Cease the fighting in Syria and let the aid workers in to act

Thank you very much, Mr President, and welcome to the Council today. Welcome also to the German Foreign Minister. I thought he was totally right; as he said, it's ever more difficult to put the human suffering in Idlib into words. It's so true as we see the terrible human consequences of the Syrian regime's and Russia's violence in Idlib province, which is escalating.

The Russian Representative asked why humanitarian agencies are finding it so difficult to to protect people, the desperate people out in the open air at the moment. And the answer is because they're being bombed, they're being shelled, they're being attacked. It is extremely difficult indeed to provide assistance to people in those circumstances. The intensity and pace of the Syrian and Russian campaign means that civilians who are able to get out of the way in time have nowhere to go. They have no shelter. They are forced to sleep in the open air. Children are literally freezing to death.

At the last humanitarian session, we said that over 358,000 people have been displaced since the first of December. That number is now over 948,000 – 80 percent of whom are women and children. And I say to my fellow council members that we should be under no illusion that this is the worst humanitarian situation thus far in this terrible conflict. The continued attacks not only directly cause civilian suffering, but they also hamper the aid effort, amplifying the scale of this disaster.

The Russian representative also talked about terrorism, and he urged us in a different context not to exaggerate problems. I would simply note that yesterday the Russian ambassador to London stated in a media interview that terrorists make up one percent of the population of Idlib. And even if that is the case, I would simply say international law does not permit you to attack the 99 percent to handle one percent.

And we remain appalled, Mr President, that civilian infrastructure continues to be attacked. On Sunday, the White Helmets reported that Russian warplanes hit a children's and women's hospital in Balioun, in Idlib. And as the United Kingdom's Minister for the Middle East said on Monday, "The United Kingdom has condemned and continues to condemn these flagrant violations of international law and basic human decency." Let me remind all military forces on the ground, especially their commanders, that following political orders is no defence against war crimes. Accountability will come, no matter how long it takes. And I want to say as well that we look forward to the report of the Secretary-General's Board of Inquiry and we urge Secretary-General to make those findings public.

We need there to be an immediate cessation of hostilities. We strongly support the Turkish government's efforts to re-establish the ceasefire agreed in 2018. And we stand behind the Secretary-General and his Special Envoy for Syria in their efforts to stop the violence and save those many lives now in

peril.

Let me turn, Mr President, to the north-east, and thank the Secretary-General for his report on implementation of UNSCR 2504 and on alternatives to the Yaroubiya crossing, as requested in 2504. That report makes clear that there is no alternative. Since the loss of the Yaroubiya crossing in the cross-border mandate, those living in areas of northeast Syria, which are not under the control of the Syrian authorities, have been denied the medicines and medical items they so desperately require. Without access through Yaroubiya or the provision of a credible alternative, medical facilities will see their stocks of vital medicines dwindle, putting their continued operation – and the Syrian patients which depend upon them – at risk.

As many have said, a particular area of concern is reproductive health stocks. We note with great concern the forecast that stocks in the north-east could be depleted by the end of March, preventing vital procedures such as caesarean sections – a preventable tragedy for Syrian women – and more widely, supplies will run out by May.

The Russian Federation have said that we can trust the authorities in Damascus to deliver aid throughout Syria. Well, let's examine that. It is, of course, welcome that in recent hours and days, the Syrian authorities have granted authorisation of humanitarian delivery. But we've heard promises before. What matters is what actually happens on the ground. And in that respect, we need OCHA to provide regular and granular data to this Council on the Syrian regime's performance when it comes both to cross-line humanitarian aid and that within the areas controlled by the authorities.

The Secretary-General's report makes clear that responses to requests are delayed for months; even when approval is given, under half are permitted to proceed. Key medical supplies are routinely removed from convoys. In 2019, there were precisely zero road convoys from Damascus to the north-east of Syria. In areas controlled by Assad, we see humanitarian aid withheld from towns and communities deemed insufficiently loyal to the regime. So we placed little faith in promises by the Syrian authorities. But we do call upon them again to meet their humanitarian obligations and we call on their Russian protectors to make them do so.

But, Mr President, for the sake of the innocent people dying in Syria, there is no alternative to cross border access.

Now, Mr President, the United Kingdom remains the third largest donor to the UN-led humanitarian response across Syria. We've allocated $152 million this financial year to projects implemented by organisations delivering cross-border aid, primarily into north-west Syria. Since the conflict began, the United Kingdom has committed over $4 billion of humanitarian funding in response to the conflict, and we remain committed to providing help to those in need. We want to continue to provide this much needed assistance. We must be sure the aid is going to those who need it most, wherever they are, on a principled basis. So pending clarity about the future of cross-border operations beyond July, and given the clear interference and obstruction of aid by the authorities in Damascus, we will be looking very seriously at this

question.

As set out in the chamber before, and as others here have said today, we will not consider providing any reconstruction assistance until a credible, substantive and genuine political process is firmly underway. Russia's contribution to Syria has been through military hardware and bombs on its people, not development aid. And that will have to change.

Mr President, we are facing the worst humanitarian crisis in the worst conflict in the world. Innocent men, women and children are dying and will die if nothing is done. It is in the hands of Syria and Russia to take or to save lives. It is their choice. The human and humane thing to do is to cease the fighting and let the aid workers and medics in to act.

It is in their hands, Mr President.

Putting the national, the health and service into NHS

The whole country is concerned about the developing situation with coronavirus – covid-19.

We are doing everything reasonably possible to keep the public safe.

I want to start by praising the exemplary response of my officials, Public Health England, the whole NHS and the wider health system.

Earlier the Chief Medical Officer Chris Whitty set out our plan to contain, delay, research and mitigate the virus.

That plan will be driven by the science and guided by the expert advice of Professor Whitty and others.

Tackling this virus is imperative and it's taking up the overwhelming proportion of my time.

While we grapple with the virus, I am determined that we don't take our eye off the long-term challenges that we also need to rise to, and the long-time changes that we need to make to our healthcare system to make it the best it can be.

Delivering our manifesto commitments including 50,000 more nurses and 40 new hospitals. Addressing the priorities of people, infrastructure, technology and prevention.

So today at this conference I want to ask this big, long-term question and formally set the health system a new goal.

The question is, how do we ensure that in today's world there is always public confidence in the NHS?

In a speech to the Royal College of Nursing in 1948 Nye Bevan gave a famously gloomy assessment:

He said: "we shall never have all we need".

"Expectation will always exceed capacity".

The service "must always appear to be inadequate".

Now I am generally sceptical of those who say 'this time is different' but today I want to argue exactly that.

My argument – and I appreciate this is a dangerous thing for a Health Secretary to say to the Nuffield conference – is that Bevan was wrong.

The service does not always have to 'appear to be inadequate', either for patients or staff.

This time can be different.

And the reason is that today's technology – unlike previous technological advances – allow us to do more in healthcare at lower cost.

Now I don't think that's ever been true before in the history of the NHS.

There have been amazing advances like heart transplants and chemotherapy that have allowed us, at greater cost, to save more lives.

Those are good technologies. But the power of modern technology is that it allows us to improve outcomes and cut costs.

Radiology in the cloud is cheaper and faster than a system based on couriers and CD-ROMs for example.

And while technology on its own solves little, technology that clinicians want to use because it meets their real-world needs, designed with their input, done with them and not to them – this has game-changing potential.

And we know because we can see it right across every part of the economy and we can see it in parts of the NHS.

Get it right and by the end of the decade we can have an NHS that functions as a platform rather than a set of loosely aligned, disconnected incommunicative silos, an NHS focused on preventing sickness, not just treating it, enhancing life, not just prolonging it. Where staff do more of what they came into medicine to do – caring, treating, healing the human things that a computer could never replace – because we've removed or improved the grind of routine process.

And to make that happen, we need to change the way we think about how change happens in the NHS.

Now policymakers love the idea – and I can tell you it's tempting – that change is something to do with top-down reorganisations and big bang structural reforms.

It's why the last couple of decades are littered with failed attempts to 'transform' the NHS by structural reform from on high.

But guess what? It's not all about us policymakers!

The answer to better healthcare lies less in complex reforms cooked up by the centre. We've tested that idea to destruction.

It lies in millions of incremental improvements, carried out at every level of the service, every day by people who feel and are empowered to make things better in pursuit of a common goal.

The small tweak to a process that improves patient flow.

The trust that saves hundreds of hours of clinical time with access to real-time test results for example.

The streaming that manages record demand on our A&Es.

These are the things that transform the NHS.

It doesn't happen on its own.

It requires strong accountability.

It requires the right data so the system can constantly learn from itself what works.

It requires the resources: including the record £33.9 billion funding increase now enshrined in law.

And it requires trust. Trust in clinicians to make those improvements. Trust in local systems to serve their population as a whole. Trust in patients to play their part in their own health.

That's how change happens in big organisations like the NHS.

But this method of marginal improvements requires people to also have a common mission.

My case is that we must free people up to innovate, and in all the large organisations where freeing people to innovate has worked it's because they've had a common goal.

Two goals for the NHS

So today, I want to set 2 goals for our healthcare system – not just the frontline NHS but the system in its broadest possible sense. The department, the central bodies, social care and the ecosystem that surrounds them.

One is a clinical goal, the other a goal of ‘user experience’.

Both are equally important. Each reinforces the other.

The ultimate clinical goal is to increase healthy life expectancy in this country.

As a nation, we have set the goal of 5 more years of healthy life expectancy by 2035.

Not just adding years to life but life to years.

But this clinical goal is not enough on its own.

Everyone in the NHS goes to work to serve patients, not just to treat them.

Indeed, the whole NHS serves our country just by existing, by giving peace of mind to everyone, even if you very rarely use it.

So the second goal I want to set is to increase public confidence in the NHS.

Confidence that the NHS will always be there for us. That the NHS will look after us and care for us with dignity and respect. That it will treat me as a person with a history and a future, not just a series of unconnected clinical episodes.

Now public confidence is not the same thing as public support – important as that is – or even public satisfaction with the quality of an individual treatment.

How you’re treated at reception, whether staff have pride and the hospital is tidy, whether someone explains to you what’s happening and keeps you properly updated.

These things might not matter from a strictly clinical point of view, but they should matter to an organisation paid for entirely by the public and which exists to serve the public.

I want to draw a parallel to what’s happening on coronavirus right now. This approach is working.

It is an explicit goal not just to tackle the disease but to maintain public confidence.

We should take this same attitude to health services in normal times too.

In the second quarter of 2019 the NHS received 50,000 written complaints on various subjects. What was the one subject that accounted for the largest proportion of complaints?

Communication.

So I’m setting the NHS the challenge that it should be as good at process and admin as it is at medicine, that if you’ve got a chronic condition you

shouldn’t have to carry a ring-binder of notes from one appointment to the next because your provider can’t access your full medical record.

That we shouldn’t be asking you to make a stressful journey into hospital when you could get the same result at home using modern digital tools.

That when you’re notified of an appointment it should never arrive after the appointment was meant to take place. That is one of the most frustrating things and it happens right now.

The National Health Service must be just that.

The National. The Health. And the Service.

Not just a hospital system but a service for the nation’s health.

So I want to take each of these in turn, because they are all important.

National

Let me take these 3 in turn: national first.

Loving the NHS is a part of our national identity.

We love it because it’s always been there for us, unconditionally, through some of the best moments in life and through some of the worst.

This is what maintains the public support for the NHS.

As the Prime Minister puts it, it’s like the whole country figuratively gathering round your bedside when you fall sick, doing everything it can to make you well again.

But that shared ideal is one of the few things about the NHS that is truly national.

Because the NHS is not some centralised command-and-control state like Bismarckian Germany.

And I can assure you as Health Secretary I know that.

It’s more like the Holy Roman Empire: a story of fragmentation, duplication and high levels of regional variation.

There is no single national NHS back office for example.

Local providers have their own teams and systems for every conceivable non-clinical activity, from booking appointments to registering patients to organising staff rotas to ordering medical supplies – with massive duplication of effort.

Nor is there a national data architecture.

I first discovered this through personal experience – like many people do.

My sister had a very serious accident just before I became Health Secretary and a near-fatal brain injury.

She received amazing, life-saving care at Southmead hospital in Bristol. She underwent 6 months of rehabilitation. And when she went back to her GP to get approval to reapply for her driving licence, despite having known her all her life, her GP had no idea – no record – no details at all.

That is not a unique experience, it's an everyday occurrence.

And when I say national there's another aspect to national we need to look at – let's look at national health outcomes.

We have a chequerboard of local variations.

Take healthy life expectancy. I think this is a very serious problem.

A person born in Wokingham can expect 72 years of healthy life. In Nottingham it's 54 years.

In Blackpool, 1 in 4 women smoke during pregnancy. In Westminster, it's 1 in 50.

So this is the first part of our project.

In the 2020s we must make it our mission to put the 'national' back into the National Health Service.

At the patient-facing end of the service that means levelling up access to healthcare.

Ending postcode inequality so for instance your chance of seeing a GP doesn't depend on where you live.

Not just delivering the 50 million more GP appointments that we committed to in the manifesto but making sure they're focused on where they're needed most.

Being a national service means having consistent standards that all patients can expect.

You want local variation where there's variation in local conditions.

It will be a central task of the new Integrated Care Systems in every part of the country to take into account local conditions when improving the health of their populations.

But we need less unwarranted variation in both commissioning and delivery of services.

Why should 3 cycles of IVF be allowed in some parts of the country while some parts offer none?

A local part of the NHS deciding it's OK not to offer IVF, with no

accountability – it's absurd and it's unacceptable in a national service.

It also means having a platform approach to the way we deliver some of things like the back office.

Building once at the centre where it makes sense to do so, so suppliers and commissioning bodies don't have to recreate the plumbing each time.

Look at NHS Login, our national ID assurance platform.

It supports a growing ecosystem of new digital services, from GP appointment bookings to remote consultations to digital maternity services – all of which require you to prove who you are.

We're also looking at a consistent way to identify staff across the system.

But the most impactful and clinically useful platform we can create is a national data architecture for the NHS.

It's a massive opportunity: for patient experience, clinical excellence and the next generation of research.

Fixing this is not, repeat not, about building a single, giant centrally owned patient database in the basement of NHS England.

Instead it's about creating an architecture so systems can talk to each other and so data can be safely accessed where it's needed.

We need the whole country to be covered by local shared care records. We need those shared care records to be able to speak to each other with common standards, we need clinicians to have the trust and confidence to use them.

And I can announce that we've just published our new draft digital health technology standard.

Designed to make it easier to commission great new digital health services, it requires developers to follow our standards on interoperability if they want us to buy their stuff.

There's much more to come.

And today we're kicking off engagement on our Tech Plan for health and care, setting out how technology will support delivery of the NHS Long Term Plan.

This includes establishing what good looks like for all forms of tech-enabled care, clarifying who pays for what, and what we need to do to drive these improvements.

I would urge you to all get involved, everybody, whether you're interested in technology or not, because developing this plan should not be left to us at the centre – it's too important for that.

There will never be a big bang moment when we flip a switch and the problem is solved.

Like all genuine improvement this is an incremental, iterative process.

Done right, this approach must be entirely embedded in evidence. It's about what works. And the evidence is abundant, it's strong and it's growing. Bringing technology in the NHS into the twenty-first century works. Modern use of data works.

Ignoring that evidence is as much of an error as blind faith in technology.

So I'm determined to drive this agenda because if we get the technology and the data right, we can do incredibly powerful things in health.

Which brings me to the second letter in NHS – H for health.

Health

According to the best evidence we have, only around a quarter of what leads to longer, healthier lives is the result of what happens in hospitals.

The remainder is down to genetics, the environment and the lifestyle choices that we make.

As a healthcare system, we actually have strong track record on improving both the broader determinants of health – the inputs – and health outcomes.

So smoking rates in Britain have halved in the last 35 years and we now have one of the lowest rates in Europe.

We lead the world in managing long-term conditions like diabetes, with fewer than one in a thousand patients being admitted to hospital in a given year.

Deaths from cardiovascular disease have halved since 1990, cancer survival is at an all-time high, male suicide is at a 31-year low.

We also have some of the finest public health officials in the world and I'm very grateful for the work they've done on our response to covid-19.

But we can and must go further.

For most of its 70 years, the NHS has been focused on curing a patient of a single illness, putting ever more funding into big acute hospitals.

This has had an impressive impact on lifespan over the past 70 years.

Yet as it enters its eighth decade, as we've seen those increases in lifespan start to slow, it's clear the NHS needs to focus more on health-span: the number of years a person can expect to live healthily and independently.

Prediction and prevention are mission-critical for delivering on those 5 extra healthy years of life.

This is partly about getting smarter in the way we use NHS resources.

Things like dedicated alcohol care teams in hospitals with the highest rates of alcohol-related admission, or quit-smoking help targeted at CVD patients.

Modernising the IT systems on which our national screening programmes are delivered, so they're easy to use and no one gets left behind.

Putting more resources into primary care and community care, and asking our army of pharmacists to do far more to keep people healthy.

Or rolling out non-drug therapies through social prescribing, right across the country.

But this approach is also about recognising that not all the answers are in the NHS.

That we need cross-government action on air pollution, properly insulated homes and urban design that supports cycling and walking.

People have been talking about the need for more prevention since the 1950s. So again you're entitled to ask: why is this time different?

Firstly because we have more and better information than ever before.

A lot of it is distributed outside the system, on Fitbits and smartphones and other internet-linked devices.

We're also creating increasing amounts of genomic data, including our project to sequence 5 million genomes.

Having all that data matters because there are still big gaps in our knowledge about what works and for whom.

Take drug responsiveness.

A few years ago, Professors Eric Topol and Nicholas Schork put together a study showing the responsiveness – the intended clinical response – of the top 10 drugs by gross sales in the US.

It shows that overall, 75 percent of patients receiving these drugs do not have the desired or expected benefit.

This ranges from only 1 in 5 patients with schizophrenia deriving a benefit from the market leading schizophrenia drug, to only 1 in 16 patients with multiple sclerosis.

This is known as the 'number needed to treat', which means the number of patients you need to treat to prevent one additional bad outcome.

Until we can safely use all the data that we hold about individual patients, that number will remain stubbornly high.

Cancer is another example.

Major trials funded by the NIHR show that many people given surgery or

radiotherapy for prostate cancer will do no better than those without treatment.

But we don’t know which people in advance.

If we can marshal all the data about a patient, then we can treat each patient as an individual, finding the treatment that’s right for them.

Bringing the ‘number needed to treat’ closer to one, saving the NHS and patients the cost and pain of unnecessary treatments.

So that’s the first big change we can harness.

The other big difference is that we now have the computing power and the artificial intelligence to do the marshalling.

Already, AI can perform as well as human radiologists at detecting certain cancers.

AI developed at MIT recently found a new antibiotic for tackling drug resistant microbes.

This is why we’ve set up a £250 million AI Lab in the NHS to identify and scale the most promising technologies and crucially, to get the regulation right.

By the end of the decade we need doctors to have all the relevant data about the patient in front of them, not just the patient’s full health record but genomic data, any self-generated data they want to volunteer, and data on similar cases.

We need them to have the AI and other decision-support tools to process that data, and we need them to have the right training to understand it all.

It can be done. It is being done in the most advanced parts of the NHS. We need to turn the NHS from a national hospital service to a health service. Making sure that we’re focused on the health of the patient.

Service

And that brings me to the third part of the NHS: ‘S’ is for service.

I’ve drawn a deliberate distinction between health and service.

Between clinical outcomes and public confidence.

To help explain what I mean, I want to tell a story.

I mentioned the problem of different care settings not being able to access vital patient records.

At Barts in East London, they’ve solved that problem for chronic kidney patients.

It works like this.

The renal unit at Barts have a data-sharing agreement with 160 local GP practices, allowing consultants to remotely view full GP records with patient consent.

It means they can see a patient's creatinine levels over time – a crucial indicator of kidney health – as well the medical history, co-morbidities, past hospitalisations and so on.

Following review of the notes, the consultant records her advice on Barts's system and the practice gets a notification.

The small minority of patients who need further investigation then get triaged into traditional face-to-face clinics.

The vast majority of patients don't ever have to go to hospital. And they get reviewed much faster.

Before the virtual kidney clinic started, the average time from referral to first outpatient appointment was 64 days.

Now the time between referral and assessment is less than a week.

It's too early to say if it's improved clinical outcomes.

But that is not the point of the exercise. The point is to improve the service.

Because if you're in a nursing home with chronic kidney disease, then getting into central London to go to Barts can be a real ordeal.

The virtual clinic improves patient access to the NHS, while removing the whole rigmarole of arranging transport, travelling in, worrying about tube delays, tracking down missing referral letters and sitting around in waiting rooms when you're not very well.

Not only did patients enthusiastically consent to their records being shared but like all the best service improvements, they were amazed that it wasn't already happening.

There are loads of other areas where we can make the service better.

As I said, the medical advances in the NHS are amazing but the process advances are far too slow.

Royal Mail should not be the default mode of communication between patients and providers.

Patients should have access to their own medical records. We know it improves the quality of the data and where they spot a mistake, it can be lifesaving.

University Hospital Southampton give their prostate patients real-time digital access to their PSA results as soon as they come out of the lab,

unmediated by a physician.

It’s incredibly popular, even among older men with less digital experience. And the reason is that people want to manage their own care.

And wherever possible, healthcare should come to you before you have to go to healthcare.

This is not as radical as it sounds.

And I know there are some people who scoff at this agenda. But let me give you one example that we now take as read.

Thirty years ago you had to go to a doctor to get a pregnancy test. Now you take the test yourself before you go to the doctor. Of course you do!

It’s not just about the technology.

Our capital building programme is about ensuring the best possible service for patients, as well as clinical outcomes.

Because patients don’t only care about the clinical treatment.

They care that the hospital looks smart. That it’s clean. That staff are friendly and well-motivated. That the food is good, and that they were told clearly what is going on.

These are the things that matter to patients, and they need to matter to every single person who works in the service. For the NHS is a service or it is nothing. And we are at the service of our nation.

At Great Ormond Street they now note a child’s favourite food or football team to help busy staff make a connection with the child. A simple change that can make an incredibly stressful experience just a little bit easier.

So there you are.

The NHS. Our National. Health. Service.

To entrench and underline the central importance of that sense of service – that’s why I’m setting today the explicit goal of raising public confidence in the NHS.

This is a hugely ambitious and exciting agenda. Everyone here has a part to play.

It’s first and foremost about people: about how we get the most out of the people who make up the NHS – how we motivate, incentivise, support and train our people. I’m proud to see the staff survey results moving in the right direction.

It’s brilliant news that we’ve increased the number of nurses in the NHS by over 8,000 in the last year alone.

And with the People Plan we will set out yet more how we can support every single person in the NHS to reach their potential.

It's about infrastructure, fixing the roofs and getting the modern buildings we need to deliver modern services closer to home.

It's about prevention of ill health to reduce pressures on the system.

And yes it's about technology, because there are historic problems that we can now fix by bringing the technology of the NHS into the twenty-first century.

We all know that demand and expectations are rising. We can't afford to stand still.

To reshape our health service we must harness the resources that the modern world can offer.

And deliver a National. Health. Service. Of which we can be proud.

Governor Addresses Annual Meeting of Financial Services Industry

Thank you for inviting me to speak with you today. It's very good to see a group of such familiar faces and a session so well attended.

This conference, hosted by TCI's Financial Services Commission, is timely on two levels. Back in the UK Brexit occurred 21 days ago meanwhile here, in TCI we now have the results of the Caribbean Financial Action Task Force's (CFATF) mutual evaluation process.

On CFATF this audience, I know, is already familiar with the report's findings so I do not intend to address this in any detail; others have already done so. What I will do is reinforce the need for us to now redouble our efforts in terms of implementing its recommendations and explain the four reasons why I think that is important.

But before that it this gathering allows me the opportunity to say a word or two about the immediate future now Brexit has occurred, an event that this audience may be more focused on than most in the Islands.

Brexit is done. We are now in the transition period. These I think are the key points:

- first we want a relationship with the EU which is based on friendly cooperation between sovereign equals, and centred on free trade. We will

have a relationship with our European friends inspired by our shared history and values

- at the end of this year – 2020 – the process of transition in that relationship will be completed and the UK will have recovered our economic and political independence. That moment is the most important thing that will happen in the UK in 2020. It will enable the UK to control our own laws and our own trade

- that is why the UK will not be extending the transition period. It simply defers the moment at which we are in charge of our own destiny

- the question for the rest of this year is whether we can agree with the EU a deeper trading relationship on the lines of the free trade agreement the EU has with Canada, or whether we have a trading relationship, based on the 2019 deal, without a Free Trade Agreement on the lines of Australia's

- let's be clear. The UK is not asking for a special, bespoke, or unique deal. We are looking for a deal like those the EU has previously struck with other friendly countries like Canada. We agree and accept that this comes with consequences for market access for both sides

- but it is worth saying the UK is a significant importer of food and other goods, and avoiding tariffs should be beneficial to both sides, given our shared commitment to high regulatory standards. In their trade deal with Canada, the EU removed 98.7% of tariff lines. For Korea they removed 99.5% of tariff lines and with Japan, the EU removed 99% of tariff lines

- either way we will be leaving the single market and customs union. Businesses will need to prepare for life outside the EU both at the end of 2020

Looking more precisely at the area of Financial Services, something this audience is focused on:

- in terms of negotiating a Free Trade Agreement, the UK is seeking to provide a predictable, transparent, and business-friendly environment for firms to undertake cross-border financial services business

- we are proposing to the EU that this could be done by agreeing comprehensive obligations on market access and cooperation

- in addition, we are willing to look at regulatory and supervisory cooperation arrangements that reflect the level of access between our markets and will seek to establish processes for dialogue on ‘equivalence’

- there was a commitment by the UK and the EU in the Political Declaration to conclude equivalence assessments by June 2020. These are technical assessments that each side will carry out separately

- these ‘equivalence decisions’ are an important tool to remove unnecessary barriers to continued cross-border business in mutually beneficial areas

- these arrangements will give both sides confidence that the negotiations are being conducted in good faith. Equivalence does not mean either side is a ‘rule taker’. We’ve already agreed with the EU in the Political Declaration that new regulation will be an autonomous matter for both the UK and the EU

- it means therefore what it says – that our rules are “equivalent” for trading purposes. Equivalence is a unilateral act, so any decisions by the EU cannot bind the UK

- if your question following from that is… “Does that mean that we will diverge from EU rules?” The answer is that we are committed to regulatory autonomy and will not agree to rule-taking by the UK in financial services

- freedom to change the rules however doesn’t mean a bonfire of regulation. The UK is committed to the highest standards of regulation and appropriate levels of supervisory oversight

- I’ll say that again because it’s important I think for this audience to absorb…”Freedom to change the rules doesn’t mean a bonfire of regulation. The UK is committed to the highest standards of regulation and appropriate levels of supervisory oversight”

- in any case in many areas the UK already go beyond what EU rules require. Where we do make changes, they will be for good reasons

And now to the CFATF report.

I do understand that the financial services sector has been challenged over the last couple of years to apply standards established by forces outside of your control. TCI is of course not alone in this. I know you – the end user –

will be suffering from regulatory fatigue.

The burdens of these challenges have also been felt by the public authorities, designing and implementing laws and policies.

Notwithstanding this, the report highlights the need for greater efforts by all of us, in this room, to mitigate the risks of money laundering and terrorist financing.

Many of you know I'm an optimist so let me start though by acknowledging we have made progress. There is good – I'd go so far as to say excellent – engagement among public sector stakeholders. They appear now as a cohesive team and that sits very comfortably with both my, and the Premiers ambitions, for serious cross government and cross department working to be the way we do business around here. In many ways they were the trailblazers and I thank them for reaching across divides, an example that others in the National Security Community and Justice sector have followed.

They also did an excellent job for us in Antigua. Their advocacy of what had done, and accomplished, an important mitigation in its own right. The report should reassure us all we are moving in the right direction in terms of the establishment of the required legal and legislative framework.

Optimism now put firmly back in its place – and returning to the realism expected of Governor's – the results are not yet what we want or others expect and the report notes gaps and deficiencies. We need to recommit.

Given the regulatory burden, why does this matter? I think it matters in four areas.

- first – because of our past – we in TCI have a job to do in changing global, at times very superficial views, about TCI

- for those globally that know little about TCI they do have in their reptilian memory the corruption scandals of the late 2000's. It doesn't help that the SIPT trial has not yet concluded. It's raised with me regularly by visitors, including visiting Bankers

- it's ironic that actually the lessons we learned from that period puts us in a very good place. We now have very considerable safe-guards that should reassure. But as we all know, reputation arrives slowly in a hand cart and leaves on an express train and TCI, I think, still has some way to go in terms of burying the ghosts of that past. Unfair, perhaps, but life is rarely fair. Until that reputation is dead and buried we will struggle to get the best money and always be at risk of the 'chancer'

- we have a clear position on anti-corruption; manifested in the work of SIPT and the Integrity Commission. With my arrival, and in the future, we will be doing far more third party due diligence on those who wish to

invest in these Islands through major development projects. We don't need to engage with those who have a questionable past or a past that is anything less than transparent and discoverable. I cannot over-emphasise that tolerance of any illicit financing from dubious sources poses a serious challenge to the overall reputation of these islands

- second our success, and any future success, as an international financial centre is linked to our acceptance by the international community as a credible and supportive partner. We cannot succeed in isolation. Accordingly, it is a matter of strategic priority, both for the management of our risk and for international acceptance that we comply with the relevant international standards, such as the FATF Recommendations

- that links to the third point. We need this industry – we need you in this room – to prosper. We are far too dependent on tourism. We all know that. We are living off the sugar high of the present boom in the US economy. I was not here but you all recall what happened in 2008. We are sat on a 21st Century equivalent of Caribbean mono-crop – be it salt or sugar – and we all know what happens to them when a ripple occurs elsewhere

- I'm not an Economist but I know the US economy will go through a cycle. We need as much diversification in this economy as we can achieve – in particular we need diversification that is not the labour intense industry that tourism produces

- these Islands have grown from a population of around 7,000 in 1980 towards a projected population of over 70,000 in 2040. A ten times increase. Much of that is because in choosing tourism, or perhaps more accurately tourism choosing us, we went for a model of needing far more labour than the Islands themselves could provide

- we are now, it seems, on a perpetual treadmill of us needing further tourist development to fuel the economy that requires yet more labour, and so on, and so on. You know – from a national security perspective – and from a social cohesiveness perspective – where that is taking us

- an industry such as yours – or those like yours – that employs small numbers of high value workers is not just important in terms of diversifying our offer from one industry, but helps us at least mitigate the treadmill of population growth we are presently on

- fourthly, and finally, I have to worry that there is money laundering going on in TCI and that money laundering has a direct impact on one of the most significant aspects of our national security, and one I'm

spending a great deal of time on personally. The societal impacts of mass illegal immigration

- we need to call this out for what it is: human trafficking – something that should be abhorrent anywhere – but particularly so in the Caribbean. The big change in our posture, on this, is to first intensify our efforts to incept the sloops – I hope you've seen a marked improvement in the last six months in our interception rate – virtually no illegal immigrants are now escaping our detection at sea and this is before a tripling of the radar coverage that will be deployed this year – but as importantly TCI's new found zeal and energy in going after the underpinning business model; taking down the networks that profit from the trade

- our arrest at sea of 29 Sri Lankans has given us an increasingly deep insight into this immoral business model both globally – working with international partners – and locally. This is the largest investigation we have run post the SIPT trial and it's the beginning of a new way of doing business here

- as part of that, understanding the money, and following the money, an important part of both our investigative and prosecutorial tool kit. Those in anyway facilitating this movement of funds are party to criminal activity that seriously damages the fabric of the country. Finding and prosecuting them sits very high on my list of priorities

In drawing this now to a conclusion I should first thank our excellent Financial Services Commission for the opportunity to address this equally excellent audience. And I should thank you – the audience – for: your engagement in the past; your attention today but far, far more importantly; for your refreshed engagement on this issue going forward

I said in the press conference that launched the National Security Strategy, last month, that we were including money-laundering and terrorist finance as a national threat that has to be dealt with from the Centre. That tells you the importance we give this. And I also said that "the fastest path to genuine National Security was national unity". I very much include this informed and intelligent audience in that national call to action. What you do, and how you do it, matters to the nation. Thank you.

Rampling: Tough economic times, UK

continues support

During his fourth visit to Baalbek, British Ambassador Chris Rampling toured ongoing UK funded projects, and inaugurated new ones, underlining the UK's unswerving support to Baalbek and its surrounding areas.

Accompanied by Governor Bashir Khodr, Ambassador Rampling attended the Lebanese Enterprise and Employment Programme's 'UK Support To Baalbek' event for small and medium enterprises (SMEs) at the Palmyra hotel, where he also announced the launch of a new mobile tourism application for Baalbek. Both projects – funded by UK aid – are aimed at creating economic opportunities and jobs, and boosting tourism to the City of the Sun, and the surrounding areas.

Under the UK-Lebanon Year of Education 2020 launched in October 2019, Ambassador Rampling visited Al Bashaer High School run by Al Mabarrat Association to see the impact of UK support designed to raise the quality of education delivered to students. The British Council has been supporting Al Mabarrat through the Connecting Classrooms programme since 2009.

Received by Col Salman Salman, Ambassador Rampling visited Four Land Border Regiment and a Forward Operating Base in Baalbek and saw how UK support to the Lebanese Army is securing the borders with Syria, as the sole legitimate defenders of Lebanon. Since 2019, Lebanon had complete authority over its border with Syria. UK support to the Lebanese Army since 2011 has reached over $92 million.

At the end of his visit, Ambassador Rampling said:

> I am pleased to be in Baalbek again, my fourth visit since I arrived, a testimony of the importance we place to support the city and surrounding areas. Baalbek represents a breadth of our UK aid programmes: through education, supporting the economy, boosting tourism and above all security which is key to the success of all our projects.
>
> The UK recognises the deep economic challenges facing local businesses and municipalities here in Baalbek and across Lebanon. We recognise the need for urgent action by the Government of Lebanon to address urgent and mounting economic pressures. We know the economic challenges are stark, and we recognise the burden of refugees that Lebanese communities continue to bear. Since 2014, UK aid's contribution to the Baalbek-Hermel region has been over $3.5 million, reaching over 125,000 beneficiaries.
>
> We are here to deliver more. Today we are investing further in

Baalbek and surrounding areas, through the Lebanon Enterprise and Employment Programme to introduce grants to SMEs, the backbone of Lebanon' economy and crucial to the country's economic recovery. We are keen to work more closely with its residents to improve access to services, and to create further job opportunities.

I'm also delighted to launch with Governor Bashir Khodr a new mobile tourism application for Baalbek to further support the economy, boost tourism to this spectacular city, and encourage more tourists whether from Lebanon or abroad to learn about its remarkable history. The new app can be downloaded by Android users, and will be available on the Apple Store in due course.

We will continue to support Lebanon through our programmes that have achieved a great deal reaching over $250 million in 2019 – in security, prosperity, education and stability.

International Trade Secretary meets US Trade Representative

International Trade Secretary Liz Truss has today (Thursday 27 February) met US Trade Representative Robert Lighthizer in London.

The Trade Secretary and Ambassador Lighthizer reiterated their commitment to get on with negotiating a free trade agreement and improving the bilateral trading relationship between the US and the UK.

The UK is set to publish its negotiating objectives next week.

The International Trade Secretary, Liz Truss said:

Securing an ambitious free trade agreement with the US is one of my top priorities, delivering benefits to towns across the whole of the UK from Edinburgh to Enniskillen.

We want an agreement that benefits both small businesses and entrepreneurs and every industry, from agriculture and manufacturing to professional and business services.

The UK stands ready to negotiate a highly ambitious free trade agreement with our biggest trading partner and will publish our negotiation objectives very soon.

Published 27 February 2020