**National Health Service reform and health care professions bill : first sitting, Tuesday 27 November 2001 (morning) / Standing Committee A.**

# PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT

## Standing Committee A

# NATIONAL HEALTH SERVICE REFORM AND HEALTH CARE PROFESSIONS BILL

*First Sitting*

*Tuesday 27 November 2001*

*(Morning)*



CONTENTS



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*Chairmen:* MR. ALAN HURST
MISS ANNE WIDDECOMBE

Atkinson, Mr. Peter (*Hexham*)
Baron, Mr. John (*Billericay*)
Blears, Ms Hazel (*Parliamentary Under-Secretary of State for Health*)
Burnham, Andy (*Leigh*)
Burns, Mr. Simon (*West Chelmsford*)
Challen, Mr. Colin (*Morley and Rothwell*)
Fitzpatrick, Jim (*Poplar and Canning Town*)
Hall, Mr. Mike (*Weaver Vale*)
Harris, Dr. Evan (*Oxford, West and Abingdon*)
Havard, Mr. Dai (*Merthyr Tydfil and Rhymney*)
Heald, Mr. Oliver (*North-East Hertfordshire*)
Hutton, Mr. John (*Minister of State, Department of Health*)
Moffatt, Laura (*Crawley*)
Murrison, Dr. Andrew (*Westbury*)
Taylor, Dr. Richard (*Wyre Forest*)
Thomas, Gareth (*Clwyd, West*)
Touhig, Mr. Don (*Parliamentary Under-Secretary of State for Wales*)
Ward, Ms Claire (*Watford*)

Mr. C. J. Poyser, *Committee Clerk*

# Standing Committee A

*Tuesday 27 November 2001*
*(Morning)*

[MR. ALAN HURST *in the Chair*]

## NHS Reform and Health Care Professions Bill

10.30 am

**Mr. Oliver Heald** (North-East Hertfordshire): On a point of order, Mr. Hurst. I welcome you to the Chair. The Opposition look forward to serving under you. We realise that you will be firm but fair. The Bill contains numerous order-making powers, many of which are being drafted—such steps are often taken in circumstances such as these—so that strategic health authorities, patients forums and so on can be established on 1 April 2002. In debating the programme resolution, and in terms of our proceedings as a whole, it would help if the Government could share with us information on any draft regulations that have been prepared and are ready to go. That would enable us to flesh out our debates and to know the exact detail of many of the proposals. Perhaps, Mr. Hurst, you could suggest to the Minister that that would be to the convenience of us all.

**The Chairman:** That is not a point of order but a matter for debate.

**The Minister of State, Department of Health (Mr. John Hutton):** I beg to move,

That —

(1) during proceedings on the National Health Service Reform and Health Care Professions Bill the Standing Committee do meet on Tuesdays at half-past Ten o'clock and at half past Four o'clock, and on Thursdays at half-past Nine o'clock and at half-past Two o'clock;

(2) 14 sittings in all shall be allotted to the consideration of the Bill by the Committee;

(3) the proceedings to be taken on the sittings shall be as shown in the second column of the Table below and shall be taken in the order so shown;

(4) the proceedings which under paragraph (3) are to be taken on any sitting shall (so far as not previously concluded) be brought to a conclusion at the time specified in the third column of the Table;

(5) paragraph (3) does not prevent proceedings being taken (in the order shown in the second column of the Table) at any earlier sitting than that provided for under paragraph (3) if previous proceedings have already been concluded.

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I join the hon. Member for North-East

Hertfordshire (Mr. Heald) in welcoming you to the Chair, Mr. Hurst. In a small but none the less significant sense, this is something of a parliamentary occasion. Members of the Committee might not be aware that you and I went to the same school, and I think I am right in saying that I was the first person educated at Westcliffe high school to become a Member of Parliament and you were certainly the second. This must surely be the only occasion on which two Westcliffe high school old boys have been involved in the passage of a Bill—one as Chairman and the other as the Minister leading the case for the Government. Others may not be terribly thrilled by that, but I am and I hope that you are too.

My hon. Friends and I are looking forward to making progress on the Bill under your watchful stewardship, Mr. Hurst, and I can promise that we will try at all times to be on our best behaviour and never to give you cause to bring us to book or admonish our conduct in any way. I am sure that the same can also be said of other members of the Committee.

The resolution, which we discussed with the Opposition parties as recently as yesterday, offers the Committee a sensible way to make progress on a Bill that is 40 clauses long. In trying to reach agreement on these matters, we have made a number of concessions, including increasing the representation of Opposition Committee members, increasing the number of sittings and lengthening the time for which the Committee sits. Such measures are needed if we are to scrutinise the legislation properly.

**Dr. Evan Harris** (Oxford, West and Abingdon): Will the Minister give way?

**Mr. Hutton:** In a moment.

I hope that members of the Committee will agree that the proposals that we ask them to endorse today are sensible and fair to both sides, and constitute a reasonable way in which to proceed.

**Dr. Harris:** In intervening on the Minister, I wanted the Government Whip also to hear my remark, but he has just left the Room. Has the Minister given any thought to the problem that I raised previously? I am having difficulty tabling an amendment given the clash on Thursday 29 November between the Committee and emergency business in the House, which was brought forward after negotiations were complete on the timetable and members were selected for the Committee. Does he see a way forward that would allow members of the Committee to take part in emergency health business in the House on Thursday afternoon?

**Mr. Hutton:** Whips have an uncanny ability to hear things even when they are not present, so the hon. Gentleman should not worry about my hon. Friend the Member for Poplar and Canning Town (Jim Fitzpatrick).

It is incorrect to say that the Human Reproductive Cloning Bill was introduced before we started discussions on the programme resolution. The Government made clear their intention to introduce that Bill some time ago, and we submitted our proposals on the programme motion to the Opposition last week. Yesterday, in the Programming Sub-Committee, we had an opportunity to discuss these issues, but the hon. Gentleman did not raise this matter. *[Interruption.]* I stand corrected if he did. On this occasion we must make some difficult choices. It is right that the Committee should meet on Thursday, and members of the Committee must decide how they want to allocate their time. I do not want to advise my hon. Friends not to meet on Thursday, and I am not in a position to help the hon. Gentleman with his predicament. My concern is to make progress with the Bill, and I ask the Committee to support me in that.

**Mr. Simon Burns** (West Chelmsford): As a fellow Essex Member may I add my words of welcome to you, Mr. Hurst. Notwithstanding the recent derogatory remarks of the Secretary of State for Health in the House that caused furore in the county of Essex, I have full confidence in an Essex man in the Chair of this important Committee.

In the Minister's opening comments, he alluded to, and glossed over, the fact that all was not well in last night's Programming Sub-Committee. The Government are seeking to rush the Bill through Committee in the same way that they are rushing their reform of the national health service, which has not been properly prepared for the added responsibilities of primary care trusts and strategic health authorities.

The Bill raises important issues about the future provision of health care in this country, and Government and Opposition members of the Committee would agree that we cannot afford to get it wrong because the danger is that problems will be inflicted on our constituents in the provision of their health care, a point that we have made on numerous occasions inside and outside the House. The abolition of health authorities and their regrouping into strategic health authorities means that 75 per cent. of funding for health care will be devolved to primary care trusts, and that is being done in an over-hasty way that holds serious implications for health care provision. There are several key issues that must be properly and thoroughly discussed in Committee, which will help the Government to avoid mistakes that they may be making in their haste. For the Committee to finish its deliberations by 18 December is too short a period.

During our discussions yesterday, the official Opposition originally wanted six members on the Committee and suggested that we should sit into January so as to have a proper opportunity to discuss in a considered and measured way the important issues concerning strategic health authorities, primary care trusts, quality and, an issue that has not yet been raised but, I assure you, Mr. Hurst, will be raised later during our proceedings, the highly contentious and irresponsible provisions of clause 20. The Government seem hell-bent on resisting any sensible approach and continuing with their ill-thought-out proposals prior to the last general election to abolish community health councils, which provide an independent voice for patients throughout the country.

*[Mr. Simon Burns]*

I am sure that as a constituency Member, Mr. Hurst, you will have received many representations from the excellent mid-Essex community health council and even from its former chairman, who was a Labour district councillor in Braintree, about their opposition to abolition of the councils. We have the impression—we want to discuss it more fully in Committee—that the Government are simply making this pernicious and petty move because they will brook no opposition. If anyone has the temerity to highlight concerns about their actions, they do away with the organisation because it does not fit in with Millbank's script on the image that they want to portray.

To do our work properly and fully, we need more Committee members than the Government have offered and to sit longer so that our discussions are not rushed, but the Government are determined not to accept that. If my information is correct, they informed the official Opposition that we could have four Members on the Committee and that we could sit until 13 December. That was totally unacceptable and we were not prepared to compromise, so the Government returned shortly afterwards and said that they would allow five Members and two extra sittings on Tuesday 18 December. We still believe that that is not long enough, but it would be fruitless to negotiate. The Government are determined to use their majority on the Committee to ensure that they get their own way.

The official Opposition are opposed to the programme resolution for the reasons outlined. We believe that we should have more time and an extra Member on the Committee to help us in the duty of an official Opposition, which is to study, question, probe and monitor legislation. We should ensure that legislation on the most far-reaching reforms to the health service, some say since 1974 and others say since its inception in 1946-48, is properly scrutinised, fine-tuned, improved when improvement is needed and changed if humanly possible. We need the opportunity to try to persuade the Government to think again about those areas that we believe are utterly wrong so that the legislation that goes on to the statute book will improve and enhance the health care provision for our constituents. For those reasons, we cannot support the Government in their programme resolution.

**Dr. Harris:** I beg to move, as an amendment to the resolution, after paragraph 5 to add

'(6) provided that Clauses 7 and 8 shall be taken at the morning sitting on Thursday 29th November at half-past Nine o'clock and be concluded by twenty-five minutes past Eleven o'clock.'.

I welcome you to the chair, Mr. Hurst, and both Ministers to the Committee. As the hon. Member for West Chelmsford (Mr. Burns) said, the Bill is important.

**Mr. Heald:** On a point of order, Mr. Hurst. Is the amendment in order? A meeting of the Programming Sub-Committee certainly took place last night, and it was a most unsatisfactory affair, but is it in order for an hon. Member to propose an amendment today?

**The Chairman:** It is in order. I have the amazing power to select or not select amendments when tabled. I have decided to select the amendment, so it is in order.

10.45 am

**Dr. Harris:** I am grateful to you, Mr. Hurst. I take the opportunity to apologise, if an apology is in order, to the Front-Bench spokesmen for not giving them notice of the amendment. I raised the matter on Thursday afternoon at the Programming Sub-Committee, as I think the hon. Member for West Chelmsford recognises, but it was never adequately resolved. It was raised, however, and the Minister is either mistaken or forgetful in suggesting that it was not.

The Bill requires adequate scrutiny because it makes quite a few changes, not least in clauses 7 and 8, which are two of the many that require scrutiny. However, matters in the House also require adequate scrutiny and when the selection was made for Committee, there was no thought that important primary legislation would come before the House on the afternoon of Thursday 29 November.

There was also a proposal for a debate in the House on the Bristol royal infirmary inquiry and the Kennedy report, which pertain to this Bill. On Second Reading, Ministers said that what they sought to introduce under the Bill dealt with some of those concerns. I had a conversation with the Government Whip and, through what could be considered unusual channels, I was given an indication that whether it was feasible to discuss issues connected to the Kennedy report in Committee at a time when the House would also be substantively debating it for the first time would be seriously considered. I was given a reassurance, which one can only assume was given in good faith, and I accepted it in the same manner.

Then followed a change in business, well after negotiations on the draft timetable were concluded. It was announced only last Thursday that the House would discuss emergency primary legislation, in which many hon. Members including me will have an interest, on the afternoon of Thursday 29 November, when this Committee is also sitting. In private meetings and the Programming Sub-Committee, I have sought flexibility for this Thursday's sitting to enable hon. Members with an interest in the emergency primary legislation to perform their duty of scrutiny in the House as well as in Committee. My amendment should not find disfavour with Conservative Front-Bench spokesmen. I apologise for not having given them a manuscript version of the amendment.

I seek to include in the timetable, while there is still time to table amendments to clauses 7 and 8, a provision allowing us to discuss those clauses during the morning sitting on Thursday 29 November, rather than be forced to miss such an opportunity due to a Second Reading, Report stage and Third Reading in the Chamber on that day. I hope that that finds favour with the Minister, with Government business managers and with the official Opposition. There is a

huge amount to debate by 5 o'clock on Thursday and we still have the scope to do that. In the spirit of co-operation, I hope that that might find favour. Clearly, I cannot vote it through by myself without support.

I have some sympathy with Conservative Members' view of the position in which we find ourselves, with large amounts of legislation being rushed through using programme motions. I should put it on the record that I accepted 18 December as a fair end date; I do not want to run with the hounds and the foxes. Nevertheless, given that we were assured that it would be possible to arrange extra sittings before 18 December, the Government should exercise flexibility in relation to the clash of scrutiny that some members of the Committee may face.

**Mr. Heald:** The trouble with packing in extra sittings on Monday and Wednesday is that it does not solve the problem that outside bodies that are watching our proceedings and want to help us as the debate matures are unable to do so if we have insufficient time in which to table amendments and new clauses that deal with certain issues in a slightly different way. It is a bastardisation of the system.

**Dr. Harris:** I am prepared to agree with the hon. Gentleman that it is far better to have an agreed programme than to have to squeeze in extra sittings.

I have no problem with five, six or seven Conservative Members serving on the Committee, and I made no representations against that. However, there is only one of me on my party's Front Bench; my colleague on the health team is serving on the Committee that is considering the Adoption and Children Bill.

I am delighted to welcome the hon. Member for Wyre Forest (Dr. Taylor), who sits as an independent and to whom the business managers who look after the minor parties have been more than willing to give a place. Conservative Members on the Select Committee on Health have done the same. The hon. Gentleman will be torn between Select Committee meetings and sittings of the Committee on Thursday mornings, and I hope that members of the Committee will understand if he sometimes has to be absent from the proceedings in order to do the job of scrutiny in the Select Committee system. As the Minister said, there are great demands on our time, and we will have to exercise judgment, but I hope that the Government majority will show flexibility.

**Mr. Heald:** The hon. Member for Oxford, West and Abingdon (Dr. Harris) makes a good point. Some members of the Committee will want to attend the debate on the Human Reproductive Cloning Bill on Thursday afternoon, and it would be convenient to deal with clauses 7 and 8, which are very important, during the morning sitting. We therefore support his amendment.

In terms of the way in which the debate in Committee matures, Oppositions parties are disadvantaged if extra sittings are packed in. Any self-respecting Member can speak at great length on any subject and make an interesting contribution to any part of the debate. However, such contributions are best when they are informed by the views of outside bodies that are concerned about the issues and have practical experience of them. Shortening the Committee's deliberations puts them at a disadvantage, and if extra sittings are packed in there is even less time for them to meet us to talk about the concerns that it is our duty to put forward. It is wrong for the only option always to be, "Let's pack in some more sittings and keep to our timetable." The Government should be more flexible on that.

The Bill is a skeleton, without flesh, a Christmas tree without baubles. *[Interruption.]* I notice that the Whip enjoyed that one. There are numerous order-making powers in the Bill, as usual, which is the modern trend. To know what is really proposed, we need to see the details of the draft orders, which will be being prepared. No one is nodding, but I am sure that they are. Why should we, as parliamentarians debating the material, not know what is really proposed? We would like to see those details.

The Minister has not jumped at the suggestion that I made at the outset that he should give us all those documents now, saying, "Oh yes, of course, let's do that." That is disappointing because we cannot really tell how long we need until we know the detail. I venture to suggest that if the Minister produced all the draft orders and regulations that are up his sleeve, it might shorten the proceedings. As it is, we will be asking a vast number of questions about exactly what is proposed.

Those are the difficulties that I see, in addition to those that my hon. Friend the Member for West Chelmsford raised. It is sad if a Government cannot meet an Opposition halfway, or at least agree to the approach to Committee business that an Opposition want.

**Mr. Burns:** Does my hon. Friend recall that, during the Committee stage of the Health and Social Care Bill earlier this year, the Minister's predecessor, the right hon. Member for Southampton, Itchen (Mr. Denham), was faced with exactly the same problem that my hon. Friend outlines? He listened to the Committee's arguments and in the end became extremely helpful. He made available, where possible, the draft orders so that we were better informed to discuss the contents of the Bill.

**Mr. Heald:** My hon. Friend makes a good point. If the Minister and his officials have not prepared the draft orders, when they are thinking of implementing the legislation on 1 April 2002, what a desperate mess they are in.

**Mr. Hutton:** It might be of benefit to the Committee if I try to respond to some of those points now. That might save some Opposition Members from detaining the Committee any further.

When I moved the programme resolution, I had not seen the amendment of the hon. Member for Oxford, West and Abingdon. I am happy to accept it; I think that it is a sensible way to proceed. In future, I am sure that Committees will benefit if some of the phoney rhetoric that we have just heard from the Opposition could be suspended. We hear such talk, claiming that

*[Mr. Hutton]*

the Government are trying to ramrod their business through and keep Committee members uninformed, every time. That is not our intention, and that is not how I intend to run this Committee.

As a signal of our intention to keep Committee members properly informed, I have produced for them a further explanatory note on the transfer of functions to primary care trusts. I wanted to mention that when debating the clause. It is now on the table for hon. Members to study. We intend throughout to try to keep Committee members fully informed. If we are in a position to share with them any draft regulations ready to be circulated and discussed, we will do so. The hon. Member for West Chelmsford rightly referred to the practices of my predecessor, my right hon. Friend the Member for Southampton, Itchen, and I am pleased to say that, when I am in a position to do the same during the Committee stage, I will.

I have considered the amendment and am happy to accept it as a sensible way of proceeding. I am grateful to him for drawing the issue to the Committee's attention.

11 am

**Dr. Andrew Murrison** (Westbury): Many of us are from Essex, either by birth or election: I add my name to that list, and I know that one of my hon. Friends sitting to my right will also do so in due course. Let us hope that that reflects the quality of the Act that ultimately emerges.

I am concerned about the haste with which such an important Bill is being rushed through. As someone who has worked in the NHS, it is dear to my heart. The Bill will fundamentally change the way in which the NHS operates; it is not, by any means, merely tweaking. Therefore, the sort of programme that we have concerns me. The issues need to be adequately exposed; in particular, we need to have the comments of outside bodies.

Only this morning I received a representation from the Local Government Association, and I am sure that many hon. Members have received the same one. Such representations seem to be arriving daily, but I am told that the normal experience is that they usually come in dribs and drabs during the Committee stage. We cannot assume that outside bodies are sufficiently organised to pass their representations to us in good time. They expect Committee stage to last a reasonable length of time so that they can comment as it proceeds. I am rather concerned that supportive outside bodies on which the Committee should rely quite heavily will not have that opportunity.

There are substantial concerns about the Bill, especially as it relates to community health councils—a subject that we shall debate in due course. Somewhat to my surprise, my postbag has been flooded with expressions of concern about community health councils. The strategic health authorities are also causing considerable concern among the general public, although that is largely the result of some misunderstandings about the way they are to be put together.

In short, I urge that we are given more time in which to debate this important Bill. I am sure that the quality of the legislation will be markedly improved as a result.

*Amendment agreed to.*

*Main Question, as amended, put:—*

*The Committee divided:* Ayes 13, Noes 5.

**[Division No. 1]**

**AYES**

| | |
|---|---|
| Blears, Ms Hazel | Hutton, Mr. John |
| Burnham, Andy | Moffatt, Laura |
| Challen, Mr. Colin | Taylor, Dr. Richard |
| Fitzpatrick, Jim | Thomas, Gareth |
| Hall, Mr. Mike | Touhig, Mr. Don |
| Harris, Dr. Evan | Ward, Ms Claire |
| Havard, Mr. Dai | |

**NOES**

| | |
|---|---|
| Atkinson, Mr. Peter | Heald, Mr. Oliver |
| Baron, Mr. John | Murrison, Dr. Andrew |
| Burns, Mr. Simon | |

*Question accordingly agreed to.*

*Resolved,*

That—

(1) during proceedings on the National Health Service Reform and Health Care Professions Bill the Standing Committee do meet on Tuesdays at half-past Ten o'clock and at half past Four o'clock, and on Thursdays at half-past Nine o'clock and at half-past Two o'clock;

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(6) provided that Clauses 7 and 8 shall be taken at the morning sitting on Thursday 29th November at half-past Nine o'clock and be concluded by twenty-five minutes past Eleven o'clock.

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**The Chairman:** We now move to preliminary business. Copies of the financial resolution that has been tabled are in the Room. I remind members of the Committee to provide adequate notice of amendments. As a general rule my co-Chairman and I do not intend to call starred amendments.

## Clause 1

ENGLISH HEALTH AUTHORITIES: CHANGE OF NAME

**Mr. Burns:** I beg to move amendment No. 1, page 1, line 5, leave out from '(1)' to 'Health' and insert 'From 1st April 2003'.

The first amendment is very straightforward. If accepted by the Government, it would change subsection (1) by saying that the proposed change of name of the health authority would have the knock-on effect of postponing implementation of the wide-ranging changes to 1 April 2003.

In "Shifting the Balance" the Government outlined a time scale for changes to PCTs, for the creation of strategic health authorities and for the abolition, in effect, of health authorities in England. According to that document, consultation on the proposed strategic health authorities will last from September to November, and the chairmen and chief executives designate will be appointed in November. That is cutting things fine. One presumes that the consultation period has been established so that the Government can properly analyse, assess and digest the results, but their intention to appoint the chairmen and chief executives in the same month as it ends—should they keep to the proposed time scale—adds to our fears that the measure is being rushed. I genuinely believe that a deadline of November 2001 for designated appointments and one of April 2002 for the establishment of the new strategic health authorities and the disestablishment of existing health authorities leaves too short a time.

With that in mind, the purpose of the amendment is twofold. First, it is designed to find out whether the Government are indeed keeping to the time scale outlined in "Shifting the Balance", what progress they are making in terms of the April 2002 target date, the way in which interested parties responded to the consultation process, and what consideration the Government have given to those responses. Apart from probing, the amendment has a second and more defined purpose, which is to advise the Government to think again about rushing in, and to accept the amendment so that strategic health authorities will not be set up until a year this April.

If the amendment were accepted, there would be a knock-on effect on consistency, clarity and the way in which the system works. I appreciate that the Government have put together a package and that therefore many elements rely on others. If the introduction of SHAs is postponed for 12 months to April 2003, it is logical to postpone changes to the functions and establishment of 100 per cent. of PCTs. They come as a package, and the one cannot work without the other. I accept, therefore, that however innocuous and helpful to the Government the amendment might be, it would have a wide-ranging knock-on effect on the first five clauses.

I urge the Minister not to reject the amendment out of hand. As I have said, it is intended to be helpful. It is not the Minister's intention to introduce botched or rushed legislation; he, like any other hon. Member—or, in his case, right hon. Member—wants the best

*[Mr. Burns]*

possible legislation. On that basis, I anticipate his appreciating the fact that we are doing the Government a service by tabling an amendment that errs on the side of caution to ensure that there is no headlong rush that will cause considerable confusion and might destabilise the position.

There are approximately 104 health authorities in England and Wales. When the SHAs are set up, they will reduce dramatically the number of bodies at what is, for all intents and purposes, the health authority level of the NHS: fewer SHAs will cover larger areas and populations. In the context of the Government's aims, I understand the logic of their proposals. However, health authorities are currently the purchasers of health care for our constituents.

**Dr. Harris:** Language is important. The Government have done little to change the so-called internal market, but they have changed the language. We no longer talk about purchasing; instead, we talk about commissioning. I fear that I am on the hon. Gentleman's side when I say that the change is only a change of language; it is not the sort of change that it was purported to be.

**Mr. Burns:** I am grateful to the hon. Gentleman. I appreciate that language is important. I was trying to be realistic about what is happening, rather than fall into the Millbank spin. He will appreciate that language will become more important if the Secretary of State has his way and brings back the internal market, about which Government Members have been so rude for the past few years. However, I digress.

Health authorities, which have been localised to cover smaller areas than the proposed SHAs, will be abolished in the next four or five months if the proposed time scale is kept to—and it will be. Many of their functions will be transferred down to PCTs, which will cause a problem because at least 130 primary care groups have not even applied for PCT status. There will be a headlong rush if the Government are to have all the PCTs in place before the 1 April 2002 deadline. Everyone knows that when structures change—especially when significant additional responsibilities and functions are placed on those structures—there is great uncertainty and a sense of feeling the way forward. Do Government want such a situation to arise? Do they fully appreciate the implications of what they are doing within their proposed time scale?

SHAs will be discussed in detail in connection with later amendments. They, too, will be finding their way in the early stages following their creation. I suspect—the Minister may be able to enlighten us—that there is conflict in several areas: for example, have the SHAs' geographical areas been resolved satisfactorily? I presume not, because that is one of the matters that the consultation process is to examine. Stories are beginning to circulate of people in some parts of the country being confused about why their geographical area is to have only one or two strategic health authorities whereas another area, perhaps in the same region but geographically separate, is to have significantly more SHAs covering its population.

11.15 am

Staffing will need to be arranged. It is fair that the Government have time scales for appointing chairmen and chief executives designate, but SHAs will need other staff. Their full role will need to be sorted out and the way in which the Government want them to fulfil their functions will have to be made clear. We must also examine the functions that the health authorities have had, in particular the handling of health service funding, which is to pass from the SHAs to the PCTs. I suspect that that will raise many problems if care is not taken, mainly because the new bodies will lack experience.

I urge the Minister to say more about the progress of the consultations and the time scale between now and 1 April 2002, especially the crucial issue of whether there will be enough time to have in place bodies that are fully competent and capable of fulfilling their functions on 1 April 2002. They might not have enough time to prepare.

**Dr. Richard Taylor** (Wyre Forest): I am pleased to be here because it is important to have an Independent Member on a Committee such as this one. I am speaking not as one who has a political background, but for patients and the professions. I support the amendment because as soon as we have strategic health authorities, we must have primary care trusts. I am very concerned that only a few PCTs have been formed so far; although they may be ready to go, I am sure that those that are still PCGs will not be ready, bearing in mind the extra services that they will have to take on which were previously county-wide. In my county, Worcestershire, two of the three groups are still PCGs and have no idea of how they will take on the extra responsibilities.

I strongly support the amendment. It was because I do not wish to delay the Bill that I did not vote against the programme motion.

**Mr. Heald:** I am following the hon. Gentleman's speech closely. Does he agree that it is extraordinary that some PCTS still have no idea what their budgets will be next year?

**Dr. Taylor:** To picking up that point briefly, my own PCT knows that it will get 75 per cent., but it badly wants to know 75 per cent. of what.

I support the amendment. I am in favour of much of the Bill, but the changes could be introduced more slowly to give some PCTs the option to start under the old health authorities so that primary care groups have a little more time to get ready.

**Mr. John Baron** (Billericay): I, too, support the amendment. It is easy for members of the Committee to make political points, but the Bill must be properly thought through because it will introduce fundamental changes to the workings of the NHS.

I want to highlight some early findings of the British Medical Association and other bodies that have suggested that we should take more time to consider the Bill. The general feeling in the medical profession is that it is being rushed through: for example, at a meeting in the west midlands a couple of weeks ago, senior health, local government and business representatives reached a consensus that the planned configuration of strategic health authorities and regions will be too large and diffuse to engage effectively with primary care trusts and local authorities.

**Mr. Hutton:** As I understand it, the hon. Gentleman is saying that the strategic health authorities will be too large, but he will be aware that Conservative Front Benchers have tabled an amendment suggesting that they should be larger still. Will he support that amendment?

**Mr. Baron:** My point is that there has not been enough clear and joined-up thinking about the responsibilities of SHAs in terms of their communication and relationship with PCTs. That leaves open many questions that people in the medical profession cannot answer: for example, how will conflicts be resolved? The BMA has noted that PCTs will be accountable for their performance to SHAs through individual performance agreements. That is fairly straightforward. However, SHAs will also be expected to manage the performance of PCTs across organisational boundaries and to broker solutions if necessary. The BMA has questioned how conflicts between SHAs will be resolved—although they will be accountable to the Secretary of State.

The BMA is concerned, as are we, that neither the Bill nor the document on shifting the balance of power within the NHS allocates responsibility for safeguarding or fostering academic activity. Unless such provision is made, benefits to the health service, including clinical service and education, will be lost. Moreover, the decline in recruitment and retention in academic medicine will continue.

The BMA has pointed out that it is unclear whether the responsibility for co-ordinating and collaborating on the provision of tertiary services will lie with SHAs or with the new regional directors of health and social care. I hope that that will be made clear in the course of the Committee's proceedings. The Bill does not make it clear to those who have to operate at the coalface how such issues are to be resolved. We need to give it more careful consideration and delay its implementation until it is suitably amended.

I have another concern, which has already been touched on by other hon. Members. Although PCTs are not directly linked to SHAs, there is a strong connection with the operation of the NHS at the coalface. My concern is that PCTs are not ready for the responsibilities that they will be taking on from next April. From visits to the two PCTs covered by my constituency, I know that they feel that, organisationally, they are a little behind the curve. I know that some PCTs are already up and running, but the fact remains that there will be quite a rush into mergers between PCTs and PCGs, whether that is wanted or not.

PCTs are taking on responsibilities for which some of them—not all, but a good number—are not fully prepared. I think that I am right in saying that one in seven of existing PCTs do not have a finance director. That is crucially important because there will be a major shift of resources to PCTs: 75 per cent. of total NHS spending will eventually end up in their hands. If the management and organisational structure is not in place by next April, there will be major problems in delivering the services that our electorate want.

The Government have supported the survey carried out by the National Primary Care Research and Development Centre in collaboration with the King's Fund. It suggests that there are many doubts about some PCTs' abilities to absorb the pace of reform. Professor David Wilkin, the project director, has said that the pace of change has been dictated by Government timetables rather than by a

"process of learning and building on experience".

That point is crucial. We are rushing into something and we need more time to consider it, not only within the House. We must delay the implementation of the legislation or there will be real problems at a time when the real crisis in the NHS—increasing waiting lists and poor care at the point of delivery—is not being confronted, at least not by the Bill as it stands. We should be addressing that, rather than carrying out a fundamental restructuring that no one in the health service or the medical professions wants.

**Andy Burnham** (Leigh): The hon. Gentleman says that no one in the health service wants the changes. Why did most major health organisations welcome the Bill's measures in the briefings that they sent for Second Reading?

**Mr. Baron:** At the moment, because the Bill is being rushed through so quickly, we are getting a response from a wide sector in the NHS and from medical bodies generally. We are getting conflicting messages from that, because no one has had time truly to consider the implications. Various reports commissioned by bodies such as the King's Fund or the National Primary Care Research and Development Centre say that the Bill is being rushed through. No doubt, the Government will find voices that say that it is not, but the bottom line is that many working in the NHS think that it is.

**Andy Burnham:** Did the hon. Gentleman read the briefing prepared for Second Reading by the King's Fund? It welcomes the Bill and endorses the proposals in it.

**Mr. Baron:** I respectfully point out that that welcome contained many provisos. Many dissenting voices suggested concerns at the way in which the Bill is being rushed through. One could refer to the findings in many other surveys. The BMA, which is working at the coal face, thinks that there are real concerns with it.

**Mr. Heald:** Something such as a PCT is a very good idea, but not if it is micromanaged by the Health Secretary, has 408 targets and is rushed through. Does my hon. Friend agree that there are ideas in the Bill that can be welcomed, but that the trouble is that it is half-baked?

**Mr. Baron:** I agree with my hon. Friend. The idea that PCTs will decentralise is wrong. If more moneys are being made available and PCTs are allowed to use them as they see fit, that would be decentralising. However, the problem is that targets will accompany extra finance. If those are not met, money will be withdrawn and not made available. This is a further micromanagement of the NHS and not a decentralising measure at all.

Although some may welcome certain parts of the Bill because they believe that it is decentralising, the detail shows that that is far from the case. That is why we need more time to consider the Bill in this place, and to delay implementation. Many in the health profession have severe reservations about the Bill and we need to delay implementation to ensure that patients do not suffer unduly.

11.30 am

**Dr. Harris:** As I said on Second Reading, I oppose this structural change because it misses the point about the challenges facing the health service. The Government seek to make structural change partly for the sake of seeming to be doing something. I have plenty to say about that, but I will reserve my comments to the debate on clause stand part. I will not respond to all the points, some of which were valid and some of which I would challenge.

I will address my remarks to the time scale. The Government seek to bring about structural change to create a flurry of activity that disguises the failings of the health service and shifts the debate and blame away from them. On the radio on Sunday evening, we heard a clue to Government thinking when the right hon. Member for Norwich, South (Mr. Clarke), the Minister without portfolio, made it clear that he accepted that the health service was not in a much better shape than when his Government came to power four years ago, and that they were running out of time to deliver an improved health service, or even the perception of an improved health service, before the next election. When we see such a rushed time scale from the Government, we must bear in mind that that lack of time will dominate their thinking on a time scale for change.

**Mr. Burns:** I am sure that the hon. Gentleman would not want to misrepresent the right hon. Member for Norwich, South. That Minister said, rather surprisingly for a member of a Government controlled by spin, that in certain areas the health service was worse under his Government than under the previous one.

**Dr. Harris:** Yes, I remember that being said. I think that the take-home message is that, on average, the health service is no better. The health service was failing when the Government came to power. They have not only failed to deliver substantive change so far, but have raised expectations of being able to deliver while foolishly sticking to spending plans, which have previously failed the health service, for more than two years.

**The Chairman:** Order. The amendments are narrowly drawn and we are slipping into a Second Reading debate.

**Dr. Harris:** Thank you, Mr. Hurst. I could offer the old excuse of being led astray, but I shall not dare.

The Government's proposal for a timetable to make changes by next April is predicated on a hope that structural change will deliver. However, I see no evidence of such structural change if the Government continue to retain so much control and responsibility, and they will continue to deserve much of the blame or praise for what happens. That will do nothing to bring about improved delivery. I suspect that the Government would prefer a time scale in which the changes are introduced by April 2003, but they know that that leaves the changes little time to bed in and would cause additional chaos to that caused in the interim, when new structures are being introduced to under-prepared bodies, hard-pressed managers and health care professionals. They know that they could not run that risk so close to the next election.

**Gareth Thomas** (Clwyd, West): We are debating an amendment on the timing of the implementation of these changes. Does the hon. Gentleman accept that there has been extensive consultation with regard to the broad thrust of the Government's policy? He need only remind himself that the Government have published several consultation papers over a long period of time, such as "The NHS Plan: A plan for investment, A plan for reform" in July 2000, and "Shifting the Balance". Unlike the official Opposition, his party has Members from Wales. Although there are several Essex Members on the Opposition Benches, there are none from Wales. Furthermore, the National Assembly for Wales produced a paper called "Improving Health in Wales—Structural Change in the NHS in Wales"; there has been extensive consultation.

**Dr. Harris:** I am grateful to the hon. Gentleman for raising that point, but consultation papers do not work if they do not mention the relevant changes. The Library's paper on the NHS plan, which is as good a summary as I have seen, states:

> "The *Plan* itself did not promise significant structural change in the roles of NHS institutions".

Indeed, many organisations that signed up to the NHS plan did not realise, although they should have done, that that did not assure them of the stability they needed to deliver its challenging and sometimes worthwhile plans, proposals and targets. People were lulled into a false sense of security by the promise that, finally, after years of change, there would be stability in the NHS, which would allow it to start delivering for patients and to get on with other areas of the Government's policy, such as the quality agenda.

Those organisations were wrong because less than a year after the publication of the NHS plan, which one should have thought would set out structural changes, the Secretary of State issued a press release—a speech went with it—on 25 April, saying that the plan was to be changed, and that this change was going to be brought in quickly.

The Government have had to consult quickly on the structures. Are they finding that they must rush important matters? According to their timetable, it is clear that they have not finished the consultation on the boundaries of SHAs. However, they propose to appoint chairs designate and chief executives designate to bodies for which the boundaries have not been set. Many chairs designate will be seeking to demonstrate in the appointment process that they have local knowledge of clinical networks and partnership issues. Can the Minister reassure me that the Government will not shortlist such positions until their boundaries are settled? If they do so, they will jump the gun, and will discriminate unfairly against applicants whose strength is their knowledge of the local area, or, as it will be called, the strategic area, the boundaries of which have not been set.

The Minister must also respond to the allegation that the unseemly rush in which managers, who are beset by performance targets—many of which are political and distort clinical priorities—that they are hard pressed to deliver have to apply for different jobs within the structure. That cannot be a healthy situation, and although I understand that it is a consequence of change—one cannot oppose all change on that basis—to do so in such a rushed way will cause significant problems at a challenging time. We know that morale is poor.

**Mr. Heald:** When one transfers a function, one tends to discuss it as though it were inanimate. We are discussing taking away the person who knows everything about, for example, the assessment of need, the planning and securing of health services and the improvement of health in a particular area, and possibly giving someone else the job. Does the Minister agree that the timing must be right in those circumstances, otherwise situations may arise where vital management issues are simply not being addressed?

**Dr. Harris:** Yes, I concur with that. The point that I want to make is that our most experienced managers are the ones on whom we rely to make some sense out of the balance between patient needs and political needs. Those managers are sorely tried at the moment. Many of the best managers will say, "Up with this we will not put"—continuous change, continuous blame and the prospect of continuous shifting of that blame, with the myth that 75 per cent of the power is being dissolved locally, when, as Conservative Front-Bench spokesmen put so well on Second Reading, that the opposite is the case.

The combination of the rush and the Government's apparent desire and need to shift the blame on to managers and clinicians will have a dramatic effect on the ability to retain managers, many of whom are effective given the under-resourcing.

I am opposed to the whole proposal, so I am not putting forward amendments to make a proposal to which I am wholly opposed any better or worse, but I have some sympathy with the thoughts behind this amendment. Will the Government jump the gun in terms of appointing or shortlisting chairs designate to strategic health authorities where boundaries have not yet been agreed?

**Dr. Murrison:** The litmus test for whether the Government are proceeding at too rapid a rate, is how far we are ahead with the appointment of chairs to the strategic health authorities. Perhaps the Minister might like to comment on that. If we are behind the curve, it may show that we are moving too rapidly and that we need more time.

The human aspect that has been alluded to is important, and has perhaps been overlooked in all of this. We are talking about people who have a huge amount of skill and experience as chairs, as members of the general public, and as officers within the national health service, seeing their career's being fundamentally altered by all of this. The way that this will work in practice, is that people will see SHAs as the bodies to which they aspire and PCTs as something to go for in the event that they are unsuccessful in becoming chief executives or chairs of strategic health authorities. Many people will be a need to get the timing right. I can tell the Minister that there is a huge amount of confusion at the moment about those who aspire to chairman roles and those who aspire to be chief executives, and how that time is actually going to pan out.

My chief concern about the timing is due to the palpable confusion in the minds of those among the general public who take an interest in these things. Constituents suggest that there is a very real confusion about the role of PCTs and the role of strategic health authorities. There is concern over the boundaries, and more particularly, about the division of responsibility between the two bodies. We must accept that the Government have got their communication wrong with this matter. It might be very prudent for the Government to think about extending the timetable, which will at least give them some time to get their message across.

There are very real concerns among the general public about how strategic health authorities will affect the treatment that patients receive, and the referral patterns in clinical networks. I am in no way an apologist for the Government, but I have spent some time over the past several days reassuring constituents that strategic health authorities will not affect, as far as I am able to tell, the pattern of referral that they might expect. A great deal of that has to do with changes to the proposed boundaries in my particular constituency.

*[Dr. Murrison]*

There is a very real need to get the message across to those people that the NHS is changing rapidly. We have heard the right hon. Member for Norwich, South reflect upon the way in which the NHS has changed for the worse over the past several years. We are rethinking the notion of "24 hours to save the NHS", are we not? However, we need to take time. The Bill will implement changes, and although I do not think that they will alter the health outputs that patients will enjoy, it is still important, especially for those working in the NHS—a deeply demoralised group of people—that we calm down, and take our time in considering the Bill. That is why I have voiced my profound concern at the pace at which things are going.

11.45 am

**Mr. Heald:** I have one or two points. When Sir Humphrey said to the Minister that something was a courageous decision, the implication was that it was a pretty stupid thing to do. The Royal College of Nursing has described the timetable for the changes as "ambitious". I suggest that a similar message is inherent there. To pick up on the point made by the hon. Member for Leigh (Andy Burnham), there are things that individual bodies will welcome in such a Bill, but all the briefings that I have seen raise concerns on a wide range of issues in it.

The Opposition have always said that a PCT, as an idea, is a good basis that could be built on. However, last year, or in 1999, when the Bill that set up PCTs was being passed, the Minister promised that they would not be forced on anyone and could evolve through the patient care group process. What has happened since to make matters so urgent that PCTs are now to be forced on all areas of the country, whether they are ready or not, on 1 April 2002? We think, although the Minister might think this cynical, that it is because there has since been a bad winter and the Prime Minister has promised the unrealistic target—or so it looks, on the proposals that have been made—of getting British health spending up to the European average, which would mean an extra £35 billion a year. This, therefore, is the alibi; organisational change.

The health press, whose writers are almost certainly not Conservatives, echoes those concerns; for example, in the *Health Service Journal*, an impartial magazine. The magazine believes that we are seeing alibi-building that is unhelpful, disruptive, mistaken and that will slow down the implementation of the NHS plan. It contains articles in which former senior officials from the Department of Health say that the process is extremely unhelpful. The RCN says that the timetable is ambitious.

The hon. Member for Oxford, West and Abingdon expressed concern about how the change will affect management functions. That is an important point. All over the country, there are individuals whose responsibility is the assessment of need, planning, securing health services and improving health. Those individuals work in health authorities, although some of them have transferred to primary care trusts. They provide the important management functions essential to the Government's delivery of the NHS plan.

What are those people doing at the moment? Are they concentrating on delivering the NHS plan? Perhaps the Minister can tell us, but I suspect that at the moment, they are writing their curriculum vitae, because they all need a job. They do not know whether they will be moving to a particular PCT or SHA, or to another region. Many managers in the NHS have pointed out that those people are key to the process of delivering the Government's ambitions and are being disrupted by the change.

Is the system ready for the change? The second national tracker survey of primary care groups and trusts carried out by the National Primary Care Research and Development Centre, in collaboration with the King's Fund and supported by the Department of Health, says that what is needed is not extra resources, but managers with the right skills and experience coming through the system. Although managers from trusts and health authorities can be taken on, they do not necessarily have the requisite primary care skills. As has been said, many of the finance staff are not yet in place.

Clearly there is a political imperative to push this through quickly to provide the alibi for performance in the NHS, but does the Minister really think that the SHAs and PCTs are ready for it to happen on 1 April 2002? In many cases, the necessary staff are not in place and they do not know what their budgets will be. It is a mess in the making. For us to ask for an extra 12 months is not a big deal. It was not prompted by political considerations, but by people who are out there trying to do the job saying that they are not ready. Will the Minister bend on this issue?

**Mr. Hutton:** I am always happy to bend in the hon. Gentleman's general direction, but, sadly, not on this occasion. The hon. Member for West Chelmsford said that he was afraid that I would reject the amendment out of hand. I will ask my hon. Friends to reject it, but not out of hand, as we have looked at it carefully and listened to Opposition Members. I was left in some doubt about whether the hon. Gentleman wanted to press it to a vote. He described it as a probing amendment, but his hon. Friend the. Member for North-East Hertfordshire made rather more of it. What is its status?

**Mr. Burns:** The Minister is again showing, as he showed last night, that he is not fully listening. The amendment is two-pronged; it is partly a probing amendment, but there is also a real intent behind it. The probing element addressed the lack of knowledge of what is going on in terms of consultation and the time scale between now and April, and the second element addressed the fact that the measure is rushed. My speech was structured around both those points.

**Mr. Hutton:** It was a very cleverly structured speech, then. *[Interruption.]* I am trying to be kind and generous to the hon. Gentleman; I am sure that that will do him no end of good on his own side of the House. He clearly wants to press the amendment to a

vote. I shall urge my hon. Friends to reject it, for reasons that I shall explain in a moment.The hon. Gentleman and the hon. Member for Oxford, West and Abingdon performed a rather disappointing and predictable double act. Conservative Members are increasingly opposed to any extra investment in the health service—

**Mr. Burns:** No, we are not.

**Mr. Hutton:** It is obvious. The hon. Gentleman has clearly not been reading the recent speeches of his right hon. Friend the shadow Chancellor, nor those of the Leader of the Opposition, who have talked about reducing the share of public expenditure to 35 per cent.

**Mr. Burns:** Rubbish.

**Mr. Hutton:** It is rubbish, but it is coming from the Opposition, not the Government.

As my right hon. Friend the Secretary of State said on Second Reading, the Liberal Democrats are opposed to any type of reform in the NHS, even successful reform, that will decentralise and devolve power. They are arch-conservatives in that sense.

Hon. Members expressed several concerns about the whole process. The hon. Member for West Chelmsford referred to the appointment process for chairs and chief executives. No chair or chief executive has yet been appointed to any of the organisations. The advertisements for the chief executive posts that we placed in September made it clear that they would be filled in December and January. It would not be right to pre-empt the consultation's conclusions on strategic health authority boundaries, so we have looked again at the matter and made it clear to those within the field—and, as I understood it, others—that the appointments would not pre-empt the conclusions of discussions relating to "Shifting the Balance". I hope that I have reassured hon. Members that it is not our intention to anticipate those conclusions.

**Dr. Harris:** I do recall that change being made, and I should have made it clear that my main concern was whether shortlisting took place and entry closed before the boundaries were established and full consultation in respect of "Shifting the Balance" had finished.

**Mr. Hutton:** I will get back to the hon. Gentleman on that point. I cannot say for certain that no shortlisting has taken place. I do know that applications are being sifted, and I shall try to confirm later today whether there has been any shortlisting.

I should reiterate that it is not our intention to pre-empt in any way the outcome of consultation on what the boundaries should be. There were some 99 health authorities in England, but there will be about 28 strategic health authorities, although no final decision has been taken in that regard. As we have said on many occasions, that is in our view the right way to deal with change in the NHS, and the best way to motivate and encourage innovation and enterprise on the part of front-line staff.

**Mr. Heald:** The Minister is giving some very helpful information. When considering the number and size of strategic health authorities, will he be prepared to accept population sizes greater than the 1.5 million guideline? As I understand it, he proposes to accept greater sizes in the north.

**Mr. Hutton:** The figure is a guideline; there is no statutory basis for constructing such a limit. According to a later amendment, the hon. Gentleman's party wants to create a statutory limit of 2 million. These issues are subject to consultation and we want to take into account the views of local people. The hon. Gentleman will be aware that, in approximate terms, we are trying to form one larger strategic health authority from four existing health authorities. We think that that constitutes the right shape, balance and size.

It is important for Opposition Members to keep in mind a point of which the Conservative party had some experience when in government. Organisational change in the NHS is always resisted. There are always voices saying that we should not change, that we are going too fast, that there should be change in other areas and so on. It is clear that we must think very carefully about all these matters and listen to what the NHS and the public say about such changes, and that is what we are trying to do. However, it is deeply disappointing to hear Opposition Members say that we should keep our heads in a bucket of extremely cold water and resist any sense of the urgent need for change. I find such attitudes very discouraging.

Of course, we must continue to make the case for change and to emphasise why it is important for the NHS, and that is what we are doing. We are definitely not talking about change for change's sake. I agree with the hon. Member for Westbury (Dr. Murrison) that, in that regard, there is a sense of history. He would expect me to say that that is an exaggerated description of some of the reforms implemented by the previous Administration, but I believe that view to be right. The internal market was a shambles that burdened the NHS with tiers of bureaucracy that led people to send bills and chase invoices throughout the service. With great respect to the hon. Gentleman, and given that he worked in the NHS during those years, I cannot believe that he considers that those reforms were sensible, helped the NHS in any material way or added to its efficiency.

**Mr. Heald:** What is the difference between paying, purchasing and commissioning?

**Mr. Hutton:** The hon. Gentleman knows perfectly well that we are not introducing the internal market that the Conservative party inflicted on the NHS with precious little support from anyone within it.

I have one caveat and cautionary note for Conservative Members. They are rediscovering their enthusiasm for public services, but they will not convince anyone in the country at large who remembers the enthusiasm shown by the previous Conservative Adminstration for public services. We are unlikely to accept any lectures from Conservative Members on that subject.

*[Mr. Hutton]*

12 noon

The hon. Member for Billericay (Mr. Baron) made a very good speech by reading the BMA's briefing. The association obviously has a friend in the hon. Gentleman.

**Mr. Burns:** What is wrong with the BMA?

**Mr. Hutton:** There is nothing wrong with the BMA, which comes to Richmond house regularly. When the Conservative party was in office, the BMA was not allowed into Richmond house. Tory Ministers stopped talking to the BMA because they were so fed up with their criticisms of Tory policies. Now, the Tories have discovered a new enthusiasm for the views of the BMA.

**Mr. Burns:** Rubbish.

**Mr. Hutton:** That sums up today's modern Conservatives.

The hon. Member for Billericay is lending his support to the BMA today, but previous Conservative Members have not been prepared to do that regularly in the past. As with other Conservative Members, he disputed whether the reforms would decentralise the NHS. It is the view of the BMA that they are radical decentralising measures, and I was surprised that he did not refer to the association's comments.

**Mr. Baron:** I have two points to make. The earlier comment that we oppose reform in the NHS is completely wrong. We are saying today that both the NHS and we in the House need more time in which to consider the reforms and implement them. Those at the coal face who must implement the reforms have severe reservations that we are rushing them through too quickly. The purpose of the amendment is to ask for one year's delay in the hope that that will give those who must implement the reforms more time. There is a real danger that a good number of primary care trusts—it is difficult to quantify how many—simply will not be ready for the deadline of 1 April 2002 because of the management and structural issues entailed.

**The Chairman:** Order. Interventions should be brief and to the point.

**Mr. Baron:** I apologise, Mr. Hurst. On the BMA, there is no harm in raising the concerns of the BMA and there is justification for doing so. That does not necessarily mean that we are endorsing those concerns. The point is that the BMA is raising legitimate issues and it would be wrong if they were not brought to the attention of the Committee. They should not be dismissed out of hand as irrelevant.

**The Chairman:** Order.

**Mr. Hutton:** Thank you, Mr. Hurst. The hon. Gentleman makes a fair point; I am not disputing his right to raise the concerns that the BMA has expressed. I am simply saying that there is a Cassandra quality to his and other Conservative Members' comments.

**Mr. Heald:** Will the Minister give way?

**Mr. Hutton:** No, I will not.

The comments of the hon. Member for Billericay diminish the substance and quality of the argument that he is trying to make to the Committee. He cannot have his cake and eat it. That is a luxury of Oppositions and that is what he is trying to do.

Conservative Members have also expressed concern about the number of primary care trusts that have been established. The hon. Member for West Chelmsford implied that very few had been established and were likely to meet the deadline of April 2002.

**Mr. Burns:** I said that I understood that 130 PCGs had not prepared fully or applied for PCT status.

**Mr. Hutton:** Unfortunately, the hon. Gentleman is wrong about that and I shall correct his arithmetic. Some 164 PCTs were established by April 2001 and a further 23 from the current round are likely to be approved soon; 23 of the remaining PCGs have been approved for establishment from April 2002; 20 have been approved but have not yet received notification of approval, which will happen shortly; 98 have submitted proposals for approval and are likely to be approved during December and January. Only 11 PCGs are still consulting and we expect all to be constituted as PCTs by April 2002. That has always been the deadline that we and others in the service have worked towards.

Another theme of the comments made by Conservative Members is decentralisation. I have great sympathy with some of the points that have been made. It is impossible to run a service as complex and diverse as the NHS from Richmond house. That is the Government's view and we have been working to find a successful method of devolving and decentralising power, of which this is the most obviously clear example. It is not true to say that the proposals have suddenly emerged during the past few months. Reference has been made to the NHS plan, and my hon. Friend the Member for Clwyd, West (Gareth Thomas) referred to it and to the equivalent document produced by the National Assembly for Wales.

The hon. Member for Westbury, who referred to those concerns, should refresh his memory and go back a little further in time. The 1997 White Paper "The new NHS" refers in paragraph 3.17 to some of the reforms that we wanted to make to health authorities, including making them leaner with no direct commissioning responsibilities. Those are precisely the proposals that we are implementing in the Bill. They have a longer ancestry than he and other Conservative Members are prepared to give credence to.

**Dr. Murrison:** The point is that Governments may put such proposals in White Papers until they are blue in the face, but if they do not get them across to the general public they have failed. My constituents believe that the Government are manifestly failing at the moment because there is so much confusion, even among those who take a passing interest in arcane

NHS structures, about how things are going and, more particularly, the effect that they will have on them and their ability to access health care.

**Mr. Hutton:** I accept that that is the hon. Gentleman's view, but it is not mine. It is unlikely that I would ever accept the hon. Gentleman's view about the success or otherwise of the reforms that we are making to the NHS.

**Mr. Burns:** Will the Minister clarify a point arising from what he said? If I heard him correctly, he said that he expected all PCTs to be in place by October next year. The strategic health authorities will come into effect on 1 April next and the health authorities are abolished. Will those areas that still have PCGs but are awaiting approval to be PCTs by October be able to fulfil the role of a PCT in advance of becoming one?

**Mr. Hutton:** No. The hon. Gentleman's problem is that he has not fully understood the time scale for making the changes. It is true that we intend to use existing powers to reorganise existing health authorities by 1 April 2002, but it is obvious that the legislation will not be in place by then. There is no prospect of that and we do not envisage being able to implement the legislation until October next year. The reforms will become operational from then onwards and fully operational from April 2003. That is the time scale that we envisage and there seems to have been some misunderstanding about that on the Conservative Benches.

The argument about decentralisation is important and underpins what we are trying to do in this part of the Bill. There is always some political knockabout surrounding centralisation and decentralisation and whether a measure is a devolved one or not. It is a legitimate and important argument, but the data is always tortured until it confesses and the statistics can be used to prove one case or another.

Conservatives may not be aware that during the last year of the Conservative Government, the Secretary of State for Health issued 298 central directions to the national health service. Last year, my right hon. Friend the Secretary of State issued 22 such directions. Most fair-minded people will consider those two figures and decide who were the centralisers and which party wanted to direct and manage the NHS centrally. With the greatest respect to the hon. Member for West Chelmsford, they would not reach his conclusion, based on those figures.

**Mr. Baron:** On the question whether we are centralising or decentralising—I hope that we will not get into party dogma on this—the Government argument is that the Bill is decentralising because, suddenly, PCTs will be spending about 75 per cent. of the resources available to the NHS. If PCTs had a large element of freedom in terms of how they spent the money, one could agree that that would be a decentralising measure. However, the fact remains that although 75 per cent. of expenditure will be devolved, strict targets and performance criteria will be set from the centre. If these are not met, money could be withdrawn. How can that be described as a decentralising measure? Surely it is micromanagement.

**Mr. Hutton:** No, it certainly is not micromanagement. It is the proper role of Government, who are accountable to the House, to set the overall standards and framework within which they expect public money to be used in the NHS; the alternative is a free-for-all, and I cannot believe that the hon. Member for Billericay and his hon. Friends support that. There must be a proper balance. I find it genuinely surprising that the hon. Gentleman takes the view that it is not a proper role for Government to determine the overall resources available to the service and to indicate the targets, results and performance to be achieved with the money.

**Mr. Baron:** The Minister misunderstands. I am not saying that there is no role for Government in running the NHS or that the Government should not provide basic safety nets and guidelines for providing the service at the coal face. However, the Government are arguing that the Bill is decentralising when clearly it is not. The Secretary of State will set microtargets, performance targets and criteria for a swathe of areas, and money will be withdrawn if those are not met. That is micromanagement. There is a role for Government and it is a question of getting the balance right, but they have gone too far in centralising, rather than decentralising.

**Mr. Hutton:** I hear the hon. Gentleman's arguments, but they do not accord with the facts; that is the problem. We are not withdrawing money from anyone, so he can forget about that.

**Mr. Baron:** Even if the authorities do meet performance targets?

**Mr. Hutton:** We are steadily increasing the resources available to the NHS. The performance assessment framework will work in a different way. Everyone will benefit from the fund. Does the hon. Gentleman not think that it is right that we set targets for the key areas of access to health care services and waiting times? Is that not a responsible role for the Government?

My understanding of the hon. Gentleman's election manifesto was that his party was committed to setting such waiting time guarantees. I am genuinely puzzled by the hon. Gentleman's argument. I accept that he can argue about the balance, but surely he cannot argue about the role of the Secretary of State in the matter. It is not true that we see the Secretary of State's role as guaranteeing a safety net for the NHS; that would be an inappropriate view of the relationship that we want to develop and maintain.

The hon. Member for Billericay is wrong in his analysis. There is no doubt, certainly in the BMA's view, that this is a radical decentralising measure that will affect the NHS for a long time to come; it is the hon. Gentleman's prerogative to disagree with that view. If he, like me, believes in devolving power, he will

*[Mr. Hutton]*

see that this is the only sensible way to organise a service as large and complex as the NHS and that it is reasonable to go down that road.

**Mr. Heald:** Under the Bill, 58 powers of the Secretary of State are gained, retained or enhanced. It is true that if some of the powers were implemented in a light regulatory mode, that would be better than if they were heavily prescriptive. Does the Minister agree that it is vital that he allows the Committee to see all the draft orders?

**Mr. Hutton:** I said earlier that I would do that if the orders were ready.

**Mr. Heald:** Will the Minister give way?

**Mr. Hutton:** No, I have answered the hon. Gentleman's question.

**Mr. Heald:** On a point of order, Mr. Hurst. Clause 1 has at least seven order-making powers and schedule 1 has numerous powers. The Minister has agreed to allow the orders to be seen. If any of them are ready, should he not give them to us so that we can debate them?

**The Chairman:** That is not a point of order but a matter for debate.

12.15 pm

**Mr. Hutton:** The hon. Gentleman and I are both lawyers, so we are used to such arguments; it is our trade. The orders are not ready because they have not been drafted. Had they been drafted, they would have been shared with the Committee.

Returning to the substance of the amendment, we have had a wide-ranging debate about the nature of the proposals, their implications for the NHS and their relationship with PCTs, a point on which I agree with the hon. Member for North-East Hertfordshire. It will be important for PCTs to get maximum managerial support as they take on their new roles and responsibilities. The Government have set out our intentions on many occasions. The national primary care development team, under Dr. Barbara Hakin—an outstandingly successful PCT chief executive in Bradford—is helping other chief executives and PCTs to take on their new responsibilities and address the significant challenges that they face.

The hon. Gentleman said that the RCN's description of these proposals was "ambitious"; they are ambitious because we are ambitious for the NHS.

**Mr. Heald:** I was referring to the timetable.

**Mr. Hutton:** It is an ambitious timetable, which leads us to the argument that is fundamental to the amendment tabled by the hon. Member for West Chelmsford. I said earlier that all organisational change meets with some opposition. That is the nature of organisations. Notwithstanding the points made by Opposition Members, there is a strong argument that having identified the changes that must be made, it is better to get on and implement them. The danger with his proposals is that they carry an additional suggestion of delay.

**Mr. Burns:** Of six months.

**Mr. Hutton:** Yes, but we could use that six months for another purpose. It is a challenging timetable, but it is achievable. We are on target to get the PCTs, which will be up and running by October 2002, through the system. Having looked at the argument and having heard what the hon. Gentleman has to say, the Committee must decide—given that we indicated the nature of the changes in 1997, developed specific proposals, made a significant start towards achieving results throughout the service and began the reorganisation that these changes will bring through—whether we should say to the NHS and the public at large, "We need to get these changes in place."

In the circumstances, the delay that the hon. Member for West Chelmsford proposes would not be helpful. It would serve no purpose other than to cause delay in the way in which he has described. We have a comprehensive system of support arrangements in place to ensure that PCTs will be able to discharge their new responsibilities, and we are currently consulting with the public and the NHS on the boundaries of the SHAs. This is an occasion for us to say that it is time to get on and do the work; that is what I shall ask my hon. Friends to do if the hon. Gentleman pushes his amendment to a Division.

**Mr. Burns:** I have listened very carefully to the Minister's comments, and I was genuinely grateful for some information that he supplied. He fleshed out our understanding and knowledge of how the clause will work, fulfilling the probing role of the amendment. One or two things that he said have concerned and slightly confused me, although I shall not pursue them in great detail.

The Minister said that the proposals were both challenging and ambitious. Given the time scale, are the Government being over-ambitious? This debate has in no way reduced my fears that the policy is being rushed and, whatever he may say, my hon. Friends and I are not alone in thinking that. There was concern, which he helpfully cleared up, that the structures would be put in place on 1 April 2002, but some PCGs would not become PCTs until October 2002.

The Minister said, if I understood his comments correctly, that the reforms would not come into operation until October 2002, when all PCTs would be in place. In one way, that is reassuring, and it has certainly clarified the situation. However, that also makes our amendment even more reasonable. Until the Minister gave that clarification, I was asking the Government to give the NHS another 12 months in which to complete preparations so that there would not be a rush that would cause confusion. Following his helpful clarification, I am asking for only six months. I do not regard that as delay or procrastination. I regard that as a commonsense way in which to help the NHS to help those involved and,

ironically, to help the Government to get their reforms right, and up and running, in the most effective and efficient way.

When one seeks to be helpful, it is not unreasonable to push an amendment to a Division. I am convinced that when the Government look back on the full year of 2002-2003, they will wish that they had taken our advice and given themselves a breathing space of six months in which better to lay the system's foundations.

*Question put*, That the amendment be made:—

*The Committee divided*: Ayes 6, Noes 10.

**[Division No. 2]**

**AYES**

| | |
|---|---|
| Atkinson, Mr. Peter | Heald, Mr. Oliver |
| Baron, Mr. John | Murrison, Dr. Andrew |
| Burns, Mr. Simon | Taylor, Dr. Richard |

**NOES**

| | |
|---|---|
| Blears, Ms Hazel | Hutton, Mr. John |
| Burnham, Andy | Moffatt, Laura |
| Challen, Mr. Colin | Thomas, Gareth |
| Fitzpatrick, Jim | Touhig, Mr. Don |
| Havard, Mr. Dai | Ward, Ms Claire |

*Question accordingly negatived.*

**Mr. Heald:** I beg to move amendment No. 2, in page 1, line 6, leave out 'Strategic' and insert 'Area'.

**The Chairman:** With this we may discuss the following amendments: No. 3, in page 1, line 11, leave out 'Strategic' and insert 'Area'.

No. 4, in page 1, line 14, leave out 'Strategic' and insert 'Area'.

No. 5, in page 2, line 2, leave out 'Strategic' and insert 'Area'.

No. 6, in page 2, line 8, leave out 'Strategic' and insert 'Area'.

No. 7, in page 2, line 9, leave out 'Strategic' and insert 'Area'.

No. 8, in page 2, line 16, leave out 'Strategic' and insert 'Area'.

No. 9, in page 2, line 18, leave out 'Strategic' and insert 'Area'.

No. 10, in page 2, line 19, leave out 'Strategic' and insert 'Area'.

No. 11, in page 2, line 20, leave out 'Strategic' and insert 'Area'.

No. 12, in page 2, line 23, leave out 'Strategic' and insert 'Area'.

No. 13, in page 2, line 27, leave out 'Strategic' and insert 'Area'.

No. 14, in clause 3, page 3, line 11, leave out 'Strategic' and insert 'Area'.

No. 15, in clause 3, page 3, line 12, leave out 'Strategic' and insert 'Area'.

No. 16, in clause 3, page 3, line 15, leave out 'Strategic' and insert 'Area'.

No. 17, in clause 3, page 3, line 16, leave out 'Strategic' and insert 'Area'.

No. 18, in clause 3, page 3, line 19, leave out 'Strategic' and insert 'Area'.

No. 19, in clause 3, page 3, line 27, leave out 'Strategic' and insert 'Area'.

No. 20, in schedule 1, page 44, line 6, leave out 'Strategic' and insert 'Area'.

No. 21, in schedule 1, page 44, line 8, leave out 'Strategic' and insert 'Area'.

No. 22, in schedule 1, page 44, line 12, leave out 'Strategic' and insert 'Area'.

No. 23, in schedule 1, page 44, line 14, leave out 'Strategic' and insert 'Area'.

No. 24, in schedule 1, page 44, line 17, leave out 'Strategic' and insert 'Area'.

No. 25, in schedule 1, page 44, line 19, leave out 'Strategic' and insert 'Area'.

No. 26, in schedule 1, page 44, line 21, leave out 'Strategic' and insert 'Area'.

No. 27, in schedule 1, page 44, line 24, leave out 'Strategic' and insert 'Area'.

No. 28, in schedule 1, page 44, line 27, leave out 'Strategic' and insert 'Area'.

No. 29, in schedule 1, page 44, line 29, leave out 'Strategic' and insert 'Area'.

No. 30, in schedule 1, page 44, line 31, leave out 'Strategic' and insert 'Area'.

No. 31, in schedule 1, page 44, line 35, leave out 'Strategic' and insert 'Area'.

No. 32, in schedule 1, page 44, line 37, leave out 'Strategic' and insert 'Area'.

No. 33, in schedule 1, page 45, line 2, leave out 'Strategic' and insert 'Area'.

No. 34, in schedule 1, page 45, line 6, leave out 'Strategic' and insert 'Area'.

No. 35, in schedule 1, page 45, line 8, leave out 'Strategic' and insert 'Area'.

No. 36, in schedule 1, page 45, line 10, leave out 'Strategic' and insert 'Area'.

No. 37, in schedule 1, page 45, line 13, leave out 'Strategic' and insert 'Area'.

No. 38, in schedule 1, page 45, line 14, leave out 'Strategic' and insert 'Area'.

No. 39, in schedule 1, page 45, line 18, leave out 'Strategic' and insert 'Area'.

No. 40, in schedule 1, page 45, line 20, leave out 'Strategic' and insert 'Area'.

No. 41, in schedule 1, page 45, line 22, leave out 'Strategic' and insert 'Area'.

No. 42, in schedule 1, page 45, line 25, leave out 'Strategic' and insert 'Area'.

No. 43, in schedule 1, page 45, line 28, leave out 'Strategic' and insert 'Area'.

No. 44, in schedule 1, page 45, line 30, leave out 'Strategic' and insert 'Area'.

No. 45, in schedule 1, page 45, line 34, leave out 'Strategic' and insert 'Area'.

No. 46, in schedule 1, page 45, line 36, leave out 'Strategic' and insert 'Area'.

No. 47, in schedule 1, page 45, line 39, leave out 'Strategic' and insert 'Area'.

*[The Chairman]*

No. 48, in schedule 1, page 45, line 41, leave out 'Strategic' and insert 'Area'.

No. 49, in schedule 1, page 45, line 44, leave out 'Strategic' and insert 'Area'.

No. 50, in schedule 1, page 46, line 1, leave out 'Strategic' and insert 'Area'.

No. 51, in schedule 1, page 46, line 4, leave out 'Strategic' and insert 'Area'.

No. 52, in schedule 1, page 46, line 7, leave out 'Strategic' and insert 'Area'.

No. 53, in schedule 1, page 46, line 10, leave out 'Strategic' and insert 'Area'.

No. 54, in schedule 1, page 46, line 13, leave out 'Strategic' and insert 'Area'.

No. 55, in schedule 1, page 46, line 15, leave out 'Strategic' and insert 'Area'.

No. 56, in schedule 1, page 46, line 18, leave out 'Strategic' and insert 'Area'.

No. 57, in schedule 1, page 46, line 19, leave out 'Strategic' and insert 'Area'.

No. 58, in schedule 1, page 46, line 22, leave out 'Strategic' and insert 'Area'.

No. 59, in schedule 1, page 46, line 24, leave out 'Strategic' and insert 'Area'.

No. 60, in schedule 1, page 46, line 27, leave out 'Strategic' and insert 'Area'.

No. 61, in schedule 1, page 46, line 29, leave out 'Strategic' and insert 'Area'.

No. 62, in schedule 1, page 46, line 32, leave out 'Strategic' and insert 'Area'.

No. 63, in schedule 1, page 46, line 33, leave out 'Strategic' and insert 'Area'.

No. 64, in schedule 1, page 46, line 36, leave out 'Strategic' and insert 'Area'.

No. 65, in schedule 1, page 46, line 38, leave out 'Strategic' and insert 'Area'.

No. 66, in schedule 1, page 46, line 40, leave out 'Strategic' and insert 'Area'.

No. 67, in schedule 1, page 46, line 44, leave out 'Strategic' and insert 'Area'.

No. 68, in schedule 1, page 47, line 2, leave out 'Strategic' and insert 'Area'.

No. 69, in schedule 1, page 47, line 5, leave out 'Strategic' and insert 'Area'.

No. 70, in schedule 1, page 47, line 7, leave out 'Strategic' and insert 'Area'.

No. 71, in schedule 1, page 47, line 9, leave out 'Strategic' and insert 'Area'.

No. 72, in schedule 1, page 47, line 15, leave out 'Strategic' and insert 'Area'.

No. 73, in schedule 1, page 47, line 17, leave out 'Strategic' and insert 'Area'.

No. 74, in schedule 1, page 47, line 20, leave out 'Strategic' and insert 'Area'.

No. 75, in schedule 1, page 47, line 23, leave out 'Strategic' and insert 'Area'.

No. 76, in schedule 1, page 47, line 26, leave out 'Strategic' and insert 'Area'.

No. 77, in schedule 1, page 47, line 29, leave out 'Strategic' and insert 'Area'.

No. 78, in schedule 1, page 47, line 33, leave out 'Strategic' and insert 'Area'.

No. 79, in schedule 1, page 47, line 35, leave out 'Strategic' and insert 'Area'.

No. 80, in schedule 1, page 47, line 37, leave out 'Strategic' and insert 'Area'.

No. 81, in schedule 1, page 47, line 40, leave out 'Strategic' and insert 'Area'.

No. 82, in schedule 1, page 47, line 43, leave out 'Strategic' and insert 'Area'.

**Mr. Heald:** All the amendments are to the same effect. They would change the name of strategic health authorities to area health authorities. Their purpose is not simply to concentrate on the name, but to ascertain whether such authorities are properly designated as strategic. We want to examine the functions that the Government intend for them, and whether it is right to describe those functions as strategic. We might go further and ask whether those bodies have a role to play.

As I understand it, the Government propose to reallocate responsibilities in the NHS so that PCTs will become the bodies that assess need, plan for it and commission services, and as such will be the main budget-holders; I do not use the word "purchaser", of course. There are to be about 30 new health authorities, covering about 1.5 million residents each, although I have heard that, in certain areas, the Government are prepared to accept far larger numbers of residents.

Will the Minister explain why it is necessary to have strategic health authorities and what is strategic about them? The research paper says that they will provide

"support to PCTs and NHS trusts to help them . . . improve the quality of the services they provide through their 'clinical governance' arrangements".

What does that actually mean? The paper goes on to refer to developing

"appropriate links with patients and the public as a whole, to ensure that services become genuinely patient-centred".

We seem to be developing a massive structure of overarching and underlapping bodies to do what the community health councils used to do. Is it really necessary to have another set of bodies developing links and ensuring that patients have a role? Can the Minister justify the claim that those bodies are genuinely strategic?

The research paper says that SHAs will

"play a part in the wider public health agenda so that they contribute to general strategies to promote good health".

What does that involve? Does the Minister really believe that a strategic role is called for? If so, how will the system operate in terms of the relationship between SHAs and PCTs?

The BMA asserts that the new structures should include a role for public health doctors. Does the Minister intend the high-level appointment of a public health doctor in each area? Would that be part of improving the quality of services within a clinical governance arrangement? I do not think so. Would it assist in developing a link with patients? Probably not.

However, it might play a part in the wider public health agenda. Is part of the strategic purpose of SHAs the appointment of public health doctors? The BMA thinks that that is important. It says:

"The BMA is concerned that with such flexibility of appointment to these key public health posts at PCT and SHA level, potentially some areas of the country may be without the expertise of a public health doctor."

The Royal National Institute for the Blind has commented on the role of sight loss and eye health promotion. Will the Minister explain whether that is a strategic issue that plays a part in the wider public health agenda, or is it the kind of thing that PCTs will deal with? Will he also respond to the RNIB's observation that the NHS and local authorities should work more closely to ensure effective service delivery in terms of sight loss and eye health promotion?

In other words, what does it all mean? [*Interruption.*] I ask that not in an entirely philosophical sense; I was hoping instead that the Minister might give a little detail and explain what the strategy is, why we need strategic health authorities, and why they should be called that rather than area health authorities.

12.30 pm

**Mr. Hutton:** I am encouraged to have an opportunity so soon in our debate to respond to the points raised by the hon. Gentleman. On noticing page after page of amendments, I thought that we would be discussing them for some time. I am grateful to him for spelling out that his amendments are essentially probing and that he is simply trying to establish what the function of these bodies should be.

The hon. Gentleman asked several questions about the public health function, which the hon. Member for Westbury also mentioned on Second Reading. Both hon. Gentlemen are rightly concerned about where the public health function will go and whether the reforms will weaken it, but in my view they will strengthen its delivery in the NHS. Given the present climate, that is one of the most important things that we must get right. All hon. Members and their constituents are aware of the growing menace of international terrorism and of the role of public health specialists in helping the NHS to cope with it effectively. I shall return to that subject in a moment, but I should first make it clear that the proposed reforms will not diminish the important role of public health in the NHS; indeed, I very much hope that they will strengthen it.

The rather quixotic desire was expressed for a seminar on the activities of SHAs, but "Shifting the Balance" and other documents provided for the Committee offer an almost exhaustive description of their role and functions. First and foremost, SHAs will have the key performance management role across the NHS. If the hon. Member for North-East Hertfordshire has talked to people in the NHS, he will know that the regional offices are too far away from the front line to carry out that role in the way that many in the service would like.

Again, this is an area in which we must make a judgment call. The Bill and the background documents show that the performance management function must be effective, but not too distant or bureaucratic, and the function must be close enough to the front line to ensure that genuine performance management responsibilities can be discharged, without creating for the sake of it—this is perhaps the hon. Gentleman's worry—another tier of bureaucracy in the NHS. Such a further tier is not what we are proposing.

The hon. Gentleman also referred to other responsibilities of the strategic health authorities, particularly their leading strategic development of services and ensuring that all parts of the NHS work together effectively. In a sense, that issue touches on another that was raised by the hon. Member for Billericay when we considered a previous group of amendments. We need a devolved NHS where as many resources and as much control and responsibility as possible are given to the front line, but where the back office functions—for want of a better expression—are properly identified and supporting arrangements established. That is a sensible balance, and although the line is perhaps not drawn in a place with which the hon. Gentleman is happy, there will certainly be significantly fewer authorities than the current 90-odd area health authorities in England to which he referred.

**Mr. Heald:** A lot of people say that all that the Government are doing is moving deckchairs. At the moment, there are two basic tiers—regional directors and health authorities—but we will end up with three: PCTs and SHAs, both of which have a health authority role, and regional directors. There will be a lot more PCTs than there ever were health authorities, so we will end up with more bodies. Is that really necessary?

**Mr. Hutton:** As I understand it, the hon. Gentleman's amendment would leave us with exactly the structure that I have just proposed—it would simply brand the bodies with a different name.

**Mr. Heald:** That is why it is a probing amendment.

**Mr. Hutton:** On this occasion, I do not feel particularly probed by the hon. Gentleman. Perhaps he will do better with later amendments. I accept that he wants a better and fuller description of the rationale behind the changes, but it is only fair to point out that the amendment would result in exactly the structure that we are proposing.

The fundamental change relates to the functions of health authorities and SHAs—that is the core of "Shifting the Balance". On reading the Bill, it is obvious that some health authority functions will remain in a different place in the NHS firmament, but most will move to PCTs. As we have made clear in numerous arguments on Second Reading and elsewhere, that is the right way to achieve our principal objective of finding a new and different system that properly confers responsibility and thereby grants the freedom to be innovative and enterprising. Those should be the hallmarks of a modern, dynamic public service. We must give those powers and opportunities to the people on the front line who actually make a

*[Mr. Hutton]*

difference, know their communities well and understand where the problems and pressure points are in the system, so that they have the tools to do the job more effectively.

It is important to call strategic health authorities by that name because it emphasises that their function should differ from that of the area health authorities to which the hon. Gentleman wants to revert. We should remember that area health authorities were commissioning bodies. Strategic health authorities will have a completely different role.

**Mr. Heald:** No one is suggesting that we go back.

**Mr. Hutton:** That is what the hon. Gentleman is suggesting—he is proposing that we establish area health authorities rather than strategic health authorities.

**Mr. Heald:** No I am not.

**Mr. Hutton:** With the greatest of respect, that is precisely what the amendment proposes. Most people in the NHS remember what area health authorities used to do, as will the hon. Member for Westbury, who is very fond of old NHS structures but has no fondness for the new ones. It would serve no purpose to allow confusion about the new health authority. The Bill needs to make crystal-clear the concept of a strategic responsibility and role, and that is what it will do in relation to the functions that strategic health authorities will discharge.

I have talked a lot about striking a balance, and it is important to make such matters clear. The system must devolve, decentralise, innovate and encourage change at a local level, but it must also be effectively managed, so that two parts do not do opposite things and thereby create the free-for-all that was characteristic of some of the hon. Gentleman's party's early reforms. Such a free-for-all does not enhance care or encourage the co-operation between different parts of the NHS that is so important if it is to be efficient and effective and to do what our constituents want: to improve access and quality of care, and make the best use of the resources at our disposal.

The challenge for us all, which we have tried to take on through these reforms, is to get right the balance between devolving and decentralising—that is what we want to do—and ensuring that the all parts of the service can work together closely, still plan sensibly for the future and secure the results that we all desire.

I have looked at the past functions of the area health authorities to which the hon. Gentleman's amendment harks back, and set out the obvious responsibilities of the strategic health authorities, and there is no obvious comparison between the two. The strategic functions of the new health authorities will be clearer and more defined. As I have said, under our proposals the new strategic health authorities will take a step backwards from service planning and commissioning. They will lead strategic development of local health services, and performance-manage PCTs and NHS trusts.

The hon. Member for Westbury made a point about public health, which also came up on Second Reading. I apologise to him because I did not get a chance to respond fully to his points then. Should the day ever dawn when he has the chance to wind up debates, he will know how difficult it can be to respond fully to all the points made by hon. Members. I did not intend him any discourtesy in not dealing fully with his points about public health.

We plan that every PCT will have a director of public health and an appropriate support team. Those directors will be board-level appointments, which is an important step forward. They will focus their activity on local neighbourhoods and communities, and on programmes to improve health and reduce inequalities. We want them to play a powerful role in forging partnerships with, and influencing, all local agencies to ensure the widest possible participation in health and the health care agenda. That generation of directors of public health will be from a variety of backgrounds, not only medical as at present.

The new strategic health authorities established by the NHS reforms will also need a doctor with appropriate strategic management skills. The SHAs will also have responsibility for the performance management of the public health function of primary care trusts. It makes absolute sense for public health doctors to fulfil that role. A successful SHA will lead and performance-manage that area to ensure that each organisation for which it is responsible has vibrant clinical governance arrangements and powerful, effective clinical networks.

I do not think that there is a substantive argument behind the amendment.

**Mr. Heald:** Is the Minister saying that an SHA will have a public health doctor but that a PCT might not, although it could?

**Mr. Hutton:** PCTs will have a public health function and a public health director. That will not necessarily be a doctor, but a consultant for public health, rather like the present arrangements.

**Mr. Heald:** As the Minister knows, the BMA is interested in the matter. SHAs will always have a public health doctor and PCTs will have a public health function, but not necessarily a doctor.

**Mr. Hutton:** Yes, that is broadly how we see the reforms working. We do not want to compromise, or affect the quality of, the public health function as it is discharged by the NHS. That is not on our agenda.

I do not think that there is much else for me to say about these amendments, other than that there are an awful lot of them. I am grateful that the hon. Gentleman has not felt the need to discuss each of them, and I hope that I have not provoked him into doing so. I do not think that they constitute a sensible way forward.

**Mr. Heald:** Perhaps the Minister will comment on the point raised by the Royal National Institute for the Blind. It has briefed all Committee members about its concern that there should be proper local

arrangements between local authorities and the NHS to ensure effective service delivery. Can I tempt him to say whether that would be an SHA role where it concerns the improvement of quality, or a PCT role?

**Mr. Hutton:** It would be both. Primary care trusts will be able to enjoy the fruits of some of the earlier legislative changes that we made to promote closer working, such as section 31 arrangements under the Health Act 1999 and the care trusts provisions of the Health and Social Care Act 2001. The strategic health authority will have an overall role in making sure that progress is being made in that important area.

**Mr. Heald:** That is very helpful.

It was not our intention to see the area health authority rise like a phoenix from the grave. If anything, the area health authority role is far more akin to what PCTs will do. I was not going back that far; I simply wanted to discuss whether the strategic health authorities were strategic and had a role and function. I am not very satisfied with the Minister's reply, partly because the details of the functions of SHAs will be set out in an order made by the Secretary of State under the negative procedure that will never be discussed by the House in detail.

**Mr. Hutton:** I remind the hon. Gentleman that we have followed the pattern that was set by the National Health Service Act 1977, where the legislation requires the establishment of the health authorities, but the functions are left to the Secretary of State to determine. We are following that pattern and it will be open to Opposition Members to call for a debate on the proposals if they are concerned in future.

**Mr. Heald:** The last time I looked, there were 2,000 negative orders, 30 of which were debated, despite the fact that many hundreds were requested for debate. This Government are a bit worse than we were but, none the less, it is not the tradition to debate negative orders even if the Opposition want to debate them.

The Minister is right that, between 1974 and 1979, many Acts were introduced on the basis that they had wide order-making powers; they were Christmas trees without baubles or skeletons without flesh. One could not tell the details of what would happen as a result of an Act of Parliament. Some people may think that that was a bad trend, but it has been followed; now, much detail is not covered by the Bill, but by orders.

One suspects that layers of bureaucracy are being added, so it is a pity not to be able to see what the functions of the SHAs will be. They will be dealt with by order. We cannot get down to the detail, or see whether the authorities will be doing anything worthwhile. The amendments are probing, but I will not press them.

12.45 pm

**Dr. Murrison:** I am grateful to the Minister for suggesting that I might be able to remember area health authorities. I can just about cast my mind back to 1974 when those authorities were rearranged, together with district health authorities and regional health authorities, and there is a sense of de"jà vu as we reinvent those structures. That might be fine were they to serve a useful function, but SHAs are looking fairly bankrupt.

PCTs are taking the best and leaving the rest. Although I am grateful for the Minister's views on where the public health function will lie, and reassured that public health consultants will find a role in SHAs, I am concerned that they are a bolt-on to the SHAs to bolster them up. I am pleased to hear that directors of public health will be attached to PCTs and, although I am doctor, I am pleased that directors do not necessarily have to be medically qualified. In the amendment, the Minister did not mention consultants in communicable disease control, so will he mention where CCDCs will sit? I expect that they will sit on SHAs.

We have not yet defined "strategic". Words are important; they mean what they say. We need to explore why the Government require the insertion of the word "strategic". Why will they be strategic authorities, rather than straight health authorities? We also need to know why 1.5 million has been chosen as a proper figure for a population served by each SHA. Presumably, it is linked with the notion of being strategic.

We must explore the need for tertiary centres in SHAs because I understand that one of the key planks in being strategic is that one has access to a tertiary centre. That appears to be the case under most of the proposals for boundaries, but there are several signal exceptions—for example, the SHA that it is proposed will be made up of Somerset and Dorset. It stretches the imagination to suppose that that SHA will have a tertiary centre, so there appear to be a few disconnects in the thoughts that are going into this, which gives me added concern about the notion of being strategic. If the authorities are to be strategic, they need to be uniformly strategic. The signs are that that is not happening.

**Mr. Hutton:** The hon. Gentleman has asked two further questions and it would be appropriate to respond briefly now, rather than to write to him later. He has asked about the arrangements for communicable disease controls and where the CCDCs will be located — at PCT level or strategic health authority level. That is an issue that we are considering. The chief medical officer is advising the Government about that, and we expect to receive his recommendations by the end of the year.

The hon. Gentleman also asked about tertiary centres and specialist commissioning. We are trying to draw a line between NHS bodies with commissioning responsibilities—PCTs—and those without, including the SHAs. The securing of specialist services will be the responsibility of PCTs, working together in collaborative and cooperative ways. It will be the responsibility of the SHA to ensure that satisfactory arrangements are in place to ensure that that process is working. For the next financial year, the current regional specialist commissioning groups will continue to exist, making sure that PCTs can build up the capacity effectively to discharge that function, with

*[Mr. Hutton]*

clear responsibility to ensure that there is a planned transition and to develop the PCT capacity to commission those services from 2003 onwards.

**Mr. Heald:** I beg to ask leave to withdraw the amendment.

*Amendment, by leave, withdrawn.*

**Mr. Burns:** I beg to move amendment No. 84, in page 2, line 3, at end insert

'provided that such area has an adult population of more than 2 million people.'.

I say from the outset, to avoid any confusion, that this is a probing amendment. In the absence of any draft regulations, I seek to tease out from the Minister some more information on the nuts and bolts of the SHAs.

The Minister will be aware that subsections (2), (3), (4) and (5) are also subject to amendments at a later stage, which have been selected, so we will have the opportunity to debate other aspects of SHAs, but the Government have included in the Bill the power to establish SHAs for England, without specifying, for a variety of eminently reasonable reasons, their detailed intentions.

The figure of 1.5 million has been bandied around as the average population that the Government anticipate an SHA will cover. Staff from the North Essex health authority seem to be working on the basis of one SHA for Essex, which would in effect be a merger of the North Essex and South Essex health authorities, giving a population of about 1.5 million. Our amendment refers to an adult population of 2 million, so, clearly, if the Government were to accept it—as I have said, it is a probing amendment—the figure would be higher because it excludes children and young people under the age of 18.

We know from the Bill that there cannot be cross-border SHAs between England and Wales. For various reasons, I think that that is a wise decision, and an inevitable one for the Government. Interestingly, under clause 1(4)(b), the Secretary of State may, by order,

"abolish a Strategic Health Authority".

I would like press the Minister on that. If he has a belt and braces approach to the Bill, he will get any eventuality into the legislation. I assume that that provision is there so that if a future Government wanted to re-organise the structure of SHAs by merging some into larger units, they would have the powers without having to revert to primary, or even secondary, legislation. Can the Minister confirm that that assessment is correct?

That raises a problem, depending on the population basis. If the level is 1.5 million, and if the Government rigidly stick to that throughout the country, any abolitions or mergers of SHAs—I presume that, in most cases, abolition of an SHA would be to enable a merger—could establish very large organisations. Those could be vulnerable to the accusation of potential detachment from the area that they seek to serve strategically because they cover too large a geographic area.

Alternatively, that provision might be in the Bill because the Government, for various reasons, wanted some areas to have SHAs covering more than 1.5 million people, if that were their average guideline figure. With experience and hindsight they might want to make an SHA larger because it was too small to fulfil Ministers' and the Department's original intentions.

I am not saying that 2 million adults, with however many children there might be, is an ideal figure, or that 1.5 million is right or wrong. From the only experience I have—on the ground in Essex—that figure seems more or less sensible, as it reflects the county boundary and keeps local roots for the body. However, will the Minister share with the Committee more information about his and the Department's thinking on the shape, form and size of SHAs in England?

**Mr. Heald:** Does my hon. Friend agree that it would be useful if the Minister explained what latitude there is on that point, and to what extent he is prepared to allow for higher figures? In a big city, it might be useful to have a much higher figure than 1.5 million people.

**Mr. Burns:** I hope that the Minister will answer my hon. Friend's point and explain what factors will be taken into account in determining—

*It being One o'clock,* THE CHAIRMAN *adjourned the Committee without Question put, pursuant to the Standing Order.*

*Adjourned till this day at half-past Four o'clock.*

THE FOLLOWING MEMBERS ATTENDED THE COMMITTEE:

Hurst, Mr. Alan (*Chairman*)
Atkinson, Mr. Peter
Baron, Mr.
Blears, Ms
Burnham, Andy
Burns, Mr.
Challen, Mr.
Fitzpatrick, Jim
Hall, Mr. Mike
Harris, Dr. Evan
Havard, Mr.
Heald, Mr.
Hutton, Mr.
Moffatt, Laura
Murrison, Dr.
Taylor, Dr. Richard
Thomas, Gareth
Touhig, Mr.
Ward, Ms

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