. Does the Minister believe that current rules and checks on the movement of domestic animals are strong enough to prevent so much illegal activity? In particular, will the Government ensure that, when they fulfil their policy on tackling puppy smuggling, they will also give the Border Force the resources that it needs to enforce the new rules?

Lord Goldsmith of Richmond Park (Con): My Lords, we believe that the network of agencies and stakeholders that work on puppy smuggling are doing a good job. We are not planning to change this, but we will work closely with the Border Force, local authorities, the devolved Administrations and so on to tackle the problem. The new measures that we are introducing should have very little additional impact on APHA, the Border Force or local authorities, but we are looking closely at the implications of these proposals and we will continue to work with them as we develop future restrictions.

Baroness McIntosh of Pickering (Con): My Lords, will my noble friend accept that the single most effective measure for reducing the smuggling of puppies is to ensure that the mother of the puppies is always present at the point of sale? Will that be included in the kept animals Bill?

Lord Goldsmith of Richmond Park (Con): My Lords, two years ago we introduced Lucy's law, whose purpose was to tackle unscrupulous breeders in this country. One of its components was a requirement that, where people purchase a puppy, they are able to see that

[Lord Goldsmith of Richmond Park]
puppy first in the context of its natural family and the home in which it was raised. That would include, of course, being with its mother.

Baroness Finlay of Llandaff (CB): My Lords, what assessment have the Government made of the risk of rabies being brought into the country through smuggled animals? What action is being taken?

Lord Goldsmith of Richmond Park (Con): My Lords, there are no proposed changes to the animal health requirements of pets entering Great Britain within this Bill, as our focus here is on stopping low-welfare practices for pets being imported. However, the Government monitor disease risk carefully, and changes to animal health requirements will be made under separate legislation. We remain aware of the concerns around non-endemic diseases and continue to monitor the disease situation carefully, but our future policy will be guided by risk assessment.

Lord Foulkes of Cumnock (Lab Co-op): My Lords, has the Minister seen the reports that Pen Farthing and his dogs were evacuated from Afghanistan following the personal intervention of the Prime Minister, encouraged by his wife? Why does No. 10 give priority to dogs over threatened human beings?

Lord Goldsmith of Richmond Park (Con): My Lords, No. 10 and, indeed, the Prime Minister have clearly and emphatically pushed back against any such suggestion today. The noble Lord shakes his head, but I can tell him from my own experience that his rebuttal is entirely accurate.

Lord Lexden (Con): Has my noble friend seen the research by the highly respected organisation Cats Protection, which shows that the market in cats is increasing rapidly, heightening the danger of unscrupulous sellers seeking profits at the expense of welfare? In view of that, is it not important, as my noble friend Lord Black suggested, to extend the protection that will be given to puppies to kittens as well?

Lord Goldsmith of Richmond Park (Con): My noble friend might well be right. If he is, I hope that that will come clear as we go through all the responses that we have had to the consultation, but based on what we know now it does not seem to be right. We are not seeing the same issues with young kittens and pregnant cats being imported. In 2020, only 17 kittens under 15 weeks and zero pregnant cats were seized and detained. Overall, the number of movements of cats into Great Britain is far lower than for dogs, making up about 9% of the total commercial movements and around 12% of the total non-commercial movements into this country.

Baroness Hoey (Non-Afl): Is it not time that we relooked at the idea of bringing back dog licence fees, as happens in other parts of the United Kingdom, which work very successfully, with some exceptions, of course, for some people?

Lord Goldsmith of Richmond Park (Con): My Lords, there are currently no plans to bring in a dog registration system of the sort that the noble Baroness mentions, but I would be very willing to have that discussion with her and hear her arguments.

Baroness Sanderson of Welton (Con): My Lords, I declare an interest as an owner of a Labrador born in the safe care of the Dogs Trust after her mother was seized at the border. Can my noble friend say whether the Government are considering the changes proposed by the Dogs Trust to reduce the maximum number of pets allowed to travel under the pet travel scheme from five to three to reduce the incentive for puppy smugglers?

Lord Goldsmith of Richmond Park (Con): My Lords, I am aware of the position taken by the Dogs Trust. We conducted extensive research and engagement right across the sector to try to understand the ideal limit that would disrupt this grim illegal trade while minimising the impact on genuine owners. A report from PDSA in May found that less than 2% of pet owners have six or more pet cats and dogs. That is why, to ensure that we minimise the impact on genuine pet owners, we decided to put in place a limit of five pets per vehicle, but there again we will be guided by the outcome of the consultation.

The Earl of Caithness (Con): My Lords, what more is my noble friend going to do to encourage high-quality breeding of dogs and cats so that hereditary diseases such as hip dysplasia are not passed on?

Lord Goldsmith of Richmond Park (Con): My noble friend makes an important point. That is not addressed in this legislation or the proposals that we have put forward, but we are raising standards of animal welfare across the board from an enforcement and penalties point of view, and across the sector in a number of different ways. I hope that one outcome of the package of measures that we are bringing in is that we eliminate the unscrupulous breeders and boost the quantity of high-welfare puppies and kittens on the market.

Net-zero Emissions

Question

2.58 pm

Asked by ***Lord Ravensdale***

To ask Her Majesty's Government what assessment they have made of (1) the contribution of the policies in the Heat and Buildings Strategy towards the United Kingdom's (a) net zero emissions target, and (b) carbon budgets, and (2) the co-benefits of the transition to net zero.

Lord Ravensdale (CB): My Lords, I beg leave to ask the Question standing in my name on the Order Paper, and in so doing declare my interest as a director of Peers for the Planet.

The Parliamentary Under-Secretary of State, Department for Business, Energy and Industrial Strategy (Lord Callanan) (Con): My Lords, to meet net zero, virtually all heat in

buildings will need to be decarbonised. The net-zero strategy outlines that we expect that emissions could fall by between 25% and 37% by 2030 and 47% to 62% by 2035 compared with 2019 levels, based on an indicative heat and buildings pathway. The heat and buildings strategy shows our robust plans to do so.

Lord Mackenzie of Framwellgate (Non-Afl): My Lords—

Noble Lords: Order!

Lord Ravensdale (CB): I thank the Minister for that response. Although I welcome the heat and buildings strategy, including the clear focus on heat pumps, it was silent on embodied carbon, which forms a large proportion of emissions from the built environment—50 million tonnes in CO_2 equivalents a year, equivalent to aviation and shipping combined—so there is a strong case to report and regulate. Can the Minister say what plans the Government have towards mandatory reporting of carbon emissions in the built environment, along with regulating to limit carbon emissions in construction projects?

Lord Callanan (Con): The noble Lord makes a very good point. We need to look at embodied carbon much more closely. Indeed, I attended and launched a session on exactly that at the COP climate change talks. We will work with industry practitioners to see what more we can do in this important area.

Lord Mackenzie of Framwellgate (Non-Afl): My Lords, I apologise for my premature intervention. Are all domestic new builds taking place since the Glasgow COP meeting last month being built to the new specifications required by the *Heat and Buildings Strategy*? If not, why not?

Lord Callanan (Con): The new building regulations for net-zero homes will take effect from 2025, but of course we are not waiting that long to take action. The new Part Z of the building regulations will kick in from next year.

Lord Lilley (Con): My Lords, does my noble friend agree that living standards generally can rise only if we produce more output per head? Conversely, living standards will fall if we need more workers to produce our existing level of output of energy or heating. Yet this strategy says that upgrading our homes and buildings to warm them without using fossil fuels will require 240,000 more workers than at present, who will no longer be able to produce other goods and services. Does my noble friend think that reducing the average living standards of the country is what people voted for?

Lord Callanan (Con): I am sure people did not vote to have their living standards reduced. Indeed, we have an excellent record of both decarbonising and growing the GDP per head of population. We have a very successful record of doing that so far, and I hope we will continue to be able to do so. I remind my noble friend that whatever our individual views on this, we now have a legal obligation to meet net zero.

Lord Broers (CB): My Lords, while complimenting the Minister and the Government on getting on with the SMR programme, I ask him whether sites are being sought for these reactors where the heat they produce can be used in district heating systems for buildings, industry and horticulture.

Lord Callanan (Con): The noble Lord links together two important facets of this work: the importance of getting on with building new nuclear capacity, which I think is widely recognised, and the importance of developing heat networks. We do not have such a tradition of heat networks in this country, but they are rapidly expanding and we are investing hundreds of millions of pounds in future heat networks.

Lord Whitty (Lab): My Lords, can the Minister confirm that after the publication of this strategy, he indicated that the decision on hydrogen-based heating for homes would not be taken until 2025? If so, what advice does he give now to householders whose boilers are running out of time? Should they buy a heat pump or a hydrogen-ready boiler, or wait until the price of air pumps comes down and a decision is taken in at least four years?

Lord Callanan (Con): The noble Lord is correct about the timescale for taking a decision on hydrogen. It is not yet a mature technology in terms of whether it would be available in sufficient quantities on a wide enough scale to be used for home heating. We are funding a large series of trials, moving towards a hydrogen neighbourhood, a hydrogen village and then a hydrogen town-level trial before we can advise people to take that forward. In the meantime, we have set our ambition to phase out the sale of gas boilers by 2035.

Lord Oates (LD): My Lords, is the Minister aware of the concern expressed by the Climate Change Committee over the lack of an integrated offer on home retrofit for home owners who want to upgrade the energy efficiency of their homes? What do the Government intend to do to work with industry to correct this clear market failure?

Lord Callanan (Con): We are working closely with industry to work up the offers we have to householders, as well as the myriad government schemes targeting mainly low-income families: the £800 million social housing decarbonisation fund, the £950 million home upgrade grants, et cetera. Then, of course, we have the £450 million boiler upgrade scheme launching in April next year to subsidise the installation of heat pumps.

Lord Hamilton of Epsom (Con): My Lords, to follow the question from the noble Lord, Lord Whitty, now that the debate on net zero is maturing and we are talking about the costs of reaching net zero, should we not have a cost-benefit analysis from the Government on how all this is working out?

Lord Callanan (Con): The legislation has, of course, already been passed by this House to make net zero legally binding, but extensive impact and cost-benefit analyses were done at the time.

Lord Grantchester (Lab): Decarbonising heat is still a massive challenge, which, as has been mentioned, can be made less so through energy efficiency measures. Given that there are 19 million homes below EPC band C standard, and given the collapse of the green homes grants scheme, can the Minister clarify how many of these homes will be helped by the energy efficiency announcements in this strategy, and by what date?

Lord Callanan (Con): The noble Lord is correct that energy efficiency is extremely important. It is very much a "no regrets" approach; we should always take a fabric-first approach to upgrading properties. As I mentioned, we have a substantial series of financial commitments: the social housing decarbonisation fund, the home upgrade grant, the boiler upgrade scheme, et cetera, to contribute towards the cost of these. The other things we need to look at, of course, are the green finance offers, which will enable people to upgrade their homes in a cost-effective manner.

Lord Birt (CB): My Lords, heat pumps appear currently to be the only proven and viable off-the-shelf option for decarbonising home heating, yet, as we all know, electricity is prohibitively expensive and the cost of the necessary insulation exorbitant. How does the Minister think the Government's target of 600,000 heat pump installations within six years can be achieved?

Lord Callanan (Con): The noble Lord is correct about the target that we have set. I mentioned the boiler upgrade scheme starting next year. We also have changes to the building regulations, as referred to in earlier questions, which will kick in in 2025, making it virtually impossible to install fossil-fuel heating systems. That will produce a large increase in heat pump installations, as will the other schemes that we have talked about; low-carbon heating can be installed under all of them.

Baroness Jones of Moulsecoomb (GP): My Lords, the campaign group Insulate Britain, which has annoyed people so badly, was asking for a national programme to ensure that homes are insulated to be low energy by 2030. The Government are nowhere near on track to do that, but it is a sensible request; it would ensure that not only would millions of people use less energy, they would be able to pay for what they use. Why not do it?

Lord Callanan (Con): I certainly agree with the noble Baroness that Insulate Britain has managed to annoy everybody. I cannot remember a campaign in this country that has been less effective at mobilising public support behind an important issue. We need to take people with us on this; irritating them, disturbing their daily lives and stopping them going about their lawful business is really not the way to do it. I hope that the noble Baroness will not continue to support these ridiculous, irresponsible campaigns. Having said that, we are spending £3.9 billion over the next few years to insulate homes, upgrade their performance and install low-carbon heating systems. We are getting on with the job quietly and successfully.

Baroness Evans of Bowes Park (Con): My Lords, the noble Lord, Lord Jones of Cheltenham, wishes to speak virtually. I think now is a convenient point for me to call him.

Lord Jones of Cheltenham (LD) [V]: My Lords, it is estimated that 50,200 heat pump installers will be needed to install a million heat pumps by 2030. Currently, there are only 1,100 MCS-registered installers and the necessary training courses are expensive. What are the Government planning to do to train another 49,000 of them?

Lord Callanan (Con): We are working very closely with the industry to do precisely that. The Heat Pump Association has recently launched an excellent conversion course for existing heating engineers to convert their skills. I have visited a couple of the training workshops being launched by some of the big heat pump manufacturers in this country. Of course, we are also working very closely with the DfE, which has responsibility for the skills to make sure that there is an appropriately qualified workforce to take this important work forward.

NHS: Elective and Cancer Care Backlog

Question

3.09 pm

Asked by ***Lord Rooker***

To ask Her Majesty's Government what assessment they have made of the reasons for the backlog of NHS elective and cancer care work that pre-dated the COVID-19 pandemic.

The Parliamentary Under-Secretary of State, Department of Health and Social Care (Lord Kamall) (Con): The backlog in elective and cancer care before Covid-19 was caused by a range of factors including a mismatch in demand and activity, which drove waiting lists' growth. To address this, the Government have provided additional investment of £33.9 billion by 2023-24 for the NHS long-term plan to grow the amount of planned surgery, cut long waits and reduce the waiting list.

Lord Rooker (Lab): That answer comes nowhere near responding to the NAO report on the NHS backlog published last week. When will we be able to return to Labour's legal legacy of 92% of patients getting treatment in 18 weeks, instead of the miserable figure under the Tories of 83% because they are running down the NHS, which has led to hundreds of thousands extra on the waiting list?

Lord Kamall (Con): I thank the noble Lord for this Question on an otherwise quiet day for me. There was growing demand on the NHS before the Covid-19 pandemic, with growing referrals across elective and cancer care. This is driven by an ageing, more affluent population. On what we do about it, we set out our ambitions in the NHS long-term plan. I do not call a £33.9 billion budget increase by 2023-24 an abandonment of the principles. We are looking at the waiting lists and are looking to get them down.

Lord Clark of Windermere (Lab): One of the reasons for the backlog is poor patient flow. The key exit block is from hospitals into care homes, and the problem is the lack of staff being attracted into those homes. Will the Government look at some unexpected ways of dealing with this issue—possibly even offering a bonus to members of staff of care homes and the NHS who spend several months working for their service?

Lord Kamall (Con): The noble Lord raises an important point about making sure that patients are released earlier from hospital into care homes, and into their own homes as well. I have answered questions previously on what is being done to make sure that it is as joined-up as possible. Some 75% of patients on the waiting list do not actually require surgical treatment but are waiting for diagnostics. The Government have invested in rolling out 100 new diagnostic centres. Some 80% of patients who require surgical treatment do not actually require an overnight stay in hospital, while 20% of people waiting for surgery are waiting for musculoskeletal or eye-related surgery. In many ways we know what the issue is—it is targeting.

Baroness Stuart of Edgbaston (CB): My Lords, the waiting lists are clearly too long. Will the Government undertake a comparative analysis of whether the backlog pre Covid was better handled in Scotland and Wales than in England?

Lord Kamall (Con): As the noble Baroness will recognise, health is a devolved matter. It is important that we look at international comparisons, so not just among the devolved Administrations but internationally. That is one of the things we are doing to make sure that we focus, improve and tackle the backlog.

Lord Brownlow of Shurlock Row (Con): My Lords, of the many millions of people in the growing waiting lists, how many are waiting for surgery and how many for appointments?

Lord Kamall (Con): Seventy-five per cent of patients do not require surgical treatment, and 80% of those requiring it can be treated without an overnight stay in hospital. One of the ways of addressing that is to make sure that we roll out diagnostic activity. We have allocated £2.3 billion to make sure that we roll out at least 100 community diagnostic centres by 2024-25, not only on NHS properties but in places such as shopping centres.

The Lord Privy Seal (Baroness Evans of Bowes Park) (Con): My Lords, the noble Baroness, Lady Brinton, wishes to speak virtually. I think this is a convenient point for me to call her.

Baroness Brinton (LD) [V]: My Lords, this week the Royal College of Emergency Medicine reports that 40 hospitals have cancelled at least 13,000 operations over the last two months because of the surge in demand, as well as the high number of Covid patients in hospitals. The Government winter plan says that there will be extra beds and staff to help, but there are no beds or spare staff right now, so what are the Government proposing to do before many of these patients end up back in A&E because of their delayed surgery?

Lord Kamall (Con): One thing that the Government are doing is looking at a number of different ways in which we can think outside the box and be multifaceted to make sure that, for example, instead of patients going directly to A&E they can be dealt with by 111 or other services. In addition, we are committed to delivering 50,000 more nurses, growing the workforce and making sure that we have a trained workforce not only in healthcare but in social care.

Baroness Wheeler (Lab): My Lords, the NAO report clearly showed that performance against NHS waiting times had been steadily deteriorating prior to the pandemic, and that during the pandemic there were between 24,000 and 74,000 missing urgent GP referrals for suspected cancer. For the most common cancer in the UK—breast cancer—it is estimated that the disruption in screening services during Covid means that 12,000 people are living with undiagnosed breast cancer, 10,600 fewer breast cancer patients started treatment and 20,000 fewer people last year were referred for breast checks. What specific action is being taken to address this deeply worrying situation?

Lord Kamall (Con): Even before the pandemic there was a growing number of referrals across elective and cancer care. This had been driven by a number of different factors, including people's awareness of cancer, the symptoms associated with it and media campaigns. In addition, one of successes of having an ageing population is that people face a number of different issues. For example, over half of cancers are diagnosed in patients over 65. We know that we have to tackle this issue. That is why we have published the long-term plan with a £33.9 billion budget.

Lord Kakkar (CB): My Lords, I draw attention to my registered interests. Is the Minister content that the NHS has a workforce strategy sufficiently robust to ensure that the extra funds provided can be effectively deployed?

Lord Kamall (Con): In June 2019 the NHS published a people plan that would improve the NHS workforce, including a dedication to recruit more nurses. We continue to work hard to deliver that commitment. Latest workforce figures show that there are 5,100 more doctors and more than 9,700 more nurses.

Lord Hamilton of Epsom (Con): My Lords, I will follow on from the question from the noble Lord, Lord Kakkar. Unlike the noble Lord, Lord Rooker, I believe that the Government have ploughed ever increasing amounts of taxpayers' money into the NHS. Does the Minister think that the Government have got good value for money?

Lord Kamall (Con): My noble friend makes an important point. What matters is not just the amount that you put in but the way that you spend it. This is why the Government announced the NHS long-term plan to look at where we should tackle issues and the

[LORD KAMALL]
nature of waiting lists and, given that much of the waiting list is for diagnostics, roll out diagnostic centres to meet that challenge.

Lord Stirrup (CB): My Lords, an exacerbating factor in the size of waiting lists more generally is the number of patients referred unnecessarily to secondary care specialists. One way of addressing this problem is to make more time available to GPs to investigate patients' symptoms more carefully. Does the Minister agree that, in looking at the overall issue of waiting lists, we have to take into account the needs of primary care as well and not just secondary care?

Lord Kamall (Con): The noble and gallant Lord makes the very important point that we have to look at the whole way we configure our system of healthcare in this country. Many things that were previously done in secondary care can be done in primary. In fact, some of the things that were done in GP surgeries can now be done in the community in diagnostics centres or even in pharmacies, as many people who have had their booster recently will acknowledge.

Lord Watts (Lab): My Lords, coming back to the point made by my noble friend Lord Rooker, when will the Government get back to Labour's figure so that people who are waiting in pain will know when they will get treatment? When will he get back to those historic levels?

Lord Kamall (Con): The Government have announced the NHS long-term plan. We have had a budget increase. We are focusing on a number of different issues. One of the challenges over recent years has been the ageing population. That should be a positive thing and we want to make sure that we look at the new health challenges that we face for the future.

Baroness Finlay of Llandaff (CB): My Lords, do the Government recognise that one-fifth of patients with cancer are diagnosed in emergency departments across the country? When patients are diagnosed late, the nature of cancer and its progressive metastasising behaviour means that, by the time they are diagnosed, the treatment burden is greater and the cost to the NHS goes up. Early diagnosis becomes the only way to tackle the overall problem.

Lord Kamall (Con): The noble Baroness makes a very important point—as did the noble and gallant Lord—about how we reconfigure our healthcare system to make sure that we catch these diseases much earlier in the system rather than waiting for secondary referral. This is not only in primary care but lots more self-diagnosis with more technology now in the home and elsewhere.

Mandatory Training on Learning Disabilities and Autism Bill [HL]

First Reading

3.19 pm

Baroness Hollins (CB): My Lords, I draw attention to my professional and family interests in learning disability and autism.

A Bill to mandate training on learning disability and autism for all health and social care staff undertaking regulated activities in England; and to provide for the Secretary of State to publish a code of practice for specialist training on learning disability and autism.

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

Health and Care Bill

Second Reading

3.20 pm

Moved by ***Lord Kamall***

That the Bill be now read a second time.

The Parliamentary Under-Secretary of State, Department of Health and Social Care (Lord Kamall) (Con): My Lords, over the pandemic the NHS has worked wonders. Throughout the greatest challenge that our health and care system has ever faced, the extraordinary dedication, care and skill of the people who work in our communities and hospitals have been unwavering, and I am sure that the whole House would want to put on record our thanks and admiration for staff across the health and care system.

The Government believe that part of that thanks must be in the form of giving the NHS the Bill that it wants, the Bill that it has asked for and the Bill that it needs to take better care of all of us. Some may say that this is the wrong time for this legislation. The Government and, more importantly, the NHS disagree. The Bill builds on the progress that the NHS made during the pandemic. Under crisis conditions, the NHS evolved, finding new reserves of incredible creativity, innovation and collaboration. It rolled out an extraordinarily successful vaccine programme, it drew on our collective strengths to deliver a programme reaching every corner of the United Kingdom and it has continued to deliver.

But the NHS has told us that the current legislation contains barriers to innovation that the Government feel duty-bound to remove. The NHS has asked for more flexibility to enable local leaders to try out new things—not as a free for all but in ways that best suit local needs and ensure that the system can evolve. The NHS has asked us to protect and nurture the innovation and hard-won lessons of the pandemic, as we begin to build back better.

Much of the Bill is not new: it builds on years of work on the ground to integrate care, on the work outlined in the *NHS Long Term Plan* and on years of experience, effort and learning, and of the system pushing the legislation to its limits to do what is best. It also builds on the *Integration and Innovation* White Paper that we published in February 2021, and on the many consultations that we have held on different aspects of the Bill. The NHS asked for legislation to make it fit for the future, and we are delivering. The Government believe that this is the right Bill at the right time, with wide support for the principles of embedding integration, cutting bureaucracy and boosting accountability.

I am sure that noble Lords will agree that one of the biggest challenges facing the NHS is the workforce. The Bill proposes a duty on the Secretary of State to report on the workforce "once every five years". The Government are asking the NHS to develop a 15-year strategic framework for workforce planning, and we are looking to merge NHS England and Health Education England to deliver this. We are on track to deliver on our promise of 50,000 more nurses by March 2024.

The Government believe that this Bill will also help to deliver adult social care reform. In September, we announced plans to invest an additional £5.4 billion to begin a comprehensive programme of reform. Last week, we published our reform White Paper, *People at the Heart of Care*. This sets out our vision for adult social care and our priorities for investment, with measures including a new £300 million investment in housing and a £500 million investment in the workforce, to bring tangible benefits to people's lives.

The Government recognise that their amendment to the adult social care charging system was considered controversial. However, it is necessary, fair and responsible. Everybody, no matter where they live in the country, no matter their level of starting wealth, will have the contribution they have to make to the cost of their care capped at £86,000. Those with lower levels of wealth will be far less likely to have to spend this amount, thanks to a far more generous means-testing regime that we will introduce. To be clear, the Government believe that nobody will be worse off in any circumstances than they are in the current system, and many people will be better off.

Furthermore, without this change, two people with the same level of wealth, contributing the same amount towards the cost of their care, could reach the cap at very different times. This is not considered fair. A fairer system is to have the same cap for everybody, and then provide additional means-tested support so that people with less are unlikely ever to spend that amount.

At its heart, this Bill is about integration. It builds on the lessons of the pandemic, when the NHS and local authorities came together as one system and not as individual organisations. New integrated care boards and integrated care partnerships will build on the progress made so far to plan, to join up services and to deliver integrated care. We are grateful for the work done to develop these clauses by both the NHS and the Local Government Association.

We have listened throughout the Bill's passage in the Commons to concerns that we are enabling privatisation. Nothing could be further from the truth. To put this beyond doubt, we amended the Bill in the other place to make it clear that that no one may be appointed to an ICB who would undermine the independence of the NHS, either as a result of their interests in the private healthcare sector or otherwise.

Many noble Lords will be aware of the integration White Paper announced in September and currently in development. I can assure the House that this will build on the integration measures in the Bill, to go further and faster and to deliver person-centred care. We expect to publish it in early 2022.

As I have mentioned, a key aspect of this Bill is removing bureaucracy where it gets in the way. While bureaucracy often ensures that there are processes and procedures in place, we all know how excessive bureaucracy can make sensible decision-making harder. We believe that health and care staff are able to deliver better when they are trusted and given space to innovate, with barriers removed. Every NHS reform has claimed to reduce bureaucracy, with varied degrees of success, but such reforms have often been top-down. These reforms come not from the top down but from the bottom up, giving the NHS what it has asked for. This includes introducing a new, more flexible provider selection regime that balances transparency, reducing bureaucracy and fair and open decision-making.

It is right that the day-to-day decisions about how the NHS is run, both locally and nationally, are free from political interference. However, it is also right that there is democratic oversight and strong accountability in a national health system that receives £140 billion of taxpayers' money every year. The public deserve to know how their local health system is being run. Integrated care boards will hold meetings publicly and transparently, and the Care Quality Commission will have a role in reviewing integrated care systems.

The Bill also ensures greater accountability from healthcare services to government, to Parliament and, ultimately, to the public. Through new powers of direction, the Government will be able to hold NHS England to account for its performance and take action to ensure that the public receive high-quality services and value for taxpayer money. Equally, we must ensure that there are safeguards and transparency mechanisms in place. That is why the Bill is clear that the new power of direction cannot be used to intervene in individual clinical decisions or appointments. The public also expect Ministers to ensure that the system conducts reconfiguration processes effectively and in the interests of the NHS and, where necessary, to intervene. In such instances, the Bill provides a mechanism for the Secretary of State to intervene, subject to the advice of the independent reconfiguration panel.

As we all know, the health challenges that we face are not static, so the NHS must continue to be dynamic. As the noble Lord, Lord Darzi, once said:

> "To believe in the NHS is to believe in its reform".—[*Official Report*, 11/10/11; col. 1492.]

The Government believe that this Bill allows the NHS to meet the challenges of today and adapt to those of tomorrow. With this Bill, we can look beyond treating disease and focus on prevention with measures to promote good health, such as tackling obesity and stopping the advertising of less healthy products to children. This Bill includes a range of important additional measures, including the establishment of the Health Services Safety Investigations Body, or HSSIB—a world-leading innovation in patient safety—and legislation to ban virginity testing to fulfil the Government's commitment to the most vulnerable.

The Government believe that the founding principles of the NHS—taxpayer-funded healthcare available to all, cradle to grave and free at the point of delivery—remain as relevant now as they were in 1948. To protect these values, we must back those who make them a reality every day of their lives by building and constantly renewing a culture of co-operation and collaboration. I commend this Bill to the House.

3.31 pm

Baroness Merron (Lab): My Lords, I am glad to speak in this Second Reading debate on a Bill that has generated much anticipation and interest; the Minister's comments today have also created much anticipation and interest. I am grateful to the many parliamentary colleagues, organisations, charities and representative bodies that have given their time to give their invaluable views and expertise to many of us in your Lordships' House. I also thank the Minister and his team for making themselves available, and for the extensive work that they have already undertaken and will continue to undertake. I look forward to the maiden speech of the noble Lord, Lord Stevens of Birmingham; I wonder how he decided to choose this particular Second Reading in which to make it.

However, I am sorry to say that this is the wrong Bill at the wrong time, as it fails to deal with the real and immediate issues in the health and care system: scandalous social care provision; no workforce planning; no strategy for integration between health and social care; weak and underfunded public health services; and inadequate levels of funding. Regrettably, the Bill does nothing to resolve the democratic deficit around accountability in the NHS, and fails to put patients, their carers and the workforce at the heart of building back a better NHS. It is not about improving well-being or addressing the social determinants of poor health. Nothing in this Bill will make much difference to the long waits for people in pain and distress, or those who experience delays in waiting for an ambulance. As for it being the wrong time, we know that the pandemic is far from over. We still await proposals for social care integration, and the most vital issue—responding to the workforce crisis in the NHS and social care—is not even at the planning stage.

Let us remind ourselves that this Bill began as a legislative response to desperate pleas from the NHS to reverse some of the provisions in the Health and Social Care Act 2012, which made it impossible to develop the *NHS Long Term Plan*. There were demands to end compulsory competitive tendering for health care services and allow much greater co-operation and joint working between various bodies. Also, it was clear that the informal organisational arrangements that the NHS had developed in the sustainability and transformation partnerships needed to be put on to a statutory basis. These have become the proposed 42 integrated care partnerships.

So, a Bill that was expected in 2017 is now with us in 2021 with the addition of extensive new powers for the Secretary of State, which give rise to deep concern. These extend to direct involvement in service reconfigurations, which could be as purely operational as moving a clinic a few yards down the road. They refer to the transfer and delegation of various functions in relation to arm's-length bodies, the regulation of healthcare and associated professions, and reporting on workforce needs. After Committee in the other place, out of the blue, the Government added a highly contentious new clause concerning the social care costs cap, which will doubtlessly stimulate many hours of debate in your Lordships' House.

We acknowledge the proposals around information standards and information sharing; setting up, at long last, the Health Services Safety Investigations Body; the introduction of Care Quality Commission powers to investigate adult social care; the reference to medical examiners; food advertising to combat obesity; fluoridation; and the banning of virginity testing.

From these Benches, we broadly support those parts of the Bill that remove the worst of the 2012 Act, but will look to add key safeguards to ensure proper governance and accountability and prevent new arrangements being open to abuse around contracting, particularly with the private sector. However, as I mentioned earlier, we do not support most of the proposed new powers for the Secretary of State in the absence of a proper case being made for them. Of course, the Delegated Powers and Regulatory Reform Committee has reported on these issues; we will be looking very closely at its report.

It is a matter for regret, as I have said, that the Government did not bring forward legislation in 2017 to solve these problems with a far simpler Bill. Having missed the opportunity to act decisively at the right time, we now have to rush through a far more complicated Bill at a more complex time.

Part 1 mostly sets out yet another NHS reorganisation of commissioning on the back of many previous attempts to do likewise. Commissioning will still be conducted on many levels and be difficult to understand and manage. What the public will make of all this is unknown—but then, perhaps nobody actually asked them.

We know that, in Committee in the other place, the Government made a virtue of the flexibility of the Bill. This extends to changes to procurement and pricing, although no details are available. There is a similar lack of detail about what will happen at place, or indeed how "place" is to be defined, or how the two headed integrated care systems will function and how the money will flow.

The Part 1 new powers of the Secretary of State that are spread through the Bill were not what the NHS asked for. Ironically, one relative success from 2012 was the separation of NHS operational accountability from Ministers; the reasons for reversing this are hard to fathom. As any former Minister, including myself, will understand, it is mystifying as to why Ministers should seek such powers.

We will seek to include amendments that will strengthen the governance of integrated care systems by requiring stronger public, patient, carer and staff involvement as a right. We will seek to ensure that the best people are elected or appointed into key roles with due regard to diversity, fairness and transparency. We will seek to prevent the potentially undue influence of private sector organisations in commissioning, and ensure that contracts are awarded with a proper and transparent process that is as good as the Public Contracts Regulations that will be disapplied. Moreover, the Part 1 clause about discharging patients before they have had their social care needs assessed needs fundamental safeguards to ensure that we do not hear once again of an elderly person being returned in the early hours to a cold and empty home. This has to stop.

Let me turn to what is perhaps the most challenging clause, the one relating to workplace planning. If there is one thing about which there is universal agreement, it is the inadequacy of this clause. Having the right workforce across the health and social care sector is the issue of the day, and the response thus far is wanting. We need to see a more resolute approach that properly plans ahead across the NHS, social care and public health. This is not just about doctors and nurses but about the entire team, including cleaners, care assistants, lab technicians and catering staff. Last but not least, there is the last-minute new clause on the rules for calculating the cap on care costs, which will be robustly scrutinised and opposed by these Benches and by many others.

Of particular interest to me as a former Health Minister are a range of other welcome provisions dealing with virginity testing, fluoridation and hospital food, to name but three of the public health measures on which I used to work. However, it is disappointing to see a dearth of proposals on dealing with the increasing and unacceptable level of health inequalities that have been exacerbated by the pandemic and well highlighted by Professor Marmot over many years.

As was experienced in the other place, we know that there will be many more proposals for new clauses to cover other matters. This is surely a Christmas tree Bill, and decorations will surely abound. We will be glad to support the three new clauses proposed in the other place dealing with duties on reducing inequality, attention to waiting times and restricting the use of the term "nurse".

Before I conclude, I wish to come back to the important matter of patient safety and the health services safety investigations body. We strongly supported the original Bill and were very disappointed when it suddenly fell off the Government's radar. Despite efforts from across the House, Ministers were unable to explain where it had gone and why it was not being vigorously pursued in the light of the urgent imperative to embed the "lessons learned" culture into the NHS.

The aim of this body is of course to improve the quality of locally conducted investigations and to reduce the incidence of future harm to patients. The benefits cannot be quantified, but the expectation and the hope are that they will far outweigh the costs incurred by the investigations, avoid costs associated with correcting or compensating for harmful incidents, and encourage health improvement. I hope this will be a major contribution to patient safety.

In conclusion, I regret to say that, however this Bill is presented, it is in effect yet another NHS reorganisation. In the last 30 years, we have seen around 20 reorganisations of the NHS, and the *British Medical Journal* has observed that

"Past reorganisations have delivered little benefit."

So the questions for the Minister are many. Why will this Bill be any different? How will the 85-year-old with multiple needs get better care based on them perhaps being treated as a whole person as a result of this restructuring? How will waiting times for elective surgery for cancer and mental health support be improved by this reorganisation? How will health inequalities, which have widened, and life expectancy advances, which have stalled, be corrected by this Bill? A real test for this Bill is: will it makes things better and, if so, for whom?

This Bill can do some good, but its timing is unfortunate at best and an opportunity missed at worst. The question remains as to whether this is the right Bill or the right time. However, if the Bill is to be implemented from 1 April, it has to be the best that we can collectively craft. We look forward to making a positive contribution to making it so.

3.44 pm

Baroness Brinton (LD) [V]: My Lords, I declare my interest as a vice-president of the Local Government Association. I welcome the noble Lord, Lord Stevens of Birmingham, to his place and look forward to hearing his maiden speech. I also offer my thanks to everyone who has briefed us. We, too, regret that the advisory speaking time is five minutes on a long and complex Bill, with many expert speakers whom I am sure the House will want to hear. We note that this time is advisory.

In principle, we have long argued for true integration of health and social care, and reforms are long overdue. The coalition Government created the better care fund, which has set a standard for integrated care in a number of places such as Torbay, but our social care system has needed reform for decades. The increasing workforce crisis and cuts to publicly funded patients, with private patients having to subsidise them, is scandalous. Covid, including the omicron variant as well as the severe winter crisis already with us, makes it much harder for substantial reforms to be in place for the end of March. I echo the comments of the noble Baroness, Lady Merron, about it being the wrong Bill at the wrong time.

The long-awaited adult social care reform White Paper, *People at the Heart of Care*, was essential for delivering true integration. Despite the Prime Minister's promise on the steps of No. 10 Downing Street two and a half years ago, I am afraid that the White Paper is deeply disappointing, not least on how integration will work in practice. Perhaps it is not surprising that Ministers have already announced another social care integration White Paper for next year. We still need to see it before the passage of this Bill. I fear that we will not. We believe that these changes will not work without the reform of workforce planning, and we will seek to strengthen the long-term planning arrangements, especially for social care, where progressive career pathways and proper skilled rates of pay are long overdue.

We too regret the powers being given to the Secretary of State. The reforms under the coalition Government by the then Secretary of State, the noble Lord, Lord Lansley, to remove them from operational decisions was the right one. Despite some of Ministers' words in briefings, we need to be convinced that this is the right move. Ministers tampering with reconfigurations, capital grants or even contracts have already led the Johnson Government into serious difficulties. Worse, giving powers to the Secretary of State to transfer or delegate powers or functions without a clear rubric about how sparsely this must be used, and in what circumstances, is also dangerous. Through some of these provisions, Parliament is once again excluded from scrutinising Ministers' actions.

[Baroness Brinton]

We are concerned about the membership of ICBs. With the increased commissioning duties on local authorities, it is important that they have a voice at the table. More than one local authority in an ICB area gives us a problem. The same is true for NGOs, charities and local enterprises that are involved in the delivery of local social care. Much of the reforms, for both ICPs and the levy, are based on older people's social care. We think it is wrong that disabled younger adults and children who need social care have been squeezed into inappropriate arrangements once again. Unpaid carers are still evidently meant to pick up much of the burden of care, especially with the new emphasis on getting people home from hospital, sometimes before assessment. It is time that the Government truly recognised the commitment and the cost of these unpaid carers and rewarded them.

Part 2 sets out the new information and data requirements for health and social care, especially the latter. We seek assurances that patient and client data will not only be protected and anonymised but cannot be sold on to commercial parties. We are concerned about the power of the Secretary of State to decide what is and is not commercially confidential. We believe that the Health Services Safety Investigations Body is long overdue, but we will seek confirmation that it is to be truly independent from Ministers. In Part 5, we welcome the proposed ban on virginity testing but also seek a ban on hymenoplasty.

International healthcare arrangements in Part 6 must protect the NHS from this Government's former aims to give countries the right to bid for NHS contracts as part of economic treaties in the Healthcare (International Arrangements) Bill of 2019. We will seek to ensure that nothing like this creeps in again.

A few weeks ago, the Government rushed the Health and Social Care Levy Act 2021 through Parliament in just a few days. It was clear to us then that the creation of a new tax mechanism deserved careful scrutiny, but this was denied to Parliament, not least because of the lack of detail in how it would work. The Minister said that the new cap arrangements are fair; they are not. They let down exactly the group of people that this Government claim they want to help: those who live outside the greater south-east, with property worth over £100,000.

There is irony in the Government saying in their document:

"It is important that the new reforms are clear and reduce complexity"

before setting out a complex structure of disregards and benefits and the bombshell that neither local authority contributions nor personal care, nor what are sometimes known as hotel costs will count towards the cap. We will oppose this.

My colleagues will cover the clauses on food and drink and the fluoridation of water supplies. We also regret the limited public health reforms to tackle inequalities.

We have argued for years that we need a comprehensive integrated health and social care system, alongside a modernised and effective NHS, managed by its leaders without ministerial interference. Our broken care system, where staff and providers have battled valiantly against all the odds, desperately needs real reform.

This Bill has some of the right ideas, but it is already clear that there are many worrying elements which will not deliver the reform or funding needed. Health and social care providers, all the wonderful staff across both sectors and the public who use and rely on our NHS and social care systems, need that reform. From these Benches, we will aim to persuade the Government to improve this Bill.

3.52 pm

Lord Kakkar (CB): My Lords, I thank the Minister for the thoughtful way in which he introduced this Bill and draw attention to my own register of interests, in particular the fact that I am chairman of the King's Fund, King's Health Partners and the Office for Strategic Coordination of Health Research.

I welcome much of what is proposed in this Bill, because it has a specific purpose— to drive integration. It has long been desired across the National Health Service that greater emphasis be placed on integrated care, including integration between primary and secondary care, between physical and mental healthcare, and between health and social care.

Clause 5 also sets some guiding principles for all NHS organisations, with the triple aim of ensuring better health and well-being, improved quality of services delivered and the most effective and efficient use of resources, applied by the state for the provision of health services. However, it fails in setting a guiding light and principle for the NHS to address the important issue of inequalities, which we have seen exacerbated during the Covid pandemic. Might Her Majesty's Government consider amendments that address this issue in Committee and ensure that there is a fourth guiding principle for all NHS organisations with a duty to address health inequalities and inequalities in outcomes?

We have heard about other important provisions in this Bill, many of which will be addressed by noble Lords today. Although there is consensus that much has to be achieved, a number of the provisions and the failure to address other issues are somewhat controversial. I hope Her Majesty's Government will give sufficient time in Committee to ensure that these issues can be properly addressed and that there can be absolute confidence, finally, once this Bill passes through your Lordships' House.

I will emphasise just three additional areas in the time remaining to me. The first is research. We all recognise that a research environment and culture is critical to the sustainable delivery of health and care in our country—research not only in terms of development of new therapies or devices but into new models of care and how best we can deploy the workforce to achieve effective and efficient delivery of healthcare. Clause 20 makes provision for integrated care boards to have a duty to promote research, but that does not appear to go far enough to ensure that the commissioning environment secures a proper ecosystem for research, driving not only the provision of facilities but a culture in the development of a workforce able to engage in research, which is the lifeblood of the future of the NHS.

There is also considerable concern about Clauses 25 and 142 regarding the change in the regulatory environment. It seems counterintuitive to provide a new system-wide regulatory obligation for the CQC,

as mentioned by the Minister in his opening remarks, yet retain the very specific provision for the CQC to regulate individual institutions. Regulation drives culture and behaviour in the NHS, and those two objectives might be in tension with each other, driving unintended consequences and undermining the capacity to achieve true integration.

Finally, there is the question of the workforce. This is critical. Your Lordships' committee on the long-term sustainability of health and care, chaired by my noble friend Lord Patel, identified this as the key issue critical to the sustainability of the NHS and the care system in our country. The provisions proposed in the Bill are welcome, but they do not go far enough. Your Lordships' committee suggested the creation of an office for the sustainability of health and care, which would have responsibility to look at demand over an extended period—some 20 years—and, from that, understand what workforce decisions and planning measures should be taken to ensure a sustainable workforce, in terms of not only numbers but its capacity to deliver over time. Those measures are addressed in Clause 35. I hope we will be to explore some of these issues in Committee.

3.57 pm

The Lord Bishop of Carlisle: My Lords, this is a health and care Bill. I will address certain specific aspects of that care that deserve further attention.

First, on integrated care, like the noble Lord, Lord Kakkar, I welcome the clear desire for integration, collaboration and local flexibility, and the placing of integrated care systems on a statutory footing. But can the Minister assure us that, in ICBs and ICPs working together to ensure co-ordination in the design and delivery of integrated care, there will be an adequate focus on prevention rather than just cure, especially in mental health needs, not least among young people with learning disabilities?

Secondly, there is pastoral, spiritual and religious care, which, as Covid has reminded us and NICE guidelines recognise, are essential aspects of care, especially at the end of life. In Clause 16, mention is made of commissioning "other services and facilities" in addition to the medical, dental, ophthalmic, obstetric, nursing and ambulance services previously mentioned. It is probably not practicable to list all 14 allied health professions in the Bill, but perhaps it could be made clear that these cover important aspects of care that ICBs should be expected, not just encouraged, to commission. That would certainly provide some reassurance for, for example, healthcare chaplains, who, among so many others, have done such valuable work during the pandemic.

Thirdly, there is palliative care. We need no reminder of the fact that we are an ageing population. A significant proportion of those with palliative care needs already do not receive the care they need. By 2040, the number of people who have such needs will have increased by up to 42%. One of the stated aims of this Bill is to reduce inequalities in the provision of care across the country. Therefore, I find it strange that there is no direct reference to palliative care services or the need for integrated care wards to commission such services in their areas.

Fourthly, there is social care. As the Minister has already reminded us, one of the biggest challenges facing social care, as with the NHS, is workforce planning and supply. We are all aware of the alarming statistics regarding vacancies, as well as morale. I am grateful that the Bill aims to improve this situation but, as almost all the briefings that we have received have emphasised, we need greater accountability, transparency and reporting on this issue. So I was disappointed to learn that a proposed amendment to Clause 34 in the other place was not accepted by Her Majesty's Government. I am equally disappointed that no mention is made in the Bill of the pay of carers, which is obviously an indication of the extent to which they are valued in our society.

Finally, my right reverend friend the Bishop of St Albans much regrets that he is unfortunately unable to speak in this debate. He has therefore asked me to pass on his congratulations to the Government on bringing forward this important legislation, and to ask the Minister whether the aspiration to reduce inequalities between patients in respect of their ability to access healthcare includes inequalities between rural and urban areas.

4.01 pm

Lord Lansley (Con): My Lords, over the last two years, we have all had cause to be immensely grateful to the National Health Service. NHS staff have responded heroically to the demands of the pandemic, and the service has shown a capacity to innovate, adapt and collaborate. The noble Lord, Lord Stevens of Birmingham, has been at the heart of that, and so we much look forward to his maiden speech today. But we are not out of these woods. There is an immensity of effort yet required, and the Government are right to allocate unprecedented resources to the National Health Service to support the recovery programme.

This Bill enshrines in law an approach that is markedly different from that which has characterised virtually all health legislation in England since the 1980s. That earlier legislation progressively built an NHS based on key principles: autonomous NHS providers held to account by commissioners, who would pay them for the services they actually delivered; patients' rights to choose a provider; money following the patient; clinical leadership; and, since 2013, an NHS that is operationally independent of politicians but with a series of checks and balances, including a mandated focus on improving clinical outcomes. In some ways, this Bill turns back the clock. Providers' freedoms are to be limited; the purchaser/provider split is blurred; the NHS is being centralised; payment systems are being delinked from activity; and political direction is being reimposed. We should use debates on this Bill to ask whether this is really the right direction, particularly given the need now for a responsive, productive National Health Service.

One could argue that this Bill reflects a journey that, in truth, started soon after the 2012 Act was passed—and was never truly implemented. We see the Bill establishing integrated care systems, for example, but they have really been around, in one form or another, for six years already, albeit not in statute. Noble Lords considering this legislation should reflect

[LORD LANSLEY]
that, much as we labour on the detail of legislation, as the House did a decade ago on my Bill, we should be aware that the NHS may choose simply to ignore it.

The Bill in fact goes beyond the NHS's own long-term plan. The powers of direction and intervention put in the Bill by the former Secretary of State in Clauses 39 and 40 are not welcome—including to the National Health Service—are a potential political own goal and should be taken out.

Although I see the presentational appeal of repealing Section 75 of the 2012 Act, relating to procurement, virtually the same provisions are contained in Clause 70 of this Bill—highlighting the folly of trying to fix problems in secondary legislation through primary legislation. The slogan is "Collaboration not competition" —ironically, precisely the words that JP Morgan and Rockefeller used when creating vast monopolies.

My legislation was criticised for making the NHS too complex. This Bill takes complexity to a whole new level. We have ICS boards and ICS partnership boards—the latter sitting on top of health and well-being boards. Each ICS is large, so the workaround is to have places within them which map to local authority boundaries. That is just on the commissioner side. On the provider side, we have new provider collaboratives which, in fairness, is where the power in the NHS will lie. The Bill makes no provision for them in terms of transparency, openness or accountability.

The partnership with local government needs to be strengthened. Integration of NHS and social care demands joint planning, so why are the integrated care partnerships and health and well-being boards not made to be the same organisation? We must look also at Clause 54; I do not think hospital foundation trusts should lose their independence.

NHS staff will rightly say that none of this is any good without a clinical workforce, but Health Education England produced the first NHS workforce plan in 2017, and my noble friend referred to the *People Plan* in 2019. Why, at that time, was Health Education England's budget cut when the NHS budget was not?

Finally, the Government put Clause 140 in at the last minute, which will mean that if someone has limited assets and must meet heavy care costs, they may end up losing virtually all of their lifetime assets before the cap is applied, but the well-off person would lose only a fraction of their assets. That is not the design of the scheme Andrew Dilnot's commission recommended to me. I believe many Members in another place want to reconsider this. We should enable them to do so by leaving Clause 140 out of the Bill when we send it back.

As ever, it is our job to revise constructively. I hope that, in doing so, we shall sustain both the independence and accountability of the NHS.

4.07 pm

Baroness Pinnock (LD): My Lords, in the absence of the noble Baroness, Lady Donaghy, I will speak next. I draw the attention of the House to my relevant interests as a vice-president of the Local Government Association and a member of Kirklees Council. I intend to concentrate on those elements in the Bill that impact on local government.

In West Yorkshire and, I suspect, other parts of England, planning is well advanced for establishing integrated care boards. There is a flavour here of a reorganisation that is already a done deal, yet there are important issues that remain unanswered by the proposals in the Bill. The first of these is that the Government proposed three reform programmes: this Bill; the adult social care White Paper, which was published last week; and the missing one—the care integration White Paper, which has been delayed yet again and will be vital as a part of all these reforms. I do not see how you can do this Bill without the White Paper that is missing. Another missing piece of reform is any detail at all about the delivery of health and care at the level defined as "place". A further, major missing element is an adequate increase in funding for local government delivery of adult social care. You cannot have one without the other: reform without the funding will simply not work.

The final missing piece is democracy and accountability to local people. An opportunity to bring explicitly elected local voices into the governance of health and care at a local level has been ignored. Robust governance models that reflect the people and places served and allow for transparency and accountability provide the best outcomes in the end. However, the model proposed provides for even greater central powers and even less for the people for whom the service is provided.

I now turn to the issue of who pays what towards the cost of their care. There are a number of anomalies in the current proposals beyond the issue of the cap; this is not about the cap. If you are in residential care, you will need to pay a contribution towards the hotel costs; that has been fixed at £200 per week. This means that, if you are living in an older care home in a part of the country with low property values, your fees might be, say, £800, of which £200 might cover the accommodation costs, as these are lower. However, in a new, modern care home, in an area of high property values, your fees per week might be £1,000, of which £400 are accommodation costs. Bear with me—the maths is coming. Under the new rules, both people would pay £200 towards the hotel costs. This is important because the individual in the modern care home would then count £800 towards the cap on their contributions, whereas the second person, in the older care home, would count only £600 towards the cap, even though the value of the care that they receive is the same. In other words, the current proposals favour people in parts of the country with higher property values. I wonder how this approach reflects the so-called levelling-up agenda.

Finally, I refer to the clause related to adding fluoride to the water supply. This is obviously in order to combat tooth decay, which is caused by an excess of sugary foods. However, prevention is better than cure, and substantially reducing sugar intake is surely a better way forward—besides which, adding fluoride to the water supply is not as straightforward as it may first appear because water can be, and is, piped from one water company to another and from one part of the country to another.

I now look forward, with immense expectation, to the maiden speech of the noble Lord, Lord Stevens of Birmingham.

4.12 pm

Lord Stevens of Birmingham (CB) (Maiden Speech): My Lords, I thank noble Lords for the warm and generous welcome. I joined the NHS on its 40th anniversary, in 1988; it is therefore a huge privilege to participate in this important debate more than three decades later.

I know that time is tight so I will cut to the chase and make three brief points. First, the Bill does indeed go with the grain of what patients can see is needed and what people across the NHS have been trying to bring about for some time now. It is not a cure-all—no Act of Parliament ever could be—but it removes legal, bureaucratic barriers to more joined-up care. The fact is that, as we dig our way out of the consequences of the worst pandemic in a century, as your Lordships have just heard in Oral Questions, GPs, hospitals and community services will need to work together in radical and new ways. This Bill will facilitate that. It is also the case that, in an era when, despite fantastic advances in medicine and science, we are seeing growing inequalities and a far higher proportion of patients with long-term conditions, just about every health system in the industrialised world is trying to move towards more integrated and preventive care.

In that respect, I should perhaps depart slightly from the noble Baroness's comments on fluoridation, if I am permitted to do so in a maiden speech. I welcome this move towards dental decay prevention. I should declare an interest on the part of my teeth, in that I happen to have had the good fortune to have been born in Birmingham just a few years after that great city introduced fluoridation. If the whole country now follows its lead, we have the potential to halve the dental decay of children in the poorest communities.

To get back to the point, my second observation is that a number of the concerns raised about the Bill are perhaps a little wide of the mark. It is hard to sustain the argument—it has not been made this afternoon, at least so far—that the Bill in some way advances the privatisation of the National Health Service when in fact it scraps the EU compulsory competitive tendering regime imposed on it. However, there is a case for the Government to consider potentially strengthening some of the safeguards in Clause 70, which would ensure that, where contracts are being let for the private sector, that is done in an open, transparent and fair way.

The Bill does not fragment the NHS. It brings together local funding for GP services, hospitals and community services. It removes the role of the Competition and Markets Authority, enabling hospitals to work together, as the pandemic has shown to be so necessary. It brings together the triple-headed Cerberus of Monitor, the Trust Development Authority and the Commissioning Board to create a unified and accountable NHS England.

The Bill puts on a statutory, transparent and accountable basis the informal local partnerships that have arisen between the NHS and local councils out of necessity. It rightly allows them local flexibility because, in a country as large and diverse as ours, one size does not fit all. To suggest that the mere existence of these local bodies somehow constitutes the fragmentation or destruction of a National Health Service makes sense only if you think that every decision in the NHS can be taken nationally. That has never been the case and would never work. As one commentator on the NHS said, in the event of a nuclear war, only two things will survive: cockroaches and the regional tier of the National Health Service.

My third and final point is that, notwithstanding its many merits, just like the NHS, the Bill is not yet perfect. There is an opportunity to strengthen the provisions in respect of social care and mental health. As a number of noble Lords have set out, just about everybody can agree that, in principle, the major challenge facing health and social care is the strength and resilience of the workforce. It is therefore ironic that, for many years now, we have been promised a detailed, funded and properly thought-through workforce plan for education and training, stretching out over five, 10 or 15 years, yet, on each occasion when that detailed plan is about to be produced, it is muzzled. Jeremy Hunt's Commons amendment sought to remove the muzzle; I hope that your Lordships will consider something similar in this House.

Finally, in respect of the Secretary of State's powers, care is needed to ensure that this does not end up inadvertently centralising a number of decisions on service configurations that are best made locally. I remember, early on in my NHS career, attending a public meeting at which the proposed closure of a small maternity unit in town was being discussed. It was a very well-attended public meeting; large numbers of people showed up. The director of public health tried to set out the case that there just were not enough births in this midwife-led unit. A voice came from the back of the hall: "How many do we need, then?" There was a bit of head-scratching and a puzzled look, then he spluttered an answer. The voice at the back of the hall came back: "In that case, give us 18 months". I can tell your Lordships that, in 18 months, that town did produce the requisite number of babies and the maternity unit is still open. That is not a decision that should have been taken in Whitehall. Yet, lurking near the back of the Bill, in Schedule 6 on page 197, are provisions that essentially do that. Nye Bevan may have said that he would like the sound of the dropped bedpan to reverberate around Whitehall, but not even he suggested that each hospital should write to him personally for permission to move the cupboard in which the bedpans are stored.

To conclude, despite all I have just said, there is considerable merit in the Bill. I believe that it is pragmatic, modest and evolutionary. It builds on many of the changes that people across the health service have looked to put in place over the past decade. Nye Bevan, the patron saint of the NHS, said that

> "legislation in this country … starts off by voluntary effort … by empirical experiment … by improvisation. It then establishes itself by merit, and ultimately at some stage or other the State steps in and makes what was started by voluntary action … a universal service."

That is the legislative task before us.

4.20 pm

Lord Patel (CB): My Lords, it is a pleasure, on behalf of the whole House, to welcome the noble Lord, Lord Stevens of Birmingham, and to congratulate him on his thoughtful, inspirational and brilliant speech. There ends the good news.

[Lord Patel]

The noble Lord did not say much about himself, so I am going to fill in the gaps. He has been a household name for many years. Coming from a council estate and a comprehensive school, he went on to win a scholarship to Oxford to read PPE, received an MBA from Strathclyde University, and attended Columbia University on a Harkness Fellowship, followed by management training in health. He worked as a porter in a hospital and as a mortuary clerk—those clients could not complain about him. He served on several management boards in England, was CEO and president of UnitedHealth Group in the United States and, finally, was CEO of NHS England—and he is still quite young.

The noble Lord is regarded as the second most important person in the history of the NHS—the first being Nye Bevan—and the fourth most important person in the United Kingdom. My first contact with him, which he might remember, was when he was very young, hardly 30, and was a health policy adviser to Prime Minister Tony Blair and subsequently to Secretaries of State for Health Frank Dobson and Alan Milburn. His efforts resulted in the NHS getting the biggest rise in funding in its history. He played a major part in the reforms that followed. One light-hearted anecdote of the time is—and he may well remember—that he persuaded Frank Dobson to make Viagra available on the NHS. More importantly, he has been a central and respected figure in health policy for most of his career. Simon Stevens makes the weather in all his dealings. He knows health, he knows policy and he knows politics, which he is deft at exploring, always in the best interests of the people.

There is another side to the noble Lord apart from health. At Oxford, as president of the Union, he was drawn into controversy following an invitation to a visiting speaker. He also took part in a debate defending the proposition that patriotism is the last refuge of the scoundrel. I do not know whether Boris Johnson opposed him, but he credits the noble Lord with his own election as president of the Oxford Union. They both toured the United States in a debating society and it is said that Boris won the hearts of the audience and Simon won their heads. Once when asked if Boris Johnson could have led the NHS instead of him, the noble Lord evaded answering and sought refuge in a book entitled *Napoleon's Hemorrhoids.*

For fun, the noble Lord indulges in competitive offshore sailing and cooking. I am told that he likes cooking without recipes: I wonder if there might be an analogy to health policies. Today, however, I thank him on behalf of us all for a brilliant, thoughtful and thought-provoking speech.

I now turn to my meagre contribution, which will be short because the time is limited. The Bill contains more than 150 clauses and 16 schedules; it proposes changes to several existing Acts. The policy objectives are equally broad: there are approximately 138 delegated powers and at least seven Henry VIII powers.

While I welcome the emphasis on increasing collaboration between and with different parts of the health and care system, the possible benefits are not clear; nor is it clear, with myriads of smaller organisations and sub-committees, who is in overall charge, or who will be responsible for improving standards of care.

The Bill has no clear plan for how workforce shortages, tackling inequalities in healthcare and the variation in care that exists will be addressed. Workforce shortages are the greatest threat to NHS and social care, as the House of Lords report alluded to. Covid-19 has exacerbated the pressures that staff have been under. They are exhausted. I know that from three of my family members. Without an adequate workforce, none of the reforms will come to full fruition.

Proposals in the Bill fall way short of what is needed and Health Education England's framework 15 will not solve the problem. The Bill includes very limited measures in Clause 35. It fails to address whether the system is training, educating and retaining enough people in the workforce to meet the needs of the service in future. There needs to be a fundamental change to workforce strategy and planning on a much firmer footing than the Bill can provide. I will strongly support amendments to Clause 35, to which the noble Lord, Lord Stevens of Birmingham, referred.

Covid-19 has exposed and exacerbated existing health inequalities. Progress on reducing inequalities is slow. The Bill has no new ideas; it merely transposes the current duties of CCGs to ICBs. One area where there is scope for improvement relates to strengthening reporting on health inequalities. NHS England should publish national guidance on performance data and indicators, which should be collected and reported on by NHS bodies.

The new triple aim is another area where the scope of the Bill can be amended to go further. It should explicitly reference the need for all NHS organisations to report on the impact that their decisions will have on reducing inequalities. The first part of the triple aim of the health and well-being of the population does not suffice. I will support amendments to address that.

There are also issues about the wide-ranging new powers of the Secretary of State, not least on reconfiguration, which I have no doubt other noble Lords will address, but also his involvement in professional regulation and regulators. I will have comments to make about safety, as I chaired the National Patient Safety Agency for five years and know much about what learning is all about. What is important is how the learning is implemented, but the Bill is very short about how that will be done. I look forward to Committee.

4.27 pm

Baroness Morgan of Cotes (Con): My Lords, it is a pleasure to follow the two previous speakers. I particularly congratulate the noble Lord, Lord Stevens of Birmingham, on an assured, entertaining at times, but also extremely interesting speech. It is good to have him in the House, particularly as we come to consider the Health and Care Bill. I know that he will make an enormous contribution through his membership.

I declare my interest as a trustee of the Loughborough Wellbeing Centre charity, which offers mental health support to those facing mental health challenges. As we have heard, this is clearly a Bill that those outside this House and Westminster, but also inside, feel strongly about, given the quantity of briefing that we have received so far. I am sure that that will only continue.

In the time available, I want to cover two points that I shall return to later. First, I alert the Minister that I and others will be picking up on two amendments tabled but not voted on in the House of Commons that recognise that the NHS is an institution that covers the whole of our United Kingdom. As we know, there are huge disparities in service quality and delivery between different parts of the United Kingdom. That is unfair on patients and, I suspect, extremely wearying for staff and those caring for those seeking treatment.

The first amendment raised in the Commons would place a duty on NHS England to consider the likely impact of its decisions on the residents of Wales, Scotland and Northern Ireland and to consider the impact of services provided in England on patient care in Wales, Scotland and Northern Ireland.

The second proposal

"would enable the Secretary of State to specify binding data interoperability standards"

across the whole of the United Kingdom. It would

"require the collection and publication of comparable information about healthcare performance and outcomes across the United Kingdom and would require Ministers in the devolved institutions to provide information on a comparable basis."

Surely, the lesson of the last 18 months of facing the Covid pandemic is that more data and more transparency are better at putting more power in the hands of patients and those seeking care.

My other point relates to mental health provision. I was delighted to hear the noble Lord, Lord Stevens, mention this and I know that it will come up elsewhere in the debate today. I am very grateful to those who have worked in this field for a very long time for pointing out that this Bill is not ambitious enough on preventing mental health issues or on the need to provide earlier support to those experiencing mental health distress. I am also deeply concerned, given the declaration that I have already given, that there seems to be no role for the voluntary and community sector in the new structure of integrated care partnerships—yet we know that the voluntary and community sectors do a huge amount to support people with health needs, particularly in mental health but with other conditions as well. They take the burden off our National Health Service and often provide that support for a much more efficient cost or price than the statutory services ever could.

We have already heard about the NHS triple aim. I would argue that the Bill should mention parity of esteem and mental health specifically in that triple aim. My understanding is that Ministers agree with this, so I hope that they might agree to say so clearly in the Bill. It sounds to me as though the triple aim may become slightly more than triple, given all the requests that my noble friend the Minister will get to expand it. So I wish my noble friend well as he takes the Bill through the House. I look forward to future proceedings and to covering the issues that I have mentioned today.

4.32 pm

Lord Turnberg (Lab): My Lords, I draw attention to my previous career as a physician in various guises. Much more importantly, I welcome the noble Lord, Lord Stevens, and congratulate him on his maiden speech.

All Governments think they know what is best for the country and its population, and nowhere is that more obvious than in this Bill. It is full of valuable ideas and aspirations, which are undoubtedly welcome, but those aspirations are entirely dependent on two critical preconditions: first, stopping the damaging loss of clinical staff and, secondly, the rapid repair of the serious deficiencies in social care. That we have too few nurses and doctors in hospital and in general practice is obvious to anyone, and no one denies that we need a workforce plan for the future. Even though we know that similar plans have tended to be somewhat inaccurate in the past, we should make it a duty to have regular assessments of need every two years, as was called for in the other place.

But now the immediate problem is not so much recruitment but an unprecedented rate of loss of staff. There is a big hole in the bucket as staff have become overworked, frustrated and, far too often, at their wits' end. Last year, we stood in the street and clapped our NHS staff in, but now, frankly, too many feel clapped out, so it is hardly surprising that nurses and doctors are tempted to leave the service. The average age of physicians retiring is now 58, according to the Royal College of Physicians, when it was 62 just two years ago. What a waste—and it is not helped by the ridiculous pension restrictions that mean the longer consultants continue to work, the more their pension is reduced. At the same time, nurses and support workers are too often in despair and GPs find themselves unable to cope with their growing workload.

Will the Minister now focus more on filling the hole than trying only to fill the bucket from the top? Will he consider new ways in which we can encourage retention: reducing non-clinical bureaucratic duties; introducing more attractive options during a clinical career; offering opportunities for nurses and doctors to come back into the service after retirement, perhaps into part-time sessional work; and sorting out the crazy rule on pensions that is such a disincentive to doctors? There is much that can be done now, through much more emphasis on retaining the workforce we have and on the return of those who have left.

I turn now to social care, which is in such a sorry state. Our patients in the NHS suffer too. According to the Royal College of Physicians, about 25% of medical beds are occupied by patients who would be much better off at home but who cannot get there. That is a quarter of beds used up when we desperately need more beds.

Of course, the White Paper on social care is a welcome step forward and, again, it is full of aspirations for the care workers on whom the service is entirely dependent. They do a tremendous job, and they deserve all the respect that we can give them, just as they respect those for whom they care. But it is clear that we do not give them that respect. It is not much wonder that they feel unappreciated, so that sickness and turnover rates are high, or that 42,000 care workers left the service in the last six months, according to the Nuffield Trust. We barely pay them enough, just around the living wage, but important though pay is, there is more to it than that. There is some training, run by their own organisation, but of course it is not mandatory. Just imagine being employed in such an important job

[LORD TURNBERG]
for which there is no professional qualification, no official registration and no clear career pathway. In other words, it may seem to some a dead-end job.

I ask the Minister, as we have done many times in the past, whether he will offer our dedicated care workers the respect they deserve by making sure that they are paid at a rate commensurate with their responsibilities, that they can be registered, as every other health worker is, after a mandatory training programme, and that they have access to a career pathway in which they can see promotion as a reward for all their hard work. They deserve nothing less.

4.36 pm

Lord Shipley (LD): My Lords, I should remind the House that I am vice-president of the Local Government Association. I want also to congratulate the noble Lord, Lord Stevens of Birmingham, on his maiden speech and on the depth of his analysis, which I hope we will draw on as the Bill progresses.

I want to say at the outset that I support the ambition of this Bill but also that I think it will work only if it is improved at further stages. I welcome the wish to make systems more effective in the delivery of services to patients and clients and more efficient in the use of public resources.

As a council leader some years ago, I knew from officers, from providers, from colleagues who worked in the NHS or in social care, from my own councillor surgeries and from door knocking at election time that there was a huge problem with the integration of health and social care support at the point it reached—or should have reached—individuals. We had growing demand for both residential care and domiciliary services, insufficient supported housing, constant bed blocking, lengthy delays in the installation of aids and adaptions, and worsening public health, not least through levels of smoking, rising alcohol consumption and obesity. All that meant that investing more in public health and in the integration of service provision to reduce the costs of administration became essential. For a while, public health did receive further investment and joint working was certainly encouraged, but I thought then that we would progress integration much faster than we have. Well, we now have another attempt, and the test of the success of this Bill is whether it will help with reducing bed blocking, improving public health, restoring the 25% cuts in spending of the past six years and increasing the number of staff working in social care.

The Bill may aim to level up health outcomes, but structures alone are not a solution in themselves but a means to an end. Poverty, low pay and poor housing all need to be addressed as well, because they contribute to poor health. Prevention of poor health in turn reduces demand for hospital beds.

The Care Quality Commission has said that successful care is when providers work well together in a place. That is right, but it is not just about working well together through the alignment of budgets. It must be about the pooling of those budgets to achieve real integration.

The Government must take care not to end up with just another reorganisation. The test is whether the Bill and related legislation will reduce administrative costs, increase capacity and improve service delivery. Will it help to reduce alcohol harm? Will it reduce obesity? Will it reduce the health inequalities of the homeless or of those suffering addictions? Place-based planning and budgeting with common administrative systems should be at the heart of this.

The Bill will need to be amended to ensure that we really do have integrated health and care systems founded on place-based partnerships with pooled budgets. I fear that if we do not do this, adult social care will be starved of essential funding, in turn forcing up council tax too much. We have too many regressive taxes in this country. Council tax is one of them, and it should not be used to make up deficiencies in mainline services.

4.40 pm

Baroness Greengross (CB): My Lords, I add my sincere congratulations to the noble Lord, Lord Stevens. I am delighted that he is joining us in this House.

May I start by saying that the Government correctly acknowledge that their White Paper proposals to be enacted by this Bill will not solve all the problems affecting adult social care in the UK? They refer to their reforms as a "journey", but we have been on this journey for decades now, and the people of this country cannot wait any longer for meaningful and equitable reforms to be enacted. People across the country are suffering now from inadequate social care, and as our population ages these problems will multiply unless we seize this opportunity at last to enact a system that is sustainable and fair.

We all know that demand for social care is not being met, causing hardship for families. Local authority budgets continue to be under great strain, private providers are withdrawing service provision, experts warn that the system is unsustainable, and the system is terribly inequitable. People with dementia, for example, must pay for their care, whereas people with cancer can rely on the NHS. That is grossly unfair.

However, under the Government's proposals, we will to see one inequitable regime replaced by another. The Government's proposed cap of £86,000 on the social care costs that individuals will have to pay is significantly less generous than that recommended by the Dilnot proposals. As a wise friend observed to me, the Government's proposal appears to be more a means of protecting the assets of the wealthy than resolving our social care funding problems. Under these proposals, most people in this country, who do not have huge personal assets, will still lose most, if not all, of their savings, and they will now be paying the Government's new levy as well.

As a result, many people with modest assets—perhaps only the value of their home, if they own one—may be worse off than before. In addition, most of the funds raised by the Government's new levy will initially be used to support the NHS, not social care. One wonders how it will ever be politically feasible for this distribution of levy resources to be realigned to pay for social care alone, which remains the Cinderella service under the Government's plans.

I recognise and welcome the Government's proposals to support the integration of housing into local health and care strategies, with a focus on increasing the range of new supported housing options available.

I welcome the Government's stronger overall support for independent living, including more funding to enable the greater adoption of technology to support independent living. I also welcome more funding to ensure that social care workers have the right training, but I have to question whether the sums proposed are adequate to meet even current needs in these areas.

The Government have to improve on their proposals, particularly in overall funding for the social care system and social care workers. The Government should reduce the cap on social care costs paid by individuals to provide much more generous support to people who have only modest assets. They should not require young people to pay the levy, given the high housing costs and the burden of student loans that so many of them face. There are better ways to raise the funds needed to provide decent care, including replacing higher rate tax relief on pension contributions with a lower flat rate relief. The levy should also be used simply to pay for social care and not the NHS, which already absorbs the bulk of government revenue.

There is not time for me to set out the myriad inadequacies of the Government's White Paper and this legislation, but in addition to a fairer system for funding social care, we know that the glaring need is for social care workers to be much better paid and to have a clear career path. Until these valuable workers are more fairly rewarded, I am afraid we will continue to see an exodus of staff to easier and better paid work. The best carers provide a wonderful service, but they do so despite our social care system, not because of it, and this remains a great injustice. They, and the people they care for, deserve so much better.

4.46 pm

Lord Desai (Non-Afl): My Lords, I add my congratulations to everybody else's on the brilliant maiden speech made by the noble Lord, Lord Stevens. The noble Lord, Lord Patel, described many of his achievements, but he failed to mention that he was a member of the Holloway ward Labour Party many years ago, of which I had the honour to be chairman. I am sure he gained lots of knowledge at that time.

There are some great constants in British political life. One is that we always say that our NHS staff are marvellous, and they are, but we do not meet their wage demands; they have to be underpaid to be marvellous. The NHS is always in crisis, and we all love it. This is the great contradiction of British political life: everybody praises the NHS, Governments never pay NHS staff adequate wages, but we all love it.

I worry that this Government's ambition, as set by the Chancellor, whom I respect very much, is to be a tax-cutting Government. A tax-cutting Government will never adequately fund the NHS. I also worry that when there is a funding crisis, all Governments reorganise the service, because somebody says, "There's a lot of waste in the NHS, and we must cut the loss and get more managers", or, "We want more integration", and so on. So I somewhat welcome this Bill, but I do not think it will solve anything very much.

The biggest failure of the NHS, if I may say so, has been that health inequalities have not been corrected as much as we hoped when it was established. When the pandemic happened, you did not need a computer to predict who was going to be last in the queue. The postcode lottery always works. Women, the elderly and racial minorities will always be the last in the queue and will suffer. This should not happen in a universal healthcare system. Unless we make that the primary concern of any reform of the health service, we will still be waiting for the next reorganisation, and the next.

This is, I am sure, a very good Bill. Lots of professionals and others who have engaged themselves with the National Health Service will find good things to say or good things to change in it. However, I would like to have seen a 15-year funding plan for the NHS, guaranteed by the Government, which would say: "We cannot do it now but within five or 10 years we assure you that, given the increasing needs of the population for health services due to age and other problems, we will meet those needs adequately and remove inequalities and problems at least by date X." That is not happening, and I do not think it will happen any time soon.

Let me say one more thing. I am an economist and have to say something about economics. One thing I said many years ago when I was on the shadow Front Bench as spokesperson for health is that, while the NHS is free at the point of service, we have to make people aware that it is not costless. We have to make patients aware that everything they do costs money somewhere in the system. At that time, I wanted to propose a smart card. Each time anybody uses the National Health Service, it tells them how much it costs, not how much money they have to pay. They just tap it and it shows the cost so that people are aware that not going to an appointment costs money and calling an ambulance costs money. If people become aware of how much it costs, we may get a little help from the patients as well as from the service.

4.52 pm

Lord Naseby (Con): My Lords, this is a watershed Bill at a watershed time for the National Health Service. I shall touch on a few issues but many more will come up in Committee. Before I do anything else, I offer my congratulations to Her Majesty's Government on two dimensions. First, for the first time in my experience, Her Majesty's Government, the NHS and the pharmaceutical industry have got together, worked endlessly and furiously—spending money, yes—and succeeded in producing vaccines that no other country has done at the same pace. That is a huge achievement. Secondly, I thank the NHS front-line staff and our new noble friend, who led them so well.

Of course there are problems. I declare an interest. My wife was phoned while at a party conference and asked to take over a practice because the doctor had disappeared. There were only about 600 or 800 patients. We scrubbed down the old butcher's shop in Biggleswade and started up, and she built up as a full-time doctor the largest practice in east Bedfordshire. My son served in the Armed Forces as an Army doctor, so I know a little bit about that world.

The greatest thing for me as a marketing man is that, if you are going to solve the problem, you have to look at what is going wrong. I shall highlight a few areas. Frankly, the GP system today is not working. It is poor. The problem arose in 2014 when—I do not say

[Lord Naseby]
anything party political here—GPs were absolved from looking after patients 24 hours a day, 365 days a year. They were given the opportunity to opt out. Some 90% did so. We went on to this new system and so it has developed. It is not a good system. The worst bit of it is that, when we hit a real crisis, as we have done, we see where it has all gone wrong.

I know it is wonderful to have all these magical technical things but triage is not working. You cannot get through to a doctor. How many people have told me that as a politician? You get through to a receptionist only after you have started at number 15 or 16 in the queue. There are no home visits. My dear wife got really bad Covid. Yes, 111 came out three times, but not once did we see our GP, although we had a couple of phone calls. She is recovered and well. Did we get a home visit afterwards? No. Does anyone who is elderly get a home visit? No, hardly anyone does. Even worse, yesterday's newspaper said that 300,000 of our citizens are housebound. Every one of those is on a GP's list, so I hope that every GP who covers those 300,000 people will be out next week ensuring that every one of them gets a jab.

Secondly, I have gone on about medical schools. I asked a Question about them in this Chamber on 26 October 2016. The point was made that medical school places were going to go up by 25%, with an additional 1,500 of them. Yes, that happened, but it was not enough. The crunch, as I said in my supplementary question to my noble friend Lord Prior of Brampton, the then Parliamentary Under-Secretary, was this:

"Today, 56% of the intake of medical students is female."

That was five years ago; it is worse than that now. I have nothing against that—I am quite happy with 50/50—but, as I said then,

"70% of female GPs today work part-time, and a recent survey by the King's Fund says that 90% of all medical students in training want to work part-time."—[*Official Report*, 26/10/16; col. 197.]

Given the cost of £200,000-plus to train a GP, I proposed at that point that we have a situation, as in Singapore, where you have to sign on for four or five years to work in the NHS, which has paid for your career. I was told that that was perfectly "reasonable" and that the Government would consult on four years. Nothing has happened. If Singapore can work this, why on earth can we not? Our young people, male and female, after they have been given a superb education, should give back to society for four or five years. My son in the Armed Forces had to do that, so the precedent has been set.

One area that will need to be looked at is obesity. The Government are working with the industry, which has worked with the Government before. We need to have a situation where we look closely with industry, and not at the proposals that are currently in the Bill.

4.58 pm

Lord Bradley (Lab): My Lords, I declare my health interests in the register. I am pleased to speak in this debate and add my congratulations to the noble Lord, Lord Stevens of Birmingham, on his excellent maiden speech.

The Government set out their laudable intentions to integrate health and social care some years ago. In 2018, they changed the name of the Department of Health to the Department of Health and Social Care. I believe that that was a step in the right direction but progress since then has been woefully slow. Recent initiatives have tended to reinforce the separation of the two services rather than their integration, and have not led to the development of seamless pathways of care centred on the needs of the individual. With this Bill strangely pre-empting a further integration White Paper, the Government seem more concerned with the architecture of the NHS, recentralising powers and decision-making to the Secretary of State than with having a genuine ambition to devolve powers to local communities to deliver efficient and effective integrated services.

Belatedly and controversially, a new clause was introduced in the Commons to set up a new funding stream for social care, but it was not clearly ring-fenced for the purpose, with most of the money initially going to support the NHS further. While that money is much needed by the NHS to tackle appalling backlogs of care, it ensures that the current crisis in social care is not addressed—particularly, as we have heard, the dire workforce situation and the failure to address funding for local authorities, where the demand on them for social care provision also remains critical.

Despite these reservations, I am sure we all want to see a system develop that genuinely addresses proper health and care integration. So much work will be done during Committee and beyond to try to improve and shape that ambition, including full scrutiny of the social care funding clauses. As a starting point today, I want briefly to raise two issues.

The first is clarity about service planning at local place level. Local services such as primary, community and many secondary care services require planning, oversight and management at local level. This Bill allows ICSs to delegate resources and responsibility to place-level entities, but there is no statutory framework for the form of local commissioning bodies or their governance and relative accountability relationships. With the abolition of clinical commissioning groups, it is unclear to me how this important function will be fulfilled in the future. I hope the Minister will be able to clarify that point later this evening.

The second issue is the structure and governance of ICSs. A dual structure is planned for ICSs, with the integrated care board and a partnership board. There is obviously a risk that ICBs will be dominated by acute trusts, with other services being relegated to the partnership board. In my view, it is essential that if, for example, parity of esteem between mental and physical health is to mean more than words, mental health trusts are recognised in statute to sit on the ICB. Similarly, it is essential that allied health professionals such as speech and language therapists and the voluntary sector are at the ICB table to ensure their voices are heard loudly and locally. Finally, how will the public voice be heard, to ensure that the best interests of the health of local populations are duly considered? I would welcome the Minister's views on this when he winds up.

I hope the Government will listen carefully to the concerns and issues raised in our debates on the Bill in order to ensure that this is not another missed opportunity to make a proper step forward, not only in the integration

of health and social care but towards early intervention and prevention programmes which tackle the root causes and determinants of ill health and health inequality, as was brilliantly articulated recently by Professor Sir Michael Marmot and his team in my home area of Greater Manchester. As Archbishop Desmond Tutu famously said:

"There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in."

That should be the guiding principle during our deliberations on this Bill.

5.03 pm

Lord Rennard (LD): My Lords, last Friday, we had an excellent Second Reading debate on the Private Member's Bill of the noble Lord, Lord Young of Cookham, on cigarette stick health warnings. As the noble Lord, Lord Kamall, said then, we have made progress over the past two decades, with a range of measures to help smokers quit and to prevent future generations using tobacco. But there is much more to be done. Smoking is responsible for the half the difference in life expectancy between the richest and the poorest in our society. There are still over six million smokers in the UK, and at current rates of decline we will miss the Smokefree 2030 deadline by five years nationally and by 17 years in the most deprived communities. So, further measures are necessary if we are to reduce health inequalities and increase healthy life expectancy, both of which are government manifesto commitments.

The detail of what is required is set out in the latest report from the All-Party Parliamentary Group on Smoking and Health, of which I am a member. I am pleased that the Government have committed to considering its recommendations for the forthcoming tobacco control plan. However, as the Minister told us on Friday that publication of the plan has been delayed from July 2021 to some time in 2022, amendments to this Bill are needed to accelerate progress in reducing smoking prevalence and to deliver the Government's Smokefree 2030 ambition.

The Minister will not be surprised to hear that I and others will table amendments to this Bill to consult on the introduction of a "polluter pays" levy on tobacco manufacturers, to fund lifesaving measures to help smokers quit and prevent youth uptake, to close loopholes in existing regulations and to ratchet up regulation of tobacco through measures such as the proposal from the noble Lord, Lord Young, to put health warnings on cigarettes themselves.

In all debates about health and social care, we spend a great deal of time discussing the costs of the increasing demands upon the system, but probably too little agreeing measures to curb the rising level of those demands. Better education and greater information about health issues is vital, but funding for public health issues has not been protected in recent years in the same way as the costs for treating the consequences of illnesses. Personally, I wish there had been much better education about diet and greater understanding of the importance of physical education in my youth. I should have learned more about issues connected with diabetes before I was diagnosed with the condition.

Across the UK, the number of people diagnosed with diabetes has doubled in the last 15 years and it is estimated that the costs associated with it account for 10% of NHS expenditure. We need to support the provisions in the Bill on restricting the advertising of less healthy food and drink and recognise the importance of these measures in reducing the significant harms that can come from diabetes. People struggling with obesity and diabetic control, children especially, are not helped by the advertising of foods that are high in fat, sugar or salt. We need to strengthen nutrition labelling requirements.

For people with diabetes who need insulin, which includes all type 1 diabetics, we need to address the short-termism that denies many of them access to continuous glucose monitoring systems and technology such as insulin pumps that can help them to maintain good diabetic control. Complications from poor diabetic control can include heart attacks, strokes and amputations, as well as kidney damage, loss of eyesight and mental health problems.

In 2017, the report produced by the Medical Technology Group showed that

"80% of the cost of Type 1 diabetes is spent on treating complications—many of which are avoidable."

We all know that the NHS is under many great pressures, but we can reduce those pressures by reducing the number of people in hospital and by looking to increase investment in technologies that help people with diabetes to improve their control.

5.09 pm

Lord Bichard (CB): My Lords, I begin by welcoming, with others, the noble Lord, Lord Stevens, and congratulate him on his maiden speech. To use an analogy that I think he will understand, in my experience maiden speeches are like kidney stones: they are much better when you pass by them.

I too welcome the emphasis that the Bill belatedly places on collaboration, integration and partnerships, which is something that many of us have been seeking for a very long time and that I was personally associated with when leading the Total Place initiative more than a decade ago. We have been seeking this because none of the major issues that afflicts us can be resolved by a single public service—even one as large as the NHS. As your Lordships' own Public Services Committee has stressed in its recent reports, better collaboration is critical to successfully addressing challenges such as obesity, diabetes and child safety. It is not just collaboration within the health service and between health and social care; it goes beyond that.

Let us be clear: we cannot legislate for collaboration, we cannot structure it into an organisation, we cannot impose it from the top down—as we have so often tried to do—and it does not happen with the flick of a switch. Ultimately, it depends upon the culture of the organisation. I have to say that, while so much about the NHS is positive, it has never in my experience been an exemplar of collaborative working, so turning the collaborative thrust of the Bill into reality will take a real effort. I hope that, as it progresses through the House, noble Lords will be able to make some amendments that make that more likely.

[Lord Bichard]

In other respects, I am afraid that I am less positive about the Bill as it stands simply because, as others have said, it seems to me to ignore so many of the health-related problems that we need to address urgently —whatever "urgently" now means. It does not, for example, tackle health inequalities, which have almost certainly worsened during the pandemic. The extent of these inequalities is a stain on our society—I am not exaggerating for effect—and others have mentioned Professor Michael Marmot, who has long sought to evidence this. Could we not at least incorporate this into the new triple aim, as the King's Fund and others here today have suggested? We have heard a lot about levelling up, but, to be honest, it means nothing to me unless the health inequalities that we are experiencing are addressed.

While the Bill was described as a health and social care Bill, there is little of real substance about social care, and the proposed changes to the social care cap are regressive, as I think most people now accept. I shudder to think how my parents would have responded to these proposals. One of their proudest achievements was to own their own home, and they would have been devastated by the threat of losing that as a result of provisions like this. I agree with the noble Lord, Lord Lansley, that this should be taken out of the Bill.

There is also nothing in the Bill to suggest that the importance of prevention and early intervention has been recognised—the noble Lord, Lord Bradley, touched upon this. The truth is that we are spending ever greater public resources on crises and ever less on prevention, not least in the way that we seek to improve the life chances of vulnerable children, for which the NHS has a major responsibility.

The extensive new powers given to the Secretary of State to intervene in local service reconfigurations, as drafted at the moment, fly in the face of the stated intent to give local places and communities greater power over local priorities. Surely there needs to be at least some stronger requirement in the Bill for local communities to be involved before such interventions are made.

There is nothing in the Bill to suggest, to me at least, that there is a real strategy for tackling current chronic staff shortages—or, indeed, for ensuring that users have a real say in the way that services are designed. We hear a lot about patient-centred care—the only way that you can achieve it is if patients and users are involved in the design of the services in the first place.

Finally, could we not resolve one of the greatest practical barriers to collaboration: the failure to share data effectively? Whenever you mention data, people switch off. It is really important. Part 2 of the Bill begins to address data sharing between adult social care and health, but, for reasons that I simply do not understand, it does not address the same issue where children are concerned.

As your Lordships' Public Services Committee identified in its recent report on vulnerable children, this is a serious practical problem. I know that it has been at the heart of many of the most tragic child abuse cases over the last 50 years. Perhaps the Minister can say in replying why we have not taken this opportunity to address that practical barrier and whether he would be sympathetic to amendments which did. It is something which the DHSC and the DfE need to do together, and I hope they will.

5.15 pm

Baroness Jones of Moulsecoomb (GP): My Lords, it is a pleasure to follow the noble Lord, Lord Bichard, who talked about his parents. My parents never owned their own home, but they had exactly the same emotional reaction to the creation of the NHS and the security it would give them in later life. I extend a Green Party welcome to the noble Lord, Lord Stevens of Birmingham. I am probably going to disagree with him today, I am afraid, and possibly many times in the future, but I welcome him anyway. I enjoyed the humour in his speech; there is never enough humour in this House, so that was fantastic.

I have no expertise in health and no role of any sort in the care system, but I do have a small expertise in government failings. It would be hard to be an expert in them, because there are so many, but I can spot when the Government are making a big mistake and this Bill is one of them. I will talk about three issues; I am going to gallop through them because I am well aware that we have been given a tiny amount of time. The first is fluoridation; the second, carrying on from that, is dentistry; and the third is drugs.

About a quarter of the population does not trust tap water and refuses to drink it. This has obvious consequences for the environment, as most of those people will be drinking water out of plastic bottles instead. Mass fluoridation is not going to help people to trust tap water. The Government are making a decision to mass-medicate populations by modifying their drinking water without any explicit informed consent. The pandemic has revealed an atmosphere in which scepticism of expert advice and anti-science sentiment runs high. Forced fluoridation risks entrenching anti-science views in a significant segment of the population, making future public health interventions that much harder. Other options have been found in other countries, for example fluoride pills or fluoridised milk.

It is obvious that the dental care crisis has been brewing in this country for a very long time. It seems harder and harder to get an appointment with a dentist or even to register with one. People are being turned away and told that the practices are full, so the Government need to get a grip on dental care and change the contracts that pay dentists. These currently operate on a quota system; those quotas are nowhere near sufficient to provide for the level of population in need. Dentistry should be provided on the basis of need, not an arbitrary quota set by the Government. On a related note, the Government need to get a handle on the severe health inequalities experienced by people facing social exclusion, such as people who are homeless, those with substance misuse issues and Gypsy, Roma and Traveller communities.

On the topic of drugs, the Government are failing completely on addiction treatment. By talking constantly about the war on drugs, they are trying to avoid the fact that that war is lost. We have to do drugs differently: we need a drugs policy which prevents criminals profiting

from the supply of drugs. That is why the Greens support a legalised, regulated system of drug control, focused on minimising harm to individuals, society and the environment. The war on drugs has been a catastrophic failure. As ex-undercover police officer Neil Woods says in his book *Drug Wars*, we have lost that war. I suggest that your Lordships read it; he was an undercover officer working among drug gangs and experienced that at first hand.

It is time to take a health and care approach to the whole drug problem—and we obviously have a drug problem at the other end of this building. I am curious as to what the Government are going to do about that. If 10 out of 12 lavatories tested had cocaine in them, there are clearly quite a lot of MPs, or staff, using cocaine. I would have thought that one of the first stops on the Minister's reconnoitring today would be to make sure that people stop using those drugs here in Parliament.

There is so much wrong with the Bill, like so many other pieces of legislation that we get in this House, that I will give the Minister two bits of advice. First, it should go back. He should take it away and say to whoever wrote it, "Make it better", and bring it back to us in the sort of condition where we can amend it and do a bit of redrafting, not the wholesale redrafting that it needs. Secondly, he made some very uplifting comments about the NHS at the start of his speech. Why not give NHS staff the pay rise they deserve? That is what we would like to happen.

5.20 pm

Lord Hunt of Wirral (Con): My Lords, I draw attention to my entry in the register, in particular as a long-standing partner at the international commercial law firm DAC Beachcroft. Unlike the noble Baroness, Lady Jones of Moulsecoomb, I warmly welcome the Bill. In its broad architecture and intent, as the noble Lord, Lord Stevens of Birmingham, pointed out in his superb maiden speech, it goes very much with the grain of what healthcare professionals want, building on existing and emerging best practice—in particular non-statutory integrated care systems. Among the innovations in the Bill, I welcome in particular the proposed new Health Services Safety Investigations Body, extended to encourage learning across the whole sector rather than just in the NHS.

Some argue that it might have been better to delay these reforms until the Covid-19 pandemic was truly a thing of the past. Ultimately it is for the Minister to allay those concerns, not me, but if anything I think the Bill is overdue. The pandemic has put the system under unprecedented strain, and although the NHS and its independent sector colleagues co-operated brilliantly to continue to deliver healthcare, some cracks understandably did begin to show.

I have been in Parliament for 45 years now, and the holy grail for me has always been a so-called seamless robe of health and social care. There are always people in hospital who would be better off elsewhere, always shortfalls in at-home care staff, and always breakdowns in communication between healthcare and the social care system. It is an age-old problem, and one that came into sharp—indeed, horrifying—focus during the first wave of the Covid-19 pandemic.

The biggest concern across both healthcare and social care is still staffing. The ability to meet demand through recruitment and, within social care especially, reducing the current unsustainable level of churn, remains the key to delivering the world-class health and social care of which we are capable. The availability and accessibility of alternative care settings—for example, at-home care—also require dramatic improvement. This will all require more people, more training and more money.

In another place there was an attempt to amend the Bill to make it provide for regular, authoritative workforce projections. Perhaps such an amendment might ultimately find its way into the Bill. I hope so.

Those who experience health inequalities have also been disproportionately affected by the pandemic. Might it be beneficial for the Secretary of State to be able to place specific requirements on the new NHS commissioning bodies to have regard to particular aspects of inequalities?

Of course, the Bill is now buttressed by the proposals in the Government's White Paper on social care, which I also welcome. I would be delighted to hear from the Minister whether anything from the White Paper might yet find its way into the Bill, here or in another place, because we must move more quickly.

No one, though, wants the NHS to live in a state of permanent revolution, so there must be no change for change's sake. Now more than ever, change must be purposeful, rational and highly effective, capturing the positives in cross-sector co-operation that we all recognise.

Many of the principles in the Bill have long been adumbrated by the opposition parties themselves, in particular the vital principle of affirming that the Secretary of State must have overall responsibility for the NHS. I therefore very much hope that we can now all work together to achieve a degree of consensus across all parties and beyond. The NHS is far too important to be a party-political football.

I already like the Bill very much indeed, and I fervently hope that we all grow to like it more and more as it progresses through all its stages, in particular in this House.

5.26 pm

Lord Howarth of Newport (Lab) [V]: My Lords, I add my warm congratulations to the noble Lord, Lord Stevens of Birmingham. There is much to welcome in the Bill—but not Clause 140, which, by excluding local authority support from the calculation, means that poorer people will lose a larger proportion of their assets in paying for social care. Especially coming on top of the regressive national insurance levy, this is shockingly unfair. I also share the concerns expressed by noble Lords about the effectively untrammelled power that Clause 39 provides for the Secretary of State.

I strongly support the restriction on advertising of food and drink. It is right to curb abuses of commercial and media freedom by food and drink manufacturers that seek to wreck human health for their profits.

I very much welcome the centrepiece of the Bill: the replacement of the driving principle of competition with that of collaboration—not only between bodies within the NHS but between the NHS, local government

[Lord Howarth of Newport]
and other community partners—and the statutory underpinning of place-based integrated care systems. While the Bill hardly begins to address the really big challenges for the NHS—integration of health and social care, workforce planning, prevention and health inequalities—ICSs point the way to making progress on all these.

I would like to describe one way in which some ICSs have already entered into fruitful partnership with non-clinical bodies. I declare an interest as chair of the National Centre for Creative Health, a charity that promotes creative engagement with the arts and culture in the interests of health and well-being. It was set up in response to a recommendation in the 2017 report *Creative Health* by the All-Party Parliamentary Group on Arts, Health and Wellbeing. A number of noble Lords took part in that work. The NCCH is working with NHS England and four ICSs: Gloucestershire; West Yorkshire and Harrogate; Shropshire, Telford and Wrekin; and Suffolk and north-east Essex. Our focus is on how cultural and community assets can mitigate the negative health impacts of social disadvantage.

Creative Health set out a mass of evidence on the health benefits of creative activity. It also demonstrated significant benefits for the health and well-being of NHS staff. Since 2017, the body of evidence has increased, as reported in the work led by Dr Daisy Fancourt at UCL for the World Health Organization and for the MARCH Network, funded by UKRI. There have been numerous other testimonies concerning the benefits of the arts for mental health during the pandemic. ICS leaders who have recognised this have been enthusiastic to work with the NCCH and local arts bodies to realise the potential of engaging creativity to further their health agendas, whether in preventive strategies or in assisting patients to recover better. Significant innovative work has been taking place—for example, in Suffolk, where sufferers from long Covid are being supported to improve their breath control through singing.

Psychosocial factors that contribute to health inequalities include isolation, lack of social support and social networks, lack of self-esteem, perceived lack of control, and doubt about the meaning and purpose of life. Engagement in music, dance, drama, pottery, art classes or reading groups can mitigate all those factors.

There are two aspects of the Bill on which I would be grateful for the Minister's clarification and reassurance. Will integrated care boards have the freedom to include in their membership nominees of community bodies such as arts and cultural organisations, and will new procurement regulations permit ICSs to buy non-clinical services from arts and cultural bodies and individuals?

Professor Sir Michael Marmot endorsed the findings of *Creative Health* in these words:

> "The mind is the gateway through which the social determinants impact upon health, and this report is about the life of the mind. It provides a substantial body of evidence showing how the arts, enriching the mind through creative and cultural activity, can mitigate the negative effects of social disadvantage."

Of course, the Marmot agenda is far broader. The Marmot review estimated in 2010 that health inequalities cost £31 billion in lost production. The Treasury should recognise the investment case for fully resourcing ICSs. More than that is needed. Until the Government mobilise other departments alongside the Department of Health to address systemic environmental and social factors in local communities across the land, there will be no levelling up, poorer people will continue to suffer unnecessary ill health, and the NHS will continue to struggle.

5.31 pm

Baroness Barker (LD): My Lords, "It's a Sin": I invite noble Lords to think back to 40 years ago, when a deadly virus came out of nowhere. The NHS had just gone through the most radical change in years; it had developed a purchaser/provider split. We should now go back and look at everything that followed from that. I congratulate the noble Lord, Lord Stevens, on his remarks, in which he talked about this legislation being "evolutionary". We have a question to ask of this Bill: to what extent do its proposals bring about change?

Looking back over those 40 years, the big changes happened when there were panics and big challenges to providers to stop them doing things that they had always done in the way that they had done them, and, crucially, when people in communities—sometimes geographical, but sometimes communities of interest—went and found the scientists and the medics and worked together with enlightened providers to bring about change. Given where we are, and given the experience of the last year, to what extent does this Bill do that?

It is a rather curious Bill; its arrival in this place was very strange. We have had very odd White Papers and a funding settlement on something that was supposed to be quite strategic, but we have not yet had the integration papers. So on the one hand the legislation is attempting to be very big and strategic, but, on the other, it seems to be all rushed and muddled. As far as I can see, it does not, for example, fully take into account some very big changes in demography.

We know that, at the moment, that we have 1 million people aged over 60 who do not have any children, and that their number will double by 2030, yet we have a health and care system that is presaged on the fact that a person will have children to oversee and manage their care. That is not in the Bill at all. It also does not take into account the enormous development and change in therapeutics and diagnostics that we are on the edge of. I want to talk very briefly about HIV. As of last week, with the major breakthrough in injectable medicine, we know that we are on the cusp of some very big changes, yet this is not reflected in the structures of the Bill.

One thing we have learned in the last year is that data and the communication of data are absolutely the driver of integration and change. I do not know whether any noble Lord has recently tried to follow a patient around a hospital—good luck with that. As for trying to follow a patient between hospital and social care—just no. What the NHS does really well is acute things in big hospitals, and it measures the outcomes. But what nobody does at all is get that same data for mental health, primary care and social care. Unless and until we begin to address the fundamental

issue of information exchange, we are quite frankly rearranging some deckchairs, because we will never get it. Given the amount of effort and money that has gone into that over the last year because of the pandemic, we should be further along the way.

I want to very quickly highlight one area in which I will be assessing the Bill quite rigorously. Both providers of the service and women know that women's access to reproductive health services and contraception has been utterly fragmented by the 2012 Act. It is now almost impossible for young women to get access to contraception in some parts of the country. We also know that, for every £1 invested in sexual and reproductive health, the NHS saves £49. Somewhere, in all our talk of place and of integration, we really have to get to grips with some of this basic information and put it into the hands of patients, who will challenge the providers to make the difference.

5.36 pm

Lord Mawson (CB): My Lords, I welcome the direction of travel the Government are taking with this legislation. It is a direction of travel my colleagues and I set out on 36 years ago this year at the Bromley by Bow Centre in the East End of London. As our work today starts to go national and to scale, I thought it might be most helpful if I set out some reflections based on many years of practical experience in this space and offer encouragement to the Government to go much further.

While some have been writing reports and undertaking yet more research, my colleagues and I, through the Well North programme supported by Public Health England, have been building innovation platforms that test these ideas in practice. We have created practical projects in towns and cities across the country over the last six years, bringing together key people from the health service, local authorities, and the social enterprise and business worlds, creating a learning by doing culture and applying entrepreneurial principles to some of our most challenging health and social problems. The detail of our work can be seen on the web. Given the limitations today, I want to focus on the importance of place for one of these real projects, undertaken by people in a real place, but first I will give a few reflections based on real experience over 36 years.

First, the present machinery of the state and health service is not fit for purpose. It is not learning lessons from good practice and has little memory of what has gone before. This legislation needs to get underneath this broken machinery, understand in detail its failings and lack of delivery, and transform it. Secondly, a modern health and care service in an enterprise economy is all about people and relationships and the building of trust between people; it is not centrally about process. Thirdly, the health narrative is out of date. If 80% of the determinants of health are social rather than biomedical, we need to seriously focus on getting upstream in the prevention agenda. It is about a new relationship between the local hospital and the context in which it is set.

Let me take to you one of these innovation platforms in north-west Surrey. I declare my interests. Ashford and St Peter's Hospitals NHS Foundation Trust sits within the North West Surrey Health and Care Alliance and is an anchor institution. Its focus on integration has placed it in a unique position to describe what works and what does not from the perspective of a place and the 450,000 people it serves. For this alliance, place is prime. First and foremost, subsidiarity needs to be more than just a principle. There should be a clear requirement for systems to demonstrably empower and delegate resources to place-based partnerships. Their learning is that, without tackling the wider determinants of health, it is impossible to shift the dial on the level of demand for healthcare, and this is a major contributor to the unsustainability of the health and care system.

One of the principles that is perhaps worth enshrining in the Bill is subsidiarity—passing responsibility and ownership as far down the chain as possible. Allowing individual staff as much autonomy as possible is a key element in reducing workplace stress and improving retention, enabling local areas to work out their own solutions.

The only way to act successfully against determinants of poor health is through engagement and activation of locally based resources, including the voluntary and charitable sector, statutory bodies such as borough councils, and the business sector, among others. Through placing out-patient physiotherapy services in private and local authority-run gyms and leisure centres, they have enabled individuals to reconnect socially, which they would not have been able to do in a hospital environment. They have de-medicalised the therapy and created the opportunity to get active through joining the gym, enabling people to take control of wider aspects of their well-being, as well as providing additional footfall, which drives business success and supports economic advantage and job security—win-wins all round.

The right solutions need to be developed with these communities and from within them. To do this in a successful and sustained way requires local intelligence, strong relationships and the freedom to act, which can come about only through the activation of place-based partnerships. The alliance view is that too much system interference, control and direction, even if well-meaning, gets in the way and works to prevent the active involvement of the voluntary sector, which has been shown to deliver five times as much benefit per pound spent as statutory services. In this alliance, the aim is that they are an equal partner.

Improved working together across the interface of health and social care leads to other benefits, and ICSs should have a duty to pursue these. In north-west Surrey, the hospital's recruitment hub, set up during the pandemic to support furloughed members of the community, successfully appointed people into the hospital workforce, many of whom have now taken up permanent employment. As well as being good for the alliance, this means that local people can continue to make a positive contribution—a major determinant of well-being—and support the local economy. The hospital is now working with local schools to build ladders of opportunity from learning into careers in health and care.

The alliance has been successful in securing one of the six new Cavell integrated primary care centres in the country, in Staines. This presents a unique opportunity to bring together hospital services, primary care, social

[Lord Mawson]
and business entrepreneurs, housing and the arts in a community setting. This team have focused together on their place and have been working together as a partnership for around five years. They have started to see the enormous potential that exists in this integrated care model.

Will the Minister agree to meet the chairman and CEO of this hospital trust so that we can share with him and the Government the lessons learned to date and the opportunities that have presented themselves, as colleagues in the alliance have simply joined the dots? A simple "yes" would do.

5.43 pm

Baroness Harding of Winscombe (Con): My Lords, I declare my interest as I recently stepped down as chair of NHS Improvement and as interim executive chair of what has become the UK Health Security Agency, including NHS Test and Trace. I congratulate the noble Lord, Lord Stevens, on his excellent maiden speech, and welcome him. Clearly, he will be a great addition to this House.

I am very supportive of the central thrust of the Bill, that of putting system-based working in health and care on a statutory footing. Modern medicine is a multi-disciplinary, cross-functional team effort. Most patients have multiple conditions and are cared for by multiple organisations. As the noble Lord, Lord Mawson, has just said, the largest determinants of healthy lifespan are not our health services but education, housing and the economy. To deliver great healthcare, the different parts of the NHS must work together, and to have longer, healthier lives, we need our NHS to work collaboratively with local government, public health, social care, the third sector and the private sector. This Bill puts that permissive, collaborative, systems-based leadership on a legal footing and, as such, I am pleased to support it. However, there are issues that we should challenge and probe in the Bill. I will focus on two.

The first, as many others have said, is workforce. These last two years have been challenging for virtually everyone in the world, but it is people working in health and care who have had to dig deepest, work hardest and bear the brunt of the fight against Covid. I thank every person working in health and care for what they are doing for all of us, day in, day out, night in, night out. Sadly, the Bill lets these people down by not being honest about the single biggest challenge that our health and care system faces: workforce. We do not have enough clinically trained people in almost every discipline, from healthcare assistants to consultants. When I joined the NHS four years ago, it was clear that we needed to do much more to support our people. From the basics of no hot food for people working overnight, to limited mental health support for people doing highly stressful jobs, through to the lack of honest and fair performance management, talent planning and career pathways, many of the basics that you would expect to find in large people organisations are not consistently available.

One of the things that is most glaringly absent is open and transparent planning for workforce numbers. Three years ago, I was asked by the then Secretary of State to lead the development of the NHS people plan. The *Interim NHS People Plan*, published in June 2019, set out significant programmes to make the NHS a better place to work, to improve leadership culture, to recruit more nurses and to change the skills mix, but it did not contain any forecasts of workforce numbers. Why was this? It was not because the work was not done—it was—and not even because the Government disagreed with the numbers. There are no forecasts because we could not get approval to publish the document with any forecasts in it. My experience is clear. Unless expressly required to do so, government will not be honest about the mismatch between the supply and demand of healthcare workers.

It is depressing that we are debating the publication of plans, because it is not plans that the service needs but people, which means spending money on training. Over the last eight years, Health Education England's budget has remained flat, while spending on NHS services has grown by over 40%. Unbelievably, today, a month after the Government's spending review, Health Education England does not have an agreed budget even for next year, let alone longer-term funding. Clearly, we must also change how we work; otherwise, roll everything forward 20 years and virtually the entire UK adult workforce will be needed to work in health and social care. However, none of that change is likely unless we are honest about the real size of the problem. The Government refused to accept an amendment to Clause 35 in the other place, and I urge them to reconsider.

My second concern is in the drafting of the new powers of direction that this Bill gives to the Secretary of State. It is right that Ministers who account to Parliament daily on NHS issues should be able to direct the NHS to act, but it is also important that we have the right safeguards in place, especially when the inevitably short-term pressures of politics conflict with the longer-term realities of science. Will my noble friend the Minister carefully consider feedback on the safeguards required for the many expanded powers of direction in this Bill, including reconfigurations, organisation structures, HSIB investigations, and foundation trusts' use of capital? The collaborative systems leadership at the core of the Bill requires openness and honesty about the difficult trade-offs that are inherent in managing our most precious public service. The Bill needs more of it.

5.48 pm

Lord Pendry (Lab): My Lords, I too congratulate the noble Lord, Lord Stevens, on his maiden speech. We all look forward to hearing more wise words from him, I am sure.

We all have waited patiently for the White Paper that was promised by the Prime Minister two and a half years ago, when he said that his Government would fix social care problems "once and for all". We have now had the White Paper and a Bill, but there is no way that it will fix the many problems that exist in the social care system. At the same time, it would be churlish not to acknowledge that within the Bill there is some recognition of what many of us have been demanding for many years, well before the Prime Minister's boast.

However, the Bill is silent on many of the problems of social care, and certainly in no way meets the needs of an integrated system between social care and the National Health Service. Instead, we shall continue to have an unequal system whereby the National Health Service will be a part of, rather than at one with, the social services. Funding allocation for social care in the Bill is far too small for the reform that is needed. There is no recognition of the important role that carers play as an essential part of supporting the National Health Service or the important role that they played alongside the National Health Service during the difficult months of the pandemic crisis.

I have always declared my interest in debates of this kind as a member of UNISON, a union with many health and social care workers among its membership. Before I was elected to the other place, I was a union official for nurses, midwives, care workers and others in the health service. Since arriving in Parliament, I have always shown an interest in those workers, who have always been at the wrong end of the wage scale. Nothing has changed in this respect; it is about time that they are recognised for the important role they play in our society.

In truth, the White Paper recognises some of the problems that exist in the workforce and includes a focus on career progression, the move towards the registration of care workers and the proposed changes to care certification. However, notwithstanding those improvements, there is virtually no coverage of the living standards of social care workers in the Bill. It shows a pathetic failure to grasp the gravity of the situation given the severe workforce crisis that exists currently. We all know that care workers are leaving the sector in droves, particularly over the past year. To put it bluntly, there is no point in highlighting the importance of a workforce if there are no workers there to be highlighted. Talk of their importance is meaningless.

To give a sense of the workforce crisis, UNISON shows the important state of the sector for care workers. Nearly 31% of care staff say that staffing levels are dangerously low and getting worse, affecting the care provided. Virtually all workers—some 97% of them—say that their employers are currently experiencing staffing shortages. Care workers have been overworked with low pay. These are all major factors among the reasons why they are leaving the sector for better pay. UNISON argues that 67% of staff say that they are thinking of leaving the sector altogether.

It is quite obvious that the Government must recognise that there is a crisis in this area and that they should do something about it—and quick. I could go on stressing the needs of care workers but time is clearly not on my side. However, I hope that this message gets clearly home to the Government because it is sadly needed.

5.54 pm

Baroness Campbell of Surbiton (CB) [V]: My Lords, I also congratulate my noble friend Lord Stevens on his maiden speech. Our past collaborations were always so productive. I look forward to working with him as a fellow Cross-Bencher.

In this debate, I will focus on the missing part of the jigsaw in the Government's Health and Care Bill. It requires further amendment if it is to address the care crisis for working-age disabled people. As drafted, this legislation hardly touches on the desperately needed funding reforms for that cohort. Instead, it is largely about inheritance. So much has been made of some people having to draw on their property and liquid assets to pay for social care that protecting accumulated wealth has become the overriding goal of reform. Under the reforms, the offspring of some wealthier homeowners will enjoy a more generous inheritance when they die. However, for disabled people, the Bill takes them nowhere and continues to limit their life chances. We all aspire to owning a home, providing for a family and saving for retirement—living life to the full. For thousands of disabled people, this is not possible without social care support.

Over a third of people who use social care are disabled people of working age. Their support accounts for at least half of council expenditure on social care. Persistent underinvestment by successive Governments has had two major consequences: first, fewer people have access to the support they need to live, even at a basic level, unless they can privately resource it, which means that they cannot play their part in the community either socially or economically; and, secondly, local councils, faced with ever-tighter budgets, are balancing their books by increasing charges for care. This effectively wipes out the funding that disabled people receive from the DWP to meet their extra living costs and avoid poverty.

The Care Act 2014 went some way to address this injustice. According to the Health Foundation, the amendment to the Care Act in the current Bill will not do so. It says:

> "Consider a disabled person with no assets, care needs amounting to £500 per week and an income of £50 per week above the minimum income guarantee. If the £86,000 ceiling is reached taking account of their care costs, they will contribute the £50 for 3.3 years. However, if the £86,000 ceiling is to be reached using only their own contributions, it will take them 33 years to reach it. Put simply, they will be 10 times worse off under this Bill."

This will clearly deny countless generations of disabled people the same economic opportunities. The Bill effectively favours wealthier homeowners over those with more modest assets and lifelong disabilities. That cannot be right.

As the national network Social Care Future clearly identifies in its material,

> "we all want to live in the place we call home with the people and things that we love … doing the things that matter to us".

Social care exists to support us all in that ambition. We know that government investment in social care for working-age disabled people will pay dividends. This Bill provides the perfect opportunity to do just that, if—and only if—it is amended. It is simply unfair to place some people at greater economic disadvantage because they happen to be disabled. I really look forward to working with the Minister on this Bill to make it fully inclusive and fair for all.

5.59 pm

Baroness Tyler of Enfield (LD): My Lords, it is a privilege to follow the noble Baroness, Lady Campbell. I want to congratulate the noble Lord, Lord Stevens, on his quite outstanding maiden speech.

[Baroness Tyler of Enfield]

Overall, I welcome the shift away from competition to greater collaboration and integration in our complex health and social care sector that this Bill signals, but, like others, I am very concerned about the timing of this legislation. The health and social care systems currently face extreme challenges, workforce shortages and burnout, a resurgence of Covid with a new, more transmissible variant, a huge pandemic-induced backlog of treatment, winter pressures and social care in crisis. Now does not feel like the right time for a structural reorganisation which will inevitably divert scarce clinical and management attention from front-line delivery. So my first question to the Minister is: why now?

Secondly, the fundamental problem that the NHS is confronting is a lack of capacity and resilience, particularly the lack of spare capacity in the system, meaning that it is continuously running at an unsustainable "hot" level of bed occupancy. The UK has 2.7 hospital beds per 1,000 of population compared to an EU average of 5.2 and significantly fewer doctors and nurses per head of population. So my next question to the Minister is: what plans do the Government have urgently to increase capacity and deal with workforce shortages, and how does this Bill help? Like others, I strongly support the calls for Clause 35 to be amended so that the Secretary of State must publish independently verified assessments of current and future workforce numbers every two years.

I wish to focus briefly on three issues that I shall pursue in the Bill. First, the Bill reads as if it is written by adults for adults. Babies, children and young people make up 30% of the population. They have their own distinct workforce, a distinct legal framework and distinct services. More needs to be done to ensure that the benefits of integration apply equally to the children's system, and this should be made explicit in the Bill.

It is vital that children are prioritised in the new integrated care systems and that a national accountability framework supports them to deliver improvements in health and social care outcomes for children. There must be a plan to set out clearly how existing duties, including leadership of local safeguarding arrangements, will be transferred from CCGs to integrated care boards without endangering the safety of children or impacting on the provision of services. Following the heartbreaking and horrific murder of Arthur Labinjo-Hughes, the Bill should be used as an opportunity to strengthen leadership within these safeguarding partnerships, to improve independent scrutiny of the arrangements, and to ensure that action is taken in response to the lessons learned.

Secondly, as highlighted in a recent report on child vulnerability by the Lords Public Services Committee, there needs to be improved data sharing to allow better joint working across health, education, and children's social care. As the noble Lord, Lord Bichard, pointed out, data sharing in the Bill currently applies only to the adult system, for reasons I do not understand. The Bill must surely be amended to make it clear that the benefits of better information and data sharing apply equally to children and that agencies can and should share data where it is in the best interests of children to do so.

Mental illness represents up to 23% of the total burden of ill health in the UK but only 11% of NHS England's budget. At present, there is no assurance in the Bill that mental health will be given equal precedence with physical health in integrated care systems or by NHS England. This is disappointing after the hard-fought and successful battle, which many noble Lords were involved in, to amend the 2012 Act to make it clear that the Secretary of State must prioritise mental health as much as physical health. While the new Bill does not remove this duty from the Secretary of State, it fails to replicate it in the new triple aim. Like the noble Baroness, Lady Morgan, I want mental health to be mentioned explicitly in the NHS's triple aim and in relevant parts throughout the Bill to specify that NHS England, ICBs and ICPs are expected to pursue "parity" between mental and physical health in all their functions and to report publicly on their outcomes.

Finally, on health inequalities, there is clearly scope for the Bill to be strengthened, as the noble Lord, Lord Patel, made clear. The pandemic has cruelly exposed and exacerbated health inequalities that have long existed in our society. I was going to set out various places where that could be done, but the noble Lord did it so comprehensively and clearly that I shall not repeat it.

If levelling up is to mean anything, the triple aim should be amended explicitly to reference health inequalities, thereby sending a clear signal to all parts of the new healthcare system that this is a priority at all levels.

6.05 pm

Baroness Cavendish of Little Venice (CB): My Lords, I welcome much in this Bill, especially the provisions on childhood obesity, and I welcome the end to the 2012 Act clauses which obstructed collaboration between primary and secondary care and community services. I congratulate the noble Lord, Lord Stevens of Birmingham, on the work that he did to formulate so much of what is in this Bill and on his maiden speech.

However, as we scrutinise the Bill, there are a number of things that we should look at. The noble Lord, Lord Lansley, will be surprised that I am going to agree with him on something for once, but I wonder what the philosophy is that is going to drive up standards of patient care. Competition in the form we used it did not work for the reasons discussed, but the danger of the new ICS structure is that we could create local monopolies and will not be focused enough on what really matters, which is driving up patient care. We need to think about how we define what we mean by success for the ICS and how we define failure. That failure regime is not clearly enough set out in the Bill. I also think that FTs should keep their independence, which Clause 54 would seek to remove.

Essentially—the noble Lord, Lord Mawson, made this point eloquently—we have best practice all over the place in this country. We have wonderful people doing wonderful things in the NHS and social care. Everywhere you look, you can find somebody brilliant, often working against the system, who is getting it right. Our problem is that we never seem to be able to spread that best practice to anywhere. The argument for ICSs is that they are bigger, they will contain more

ambition within them, and so we will be able to drive their ambition in that way and bring the laggards with us. I think that will be largely true, but we need to make them entrepreneurial. A number of noble Lords in this debate have proposed all sorts of extra people who might sit on these boards. I would only warn that talking shops really do not get things done; we have far too many of them already and I hope that we will be able to keep these things relatively slimline.

As many speakers have said, the biggest limiting factor in the NHS and care at the moment is staff. I would support a new amendment to Clause 35. I suggest that we consider removing the reference to the OBR which Jeremy Hunt made in his amendment; that would make a big difference. I do not think that it is necessary for the workforce strategy to be consistent with fiscal projections, and I hope that might be considered by the Minister.

As the noble Baroness, Lady Harding, and others have said, we also urgently need to retain staff. We need to train them; yes, HEE needs a bigger budget, but we need to retain the wonderful people that we have. If there is any chance within the structure of this Bill to remove every impediment possible to resolve the pension issues for GPs and to reduce paperwork wherever we can, I urge that we should take it.

We need much better data sharing, but when I was working as a temporary adviser to the DHSC last year, I had a worrying conversation with a wonderful receptionist in a care home. She said to me, "I haven't been able to talk to a single family today; I've got grieving families trying to get through to me on the phone. They can't get through because it is clogged up with people from local authorities, people from the Department of Health, people from Public Health England, who are calling me to find out the data." That was a major failing in the pandemic, and we are in danger of making the same mistake again. We must commission for outcomes, but we must find ways to measure them which do not mean multiple agencies—I should have added the CQC, on which I used to sit, to that list—ringing up front-line staff, who have better things to do. We would raise the morale of front-line staff if we stopped asking them to input data into systems again and again.

I want to make two further points. First, if we are serious about parity between mental and physical health, I suggest that we use that phrase to replace "health" in the Bill wherever we can. Finally, Covid-19 has of course exposed what we have long known about health inequalities in this country. I urge the Minister to consider whether the triple aim could be expanded more explicitly to focus on health inequalities.

6.09 pm

Lord Bethell (Con): My Lords, I thank the Minister for his extremely good introduction to the Bill, He has taken to the job incredibly quickly, taking on this massive Bill so enthusiastically; it is incredibly impressive. I also make a personal testimony to the noble Lord, Lord Stevens, who I knew from the battle against the pandemic over the last two years. His expertise and experience were brought to bear against that awful disease, and I am so pleased to see him now in the Chamber contributing to this important debate.

The Minister is right: this is a proportionate and welcome Bill that enables us to make important changes. The noble Lord, Lord Stevens, is right that it came originally from the health and care system. We should remember that when we comment on it, because it is an omnibus Bill that gives those at the front line the tools they need to improve the system. I completely endorse those who have spoken about the importance of collaboration. My noble friend Lady Harding spoke much more fluently than I possibly could. Medical clinical care very often involves complex issues that need a huge amount of collaboration and work to succeed. Therefore, this Bill should try to smooth out anything that creates inadvertent competition, barriers to discussion or hurdles to getting things done. I think that it gives the system the tools to be able to do that.

I also endorse those who have talked about the importance of prevention. The noble Baroness, Lady Cavendish, is absolutely right; the noble Lord, Lord Stevens, called it a challenge that many advanced economies are facing and he is entirely right. Prevention is key. The pandemic showed us that our current health system is living beyond its means, and we have nothing but challenges ahead of us. The population health measures enabled by the ICSs are potentially critically important. This Bill only enables that potential; I would endorse its power and encourage the Minister to run really hard at prevention.

That is why I support Clause 4 on cancer detection, which was introduced in the other place. It touches on the point referred to by the noble Baroness, Lady Cavendish; by putting an emphasis on outcomes rather than the operational details of cancer detection, it is trying to introduce an important inflection point that I think could be duplicated elsewhere. That is also why I support Schedule 17 on junk food advertising; we have to seize the nettle on that. There was so much sadness in the daily meetings that I used to attend in ICU units. When the numbers of people being intubated were ticking up, so often they were because of comorbidities created by overweight. We need to tackle our obesity epidemic; that is why Schedule 17 is so important. I would also endorse those who have supported the work on hymenoplasty; while I welcome the Government's moves in this area so far, I think they can go further.

What I really want to endorse is innovation. Data has been mentioned by a large number of noble Lords. The noble Baroness, Lady Cavendish, talked a bit about productivity; the noble Baroness, Lady Barker, talked about patient care; one noble Lord talked about safety. They are all absolutely right. Clauses 81 to 87 in Part 2 are critical, and I would like to hear the Minister's endorsement of those. I also support the commitment to research. The noble Lord, Lord Kakkar, spoke very well—much better than I could—about the case for strengthening ICSs' commitment to research. If the NHS is to achieve what it needs to achieve, it needs to double down on its ability to deliver research; this is an area that the Minister should very firmly commit to looking at, as the Bill makes its progress.

6.14 pm

Baroness Bakewell (Lab): My Lords, I welcome a Bill that brings together the National Health Service and social care. How could I not? It is a long overdue

[Baroness Bakewell]
development. However, I have serious reservations about the Bill's direction of travel. I fear that the reforms set out here will fragment and disconnect the NHS from the very people—the patients—it was created to serve. The proliferation of protest groups and increasing numbers of petitions, as well as individual cases to challenge existing changes being taken all the way to the High Court, all bear witness to a popular groundswell of opposition to what is happening.

There also comes a warning this week from former Health Secretary Jeremy Hunt about the risk of equity-funded investment in care homes. When the motive is profit, he says, standards of care are squeezed. The NHS motive is exclusively private care—and so we come to the continuing inroads made into the NHS by Centene, America's leading health insurance company and its subsidiaries in this country under Operose. They have been steadily buying up surgeries around the country and including them on their schedule of profit-making enterprises designed to offer good returns to their global shareholders.

Anyone with any knowledge of American healthcare, whether first-hand or reported, will know how expensive it is. The level of your care depends on the level of your insurance; without insurance, you can be refused care. The *New Yorker* recently reported that American hospitals are closing at a rate of 30 a year. It reported that, increasingly, hospitals are seen as businesses—that

"a fifth of hospitals are now run for profit, and, globally, private-equity investment in health care has tripled since 2015."

In 2019, according to this report, some £60 billion was spent on acquisitions globally. That "globally" includes—indeed targets—us and our NHS.

Centene and its British subsidiary Operose now own 70 surgeries around the country, from Leeds to Luton, from Doncaster to Newport Pagnell, from Nottingham to Southend, and in many other areas, Centene/Operose now owns and runs for profit surgeries formerly owned and run by NHS doctors. It is now the biggest provider of GP services in the country. It has further designs on the existing fabric of the NHS, seeking to have its representatives sitting on the boards of CCGs, and making decisions about the deployment of NHS funding. This is a direction of travel that needs to be monitored and checked—and it will be.

Why does all this matter, as long as patients have good and free treatment at the point of delivery, wherever they need it? What is the reputation of the company Centene in America? It is not good. Since the year 2000, there have been 174 recorded penalties against Centene, its subsidiaries and its agents for contract-related offences against its patients. The fines paid by Centene go into millions—billions—of dollars. This is not a fit company to be part of the NHS. I repeat the Government's campaigning cry: "Take back control"—of our NHS.

6.18 pm

Lord Crisp (CB): My Lords, I first congratulate my noble friend Lord Stevens on an excellent maiden speech. I agree with him that there are substantial opportunities in this Bill, although some things are missing, some of which he referred to, such as mental health and determinants of health. As other noble Lords have discussed, however, I feel the complexity of some of these processes and the difficulty of getting one's mind around how this will actually work.

I agree with so much that has been said about social care, particularly on the cap. I trust that your Lordships' House will send this back to the other place rapidly for it to think again. I also agree with many points that have been made on the workforce, although I would make a single observation—that we need to pay attention to changing roles as well as to numbers. In the case of primary care, it will not look in 15 years' time as it does now. This is for all kinds of reasons, including the way that nurses are taking on a much bigger role; they will continue to do so, and I suspect they will be the lead providers in primary care in 15 years' time. That is a simple prediction that I may come to regret.

When you make a change such as this, you disrupt the system and some arrangements that used to work. There are two more specific points that I should like to explore in Committee. One is how we ensure that primary care—GPs, but primary care more generally—still has a significant role in approving plans. I recognise that there are practicalities around that, but it is vital that it retains some impact. I also think it is very important that foundation trusts can maintain sufficient independence of action. I know that the concern of NHS Providers is about control of capital in that regard. Some things need to be explored further.

However, my main observation is to follow other noble Lords in saying that we are talking here about integrating health and social care, but that is 20% of the issue; there is so much more outside that. We know all about social determinants; many have mentioned them. We know the massive impact of education, employment, training and housing—both positive and, I may say, negative—on health, and we know the science that underpins that: about relationships, how social isolation leads to dementia; how exercise, exposure to nature, and such aspects, make change. We need to capitalise on that.

I want to make two points that are slightly different from what others have said. First, this is not just about prevention. Prevention is about the causes of ill health; we need to be thinking also about the causes of health, and the two things are often run together in ways that are unhelpful. Creating health is about creating the conditions for people to be healthy and helping them to flourish. It is about human flourishing, eudaimonia, if one wants to go back to Aristotle.

The second point, which goes alongside it, is that the health of the individual is intimately connected with the health of the community in which they live. This is a point that the noble Lord, Lord Mawson, in particular, exemplified with his discussion about Well North, but also his early experience in Bromley by Bow. There are now examples all over the country of people starting to bring together the things that improve communities with the things that improve individual health. That is a vital part of the future. We have known that for years, but we have not known how to connect it properly with the NHS. I speak as a former chief executive of the NHS in England who failed to make that happen.

My question to the Minister is: how will the Government ensure that those other groups in society—voluntary organisations, housing associations, employers, schools, educators and so on—contribute to creating health and, thereby, supporting the NHS to do its vital work? We need to see health in terms of wonderful healthcare and services and prevention of disease, but also creating the conditions for people to thrive. The underpinning thought here is that our health as individuals is intimately connected with the health of our communities, of society at large and, ultimately, of the planet.

6.22 pm

Baroness Blackwood of North Oxford (Con): My Lords, it is a pleasure to follow the noble Lord, who was chief executive at my father's hospital. I refer to my role as chair of Genomics England, as declared in the register.

The future of health and care must be collaboration, increased productivity and innovation. To that end, there is much to welcome in the Bill. As the noble Lord, Lord Stevens, put it so clearly in his outstanding maiden speech, the Bill is based on recommendations from NHSEI and local health and care leaders, so it is no surprise that it removes statutory barriers that are preventing front-line NHS leaders responding to current challenges. The NHS Confederation agrees. It says that it is not a top-down reorganisation; it is providing a legislative framework for what is already happening on the ground. The King's Fund says that it has nothing to do with privatisation.

Moreover, I cannot count the number of times we in this place have agreed that integration of services is absolutely critical for delivering higher quality care, and this Bill enables that through health and care partnerships. We have also frequently violently agreed on the unintended consequences of the internal market, so I am looking forward to an outbreak of consensus on the abolition of mandatory tendering, as well as the many public health measures for which I have heard many in this place campaign. It is a move away from competition to collaboration, which can be only beneficial, particularly when the NHS is facing so much pressure.

Having said that, I also say that there are many genuine issues for debate. Others have raised workforce planning, social care and the Secretary of State's powers very eloquently, so I will not speak to them now—there will be time for debate—but I strongly associate myself with the eloquent contribution of my noble friend Lady Harding. Instead, I add my voice to those who have called for the Bill to go further on clinical research. Evidence shows that research-active hospitals have better patient outcomes, more satisfied staff and higher CQC ratings. For patients such as me with rare diseases, participation in clinical research may be the only way to access effective treatment. We have all seen the impact of the pandemic on the landscape of research. On the one hand, the response to Covid-19 has been phenomenal. RECOVERY, PRINCIPLE and the vaccine trials have all demonstrated our capacity to deliver clinical research with global impact at unprecedented pace and scale. We should be incredibly proud of that.

On the other hand, non-Covid clinical research has faced enormous disruption. Many studies have been paused or cancelled altogether, as those research staff were redeployed either to front-line activity or to Covid studies. Data from the ABPI shows that the number of participants enrolled in commercial clinical trials was 15% lower in June 2021 compared to June 2019, while in Spain and Italy enrolment rose by more than a third during the same period. As a result, the UK has now fallen to fifth in Europe in phase 3 trials initiated per year. As we restart care, we must ensure that non-Covid research is also reprioritised. Of course, that will require the staff and resources to ensure capacity to deliver research at the same time as NHS recovery. I believe that this is exactly what the Minister wants. The Government have set an ambition for the UK to be the destination of choice for clinical research, but we have to ensure that we have the capacity within the health and care system to deliver that research and prioritise it while delivering that recovery. We can start with that today.

Like the 2012 Act, the Bill only includes a duty "to promote research" in Clause 19. While welcome, that has too often allowed clinical research to fall down the agenda. We can do more. The Bill provides a once-in-a-decade opportunity for us to embed research right at the heart of the NHS by putting that ambition on a statutory footing.

The Bill would be stronger if we mandated integrated care boards to ensure that the NHS organisations for which they are responsible are conducting clinical research. They should publish and transparently track that research in their annual reports and joint forward plans to understand exactly how that clinical research is being delivered in a way that meets the needs of local communities and ensures that they are increasing the diversity of participation.

Those proposals are supported by a long list of medical research and patient charities, as I am sure would be expected, but also by a number of colleagues in the other place who tried to push forward such amendments. Sadly, so far, they have failed. I urge the Minister to think again as the Bill goes through the House, because we have the opportunity with it to encode clinical research—and the hope that it gives so many—directly into the DNA of the NHS. Please do not let this opportunity pass as we take the Bill through this House.

6.28 pm

Baroness Hollins (CB): My Lords, I declare my registered interests, including my presidency of the Royal College of Occupational Therapists and the Royal Medical Benevolent Fund, and my chairmanship of the oversight panel reviewing the care of people with learning disabilities and autistic people who are being detained in long-term segregation. I plan to make five short points but, first, I welcome the encouraging maiden speech of my noble friend Lord Stevens of Birmingham, and I am glad that he highlighted the importance of mental health.

I introduced an amendment to the Health and Social Care Act 2012 with support from many noble Lords, including my noble friend Lord Patel. It committed the Government to parity for mental and physical health and illness. Some progress has been made, but not nearly enough. The Royal College of Psychiatrists suggests that there is scope to extend the commitment

[Baroness Hollins]
to mental health in the Bill across all levels of NHS organisation, including on integrated care boards. I agree.

My next point is that getting it right for people with learning disabilities would be a litmus test of how far we have made adequate and safe provision for everyone. That is what addressing inequalities is about. People with a learning disability face many barriers which contribute towards premature and avoidable mortality, including discrimination, such as the inappropriate application of "do not resuscitate" orders; or existing legal duties not being met, such as providing reasonable adjustments or meeting requirements of the Mental Capacity Act.

I support the proposed new legal duty on the CQC to assess the performance of local authorities in discharging their regulated care functions under the Care Act, as recommended by the Health and Social Care Select Committee. Mencap suggests that there should be a specific duty on ICBs to take account of the needs of people with learning disabilities. This goes further than the recommendation in the autism strategy, which is simply for a named learning disability and autism lead.

My third point is about education and research, both of which are essential to recruitment, retention and equality right across all care, well-being and health services. I will focus on education for a moment. Education is central to reducing discrimination and removing the barriers to equal access. The Government have stated their intention to introduce mandatory training in learning disability and autism for all health and social care staff. This recognises failings in existing mainstream health and social care training. Furthermore, an annual turnover of nearly one-third of all social care staff is a shocking waste of human resources. I would support meaningful training and valued career pathways, especially for direct care staff. We could learn such a lot from countries such as Germany.

If we do not plan for future generations by making children and families central to this legislation, including families with disabled children, we are letting down future generations. Beginning with the first 1,001 days, from conception to the age of two, would build the foundations needed for lifelong health and well-being.

Finally, care is not secondary to health but fundamental to it. The current system is often too mired in bureaucracy, with budget wrangling leading to poor service provision and poor outcomes. In my view, we urgently need a national care and health Bill that is genuinely integrated. It should see people of all ages as whole people whose mental and physical health and well-being cannot be divided up into packages, having been thought about and funded from within different organisational structures.

This Bill is an opportunity to bring true integration between health and social care and between mental and physical health services and to improve outcomes for everyone. We should also remember the social determinants of health, the role of the voluntary sector and the informal elements of care and well-being. I hope the Minister will consider my points as the Bill progresses, and I would welcome a discussion around supporting the amendments required to enable them.

6.32 pm

Baroness Pitkeathley (Lab): My Lords, it is a privilege to follow the noble Baroness, with her wealth of experience in this field, both personal and professional. I too welcome the noble Lord, Lord Stevens, and look forward to working with him again.

It has always been my role in your Lordships' House to remind colleagues that, whatever reforms we make to health and social care, however many new acronyms we have, and however many new structures we set up, the bulk of health and social care in our society is provided not by paid professional services of any kind but by the so-called informal sector, the unpaid army of family, friends, neighbours and communities on whom we all rely.

Carers play an essential role in supporting the NHS and social care systems. Without their support, our systems would not have been able to cope with the increased demands they have seen during the pandemic. For many years, we have used the estimate of 6 million unpaid carers. During the pandemic, about 4.5 million people took on new caring responsibilities. Their total contribution is now estimated to be worth £193 billion every year—more than the cost of the NHS itself.

My test of any new legislation on health and social care is: how does it affect carers and will it help them be recognised for the vital role they play? The answer to that question is only partly positive. Carers welcome greater integration and collaboration between health and care services—the stated aims of this Bill—since their lives are made even harder when services are not joined up and data is not shared effectively and efficiently. I very much welcome the duty in Clause 6 to consult carers, and the duty on integrated care boards in Clause 20 to consult them around planning and commissioning.

There are some large omissions in the Bill which will have to be rectified if carers are not to suffer as a result of its introduction. For example, I suggest that a new duty should be placed on the NHS to have regard to carers and to promote their health and well-being. Carers are not systematically identified, supported and included throughout the NHS, although good practice does exist. In most social care systems, carers are legally recognised, but this does not apply to the NHS. For effective integration to be achieved across the system, there needs to be a statutory duty to have regard to carers and to promote their well-being. I remind your Lordships of the negative effects of caring on carers' own health, with three-quarters of them reporting that their own physical and mental health is affected as a direct result of caring responsibilities.

Clause 80 is of great concern. This has been extensively debated in the other place. Incredibly, it actually removes rights from carers—rights which were hard fought for by me and many others during the passage of the Care Act 2014 and in other legislation. This Bill repeals the legislation that gave carers a fundamental right to an assessment and ensured that services were provided to make sure that hospital discharges are safe. There are endless horror stories about unplanned discharges with which I could regale your Lordships if time permitted. Some 68% of carers say that they were not asked whether they were willing and able to care at the point of discharge. Some 61% report that they were

not given the right information and advice to help them care safely and well. Surely we must, at the very least, maintain carers' rights, not reduce them—so this must be amended. I am sure that the Minister, with his understanding of carers' needs, will be sympathetic.

I have two other areas of concern. The first is about the definition of "carer". This is not defined in the Bill. Since the NHS is an all-age service, we assume that the definition that already exists under previous legislation will apply and that young and parent carers will therefore be included—but this must be defined and clearly stated in statutory guidance.

I also share the concern mentioned by many other noble Lords about the cap. Research by Carers UK found that 63% of carers were contributing financially in their role. For some, the contribution was relatively modest but, for others, it ran into hundreds of thousands of pounds. These proposals without the cap will leave many carers with low or modest assets very worried indeed.

I know that many of your Lordships recognise the contribution of unpaid carers. Indeed, many of us will be carers at this very moment, will have been carers in the recent past, or expect to be carers at some point in the future. I am confident therefore that we shall be able to amend this Bill to make it another important step in the hard-fought process of getting unpaid carers the recognition and support they so richly deserve.

6.38 pm

Lord Kerr of Kinlochard (CB): My Lords, unlike Mr Gove, the House has definitely not had enough of experts, as our welcome for the noble Lord, Lord Stevens of Birmingham, has shown.

I am an amateur, but a couple of years ago I was lucky enough to serve on the Economic Affairs Select Committee, under the brilliant chairmanship of the noble Lord, Lord Forsyth of Drumlean. I am sorry he is not here today. We wrote a report called *Social Care Funding: Time to End a National Scandal*, which is well worth rereading in the context of this Bill. I have been trying to work out whether the Bill does much to deal with this national scandal and have concluded, sadly, that it does not—indeed, it does not really try.

I would not have raised national insurance contributions to provide the money that the National Health Service so badly needs right now. Taxing work rather than taxing wealth is intrinsically and fundamentally wrong. But what really sticks in my craw is to brand the increase in national insurance contributions as needed to fund social care, and then to ensure that none of the money can go to social care for at least two or three years—probably never.

In my view, social care funding has to be ring-fenced. If the money is all in one pot, the NHS will always snaffle it for understandable, well-known reasons. An ageing population brings ever-increasing demands; the more successful the NHS, the greater the demands on it; and welcome advances almost always bring strongly positive relative price effects—medical inflation runs well ahead of general inflation. Medicine also provides the prestige jobs. Social care is the poor relation, struggling for attention and not getting it at all in this Bill.

I am all for improved co-ordination between hospitals, GPs and care workers, and I welcome some of the provisions in Clauses 21 and 26, as mentioned by the noble Lord, Lord Stevens, but they do not address the funding problem. Continuing to rely on local government to find much of the money seems to me to be both hypocritical and inequitable. It is hypocritical, because local government has been squeezed by a decade of cuts and because central government will always want to minimise the taxes for which it is blamed, while someone else gets the blame for inadequate local services. It is inequitable, because some parts of the country will always be richer than others.

Of course, the link to business rates is particularly regressive. The 2019 report from the Select Committee pointed out that

"Demand for social care is often greatest in areas where business is least buoyant."

Social care needs central funding.

On staffing, current levels of pay and conditions for the 1.5 million people who work in the care sector are a scandal that the Bill does not address. Nor does it look at how to find them. In 2019, 8% came from elsewhere in the European Union and 10% came from further afield. They are insultingly and quite wrongly classified as unskilled workers, so will the Home Secretary let them in?

Thirdly, the Bill ignores unpaid carers, that unseen army of friends and family—often children—on whose kindness we trade unfairly. They need help, but the Bill does not mention them; the words do not occur in it.

Fourthly, reading the Bill, one would think that social care is for those in their declining years, and I join those, like the noble Lord, Lord Bichard, who find Clause 140 shockingly regressive. The fact is that well over 50% of what is now spent nationally and locally is to help people of working age, not to fund care homes but for daycare centres, home visits and helping those with disabilities. The provision of social care is notoriously patchy across the country. The Bill will not cure that, and I do not think that a cure will be found until social care has its own ring-fenced national funding, its own national standards and, in my view although not that of the Select Committee, its own national service: an NCS to match the NHS.

So my biggest concern about the Bill is what is not in it. A fortnight ago, the Health Secretary told the other place that it reflects the Government's

"commitment to end the crisis in social care and the lottery of how we all pay for it."—[*Official Report*, Commons, 23/11/21; col. 311.]

I only wish that were true, but I fear that an opportunity is being missed.

I will make one last point very briefly. I was struck by Mr Javid's rejection of the suggestion that he be required to obtain the consent of the relevant devolved Government before making regulations under the Act in an area of devolved competence. Surely that is what the devolution settlement requires? Whatever happened to the Sewel convention? I rather hope that a version of Amendment 82, which was rejected in the Commons at the Government's insistence, will be retabled in this House.

6.43 pm

Lord Farmer (Con): My Lords, I join with all noble Lords to welcome the noble Lord, Lord Stevens of Birmingham. I really enjoyed his constructive and funny maiden speech.

If integration is the aim of the Health and Care Bill, it fails in one extremely important respect, brought into stark relief by the tragedy of Arthur Labinjo-Hughes. I say this not to appropriate a hard case, but because the two reviews led by the noble Lord, Lord Laming, following similarly horrifying child deaths, both stressed the need to integrate all the services that should keep children safe. Although prevention and early intervention in the form of family help have been missing for too long from the pipeline that led to children's social care, this lack is now finally being rectified by the Government's focus on rolling out family hubs. Yet this important new infrastructure, which also integrates paediatric health, goes unmentioned in the Bill.

Family help needs to include an emphasis on the prevention of family breakdown, the elephant in the room of children's social care policy. As I said yesterday after the repeat of the Statement about Arthur,

> "Evidence shows that children on the at-risk register are eight times more likely to be living with a natural parent and their current partner"—[*Official Report*, 6/12/21; col. 1677.]

than the national distribution for similar social classes. Children living in households with unrelated adults are nearly 50 times as likely to die of inflicted injuries than children living with two biological parents. When both mother and father feel kin altruism towards a child, this can make a significant and decisive difference to that child's health. Good family and other relationships are health assets, so the Bill should treat family-based interventions as part of the overall health approach and recognise the need to integrate them with physical and mental health provision.

Even absent this monstrous case, the Health and Care Bill should be reinforcing and integrating other cross-departmental work in government, such as the commitment to champion family hubs for families with children aged nought to 19—or up to 25, if there are special educational needs. Family hubs build on the work of children's centres but go far beyond it and are central to the implementation of the Start4Life workstream, based in the Department of Health and Social Care. In fairness to the Government, this agenda has gathered considerable momentum since the Bill was published, and family hubs are now a big-ticket spending item in the £500 million spending-review commitment to support families.

They can also work preventively to meet children's health needs, in relation to childhood obesity for example, as close to home as possible. In Essex, family hubs deliver midwifery and immunisation services and prevent unnecessary attendances in GP practices and A&E. They also deploy community-based clinical expertise for conditions such as allergies, continence, perinatal mental health, speech and language services and neuro-developmental conditions such as autism. This means that busy parents, who often have several children to look after, are spared lengthy and expensive hospital visits. When getting to that visit proves too difficult for the family, the ill child goes without treatment, and hospital-based services have yet another wasted appointment.

A preventive community asset-building approach requires out-of-hospital care to be protected and enhanced, possibly by ring-fencing funding for community-based provision. Yet the importance of preventive health support and treatment has not been adequately covered in the Bill. It is simply listed as one of several commissioning requirements of ICBs, with no broad mention of children's health. Only young children are mentioned in the context of maternity services. Finally, the desired short and long-term health and well-being outcomes for children and families need to be determined, achieved and measured.

In summary, children's community health provision must begin with a preventive community asset-building approach and be aligned and integrated with public health and local authority-funded early-help provision. As Dame Rachel de Souza, the Children's Commissioner, said about Arthur, the life of a child is of "inestimable value". The omission of school-age children, young people and family support was always puzzling, given the integrating imperative of the Bill. It makes even less sense in the wake of this tragedy.

6.49 pm

Baroness Masham of Ilton (CB) [V]: My Lords, I am very pleased to follow the noble Lord, Lord Farmer. I am driven to start my contribution by referring to the cruelty of the evil stepmother and terrible father of little six year-old Arthur. I hope this Bill will update and include safe children's services. In doing nothing, incredible harm was done to this little boy, who was starved, poisoned with salt and beaten to death. I feel very sorry for the relations who tried to warn services but were ignored. Over the years, there have been too many terrible deaths and cases of cruelty towards neglected vulnerable children. I am glad that the noble Baroness, Lady Tyler of Enfield, is also supporting children today.

This Bill should improve communication and co-operation between services. Emergency services should be able to retrieve patient GP notes. X-ray and scan results should be able to be shared between hospitals and trusts. So much more should be done to speed up diagnosis and make emergency medicine a priority. It seems very concerning that there are young, bright people who want to train in medicine but there are not enough training places. We need more doctors, radiologists, radiographers, nurses and therapists, as well as all the other staff. The workforce is vital, as it is in social care and for disabled people living in their own homes. We have reached a crisis point.

The Bill can be improved if patient voices are included. Many people feel that the patient's voice should be included in both the integrated care boards and the integrated care partnership by Healthwatch or a similar body, which could collect data from all the different sources representing patients. Patient-public engagement needs retaining, and there needs to be more clarity around the relationship between ICBs, partnership boards and the CQC.

Reorganising the NHS and care services in the middle of a pandemic is an enormous challenge for all concerned. The Bill seems to be encouraging local services, with some hospitals in rural areas having

been downgraded. In order to get adequate services and specialised healthcare, patients have to travel miles and some patients need help to do this. Patients should not miss out because of where they live. Can the Minister confirm that all patients who need the necessary specialist treatments will get them? Patients with rare conditions also need access to the appropriate medicines, and very rare medicines should not be restricted. This includes end-of-life medicines, which should not be devalued.

The number of Members taking part in this debate shows how important health and care is to this country. Will the Minister tell us how much importance is being put on public health and the prevention of ill health? The extra workload due to coronavirus should not mean that other infections are put to one side. Working together and not in silos should help the social care providers; that seems to be what is needed.

In this Bill, who takes responsibility for sexually transmitted diseases such as HIV/AIDS, hepatitis, gonorrhoea, TB and many more infections? The global problem of drug resistance must not be neglected. There is also a growing problem of urinary infections and resistance.

We need to fight for our health. Therefore, scientists who produce vaccines should be supported. They need to know that the funds will be forthcoming so they can go ahead and produce new vaccines to fight new variants. Their research is vital to keep society safe. I hope this Bill will also keep our health and social care safe. I end by congratulating my noble friend Lord Stevens on his splendid maiden speech.

6.55 pm

Baroness Cumberlege (Con): My Lords, it is always a great pleasure to follow the noble Baroness, Lady Masham of Ilton. Listening to her makes me realise how wide-ranging this Bill this. It is complex, as well, and will be a great challenge to our Minister as he guides it through this House. Not only does there seem to be a growing acknowledgment of the Bill's complexity; there is also a consensus that the workforce crisis is the most significant challenge facing health and social care. All roads lead back to this problem. If we do not have the right numbers of staff with the right skills and qualifications, we will not be able to reduce the backlog. If we do not have the staffing capacity in social care, we will not be able to help people leave hospital. If we do not have sufficient capacity in primary and community care, unnecessary strains will be placed on secondary care. While the workforce problem remains at crisis level, we are still putting patient safety at risk.

There is no single solution. It is difficult; it requires a range of actions focused on recruitment, retention, pay levels, career pathways and better use of the skills of the wonderful people who work in both health and social care. It requires short-term fixes, where we can enact them. It certainly requires long-term planning and a clear strategy.

I listened carefully to the debates when the Bill was in the other place, particularly at Report stage, and to the right honourable Jeremy Hunt. I am very grateful for his thoughts and for those of the King's Fund, NHS Providers and all the other people who have been supporting us and pressing us with ideas. As the Bill progresses through your Lordships' House, I hope that we will explore what steps we can take to ensure that it sets us in the right direction on the serious workforce issue. With the support of noble Lords, I will seek to amend the Bill.

I am also concerned about the extensive powers of the Secretary of State to intervene in local configurations, and about the sheer range of delegated powers that the Secretary of State will have, which could impede the independence and effectiveness of NHS England and Improvement. I look forward to examining these issues in Committee.

Your Lordships will know that I have spoken in some detail in previous debates about the recommendations in our review *First Do No Harm*. Thankfully, I am not going to repeat those points today, but the fact is that the healthcare system—the whole system—failed. It let patients down. These were not a few isolated incidents; there was a pattern. It affected thousands of people, significantly, women and children. It was not just minor inconvenience or short-term problems; it was harm of the most devastating nature that continues even today. It was all the more devastating because it could, and should, have been avoided.

I am pleased that the Government have agreed to implement some—sadly, not all—of our recommendations. Once enacted, those recommendations will improve patient safety and reduce the risk of avoidable harm. Although we can do more to reduce avoidable harm, we can never prevent it completely. Therefore, when things do go wrong, we need a system that is responsive and compassionate. Surely, that is the hallmark of any decent society.

During latter stages of the Bill, I intend to table amendments to establish redress schemes for those who have already suffered and for a fresh way of dealing with similar cases in the future—one based not on apportioning blame and not stressful, expensive and time consuming, but instead a no-blame non-adversarial system focused on systemic failings administered by an independent redress agency. Such a system exists in other parts of the world and it works well. We should have it here.

Finally, I see the main aim of this Bill as to recognise and correct failings in the experience of patients, remove barriers to delivery, and decide whether following the science is best delivered by politicians and civil servants or top management and medical expertise. These are big questions to which we must find the answers.

7.01 pm

Baroness Chakrabarti (Lab): My Lords, I join the welcome to the noble Lord, Lord Stevens of Birmingham.

The pandemic has been a magnifier of every single inequality on the planet. I hope we can all agree on our enormous good fortune to live in the land of the NHS, arguably the greatest experiment in compassionate collaboration in the history of the world. It is cause for genuine patriotism without the slightest risk of xenophobia because this service is not just envied the world over, it was built by the hard work, endeavour and innovation of people from all over the globe as well. It even has "National" in its title and mission.

[Baroness Chakrabarti]

While some noble Lords have spoken eloquently about the need for local flexibility and responsiveness, I fear the Minister will have to do more to convince your Lordships' House—let alone those watching anxiously outside it—that this Bill will address widening inequalities in health, care and other outcomes, rather than baking in fragmentation and privatisation, notwithstanding his welcome opening remarks about the founding mission of a service which should be cradle to grave support, available to all and free at the point of use.

I join my noble friend Lady Bakewell in seeking greater safeguards to prevent private companies taking representation in NHS governance structures in a clear and institutional conflict of interest, inevitably necessitated by a profit motive, that will always threaten the principle of universal provision where there is limited supply and limitless demand. Similarly, public health and care professionals should be the default providers of these vital services that have proved as vital to the safety of the nation as the police and military over the last couple of years.

The complexity of this reorganisation has already been remarked upon at length, but I fear that it conceals rights of direction without corresponding overarching legal responsibility upon the Secretary of State. I would like to hear the Minister's specific explanation of provisions to the contrary. Statutory powers and functions should not be capable of delegation to non-statutory bodies. All those working in health and care should be protected, not just with warm words and applause, but with statutory recognition of terms, conditions, pensions and collective bargaining alongside appropriate management and regulation in the public interest.

As others have said, it is high time for a national care service to dovetail with our National Health Service, giving cradle to grave security for those in need of it and a parity of respect and protection to those working within it. Likewise, lifting mental health provision from its current Cinderella status and investing in such services as lifestyle and preventive care would save billions from being wasted on substance abuse and criminal incarceration, and provide rewarding careers for young professionals in an otherwise increasingly automated world.

Finally, I will say a word on the vaccinations, to which perhaps nearly all of us in your Lordships' House owe our lives. Those who peddle non-science about vaccines are just as dangerous and irresponsible towards their neighbours here and around the world as those who deny global warming. They of course have a right to express their views, but I suggest we have a duty to do more to correct their falsehoods.

Given that most of the initial investment in the world's major vaccines, including here in the UK, came from public and philanthropic sources, not to allow a narrow and time-limited vaccine patent waiver at the WTO so that the poorer nations of the global south can speed up vaccination and defeat variants, is as incomprehensible a decision as any I can think of. Future generations will have little forgiveness for it, let alone respect.

7.06 pm

Baroness Meacher (CB): My Lords, I rise to respond to this very important Bill and in so doing warmly welcome the noble Lord, Lord Stevens, who will clearly make a very significant contribution to the work of this House.

My biggest concern is that the Government are planning a major NHS reorganisation at a time when the NHS has suffered—and continues to suffer—the greatest workforce stress since its inception. Medical staff are burnt out, they are retiring early, leaving the service mid-career, reducing their hours, or planning one or other of these steps in terrifying numbers. Others have referred to this problem. Managers throughout the service, many of whom are doctors and nurses, will be focused on their own jobs and futures rather than tackling the unprecedented staffing crisis.

I gather the Government are considering deferring the implementation of this Bill for six months. But this is not a situation that is going to be resolved in a matter of months. I understand that the CEOs of the ICBs have already been appointed and for months senior staff have been focused on the forthcoming reorganisation, with detrimental consequences to the service.

Having said all that, I want to mention six issues. First, as other noble Lords have said, the urgent need is for the Government to focus their attention on workforce numbers, not only now but in the future, to deal with a haemorrhage of staff and the growing needs of the ageing population. The noble Lord, Lord Turnberg, put it rather well: they need to fill the hole at the bottom of the bucket as well as filling the bucket from the top. I will therefore be supporting the Jeremy Hunt amendment, which seeks to address this issue.

My second point is another general issue. I serve on the Delegated Powers Committee which recently published a major report condemning the growing trend toward skeleton Bills, excessive use of Henry VIII powers, disguised legislation and rules masquerading as guidance, which are never seen by Parliament and yet which government expect and require to be followed. The committee has not yet looked at this Bill, but on my reading of it there are at least 150 delegated powers, a tiny number of which involve some sort of parliamentary scrutiny. Huge parts of the Bill are skeletal, with disguised powers. When the Delegated Powers Committee reports, I hope this House will look very carefully at the powers in the Bill and amend them as appropriate. I hope the Government will support those changes.

Thirdly, I and many others have strongly welcomed the move away from the old legislative focus on competition on the assumption that this would improve services. Of course, it has not. There is a strong argument for having the NHS as the default option for NHS contracts so that private companies are involved only where absolutely necessary. A powerful argument for this approach is the fact, which I very warmly support and welcome, that the Government want to establish a joined-up collaborative service. Fracturing of the service works against that objective.

Fourthly, there is the composition of the ICBs, which I think we will talk about a lot. Private company representation is an issue, but most important will be

to ensure clinical leadership, not only on ICBs but at every level of the integrated care system. We must also ensure representation on these boards from the many sectors of the NHS; public health and mental health must surely be included as essential on every ICB. We should take account of the pervasive impact of mental health problems and the permanent underfunding of mental health services, with appalling consequences for those affected. Finally, the voluntary sector also needs a voice on those boards.

Fifthly, end of life care and the urgent need to establish patient choice in palliative care are not mentioned in this Bill. Only 4% of the population have completed advanced directives and the medical profession in general is much more aware of the need to respond to the patient's expressed wishes. Crucial to high-quality palliative care is the patient's right to choose at the very end of life, and the Bill needs to play its part in this area—we cannot afford not to.

Finally, children's services are also remarkably absent from the Bill; I believe the Government will want to put this right. These are just some of the most important issues and I look forward to the Minister's response.

7.11 pm

Viscount Bridgeman (Con): My Lords, I add my congratulations to the noble Lord, Lord Stevens. His matchless experience of healthcare has been communicated to us with a pleasantly light touch.

I rise to speak to the proposed new subsection (2A) outlined in Clause 4(2) of the Bill, to which my noble friend Lord Bethell referred. This was one of three amendments made to the Bill in another place which were accepted by the Government. The mover of this amendment was my honourable friend John Baron who was for nine years the chairman of the APPG on cancer.

The OECD has confirmed that the survival rate for cancer in the United Kingdom ranks near the bottom of the table when compared with other major economies. For some cancer types, only Poland and Ireland were below us. As we have improved our survival rates, so have other countries, and there is very little evidence of our closing the gap with a better performance, despite the considerable increase in health spending in recent decades.

In their research, my honourable friend and his committee discovered that, once a cancer is detected, the NHS performs largely as well as other comparable health services. However, where our NHS falls down is in catching cancers at their crucial early stages. The APPG campaigned, with some success, for a one-year survival rate indicator to be adopted by the NHS at local level. The advantage of adopting this yardstick was that it gave local NHS bodies the opportunity to promote initiatives which boosted early diagnosis. It also gave them the flexibility to devise their own solutions. However, the APPG uncovered the tendency of local clinical commissioning groups to focus on process targets, with funds being released against performance against them.

In recent decades, the NHS has been beset by numerous process targets, of which waiting times is a high-profile example. As a result, these yardsticks have been used at the expense of front-line measuring of the success of the treatment of, among other things, early cancer. The new subsection (2A) proposed in Clause 4(2) addresses the problem by proposing that NHS England should be required to include

"objectives for cancer treatment defined by outcomes for patients with cancer"

and that these are to have

"priority over any other objectives relating to cancer treatment."

The objective of the proposed new subsection is clear. Process targets may have their place, but it is the simple, clinical procedures of defining outcomes for patients with cancer which will hopefully concentrate resources on early diagnosis, which is currently the Achilles heel of the NHS.

I look forward to scrutinising in Committee this new amendment, which was initiated by John Baron in another place. It is the bedrock of a key change of emphasis in cancer treatment which has, I am happy to say, been adopted in principle by Her Majesty's Government.

7.14 pm

Lord Brooke of Alverthorpe (Lab): My Lords, I am grateful to the Minister for his introduction. I think he would be wise to reflect on what happened in 2012; he was not around, but there was a period of pausing to reflect before the Government decided to return to the work and move on. Given the problems we may encounter this winter, it is vital that health, not reorganisation, comes first, and the Government should be willing to delay if need be.

Changes to the Bill are needed. I am no expert on the overall structure of the NHS and its related bodies; my interest is primarily in welcoming in the Bill the mention of the narrow areas I work on, including public health related to obesity, diabetes, addictions, alcohol and so on. I welcome the movement on obesity, but more work needs to be done there. I give notice that I will raise some issues that were raised in the Commons concerning labelling, calories and alcohol.

The other big issue that I know a little about is the workforce. There is another angle from which we can try to approach this shortage of resources; we can look perhaps at the further development of social prescribing. As we all know, there is a considerable fund of support and enthusiasm for the NHS. Some 750,000 people volunteered to give service in the early part of the Covid pandemic, but nothing has really been done; from what I hear in speaking to some of them, they were not even contacted afterwards or given anything to do.

This is a major failing on our part, so I hope we might look beyond the NHS structure and see whether we can get greater resources there to help us. Matt Hancock's idea of the National Academy for Social Prescribing is good. There is no reason why we should not endeavour to increase the number of people working in that area and have a faster rollout than presently planned. If we could do that, it would to a degree ease burdens on the staff in the NHS itself. We should look further to see how we can have greater public and patient involvement in the National Health Service. We have seen the great fund of good will there over the course of the past two years. I regret to say that we have not really built any kind of structure to pull more people in, one way or another.

[Lord Brooke of Alverthorpe]

I was interested in NHS charities. In 2018, I talked to the noble Lord, Lord Stevens, about creating a national charity for the NHS to which people like me could leave something in their wills. At present, I have nothing designated for the NHS, but I would like to give something. As I get older and have to have more and more treatment, I am sure I will feel even more grateful. There is a local charity in Chelsea and Westminster where I live, but it is not well known. Communications need to be reviewed to establish closer relationships between the charities and the public. There is a great fund there, with money and physical resources available for the NHS, if the authorities are prepared to look down more, rather than looking upwards all the time. That would be to the benefit of the country overall.

7.18 pm

Baroness Murphy (CB): My Lords, I am an NHS recidivist, like many in this House today, but, after 40 or 50 years of employment in it, I am not necessarily a great fan.

Somebody mentioned 20 reorganisations; I can think of nine that I was personally involved in, some of which I was very enthusiastic about at the time. Looking back, I see that none of them addressed the NHS problems of chronic low productivity and some very poor outcomes—the noble Viscount, Lord Bridgeman, mentioned some relating to cancer. I know some of the data is difficult and not easily comparable, but we are consistently producing poorer outcomes than we should be getting for the resources we are putting in, particularly resources going into those who are employed in the NHS.

The third great problem is, as always, the attitudes—the hangover—which are particularly marked in some parts of the country. Certainly, there are the attitudes of the NHS to its patients and to our feeling that we are supplicants asking for help when we should be receiving a service as of right. These attitudes have not really shifted and have, in many ways, got worse.

I understand why we might be having a reorganisation now. After all, the direction of travel that we have been moving in for so long has come to a bit of a standstill because of the difficulties of foundation trusts not being able to exercise any powers because they are in debt. The direction of travel seems to have come to a full stop. Everyone is asking for better integration between health and social care. We must deliver that. The difficulty is that, if you look at where integrated social care works, it does not work because of senior management only. We have had integrated care boards in Northern Ireland since 1973. I have visited and seen them enthusiastically in action. In fact, at senior level, they work quite well, and some interesting programmes have come out of them. However, when you look at them on the ground, you see that health and social care staff are not necessarily working together. They must be collocated in teams that are jointly managed to make a real difference to individual patients and their carers.

This Bill is a little part of the start of a system that could work but there are some great big holes. For example, I would like to know to whom the integrated care partnerships are accountable. Certainly, we cannot see any way that their strategic plans might be necessarily taken over by the integrated care boards. Do we have some guarantee that they will take notice of what the integrated care partnerships want?

The other problem is the great white shark of the NHS swimming alongside a shoal of sardines, including local authorities, care providers and independent sector care provision. I have seen it time and again: the shark always gobbles up the resources. We saw it again in the recent care Bill. I want to know how that will be addressed. Can the Minister guarantee that we will get mental health as an equal partner on the integrated care boards? That seems utterly essential. Public health must also be in there. Can the Minister reassure us that that will be in statute?

Another problem with this Bill is the clawing back to centre of powers. Again, I understand the frustrations that Ministers see. I remember watching Sir Edward Heath hold up the closure of a rather second-rate neurosurgical unit for 10 years because it was in his constituency. I watched Sir Frank Dobson being seduced by consultants at Barts and the London and ending up with a profoundly expensive two-site system that was quite unnecessary for east London. I want to know how—I hope that the Minister will be able to reassure us on this—those doing the detail on this Bill will somehow constrain ministerial meddling.

7.24 pm

Lord Sharkey (LD): Like other noble Lords, I welcome the noble Lord, Lord Stevens of Birmingham, and congratulate him on his frank and witty maiden speech. I declare an interest as chair of both the Association of Medical Research Charities and the Specialised Healthcare Alliance.

Last year, members of the Association of Medical Research Charities contributed £1.7 billion to medical research in the United Kingdom—more than either the NIHR or the MRC. The Specialised Healthcare Alliance's 120-plus members campaign for those with less common and rare diseases, which affect some 3.5 million people in the United Kingdom. Both organisations bring the patient's voice and interests to medical research in the UK. I will focus my remarks on medical research and rare diseases.

The Bill before us does not offer any significant differences in these areas from its predecessor, the 2012 Act. In Clause 20 on page 17, the Bill sets out a duty in respect of research for each ICB. As the noble Baroness, Lady Blackwood, explained, it says only that ICBs will have a duty to "promote" research. This is equivalent to the duties already existing in the 2012 Act. In the Commons, there were significant attempts to strengthen this and upgrade the duty to promote to a duty to conduct. We believe that the amendments proposed to achieve this—notably from Chris Skidmore, a former research and innovation Minister, and my colleague, Wera Hobhouse—had real merit. We will want to return to them in Committee.

We will also want to make sure that, to make a duty to conduct research effective, this duty will also extend to eligible organisations for which ICBs are responsible. The benefits of making it a duty to conduct, rather

than just promote, research are well evidenced and wide-ranging. They include improved patient outcomes, improved job satisfaction among health workers and significant gross value added being generated. It is well evidenced that patients treated in research-active settings have lower mortality rates and increased confidence in the care they receive. There is an equally strong body of evidence that shows that engaging in research improves job satisfaction, boosts staff morale and can reduce burn-out. Research also presents the ideal opportunity for patient involvement.

I now turn to rare diseases and patients with complex conditions. The proposed structural changes in dealing with these areas would benefit from some additional safeguards and reassurances. The plan to delegate or transfer the commissioning of certain specialised services from NHS England to ICBs makes it vital that minimum national standards are strictly observed. I know from conversations with NHS England that that is its clear intention. However, we need more detail on how this is to be done, how it is to be monitored and how any corrective actions may take place. Also, what mechanisms will be in place to take advantage of learnings across ICBs and generate continuous improvement? It is especially important that we know what measures will be in place to prevent the fragmentation of the care for people with complex comorbidities. We shall want to ask how the interests of this group can be embedded in the ICB decision-making process.

Finally, I turn to the question of approvals. We want to see provision made in this Bill for establishing a new assessment route for medicines for people with rare and less common conditions, with better engagement with these patients and faster timescales—perhaps something analogous to the approach taken to the creation of the highly specialised technologies appraisal programme of 2012. We will want to discuss this issue in Committee.

The UK is already a medical research superpower, as recent events have demonstrated. If we are to maintain and profit from that position, as the Government wish, investment in research is absolutely critical. That investment does not only require proper funding; it requires collaboration between funders, especially between medical research charities, the NHS, our research universities and industry. It also requires recognition of the importance of listening to patients and patient groups and involving them in every step. I look forward to raising all these matters, as well as the Government's bizarre and overenthusiastic use of delegated powers, in more detail as the Bill makes progress.

7.29 pm

Lord Birt (CB): My Lords, I have finally reached the head of the long queue to, like other noble Lords, congratulate the noble Lord, Lord Stevens, on his trailblazer of a maiden speech. As we all know, he has been at the forefront of health reform for decades. He signalled today that he has lost none of his vim and vigour, it has not abated and he will continue his lifetime's work in your Lordships' House. We are lucky to have him.

I declare an interest as chair of a company that supplies services to the care sector as well as to other sectors. Like some others, I broadly welcome the Bill and its companion piece—this month's White Paper on adult social care. Indeed, the White Paper is notably impressive; I have not found myself saying that many times in this House. It is absent of political rhetoric and plainly the result—as has been made clear today—of a long and sensitive consultation both with providers and with those for whom they care. It sets out a truly daunting challenge, making clear the sheer complexity of the conditions that can strike any of us, or our families, at any moment, as well as the sheer scale of current demand. Last year, a fraction under 2 million requests were made for care support. Nearly 850,000 people are currently receiving state-funded long-term care. I make three sets of observations.

First, on front-line integration, I strongly welcome the introduction of the new bodies that will ensure proper integration of the services provided by many categories of public and private suppliers of care at local level; and I welcome the plan that that these new bodies, and local authority providers, will be regulated by the CQC. However, both the Bill and the White Paper are silent on how this integration will be achieved. Almost all large organisations—I have worked in many—struggle with the task of providing a seamless experience for the users of the services they offer, in both the public and the private sector. Which of us has not spent fruitless hours on helplines, passed from pillar to post? How will the integrated care partnerships operate and their success be measured? Will the multiple parties that provide care share a common technology platform? How will user data be shared? Will there be common measures of success? How will good practice be syndicated? That point was made by the noble Baroness, Lady Cavendish. In the last months of my father's life, the help he received in navigating the multiple parts of the health and care system was well-meaning but chaotic. Will there be a nominated personal navigator for those with complex care needs to help them steer the best path through?

Secondly—many have raised this point—the workforce in adult social care is of a staggering size. Currently, 1.7 million people work in the sector. The White Paper fully recognises the contribution made by those who work in care, but does it go far enough? Do we not need to celebrate the increasing skills now needed in the social care sector? Do we not need a clear career progression with a status and a hierarchy something akin to those deservedly enjoyed by those who nurse? When I worked in government, I was struck—very much like the noble Baroness, Lady Harding—by how poor workforce planning had been in the health system. The elephant in the room is that, plainly, the Treasury bears considerable responsibility for that. There are already chronic worker shortages in care. In the next 20 years, the number of over-85s is projected to increase by nearly 1 million. Like many of your Lordships, I am hoping that I will be among their number. The forecast is that, by 2035, we will need one-third more care workers than we employ now. We will need to transform our approach to strategic workforce planning to bring that about. Will the Government do that?

Thirdly, on the social care contribution cap—which, again, many have mentioned—I recognise that the Government's new proposal is an improvement on the old, but it has an utterly disproportionate impact on

[Lord Birt]
those with little wealth. I urge the Government to think again, to design a scheme where everyone with assets makes a contribution to their care costs, but which is progressive, where those of greater means assume a greater burden.

Overall, though, I welcome the Bill, and the social care White Paper, as real steps forward.

7.35 pm

Lord Prior of Brampton (Non-Afl): My Lords, I should first refer to my declaration of interest—in particular, that I am currently chairman of NHS England. Looking down at the noble Lord, Lord Stevens, and also seeing the noble Lord, Lord Adebowale, and the noble Baroness, Lady Harding, I could almost believe we were back at a board meeting at NHS England. I will give the House an idea of the kind of chief executive the noble Lord, Lord Stevens, was. At the beginning of a board meeting he would tell us what he thought, and then, to avoid any unpleasantness, at the end of the meeting he would tell us what we thought, so we all went away perfectly happily. It was a very good arrangement. It is wonderful to see him here in this House, and he will make a huge contribution, I am sure, in the years to come.

The phrase "another NHS reorganisation" is designed to send a chill through the sturdiest of hearts of all of us who have worked in the NHS for many years, so why do I actually think that the Bill is the right thing at this time? First, there is a pragmatic reason: it has very wide support from within the NHS; it goes with the grain of NHS culture; it is a Bill to be delivered bottom-up. Secondly, there is another pragmatic reason: it is already happening on the ground. NHS England and NHS Improvement already operate as one organisation, and locally integrated care systems have been and are being created. Thirdly, this is not some new-fangled ideological concept dreamt up by an ambitious Secretary of State. The process towards integration was launched some seven years ago by my former colleague and noble friend Lord Stevens. Then, it was called the five-year forward view. The underlying philosophy of the Bill has been road-tested in numerous places across England for seven years.

Fourthly, the fundamental basis of the Bill is, I think, unanswerable. I quote something verbatim from the *NHS Five Year Forward View* written seven years ago which is still true today:

> "The traditional divide between primary care, community services, and hospitals—largely unaltered since the birth of the NHS—is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three."

Finally and fifthly, the ICS structure will enable the NHS more effectively to deliver population health and, in particular, to address the growing and unacceptable levels of health inequality that disfigure our society.

For all those reasons, I support the Bill. I hope, however, that the Government will recognise that the improved accountability and transparency that resulted from the purchaser-provider split, the productivity gains that came from the incentives built into payment by results, and the innovation value driven by competition should still be kept as drivers of improvement and change within the ICS structure. I also hope—this will not be popular on all sides of the House, although it used to be popular on the other side—that this Government will publicly recognise the very important contribution that the private sector can make to delivering high-value care. I hope these issues will be debated fully in Committee.

The Bill, in whatever shape it finally takes, will not on its own mend a healthcare system that is extremely fragile, as many healthcare systems are in the developed world. Most health systems in the developed world are not, in reality, health systems; they are late-stage sickness and emergency care systems. By using digital technologies and predictive AI, by incorporating genomics, by focusing on population health, out-of-hospital care and self-care, and by investing in precision, personalised public health, we have a chance of changing what has now become an outdated model.

There are four particular issues I will leave with the Minister. The first is the workforce. I commend the amendment put forward by Jeremy Hunt in the other House. Long-term workforce planning is essential to the future of the NHS. The second is mental health. We have made huge progress but we are not there yet; there is no real parity of esteem in the provision of services and funding for mental health. Thirdly, I would like to see the ICBs committed to achieving net-zero carbon emissions, which the NHS as a whole is now committed to. Finally, on social care, I thought the contribution by the noble Lord, Lord Kerr, was pertinent. He is absolutely right: we are at the beginning of reforming social care, not the end.

7.40 pm

Baroness Altmann (Con): My Lords, I too congratulate the noble Lord, Lord Stevens, on his excellent maiden speech. I am delighted that he has joined the House, with all his many years of expertise in this area. I look forward to his contributions at future stages of the Bill.

In the time available, I will focus on issues relevant to elderly social care. Some 10 million adults are affected by care needs. Some are short term and others very long term, but over the next 20 years the number of people over the age of 85 will rise from 1.4 million to 2.4 million. Estimates suggest that about 44% of the over-65s already have some form of disability. Clearly, the costs of delivering social care and the amount spent on it in our society will significantly increase.

Council expenditure on care is already over £20 billion a year, with around half of that on the over-65s. But this is almost the same in real terms as it was in 2010. What has happened is that councils are increasingly rationing care, and unmet care needs, especially among the elderly, are rising inexorably. The funding is starting from an exceptionally low base. Much more attention needs to be given to delivering social care.

There are welcome points in the Bill. I welcome the intention to provide a care and support plan to arrange services in order to help people live independently and to prevent or delay the need for care, and the recognition that it is best if people can stay in their own homes. I also welcome the new CQC duties to independently review and assess local authority performance in delivering what the 2014 Act was designed to deliver, which we still have not yet successfully done.

I echo the points other noble Lords made about the need to invest in the workforce, and the fears. What is the Government's plan to ensure additional workforce capability and capacity now? I fear that we have had a couple of unforced errors—mandatory vaccination for care home staff before it is required in the NHS, and new immigration controls that mean we cannot get staff in from overseas. The pay for social care workers, for whom there is already a 30% turnover rate across the sector, especially front-line staff, is now lower than for shop assistants or cleaning staff, who have better working conditions. I would welcome the Government's estimate of the number of care staff needed and how they plan to deliver those.

I welcome the extension of prevention measures and the focus on commissioning, with the CQC overseeing the payment of fair rates for care, but I note that the Government continually say that they intend to move towards the local authority paying a fair rate to cover costs. In 2017, the CMA estimated that self-funders pay an extra 41% to cross-subsidise the underpayments by those funded by the councils. Do the Government have an estimate of when councils will actually pay enough to cover the costs, so that we do not put extra burdens on the very people who need care and are funding it themselves?

Regarding the care cap, £86,000 is not a cap on the amount people need to pay for care. Clause 140 has made the inequity even worse. With a fixed cap, those of more modest wealth will inevitably lose far more as a proportion of their assets than people who are much wealthier or who live in areas with higher property values. I hope the Government will pay close attention to the needs of elderly people who do not yet receive care, and the unpaid carers who will look after them, often at the expense of their own health.

7.45 pm

Baroness Neuberger (CB): My Lords, I declare my interests as in the register, specifically as chair of University College London Hospitals NHS Foundation Trust and of Whittington Health NHS Trust, and as vice-chair of the UCL provider alliance. I am grateful to the King's Fund and others for their briefings, and declare a further interest as a former chief executive of the King's Fund. I add my congratulations to the noble Lord, Lord Stevens of Birmingham, on his superb maiden speech and share his concern that there is not a greater focus on mental health in this Bill, and indeed on the determinants of health and public health in general.

We have so little time to speak that I will simply support what many noble Lords have already said in asking for further assurances around workforce planning and education and training, given that we have an absolutely exhausted workforce and we face tough recruitment issues. If it is bad in health, it is completely dire in social care. I also echo what other noble Lords said about the Secretary of State's new powers and the effect on the poorest of the way the £86,000 social care cap is designed.

I will focus on three specific things. The first is capital spending limits for NHS foundation trusts, because the present drafting differs significantly from what was set out in the NHS's 2019 legislative proposals. I hope we can go back to those proposals, which were a sensible compromise between system and organisation. That is particularly important for specialised commissioning, given that ICBs are set up largely to be accountable to their local populations. In north-central London, only a third of our provider income and asset base relates to north-central London residents, so safeguards are essential to ensure that ICBs have a statutory responsibility to maintain and develop specialised service assets, as well as those serving their populations.

The Bill appears to say that NHS England can pass many of its commissioning activities but not its responsibilities to the integrated care boards. Delegating complex commissioning arrangements for those specialised services where there is no evidence base for joining up pathways of local care will lead simply to a fragmented approach. Providers such as my own, UCLH, Great Ormond Street and others providing regional or national specialist services face the prospect of agreeing contracts with 42 ICBs rather than a single commissioner, adding significant bureaucracy and transaction costs. I wonder whether that can be sensible.

I am absolutely delighted that the membership of the ICBs will include, among others, representatives from local authorities. The guidance from NHS England states that it is expected that the local authority representative

"will often be the chief executive".

This wording implies some flexibility, but there is a very strong case to be made for the local authority representative being one of the local council leaders, who are, after all, the elected representatives responsible for running local services, including children's and adult services—precisely those services where we need improved integration with health, as many noble Lords have said. I hope the Minister can give us an assurance that each ICB will have the freedom and flexibility to reach this decision locally.

Lastly, most of us will warmly welcome the Health Service Safety Investigations Body. The Bill makes provision for creating a safe space within investigations to enable clinicians and others to provide information without the fear that that will be disclosed or used for disciplinary purposes. That is understandable, but the clause as drafted seems to cut across the unique constitutional role of the Parliamentary and Health Service Ombudsman to investigate complaints about the NHS and other public services.

The Bill prohibits the national ombudsman from accessing information held in the HSSIB safe space without seeking permission from the High Court. Schedule 14 appears to strip the ombudsman of long-held constitutional powers by being excluded from the safe space while the same exclusion does not apply to coroners. This would be the first restriction on the ombudsman's powers since it was established back in 1967. It contravenes international standards set out in the Council of Europe's Venice principles and the United Nations resolution on the role of the ombudsman, which was co-sponsored by the UK Government, and it will undermine public confidence in the administrative justice system, with patients feeling that they have less access to justice and public accountability when failed by NHS services—because we do not always get it

[Baroness Neuberger]
right, as the noble Baroness, Lady Cumberlege, has made abundantly clear. I welcome the broad thrust of the Bill, but there is still much to clarify and change.

7.51 pm

Baroness Kennedy of The Shaws (Lab): My Lords, my little granddaughter is appearing today in her first school nativity play, rather wittily titled "A Midwife Crisis". I am sure it was a midwife crisis, but a veil was drawn over the actual birth of the infant child—I think it was a do-it-yourself affair. Sadly, we too have a midwife crisis, along with a nurse crisis, a doctor crisis and indeed an across-the-NHS crisis.

If we take the pulse of the NHS, we find that it is in serious trouble. If we ask why, the quick answer is now always "Covid"—but of course that is not true, and the Benches facing us know that in their hearts. When the Conservative Party came into government in 2010, waiting lists were low. Today waiting lists are at 6 million, and they were already at 4 million before Covid struck. Why? The answer is that for a decade annual NHS funding increases had been at their lowest levels ever. That withdrawal of funding was described as efficiency cuts. How can it ever be efficient to cut 17,000 beds or to have over 100,000 vacancies for doctors and nurses? George Osborne, in his austerity policies, took a scythe to training places in his very first Budget. So let us not hear from the Conservative Benches that somehow this has all just come upon us by surprise; it was a deliberate set of policies.

Let us look at the whole business of the public health budget. Colleagues spoke about its importance in creating health and preventing illness. That budget has been cut by 24% since 2015-16. Do we think it is going to be restored in the Bill? Not one bit, yet that money would be well spent because it would reduce the number of people who got ill. As we know—all the statistics have shown it, along with the work of the Institute for Fiscal Studies—the Sure Start programme, which was cut, in itself reduced the hospitalisation of children by 18%, but that project has been thrown to the winds.

There is now an emergency in our hospitals and GP surgeries, and people are worn out. I recently completed a report for the Royal College of Surgeons on improving diversity and inclusion in the surgical profession. When you dug deeper and asked why women had left the profession in their thirties, the answer was that it was the whole business of their lives. Staying on was impossible because of the failure of any real consideration of the demands made on people's lives and the ways in which women just found it too difficult to combine all those things, including childcare and having a home somewhere close to where they worked. If you are married to another doctor, they are often sent miles away and given a job nowhere connected to you. That whole lifestyle has not been considered in any of this. However, the Bill addresses none of that.

The original plan was worthy: it was to undo the vandalism done to the NHS by David Cameron and the noble Lord, Lord Lansley—I make no apologies about saying that, even if he is in this Chamber—which blew the NHS into marketised fragments that were forced by law to compete rather than co-operate. Now the word is "collaboration", but that was not the word being thrown around then. The whole point is that in 2012 that Act opened up all contracts to private tenders. Competition law should have no place in the running of our National Health Service because services need to work together. Yes, the word should be "collaboration", and I have heard it from any number of persons in this House. Collaboration and integration should be the bywords of our National Health Service.

The original plan was to have integrated care systems across the country to rationalise and plan local services. The idea was to include local authorities and combine social care with health, but the Bill does not marry social care and health. The NHS and local authorities could be pooling their resources, but there is no machinery for doing so in the Bill. The Government have given themselves the absolute power to appoint all the directors of an integrated care service, and refuse to bar private providers from sitting on those boards. The Government have also resisted an amendment in the other place to make the NHS a preferred provider in any tendering process. This is all about privatisation, and it is always done by stealth. Look at all the disgraceful cronyism that was displayed in distributing contracts at the outset of Covid. Many in this Government have a distrust of public service. They refuse to accept all the evidence that a state-run NHS is a success story, yet we spend less money on it than our comparators, we run it with too few doctors, nurses and other healthcare professionals, and we pay them all badly.

This could have been a great opportunity to create an even better NHS but also to create a unified national system of health and social care that worked together in a seamless way. Unfortunately, it is in the hands of an ineffectual, incompetent and ill-led Government, so I do not have much confidence in what is being promised.

7.57 pm

Baroness O'Loan (CB): My Lords, I congratulate the noble Lord, Lord Stevens of Birmingham, on his excellent maiden speech. I think, too, that this is an appropriate time to pay tribute to those staff in hospitals, care homes and the community who have laboured so hard over the past two years. However, routine medical care did not happen. Elective surgeries were cancelled and treatment for the most serious conditions and illnesses was limited or not delivered, and now we have a major problem. The problem is actually worse in Northern Ireland, where people routinely wait five years for necessary treatment. Across the UK, the frustration of doctors and other medical practitioners at their inability to provide essential services because of staff shortages—resulting in part from the Covid emergency, but not just from Covid—is well-known.

I first served in 1996 on one of those health boards to which the noble Baroness, Lady Murphy, referred. Then people remained in hospital because they could not be discharged to their own homes with proper care packages or to residential and nursing accommodation. Some 25 years later, it is still a problem. For 25 years the issue has been discussed, papers written, committees formed, strategies devised—and the problem has got much worse.

The compulsory immediate Covid vaccination of staff, low levels of salary for the intense and difficult work of caring for those with reduced mobility, dementia and serious ill health, and a lack of support have resulted in a further loss of staff from the care sector. Care of this kind is inevitably resource-intensive. It is not just mechanistic; it requires a compassion and humanity that very often simply make it possible for people to settle in places where they would rather not be but must be. Will the Government ensure that there is a change of philosophy that will result in a greater respect for and appreciation of those who care in such circumstances, consistent with our proudly-proclaimed Great British values?

The repeal of Section 75 of the Health and Social Care Act 2012 is welcome. The new processes, which are still being developed, must enable proper procurement and remove unnecessary bureaucracy but ensure that contracts are awarded with proper scrutiny and that there is consideration of the impact of individual contract awards on the provision of services generally. Can the Government give an assurance that accountability and transparency really will result from the passing of this Bill?

There is also a need to ensure that the creeping privatisation of the NHS will not result in increased costs, reduced equality of access to services, and longer waiting lists. The public sector NHS trusts and NHS foundation trusts must be the default provider of NHS services.

The potential conflicts of interest for those such as employees of private healthcare providers as members of ICBs has been referred to repeatedly. They will be responsible for the commissioning of NHS services. I can see the benefit of private sector experience, but government must ensure proper accountability and there must be a mechanism for regulating and identifying conflicts of interest when they emerge.

Finally, the proposed level of delegation of power to the Secretary of State over operational clinical matters is quite simply unacceptable.

8.01 pm

Lord Sandhurst (Con): My Lords, I add my congratulations to the noble Lord, Lord Stevens of Birmingham, on his very uplifting maiden speech.

I shall direct my remarks to Clause 4. This inserts a new provision into Section 13A of the National Health Service Act:

"The objectives that the Secretary of State considers NHS England should seek to achieve which are specified in subsection (2)(a) must include objectives for cancer treatment defined by outcomes for patients with cancer, and those objectives are to be treated by NHS England as having priority over any other objectives relating to cancer".

This is a very specific and important mandate. Henceforth, successful management will be judged by "outcomes for patients": how many survive and for how long.

Let me explain why this is important. For the first time, cancer survival rates from the date of diagnosis will be given priority over other objectives in the treatment and management of cancer. Hitherto in respect of cancer this country has focused for too long on targets, such as the two-week wait to see a specialist after a referral and the 62-day wait from referral to first definitive treatment. Those targets are not irrelevant or unimportant, but they are only part of the picture and have distorted the way we have managed cancer. They have had too much priority as measures for achieving funding support. They have not resulted in better results.

Over the last 20 years, there has been only limited evidence of cancer survival rates catching up with international averages in other prosperous countries. Professor Sir Alex Markham, the founding chief executive of Cancer Research UK, has observed that

"comparable health services abroad continue to outperform the NHS in terms of cancer survival. They all remain focused on cancer outcomes and the UK would be foolish not to do likewise".

This clause should put that right.

When it comes to treatment after diagnosis, I understand that the NHS largely performs as well as other comparable health services. However—this is the important thing—it is not as good at catching cancers in their crucial earlier stages. If the new commissioning bodies under the Bill have to focus on outcomes, they will monitor survival from date of diagnosis. They will have to collect that data, identify dates of diagnosis and match outcomes. This will show which places are doing better than others. Researchers can then establish what the more successful places do and how they differ from the less successful ones. That way, routes to success may be identified. Improvements can and should follow. That is true evidence-based medicine.

Hitherto, data collection and data transparency have not been a strength. As Bowel Cancer UK told the APPG on Cancer, the priority should be to

"improve the quality and use of data"

produced. Indeed. Another point is that data on the less common cancers are not used consistently throughout the NHS. The focus to date has been on the so-called big four: breast cancer, prostate cancer, bowel cancer and lung cancer. Yet it is a fact that the other less common cancers, taken as a whole, constitute more than 50% of cancer cases in England at any one time.

The new statutory obligation addressing outcomes for all cancer treatment would ensure that such data are collected across the range of different cancers. This new provision will provide the springboard for long-overdue improvement in cancer detection and cure. I commend it to the House.

8.06 pm

Lord Sikka (Lab): My Lords, the NHS was founded on the principle of not for profit and serving all people equally, with dignity and respect for patients and staff. This Bill violates those principles. It accelerates privatisation of the NHS. At my local hospital many services, such as physiotherapy, have already been privatised, and employees had to reapply for their jobs on inferior terms. The Bill neither protects employees nor prioritises patient care. It enables private companies to secure NHS contracts even though they do not deliver value for money. A typical cataract operation is 50% to 100% more costly in the private sector than on the NHS. It is the same story for knee and hip replacements.

Around 11% of the annual NHS budget goes to private companies, which have shareholders and overpaid executives to appease. Up to 25% of the amounts paid to the private sector disappear in dividends, interest

[LORD SIKKA]
payments, lease payments, rents and other intragroup transactions, often to an offshore affiliate. This leaves very little for front-line NHS services, and the waiting lists inevitably grow. The likes of Virgin healthcare have milked the system and pay little or no corporation tax. This Bill will facilitate even more of the same and rob the NHS.

The 42 independently run integrated care systems would be responsible for commissioning and delivering services to a group of people on a geographical basis. This heralds further fragmentation of the NHS and will create another postcode lottery.

The Minister, like many others, has mentioned integrating the health and care services, but the issue of merging the budgets is highly problematic. Take the NHS: it is free at the point of delivery, but social care is not—it is means tested. The Bill offers absolutely no clarity about how the budgets are to be merged, and there is nothing in it to prevent some NHS treatments or services being reclassified as social care and thus force people to pay more for the services. Social care budgets are fixed and capitated; overspends are not allowed. If the same was to be applied to the NHS, many people would simply not receive the treatment to which they are entitled. I hope that the Minister will clarify these issues.

Of course, we could eliminate lots of problems simply by accepting the principle that social care must be free at the point of delivery and paid for through taxation. However, I fear that a party or Government addicted to hurting the poor will somehow not accept that new policy, so we have a problem.

The Government have made some cosmetic adjustments to the Bill, but employees or personnel from private healthcare companies can still sit on the boards of the 42 ICSs and influence NHS commissioning decisions. This creates conflict of interest and must be absolutely banned. I do not recall any public marches or petitions urging the Government to ensure that individuals from Centene, UnitedHealth, Bupa, Spire and other private companies must somehow make NHS decisions. This is an ideological decision by the Government; there is no other explanation. I hope the Minister will explain the ideological basis of this meddling by the private sector.

It is also a matter of concern that the Bill gives the Secretary of State numerous powers and that he is accountable to nobody, least of all Parliament. There is no real public accountability. Should we really be trusting things to Ministers? We have already seen how they have abused their position in awarding lots of Covid-related contracts to cronies and party donors, without any public accountability. We are still awaiting details of those. What is there to prevent the Minister abusing his or her power in the future? There are absolutely no guarantees in this Bill.

8.11 pm

Baroness Hodgson of Abinger (Con): My Lords, I thank the Minister for introducing this Bill. I draw the attention of the House to my interests: I was a non-executive director of a health authority, and am chair of ISCAS, the Independent Sector Complaints Adjudication Service.

I welcome the Bill in so far as it contains changes that the NHS requested, promoting local collaboration and reducing bureaucracy. My only hesitation is how such a fundamental reorganisation will affect the NHS when it is already under such huge pressure from the pandemic.

While the Bill is mostly structural, the real test is whether it will deliver positive change for patients. I note that one of its aims is to deliver a range of targeted measures to support people at all stages of life. In the debate on 14 October, the noble Baroness, Lady Finlay, spoke movingly about hospice and social care. Can my noble friend please tell me whether the integrated care systems will have a duty to commission end-of-life and palliative care services to meet the needs of the population? I think I was told that, at present, 60% of these have to be raised from charity, which is unimaginable for other forms of healthcare. Surely, end of life is a critical and essential time when a patient needs most support.

Continuity of care is also a very important factor, especially in the care of the very young and the very old. In the debate of 14 October, I cited an article in the *Times* about a Norwegian study published in the *British Journal of General Practice*, which demonstrated the benefits of having the same GP for years. It showed that those who had the same doctor for between two and three years were about 13% less likely to need out-of-hours care, 12% less likely to be admitted to hospital and 8% less likely to die that year, rising to 30%, 28% and 25% after 15 years. It was stated:

"It can be lifesaving to be treated by a doctor who knows you."

Yet in the UK, GP practices are becoming bigger, and the relationship between doctors and patients less constant. While patients over 75 in the UK are also given a named GP, some doctors interpret this as just having to look at patient records. While I understand that patients who wish to be seen urgently cannot always see their GP that day, how can a doctor deliver appropriate and responsible care of a patient without ever meeting them?

To deliver good healthcare and care needs good staff, and the BMA estimates that the NHS is currently facing a shortfall of 50,000 doctors. Many GP practices seem overstretched. Can we ensure that we train more GPs and change the system so that it is advantageous for them to work in GP practices rather than as locums? I know that many people now feel that they have to fight to get an appointment with a GP, or are simply unable to get one. We need to ensure that carers, both paid and unpaid, get the recognition and status that they deserve. A good carer is invaluable and we have a shortage of them too.

I hope that these changes in the Bill will ensure more focus on prevention rather than cure—reducing smoking and obesity, ensuring a better diet and other initiatives would result in a healthier nation. Health checks and screening are also important, to pick up issues such as cancer earlier, when it is easier to treat. Checks for older people are also vital to pick up issues early so that they can lead fuller lives and thus need less care—which all reduces the burden on the NHS.

Part 4 of the Bill will establish the Health Services Safety Investigations Body in statute. The impact of clinical negligence on a patient and their family can be

devastating. Moreover, the costs have quadrupled in the last 15 years to £2.2 billion in 2020-21, equivalent to 1.5% of the NHS budget and eating into resources that should be available for front-line care. Surely we urgently need to find a better way to deal with these cases rather than resorting to law, which can take years to settle, putting a patient through yet more stress. I gather that nearly a quarter of the costs of clinical negligence go to legal fees.

I congratulate those who campaigned—and welcome the provisions—to make the practice of virginity testing an offence. It is a horribly demeaning process and an abuse against women. However, surely it is inextricably linked with hymenoplasty, and any commitment to ban it will be undermined if we do not ban them both together.

To conclude, in welcoming this Bill I am mindful that how we treat our elderly, infirm and ill of health is a measure of our society. We must not be found wanting.

8.16 pm

Lord Ramsbotham (CB): My Lords, when you are number 55 in a 74-strong speakers' list, you have not got much new to say. As other noble Lords have said, there is much to be welcomed in this Bill—certainly including its intention and stated aims of integration and innovation, particularly for those who require rehabilitation.

However, as always, the devil is in the detail. I must thank Nicola Newson for an outstanding Library briefing. I also join others in congratulating my noble friend Lord Stevens of Birmingham on a superb maiden speech.

Yesterday, the Prime Minister announced in his speech that drug users were to be offered rehabilitation, but I did not hear him refer to the Bill. This is a pity, because I can think of no other form of rehabilitation that is so subject to local conditions and arrangements and therefore so natural to be included in an integrated care system along with speech and language and all the other subjects requiring rehabilitation.

As other noble Lords have pointed out, when the Bill was in the other place there was considerable concentration on workforce issues, which seem to me to be paramount. There are simply not enough doctors, nurses or other healthcare professionals to go round, particularly in the midst of a pandemic, and the future looks very worrying, particularly where replacements are concerned.

It seems to me that we will have our work cut out to try to improve the Bill, bearing in mind the fate of perfectly reasonable amendments tabled in the other place. Yet try we must, because there are too many long-term and national issues at stake.

8.20 pm

Lord Shinkwin (Con): My Lords, I congratulate the noble Lord, Lord Stevens of Birmingham, on his excellent maiden speech. I also applaud the work of John Baron in the other place, as my noble friend Lord Sandhurst and others have done, on focusing the Government's attention in the Bill on cancer outcomes, and of my old chief executive, Professor Alex Markham, with whom I was privileged to work at Cancer Research UK.

It is an absolute pleasure to follow my noble friend Lord Ramsbotham, who does so much for those of us with communication needs, and I count myself among them. It is also appropriate because I am going to focus my remarks on how the Bill represents a golden opportunity to breathe life into building back better so that for children and young people with communication needs, and their families, it is more than just another soundbite.

Of course, I appreciate that that is also what my noble friend the Minister wants, because we all have a common interest in countering the post-pandemic scepticism about politicians' ability to deliver. I suggest that the best way of doing that is to make the Bill a vehicle for hope: hope for the 62% of children with communication needs, whom the Royal College of Speech and Language Therapists found did not receive any speech and language therapy during the first lockdown; hope for their families; in short, hope that the future will be better, because the prospects of these children and young people will be improved by the Bill.

Just to be clear, I am not talking about hanging more expensive baubles on the Christmas tree. Rather, I am talking about making sure that all the lights on the tree actually light up—in other words, ensuring that everything works, that the Bill does what it says on the tin, and that the systems are truly integrated. The question is: what does that look like for children and young people with speech, language and communication needs who, sadly, despite constituting 10% of children overall, are still so far down the priority list?

First, the Government could build on the welcome precedent they set recently in the domestic abuse legislation in ensuring that guidance refers specifically to people with communication needs. Can the Minister ensure that the integrated care systems guidance regarding babies, children and young people includes specific reference to those with speech, language and communication needs?

My noble friend the Minister will know better than I that the long-term cost of not supporting children and young people with communication needs can far outweigh any short-term savings. For example, children with communication needs are at greater risk of mental health problems, unemployment and potential involvement in the criminal justice system if their needs are not identified and adequately met from an early age. So it is in everyone's interest that integrated care systems give due regard to meeting their needs.

I would therefore value my noble friend's reassurance that integrated care systems will not be allowed to consider children's and young people's communication needs as optional, given how this could exacerbate postcode lotteries, with all the longer-term false economies that I have already alluded to. Would my noble friend consider putting the guidance on to a statutory footing?

In conclusion, I ask my noble friend if he would be prepared to meet with me and the chief executives of I CAN and the Royal College of Speech and Language Therapists to consider how we can ensure that the Bill improves data and information sharing for children as well as adults and that, in the same vein, the barriers currently preventing local authorities and the NHS from planning and delivering services in a joined-up way for children with communication needs are removed?

8.26 pm

Lord Stirrup (CB): My Lords, I add my own warm congratulations to my noble friend Lord Stevens of Birmingham on his excellent maiden speech.

One of the most dispiriting and dislocating experiences that any large organisation can suffer is to be subjected to repeated waves of substantial reorganisation. It diverts attention away from the delivery of outputs and on to issues of structure and process, and just as, and often before, one set of changes is embedded, another looms. This leads to confusion, reduced efficiency and poor morale. So the Bill, representing another upheaval for the NHS, carries considerable risk.

I acknowledge that some of what it proposes goes with the grain of evolving practices in parts of the NHS and that it incorporates a number of welcome changes. The shift to a more integrated approach to health and care is long overdue, and the abandonment of the competition straitjacket will be cheered by the vast majority of practitioners. The question remains, however, whether such improvements could have been secured in a way that would be less dislocating for the NHS.

It is important to remember that a Bill such as this sets only a broad framework and that giving it effect requires a great deal of subsequent detailed work. At a time when Covid continues to stretch the NHS and the medical profession, perhaps even more so in the months ahead, does this represent the best use of scarce resources?

Turning to points of detail, in the time available I will touch on just one provision that the Bill does contain and two that it does not. Like other noble Lords, I worry about providing for increased political control over managerial decisions. I can understand how frustrating it might be for Ministers to have no control over decisions but nevertheless to have to bear the public and political consequences of them, but they need to ask themselves whether their closer involvement in the process is likely to lead to better decisions. I fear not. We have seen in the past that political priorities, often driven by dramatic headlines, are likely to be out of kilter with long-term health strategies.

While I am on the subject of strategies, I am disappointed that the Bill has nothing meaningful to say about planning and delivering the future NHS workforce. A quinquennial description of a system does not constitute a strategic response. Effective personnel planning has a simple equation at its heart: workforce equals the average annual intake times the average return of service. All three elements of this equation are crucial. The workforce requirement must be defined, and recruiting and retention must be appropriately balanced to maintain the right spread of experience and expertise. At the moment, we have no idea of the requirement, but we know that we are not training enough medical personnel and that retention is poor and getting worse. If we do not take urgent action to address these problems, none of the proposals in the Bill, no matter how worth while, will make a substantial difference.

The most pressing need is to improve retention. Defining the requirement and increasing recruitment are important but they will take some time to have an effect. Stemming and, if possible, reversing the increasing outflow of trained personnel will have the quickest impact on capacity. On a number of occasions, I have asked the Minister's predecessors what actions are being taken to address the problem and received nothing but vague reassurances. Meanwhile, the situation has worsened. Will the Minister now undertake to set up an empowered task force to remedy this crucial situation?

Finally, I have pointed out in previous debates that the NHS is an ungoverned system in that it faces ever-increasing demand and ever-increasing technological opportunity. No enterprise can succeed in the long term unless it manages its outputs as well as its inputs. At the moment, the NHS's outputs are varied on a haphazard and sometimes irrational basis, often through uncontrolled waiting lists. Unless and until we face up to the fact that the NHS cannot do everything, we will never have a properly governed system. Because of the imbalance between growing demand and opportunity on the one hand and inevitably limited resources on the other, healthcare is rationed always and everywhere. The question for us is whether we wish to devise a fair way of doing that or to continue with our present, incoherent system of force majeure.

The current Bill, like all its predecessors, has nothing to say about this. It therefore treats a number of distressing symptoms but does not address the underlying condition that threatens the long-term well-being of the NHS. In this regard, it is another missed opportunity.

8.31 pm

Baroness McIntosh of Pickering (Con): My Lords, I refer to my declaration of interest in the register: I currently work with the Dispensing Doctors' Association and my father was a dispensing doctor. I congratulate my noble friend the Minister on introducing the Bill, which I broadly support—particularly its emphasis on greater collaboration between GPs, hospitals and local authorities.

If I can paraphrase the noble Lord, Lord Stevens, whom I congratulate on an excellent maiden speech, I agree that all health services are local. However, I disagree with him on his support for the fluoridation of the water supply, and refer him to the case of the petitioner, Mrs McColl, against Strathclyde Regional Council. You might say that I cut my legal teeth on this case because I spent nine months as a Bar apprentice and the remaining time as a devil; my devil master was one of the advocates for Strathclyde Regional Council. Crucially, Mrs McColl had dentures; she had no teeth. She argued that fluoride is a carcinogen and that the action Strathclyde Regional Council sought to introduce, which the Bill also seeks to introduce, was unsafe, ineffective and illegal. I agreed with her. She won her case. I cannot see how it is appropriate to prescribe such an interventionist action that could be achieved by other means: either regularly brushing children's and adults' teeth with toothpaste containing fluoride or reducing sugar in the diet. So, on that, we will disagree, but I warmly welcome the noble Lord to the House and congratulate him on his excellent maiden speech.

I am grateful to my noble friend the Minister for the meeting we had to discuss these issues, at which he heard me argue that the NHS and the Department of Health and Social Care tend to be urban-centric. A lot of that

has been proved in many of the speeches this evening. Dispensing doctors have a unique role to play. They are general practitioners who are permitted to dispense medicines—in effect, a GP and a pharmacy rolled into one—for patients who would otherwise have difficulty accessing one or both, not least due to the distance from their home. All these services are in rural areas only. I pay tribute to the role that dispensing doctors play as an integral part of the health service in rural communities, building strong relationships with their patients. They are crucial to the delivery and promotion of preventive services and well-being, which is so dear to the heart of the Conservative manifesto.

I will focus on delivering healthcare and social care in a rural setting. I urge my noble friend to confirm that he will redress the inequalities already identified in this Bill, particularly by the right reverend Prelate the Bishop of St Albans, to restore the balance in favour of spending on rural areas as opposed to urban areas and in favour of spending on primary care as opposed to secondary care. Does he share my concern that the ICSs will be full of secondary care practitioners and that primary care practitioners may not be as well represented as they might be?

I share the concerns expressed by others this evening about the number of GPs, many of whom are facing retirement in the next five or 10 years and have real concerns about their pensions. Again, I regret the fact that the Government—as shown both this evening and with the Health Secretary's acceptance to the health Select Committee next door in the other place—have not kept their commitment to increasing the number of doctors in the next four, five or six years. That is deeply regrettable.

Will my noble friend the Minister use this opportunity to redress the balance in spending between urban and rural areas? Rural areas are facing issues with isolation and the distance that patients have to travel to access healthcare; they also have disproportionately higher levels of older people with chronic conditions. This is a golden opportunity to address these issues; I warmly invite my noble friend to do so.

8.36 pm

Lord Rooker (Lab): My Lords, I, too, congratulate the noble Lord, Lord Stevens of Birmingham, particularly on his robust defence of fluoridation in Birmingham. I am going to concentrate on one clause, one schedule and one issue: Clause 144, Schedule 17 and part of the Government's plan for tackling childhood obesity.

I have lost count of the reports from Select Committees and the National Audit Office on this vital issue, which, irrespective of the damage to health, is on course to bankrupt the National Health Service. I am informed that, since the early 1990s, there have been 14 reports containing 700 recommendations. No Government have done enough. When the coalition came in in 2010, there was a flurry of activity. The outcome, a serious plan, was effectively squashed by Theresa May in 2016 under pressure from the food industry. I was at a meeting of the Parliamentary and Scientific Committee when I heard officials—I shall not name them as I had worked with one of them before—spell out what was planned, but it did not come about.

So, it is better late than never that the Government are acting. There is increased political will to act; this is to be welcomed and actively supported. We have moved on from the "nanny state" arguments nurtured by the food industry. Besides this Bill, though, I would like to know what the Government have been doing since September 2020, when the National Audit Office published HC 726, its report on childhood obesity. Its key findings were worrying, and the five recommendations were a serious plan of action. I have looked but, to be honest, I have not been able to get the detail.

The figures on childhood obesity are startling and on the move. They are not static—we are getting fatter. The National Audit Office's report pointed out that 20.2% of 10 to 11 year-old children were obese in 2018-19. That figure rose to 26.9% for children in the most deprived areas. The brief from the Obesity Health Alliance gives more up-to-date figures. The last year has shown the fastest increase in child obesity on record. More than 40% of children are obese by the time they leave primary school; for year 6 children, the figure is up from 21% in 2019-20 to 25.5%. It will be really difficult to reverse this trend.

I am about to make my only politically incorrect point. I could not help but notice, in recent years, the astronomical size of some teachers in primary schools. Emerging evidence shows that, besides a 1% year-on-year growth in obesity, the Covid pandemic's impact is likely to have accelerated the pace of increase in childhood obesity, so there is even more reason to be concerned.

I will support the Government's action and spur them to do more. They could do a lot worse than adopt the *10-year Healthy Weight Strategy* published by the Obesity Health Alliance in September this year. "Healthy weight" is a good way of describing the desired outcome. It does not conjure up too much negativity. I will be watching to ensure that there is no watering down of the modest proposals by the men who made us fat. In this respect, I prefer the evidence from the National Audit Office to that from the food industry on the effects of advertising.

Talking of the men who made us fat, the BBC should show again the 2012 BBC Two documentary "The Men Who Made Us Fat". The science and methods, both physical and behavioural, that the food industry uses to get us to eat more are eye-watering in their lack of concern for the consequences to public health. I commend the Government and urge them to do more, and I will oppose any watering down.

As an aside, exactly two years ago this week I lost two weeks of my life without warning, with clots, sepsis, pneumonia and a lump. The staff at Hereford County Hospital stopped me going over to the dark side. So far, so good, and I am very pleased to say that I am part of a clinical trial to check the effect of the booster on those who have had leukaemia and lymphoma —a trial called "Prosecco".

8.41 pm

Lord Warner (CB): My Lords, fancy having to follow that. I first congratulate the noble Lord, Lord Stevens, on his excellent maiden speech. I have known him, on and off, for several decades, and am pleased to see that, after seven years of managing the NHS, he retains his sense of humour.

[Lord Warner]

I declare my interest as a member of the Dilnot commission and I certainly welcome the decision finally to implement our proposals, 10 years after we reported. I note that even now the Treasury cannot resist using a meaner means test than we proposed. That approach does not do much for the Government's levelling-up agenda and I wonder whether Michael Gove's department was consulted before the decision was made.

We must reverse this mean-spirited approach. The Dilnot commission's proposed individual cap was served up to deal with a problem that we were asked to solve: the unpredictable high care costs that fell on individuals randomly and unfairly. We were not asked to deal with the underfunding of the adult social care system that has built up under successive Governments. However, back in 2011 we did say that there was an underfunding of £1 billion a year on annual expenditure of about £15 billion. That £1 billion a year has now risen to at least £8 billion, with no credible plan to rectify matters. Publicly funded adult social care faces an existential crisis, which this Government have simply failed to address and do not address in this Bill.

I will now identify a few issues that I shall be raising during the Bill's passage. The first is the issue of timing, whatever the contents of this Bill. I have been involved with two NHS reorganisations. As a civil servant, I was involved with Keith Joseph's disastrous and expensive 1974 reorganisation. In 2005, as the Minister for NHS reform, I was involved in tidying up someone else's reforms. Like others, I am also a veteran of the passage of the 2012 Act, which this Bill is correcting. Perhaps I can give a little advice to the Government from this experience.

NHS reorganisations are always more expensive than their architects think. They take longer to complete than they think, and their implementation disrupts service delivery. The 2012 Act changes were estimated to have cost about £3 billion and to have disrupted NHS operations for about three years. A large number of deficiencies in this Bill have been identified this afternoon and evening, and these cannot easily be put right in time for the Bill to be implemented from next spring. I shall therefore raise the issue of a sunrise clause in the Bill, given the variable pandemic that the NHS is handling and the backlog of treatments it faces. There is a backlog of 5.8 million patients if we believe government estimates, or a queue of 13.6 million patients if we believe the recent estimate by the LCP health consultancy. Whichever one we plump for, this is hardly the right time to get a tired NHS staff distracted and anxious about another NHS reorganisation.

I turn very briefly to other issues. Clauses 18 and 68 deal with patient choice, which I welcome, but I hope to table amendments that would provide a mechanism to enable patients to exercise choice from among public or private providers of NHS services at NHS prices when they face long waits for treatment.

I do not have time to go into many other details, other than to raise again my intention to resurrect two recommendations, 33 and 34, from this House's 2017 Select Committee report on the long-term sustainability of the NHS and adult social care. The recommendations proposed an independent office for health and care sustainability. Such a body would have no operational responsibility and it would report to Parliament regularly on issues around health and social care funding and the workforce. The recommendations were not taken up by Jeremy Hunt when he was Health Secretary. Since then, however, he seems to have had a change of heart and thinks that something along these lines is needed to keep Governments honest, as I think he said. Blessed is the sinner who repents, and we need to return to this issue in Committee on the Bill.

8.47 pm

Lord Addington (LD): My Lords, it has been a long debate and a lot of very interesting things have been said. I wish to concentrate on the health part of this Bill.

Most of the things that scream "health" to me are in the back of the Bill. There is the traditional subject of fluoridation. It is nice to know that that fight is still running. I would side with the noble Lord, Lord Stevens, whom I welcome to the House, and the noble Lord, Lord Rooker, on this one. I think there are few rounds left in it, but let us see whether we can win it now.

When it comes to advertising restrictions for unhealthy foods, this should have happened a long time ago, and we have been talking about it for an awfully long time. Talking about the lobbying on this, I can remember at a party conference being entertained to dinner by somebody who tried to convince me that if you did not serve full-fat, fizzy drinks to children and offered them just water, they would, lemming like, leap on to the roads to get those drinks and be run down in their thousands. It is not a very good argument, and I did tell them that by the end of the meal.

I would like to look at something which is not really in the Bill, namely the wonder drug when it comes to health, which is exercise. The Bill does not address it very much, but the fact is that exercise in most forms is one of the things that improves your health and your resilience to infection later in life. The Bill does not do very much to encourage it. The Department of Health has the political muscle and goes into all other parts of government in certain ways—so why are we not pushing it from the Department of Health and why are we not using this Bill as a vehicle for it?

While it is a wonder drug, it also has a wonderful sugar-like quality—among all the varieties of exercise and sport, there will usually be one for you if you keep at it. However, just saying, "Go out there and do it" does not work; we know this, and it is a fact that the Government are starting to address. We have had an Agriculture Act encouraging farmers to turn bits of land into footpaths, but that will not help if we have not encouraged the rest of government to make them accessible. Are we making a car park or a bus route available? Are we getting various bits of government to talk to each other?

Sports have a small crisis coming up due to lack of activity caused by the pandemic. We are losing adult players who provide the administration and coaching for younger players. There has been a fall-off, and many sports are struggling to get them back in; my own rugby union is suffering from this. Can the Government do something coherent to help? Surely there must be a way to put something in the Bill to support exercise. This is done on a voluntary basis, and—let us face

it—mainly funded by those taking part. Am I the only person here who has paid subs to join a club and paid match fees?

We need to make sure we get something in here to help us. A little encouragement and help—a little cohesion between bits of government—is required to get the best out of this opportunity. I look forward to Committee, when I will be encouraging noble Lords to put something in the Bill to make the situation easier. We are missing out the biggest assist we could have for public health: making exercise, recreation and sport easier to do. They have survived this long because people enjoy doing them. If any Government cannot cash in on that, heaven help them.

8.52 pm

Baroness Bull (CB): My Lords, I join other noble Lords in welcoming the noble Lord, Lord Stevens, to this House, and I join in the welcome for this Bill, in so far as it enables greater local collaboration to deliver integrated care. However, I also share concerns expressed across the House today that the Bill must do more to address the health inequalities exposed and exacerbated by Covid. The Bill offers a chance to make progress on reducing unfair, systematic and avoidable differences in health between different places and communities, yet its core duty in relation to this—

"to have regard to the need to reduce inequalities between patients"

in terms of access to and outcomes from health services —is unchanged from the existing legal framework despite this duty having failed to deliver the change required.

The narrow focus on access to and outcomes from health services ignores the key point that health outcomes are influenced most strongly by the social, economic and environmental conditions in which people live. As my noble friend Lord Mawson explained so well, NHS organisations are significant local players; they are rooted in their local communities, yet they operate at scale. By acting in place-based partnerships with local government, the voluntary sector and other anchor institutions, they could positively influence the broader social determinants of health in their locality; but retaining the current duty, as narrowly defined, misses this potential.

The new triple aim also fails to mention health inequalities, missing the chance to drive home the need for action. The Minister in the other place argued that the requirement to promote health and well-being, combined with existing duties, obviated any need for a specific reference, but the widening gulf in inequality suggests that existing duties are not enough. I hope that the Government will heed the calls today, including from my noble friend Lord Kakkar, for this omission to be addressed.

Also missing from the Bill is the explicit inclusion of parity of esteem for mental and physical health. A decade after the Health and Social Care Act 2012 placed a duty on the Secretary of State to secure parity of esteem, mental health services are still underfunded, with mental illness representing up to 23% of the burden of ill health but only 11% of NHS England's budget. This Bill must unambiguously restate the commitment to parity, offsetting any suggestion that "well-being" be understood as a proxy for mental health; it is not the same thing.

One group disproportionately impacted by health inequalities is the 1.2 million people in England with a learning disability and/or autism. Annual mortality reviews have highlighted their increased likelihood of dying from causes that could have been treated, and of dying younger than their peers in the general population: 23 years younger for men with a learning disability, while for women it is 27. The *NHS Long Term Plan* prioritises people with a learning disability, while the Government's autism strategy expects that all integrated care boards established by this Bill will have

"a named executive lead for autism and learning disability".

So will the Government follow their own advice, and stipulate in the Bill that ICBs include this named lead?

Other noble Lords have spoken on changes to the cap. I want to highlight the impact on working-age adults in the social care means-tested system of the Government's announcement on 17 November that local authority contributions towards care would no longer be counted towards the cap on a person's total care costs. In England, a quarter of a million working age adults rely on social care to live independent lives, and they stand to be particularly disadvantaged. They are disproportionately asset- and savings-poor. They are likely to receive care for longer periods and therefore to accrue higher costs. They are also more likely to pay care costs that do not contribute to the cap, such as the cost of a personal assistant to enable them to work or enjoy social activities. Sir Andrew Dilnot proposed a zero cap on anyone developing an eligible need up to the age of 40 on the basis that they could not be expected to have planned for their needs, nor to have accumulated assets to pay for them. If the Government continue to reject a zero cap, how will they mitigate the risk of catastrophic care costs on those least able to bear them?

Finally, the Minister stressed again in his opening remarks that much of this Bill simply puts existing integration efforts into legislation or gives effect to policies emanating from the NHS itself; in other words, we are told that disruption is minimal. But this Bill is just one among a suite of reforms, White Papers, reviews, transformations and reconfigurations. The Government need to do more to articulate a vision for how they work together, and how, as a whole, they will deliver for communities, patients, service users and the workforce. They need to demonstrate to the people who will have to implement these changes, while dealing with the impact of a global pandemic, how all these measures will combine to significantly improve health and care.

8.58 pm

Lord Moylan (Con): My Lords, as a fellow Brummie by origin, I congratulate the noble Lord, Lord Stevens of Birmingham, on his maiden speech. I also express my very strong agreement and support for my noble friends Lord Sandhurst and Lord Shinkwin in the emphasis they have placed on Clause 4 and the importance of improving cancer outcomes.

With regard to the speech by my noble friend Lord Naseby, I will say how remarkable it is that we seem to have accepted, almost without dispute or protest, the transformation in GP services in this country, which are no longer delivering what we have traditionally expected them to deliver. That is perhaps something that can be explored further as this debate continues,

[Lord Moylan]
because it seems to pass by with nobody commenting, as if it would be rather rude or impertinent to say something about it. But it is a real phenomenon, which is being deeply experienced.

I generally support this Bill—it is a very good Bill—but I would like to make three points. First, we take it for granted nowadays that Nye Bevan was right to insist on a topdown centralised National Health Service. But that view was contested at the time, and by no less a person than Herbert Morrison, with his long service in local government.

I am grateful to the Library for finding for me a rather fiery Cabinet minute from Morrison arguing for local authorities to keep their role in healthcare provision. That did not happen, but perhaps if it had happened, we would have had a less troublesome bifurcation between the health service and social care that we have spent so much time since trying to address. We are back here now trying to do something to fix and amend that relationship.

My concern, with my experience of local government, is simply this: that the new statutory integrated care partnerships must maintain a proper balance between the National Health Service and local government and respect the democratic and local character of the latter. As was said, I think, by the noble Baroness, Lady Murphy, there must be the threat that when you have such a large shark in the room, some of the minnows get squashed. That might not be an exact analogy, but the drift is clear.

My second point is that I will be supporting my noble friend Lady Morgan of Cotes in her proposals for the collection of UK-wide health outcome data on an interoperable basis. The pandemic has shown that everyone in the UK is entitled to the same high health outcomes from our National Health Service. To achieve that, we must have comparable data and appropriate mechanisms.

My third and final point—I am sure that at least some noble Lords will recognise this, which the pandemic has brought to the fore—is that health policy is increasingly seen as the new form of social control. One hears calls for non-medical conditions such as gambling addiction to be treated as a medical problem. The phrase "public health approach" to a problem is the new code for policies designed to coerce, tax and nudge people into doing what is thought best for them.

This Bill gives us fluoridation. It gives us an advertising restriction on what are thought of as unhealthy foods, but even government figures, despite the catching enthusiasm of the noble Lord, Lord Rooker, show that this would result in a trivial reduction in annual calorific intake. In Committee, as the noble Lord, Lord Rennard, has already told us, we can expect a raft of further amendments of an illiberal character. I will end by saying that these will not be uncontroversial, nor should they be.

9.03 pm

Baroness Morgan of Huyton (Lab): My Lords, I draw attention to my interest in the register as chair of Royal Brompton and Harefield hospitals, now part of Guy's and St Thomas' Trust. Like others, I pay tribute to both the speech and the work of the noble Lord, Lord Stevens, and thank him for assisting us in making a merger of two trusts work where both sides wanted to do it.

Like so many of us, I am hugely proud of the NHS, its formation and its evolution, but I am also hard-headed. To be funded properly and remain broadly supported as a universal service, it needs consistent investment and intelligent, well-evidenced reform. I was aware of that before the 1997 general election, when I felt that the very foundation of a universal service was at stake. Underneath the warm noise, I feel that somewhat now again. I am hugely supportive—indeed, incredulous—of those who work in the NHS, but that must not morph into unconditional support without challenge for the outcomes and delivery of the service around the country.

I have spent more time, really, connected to a different public service—education—where arguably there has been a more sustained principle of reform for 20 years or more. We have seen a sustained push to raise standards across the piece, with a particular focus on under-attainment and disadvantage. We have seen devolution of budgets and responsibility to the front line, clear accountability and action on failure, facilitated by inspection and data, and support for getting talented people into teaching and leadership. Do not get me wrong: it has not all been rosy, and I have had many disagreements, but today is not the time for that. My point is that there has been a visible approach and journey over the last couple of decades.

Contrast that with health: centralisation, then decentralisation; PCTs; SHAs; CCGs; regional NHS bodies; Monitor; NHS England and NHS Improvement—then merged; we could all go on. Now we have ICSs, acute collaboratives, myriad reviews and too many meetings and demands for information. Those demands are made on the very people who are trying to deliver services for patients all the time.

The Bill, laudably, aims to improve and move the NHS from a siloed approach to a properly comprehensive system of health and care. It wants patients to be treated at the right time and in the right place and outcomes and treatments to be more equitable. Who would not support that? Of course we want greater integration; it makes complete sense, but the devil is in the detail. What I and, I suspect, others will want to understand during the passage of the Bill is how it will improve outcomes—or will it simply even things out? Will there be action on failure or a soggy "Let's all help each other out"? By that, I do not mean shouting at press conferences at overstretched people, because we all know that simply will not work.

Will there be space to encourage clinicians, managers, scientists and entrepreneurs to be innovative and drive new practice and efficiencies? Will there be incentives to get improvement? Will AI and machine learning really be exploited? Where is the focus on life sciences to harness the huge opportunity that a national health service offers? Will data be used to empower patients, and will data systems work so people are not tied up with endless requests from the layers—using different data systems, of course?

I also wonder whether Covid "gold" has, understandably, in many ways allowed a command-and-control system to become paramount. How we will turn that back to allow talent and ideas to flourish, or will that be sacrificed? I have to say that the Statement from the department on foundation trusts and capital is a warning sign for me. We must incentivise performance at the front line.

Will the really hard issues be examined and reformed—I am thinking particularly of primary and community care—or will that be left to "working together", with the usual focus on hospitals, albeit probably through the parallel acute collaboratives? Crucially—others have said this far better than me—where is the comprehensive workforce plan? Without it, too much of this will be hot air.

I suppose I am sceptical—and I do want to be convinced—because I find it unusual, let us say, to see integration leading to extra layers and bureaucracy. Of course I want better partnership, better leadership and better care and for that to be spread widely around the country. But I have to say that my experience as an NHS chair for four years has been that good governance has to be tangible, transparent and provide clear differentiated responsibilities and accountabilities. You need strong and effective boards with a range of backgrounds and experience, and I do not really see this here. The governance is a muddle and I suppose that in some ways, I am arguing that I do not think it is bold enough.

I get the arguments for more integration of local care—of course that makes sense—but I do not yet see the Bill delivering what we really need. My plea is that, together, we really examine the Bill on the basis of why, what, how and who. Otherwise, we will end up doing another set of reforms five years from now and will not deliver the modern, integrated, universally supported system we all need and want. Please let us take the chance to get this right, or at least make it much better than now.

9.08 pm

Baroness Uddin (Non-Afl): My Lords, I spent some decades of my personal and professional life trying to improve health and social care through the statutory and voluntary sector. I welcome the prospect of refining the Bill in the interest of service users and staff alike, to whom I pay my deepest respects in the light of what has been an impossible and worsening situation for the health of our nation.

I recently witnessed two contrasting events: a patient in an acute ward for mental health, and another progressing though intensive care and then a surgical ward. The staff shortage and lack of adequate care support is indeed grave at every level, and I know my family will not be the first or last to share these harrowing experiences. Therefore, my principal reaction to the many aspects of this ambitious legislation and the report on adult social care is that they ring hollow as wishful prayers.

The Government have said that the Bill is driven by NHS demand. I fear that most frontline staff across the service do not agree; nor have they asked for the inevitable fragmentation and the huge structural upheaval which may result, given the existing shortage of staff and funding within the NHS and care sector as it struggles with Covid.

Of course, I hope that the panacea on the written papers will improve service users' actual experience. Given the glaring lack of any meaningful references to workforce development and, ominously, of any indication that the long-standing consequences of inequalities and discrimination are being addressed, my confidence is rather low at this point.

We are asked to respond to a 10-year plan fit enough to address a massive, long-standing crisis where people are waiting to receive the urgent care to which they are entitled: 1.5 million hours of commissioned care is not being delivered and at least 400,000 adults and families are waiting for formal assessment. This gravely undermines the human rights of those who may already be experiencing a great deal of indignity, pain and desperation. Does the Minister accept that the new proposed boards and commissioning structures may create an even greater backlog of unmet needs?

How do the Government propose to address these anomalies while introducing the new challenges of means-tested personal care and private care companies into an already frail NHS, which struggles to manage current demands? According to the Royal College of Nursing, the Bill as it stands does not address nursing staff concerns, ensure patient safety or give adequate weight to staffing shortfalls in the NHS and the social care sector.

According to other leading experts, including ADASS, £1 billion for the social care sector, while extremely welcome, is not aligned to the reality of the £7 billion investment required to meet urgent needs, and is unlikely to remedy the current crisis in social care. The fear is that the prolonged and chronic historical underfunding—the insufficient resources allocated for social care in the community, which is a disjointed system at local level—will exert even more pressure and cause untold misery and suffering for individuals and families who are among the most vulnerable: the elderly, the disabled with learning disabilities and autism, and people needing mental health support. Integrated care will therefore remain dysfunctional locally, regardless of the fact that half the available social care budget is spent on working-age adults with learning and physical disabilities and the elderly to empower care in the community.

We know that supported housing is seen as a critical linchpin of independent living and is projected to increase by 2030. With only £300 million for these options, does the Minister accept that the Government will have to broaden their reach to widen the network of providers, including specialist and BAME providers, to provide comprehensive and equal care across all communities?

How will these proposals affect the lives of black and Muslim men experiencing mental health crisis who are festering in hospital wards without adequate support, counselling and rehabilitative programmes, and with next to nothing on prevention? I am pleased to hear the new announcement for funding for drug and alcohol treatment. As an experienced leader in the field of dealing with substance misuse at local and national level, I can assure the House that adequate funding for resources and social work support is indeed effective

[Baroness Uddin]
in preventing revolving doors, which can save the NHS and the justice system millions. As the distinguished noble Lord, Lord Ramsbotham, clearly and eloquently said, the Bill should be the right place to consider this service.

Caring institutions and organisations are often run by poorly paid and undertrained staff, including social workers, who are once again in our sight for scrutiny. I declare my interest as one. I have worked in child protection and with domestic violence victims and survivors, as well as those with disabilities and substance misuse problems. I understand the horrendous pressures at the front line.

I have two final points. The APPG on Children, alongside many leading NGOs, is anxious that the Bill does not do enough to bring the benefits of integrated working to children and families. I support its asking the Government to commit to assess the Bill's impact on children within two years of its implementation. Lack of investment in social work, police and education has once again led us to a tragic death, that of Arthur Labinjo-Hughes. As a social worker, I have witnessed the demeaning and catastrophic effect of child abuse. Heartbreakingly, it is a fact that lessons learned from what happened to diminish the hope, the smiles and Arthur's last breath may not prevent the last cry of a child unless we empower staff at the front line of managing complex violence and abuse in our midst.

Finally, I draw the House's attention to the points raised by the Inter-Collegiate and Agency Domestic Violence Abuse coalition. It views the Bill as an opportunity to deliver the health needs of survivors of domestic abuse. It rightly asks that the guidance for integrated care systems and partnership boards be placed on a statutory footing to ensure that it is adhered to across the health service. I agree with the noble Lord, Lord Shinkwin, that this guidance should also apply to those with learning disabilities and communication needs.

I welcome and congratulate noble Lords—

Earl Howe (Con): My Lords, contrary to the clock, the noble Baroness has been speaking for nearly eight minutes. Perhaps she could bring her remarks to a conclusion.

Baroness Uddin (Non-Afl): I welcome and congratulate the noble Lord, Lord Stevens of Birmingham. I hope that we will all work together to enhance this Government's efforts for better regulation. I hope that we can safeguard the needs of the most vulnerable in our society.

9.16 pm

Baroness Sater (Con): My Lords, I draw the attention of the House to my interests in the register. In particular, I am chair of the Queen's Club Foundation and president of Tennis Wales. My purpose in speaking during Second Reading is to highlight the growing importance of sport, recreation and physical activity as essential components of the proactive health policy sought in many of the measures in the Bill. My noble friend Lord Moynihan and I have been working on this important issue. He was keen to speak today and offers his apologies as he is in Wales for long-standing school governor meetings. However, he will be with us in Committee.

The background to our concern, also shared by my noble friend Lord Hayward, is the notable move that sport and recreation has made from isolation from government policy up until the 1990s to taking centre stage in both health and education policy-making. Indeed, there is hardly a department of state where sport and recreation do not feature as an important strand of policy-making. While this debate is not about schools, who can deny that making sure that physical literacy is at the centre of modern educational policy is vital in the decade ahead? Participation levels have remained stubbornly low in the UK. Despite winning the right to host the Olympic and Paralympic Games in London 2012, the excitement in the build-up as we prepared to host the games from 2005 to 2012, and the much-fought-for sports legacy which was meant to raise the bar for sports participation across the country, our levels of participation and enjoyment of an active lifestyle have actually fallen as a percentage of the population.

The Key Data on Young People material recently published by the Health Foundation makes compulsive reading. What is known and appreciated is that the risk factors for later mortality are laid down in the teens and early 20s. The major risk factors leading to mortality or illness in later age are directly related not just to tobacco use or alcohol, for example, but to obesity and a lack of physical activity. If we take action and reverse this trend, physical activity can and must become a major factor in redirecting our health policy away from simply addressing illness to preventive work aimed at improving levels of physical fitness, well-being and mental health.

Covid has now changed the picture for the worse. In January this year, experts expressed deep concern that the coronavirus pandemic has had a huge impact on children's physical activity levels. New figures from Sport England show that the majority of young people failed to meet the recommended 60 minutes of daily exercise in the 2019-20 academic year. That was a decrease of almost 2% compared with the previous 12 months. Almost a third of children—2.3 million—were classed as inactive as a result of lockdown restrictions, not even doing 30 minutes per day. That was up by 2.5%.

There appears to be little evidence that we have returned to pre-pandemic levels—an essential starting point to address 15 years of flatlining, growing obesity, growing inequalities and a crisis of fitness among young people. The Bill provides us with the opportunity to address this fundamentally important challenge. In Committee, we intend to introduce amendments to the Bill to ensure that the original plans for an Office for Health Promotion are enshrined in legislation, so that participating in sport and physical activity is at the heart of the Government's plans and that people can and should enjoy healthier, happier and more productive lives.

On 29 March this year, the Government issued a press release announcing the welcome news that the Office for Health Promotion would be up and running by the autumn. The Prime Minister publicly welcomed the move, as we did. He said:

"The new Office for Health Promotion will be crucial in tackling the causes, not just the symptoms, of poor health and improving prevention of illnesses and disease … Covid-19 has demonstrated the importance of physical health in our ability

to tackle such illnesses, and we must continue to help people to lead healthy lives so that we can all better prevent and fight illnesses."

However, this welcome news—which I saw as a watershed step in the right direction by the Department of Health, underpinning, as it did, the vital importance of seeing sport and recreation as an inherent part of wider policy initiatives for social prescribing, physical and mental well-being and a fitter population more capable of tackling obesity and sickness, as well as a preventive policy for a healthy lifestyle—has been dropped.

In its place, an Office for Health Improvement and Disparities was formed. I say "in its place", because the words of the Prime Minister had been erased from descriptions of the substitute body taking the place of the Office for Health Promotion. Mention of physical activity was completely deleted, resulting in the stark absence of any reference to its vital importance.

Whatever the final shape of the approach taken, I believe a key division in the Department of Health, bringing together the policy strands of active lifestyles, health and well-being, should be at the heart of British policy formation, and could achieve far-reaching benefits for all members of our community, particularly the hard-to-reach groups. My noble friends Lord Moynihan and Lord Hayward and other colleagues who share similar views look forward to exploring ways in which this can be achieved when we return to the Bill in Committee early in the new year.

9.21 pm

Baroness Finlay of Llandaff (CB): My Lords, I declare my interests in medicine and physiotherapy and as a Bevan Commissioner. Like others, I welcome the noble Lord, Lord Stevens of Birmingham, who clearly brings a veritable wealth of experience.

In the debates during the previous health and social care Bill, there were two references to the Titanic, and it felt as if we were commissioning different lifeboats. The lifeboats never arrived. We have two separate systems, health and social care, both of which are creaking under current pressures and severe workforce shortages. Integration is essential and complex. Integrated care boards need comprehensive membership, with a broad overview for patients and children.

Specialist palliative care services, like maternity services, must be commissioned as core. Would you depend on fundraising events for a woman to be able to have a caesarean section in obstructed labour? No. So why do we allow distress in severely ill people to go unaddressed because there is no specialist palliative care service commissioned? I do not mean after-care, as was suggested in the other place. Good specialist palliative care must be commissioned to be integrated across the trajectory of a person's serious illness, to deal with problems in a timely way when the prognosis is unknown, not just when people are actively dying.

Children and young people need to be considered in all parts of the system, with integrated services and early mediation for disputes between clinicians and loving parents. Abuse, alcohol and drug addictions, the promotion of cosmetic procedures, dental caries and nutritional problems are all part of the public health emergency for children and young people we now face. Underpinning all of this for children is data. There is a desperate need for a unique identifier for a child that goes across health and social care. Some 46 years ago, I admitted a child who had been dipped in boiling water. The case went to the Old Bailey. This week, we heard of a child being brutally assaulted and killed. Has nothing changed? We cannot continue to have social care data kept separate from healthcare and not linkable to education and police records. To improve life chances, we must have relevant information rapidly available. Across the UK, transferable and comparable data is also imperative for decisions in devolved Administrations to be made in the best interests of the patient. This Bill needs to show that.

Seven years after Framework 15, workforce projections remain uncertain. Some 48% of advertised consultant posts went unfulfilled across the UK last year, and there are long-term vacancies on top of that. Unless workforce planning, education and training improve, underpinned by research initiatives and findings, care provision will not improve.

We also need to recognise the appalling work environments, where staff do not feel looked after or valued. Social care will only have the status that it deserves if there is an integrated career path with the NHS, with staff travel time paid for and staff able to access support and advice if they are concerned about someone—with their opinion being valued—without having to go through multiple hoops.

Cancer outcomes at one year are falling behind that of our European colleagues, yet our research is ground-breaking. Sticking with process targets is not good enough. We must not water down the amendments so ably introduced in the other place and accepted by the Government.

Disease does not respect the clock or the calendar. The Bill fails to address the overwhelming number of problems that arise during the three-quarters of the week that is out of hours. The Bill also fails to address the large number of people being treated in inadequate premises because overcrowded emergency units are unable to move sick patients through to wards because there are no beds. Currently, one cannot expect ambulances to offload in a timely way or expect staff to give each patient safe care. Discharging into the community to assess needs in people's homes makes sense, but where is the workforce to do it? Physiotherapy and occupational therapy are essential in every team to avoid deterioration as well as to restore well-being.

Until health and social care are integrated, we will not solve any of the problems that we face. I believe that the budgetary systems need to be combined. Clause 140 feels like trying to apply an enormous sticking plaster to tackle the underlying chasm: the gap between the current rationing of social care by means-testing versus an NHS free at the point of delivery. The success of the integrated vision in the Bill rests on social care being an equal partner to the NHS, but significant work is required if parity is to be achieved. We have much to do.

9.27 pm

Lord Reay (Con): My Lords, I extend a warm welcome to the noble Lord, Lord Stevens, although like my noble friend Lady McIntosh, I respectfully disagree on the topic of water fluoridation, a measure that I strongly oppose and that I will focus on tonight.

[Lord Reay]

It is disappointing that mandatory fluoridation has been slipped, virtually unnoticed, into the nether regions of such an important Bill, without its own debate and without proper scrutiny. Moreover, it all seems very rushed. I stand before noble Lords today not as a scientist or a connected party of a lobby group but as someone who has grave concerns about the risks posed by widespread water fluoridation. I contend that high-quality evidence that has come to light in North America since 2017 suggests that fluoride can damage the developing brain and reduce IQ. I conclude that water fluoridation has not been adequately researched by those who have initiated the Bill. The practice cannot be considered safe and should not be extended throughout the country.

In Europe the only countries that have agreed to water fluoridation are Ireland and the UK, with 10% population coverage, with Spain, Poland and Serbia having done so to a very minor extent. In studies in 1999 and 2001, the Centers for Disease Control and Prevention acknowledged that fluoride's benefits are mainly topical, not systemic. There really is no need to swallow fluoride or put it in drinking water, when topical treatments like fluoridated toothpaste are available.

Children, particularly bottle-fed babies, are unfortunately being overexposed to fluoride. Infants consuming formula mixed with such water receive the highest exposure to fluoride by body weight—a dosage 100 to 200 times higher than a breastfed baby. This overexposure leads to dental fluorosis, or discolouration of the enamel, when the permanent teeth erupt. Since we have now learned that fluoride crosses the placental membrane, it is evident that the foetus receives an even higher exposure than a bottle-fed infant at a more vulnerable time.

Proponents claim that over 60 years of research has demonstrated that the measure is safe and effective. However, most of that research has focused on the hard tissues: the teeth and bone. It is only recently that high-quality research has focused on other tissues, with disturbing results. According to recent US Government-funded studies published in leading global journals—Bashash, 2017 and 2018; Green, 2019; and Till, 2020—fluoride has the potential to damage the developing brain of both the foetus and the infant, leading to lowered intelligence and increased symptoms of ADHD. Making these observations even more alarming is that the damage was observed in fluoridated communities in Canada—a country that fluoridates at 0.7 parts per million, versus 1 part per million in the UK. The Till paper showed an IQ decline of 9 points among bottle-fed children in fluoridated versus non-fluoridated communities. These findings are so serious that they make any discussion of dental benefits of this practice moot. You can repair a damaged tooth but not a damaged brain.

The irony of the Bill's proposals is that they will harm most those whom they seek to help. Those most likely to suffer from poor nutrition, and thus most likely to be vulnerable to fluoride's toxic side-effects, are the less well-off, who are the very people being targeted by the proposed fluoridation programmes. We should be spending our efforts trying to increase the access to dental care for low-income families and invest in programmes such as Childsmile in Scotland.

In his written evidence to the recent White Paper, Professor Stephen Peckham, government adviser to the current Select Committee on Health in the other place, chaired by Jeremy Hunt, stated that

> "if the Secretary of State was looking for ways to improve oral health then water fluoridation should not even be considered given its lack of effectiveness. More attention should be given to schemes such as Childsmile in Scotland which has been proven to reduce inequalities, reduce admissions for tooth extractions and provide broader public health benefits beyond oral health. Such a scheme links very clearly to addressing obesity issues as well".

Professor Peckham rebuts government claims in the White Paper that water fluoridation is proven to improve oral health and reduce oral health inequalities. He argues that such claims are based on inconclusive evidence and studies predominantly carried out pre 1975, before the wide use of fluoride toothpaste. Peckham further argues:

> "We should not be considering any new schemes given the increasing amount of evidence linking fluoridation to harmful health effects."

Only eight years ago, the Government made a decision to transfer decisions on this issue from the NHS strategic health authorities to local government. The specific reason given was that local communities should have a stronger say. This Bill reverses that position and reverts to the centralisation of control with the DHSC.

Surely, if health measures are to be imposed on the individual and if the community's final say in the matter is removed, the scientific evidence should show overwhelmingly that the measure is both beneficial and safe. In the case of water fluoridation, I do not believe it is either. At the very least, I urge a delay in proceeding with this measure until the National Toxicology Program in the US—which for the last five years has been undertaking a systematic review of the fluoride neurotoxicology studies—publishes its report, expected in early 2022. The public will not easily forgive us for rushing ahead without availing ourselves of the best scientific research on the matter.

9.33 pm

Baroness Watkins of Tavistock (CB): My Lords, I welcome the noble Lord, Lord Stevens of Birmingham, to this House and enjoyed his erudite speech—and I am supportive of the fluoridisation of water. I draw attention to my interests as outlined in the register, particularly as a registered nurse and chair of a small housing association that specialises in housing for people leaving care.

This Bill is welcomed by many health and care communities, and I support its emphasis on collaboration and integration between mainstream NHS providers, public health, social care, the voluntary sector and, in some cases, the independent sector. This will be essential to meet our health challenges and increase productivity. The Bill refers to patient-focused care provision, yet future success will be achieved only if people take greater responsibility for their own health based on public health advice. For this reason, I suggest that the term "person-centred care" is substituted in many parts of the Bill to emphasise the partnership in care between service users and professionals. How can this House be assured that the structural changes proposed

will reduce health inequalities and ensure parity of esteem between mental health, learning disability and physical healthcare services?

There is a concern that in ICBs there may be an overrepresentation of local acute trusts. I support amending board structures to mandate representation for mental health and learning disability providers; a member of the local community to represent users and carers; and a nominee from social services and public health. This will be vital to achieve balanced decision-making and fair allocation of resource.

In 2020 the World Health Organization launched a vision for nursing, with a clear policy committing all nations to increase the proportion and authority of nurses in senior health positions. I hope the Government will consider this in their new structures.

I support proposed amendments to ensure that the Secretary of State must lay regular reports before Parliament outlining the system in place for assessing and meeting the needs of the health, public health and social care workforce in England. Reports should include independently verified workforce numbers—in full-time equivalents, not headcount—and should indicate the proportion who have been trained in the UK and those recruited from overseas. The World Health Organization is clear that while healthcare workers' migration can be positive, wealthy countries should not be overreliant on recruitment at the expense of lower-income and middle-income countries. Reports should identify the number entering training in the UK and the number of leavers, and should provide information on retention, including examples of best practice.

The Bill introduces the NHS payment scheme, designed to enable the integration of service delivery. To realise this ambition, there must be central prioritisation of early intervention and timely discharge. In August 2021 there were 25,836 days of delayed discharges for mental health services; 32% were attributed to social care and 11% to housing. The proposed payments system may make it easier to prioritise proactive community care, but this priority needs mandating in order to ensure that the new payments scheme drives reductions in delayed transfers of care and does not simply continue to accommodate extra bed days in hospital.

Patient safety and the relationship to safe staffing cannot be overemphasised. Amendments are necessary to promote workplace health and safety, including in community settings; the supply of PPE and other safety equipment; and clear mechanisms for staff to raise and resolve concerns. Staff teams should include relevant skill mix, adequate time for clinical supervision and access to continued professional education in data management, new research findings and interpersonal skills to provide contemporary evidence-based practice. I look forward to working with others in Committee to ensure that amendments concerning the issues that I have raised are considered.

9.38 pm

Baroness Jenkin of Kennington (Con): My Lords, 63% of people in England live with obesity or are overweight. At last obesity is recognised as a significant health challenge that needs to be addressed. The figures are stark: none of the obesity strategies published by Governments since 1992 has successfully reduced the prevalence and inequalities of obesity. Researchers from the University of Cambridge studied why this was the case. They analysed England's 14 obesity strategies and 689 obesity policies proposed by Governments over the past 28 years, and found that obesity policy has been largely unfit for purpose.

Around 76% of all policies had no plan to monitor or evaluate whether they were working. A further 81% were published with no cited evidence, for example on whether the policy was likely to be effective, while 91% included no cost or budget for implementing policies. Just 8% of the policies that the academics looked at included all the necessary details about how the strategy could readily be implemented. A total of 43% of the policies they studied required people to make changes to their lifestyle, such as diet or exercise, which, sadly, we know do not work. Just 19% of policies focused on making it easier for people to be healthier by shaping the choices available to them.

That is where this Bill, specifically Schedule 17, comes in. Every child has a right to be healthy, no matter where they live. It should be a simple principle to follow that we make it as easy as possible for children to access healthy, nutritious and delicious food to ensure that they get the best start in life. We want them to grow up fit and healthy in an environment where picking the healthy option is the easy option.

The reality today makes this hard. At school, on the street and on their screens, young people are overwhelmed with unhealthy food options: canteens selling cakes, doughnuts and cookies, while failing to provide enough fresh fruit and vegetables; fried chicken shops and other cheap, unhealthy fast-food options opening up on every other street corner; and a bombardment of advertisements for unhealthy food on TV and online, beamed into children's eyes all day every day. With unhealthy food so regularly in the spotlight, it is no wonder that it plays such a starring role in children's minds.

This food environment has resulted in a public health crisis. One in three children leaves primary school overweight. Childhood obesity is increasing at an alarming rate made even worse by the pandemic. Recent NHS data shows the biggest year-on-year increase in childhood obesity on record. The problem is not just getting worse; it is getting worse faster.

An unhealthy diet is linked to many negative outcomes in life. It is a path that leads to a higher risk of preventable conditions such as type 2 diabetes, tooth decay, heart and liver disease and cancer, and leads to poor performance at school, bullying and mental health issues. It results in many potentially avoidable deaths, including the likelihood of hospitalisation, even death, from Covid if the person is overweight, and costs our NHS in excess of £6 billion a year—and climbing. The impacts are not shared evenly across society. Children from deprived areas are more than twice as likely to have obesity than their more affluent counterparts.

I support the restrictions on advertising unhealthy food and drink on the television, on-demand programme services and online. I commend the Government on bringing these proposals forward. Advertising is very different today. It is no longer confined to just a billboard in town, the back of a newspaper or a 30-second spot

[Baroness Jenkin of Kennington]
on television. Marketing companies can now reach us all day every day online, through our phones, tablets, computers and more. The young people at Bite Back 2030 published research earlier this year reporting that children in the UK see nearly 500 online junk food adverts per second. They see endless streams of advertisements for unhealthy food on their social media channels, saying that it is "overwhelming" and "like the wild west". They feel hopeless against the narrative that junk food is the only option.

Marketing is manipulating young people to crave more, buy more and eat more unhealthy food. Between 2010 and 2017, spend on food and drink advertising increased by 450%, yet just 2.5% of total food and soft drink advertising spend goes towards fruit and veg. The other benefit of these restrictions is that they will level the playing field, incentivising the marketing of healthy foods and giving businesses that want to prioritise child health more of an opportunity to be innovative and creative in the way they put healthy food in the spotlight. These restrictions are regarded by many as an opportunity for companies to innovate and champion products that benefit, rather than harm, public health.

Children's health must come first. The legislation does that by making it easier for young people to live without the constant reminder that they could eat a burger, order some chips or grab an ice cream. That is a good thing and very much a step in the right direction.

9.43 pm

Lord Adebowale (CB): My Lords, I declare my interests as the founder and co-chair of Visionable, a provider of services to the NHS; as a board member of Nuffield; and as an adviser to Telstra UK. I also chair the NHS Confederation, the largest body representing health leaders in the UK.

I welcome my noble friend and colleague, Lord Stevens, to this House. We have often had debates. It is great to see him here. It is obvious now to all of us that he is very smart and very funny. He is a certified national treasure. He has been welcomed to the House, and deservedly so.

I want to make a few points on this Bill—hopefully briefly, given the hour. First, this Bill is a ground-up Bill; it is not an imposition from on top. Rather oddly, it would be strange if we did not support the Bill, not least because the restructuring would be the result of us not supporting it. We have chairs of ICSs in place; we have chief executives of ICSs in place; and we have strong relationships across health, local government, housing and education in place. This Bill provides the legislative infrastructure to enable ICSs to go faster. Not to support this Bill is a backwards step. I know because the last Bill, in 2012, could be seen from space. I chaired the NHS England sub-committee that authorised some 211 CCGs. I wake up perspiring in the middle of the night at the thought of going back there. This is better, and it is not just me saying that; it is the majority of health leaders in the UK.

I also point out that those noble Lords who are concerned about privatisation need not worry. I say that again because the leaders in the NHS Confederation, in the health system, in the acute care system and in the social care system are not. Personally, as the son of a nurse of 40 years, I would not be standing here supporting this Bill if that were the case. I would not support this Bill, and neither would members of the NHS Confederation. It is already in place and happening because the people leading those systems believe that ICSs and population health will make a significant contribution to the thing at the top of 95% of their to-do lists: health inequity and inequality, exampled by the experience of Covid. The Covid experience has forced systems to work together—for example, local authorities to work with acute trust and acute trust to work with social care. It is imperfect but necessary. It is as a result of that learning that we need population health and the infrastructures to support it. To that extent, I support this Bill.

There are examples. Many Peers have talked about particular sections of the community. The noble Baroness, Lady Hollins, referred to people with learning disabilities. In West Yorkshire and Harrogate, the ICS decided to prioritise people with learning disabilities as part of its acute waiting list response. It could do that because it was operating on a good understanding of population health needs, stratified according to real need in that area. That is what ICSs can do, and that is what we should encourage them to do.

However, there are some concerns. Ministerial powers are the number one concern of many health leaders. I do not quite understand it, to be honest; I am not convinced by the introduction to the Bill from the noble Lord, Lord Kamall. The powers are sweeping. In informal discussions, I did say to him that my feeling was this: why would he want all these powers? How would he feel having them? It is the equivalent of attaching a lightning rod to your derrière and dancing blithely into the middle of a lightning storm. Why would you do it?

More seriously, let me give noble Lords an example of why this really matters in practice. Following a review of Kent and Medway's stroke service in 2015, the local council referred a decision to create three hyperacute stroke units—HASUs—to the then Health and Social Care Secretary, who then passed it to the independent reconfiguration panel, which approved the changes in autumn 2019. The green light for the decision sat on the desk of successive Health and Social Care Secretaries until just a few weeks ago. This means that those HASUs will not be up and running until 2024. It is estimated that 25 people a year would avoid death or disability if HASUs were established, so those delays have cost lives.

These powers are not necessary. They work against the very principle of this Bill: to distribute leadership so that it is as near as possible to the people who need health and social care. I will be supporting amendments to this Bill that reduce the powers of the Secretary of State so that the Government can benefit from the principles enshrined in this Bill.

The noble Baroness, Lady Harding, summed up the position on the workforce brilliantly, ably supported by my noble friend Lord Stevens. The fact is that, without a credible plan, you plan to fail. It is as simple as that. The thing in the room that people are afraid of noting is that a proper analysis will cost money. Well, not having a proper analysis will cost lives and money.

I will say a couple of things to close. First, I support the comments of my noble friend Lord Stevens on mental health and I will support amendments that give greater clarity on that issue. Secondly, the idea that we might slow down this Bill is for the birds. We need to examine it, obviously, but we need to move with full speed because people are waiting for services that are joined up. The then chief executive of the NHS commented on the last major change as being one that could be seen from space. This is not that change. It is a change which will enable health and social care to be felt by patients and citizens, which is what I commend this Bill to the House to do—though it is not for me to commend it. However, we should support this Bill for that reason and support the leaders of our health and social care system, who have worked so hard through the pandemic. Now they want this support; let us give it to them.

9.50 pm

Baroness Bennett of Manor Castle (GP): My Lords, I am going to structure this speech untraditionally, beginning with a short list of some of the issues that I expect to pick up in Committee and adding to the list already laid out by my noble friend Lady Jones of Moulsecoomb as her agenda. The British Association of Social Workers is concerned about the dilution of local authority responsibilities. The Institute of Alcohol Studies points out the failure to address the harm done by advertising for alcoholic products. The Venice Commission concludes that it undermines trust in the Parliamentary and Health Service Ombudsman. Unpaid carers are deeply concerned about Clause 80, as the noble Baroness, Lady Pitkeathley, outlined, and, of course, multiple organisations and Peers are gravely concerned about the lack of workforce planning.

I want to spend most of my time looking at the big structural changes introduced by this Bill—astonishingly, as many noble Lords have noted, at a time of tremendous pressure and struggle for our health service. The warning from the British Medical Association that the Bill will

"do more harm than good"

in this context must be noted. I want to engage particularly with two speeches, starting with that from the noble Lord, Lord Lansley. He raised the way the kind of structures created by the Bill reflect those that

"JP Morgan and Rockefeller used when creating vast monopolies."

Those noble Lords, among them the noble Lord, Lord Stevens of Birmingham, insisting very vigorously that the Bill is not about privatisation—really, really it is not—might like to reflect on that analogy.

The noble Lords, Lord Lansley and Lord Adebowale, noted that integrated care systems have been around in one form or another for six years already. They were brought in de facto into the NHS, without parliamentary oversight, and now we are being asked to approve that model. Somehow, that makes me think of the Henry VIII powers that, rightly, so exercise many of the legal experts in your Lordships' House. I do not believe anyone disagrees with the idea of integration. Regarding each individual engaged with the system as a person needing a mixture of medical and other care, not as a set of conditions, is obviously essential and all too rare. But the big question is, how? There is an important question to ask about models: what are their origins?

The origins of so much thinking about healthcare systems in the UK come from the United States—as do many of the personnel, who come from giant American healthcare companies. I am talking, of course, about the top of management. That is astonishing, when you think that the world's richest country can reasonably be classed as having the world's worst health system. It is a system that absorbs enormous resources—financial, physical and human—to produce astonishingly bad outcomes, whether measured by mortality, morbidity, the actual volume of care provided or inequality. Yet we seem to draw most of our thinking, and many of our senior personnel, from the US.

Maybe I am wrong that this is a failure; maybe the issue is the purpose of the system. If you acknowledge that the purpose of the US healthcare system is to be a cash cow, not a care provider, then on that measure it is a raging success—one that is already consuming about 8% of England's NHS spending and providing a quarter of our mental health in-patient beds.

It has not always been so. Think back to 2015, when Hinchingbrooke Hospital was briefly in the hands of the healthcare company Circle. Soon, care was rated "inadequate"; the company complained that it was not making any money and handed it back to the Government. Multinationals have found it hard to make money from operating some elements of our current health system but now, potentially, they will have a new way of taking over.

The integrated care board model is closely based on health maintenance organisations, also known as managed care organisations. These are responsible for providing only limited free services to an identified group of people. In the US, they are like customers, but very constrained ones. The sad reality of where we are now in the UK is that, with our level of spending on health significantly below that of nations of comparable wealth, we are already heading towards this. A survey by openDemocracy found that one in five people had had a doctor or other health professional suggest that they needed to go private to get the care that they needed. Nine out of 10 patient-facing staff said that they had been unable to give a patient treatment or a procedure that they would benefit from. With a block of patients and a fixed budget, how much further might this Bill take us down that road?

Lest noble Lords think I am going out on a limb here, I point out that the BMA has noted that the Bill

"risks making it easier for private companies to win NHS contracts without proper scrutiny."

We have already seen this in action in our social care system over decades under successive Governments. The Bill does nothing to tackle the predatory financing that has consumed our care homes sector, with 84% of beds provided by for-profit companies, and one-sixth of the fee for a bed in financialised homes going towards interest payments.

If this brief outline has left noble Lords wondering or puzzled about the apparent lack of resistance from the Front Bench on this side to the basic structural changes here, where should they go? I suggest they read the work of Professor Allyson Pollock, Peter Roderick

[Baroness Bennett of Manor Castle]
and Caroline Molloy on openDemocracy and, on social care in particular, the work of the APPG on Limits to Growth.

9.57 pm

Lord Harries of Pentregarth (CB): My Lords, I too thank the noble and national "treasure"—the noble Lord, Lord Stevens—and welcome him to the House. I wish to focus on three areas: care homes, care workers and carers.

Last night, "Panorama" examined the financial structure behind two big care home chains. It discovered that the ultimate owner was a private equity company based in a tax haven, and that between that owner and the home there might be more than 100 other shell companies. Furthermore, the equity companies owning the chain changed frequently, each time taking more money and loading the debt on care homes.

The result was that at least 20% of the money that should have gone to support the resident was used to pay interest on the debt and dividends to shareholders, leading in some cases to poor care. Moreover, in a number of cases, the debt became unsustainable, so the home had to go into receivership, with the residents left in great uncertainty about their future. Is the Minister content that the present Bill will be able to ensure that the financial structure behind care homes in the future will not be of this type, able to load debt on to homes in a way that harms residents?

That having been said, the vast majority of care homes provide dedicated service. This was very much shown in the first phase of the pandemic when, for example, care workers actually lived in some homes to safeguard the residents from infection. However, there are now 170,000 vacancies in care homes and almost every home in the country has been hit by staff shortages, as underpaid and exhausted care workers leave. This raises the whole question of their pay, conditions and status.

There is a totally unacceptable turnover rate of care workers, as the noble Lady, Baroness Altmann, emphasised, while their average pay compares very unfavourably with that of a shop worker. Of course, this applies not just to those working in care homes but to the vast number now working in the community, trying to care for people in such a way as to keep them in their homes. We are still in a position where far too many hospital beds are being occupied by those who should be cared for in the community. That depends on care workers actually being available.

I believe in and greatly value the business sector of our society, not least innovators and genuine entrepreneurs. The whole country depends on their success but no less should we value the care sector and recognise this in the status that it is given, which should be reflected in how its workers are paid and treated. At a time when we will soon have 1 million people suffering from dementia and with the prediction that by 2050 that figure will be 2 million, we are no less dependent on the care workforce than we are on those working in business.

I welcome the Government's recent statement that they are spending a least £500 million so that the social care workforce has the right training and qualifications and feels recognised and valued for its skills and commitment; they are also prioritising workforce well-being and support, including better access to occupational health services. The second question I ask the Minister is this: is he satisfied that this Bill, as set out at the moment, will ensure that this very excellent aim will be properly checked and monitored?

I now turn to carers—that is, those caring for a relative or friend on a voluntary basis. The support provided by people caring for a family member or friend who is older, disabled or has a long-term condition is vast. Prior to the pandemic it was estimated to be worth £132 billion per annum and during the pandemic, in one year, at about £193 billion. With an ageing population we are likely to continue to see a rise in the number of people providing care in this way. Carers' health is often impacted by caring. Those who care for people in their house for more than 50 hours a week are twice as likely to be in bad health than non-carers. Carers UK has suggested some interesting amendments to this Bill to ensure that this element of the care sector is properly recognised and taken into account.

Finally, the word "care" is a precious one. The categories of "care worker" and "carer" are fundamental to our society. They need to be recognised accordingly, both in our attitudes and in the law, the latter so often being powerful in shaping those attitudes. I hope that as a House we will be considering amendments which ensure that that is indeed the case.

10.02 pm

Baroness Walmsley (LD): My Lords, being asked to make a winding-up speech is a mixed blessing. There may be nothing new to say, but at least one has more than five minutes in which to say it. Like the Minister and the noble Baroness, Lady Thornton, one has to listen to the vast majority of the debate. I am sure they will join me this evening in saying what an absolute pleasure it has been. We have heard passion, compassion and expertise, all peppered with a little bit of humour—and I am right with the noble Lord, Lord Rooker, especially on the medication. It has certainly emphasised why we need your Lordships' House: to give detailed scrutiny to Bills coming from another place. In that respect, are we not very lucky to have been able to welcome the noble Lord, Lord Stevens of Birmingham, to our ranks? I welcome him and congratulate him on his maiden speech.

When I look at a Bill like this one, I ask myself whether it will deal with the most urgent issues in the sector. So I have a little list of the questions. Will this Bill fix the crisis in social care; reduce health inequalities; ensure parity of esteem between physical and mental health; reduce the backlog of treatments while improving patient safety; improve access to primary care and reduce the demand on A&E; enable those who need social care to get it and help unpaid carers; provide the right number of qualified staff in both the NHS and social care; enable the commissioning of multi-agency pathways; improve recruitment and retention of NHS and care staff to enable them to work within safe staffing levels; enable public health to carry out prevention activities and protect us all from future pandemics; enable research and innovation to be implemented as quickly as possible and ensure that patient data is shared only in the patient's interest and with appropriate

security? Unless the answer to these 12 questions is "yes", the Bill should either be ditched or considerably amended. It is quite clear from this evening's debate that your Lordships are determined to do the latter.

Like the noble Lord, Lord Warner, I start with the fundamental issue of why the Government want to push these measures through at a time when the NHS is stretched beyond endurance and social care is at breaking point. Thousands of hospital beds are occupied by Covid patients; others cannot be discharged because there is not enough social care. No wonder—some care homes have had to close because they did not have enough patients to make them pay during the pandemic; others have had to close sections of beds because they cannot get enough staff. The backlog for elective treatments is not going down well enough, and both health and care staff are exhausted. GPs and pharmacists are trying to do their usual job while at the same time stepping up the vaccine programme. A White Paper on social care was published less than a week ago and another is promised next year, and it is at this time that the Government have chosen to change the structure of the health and care system.

The Minister will no doubt say that many of these changes have been requested by the health and care sector to enable them to continue to work more closely together without legislative barriers. We know that many areas have been preparing for the change for some time. That is all true, and the direction of travel is most welcome. However, winter is upon us, and services are not showing the resilience we need in preparation for it while at the same time having to prepare for these imminent changes.

The Government are taking a very big risk by asking the system to make these changes now. Can the Minister please be clear about why he is so confident that it can be done next April without the NHS and care providers taking their eye off the very heavy ball they are already carrying? None one of us wants to see a "Titanic" disaster, but the iceberg is upon us.

I move to the obvious potential benefits of the new integrated care systems, if they are set up correctly and with everything thought through. The Bill has been described as broadly permissive, and this may allow services to be arranged to suit the particular conditions of each of the 42 areas and the sub-areas between them. However, there is a danger that funding will be sucked in, as usual, to the large hospital trusts in each area and social care and community services will be left behind. From these Benches, we are particularly concerned about this. How will that be avoided? How will all the relevant interests be appropriately represented? For example, certain aspects of health such as mental health, sexual and reproductive health, as mentioned by my noble friend Lady Barker, public health and prevention services such as anti-smoking, mentioned by my noble friend Lord Rennard, and weight loss pathways, as mentioned by the noble Baroness, Lady Jenkin, may not get the attention they need right at the heart, at the ICB level, where budget decisions are made. In Committee, we will of course probe how this can be achieved. However, if representation of these services is made at the right level, there is potential for improvement.

If major changes are to be made, there is one overriding issue that must be at the heart of all ICS management, and that is addressing the health inequalities in their area. Although some parts of the country suffer more than others, no ICS will be without a group of people and neighbourhoods where health outcomes are well below the average. How does the Minister expect the ICBs to deal with this? It is not only the right thing to do but also best for the economy. People are not productive if they are not well fed, a healthy weight, active and with good mental well-being. Indeed, if the NHS is to survive financially, we need to work on prevention of ill health and avoid an older population with multi-morbidities. How much more cost effective it will be to prevent this than to pay for its effects.

Inequality also exists in the ability to pay for care, and we will probe the effects of the Government's recent cap proposals, as my noble friend Lady Pinnock explained. Reflecting what the noble Baroness, Lady Pitkeathley, and the noble Lord, Lord Kerr of Kinlochard, said, can the Minister say where the responsibility for family and friend carers will lie under the new regime? There are millions of unpaid carers in this country, some of them still children and some very elderly themselves. The recent White Paper says very little about them, but it is somewhere in this new system that the responsibility for their welfare will lie. Where is it?

My noble friend Lady Tyler, the noble Lord, Lord Farmer, and many other noble Lords have pointed out that, at the other end of the age scale, the Bill says nothing about children and there has been no child impact assessment. I will not repeat everything that they said, but can the Minister tell us whether we will get a child impact statement? Where will the responsibility for safeguarding children lie? If it is going to the ICBs, that is a very long way from the place-based committees where all the delivery of services are made, and the current system already leaks, so we must be very careful.

My noble friends Lord Shipley and Lady Pinnock have talked about local authorities, which have numerous responsibilities for social care and public health. This Bill should be creating a partnership of equals between the ICS and local government. In Committee we will probe how local authorities can influence the distribution of budget from the ICB. Many ICSs will cover several local authorities and some authorities will cross two ICSs. How will that work? Of course, it is at local level that all the services that we are talking about will be delivered, so we will also probe the relationship and lines of accountability between the place-based committees and the ICB. In his introduction, the Minister mentioned the phrase "bottom up". The epitome of that in this new structure is the place-based committees and the voice of the patients they represent. How will their voices be heard at an appropriate level?

The Government are hoping that the new integrated care systems will be more financially efficient than under the old regime. This may be so, but it is vital that it is not at the expense of quality. We welcome the removal of the dominance of competition in procurement, with more emphasis on quality and collaboration, but we will be watching very carefully to ensure transparency

[Baroness Walmsley]
in procurement. Contracts must go to companies and service providers who are chosen on their merits and not on who they know. The ICS board, however large or small it is, must be seen to be independent and not influenced by private interests, because it will have enormous power.

Talking of power brings me to the new powers of the Secretary of State. There may be justification for some of them for accountability's sake, but these must be tempered by appropriate limits, consultation and transparency. However, there is more than a little tension between the Government's stated objective of being broadly permissive towards the ICSs and giving more power to the Secretary of State, especially the power to intervene at an earlier stage in local service configuration, and even to propose a new local reconfiguration himself or herself. That is going too far and is against the spirit of the Bill.

If health and care organisations and providers are to work more closely together, a lot of patient data will be exchanged. The objective is to have a common system so that information can be quickly and accurately exchanged. We will scrutinise this part of the Bill to ensure that this is always in the patient's interest with an appropriate level of need to know, privacy and accuracy. The mandatory health services safety investigations body appears in Part 4 of the Bill.

I well remember hearing a previous Secretary of State, Jeremy Hunt, at a King's Fund lecture several years ago, describing how it would seek to find out what went wrong without apportioning blame, so that learning could occur across the system. It struck me then, as it does now, as a very worthy objective. He said it would be based on the Air Accident Investigations Branch, which has been very successful. For it to work in the interests of patients, it must be independent and have the trust of staff. The so-called safe space in which staff can explain what happened is a very important element of this, and I would be concerned about any attempt to encroach on it. We will look at that in detail at a later stage.

I end on the most important factor of all in the delivery of health and care services: the workforce. Over the past few years, the number of vacancies has been growing and is now chronic—not helped, particularly in the case of social care, by Brexit. Safe staffing levels have been breached, and that means that patients are in danger, so we will lay amendments to ensure the provision of sufficient staff with the right level of training to ensure safe staffing levels. Planning for the provision of enough qualified staff has not been good enough, and a review of workforce planning every five years will not do. Given how quickly things can change, that is not often enough.

We will support efforts to provide more accurate predictions of need and more frequent review of the plans to provide them. We are also concerned that the focus could be on NHS staff only and that care staff will be forgotten. Does the Minister agree that they, too, need skills and career paths to ensure high-quality care and encourage recruitment and retention? We look forward to the delivery of the £500 million for this promised in the White Paper and wonder whether the Minister can say how the training will be delivered in the new integrated service. It will be one of the most important duties of the new integrated care systems.

This must not be just another NHS reform Bill. It must be about improving the health and care of the whole nation. I look forward to the Minister's replies to these important questions.

10.17 pm

Baroness Thornton (Lab): My Lords, first, I declare my interest as a non-executive member of a hospital trust in London; indeed, my chair is in the Chamber. I was also on a CCG for three years and it got absorbed into its local ICS, so I have lived this story, too.

I thank noble Lords for a debate that has done as much justice to this Bill as time has allowed. I congratulate the noble Lord, Lord Stevens, who is much too young to be a national treasure, if he does not mind me saying so. I also thank the outside organisations and the Library for the many briefs. Patient groups, royal colleges, regulators, trade unions, the EHRC, health charities, campaigns, and even a chocolate manufacturer, on behalf of the confectionery industry, and a large optician chain have a close interest in the Bill and have troubled to tell us so, and I thank them very much.

I particularly enjoyed the contribution from my noble friend Lord Howarth, linking, as he did, the arts and health and well-being. All I can say to my noble friend Lord Rooker is that I would not mind being on the prosecco experiment myself, particularly at this time of night. For my part, I intend to focus on the core of the Bill, the NHS reorganisation. The key questions about the Bill are surely these. What does it do for patients? How does it address health inequalities and the NHS workforce? Does it make things better or worse, or is it silent, and what can we do in this House to improve it to tackle those challenges? That is surely our job.

On the workforce, for example, my noble friend Lord Turnberg, the noble Lords, Lord Stevens, Lord Kakkar and Lord Patel, the noble Baroness, Lady Watkins, and many others pointed to the fact that, without a plan and a comprehensive strategy that covers all the health and social care workforce, it is not possible to deliver better care for patients to address health inequalities, which is why amendments about the workforce will receive significant attention as we move forward.

Many of us were in the House during the passage of the Health and Social Care Act 2012, which was never fully implemented because it was a bit of a mess, if I may say so. I remember the tangled spaghetti of organograms resulting from the 2012 reforms. If the noble Lord, Lord Stevens, thinks that this one is worse, I dread to think what that would look like. Of course, we will have to untangle that.

As my noble friend Lady Merron said in her opening remarks, we are not convinced that this is the Bill that the NHS and social care need at this time. In 2017, the Government should have prepared a Bill that simply implemented changes to reverse the worst of the 2012 Act, stop the pointless bureaucracy and ease the implementation of the NHS long-term plans. However, we are no longer in 2017: we have been through the

biggest public health disaster of modern times. We can be grateful for the huge strengths of our NHS, but the pandemic has also amplified the inequalities and serious flaws that need addressing.

I will give three examples of what we have to address in the Bill. We all understand that primary care provides the vast majority of NHS care and will play a more significant role in prevention, tackling health inequalities and supporting capacity issues in the hospital sector under the *NHS Long-Term Plan*. Therefore, it is vital that primary care has an input into the new integrated care partnerships, which will advise the integrated care boards, which are usually much smaller. The key point is that working towards genuinely integrated health and social care, focused on the needs of individuals, is not recognised in the Bill as it stands. For example, where is the role of health and well-being boards? They are stuck in some kind of floating structure, as the noble Lord, Lord Lansley, pointed out.

I turn to the second thing that is missing. We know that social enterprises and charities are vital in the delivery of health services. Social enterprises, for example, are delivering one-third of all community health services and two-thirds of all out-of-hours health services. They deliver care services, dentistry, mental health services, addiction treatment and many more services. They are a serious and significant part of local health systems. These organisations should not be left out of the decision-making processes.

My point is that we must find a way to do two things. We must ensure that these excellent providers of services are involved in the planning of services at ICS level. We must also ensure that the issue of social value is recognised. The NHS is committed to using social value within commissioning and procurement decisions. Unfortunately, the Bill does not include any reference to social value, which means that the new procurement system for the NHS may go against the grain of the rest of the public sector.

The third issue to address is integration and social care. While the Bill was in Committee in the Commons, we learned that, at some point, there is to be an integration White Paper, which certainly was not in the disappointing document that was launched last week. There is still no overall strategy or plan to address the immediate scandal of inadequate social care. Many in government do not appear to understand that social care is about not just the old and care homes but children and young people with disabilities, as the noble Baroness, Lady Campbell, explained to us.

There is a 10-year vision in the paper launched last week, but it has no milestones, no targets, no strategy and not much funding. It has vague promises, and waters down the Care Act 2014, so we on these Benches will look carefully and critically at that part of the Bill. Let us not pretend: this is an NHS Bill and not yet a health and social care Bill. Surely our job is to make it into that.

Of the many briefings we received on the issue of health inequality, to which the Bill refers, I was struck by the one from the EHRC, which suggested that integrated care partnerships' strategies should

"include an explicit focus on addressing inequalities in access to and outcomes from services, and that groups sharing protected characteristics"

should be

"fully consulted on their development … Integrated Care Partnerships are required to include representatives from social care and mental health to ensure parity of esteem and a genuine 'whole system' approach."

My noble friend Lord Bradley, the noble Baroness, Lady Bull, and others have said this today.

In the Commons, the Government levelled criticism at my colleagues over their desire to put safeguards into the Bill and the Government's desire to leave maximum latitude for local solutions. There is an irony here. The Government want to control appointments. They want to agree all the so-called flexibilities and not leave them to local planning at the moment. The Bill is far more top-down system management of the old school, so the Minister can expect some discussion around reconfiguration.

There are concerns about how the new bodies will be accountable. I join my noble friend Lady Morgan in a plea for clarity about this. How are the new bodies accountable and to whom? There is also nothing in the Bill at the moment about accountability to the public and patients.

We need to address issues about who can and should sit on boards that allocate the billions; about restrictions on deals with private providers, on which I am sure that my noble friends Lady Bakewell and Lady Chakrabarti will hold our feet to the flames; about making sure that procurement is done properly; about the new bodies being far more open and transparent than current ones; about respecting the whole NHS and social care workforce, not just doctors and nurses; about including children and safeguarding; about removing fragmentation between different flavours of provider bodies; about a genuine and active role for local authorities in preparation for real integration; and more. I fear we may be here for some time.

We on these Benches absolutely want the Bill to be amended to achieve the outcomes we all agree about—for example, the plea from the noble Baroness, Lady Blackwood, about innovation, and workforce rights, dealing with inequality, transparency, local design and population health. We want to work with our colleagues across the House to ensure that the Bill reflects all those things that we agree about.

The Commons had 21 sittings in Committee and did not even scrutinise the social care cap amendment and other government amendments inserted on Report and at Third Reading. We will have to do that too. I congratulate your Lordships' House on giving the Minister a clear insight into the scrutiny we believe the Bill now deserves and will receive in the coming weeks. I congratulate him and the Bill team in anticipation of the efforts they will have to put into that. I look forward to the Delegated Powers Committee's report. I also ask him to ensure that the House is given sufficient time in Committee and at the other stages to give the Bill the scrutiny and thought that our NHS and social care system deserve.

10.28 pm

Lord Kamall (Con): My Lords, I put on record my thanks and gratitude for this excellent and wide-ranging debate. I hope noble Lords will understand that I may

[Lord Kamall]
not be able to answer every point in the time available—unless they are prepared to stay here all night. I am grateful for the constructive and thoughtful contributions of noble Lords from all sides of the House. When I first entered this House, a noble friend who was a Minister here and in the other place said that, in the other place, you are probably one of the few experts on the Bill you are taking through, but in this place there will be at least one other expert. I disagree: there are many experts who will know far more about this than I do, but I look forward to learning from noble Lords across the House and listening to their expertise.

I echo those who praised the excellent maiden speech of the noble Lord, Lord Stevens. He will be a valuable addition to the House. I caution against describing him as a treasure, because the problem with treasures is that people want to lock them away, put them behind a glass case, or bury them.

The noble Baroness, Lady Merron, asked how the Bill would be different from previous reorganisations. I make it clear that this is not a reorganisation that comes from my office or my right honourable friend the Secretary of State's office in Victoria Street. Instead, the Bill builds on the evolution up and down the country over the last decade led by the noble Lord, Lord Stevens of Birmingham, to deliver joined-up care.

This is the right Bill at the right time, as the noble Lord, Lord Adebowale, said. I was extremely struck by the contributions of the noble Lords, Lord Kakkar, Lord Adebowale, Lord Stevens, and my noble friends Lady Harding and Lord Hunt of Wirral, in support of the principles underlined in the Bill. I am grateful for their support. As the noble Lord, Lord Stevens, said, the Bill is not a cure-all; no Act of Parliament could ever be. However, it can set the framework for people to find solutions that work; that approach has been the guiding light.

I will now address some of the issues raised across the House. As the noble Lord, Lord Mawson, said, integrating services around people is the only sustainable way of delivering high-quality health and care systems and, more importantly, delivering improved outcomes for everyone. This has been a goal of health systems across the world, and it is at the heart of the provisions in this Bill, including putting new integrated care systems on a statutory footing. To meet that challenge, a key principle of the Bill is to ensure that the legislative framework is flexible and responsive to local population needs. It is right that local areas should be able to determine the arrangements that work best for them. Frimley is not Cumbria; we should not try to create a one-size-fits-all single model for both.

To protect this flexibility, I ask noble Lords to consider whether it is appropriate to add additional prescriptions on membership and duties for integrated care boards and integrated care partnerships, although we will, of course, be happy to consider suggestions for additional guidance and support for the system. In that spirit, I hope that I can reassure the noble Baronesses, Lady Tyler, Lady Walmsley, Lady Masham, and other noble Lords who raised this, that we are working with NHS England and the Department for Education on bespoke guidance in relation to children, including the vital issues of safeguarding, special educational needs and disabilities.

I thank my noble friend Lord Farmer for raising the role of family hubs, and for his sustained work in advocating for the family hub model. I assure him that this Government have committed to championing family hubs and we are working to roll them out. I also assure the noble Baroness, Lady Pitkeathley, and other noble Lords that we are fully committed to supporting carers, including consulting them in the development of services. I reassure the noble Baronesses, Lady Finlay and Lady Meacher, and my noble friend Lady Hodgson that integrated care boards will be responsible for commissioning palliative care services as part of a comprehensive healthcare service.

This may be a convenient moment to consider the question of parity of esteem, as raised by a number of noble Lords, including the noble Baronesses, Lady Thornton and Lady Watkins, my noble friend Lady Morgan of Cotes, the noble Lord, Lord Bradley, and others. References to health in the Bill will already apply to mental, as well as physical, health. Likewise, I hope that I can reassure many noble Lords, including the noble Lords, Lord Patel and Lord Desai, and the noble Baroness, Lady Walmsley, that tackling inequalities is deeply embedded in the Bill. Given the backgrounds of both my right honourable friend the Secretary of State and myself, we believe very strongly in tackling inequalities. At the same time, I remind noble Lords of the establishment of the Office for Health Improvement and Disparities, with the focus on disparities and tackling inequalities. It is important that we give our support in tackling disparities right across our nation.

Integrated care partnerships will plan to address local needs, including the wider determinants of health, and the triple aim places new duties on NHS bodies to consider the health and well-being of the people of England when discharging all their functions. I listened carefully to the concerns raised by the noble Lord, Lord Mawson, and the noble Baronesses, Lady Merron and Lady Pinnock, on the principle of subsidiarity—the role of place. We want to empower local leaders to support integrated and person-centred care at place level.

The noble Baroness, Lady Brinton, my noble friend Lord Lansley, the noble Lord, Lord Bradley, and others raised the question of why we are putting forward a two-board approach. This approach recognises the importance of integration, both within the NHS and between the NHS and its wider partners. I reiterate that this was co-designed with both the NHS and the Local Government Association. I hope that I can reassure the noble Lords, Lord Howarth and Lord Crisp, that ICPs—integrated care partnerships—will have flexibility to draw members from a wide range of sources including organisations with a wider interest in local priorities, such as housing providers and education, as well as art and culture organisations.

The noble Lord, Lord Kakkar, asked why the Bill provides for CQC assessment of integrated care systems. It is important that members of the public can understand how well their health and care system is collaborating and that their local hospital is providing a safe, high-quality service.

My noble friend Lady Blackwood and other noble Lords raised the importance of research. I assure the House that we share the objective of wanting to see research embedded in the health and care system, not only to improve healthcare outcomes but to contribute to the goal of making the UK a hub for life sciences globally.

To address the contributions from the noble Baronesses, Lady Bakewell and Lady Chakrabarti, I assure the House that we have no intention of opening the door to privatisation. As the King's Fund has said, there is nothing in the Bill that is likely to drive more NHS funding towards private companies—a sentiment echoed by the noble Lord, Lord Adebowale. I also remind noble Lords that successive Labour and Conservative Governments have seen the value of collaboration between the voluntary sector, the private sector, social enterprises —as mentioned by the noble Baroness, Lady Thornton, and the noble Lord, Lord Kerr—and the state.

On integrated care boards, the right reverend Prelate the Bishop of Carlisle and the noble Baroness, Lady Walmsley, asked about transparency. Integrated care boards are covered by the Public Bodies (Admissions to Meetings) Act and will be bound by the principles of openness and proper public engagement.

I listened to my noble friend Lord Bethell with great interest. I agree that data sharing is essential to true integration. I know that many other noble Lords support this but they also, rightly, raised some concerns. The information provisions in this Bill are part of a wider range of commitments set out in the draft data strategy. We will ensure that the system has the ability and competence to share and use data appropriately and effectively to benefit individuals, populations and the health and social care system.

I listened carefully to the many contributions on social care from the noble Baronesses, Lady Thornton and Lady Campbell, and many others. Social care reform is a challenge ducked by generations. Successive Governments have commissioned reports on social care only to see them gather dust on bookshelves and never be enacted. This is the first attempt for many years to tackle a long-standing issue. Many noble Lords have spoken about it being ignored for 10, 20, 30 or 40 years. Anyone who has looked at the history of demographics and economic history will know that this challenge was coming a long time ago, yet successive Governments have kicked it down the road. We hope that this Bill, alongside the upcoming integration White Paper and the recently published social care White Paper, will go towards meeting that challenge. The social care White Paper sets out a 10-year reform vision that puts people at the centre of social care. It will ensure greater choice, control and support to lead an independent life with fair and accessible care.

We are backing that vision with investment. The Prime Minister has announced an additional £5.4 billion to begin a comprehensive programme of reform, including an extra £3.6 billion to reform the social care charging system, an extra £300 million of investment in housing, £150 million of additional funding to improve technology and increase digitalisation across social care, and £500 million of investment in the workforce. As technology improves, we hope that the nature of social care will change, enabling many more people to spend longer lives in their own homes with adaptations and better technology. Would it not be great if the United Kingdom were at the forefront of those technological developments?

I recognise the strength of feeling in relation to Clause 140, but I remind the House that it is absolutely essential that noble Lords look at the package of social care reforms as a whole. Our reforms will stop unpredictable and unlimited care costs, significantly increase the means test to help those with the least wealth and help people to plan for the future.

I hope that noble Lords will recognise that, as my right honourable friend the Secretary of State said in the other place, nobody will be worse off in any circumstances than they are in the current system and many people will be better off. The reforms mean that the Government will now support an extra 90,000 older care users at any given time. Comparisons have been made to previous proposals for reforms to the charging system. I remind noble Lords that many of these were not in fact acted on, partly due to concerns over unaffordable costs. Unlike previous proposals, our reform package is credible, deliverable and affordable.

There has rightly been much discussion of workforce planning for the NHS and adult social care. I have listened carefully to the contributions on this very important subject made by many noble Lords, including my noble friends Lady Harding and Lady Cumberlege, the noble Lord, Lord Patel, and the noble Baronesses, Lady Cavendish and Lady Thornton. Ensuring that we have the health and care workforce that this country needs is a priority for this Government, and the most recent figures show that there are record numbers of staff working in the NHS, including record numbers of doctors and nurses.

The Bill builds on this work. Clause 35 will bring greater clarity and accountability to this area. The department has also commissioned Health Education England to work with partners to develop a long-term 15-year strategic framework for the health and regulated social care workforce. For the first time, this will include regulated professionals in adult social care. That work will look at the key drivers of workforce supply and demand over the longer term and set out their impact on the future workforce. We anticipate publication in spring 2022. Supporting all this work is our recent announcement of our intention to formally merge Health Education England with NHS England. Such a merger will help to ensure that workforce is placed at the centre of NHS strategy.

I now turn to some of the wider issues raised during this excellent debate. I beg your Lordships' indulgence, as time may not permit me to answer every point raised, and I commit to write to noble Lords whose points I do not address. I hope noble Lords will forgive me for the time I may take to write some of those letters.

On the power of direction for the Secretary of State, I am afraid I cannot agree with the characterisation suggested by some noble Lords. Instead, I would echo the former shadow Minister in the other place who said that

"the public think that the politicians they elect are accountable for the decisions taken in the interests of their health".—[*Official Report*, Commons, Health and Care Bill Committee, 21/9/21; col. 393.]

[Lord Kamall]

We agree. I would also like to assure the noble Lord, Lord Stevens, that Ministers have no intention of requiring hospitals to report on the movement of a broom cupboard. I am afraid that is a mischaracterisation, albeit a witty one, of how Ministers intend to use their power.

We anticipate that Ministers will be involved only where decisions become particularly complex or a significant cause of public concern, or if they cannot be resolved at a local level. Local NHS commissioners will continue to be accountable to NHS England and for developing, consulting on and delivering service change proposals. However, we believe that strengthening democratic oversight will make it more likely that the right decisions will be taken. Any decisions will be based on the evidence and consultations that have taken place, and where the Secretary of State chooses to intervene they will, rightly, be accountable to Parliament and the public.

I welcome support for the establishment of the Health Service Safety Investigations Body and agree with the noble Baronesses, Lady Merron and Lady Walmsley, and others that it is essential that the HSSIB is an independent body and a safe space. This is what the Bill delivers. It was always difficult to achieve the right balance between openness and getting people to come forward so that we can make sure that we improve and learn lessons.

As raised by the noble Baroness, Lady Meacher, the Bill contains a number of delegated powers. Many of these are not new but simply reflect the replacement of clinical commissioning groups with the new integrated care boards. Far from a power grab by the Secretary of State, many of these powers will be exercised by the NHS.

The noble Baronesses, Lady Pinnock and Lady Jones, and my noble friend Lord Reay raised the question of fluoridation. I gently remind noble Lords that although tooth decay can be prevented or minimised by adherence to a healthy diet, water fluoridation is seen to be the only intervention to improve dental health that does not require sustained behavioural change over many years. It also disproportionately benefits poorer or more disadvantaged groups.

As many noble Lords have commented, prevention is in many ways better than cure. That is why we are so concerned about childhood obesity, a concern shared by noble Lords across this House. It is one of the biggest health problems this nation faces, and I am grateful to many noble Lords for the support that related measures have received today. We want to be quite clear that, as these measures are taken forward by local integrated boards and commissioners, we must rely on evidence, learn lessons and, when something does not work, try something else. We have to use the power of discovery to make sure that we are finally able to put obesity to bed or to reduce it on a significant scale.

I was also grateful for the intervention of the noble Baroness, Lady Brinton, in relation to reciprocal healthcare agreements. I hope I can assure her that such arrangements will be entered into only when they are in the best interests of the people of the UK and the NHS. The NHS is not, and never will be, for sale to the private sector, whether overseas or domestic.

I thank my noble friend Lady Cumberlege for her remarks and for her tireless work in championing patients, ensuring that the voices of patients and their families were heard in her *First Do No Harm* report. My noble friend continues to be a voice in the House for patients in general, and for the women and their families who have been so terribly affected by matters covered in her review. She continues to champion their cause and their calls for redress. We are committed to making rapid progress in all areas set out in our response, and we aim to publish an implementation report in the summer of 2022.

Finally, I welcome those, including my noble friend Lady Hodgson, who raised the issue of hymenoplasty. The Government agree that this is a repressive and repulsive procedure. We have convened an independent expert panel to make a recommendation on whether it should be banned. That recommendation will be published before Christmas.

This Bill is the product of extensive engagement with stakeholders across the health and care system, including partners in local government as well as the NHS. It will provide a platform that empowers local leaders across health and care to build back better and to continue to deliver a world-class service, fit for the 21st century and beyond. I urge noble Lords across the House to trust the judgment of our health and care staff as much as we value their commitment and their care. I know that noble Lords will work together to make this Bill better during the coming weeks and I commend the Bill to the House.

Bill read a second time and committed to a Committee of the Whole House.

House adjourned at 10.47 pm.

Grand Committee

Tuesday 7 December 2021

3.45 pm

The Deputy Chairman of Committees (Lord Brougham and Vaux) (Con): My Lords, Members are encouraged to leave some distance between themselves and others and to wear face coverings when not speaking.

Customs Safety and Security Procedures (EU Exit) (No. 2) Regulations 2021

Considered in Grand Committee

3.45 pm

Moved by ***Viscount Younger of Leckie***

That the Grand Committee do consider the Customs Safety and Security Procedures (EU Exit) (No. 2) Regulations 2021.

Relevant document: 22nd Report from the Secondary Legislation Scrutiny Committee

Viscount Younger of Leckie (Con): My Lords, we are here to discuss a statutory instrument related to the introduction of customs controls. I note that this instrument was included for information in the Secondary Legislation Scrutiny Committee's 22nd report of the Session 2021-22, although it was not drawn to the attention of House. This instrument will also be debated in the other place tomorrow.

The instrument delays for a further six months the introduction of safety and security declarations on the movement of goods into Great Britain where they were not required before EU exit. The Government are introducing it as part of a programme of measures to phase in the introduction of border controls in order to provide relief to businesses given the unforeseeable and ongoing impact of Covid-19 on businesses and global supply chains. The waiver extension will provide more time for businesses that move goods into Great Britain from the EU to prepare for new customs requirements. This is to avoid potential disruption to UK supply chains and at our borders. With this extension, safety and security declarations on these imports will be required from 1 July 2022, instead of the start of next year.

I will now focus on the detail. The UK's approach to safety and security requirements in its customs regime is governed by the overarching principles in the World Customs Organization's SAFE framework of standards. The SAFE framework aims to support and facilitate secure supply chains and trade at a global level, while helping to tackle movement of illicit goods such as drugs and weapons. It requires customs authorities to collect and risk-assess data on the movement of goods before they arrive in or depart their customs territories. The data adds to other intelligence sources to keep borders secure. Business and traders are required to provide data in the form of safety and security declarations.

Since the transition period ended on 31 December last year, most traders moving goods from Great Britain to the EU have been required to submit safety and security data on their movements. This has contributed to the intelligence available to Border Force to help it target checks effectively. The EU also requires safety and security declarations on imports and exports. It is worth mentioning that, following the end of the transition period, Border Force and the Home Office continue to co-operate closely with EU authorities and other law enforcement partners overseas to protect our communities and keep our borders secure.

At the end of the transition period, safety and security declarations also became due on imports to Great Britain from the EU. However, the Government granted a temporary waiver, meaning that goods imported into Great Britain from the EU, and from other territories such as Norway, where declarations were not required previously, do not need safety and security declarations. This waiver was designed to give businesses more time to prepare for the introduction of new border controls, and was part of the so-called phased approach, introducing customs controls in stages.

I make it clear that there is no safety or security concern arising from this waiver. While safety and security declarations provide information used to help risk-assess goods entering and leaving Great Britain, they are not the only way we can manage these risks. Other forms of intelligence continue to be used to keep our borders secure, as they were before EU exit, when safety and security declarations were not required for these movements.

Safety and security declaration requirements for these movements were due to be introduced from 1 January 2022. However, as noble Lords will know, in September, the Government announced that we would grant an extension to the current waiver. This extension is due to last for six months. The waiver will now end on 30 June 2022, meaning that safety and security declarations will be required for these imports from 1 July 2022.

This measure does not have any impact on the safety and security declarations required on goods moved from the rest of the world, which are already being submitted.

The extension has been designed to support businesses facing challenges in preparing for this new declaration requirement due to the unprecedented disruption caused by the Covid-19 pandemic. It will benefit UK-based businesses, but we are thinking beyond our own borders. The additional time will be particularly helpful for smaller hauliers, who may not speak English as a first language and are likely to have suffered from a lack of resource. The pandemic has had longer-lasting impacts on businesses than many observers expected—both in the UK and around the world. Giving businesses more time to prepare for new customs requirements will help avoid potential disruption to our borders and supply chains, and protect UK manufacturers and consumers.

Safety and security declarations were not required for imports from the EU before exit day. As a result, this extension will not significantly increase security risks to the UK. Border Force will continue to use

[Viscount Younger of Leckie]
intelligence sources to risk-assess the movement of goods and to secure our borders in the same way as it does now.

This instrument does not affect safety and security requirements in Northern Ireland. Northern Ireland remains aligned with the EU's safety and security zone, as governed by the terms of the Northern Ireland protocol. This means that there are no safety and security requirements for goods moved between Northern Ireland and the EU.

This instrument also has no effect on safety and security declaration requirements for goods imported from the rest of the world, for which these declarations will continue to be required.

In conclusion, this waiver on the requirement to submit safety and security declarations will allow us to support businesses affected by Covid-19 and related global supply chain issues. It will give them additional time to prepare for the new requirements. I beg to move.

Lord Tunnicliffe (Lab): My Lords, I am grateful to the Minister for introducing this statutory instrument. It is the latest in a long line of postponements to the introduction of post-Brexit customs controls. I experienced a strong sense of déjà vu when I saw the original announcement of this extension back in September. That sensation returned upon seeing this statutory instrument listed in *Forthcoming Business*.

I believe this is the first time that the Minister has dealt with this issue, so he will no doubt find it a novel experience. This probably cannot be said for his officials. I am sure that, despite not being able to say so, they are frustrated that they are still dealing with this, rather than turning to other issues.

We are fast approaching a calendar year since the end of the transition period. It is considerably longer since the original withdrawal agreement and accompanying framework for the future relationship were agreed. It is more than six years since the referendum itself. During that time, the UK Government—whether led by Theresa May or Boris Johnson—were clear that the UK would exit the EU single market and customs union and that this would require a variety of new checks as goods entered and exited the country. While the finer points of detail were left until late in the negotiations led by the noble Lord, Lord Frost, on the EU-UK Trade and Cooperation Agreement, the general destination was clear. The Government knew enough to start their work ahead of time. We were told that work was in hand.

We have travelled so far in terms of time elapsed, yet Ministers do not seem to be making a huge amount of progress to deliver on their long-standing promises. HMRC's justification for this extension is unchanged from the last time we debated this policy: it is to allow industry time to adjust, particularly in the light of the pressures caused by Covid-19 and the wider supply chain disruption.

I am completely in favour of supporting industry through challenging times, but even here the Government's response has been lacking. Of course, this is just one part of a package, but that package has been criticised by various sectors, including agriculture and the road haulage industry. When we first debated waiving various import and export requirements in 2019, we were told that the powers were a contingency measure that would likely not be needed. But not only were they enacted, they were then extended. We as the Opposition probed the Government on their longer-term plans and ambitions but were supportive of the instrument. I feel that HMRC's reasoning is beginning to wear thin, but it certainly has been an exceptional time for UK businesses.

My issue with this latest SI is not the Government's decision to further extend this rather limited import declaration waiver but their complete lack of openness. Back in June, the Minister, the noble Lord, Lord Agnew, said very clearly:

> "The Government do not plan to extend these waivers any further. Traders will need to comply with full safety and security declarations on exports from 1 October 2021 and on imports from 1 January 2022."—[*Official Report*, 22/6/21; cols. GC 58-59.]

What went wrong? While we are now responding to the arrival of a new strain of Covid-19 with some modest measures, we have been free of curbs on business activity for several months. Although supply chain issues continue to bite, the Government have done what they can, or so we are told, to ease the pressures on business.

I appreciate that the Minister has not responded to previous debates on this topic but could he please provide a full, honest rationale for this new extension? Is it really related to the pandemic and wider supply chain issues, or is it actually about the readiness of new inland customs facilities or even the IT systems they rely on? Bearing in mind that the Government have been wrong on this before, does the Minister expect this to be the final extension, or is it possible that we will see the waiver run until September or December 2022?

Viscount Younger of Leckie (Con): Well, my Lords, I have taken part in many debates since I entered the House in 2010 but this one represents a record in that there is only one other Peer here for me to address. I am extremely pleased that that happens to be the noble Lord, Lord Tunnicliffe, whom I thank for his remarks, and I hope I can fully answer his questions.

The instrument proposes a further six-month extension to the waiver on safety and security declaration requirements that would otherwise apply to imports to Great Britain from the EU. In 2020, the UK imported £301 billion worth of goods, from mechanical parts to fresh produce, from the EU. This was 50% of all UK imports. Given the disruption caused by the pandemic, we are keen to ensure that traders have time to prepare for new customs requirements, which will protect UK supply chains and consumers.

After those opening remarks, I shall seek to answer—I hope in full—the questions and observations raised by the noble Lord. He quite rightly noted that, during previous debates, the Government said that we would not extend this waiver and that traders would have to comply with full safety and security declaration requirements on all exports from 1 October 2021 and on imports from 1 January 2022, as I mentioned in my opening speech. However, I assure the noble Lord that traders have been complying with full safety and security declaration requirements on all exports since 1 October 2021, when that waiver ended. A huge amount of

work went into ensuring that businesses were ready for those requirements, and they have been operating successfully, without disruption, since October.

4 pm

However, as I mentioned previously, the unprecedented impact from the pandemic has lasted longer than we could have imagined. While many businesses have taken steps to prepare for the requirements, many more are continuing to struggle with the economic impacts of this pandemic. Over the last six months, we have seen the knock-on effects of the pandemic on global supply chains, representing a further challenge to businesses, particularly smaller traders and hauliers. More recently, although this was after the Government's initial announcement of the extension of this waiver for imports, we have seen further disruption due to the new omicron variant, as the noble Lord knows only too well.

These ongoing impacts have seen businesses operating in unprecedented circumstances, which is why the Government have taken the decision to further extend this waiver. This extension will support businesses and provide them some welcome relief. As the noble Lord knows, the Government have extended the delay only to the introduction of safety and security declarations; full customs declarations will be required from 1 January 2022. The Government have always taken a staged approach to new customs controls to avoid any cliff edges, and this extension will give businesses time to ensure they are ready for new customs requirements.

The Government are ready to implement safety and security requirements. I reassure the noble Lord that the S&S Great Britain IT system, which receives and risks these declarations, is up and running and being used by traders that import goods from the rest of the world. Inland border facilities are also already in use for Dover and Eurotunnel, and will be in place for Holyhead from 1 January.

To sum up, the Government are introducing this SI as part of our efforts to provide additional support to businesses and help them recover from the lasting impacts of the pandemic. This will also support them to manage the pressures on global supply chains that we are seeing around the world.

Motion agreed.

Solvency 2 (Group Supervision) (Amendment) Regulations 2021

Considered in Grand Committee

4.03 pm

Moved by ***Viscount Younger of Leckie***

That the Grand Committee do consider the Solvency 2 (Group Supervision) (Amendment) Regulations 2021.

Relevant document: 22nd Report from the Secondary Legislation Scrutiny Committee

Viscount Younger of Leckie (Con): My Lords, I beg to move that the Committee considers the Solvency 2 (Group Supervision) (Amendment) Regulations 2021. This instrument is being made to address deficiencies in retained EU law relating to the supervision of UK insurance groups under the insurance prudential regime known as Solvency II.

The onshoring of large amounts of EU legislation into domestic law was a vast, complex and time-pressured process. I hardly need remind your Lordships that over 60 statutory instruments were passed; one of these related to Solvency II. This was not an easy feat, since Solvency II is a particularly technical and complex regime, so it is unsurprising that, among the sheer volume of complicated work, there was an oversight that means a technical fix now needs to be made. By this instrument, we are taking action now to ensure that this oversight is addressed well before any potential issues materialise from 1 April 2022.

I will explain what the instrument does and why it prevents a cliff edge on 1 April 2022. The UK Government have made equivalence decisions which assess that the insurance group supervision regime in another country, a so-called third country, is equivalent to the UK. To date, Bermuda, Switzerland and the EEA countries have been determined to be equivalent to the UK for the purpose of insurance group supervision. This instrument will ensure that the UK Government's equivalence decisions achieve in full the objective of avoiding unnecessary duplication of supervisory work.

I will give a practical example of the type of duplication this instrument seeks to remove. Where a waiver is granted by the PRA, a UK subgroup that is supervised at ultimate parent level by an equivalent supervisor will not need to submit quarterly and annual group reporting templates to the PRA, or prepare an annual report known as the "own risk and solvency assessment", or publish an annual group report known as the "solvency and financial condition report".

Using a typical large insurer as an example, I will illustrate how extensive these submissions are and the time and cost savings this instrument may achieve. The solvency financial and condition report of a large insurer can be over 100 pages long. It has qualitative and quantitative materials and sets out aspects of the insurer's business and performance, system of governance, risk profile, valuation methods used for solvency purposes, and capital management practices. The production of such a report requires analysis and co-ordination by experts in multiple disciplines such as actuarial, finance, accounting, internal audit, IT and risk management, not to mention board and senior management input and review. I stress that this is only one example of the supervisory compliance materials that we are seeking to remove.

The costs of duplication would vary from firm to firm but comprise initial one-off costs as well as ongoing costs as high as £500,000 per annum. Without this instrument, the UK subgroup must duplicate these materials at the UK subgroup level, when its parent already produces equivalent materials for submission to the third country supervisory authorities. The advantages are: reduced regulatory compliance cost for the insurance groups; reduced supervisory cost for the PRA; and reduced need for co-ordination between third country supervisory authorities and the PRA where duplicative materials are being reviewed.

[Viscount Younger of Leckie]

The statutory instrument affects UK insurance groups whose parent companies are domiciled in equivalent third countries. Such insurance groups are supervised at two levels: the UK insurance group level is supervised by the PRA, and the ultimate parent group level, the so-called worldwide group, is supervised by the supervisory authority in the relevant third country. Currently, a total of 11 insurance groups are expected to benefit from this instrument. Of the 11, five have parent companies in EEA countries and six have parent groups in Switzerland or Bermuda. Examples of such groups include AXA, Allianz, Ageas and Hiscox. To take Hiscox as an example, it has headquarters in Bermuda and is listed on the London Stock Exchange. With this instrument, the PRA may rely on the supervisory authority in Bermuda to conduct group supervision of the entire group, of which the UK subgroup of Hiscox is a subset.

I assure noble Lords that this is not a relaxation of prudential standards; the proposed changes aim to provide full effect to the Treasury's equivalence determinations. Although the UK group supervisory requirements are waived, the main safeguard for UK policyholders remains. This main safeguard is the continued supervision of solo UK entities belonging to these UK subgroups. This supervisory work cannot be waived.

In addition to this main safeguard, UK policyholders are further protected via the requirement for UK subgroups to submit supervisory materials to the PRA, where necessary, beyond the reliance that the PRA may place on equivalent supervisors. For example, UK subgroups are still expected to submit the annual consolidated statutory accounts to the PRA. They also need to notify the PRA prior to taking certain actions, such as the acquisition or disposal of subsidiaries and changes to existing borrowing facilities. This ensures that the PRA is still able to protect UK policyholders while supervising the solo UK entities belonging to such groups in a proportionate manner.

The instrument enables the PRA, when certain conditions are met, to defer to third country supervisory authorities, if the UK has determined that the third countries are equivalent for the purposes of insurance group supervision. The conditions are: where compliance by firms would be overly burdensome; and where waiving the requirements does not adversely impact the PRA's advancements of its objectives. In this circumstance, the PRA may disapply or modify regulatory requirements, which amounts to issuing waivers to UK insurance groups. In effect, the waivers exempt these UK insurance groups from demonstrating to the PRA compliance with Solvency II group supervision requirements at the UK subgroup level. This is in recognition that compliance at the UK subgroup level has already been supervised by virtue of being a subset of the ultimate group that is supervised by the equivalent third countries.

Pre-EU exit, the European Insurance and Occupational Pensions Authority issued guidelines to allow EEA supervisors to issue such waivers. It was under such guidelines that the PRA was able to issue waivers to affected UK insurance groups pre-EU exit. However, these guidelines ceased to have effect in the UK following EU exit. Consequently, existing waivers are due to expire on 31 March 2022, and this statutory instrument confers on the PRA the power to issue new waivers.

On 2 December 2021, in its 22nd report, the Secondary Legislation Scrutiny Committee listed this instrument as an "instrument of interest". The report noted

"the absence of a level playing field"

in that

"while the UK has granted equivalence to the EU in relation to the supervision of insurance groups, the EU has not reciprocated."

While that is true, I urge the Committee not to conflate two separate matters. Equivalence determinations are made by the UK and the EU unilaterally. One decision is within the power of the UK Government, and another is beyond the power of the UK Government. Where the UK Government have unilaterally determined equivalence, we have a duty to ensure that our decisions are meaningful and achieve their objectives in full. This instrument ensures that we do not undermine our own equivalence decisions with deficiencies in our domestic law. So, rejecting this instrument does not increase the probability of the EU reciprocating equivalence decisions. Conversely, it would penalise UK insurance groups and our regulator by increasing regulatory compliance and supervisory cost.

After that rather full explanation, I conclude by saying that the Treasury has worked closely with the PRA in drafting this instrument. It has also engaged with the UK insurance industry through its industry body, the Association of British Insurers—ABI. The ABI has informed the Treasury that the industry welcomes this statutory instrument and has no concerns with it. I beg to move.

Lord Tunnicliffe (Lab): My Lords, I appreciate the Minister's introduction of this second statutory instrument. It is a somewhat simpler SI than the previous one but will nevertheless be important in the day-to-day regulation and operation of insurance groups.

As the Minister outlined, the regulations make a series of changes to ease the regulatory burden on the Prudential Regulation Authority—PRA. This is intended to save costs for both the regulator and insurance groups themselves. Under the new arrangements, the PRA would be able to defer to the decisions of the regulatory body or bodies of relevant third countries in certain circumstances. In practice, this is likely to be EU bodies, although the provisions cover non-EU third countries too. Where third countries have been deemed a regulatory equivalent to the UK and happen to host the parent company of a PRA-regulated insurance group, the PRA may choose to defer to relevant decisions made in the other jurisdiction, avoiding unnecessary duplication of work and costs.

4.15 pm

We do not oppose these measures. As is noted in the supporting documentation, the current temporary arrangements are due to lapse in March 2022, and it makes sense to adopt a more permanent approach along the lines of this one. The changes, however, are very interesting when considered in a broader sense. First, they provide an example of how our departure from the EU simultaneously changed everything and nothing. Like many sectors, financial services were

relying on cross-border trade and collaboration; that is as true for the regulatory bodies as it is for the firms themselves, whether they are commercial banks, traders, insurance brokers and so on. We may have completed the technical exercise of leaving the EU's regulatory framework, but this SI makes it clear than an ongoing engagement with it remains a necessity.

Therefore, when Mr Sunak said in July that his failure to secure an equivalence decision from the EU meant that the UK was free to take advantage of its new-found freedoms, that was true only on a certain slightly superficial level. We may be free in some senses, but the international policy framework and sectoral norms mean that we cannot and should not become some kind of regulatory pariah. There may be other areas in which the UK can exercise greater flexibility, but even they must fall within certain boundaries.

Secondly, as observed by the Secondary Legislation Scrutiny Committee, this measure resembles something of a one-way street. Through choice, we are affording a certain status to non-UK regulators that our own bodies do not enjoy among their peers. That is not in and of itself a problem, but it is representative of an approach that has left our financial services sector at a disadvantage vis-à-vis what it once took for granted. The lack of content on services in the UK-EU trade deal, coupled with the Government's failure to secure relevant equivalence decisions earlier in the year, means that our current arrangements fall far short of what we had and what businesses were promised throughout the negotiations.

As I said in my previous speech, we are now nearly a full calendar year into our new relationship with the EU. After a few initial shocks, and with some notable exceptions, businesses are generally adjusting and trying to make the best of the new arrangements. While firms can live with the current rules, many would much prefer the UK to build on existing trade agreements through sensible sector side deals. With that in mind, can the Minister confirm whether the UK has sought a reciprocal agreement in this area? If so, what was the outcome; if not, why was it not deemed appropriate? Although it may fall outside the narrow scope of this SI, can the Minister comment on what came out of our applications for equivalence decisions across the broad spectrum that is financial services? Are they still alive and could the European Commission still choose to respond favourably, or have the Government formally withdrawn from the process?

Like the sector itself, we remain of the opinion that striking additional agreements with the EU on a case-by-case mutually beneficial basis is both possible and desirable. The key ingredient, as ever, is political will. I reiterate that we do not oppose this SI, but I hope that the Minister can provide some hope of an improved deal for the sector going forwards. These measures may make sense on a practical level, but they do little to instil confidence that the Government have a firm grip on what needs to be done to support different strands of our financial service sector, which is after all a cornerstone of the British economy.

Viscount Younger of Leckie (Con): My Lords, rather like buses, this is the second debate in a row with only one other contributor. I say again that I am pleased that it is the noble Lord, Lord Tunnicliffe. I thank him for his general support for these measures and for his contributions.

Before I attempt to answer the noble Lord's questions, I would like to spend a little time reminding noble Lords that the UK's financial services sector is one of the most open, innovative and dynamic in the world. The insurance sector is the fourth largest in the world: it is a world leader in the provision of complex and bespoke forms of insurance and reinsurance. UK insurance firms held around £1.9 trillion in invested assets at quarter one 2020.

In July this year, the Chancellor of the Exchequer set out his vision for a globally competitive financial services sector, in which nimble policy-making and agile regulation benefit businesses, consumers and the economy, while ensuring appropriate protections and promoting financial stability. In this spirit, we should cut disproportionate duplication in supervisory work, so that we have every chance to compete globally and attract foreign insurers to the UK.

The noble Lord, Lord Tunnicliffe, started by asking for confirmation of whether the UK has sought a reciprocal agreement from the EU in this specific area. If so, what was the outcome? If not, why was it not deemed appropriate? A reciprocal agreement would involve the EU granting equivalence to the UK in respect of insurance group supervision. To reassure the noble Lord, the UK has sought an equivalence determination from the EU for Solvency II, including for insurance group supervision, but the EU has not granted an equivalence determination for the UK. However, it should be noted that a reciprocal agreement will benefit EU insurance subgroups with parent companies in the UK, rather than UK subgroups.

The noble Lord asked what came of the UK's applications for equivalence decisions from the EU across the broad spectrum of financial services. He asked whether these are still live and whether the European Commission could still choose to respond favourably or whether the UK Government have formally withdrawn from the process. He also asked whether I am able to provide some hope of an improved deal for the sector, going forward.

Ultimately, equivalence is an autonomous unilateral process. As the noble Lord would expect, I am unable to speak for the Commission on how it may proceed, but the Government have made sure that the EU has all the information that it requires to make a positive decision for the UK for all equivalence regimes. We have been clear that the EU will never have cause to deny the UK equivalence because of poor regulatory standards. Again, I reassure the noble Lord that the Government remain open and committed to continuing dialogue with the EU, including about its intentions for equivalence. With those answers, I commend this instrument to the Committee.

Motion agreed.

The Deputy Chairman of Committees (Lord Brougham and Vaux) (Con): We will pause for a minute to change Ministers.

Heavy Commercial Vehicles in Kent (No. 2) (Amendment) (No. 2) Order 2021

Considered in Grand Committee

4.24 pm

Moved by ***Baroness Vere of Norbiton***

That the Grand Committee do consider the Heavy Commercial Vehicles in Kent (No. 2) (Amendment) (No. 2) Order 2021.

The Parliamentary Under-Secretary of State, Department for Transport (Baroness Vere of Norbiton) (Con): My Lords, the order before the Committee today was considered previously in an earlier form and I must start with an unreserved apology for having to bring this legislation back to your Lordships' House.

On 19 October the Grand Committee considered three statutory instruments on heavy commercial vehicles—HCVs—which underpin Operation Brock, the multiagency response to cross-channel travel disruption at the Port of Dover and Eurotunnel. I regret to have to tell the Committee that there was an error in the legislation as passed. This resulted from an error in the drafting of a technical definition and requires correction. Therefore, I am asking noble Lords to consider the regulations, amended slightly to take account of the error, once again.

As I explained back in October, three pieces of legislation underpin Operation Brock. This legislation was first put in place in 2019 in preparation for a potential no-deal departure from the EU and has been amended on several occasions since. Operation Brock replaced Operation Stack. When there is serious disruption at Dover or Eurotunnel, Operation Brock allows trucks on cross-channel journeys to be queued on the coastbound carriageway between junctions 8 and 9 of the M20.

The error which has occurred is in the second of those three orders: the Heavy Commercial Vehicles in Kent (No. 2) (Amendment) Order 2021. This amended the Heavy Commercial Vehicles in Kent (No. 2) Order 2019. When Operation Brock is active, the 2019 order restricts cross-channel heavy commercial vehicles from using local roads in Kent other than those on the approved Operation Brock routes.

The error which was introduced by the subsequent order is in the definition of the roads from which heavy commercial vehicles are excluded when Brock is active. While the error does not prevent the Kent Resilience Forum initiating Operation Brock, it would affect the extent of the enforcement powers that would be available against HCVs using specific roads to avoid any Brock queue. The new instrument before the Committee corrects the error so that the legislation works as intended.

Once again, I apologise most sincerely for the mistake in the earlier legislation and that noble Lords are being asked to consider this order again. We had a good and thorough debate in October and I hope noble Lords will have seen my subsequent letter, dated 1 November, providing further information. I commend this order to the Committee and I beg to move.

Lord Bradshaw (LD): My Lords, it is a pleasure once again to address your Lordships' Committee following a long absence. I have, however, kept fairly well abreast of what has been going on here while I have been away.

What I would like to know is this: because many drivers of HCVs come from Europe, how many have registered for the visas which allow them to work in this country? This is not strictly relevant to this SI but it is important in the context of the amount of traffic which is likely to need regulation under this order. If drivers from the continent are not coming here, it is unlikely that many of these provisions will be needed anyway.

I would also like to know what the effect has been on the volume of traffic passing through the channel ports which would in fact amount to pressure on the roads in Kent. The information available to us suggests that there are a lot fewer drivers from the continent coming here, so that should manifest in there being less flow through Kent.

4.30 pm

I should also like to know whether, in light of the pressure on HCVs generally, anything has happened with extra traffic coming by rail through the Channel Tunnel. This is not strictly relevant to this order. None the less, it affects the amount of traffic on the roads—sadly, I am unaware of anything having been done.

Lastly, although this is again not relevant to this order, I want to raise the appalling state of the working conditions of many drivers of heavy commercial vehicles. They contrast most unfavourably with those on the continent. The Government announced that they were going to look at improving the lot of the HCV driver. Unless they make the conditions of work for these drivers better, they are going to score no points at all for what they are doing. This is particularly so for women drivers, whom they are hoping to attract to the profession.

I have no objection to these proposals, but I think the Minister should address these issues if we are to get our traffic with the continent on to a firm footing. I will take the opportunity of raising this in other communications.

Lord Rosser (Lab): My Lords, I take this opportunity to say how nice it is to see the noble Lord, Lord Bradshaw, back in action again. As usual, he made some interesting and relevant comments, even though he often sought to say that they were not strictly relevant to the order. Indeed, some of my questions are geared to the extent to which we need this order, though we certainly do not oppose it.

I think I have understood the reason why we are here today. I thank the Minister for her explanation. If I have understood it correctly, this order corrects an error in a previous order, since the words in the order we are now discussing between "means all" and "other than" at the top of page 2 were left out from the definition of,

"the relevant class of road."

That meant that the police did not have the powers to impose a fine of, I think, £300 on drivers who were not using the roads specified in the order. When Operation Brock is in force, the 2019 order restricts cross-channel

heavy commercial vehicles from using local roads in Kent, apart from those on the approved Operation Brock routes.

How often have the provisions of the order had to be brought into effect since it was first put in place, because of bad weather and industrial action causing serious delays at the cross-channel ports? I think these were the two specific instances which the Government previously gave to justify the order. I say that bearing in mind that the Operation Brock arrangements—which replaced Operation Stack—are now permanent rather than temporary. If the answer is that the provisions of the order have never, or very rarely, been used, do the Government expect the Operation Brock arrangements to be brought into operation more or less frequently in future? For what reasons might this happen—over and above bad weather and industrial action, to which the Government have previously made reference?

If these arrangements have never been brought into operation, how close have we ever been to that happening? Do the Government think it would ever be necessary to bring the Operation Brock arrangements into effect because of disruption at the ports, following a breakdown in our new trading arrangements with the EU, or could such a breakdown never result in a level of disruption that would reach the threshold for bringing the Operation Brock arrangements into effect?

What is the definition of "serious delays or disruption" at the cross-channel ports that might lead to the Operation Brock arrangements being brought into effect, and who makes the decision on whether the serious delay or disruption threshold has been reached? For example, have the arrangements had to be brought into operation recently because of any blockading of French ports by fishing vessels?

Finally, is there a cost to making the Operation Brock arrangements permanent? If so, what is that cost, including how much per day and per week on each occasion that the Operation Brock arrangements are brought into effect? How much does it cost per day and per week to have the Operation Brock arrangements on standby, ready to be brought into effect as and when required?

I do not think the Minister will be wondering why I am asking these questions, but they are similar to those raised by the noble Lord, Lord Bradshaw. How often, frankly, will these provisions be needed? Are we justified in having them on a permanent basis? I am sure she will respond on that issue.

Baroness Vere of Norbiton (Con): I thank both noble Lords for their contributions to this short debate. I hope to answer as many questions as possible, although I admit that some of the topics are slightly beyond what I had prepared for today. I will write an additional letter. I note that I have already written one which, I believe, covers some of the points raised, but I will read them out from the letter none the less.

I reassure the noble Lord, Lord Bradshaw—I too welcome him back to his place at transport SIs—that traffic with the continent is on a firm footing already. The visa issue he raised will not make any difference at all to the traffic going to and from the continent, but I can tell him that details of the number of temporary work visas granted for HCV drivers in food distribution—that is the narrow band allowed to take up these visas—will be published in the usual way via the Home Office's quarterly immigration statistics.

In general, the issue here is not necessarily what the business-as-usual traffic in Kent is but whether the scale of disruption happening at the short straits is necessary to protect the people of Kent from extreme congestion as people suddenly decide to rat run through the villages, create havoc and basically stop its economy and social life. That is what we are trying to do with Operation Brock. It is critical to have it on standby so that we can deploy it when needed.

Before I turn to the comments of the noble Lord, Lord Rosser, I might as well mention HCV parking, an incredibly important point that the noble Lord, Lord Bradshaw, raised. The Government are well aware of the issues around drivers' working conditions. I was in Kent only last Friday, at Ashford International Truckstop, which I had the honour of unveiling a plaque to open. I think it was my second plaque, and I was very pleased with it. It is a very high-quality facility; it has space for 650 vehicles and is located very close to the M20, so will really help people using the short straits. If I can replicate that standard in all the hot spots across the country for HCV parking, I will be happy, but first we have to find where those hot spots are. There is much work to be done; we have a pot of £32.5 million, which we will use to work with the private sector to ensure that our truckers have safe, secure, warm, comfy places to stop.

I turn to the issues raised by the noble Lord, Lord Rosser, who described the minor change to the order very well. It occurred because of circumstances that conspired against us; nevertheless, the system should have made sure that the right SI went to the final place. It did not, and we are reviewing our procedures yet again to make sure that that cannot happen again in future. It is a very minor change.

The usage of Brock is a decision for the Kent Resilience Forum, because it understands its local community best; it understands traffic flows and how disruption would spill over into local communities. The Kent Resilience Forum is made up of all sorts of stakeholders, including the police, the council, National Highways and people who have the interests of Kent at heart and are able to get Brock on to the M20 as quickly as possible to ensure that we coral the HCVs and manage the flow carefully.

Some of what the noble Lord, Lord Rosser, mentioned is already in the letter that I sent on 1 November. There is a lengthy section about costs, which I hope will reassure him. I am happy to answer any further questions he has on that, but the letter sets out the costs to Kent County Council and National Highways of the barrier either being in place or sitting around waiting to be put in the place, in the event of disruption.

Of course, it is for the Kent Resilience Forum to decide what serious disruption looks like and the circumstances in which it might occur. We can probably think of all sorts of cases. We do not know what future weather conditions will be like. Storms in the English Channel may be more frequent; who knows? If I were to stand here three years ago and say that we would need it in the event of a massive global pandemic, you

would have laughed at me, so I am not now going to think of a list of situations that would lead to serious disruption. It suffices to say that this decision is not taken lightly; it is resource-intensive and creates disruption. Nobody wants a queue of truckers on the M20, but it is necessary to protect the people of Kent. That is the balance that needs to be struck in the deployment of Brock.

We deployed the QMB at the start of 2021, when we were not sure what the arrangements at the French border would be and whether they would cause delays. It was stood down in April and then deployed again in July. Noble Lords will recall that there was some uncertainty back then as to what would happen at the French border over testing and how long it would take people to get through at the French side. Certainly our numbers were not looking great, even for very small levels of traffic going to France. It was deployed on a precautionary basis for a further two weeks in July, but was subsequently removed when the disruption was not as significant as we thought it would be.

I will write with any further insights I have on that but, in the meantime, I commend these regulations to the Committee.

Motion agreed.

Committee adjourned at 4.43 pm.