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

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OFFICIAL REPORT

Standing Committee A

NATIONAL HEALTH SERVICE REFORM AND HEALTH CARE PROFESSIONS BILL

Second Sitting

Tuesday 27 November 2001

(Afternoon)

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Standing Committee A

Tuesday 27 November 2001
(Afternoon)

[MISS ANN WIDDECOMBE *in the Chair*]

NHS Reform and Health Care Professions Bill

Clause 1

ENGLISH HEALTH AUTHORITIES: CHANGE OF NAME

Amendment moved [this day]: No. 84, in page 2, line 3, at end insert

'provided that such area has an adult population of more than 2 million people.'.—[*Mr. Burns.*]

4.30 pm

The Chairman: Before I ask Mr. Burns to conclude his comments, I remind members of the Committee that all mobiles and pagers should be set on silent, or should not be on at all.

Mr. Simon Burns (West Chelmsford): May I be the first, Miss Widdecombe, to say what a pleasure it is to have you as co-Chairperson of our proceedings?

As I was saying when we adjourned for lunch, amendment No. 84 is purely a probing amendment by which we are seeking to find out more about the Minister's views on the composition of the strategic health authorities in terms of the average number of people that each will represent, and to tease out of him more information about how he thinks that SHAs will work.

Dr. Andrew Murrison (Westbury): It is a fairly fundamental law of physics that large bodies tend to consume small ones, and one of my concerns about SHAs relates to their size. As far as we are able to tell, they will be of diverse size. One of the stringencies placed upon those deciding on their boundaries is that the authorities should relate to a tertiary centre, such as a major teaching centre or major hospital. My own area of the south-west provides an example of where the proposals fall well short of that. The minnow that is Somerset and Dorset—I mean that in the nicest possible way—relates at best to Taunton, which is not a major centre. That will leave Devon and Cornwall looking towards the Peninsula medical school and Plymouth, which is a major tertiary centre. The remaining area of Avon, Gloucestershire and Wiltshire will look towards Bristol royal infirmary and the Bristol teaching hospitals.

That creates real instability. It is likely that there will be some mergers as time goes by. In the south-west, the three SHAs will probably reduce to two, with Somerset and Dorset being split between the SHA for the far west and Avon, Gloucestershire and Wiltshire. Such changes bring more uncertainty for those who work in the service. We should be able to anticipate that to ensure from the outset that SHAs can plan for the long term in a period of some stability. Members of the Committee have commented on the importance of stability in the national health service, which has undergone almost perpetual change since 1974. This is one area where the Government can give a steer by offering the prospect of stability at SHA level.

Of course, reducing the number of SHAs in the south-west from three to two and repeating that across the country would strip out a layer of bureaucracy and associated costs, as well as giving many of them much more cogency. I urge the Minister to think in terms of reducing the number of SHAs, perhaps by increasing the numbers of people that they will serve.

Dr. Richard Taylor (Wyre Forest): I was delighted that in the letter from the Secretary of State for Health that was circulated with the White Paper, "Shifting the Balance", he emphasised that consultation would take place according to boundaries. Natural geographical boundaries for health care seem to be the most sensible way of deciding the constituent members of strategic health authorities. Will the Minister confirm that the authorities will not be rigidly bound by numbers, whether too small or too great, but that the natural geographical boundaries, whether they have tertiary centres or not, will be used?

I have a natural geographical area in my part of the country that has long been known as West Mercia, which is an example of an ideal grouping without a tertiary centre. I make a plea for geographical boundaries and not boundaries based on absolute numbers.

Mr. John Baron (Billericay): Will the Minister consider another issue concerning the boundaries of strategic health authorities pertaining to existing clinical networks? The Government have stated that SHAs would be coterminous with an aggregate of local authorities and that the boundaries would not cut across Government office boundaries. That is fine, but existing clinical networks do not always align with local or central government boundaries. Securing delivery of health care must be the overriding determining factor when resolving difficulties, so consideration must be given to the role of the clinical networks. I hope that the Minister will forgive me if I refer to the BMA again, but it suggested that an appropriate solution might be to manage any lack of coterminosity at the new regional director of health and social care level instead of with the 28 SHAs to ensure that such decisions are taken at the appropriate strategic level. That would give weight to existing clinical network boundaries instead of historical administrative boundaries, which are largely based on geographical features. Will the Minister consider that point, because existing clinical networks are important to the overall functioning of health services at local level?

Mr. Oliver Heald (North-East Hertfordshire): I join in the welcome to you, Miss Widdecombe, as our co-Chairman.

I want to add one or two points to those of my hon. Friend the Member for West Chelmsford (Mr. Burns). To have a guideline of 1.5 million residents as the basic

[Mr. Oliver Heald]

unit for a strategic health authority is acceptable, although we could argue about what the number of residents should be. However, some flexibility is required from the Minister if it is to work well. My understanding is that, in some city areas, it is proposed that strategic health authorities should be much larger than 1.5 million residents. I should be grateful if the Minister would tell us whether that is right and give us some idea of the scale of difference that is acceptable to the Government.

In my area, it has been suggested at regional level that Hertfordshire should be combined with Bedfordshire to achieve a unit of approximately 1.5 million; a similar size to Essex, to which my hon. Friend the Member for West Chelmsford referred. That is a convenient way of dealing with the matter and would meet some of the clinical networks, but if there were no constraint in terms of having to use local government units to build strategic health authorities, or by the 1.5 million figure, some of the other issues could be considered. For example, to the east of the county, many patients go to Addenbrooke's hospital in Cambridge. Further down the east side of the county, many residents go to Harlow in Essex for hospital treatment. To the south of the county, Mount Vernon is the cancer centre, as the Minister knows, and many of its patients come from north London.

Everyone at regional level, and everyone else involved, is doing their best to come up with a solution for a strategic authority that will work. Will the Minister explain why the figure should be 1.5 million, because a larger number would give greater flexibility?

What is the thinking on having coterminosity with local government areas? Would that be convenient where social services and the NHS were working together? Does the Minister hope that there will be joint working with mental health services? If that is necessary, what is his response to the submission by the Democratic Health Network, a body set up by the Local Government Information Unit? It states that

"the Government has given no clear rationale for the number of the proposed new SHAs. We would wish to see much closer working between health and local government at both regional and sub-regional level. It will not be helpful that the proposed new SHAs will not be co-terminous with other government regional or sub-regional structures."

The Minister will know that I am not a great one for regions. However, the network has 100 members from local government; it is a body with a voice. It has asked that question. Will he respond to it? This is not something that I would favour, but it is the Opposition's job to put forward submissions when bodies of importance issue them.

The Democratic Health Network goes on to say:

"If the main role of Strategic Health Authorities is performance management, we do not understand why up to 30 SHAs are necessary and why they cannot be made co-terminous with the English regions . . . which would make it much easier to co-ordinate regional health policy with other areas of regional policy and with political and administrative structures at regional level."

One can see what it means. The Minister accepts that in parts of the country where there are cities and great urban areas, there should be larger SHAs that fit in with the sub-regional pattern.

I should like the Minister to explain whether this is a patchwork with big SHAs on the one hand and little ones on the other. What is the meaning of the guidance figure of 1.5 million? It obviously means something in Hertfordshire because that region has said that 1.5 million is an important guideline. If something totally different is happening in the west midlands or Yorkshire, how will he reconcile the one with the other? Will the Minister give us a clearer picture of what is going on?

The Minister of State, Department of Health (Mr. John Hutton): May I say how pleased we are to see you in the Chair, Miss Widdecombe? My Front-Bench colleagues and I would rather you were in the Chair than on the Opposition Front Bench.

Mr. Heald: Does the Minister accept that I would always be happy to vacate this slot should my right hon. Friend the Member for Maidstone and The Weald (Miss Widdecombe) want to return to the fray?

Mr. Hutton: You would rule me out of order if I started to argue the merits or otherwise of appointments to the Opposition Front Bench, Miss Widdecombe. I do not intend to go there, and I notice you no longer intend to go there either.

The debate on amendment No. 84 has raised two questions. First, where do we draw the lines in relation to the boundaries of SHAs? The hon. Members for Wyre Forest (Dr. Taylor) and for Billericay (Mr. Baron) have referred to that matter. Secondly, what criteria do we use to draw the lines? The hon. Member for North-East Hertfordshire will be aware from his experience as a Minister that such lines are difficult things to get right. We are putting the structures in place; they are our creation. However, drawing precise boundaries and lines across the map of England is necessarily complicated, and raises issues such as those that the hon. Member for Westbury (Dr. Murrison) mentioned about local perceptions of where boundaries are, and what affinities local people feel with the communities around them.

Opposition Members ask me where we are drawing the lines; we are consulting on that. I hope that all Opposition Members will want to add their views to the consultation process that we have initiated, and some have already. I am sure that the hon. Member for Wyre Forest has, because he is that sort of man. It is up to hon. Members, if they feel concern about such issues, to input into the consultation process. That is the melting pot out of which final decisions come.

The criteria to which Opposition Members have referred—the existence of clinical networks, the importance of coterminosity with local authority boundaries and the issue of regional office boundaries—are important in making decisions about where the boundaries of SHAs should be fixed.

4.45 pm

The reference in the consultation document to a guideline population basis of 1.5 million people—not simply adults, to which the amendment refers, but including children—is also important. Of course we need flexibility in such areas when coming to sensible decisions and, wherever we can, we will refer to the weight of local opinion that emerges through the consultation exercise.

We will not make final decisions through an arbitrary approach to those criteria, but the amendment would force us into doing that. We have issued a document referring to the criteria, and I will return in a minute to Opposition Members' concerns about those criteria. The hon. Member for North-East Hertfordshire said that we need flexibility to make the proposals work well. His amendment, by design, removes from the Bill the flexibility that he wants to ensure is a principle underpinning the decision-making process about the boundaries of SHAs. I accept that the amendment was designed to illuminate and inform the debate, but we must look at the proposed words. I have to tell my hon. Friends that it would be a mistake to go down that road.

Important issues have surfaced, such as observing coterminosity with local authority boundaries wherever we can. The amendment would compromise our ability to do that. I am sure that it is obvious to hon. Members that we want coterminosity because health and social care, the two key pillars of our care system, have developed historically as two separate tribes that do not always work well together. We see the consequences of that in various areas in the NHS. Delayed discharge is the obvious example; another is the problem in accessing mental health services. NHS and social care providers need to work together as closely as possible there because mental health lends itself to such a solution. People with mental health problems have a high degree of dependence on social care services. If the NHS is to do its job properly in delivering effective care, those two great pillars of the welfare society must work more closely together.

The principle of coterminosity between the boundaries of SHAs and those of local authorities fits with the strategic development of services that we want to see. That would be difficult to achieve if the boundaries of SHAs cut a big swathe across the boundaries of social service authorities, so that the same social service authority provided services to a range of PCTs in different SHAs. That would not be the sort of strategic development and coherence that we want, and that SHAs are intended to facilitate and promote.

The argument, as in earlier debates, comes down to how we juggle the various criteria, which most hon. Members recognise as important, in a framework that does not twist the Secretary of State's arm, forcing him to make decisions on arbitrary criteria in the Bill that he has no power to waive. If one takes that to its logical conclusion, the difficulty would be presented in stark terms; the hon. Gentleman's amendment would not allow the Secretary of State to constitute an area with a population two short of 2 million as an area that could have a SHA. With respect to the hon. Gentleman, that does not make sense and would contradict the principle of flexibility that I am sure we share.

I was asked a number of pertinent questions about the guideline of 1.5 million in the consultation exercise. The document makes it clear that we have attempted to provide flexibly. He asked me for a guide for the range of populations that could come within the boundaries of a single SHA. It is clear in the proposal for Durham and Tees valley in the north east that if Ministers decided to set up an SHA there, the population that would be served would be 1.2 million.

Another example is in the east midlands. The proposed boundaries for mid-Trent would include Lincolnshire, north and southern Derbyshire, north Nottinghamshire and Nottingham, making a substantial population of nearly 2.7 million. It is obvious that, in "Shifting the Balance"—and with the consultation under way—there is flexibility over the size of populations that need to be served and serviced by the SHAs. That reflects the important point made by hon. Members about the importance of clinical networks, and the point about tertiary centres made by the hon. Member for Westbury.

We are trying to juggle a number of criteria, which we have set out clearly. We have made no secret about the criteria that we intend to use. We want the proposals to command as much support as possible from the local communities that they will serve. Opposing views are forming part of the consultation process and they will be drawn to Ministers' attention as important arbiters of local opinion. As many hon. Members recognise, we then need to make the judgment of Solomon and are unlikely to be able to keep 100 per cent. of people happy. However, the criteria will be transparent and powerfully informed by the strength of local support for the proposals. Ministers will try to approach the task flexibly with a clear view of the end game. That is not a monstrosity of bureaucracy that cuts across obvious boundaries, but a new system for the NHS that complements the framework of the responsibilities on local authorities and regional officers of government.

Mr. Baron: I welcome what the Minister says and ask him to consider how we manage the lack of coterminosity. Any boundary that we draw will probably alienate one small section, but the bottom line is how one manages the lack of coterminosity. When it comes to the boundaries of clinical networks, the answer is to manage that lack at the new regional director of health and social care level, rather than at the SHA level. That would provide one step back to oversee the true strategic approach to managing that matter.

Mr. Hutton: That is one suggestion, on which I will reflect. However, the consultation exercise, which ends on Friday, is for communities in the NHS, local authorities and the public at large to help us to get the decisions right now. It is important to get coterminosity with local authority boundaries right

[Mr. Hutton]

and to reach decisions that will reflect the natural referral patterns around clinical networks, to which the hon. Member for Billericay referred.

By definition, any organisational change throws up the possibility of upheaval. We want to minimise that disturbance, while getting the basics of decisions right. We will consider the hon. Gentleman's comments, but the role of the regional directors is further away in the back office than he might imagine. It may be helpful to him and other hon. Members if I set out my thoughts in writing.

The amendment has been designed to extract further comments from me on the nature of the boundaries for SHAs. However, the problem with the amendment—as, I am sure, the hon. Gentleman understands—is that if it were to be included in the Bill, it would necessarily require us to run a different consultation exercise. Given all that he and his hon. Friends have said today about not delaying the process unnecessarily and unreasonably—

Mr. Burns: Not rushing it. [*Interruption.*]

The Chairman: Order.

Mr. Hutton: Thank you, Miss Widdecombe. I need protection from the bad boys on the Opposition Front Bench who sometimes misbehave. It is clear that the amendment tabled by the hon. Member for North-East Hertfordshire would strike out the present consultation exercise and require us to start again. I have explained the timetable by which we are currently operating. We intend that the changes will come through in October 2002 and take full effect from April 2003, but the amendment would make it harder to stick to that. The hon. Gentleman might not agree with that timetable—that is his prerogative—but, from my point of view, the amendment would delay progress of the reforms that we want to see.

Mr. Heald: I have two points to take up with the Minister, which I raised during my short contribution. The first concerns the regional aspect. If Hertfordshire and Bedfordshire were placed together, they would constitute a sub-regional group because they are a quadrant of the region. I forget the precise name—perhaps it is the western quadrant—but I note that an expert sitting not far from the Minister may be about to tell him the answer. According to Government thinking, will such sub-regional structures form the basis of the strategic health authorities? Is there a regional aspect to the matter? As the Minister will recall, the Democratic Health Network is keen to have such an aspect, as it clearly would be a good thing from its point of view.

Secondly, the Minister will recall intervening when the point was made that people in the west midlands are concerned that the strategic health authority might prove too large. What area and population will the west midlands authority cover? Will it be a large authority such as that for mid-Trent, to which he referred, with well in excess of 2 million people?

Mr. Hutton: I do not have in front of me details on the proposals for the west midlands, but as our debate progresses I might be able to get that information. However, the "Shifting the Balance" consultation document made it clear that in establishing the two principles that we intend to follow, we will not allow the boundaries of strategic health authorities to cross Government Office boundaries. That is an important point, and further than that I am not sure I can go today. In a sense, the hon. Gentleman and his hon. Friends are asking me to announce decisions on certain strategic health authority boundaries. I cannot do so because consultation has not finished and it would be wrong for a Minister to pre-empt that process.

Mr. Burns: May I seek clarification on something that the Minister said to my hon. Friend the Member for North-East Hertfordshire a moment ago, so that we do not get totally confused? In an earlier debate, the Minister said that, in effect, all PCTs would be in place by October 2002, when the system comes into effect. However, about three minutes ago—just before my hon. Friend's intervention—I think he said that although PCTs will be in place by October 2002, they will take full effect from April 2003. Assuming that I heard him correctly, I find that confusing.

Mr. Hutton: I do not want ever to confuse the hon. Gentleman. I was referring to the first full financial year in which the arrangements will take place, which, obviously, is April 2003. The basis for the measures will not come into operation until October 2002, which is the half way point. I repeat that I was referring to the first full financial year.

Perhaps I am wrong, but I hope that my comments have been of some value to hon. Members who have raised these concerns. The amendment is completely unworkable and unacceptable. It would build rigidities into a system that, as the hon. Member for West Chelmsford himself has said, has a paramount need for flexibility. I urge my hon. Friends to reject it.

Mr. Burns: You were not here, Miss Widdecombe, when, at the beginning of my remarks, I made it plain to the Minister that these were probing amendments, and, to be fair to him, he has fully acknowledged that fact. We are grateful for the further information that he has made available.

I should be the first to agree with the Minister that if the amendment were to be agreed to tonight, it would place any future Secretary of State, regardless of their political complexion, in a straitjacket. I sympathise with the Minister's comments that if one were two people short of 2 million, one would not be able to set up a SHA, which clearly would be ludicrous. That was not our intention in so far as we used the amendments as a vehicle to probe him, a process that proved illuminating and enlightening. In light of his response, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

5 pm

The Chairman: Before we come to amendment No. 85, for the convenience of the Committee I should say that having examined the scope of the amendments and clause 1, I am not minded to have a stand part debate on clause 1. I am therefore happy for members of the Committee to go a little wide in the course of the debates on the following two amendments. That is not a general invitation.

Mr. Heald: I beg to move amendment No. 85, in page 2, line 7, at end insert—

'(c) A Strategic Health Authority shall only be established under paragraph (a) above provided that there has been consultation with general practitioners, nurses and other health professionals in that area.'.

The Chairman: With this we may discuss the following amendments: No. 86 in page 2, line 7, at end insert—

'(cc) A Health Authority shall only be established under paragraph (b) above provided that there has been consultation with general practitioners, nurses and other health professionals in that area.'.

No. 87, in page 2, line 14, at end insert—

'and such an order shall only be made following consultation with health professionals, local authorities and other interested parties in that area as to the name proposed.'.

No. 88, in page 2, line 21, at end insert—

'and such an order shall only be made following consultation with health professionals, local authorities and other interested parties in that area as to the name proposed.'.

Mr. Heald: The amendments are designed to ensure that there would be consultation with general practitioners, nurses and other health professionals in the area concerned before the establishment of a SHA, or a health authority in Wales. The Minister has already said that there has been consultation with the public concerning the general concept, and that consultation, which is due to be completed shortly, is continuing on the boundaries of SHAs. The decision on the boundaries will be made in December of this year.

The proposed provision is designed not to duplicate that process, but to allow wider consultation on the establishment of a SHA. It would allow issues such as the impact of the changes on local implementation of the NHS plan, and other practical matters, to be dealt with on the basis that local practitioners can bring their common sense and experience of events in their area to bear on the decision. If a SHA was not ready for implementation, or if it would damage patient care to implement a SHA, it need not go ahead. The Government would know the worst and be able to react to it.

Worries are being widely voiced about whether the changes are for the best, and there is a long article about the subject in this month's *Health Service Journal*. The article cites commentators who take the view that the effect of these changes will be negative, and it points out that there seems to be an irresistible urge for Ministers to put their stamp on the NHS, often to political time scales that do not fit with time scales that would effect substantial and good-quality change in the system. The article quotes a professor of health economics at York university, Alan Maynard, who describes structural re-organisation as

"a wonderful substitute for change . . . It's displacement activity, a whole lot of smoke with everybody doing an awful lot, but nothing that creates change at all. You change the name, you change the sign on the door—what difference does that make to the service? Implementing real change is perhaps a 10-year enterprise . . . reorganisation distracts everybody—but does concentrate people's minds on the bottom line, which is 'Am I going to have a job tomorrow?'"

Managers should be worrying about how to implement the NHS plan and other improvements.

The article quotes other people, such as Dr. Charles Webster, the author of the official history of the NHS, who states:

"I think the majority of reorganisational changes are done as a surrogate for spending more money." A battery of criticisms is being levied.

Mr. Burns: Does my hon. Friend agree that, given the problems within the health service, with our constituents facing longer waiting time, problems with accident and emergency services and having to wait on trolleys, the Secretary of State for Health is confusing activity with action?

Mr. Heald: I am sure that that is right. The general flavour of the remarks that managers are making in the health service is that because the Prime Minister's promise to increase the spending on health up to the European average, which would involve spending, on one view, £35 billion a year more than we are at the moment, is unrealisable, we are having yet another reorganisation, and there is a developing cynicism out there.

The former head of press and publicity at the Department of Health, a man who has worked under Conservative and Labour administrations, has put it this way:

"I think they are in danger of disappearing up their own fundament."

Mr. Burns: Who is that?

The Chairman: Order.

Mr. Heald: I should tell the Committee that it was Romola Christopherson.

Mr. Hutton: The hon. Gentleman has changed Romola Christopherson's gender. She is a woman.

Mr. Heald: In that case, her comments carry even more weight. The Minister would no doubt agree that we should not suggest that her views are in anyway less important because of that. If anything, her experience working over all those years for both Governments gives her a unique position from which to comment.

Mr. Burns: Unless Romola Christopherson has changed her position recently, I think that she now works in the press department at No. 10. She certainly went from the Department of Health to No. 10, which may be the cause of some of the problems between the Department of Health and No. 10 at the moment.

Mr. Heald: There obviously are problems, but I rather doubt whether they are the result of Ms Christopherson going there. It does say in the article that she has retired from the civil service, so it may well be that she is no longer working at No. 10, if she did previously.

The article also states:

"David Hunter, professor of health policy and management at Durham University, is concerned that 'we don't seem to have learnt anything from the mistakes we made then . . . What is even more worrying is that at times of other changes, at least one or two parts of the system have been stable. This time, it's everything that's changing. It looks like a recipe for disaster.'"

Mr. Hunter makes the point, which I do not think has been made so far in this Committee, that about three years ago, the Secretary of State for Health at that time, the rt. hon. Member for Holborn and St. Pancras (Mr. Dobson), said:

"The last thing we want is a big bang reform"

of the NHS. Yet, here we are three years later having yet another reorganisation of the health service. It is hard to understand why the Government are taking this approach.

The Royal College of Nursing also has concerns that there should be a proper balance on the boards of the strategic health authorities, a point that it has made quite forcefully. Would the Minister be happy to see that happen? Clearly, the nursing profession has a particularly important role in that area.

The amendment proposes consultation before action. Does the Minister agree that, instead of airy-fairy consultation on broad principles, or simply looking at boundaries, what is really needed is to ask practitioners on the ground whether their area is suited to the changes? If they think not, let us not have a SHA and all the changes there, or let us leave it until the area is ready. As the Minister knows, we have always accepted that PCTs are a good basis on which to go forward provided that they are properly organised, have the staff that they need, and have had their budgets sorted out with everyone ready to start. The concern is that SHAs could end up being strategic about organisations that are not really strong enough to take the burdens that will be placed on them. I look forward to the Minister's comments on the amendments.

Dr. Murrison: We have yet to discuss the position of academic medicine in the proposed changes. Academics have been highly critical of the Bill, and with good reason. They are not mentioned in it very much. If SHAs have a role, I should have thought that it would be heavily tied in with academic medicine. We have talked about the different sizes of SHAs and how they might link with tertiary centres. Tertiary centres are intertwined with academic medicine, and I am concerned that insufficient weight is being given to such links. That is certainly suggested by the different sizes that the Minister has implied will come out of the consultation process. If proper tertiary centres are not part of a particular strategic health authority, it will lack an academic focus.

We have progressed in recent years. Academic medicine is no longer solely the prerogative of teaching centres, but, nevertheless, there has been a drift back towards large centres in recent years. Funders seem to be more impressed by large centres, a situation that is likely to continue. Referring from convenience to the south-west, the minnow SHA covering Somerset and Dorset would lack such a tertiary centre, and a proper focus of academic medicine. I am concerned that academics' views and worries about being sidelined are not being properly registered. I hope that the Minister will bear in mind the needs of academic medicine in this country. If SHAs have a role—some doubt is emerging about that—promoting academic medicine in their areas might be it.

Dr. Taylor: The amendments place me uncomfortably on the horns of a dilemma. This week's *Health Service Journal* tells us that there is an absolute plethora of consultations. They are running at the rate of about one a week. Much as I want to see meaningful consultation, as alluded to by the amendments, it is difficult to square that with the current tremendous rate of consultation. Consultation is getting into bad repute because it is so often on a preferred option, and that option often succeeds. I believe that there were 32 consultations last year. Can the Minister tell me, now or at a later date, how many of those had a preferred option, and how many of them overturned that option? It would be reassuring if we could sometimes see that consultation was meaningful and overturned the preferred option, which may not be the best one.

Amendments Nos. 87 and 88 mention consultation with

"local authorities and other interested parties".

Something that we risk losing with the abolition of community health councils is their role as statutory consultees. Will they be replaced with other statutory consultees?

5.15 pm

Andy Burnham (Leigh): The setting up of SHAs is an extremely important step. They will play an important role in working across an entire region to raise the general standard of health and to tackle the fundamental problems, such as health inequalities, that were bequeathed to us by the Conservative Government. For example, they will play a key part in consultations with regional development agencies.

The problem with the amendments is not their principle, but the fact that they are too narrowly drawn in focusing first on NHS staff and health professionals and, secondly, on the name proposed for the SHA rather than more widely on its boundaries. That does not reflect current practice in the health service, where there is wide consultation not only within the profession, but across community, local and voluntary groups. There may be a case for enshrining that good principle in legislation.

Perhaps the Government might consider amendments that, instead of focusing too narrowly on health professionals, would require consultation with the range of bodies that are affected by the creation of SHAs.

Mr. Burns: That was an interesting speech. The hon. Member for Leigh (Andy Burnham) gives the distinct impression that he supports the idea of consultation, but thinks that the trouble with the amendments moved by my hon. Friend the Member for North-East Hertfordshire is that their scope is too narrow in terms of who would be consulted. I assume that he has conceded the principle of the amendments but thinks that their scope should be widened. Carrying that to its logical conclusion, if we pressed them to a Division he would support us with the proviso that, if they were accepted, he would try to amend them on Report to widen their scope so that they were 100 per cent. consistent with his views.

Andy Burnham: The real problem with the amendments is that they do not reflect current practice in the NHS and in Richmond house. They are far too narrowly focused on health professionals and NHS staff. The hon. Gentleman cannot have been listening when I said that SHAs will have an impact far beyond the NHS, especially in terms of regional government and regional development agencies. I do not support the amendments, but I do not think that the Minister would have a problem with them in principle.

Mr. Burns: I am most grateful to the hon. Gentleman. I had forgotten that he is sitting next to a Government Whip, so no doubt he had to put it on the record that he had overstepped the mark and was heavily backtracking to remain within the bounds of the controls.

My hon. Friend the Member for North-East Hertfordshire has moved some important amendments today and, unlike the hon. Member for Leigh, he is right because it is crucial that when an important new structure with the vital role, as the Government keep telling us, of the strategic overview of health care provision throughout the country is set up, there should be consultation within the local community. Perhaps, as the hon. Gentleman said, we have been a little modest in suggesting who the consultations should be with. Perhaps the amendments are right in principle and would enhance and improve the Bill, but need to be considered further at a later stage to ensure that we have not missed out any people or organisations that should be included in the consultation process. I presume that the Minister will also be sympathetic to the amendments, even if he believes, like his hon. Friend, that they are a little narrow in suggesting who should be consulted.

There is a similar precedent for consultation. At the beginning of the debate, Miss Widdecombe, you kindly said that we could go slightly wide of the amendments, but I assure you that I do not seek to test your patience and I shall watch you very carefully so as not to overstep the bounds. I am trying to explain that there is a precedent. During the proceedings of the Health Act 1999, Miss Widdecombe, you were the shadow Secretary of State for Health and leading for the Opposition. You will be familiar with the fact that when the Government set up the PCTs they were anxious that they should emerge as voluntary organisations after full consultation with the local community. We are setting up new groups or structures within the health service and there is a precedent for the SHAs—the original powers taken by the Government to set up the PCTs and PCGs in 1999. I am sure that you will remember, Miss Widdecombe, that the then Minister of State, ironically, Standing Committee A, during the afternoon—there are many similarities that I hope will keep me in order—on 27 April 1999, said:

"Given some of the comments that have been made, it is important to emphasise that we do not intend a headlong rush"—

We have heard a lot about headlong rushes today, particularly this morning—

"to be made into PCTs and that it is not a part of our agenda to impose PCTs on the national health service."

This is my point:

"We want measured and voluntary change, and progression to trust status that is driven locally and based on local views. Full and proper consultation must therefore always occur before a PCT is established, and due consideration should be given to the views of a full range of local stakeholders."——[*Official Report, Standing Committee A*, 27 April 1999; c. 252.]

The then Minister, like the hon. Member for Leigh, had a broader vision of the bigger picture than I have, and that is my fault. The hon. Gentleman's criticism is that our amendments are too narrow, and I accept that. I plead guilty.

Mr. Heald: It is only right that I should plead guilty, because I drafted the amendments. Does my hon. Friend agree that the reason for choosing those particular stakeholders was because the Royal College of Nursing had said that it was worried about the time scale envisaged for the proposals, which talked about new organisations. It was concerned that the programme was ambitious and the BMA—the doctors—said much the same. It used the words "ambitious timetable". Those concerns came to us, but I accept that I may have drafted the amendment too narrowly.

Mr. Burns: My hon. Friend is right to draw attention to those important views from outside bodies whose members are working day after day in the health service and who have a far greater comprehension of what is going on than any politician.

Although the Minister was referring to PCTs, the precedent exists and we strongly believe, as does the hon. Member for Leigh in a wider way, that the same criteria for consultation, discussion and consent should apply to the SHAs before they are established. Given the power of our arguments, I hope that the Minister would be prepared to accept the pleading from his hon. Friend, and from us, and agree to the amendments as a halfway house, or building block, that can be improved on, enhanced and expanded by the Government on Report. The Government could use their majority to ensure that we improve the Bill in such a fashion.

Mr. Hutton: This has been a useful debate and I thank all hon. Members who have taken part. The hon. Member for West Chelmsford asked me to take into account the arguments of my hon. Friend the Member for Leigh, which I am prepared to do because he made a good case with good arguments. I should

[Mr. Hutton]

also say that I am grateful for that, just in case, with the Whip sitting next to him, I cause any problems, but I am not trying to encourage other hon. Friends. I want to put what I am saying on record because I do not want to be disingenuous to the hon. Member for North-East Hertfordshire who moved the amendment.

My hon. Friend is right. The architecture of the Bill includes a duty on the Secretary of State to set up SHAs, so we must be clear that the Bill will require him to do that anyway. He is right about the principle of consultation and the argument must take place in that context. We believe, and I hope that the Committee will endorse the view, that it should be a statutory duty to set them up. We could not pull the rug from under the Secretary of State and say that they cannot be set up under certain circumstances. The proposals are coherent.

SHAs should cover every part of England, but I accept the point made by my hon. Friend that the National Health Service Act 1977, or any other subsequent piece of legislation, which the Conservative had 20 years to change and amend, does not require consultation on the establishment of health authorities, and it never has done. Currently, the Secretary of State is required to establish health authorities under statute. My hon. Friend is right to draw attention to the fact that previous Governments, as well as this one, have operated the practice of consulting the public, professions in the NHS and groups outside on proposals to change the boundaries of health authorities; mergers are an example. We are in the middle of consultation now about the establishment of the new SHAs.

I could not accept the suggestion of the hon. Member for West Chelmsford that we should consult on the principle of establishing SHAs because we believe that that should be covered by an express duty on the Secretary of State. As suggested by my hon. Friend the Member for Leigh, there is scope for considering consultation processes under the Bill in respect of changing the name of health authorities and the boundaries and mergers of SHAs. I am prepared to reflect further on that and consider amendments on Report if necessary. The principle, to which my hon. Friend referred, is important and I am happy to consider it further.

I am prepared to reconsider how the proposals will affect SHAs in England, but I cannot accept the amendments as they would apply to Wales, for two reasons. First, those are devolved matters. This House has given responsibility for them to the National Assembly for Wales, and we should respect that devolution settlement, not seek to fetter the Assembly's powers in that way.

Secondly, more practically and perhaps importantly, the health authorities in Wales will be abolished by 2003 anyway. There seems little point in establishing such consultative proposals for bodies that will be scrapped in Wales in 18 months' time. With that caveat, and bearing in mind my hon. Friend's request to look at boundary changes and name changes, I can tell the hon. Member for North-East Hertfordshire that we will reflect further on the matter and table an amendment, if possible, on Report. I hope that, in that spirit, he will not press the amendment.

5.30 pm

Mr. Heald: The Minister's approach has been constructive. I join him in congratulating the hon. Member for Leigh. His viewpoint met us halfway and encouraged the Minister to move further as well.

The Minister has not gone the whole distance, as we would like him to. He says that he will consider placing consultation requirements in the Bill, which is welcome, and he mentioned consultation on names and boundaries. However, he did not agree to consultation on practical matters such as whether an SHA could deal locally with robust arrangements that were ready to be put in place, or whether the timing was right. Many concerns expressed have been on such matters as insufficient staff for PCTs and arrangements not being fully in place, as we have discussed, for a start in October or even in April 2003.

I should like to press the Minister further. Is he simply agreeing to consultation on names and boundaries with the wider group of people mentioned by the hon. Member for Leigh, or is he prepared to consider consultation on some of the more practical issues that I raised about whether local arrangements are ready for the changes to be implemented, whether staffing of PCTs is sorted out and so on? In other words, is he prepared to find out from doctors, nurses and local people whether the proposals can, practically, be implemented?

Mr. Hutton: I have probably gone as far as I can today in giving commitments to the Committee to re-examine the proposals. I shall certainly reflect on what the hon. Gentleman has said, but I repeat the point that I made at the outset: there will, I hope, be a statutory duty to establish SHAs, and I would treat with extreme caution any proposal from the hon. Gentleman that that should somehow be subject to caveats, or made conditional upon another range of circumstances. The Secretary of State will have to be satisfied that the SHAs are capable of delivering the functions that he has in mind for them. That is his responsibility, and he must discharge it. I have gone as far as I can on areas where we can look at amendments to the Bill.

Mr. Heald: We have seen some progress on the amendments, so, in that spirit, it would be right for me to withdraw them. I hope that the Minister will consider what the BMA and the RCN have said. Obviously, if the representative bodies of the two main health professions combine to say that they are worried about the time scale for arrangements being enforced, that is a matter for concern. We hoped that this consultation process would be a way, not of second-guessing the Minister, but of ensuring that local services do not collapse, with inadequate management, causing a deterioration and the delay of much of the progress that we hope to see during the

coming years. I hope that the Minister will think further on the matter; he has said that he probably will. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Mr. Burns: I beg to move amendment No. 90, in page 2, line 33, at end insert—

'(2A) Subsection 126(1) of the 1977 Act is amended by the insertion after the word "Parliament" of the words "; save that no statutory instrument shall be made under section 8 above unless a draft of the instrument has been laid before, and approved by resolution of, each House of Parliament.".'.

The amendment is very straightforward. As is patently obvious, we are seeking to reverse secondary legislation procedures that will set up SHAs. Unless I am mistaken, there are 58 separate order-making powers—[*Interruption.*] My hon. Friend the Member for North-East Hertfordshire tells me that it is slightly less than 58, but, in any event, the vast majority of the considerable number of order-making powers in this legislation are negative procedures.

At this point, I will offer to do a deal with the Minister. I will not mention issues that some of his right hon. Friends may have supported in 1983 or in 1987 if he agrees not to offer the bog-standard ministerial response that the Opposition did not do things in the way that I am suggesting when in government. Life has moved on and people have changed their views on certain issues. I shall explain why I have changed my views on the Bill after the Minister has intervened.

Mr. Hutton: Why is the hon. Gentleman so reluctant to talk about the record of his party in government? He is right to say that life has moved on; he is sitting on the Opposition Benches and we are sitting on the Government Benches.

Mr. Burns: I shall not digress, except to say that I was not talking about the Conservative Government. I said that I would do a deal with the Minister; unless he advances the hackneyed argument that most Ministers advance these days, I will not remind him that his right hon. Friend the Prime Minister fought the 1983 general election on CND's platform of withdrawal from Europe.

The Chairman: Order. CND has no relevance whatever to amendment No. 90, which is concerned with procedures for draft instruments.

Mr. Burns: I am extremely grateful for that guidance, Miss Widdecombe, because it helps me make the point that life has moved on and that issue is no longer relevant. I hope that the Minister will not offer the hackneyed arguments to which I have referred, but will instead advance an intellectually coherent argument against the amendment—I am sure that he does not accept it—based on reasons why the negative, rather than the affirmative, resolution should be used.

You have graciously and kindly said, Miss Widdecombe, that our debate can go slightly wider, but I shall be careful not to abuse your generosity. As you would have realised had you been here this morning, and as anyone who has studied the clause will realise, it sets up an important new or reformed structure in our health care system. We have argued time and again this morning and this afternoon—I can assure the Minister that we will do so again in respect of clause 2—that the Government are rushing far too quickly into imposing the new structure on the health service. In a spirit of helpfulness, we are urging a more cautious approach that ensures that proper foundations exist on which to build their aims. One way to do that is to accept the amendment, which would reverse the onus to enact secondary legislation through the negative procedure.

This morning, my hon. Friend the Member for North-East Hertfordshire pointed out to the Minister that in one particular Session, there were more than 2,000 negative resolution statutory instruments, of which only 30 or 31 were debated in Parliament. Putting legislation into the negative format gives the Government carte blanche. The way in which the system works in terms of secondary legislation means that it is extremely difficult to find parliamentary time for such matters, especially if the Government are determined to restrict and hamper the Opposition's ability to express an opposing view in Parliament.

It is important for democracy, and it is important for the NHS, that we have affirmative procedures, in which case the order setting up the SHAs would have to be debated in both Houses of Parliament. There would be an opportunity for Members, and those in another place, to scrutinise line by line, as we are doing to the Bill, a far-reaching proposal, which would ensure that the Government have got it right. Even at that late stage, they would have the opportunity to advise or warn the Government if they discovered that there were faults and flaws in their proposals. Once the Government recognised the strength of the case, they would have the opportunity to rectify the problem before inflicting a flawed piece of legislation onto the NHS.

Mr. Peter Atkinson (Hexham): My hon. Friend points out an important aspect of the Bill. In clause 1, the Secretary of State is taking substantial powers to

"vary the area of a Strategic Health authority . . . abolish a Strategic Health authority . . . establish a new Strategic Health Authority".

If that were done against the will of local people there would be an enormous argument. If, for example, the Secretary of State decided that Chelmsford should be welded into east London, many of my hon. Friend's constituents would become angry. That could be imposed without representation being made unless the Secretary of State was to accept a prayer against that resolution. That is wholly undemocratic.

Mr. Burns: My hon. Friend is right, and he anticipates a point that I was seeking to move onto during the course of my remarks. Clause 1 contains substantial powers for the Secretary of State, and he can exercise those powers notwithstanding the Minister's generous concession during our debate on the last group of amendments. It would be a step

[Mr. Burns]

forward if, on Report, the Minister were to come up with proposals that were acceptable to the House, and they were embodied in the Bill; what a paradox.

The Minister is in a conciliatory mood today, and he has listened to my arguments and those of my hon. Friend the Member for North-East Hertfordshire and the hon. Member for Leigh. He has seen that there is reason to look further, and he may come forward with amendments on Report. It is unusual for the Government to concede a point in Committee to the Opposition, and it is very unusual for a Government Back Bencher to contribute to the debate. However, when such a Back Bencher hits the jackpot and comes up with an idea that the Minister thinks is worthy, that is a bonus, so it must have merit.

The Minister could go away and return with a set of proposals that, for the sake of argument, we might find acceptable. If they were then included in the Bill, the Minister will have increased the powers of consultation on a number of issues that are vital to local people, communities and organisations that are directly affected or which have an interest in strategic health authorities and health care in their region.

5.45 pm

That would be a step forward, but the contradiction is that the powers in the same Bill allow the Secretary of State to ride roughshod over the results of any local consultation carried out in good faith if he is not minded to accept the advice or the views that are thrown up during the consultation process. That seems extraordinary. We must be consistent; the consistent approach, given the Minister's earlier statement, is that the Secretary of State should be held to account.

The affirmative resolution procedure could be described as consultation because a Committee of Members of Parliament—reflecting all views and parties, and able to be consulted—have the opportunity to contribute to the debate and decide whether to vote for the order to become law so that the SHAs can be established as the Secretary of State has specified. Alternatively, it could be thrown out—a statutory instrument cannot be amended—and the Secretary of State could be told to look at the matter again because he has got it wrong or is acting in contradiction of the views of local people following the consultation. He could then start again from scratch and return to the matter in the House and in another place.

Mr. Heald: Does my hon. Friend agree that the section 60 power in the Health Act 1999, which provides wide order-making powers in health matters, has recently been used successfully to allow consultation and the views of those who are not Members of Parliament to be heard? The draft Nursing and Midwifery Order and the draft Health Professions Order were considered yesterday and representatives of the nursing profession, the midwifery profession, health visitors and so on with particular views were able to express them and to lobby Members of Parliament. The same applied to chiropodists and podiatrists who were unhappy with aspects of the Health Professions Order. If such bodies have concerns, it is better, when the time comes for a decision to be made, if they can make representations. The Royal College of Nursing and the BMA both have worries, so would that not be the best approach?

Mr. Burns: Again, my hon. Friend is absolutely right and I hope that the Minister was listening carefully to the powerful way in which he made his case. It is important that not only Members of Parliament, but outside organisations connected with health care and the national health service have the opportunity to input their views on the proposals in draft legislation, whether primary or secondary legislation. It is equally important that they believe that their views have been considered and given a fair chance. If the Government do not agree with their views, and if both Houses of Parliament do not share those views, it is only right that the orders should go on to the statute book. However, there must be that power to determine whether the Government are right. I warn the Minister that this is the first of several debates about this issue, because most of the order-making powers in the Bill are subject to the negative resolution procedure and most deal with important matters. I hope that he will think carefully about that.

Mr. Peter Atkinson: It has suddenly occurred to me that my hon. Friend's advice to the Minister is not in the best interests of the Opposition. Most Members of Parliament know that once they interfere in local politics, they are likely to get their hands bitten hard. In this case, the Secretary of State will become a referee between several warring factions who think that boundaries should be somewhere other than where he has decided. Ultimately he will have to adjudicate, thereby becoming deeply unpopular. If he followed my hon. Friend's advice, he would at least avoid some of that flak.

Mr. Burns: I fully understand my hon. Friend's point and would not want to be a Secretary of State placed in the position that he describes. However, I am afraid that, on this occasion, I cannot agree with my hon. Friend. Democracy, proper consultation and the opportunity fully to debate and consider legislation is more important than the situation in which an individual Secretary of State might find himself.

Too much legislation, especially secondary legislation, is going through the House on the nod. That does a disservice not only to the bodies and organisations that are directly affected by it, but to the working of this place. It also builds up the frustration of interested parties whose lives are affected either by the work that they do in those organisations or through the representative role that they play. Many organisations feel that they are being ignored, bypassed and sidelined on issues that are crucial to many people.

In the light of that, I hope that the Minister will have an open mind and be prepared to think again. I leave him with one thought. When Labour in opposition between 1992 and 1997, many of his colleagues who were then on the Front Bench—I am ashamed to say

that I do not remember if he was one of them—made the same speech in Committee against my Government that I have made today against his Government. They spoke passionately and with conviction and belief, but they were frustrated. The Minister must know what we are going through, and I hope that he will want to try to stop that ping-pong effect between the Government and the Opposition.

Dr. Evan Harris (Oxford, West and Abingdon): First, I apologise for my late arrival in this afternoon's sitting. I said this morning that as I believe that the whole clause is fatally flawed I do not have much to say about amendments that seek to make it better. I was surprised to find that there is some compromise in the air regarding consultation. I was also surprised, but delighted, to see you in the Chair, Miss Widdecombe. I remember the times that we spent debating the Health Act 1999, sometimes with the Minister. That is where I learned how to deal with Standing Committees. If I perform badly, it will not be a reflection on what I learned from you, Miss Widdecombe. I enjoyed the experience a great deal.

I am somewhat hampered, in that I understand that there may not be a stand part debate. I do not argue with your decision on that, Miss Widdecombe, but I regret it because we have not had an opportunity to debate the fundamental problem—the abolition of health authorities and the creation of larger beasts called strategic health authorities—that none of the amendments tackle. In so far as I am in order, I will attempt to make a few remarks on the order-making powers during discussion on the amendment.

Mr. Burns: The hon. Gentleman has been a member of the Committee since its inception. If he does not feel that any amendments deal with the fundamental issue to which he refers, why has he not tabled amendments to deal with it?

Dr. Harris: The amendment that I would like to table is one that deletes clause 1. I can support that principle by voting against clause 1 on the stand part vote, so amendments are not required. I made that clear earlier, and I am sorry that the hon. Gentleman did not understand my point. I make it again now. We can have long debates about improving something that is fatally flawed, but it is important to come down to the nub.

Mr. Heald: On a point of order, Miss Widdecombe. As one or two hon. Members were not present when you made your ruling, it may be convenient for the Committee if you confirmed that you would allow considerable latitude in the discussion of the amendments.

The Chairman: I am not sure whether my words were "considerable latitude". I said that, having examined the scope of the amendments and the clause, I was not minded to allow a stand part debate and that, in the light of that, I was prepared to allow discussion to go slightly wide. I stressed that that was not a general invitation to discuss anything and everything. If the hon. Member for Oxford, West and Abingdon wishes to make remarks that are slightly wide, that will be in order.

Dr. Harris: I am extremely grateful to you, Miss Widdecombe, and to the hon. Gentleman, for that clarification. On Second Reading I made several remarks that I would otherwise have made in a stand part debate, and I do not intend to take up the Committee's time by repeating them. I should be grateful if you would bring me to order should I step beyond the latitude that you have so kindly and wisely granted.

I agree with the principle that it is correct when scrutinising legislation to ensure that the Government are not taking the easy path with the negative procedure for statutory instruments. When we discuss other order-making powers in the Bill, there will be occasion to raise that. The remarks of the hon. Member for West Chelmsford are reasonable in general, but this is not the order-making power upon which to go to war over negative and affirmative resolutions. If every change that was conceived had to go to a Standing Committee, we would spend much time looking at minutiae and miss the bigger picture, and that would, to a certain extent, play into the Government's hands.

The wider picture is yet another example of the continual upheaval in the health service, with the loss by local health authorities of their strategic functions to a much larger body with which local people will find it hard to identify. Although there will be coterminosity, in that we are told that an SHA's wider boundaries will not cross the boundaries of the local authority or the regional office, there will still be a loss, certainly for counties, when, for example, the Oxfordshire health authority that people know so well and sometimes love—or sometimes hate—is removed. It cannot be replaced, even with greater consultation over SHAs and PCTs.

Any gain is lost if the clause is passed, so I do not think that asking for affirmative resolutions when boundary changes occur is especially helpful. There will always be arguments about what the boundaries and the name of the SHA should be. In the end, the Government have to make a decision, and will, presumably, be indirectly held to account for it.

As the Government are taking broad powers to make changes, it is appropriate to question why the Government want to devolve responsibilities to PCTs, which for all their localness, do not have the same understanding of and identity with local communities that health authorities have. Health authorities are population-based groups, whereas PCTs, by definition, cover those people on the list of GPs in the area. While they may be smaller than health authorities, they lose a lot in terms of accountability.

In the areas that I know of, the names of the PCTs do not necessarily follow those of natural communities. The Government will have difficulties naming SHAs under some of the powers that the amendment is discussing, when trying to identify natural communities.

Mr. Hutton: The hon. Gentleman is not right in what he said about primary care trusts. PCTs come in various shapes and sizes. For example, the PCT that covers my constituency is coterminous with the previous boundaries of the health authority.

6 pm

Dr. Harris: The concept of the boundary of the PCT is a curious one. As I understand it, the people served by the PCT are those who fall within the ambit of the primary health care services in that area. Indeed, one of the arguments for the establishment of the PCT was the focus that the Government want to give to primary care to have a greater role in commissioning outwith health authorities. Health authorities cover geographically defined areas, and there will be some significant overlap in population terms between PCTs, simply because they are at the boundaries of conurbations. I do not know whether the Minister —

Mr. Hutton: The hon. Gentleman is right on that point, but he is wrong in assuming that there is no possibility of coterminosity between PCTs and health authority boundaries. Often there will be. Some PCTs are set up on the same boundaries as health authorities.

Dr. Harris: Presumably they have seen the virtue of that conterminosity with the commissioning population. Therefore, if commissioning is the key—certainly some of the functions of the commissioning and overseeing of services—I would prefer to see that done and supervised on a population-based approach.

Mr. Hutton: Once again the hon. Gentleman has missed one important factor—the PCTs are established following local consultation. I accept his point about the boundaries sometimes being a mysterious process, but whatever the boundaries are, they are informed by the strength of local opinion, particularly with the GPs and in primary care.

Dr. Harris: There would be more merit in that argument as a total rebuttal if the formation of PCTs was an option that local populations could choose following consultation. But the Bill, and specifically the next clause—which I will not deal with now—does make that compulsory, and therefore less of a consultative issue.

It is relevant to the discussion to ask the Minister for clarification on a matter that he raised earlier, which we could not discuss then. He provided a clarification note about the functions currently conferred on health authorities and transferred under the Bill in the main to PCTs and, in one example, to SHAs, with regard to which he has an order-making power, which we are discussing here.

Personal medical services and personal dental services will be transferred to SHAs because, as the Government explain in their note, technical and legal barriers prevent the direct conferral of all PMS and PDS functions to PCTs in the Bill because the National Health Service (Primary Care) Act 1997 requires a distinction between the commissioner and the provider of PMS and PDS pilots. I understand that. I was concerned about the loss of the purchaser-provider split when PCTs were going to be doing the providing, as well as the commissioning and running themselves.

Does the Minister think that there is an argument for ensuring that more of those services, particularly the management of family health services and general medical services, might have been transferred to a SHA rather than to a PCT, where there will be a concern that it is the people against whom there may be complaints and general issues of performance who are in charge of managing that performance.

Mr. Hutton: It is important that those services should be as close to the front line as possible. That is why we have taken the decision on the point he mentions. Personal medical services are particularly difficult because some PMS pilots are directly provided for by PCTs and it is important to respect the commissioner-provider divide. That is regulated under clause 4, so I am sure that we will have an opportunity to discuss it later.

Dr. Harris: On that basis, I shall not pursue it any further now.

On Second Reading, I raised the question of the public health function. Concerns have been raised and while there is certain support for the concept of moving the public health function from local health authorities to PCTs, concern has also been raised about the loss of expertise and people through that change, and the loss of a strategic overview because SHAs will be much larger and will have a rival in the shape of a more local director of public health. How will the Minister ensure that we do not lose the effective public health function? I hope that he will accept that it has been performed well at health authority level so far. In respect of infectious disease control and other matters, the regimes are tried and tested at that level. It would be unfortunate if, despite gaining the benefits that the Minister claims for this move, the public health function was lost. There is a question over whether sufficient specialist expertise exists in public health to provide the function under multiple PCTs, rather than under a single health authority.

I am grateful for your patience, Miss Widdecombe, in allowing me to stray beyond the exact boundaries of the amendment. I shall seek a Division at least on clause 1 stand part and, because of our concern about change for the sake of it and appearing active to hide failure to deliver, my party cannot support what amounts to vandalism of the health service.

Mr. Hutton: I will reply to some of the points made by the hon. Member for Oxford, West and Abingdon (Dr. Harris) shortly. On public health, he may have missed my earlier attempt to clarify those points. I hope that he will not take offence, but I will send him a copy of my earlier remarks rather than attempt to repeat them. There may be video too, but he would not want to watch that.

On both sides of the Committee, there must be a sense of déjà vu about these debates. The hon. Member for West Chelmsford is probably right to say that in

opposition my colleagues have tabled similar amendments to those tabled today. During every Bill for which I have ever had responsibility in Committee, amendments have been tabled that seek to do broadly what the hon. Gentleman has tried to do.

I say to the Committee, and particularly to the hon. Member for West Chelmsford—he dealt with similar arguments as a Minister—that my job is to strike the right balance between order-making powers that should be subject to affirmative procedures because of the issues that they raise and those issues that can be dealt with by negative procedures. It is legitimate for hon. Members to disagree with that, but it would wrong for the hon. Gentleman to imply that because I have made a decision on such powers my motive is to sideline Parliament or ignore the parliamentary process to get what I want in a back-handed way. That would not be true.

I have always tried to discharge that aspect of my responsibility to the best of my ability. I recognise the responsibilities that we have to Parliament, to the House and to the democratic process, which we all hold dear. I do not appreciate the hon. Gentleman's suggestion that these clauses have been cobbled together in a deliberate attempt to sideline Parliament because that is not the case.

However, I welcome the hon. Gentleman's new-found role as guardian of the constitution, and he performed it well. It is also appropriate for us to point out what he rightly described as some inconsistencies. This is not all one-way traffic and although he might like a polite veil to be drawn over the record of the Administration in which he served, I am not prepared to do that.

In the context of these debates, it is necessary to compare and contrast. It is perfectly reasonable for me to make the point that if the hon. Gentleman were standing in my shoes—admittedly, it would be a different Bill—I doubt whether he would have drawn the line between affirmative and negative resolutions in any place other than where this Bill has drawn it. It is a question of balance and judgment, and Ministers are accountable in that regard. If the hon. Gentleman were to have ministerial responsibility again, I very much doubt whether his conversion would be translated into action such as that proposed in the amendment.

I should draw the hon. Gentleman's attention to one other point about the amendment that explains why I am unable to accept it. As I understand it, it would require that affirmative resolution procedures be followed in relation to any order to vary the establishment orders, including any order that transfers staff, property, rights or liabilities under this provision. The Opposition Whip, the hon. Member for Hexham (Mr. Atkinson), is present, as is the Government Whip, my hon. Friend the Member for Poplar and Canning Town (Jim Fitzpatrick), and it is incumbent on us as Members of the House to consider whether it is a sensible use of our time to make such matters subject to the affirmative resolution procedure. As the hon. Member for Oxford, West and Abingdon rightly said, this is not a die in the ditch issue, and I am sure that in his heart of hearts the hon. Member for West Chelmsford probably realises that. On this occasion, he has chosen the wrong issue about which to make such points.

There is a sense of ritual familiarity about these arguments, and I do not dispute the passion with which the hon. Gentleman holds his views on the constitutional propriety of this or any other point that he has made, but this was the wrong issue to which to address his concerns. As I have said, the clause deals with the negative resolution procedure in a sensible way and I hope that my hon. Friends will support that view and reject the amendment.

Mr. Burns: I have listened to the Minister's comments and, naturally, I am disappointed. I thought that, like a number of sinners, he might feel that he could repent, but it is clear that he is not prepared to do so on this occasion. Regrettably, therefore, this is a missed opportunity. I am being in no way derogatory, but the Minister seemed a little sensitive to the apparent suggestion that he was seeking to sideline Parliament. I might so accuse a number of his colleagues, but I would not aim that accusation against him on a personal basis.

Mr. Hutton: I did not assume that the hon. Gentleman was making personal comments.

Mr. Burns: I am grateful to the Minister for that reassurance. Although I am disappointed that he is not prepared to accept the amendment, I do not wish to press it to a Division at this stage. I should like first to read the official record, reflect on what the Minister has said and consider our position.

Amendment, by leave, withdrawn.

THE CHAIRMAN, *being of the opinion that the principle of the clause and any matters arising thereon had been adequately discussed in the course of debate on the amendments proposed thereto, forthwith put the Question, pursuant to Standing Orders Nos. 68 and 69,* That the clause stand part of the Bill:—

The Committee divided: Ayes 9, Noes 6.

[Division No. 3]

AYES

Burnham, Andy	Moffat, Laura
Challen, Mr. Colin	Thomas, Gareth
Fitzpatrick, Jim	Touhig, Mr. Don
Havard, Mr. Dai	Ward, Ms Claire
Hutton, Mr. John	

NOES

Atkinson, Mr. Peter	Harris, Dr. Evan
Baron, Mr. John	Murrison, Dr. Andrew
Burns, Mr. Simon	Taylor, Dr. Richard

Question accordingly agreed to.

Clause 1 ordered to stand part of the Bill.

Schedule 1

ENGLISH HEALTH AUTHORITIES: CHANGE OF NAME

6.15 pm

Mr. Hutton: I beg to move amendment No. 95, in page 47, line 5, at end insert—

"In section 125 (protection of members and officers of authorities), before paragraph (a) there is inserted—

'(za) a Strategic Health Authority;'.".

The Chairman: With this it will be convenient to take Government amendment No. 96.

Mr. Hutton: I acknowledge that the amendments are extensive, but they are technical and minor. They simply tidy up loose ends to ensure that references to health authorities in a wide variety of statutes are fully reflected in the Bill. I can assure the Committee that they raise no substantive policy issues.

Mr. Burns: I am grateful to the Minister for his explanation. I am not a lawyer, but it seems even to me that the amendments are heavily technical. I have one question. Why have they been tabled now rather than being included in the Bill when it was published? Is it simply because some events have moved on, creating a new need, or was there an error at the time, leaving them genuinely forgotten? Such things often happen in the drafting of legislation.

Mr. Hutton: I am sure that the hon. Gentleman does not expect me to say that they were forgotten.

Mr. Burns: They could have been.

Mr. Hutton: They were not forgotten, they were just not spotted. There are dozens and dozens of references to health authorities in previous legislation. The Committee might be interested to know that we are here amending a piece of legislation dating back to 1875, the Public Health Act of that year. It is interesting, for those of us who like parliamentary history, to think that the House is amending legislation that our predecessors made in 1875.

The amendments are technical. We had a choice, because had we found the need to make these changes later, we could have done so using orders under clause 37. We are trying, however, to ensure that the Committee is involved in changes, so we tabled amendments, rather than using a later order-making power.

Amendment agreed to.

Amendment made: No. 96, in page 47, line 43, at end insert—

"PART 2

AMENDMENTS OF OTHER ACTS

The Reserve and Auxiliary Forces (Protection of Civil Interests) Act 1951 (c. 65)

In Part 1 of Schedule 2 to the Reserve and Auxiliary Forces (Protection of Civil Interests) Act 1951 (which makes provision about payments to make up civil remuneration), in paragraph 15—

(a) in the entry in the first column, before 'a Health Authority' there is inserted 'a Strategic Health Authority,', and

(b) in the entry in the second column, before 'Health Authority' there is inserted 'Strategic Health Authority,'.

The Hospital Complaints Procedure Act 1985 (c. 42)

In section 1 of the Hospital Complaints Procedure Act 1985 (hospital complaints procedure), in subsection (1)—

(a) for 'Health Authority and' there is substituted 'Strategic Health Authority and Health Authority, to each', and

(b) after 'which that' there is inserted 'Strategic Health Authority,'.

The Disabled Persons (Services, Consultation and Representation) Act 1986 (c. 33)

(1) The Disabled Persons (Services, Consultation and Representation) Act 1986 is amended as provided in this paragraph.

(2) In section 7 (persons discharged from hospital), in subsection (9), in paragraph (a) of the definition of 'the managers', after 'means the' there is inserted 'Strategic Health Authority,'.

(3) In section 16 (interpretation), after the definition of 'statutory services' there is inserted—

'"Strategic Health Authority" means a Strategic Health Authority established under section 8 of the 1977 Act;'.

The National Health Service and Community Care Act 1990 (c. 19)

The National Health Service and Community Care Act 1990 is amended as follows

In section 4 (NHS contracts), in subsection (2), before paragraph (a) there is inserted—

'(za) a Strategic Health Authority;'.

In section 4A (provision of certain services by persons on ophthalmic or pharmaceutical lists), in subsection (1), after 'under which' there is inserted 'a Strategic Health Authority,'

In section 8 (transfer of property, rights and liabilities to NHS trusts), before 'Health Authority', in each place where it occurs, there is inserted 'Strategic Health Authority,'

In section 21 (schemes for meeting losses and liabilities of certain health service bodies)—

(a) in subsection (2), before paragraph (a) there is inserted—

'(za) Strategic Health Authorities;', and

(b) in each of subsections (3), (4) and (5), before 'Health Authority' there is inserted 'Strategic Health Authority,'.

In section 49 (transfer of staff from health service to local authorities), in subsection (4)(b), after 'means a' there is inserted 'Strategic Health Authority,'

In section 60 (removal of Crown immunities), in subsection (7)(a), at the beginning there is inserted 'a Strategic Health Authority or'

In Schedule 2 (which makes provision about NHS trusts)—

(a) in each of paragraphs 4(1), 4(2), 5(3), 13, 30(2) and 31, before 'Health Authority' there is inserted 'Strategic Health Authority,', and

(b) in paragraph 30(1), after paragraph (a) there is inserted—

'(aa) a Strategic Health Authority, or'.

The Health Service Commissioners Act 1993 (c. 46)

In section 2 of the Health Service Commissioners Act 1993 (bodies subject to investigation), in subsection (1), for paragraph (a) there is substituted—

'(a) Strategic Health Authorities,'.

The 1999 Act

The 1999 Act is amended as follows

In section 20 (functions of the Commission for Health Improvement)—

(a) in subsection (1)(c), before 'Health Authorities' there is inserted 'Strategic Health Authorities,', and

(b) in subsection (7), in the definition of 'NHS body', after 'means a' there is inserted 'Strategic Health Authority,'.

In section 21 (arrangements with the Audit Commission), in subsection (1)(b)(iii), after 'relate to' there is inserted 'Strategic Health Authorities,'

In section 26 (co-operation between NHS bodies), after 'duty of' there is inserted 'Strategic Health Authorities,'

In section 28 (plans for improving health etc)—

(a) in subsection (6)—

(i) in paragraphs (b) and (g), before 'Health Authorities' there is inserted 'Strategic Health Authorities,', and

(ii) in paragraph (h), after 'provision by' there is inserted 'Strategic Health Authorities,', and

(b) in subsection (9), after 'duty of' there is inserted 'Strategic Health Authorities,'.

In section 31 (arrangements between NHS bodies and local authorities), in subsection (8), in the definition of 'NHS body', after 'means a' there is inserted 'Strategic Health Authority,'

In section 61 (English and Scottish border provisions), in subsection (2), for 'Health Authority' there is substituted 'Strategic Health Authority'

The Health and Social Care Act 2001 (c. 15)

(1) The Health and Social Care Act 2001 is amended as provided in this paragraph.

(2) In section 7 (functions of overview and scrutiny committees), in subsection (4), after 'means a' there is inserted 'Strategic Health Authority,'.

In section 46 (directed partnership arrangements), in subsection (5), in the definition of 'NHS body', after 'means a' there is inserted 'Strategic Health Authority,'.".—*[Mr. Hutton.]*

Schedule 1, as amended, agreed to.

Clause 2

Primary Care Trusts

Question proposed, That the clause stand part of the Bill.

Mr. Burns: I welcome the opportunity to debate clause 2, about which we have serious reservations. It is the crucial first clause that deals with primary care trusts. PCTs will be established by orders by the Secretary of State, and the purpose of this short but important clause is to give him the powers to do so.

The arguments about PCTs are a replica of the arguments that we had this morning about SHAs. I am glad that I will not unduly bore you, Miss Widdecombe, because you were not here. We strongly believe, on the basis of even more evidence than there is in respect of SHAs, that the Government are rushing headlong into these reforms without leaving enough time for the preparatory work that is needed to bed them down and have them up and running in time for them to operate at maximum efficiency from the start.

The clause gives the Government powers to ensure that a fundamental change to the health service and its funding will take place by statute. That is important because when they introduced the legislation that set up PCTs—as you will know, Miss Widdecombe, because you were involved in opposing it—they always said, on the record in this House and in another place, that PCTs would be created only by local consent through consultation with doctors, nurses and local communities. The then Health Minister, the right hon. Member for Southampton, Itchen (Mr. Denham), and the Government spokesman in another place, Baroness Hayman, said that the Government had no plans whatever to force PCTs on local communities and health care providers; they were to emerge as and when they wished. All such concerns have been brushed away in this headlong rush to get a piece of legislation on to the statute book.

As I said to my hon. Friend the Member for North-East Hertfordshire, the Secretary of State is confronted with many problems in the health service. Every member of the Committee will know about those through their dealings with constituents. Problems with waiting lists, whether it be the numbers of people waiting or the length of time that they have to wait; waiting times at accident and emergency departments in hospitals all over the country; the trolley waits that we hear so much about in the media and from our constituents; the postcode lottery of getting drugs such as beta interferon: those are the problems facing real people in the real world.

The Secretary of State is confusing activity with action. He thinks that if he introduces yet another structure of reform, he will be seen to be doing something. In truth, as anyone who has one iota of knowledge of the health service will have realised, there is nothing in the clause or the Bill that will help to overcome or minimise the problems facing our constituents day in, day out. They must wait longer for health care from our hospitals and suffer the indignity that the Government have created with a vengeance; a waiting list to get on to the waiting list. The irony is not only that people must wait to go into hospital; they must wait to come out of hospital because of bed-blocking problems. Clause 2 does nothing to deal with those problems.

Andy Burnham: If the picture is as the hon. Gentleman paints it and the proposals will do nothing to help the health service, why are they supported by organisations across the health service, representing a vast and diverse range of interests?

Mr. Burns: I can answer that very simply. The hon. Gentleman did not hear what I said; the Bill does nothing to solve the problems facing our constituents, including hospital waiting lists and other health care issues. That is a different point from that raised by the hon. Gentleman.

The clause transfers 75 per cent. of the funding that, under the existing system, goes to the health authorities and the acute trusts directly to the PCTs. That is a significant new responsibility for them because, clearly, they have not had to deal with such matters, which were previously the responsibility of the health authorities. They must also identify and provide for the range of health care within the area that they cover; that is another huge new responsibility.

Laura Moffatt (Crawley): I am not entirely sure what the hon. Gentleman was doing before the 1997 election, but my party and I were talking to GPs about what they wanted. They wanted power in their hands and that is precisely what the Bill enables them to have. To say that it will make no difference to local health care is nonsense.

Mr. Burns: Strangely, I was also talking to my GPs and I cannot believe that Chelmsford in Essex is different from Crawley in Sussex. If I remember correctly, my GPs were telling me at the time that they were terrified that a Labour Government would take away the extra powers that they had been given as fundholders. They did not want that because they liked the extra freedom and power to be able to look after their patients. That is what I heard from my GPs before the 1997 general election.

Dr. Murrison: Does my hon. Friend agree that what GPs really want is a period of stability with no change to allow them to get on with their job, which is treating patients? Does he also agree with Dr. Charles Webster, to whom he referred earlier, who said that none of this mucking around does much good for morale?

Mr. Burns: My hon. Friend is absolutely right. There is a lot to be said for stability, but it must not be a panacea for no action when action is needed.

Mr. Hutton: The hon. Gentleman and his hon. Friend make the case for no change and for organisational stability. That is precisely what his hon. Friend said and he agreed with it. Perhaps he would explain to the Committee what the structural reforms to the NHS are that his right hon. Friend the shadow Chancellor of the Exchequer has been saying are necessary. How does that square with the desire for no more change?

Mr. Burns: As I continue, my view will become apparent to the Minister. Sadly for him, I have not fully developed my argument, which should not come as a surprise, because it was made powerfully by my hon. Friend the Member for Woodspring (Dr. Fox). I echoed his comments on Second Reading and they were echoed by most speakers in our debate this morning on the parallel issue of strategic health authorities. The problem is two-pronged. Having given the PCGs and PCTs power to develop on a voluntary basis with full consultation and consent, as the right hon. Member for Southampton, Itchen (Mr. Denham) and Baroness Hayman said, the Government have made a formidable U-turn, sweeping that away and imposing it in statute.

Mr. Hutton: The hon. Gentleman obviously needs time to develop his argument and I am happy to give him that. However, in an earlier debate, did he not pay tribute to politicians who sometimes change their minds on policy?

Mr. Burns: Absolutely. No one should remain in a time warp, but politicians usually change their minds over many years when they have discovered that a policy or philosophy is discredited, outdated or irrelevant to changing needs. PCGs and PCTs were created just over two years ago and they are not outdated or irrelevant to needs. The Government have gone against the assurances that were repeatedly given in the House and in another place that PCGs and PCTs could develop on a voluntary and consensual basis.

My second point concerns strategic health authorities. I am even more convinced that the Government are rushing headlong into setting these organisations up and having them in place. We have established from the Minister's helpful contributions that they will all be established by October next year, although the first full financial year of their operation will be April 2003—March 2004. We believe that that is too short a time in which to set them up. More and more people who work in the health service are expressing concern about the rush. They fear that the PCTs—and, even more so, the PCGs that are still developing towards PCT status—will not have built up enough confidence and expertise to be able to cope fully with what they are expected to do. Ministers have boasted frequently that this massive and significant reform is marvellous for the health service. I do not disagree; it is massive, and it is significant in its way. However, I question whether the new bodies—particularly the PCTs, which are heavily reliant on the contribution of local health experts—will have the expertise and confidence to carry out their functions in a workable and clear way from the start.

I suspect that the Minister is aware of that, but if he is not, he will become aware of it with a vengeance. If the expertise is not there and those involved get it wrong, there will be the mother of all protests immediately afterwards. If the Government of the day shifts the money down to that level of the health service, it will become apparent, almost immediately, when problems emerge. Constituents of ours, and patients, will quickly find out that the system is not working.

I do not see how Ministers can be so confident that this scheme will work successfully from the start without hiccups or more serious complications. On the law of averages, I do not think that that is possible. I am not telling the Minister to scrap the Bill because the Government are entitled to introduce reforms and to use their majority to change systems if they want to. However, before the Government mess up the provision of health care, they must ensure that it works from day one. I am not confident—nor are many of those working in the health service—that this will work because so many concerns exist over the fact that experience and the depth of expertise have not been built up to allow such a revolutionary new responsibility to be placed on those people.

There is also a problem of morale. As has been said in earlier debates, we are seeing the abolition of health authorities that are, by the nature of their current functions, significant employers. There are morale problems because of uncertainty over jobs, and the ability to transfer jobs, as health authorities disappear; particularly because, logically, the SHAs will employ fewer people. Presumably, some people will seek employment in PCTs, but they will still be new to that concept even if they have a great deal of experience of working in the NHS.

We helpfully corrected the Minister's figures by saying that, at the moment, we believed there to be 130 PCGs that were not far forward in seeking PCT status. It is a relief to see—from the breakdown of the

Minister's figures—that the situation is not precisely as has been suggested, but there are still a number of PCGs that are only moving towards PCT status. Presumably, they will concentrate on achieving that status rather than on what they should be doing once they have it. That will lead to inexperience, uncertainty and, perhaps, a sense of optimism that is not based on reality.

For the Minister's sake, I hope that the Bill is a success, but I do not think that it will be with the current time scale and with what seems like the inexorable rush towards having the system up, running and in place before it has been tried and tested. That is why I do not think it unreasonable to urge Ministers to delay the introduction of the whole system in the same way as we have urged delay for the SHAs. I am not suggesting delay through prevarication simply to prevent the Government from fulfilling their aims; that is not my intention. I am proposing simply a delay, and not an especially long one. We have boiled down the time scale that the Minister gave to six months from October 2002 to April 2003. That is not a long time; in May, June or July 2003, the Minister may, with hindsight, come to dearly wish that he had heeded the advice of others and accepted that delay to allow time to bed in.

Mr. Hutton: I am following the hon. Gentleman's arguments closely, and they have a certain familiarity. Given his many concerns, where are his amendments to the clause?

Mr. Burns: As the Minister probably knows, because I am sure that he reads the Order Paper—or, at least, his parliamentary staff does—there are two amendments to clause 2 on the Order Paper. The first seeks to postpone the introduction of PCTs until 1 April 2003; the second concerns the order-making powers. As the Minister also knows—and as I heard many of his colleagues say when his party was in opposition—the joys of Opposition spokesmen in not having the Rolls-Royce facilities of a first-class civil service really tax their ingenuity. The Minister will know that the amendments are starred and that, in their wisdom, Miss Widdecombe and Mr. Hurst have, rightly, not selected them.

Mr. Hutton: I hear the hon. Gentleman's points, and I have some sympathy with them, but can I ask where all the Short money is going? He has £3 million of it.

Mr. Burns: I think that you would chastise me quickly, Miss Widdecombe, were I to seek to answer that question.

The Chairman: I would.

Mr. Burns: I hope that you agree, Miss Widdecombe, that the Minister gets full marks for trying it on but, sadly, he will not be successful tonight.

Dr. Harris: I think that the Conservatives' decision not to table amendments to the clause is right, because they have the same approach as me. On reflection, they may have tabled some amendments that were starred, but they are quite right if they have decided that the clause is so flawed that it needs to be opposed in its entirety. The clause is unamendable and unimprovable if one is opposed to the measures for reorganisation that the Government are taking. I welcome the fact that the Conservatives also take that view.

Mr. Burns: I heard the hon. Gentlemen's comments with interest. I am grateful to him for contributing at this stage in my speech and thank him for his comment. I will not detain the Committee any longer because, as the hon. Gentleman said, the clause is important. We have serious concerns because we believe that the Government are mistaken in seeking to rush the matter. I am sure that many of my hon. Friends wish to raise important points about their concerns.

Dr. Richard Taylor: I have one brief question. I am relieved to hear that the establishment of PCTs will be delayed until October 2002 and fully implemented in April 2003, but I am very concerned about the possible transition vacuum. What will happen when health authorities have gone, SHAs are in place and PCTs are not yet established?

Mr. Baron: I add to the valid concerns expressed by my hon. Friend the Member for West Chelmsford my concern at the speed with which PCTs are being introduced. I question whether PCGs and PCTs are ready for the reforms. I think that the changes in the Bill, especially in relation to the establishment of PCTs, will divert activity and resources away from front-line patient care when it is most needed. It seems that the remaining 130-odd PCGs will be rushed into becoming PCTs whether they like it or not, and some existing PCTs are struggling.

6.45 pm

I draw the Committee's attention to a study undertaken by the National Primary Care Research and Development Centre in collaboration with the King's Fund, which was supported by the Department of Health. The second national tracker survey of 71 primary care groups and trusts, to which reference has been made, concluded:

"Progress in commissioning, health improvement and partnership working is slower. Lack of reliable and timely information and insufficient managerial capacity remain problems."

Professor David Wilkin, project director of the survey, said that

"there is a real danger the management of the organisational changes is going to divert attention from the core functions of improving care."

He also said that the pace of change is being dictated by Government timetables rather than by a

"process of learning and building on experience".

It is easy to dismiss such observations, but the fact is that this group, which has the backing of the Department of Health, has severe reservations about the speed at which PCTs are being brought into existence.

I have two further concerns about the introduction of PCTs, one of which relates to skills and the other to funding. On skills, Professor Wilkin pointed out that resolving this issue is a question not of extra resources,

[Mr. Baron]

but of getting managers with the right skills and experience into the system. Managers from trusts and health authorities can be, and indeed are being, taken on, but they do not necessarily have the skills needed to cope with the additional roles and functions that PCTs will be taking on. In my view, that will cause some concern and disruption to the delivery of care.

PCTs are already experiencing difficulties in recruiting clinical staff who are competent, willing and able to participate, but the problem is not just with such staff. There are also other areas of management for which PCTs are struggling to find recruits. Finance directors play a crucial role, bearing in mind that, by 2004, PCTs will have under their control some 75 per cent. of national health service expenditure. Yet at the moment, a good number of PCTs cannot find finance directors, let alone ones with competent experience relevant to taking on the new roles. I would welcome the Minister's views on that.

I should also like the Minister to deal with the issue of funding. Will PCTs be saddled with health authorities' outstanding deficits as part of the devolution process? If so, PCTs could be left without the resources to implement their devolved responsibilities, let alone to achieve the Government targets on which much of their funding depends. With ever-increasing central directives and no additional resources, there will be arguably little opportunity to improve provision of health care over and above that which has been supplanted. I ask the Minister to clarify the precise funding requirements and relationships, so that we can ensure that PCTs are able to deliver the health care that we expect from them.

Whether in terms of skills or funding, we return to the central concern that PCTs are being rushed. As someone who, I admit, believed that the deadline was April 2002, I am obviously pleased to hear that it is October 2002. However, I have spoken to the two PCTs that cover my constituency, and the Minister might be surprised to learn that they were under the impression that the deadline was April. Moreover, their chairmen and chief executives have told me that they are worried about a management skills shortage.

In conclusion, I can only reiterate the view expressed by many members of the Committee; we should reconsider the timetable that the Government are forcing through, and contemplate introducing the April 2003 deadline.

Dr. Harris: I am conscious of the time and the fact that it would be convenient for us to hear the Minister's reply shortly, so I shall not detain the Committee. We oppose the proposals on imposing PCT status and imposing upon PCTs the transfer of powers from health authorities and we intend to vote against the clause.

I should like the Minister to clarify a couple of points. I echo the comments of the hon. Member for Wyre Forest about the vacuum that will be caused by a delay between the compulsory abolition of health authorities and the establishment of the remaining PCTs capable of taking on this huge range of additional responsibilities.

At what point in the interregnum between the publication of the NHS plan and the press opportunity of 21 April 2001 did the Government decide to change their position of allowing PCGs to choose PCT status and take this measure to impose PCT status on them?

Do the Government recognise the contradictions in their position? I shall try to cover this in less confrontational terms than those used on Second Reading. The Government have an agenda to end what they describe as the postcode lottery of prescription and the provision of treatment. I accept that my party has previously used those descriptors in expressing concern about the situation, but I have never been convinced that local decision making about priorities in a cash-limited system is always a bad thing. Indeed, it need not be local at the commissioning level; it could be local at the prescribing level. Does the Minister appreciate that any system that does not have completely centralised control will involve some geographical variation in the provision of services and the availability of treatments? He cannot say that he wants to devolve power, budgets and responsibility locally while at the same time seeking to abolish, or at least bear down on, geographical variations in the provision of treatment—what he calls the unacceptable variations of the postcode lottery.

Mr. Hutton: I am genuinely puzzled by the hon. Gentleman's comments. The logical conclusion of his argument is that there should be centralised control of the NHS, yet that is clearly not his view.

Dr. Harris: I have written articles, which I would send to the Minister if I thought that he would read them, arguing that one cannot in all honesty say that there should be an end to geographical variations in the provision of treatment, or what some people lazily call the postcode lottery. Such decisions are not made in a lottery fashion, but after due deliberation by hard-pressed commissioners with limited budgets and a sense of guilt that they cannot fund everything that they wish to. The Government cannot bear down on that at the same time as saying that there will be devolution of real power, budgets and responsibility to the health authority or PCT.

Organisations such as the BMA should be cautious before accepting the Government's offer of all this responsibility and a budget to spend, because they will at the same time either centralise decision making to clamp down on what they describe as unacceptable geographical variations or use the opportunity of this apparent devolution to ensure that the blame for the inability to provide services in the postcode lottery is placed on PCTs, as was previously the case with health authorities. There are two different positions, and I am not clear which one the Government are adopting. I urge organisations such as the BMA to hold fire on deciding whether they think that this is a good thing

until they understand whether what is being devolved on them is blame or the ability to make rationing decisions within a capped budget.

Unless the Government clarify which way they will go, the accusation will stand that they seek merely to decentralise the blame for rationing. This is going wider than PCTs, and I can remember having many debates around the subject of rationing with you, Miss Widdecombe, in which we shared a common view that we must be up front about the issue and then discuss the degree of rationing of additional funds.

Finally, I should like the Government to address the concern that they claim that these changes will save money in management terms. There are many who argue that if managers can be found to do the work, creating more commissioning authorities while still having SHAs that need people in responsible jobs who are being paid the going rate will increase, or at least maintain, the degree of management. It is hard to understand how the Government can have it both ways. They claim that their new system will not be under-managed, but the new bodies will receive a series of extra powers although they will have little experience, no option to opt in—the enthusiasm is not there—and will simultaneously be asked to deliver huge savings in management costs.

I asked on Second Reading, and I shall ask again today, whether the Government will be willing to subject their claims of management savings in this reorganisation, and others, to the scrutiny of an independent audit body, which the Government could propose and we could discuss? The Government must decide their answers to those questions, which illustrate the confusion that exists. I am concerned that the proposals mean significant upheaval and change, which is not the main priority for the NHS at the moment.

Mr. Heald: Will the Minister say a little more about one aspect of the structure? It is clear from clause 1, which we have already debated, that there is a power for the liabilities of health authorities to be transferred to SHAs, and no doubt such liabilities could be transferred to PCTs because there are similar powers in schedule 3. Are the Government in a position to explain what will happen to PCTs as regards debts that have built up in health authorities over many years?

Mr. Hutton: I can reassure him and the Committee that there is only one health authority that has a deficit. The issue of the potential transfer of liability only arises in that one case. My understanding is that that deficit will be resolved by the end of this financial year.

Mr. Heald: I am grateful to the Minister. As regards general liabilities and ignoring the question of that one historic debt, which is of course of great interest to me, can he tell us what will happen to the various liabilities that any company, corporate body or in this case health authority has at any particular moment? Are those liabilities something about which he can tell us in Committee?

The evolutionary principle, which was set out in 1999, was designed to ensure that PCGs could not go on to become PCTs if local people in consultation felt that that was right. That decision would have involved weighing up a range of different concerns. It would have involved an analysis both of the PCT's practices in the area and of its strengths and weaknesses; it would have involved looking at the robustness of the management, and thinking about whether staff with particular areas of knowledge could be recruited; it would have been about the premises, their location and a whole range of matters. Of course, above all, it would have looked at the sort of services that would be available to local people.

7.15 pm

It is rather shocking to see that the Government have gone back on that approach, and that they have not explained why. I hope the Minister will be able to tell us why he is abandoning the points made by Baroness Hayman, such as the fact that primary care trusts will be established by the Secretary of State, and that progression to trust status will be determined by local views; that the Secretary of State will be able to establish primary care trusts only after local consultation; and that the views of the primary care groups, local GPs and other professionals, as well as the wider community and the local NHS, will be key considerations for the Secretary of State.

Is the Minister really indifferent to bodies such as the Royal College of Nursing, which was obviously told that this scheme was to commence in the year 2003? The Royal College of Nursing has voiced concerns over the viability of the successful implementation of the proposals in the time scale envisaged. PCTs are relatively new organisations, and the expectation that they will be able to provide the proposed services by 2003 is very ambitious. PCTs will need support if they are to take on new responsibilities.

If it were just the Royal College of Nursing—although I would never put it in this way—one might say that only one body of health professionals takes that particular view, but everybody else disagrees. If so, we could do what the Minister seems to want to do, which is to ignore it. However, what the British Medical Association—the main representative group for doctors—says is almost word for word the same. The BMA says that it is concerned that PCTs, where they exist, are relatively new organisations and that the demands may well be beyond their existing capacities. They are already experiencing difficulties in recruiting clinical staff who are able, willing and competent to participate. The BMA states that the PCTs will be up and running by spring 2003; it has obviously been told that as well. This is an ambitious timetable, given that there remain approximately 130 primary care groups, many of which have not yet made any preparations towards PCT status.

In the light of those comments from the two main representative bodies of health professionals, the Committee is entitled to ask the Minister whether the PCGs and PCTs are ready for these reforms. The answer seems to be no. The Minister is aware of the tracker survey, which has already been referred to.

[Mr. Heald]

This survey states that progressing, commissioning, health improvement and partnership working are slower, and that a lack of reliable and timely information and insufficient managerial capacity remain as problems. Professor Wilkin's views have also been referred to. The message is that the groups are not really ready for this change. The executive summary looks at more detailed points about the wide variation in the numbers and type of staff available to PCTs and PCGs, making the point that this is likely to be reflected in a varying capacity to deliver improved services.

I know the Minister found it deeply shocking when my hon. Friend the Member for Woodspring said on Second Reading that the average number of managerial, financial and administrative staff employed by PCGs was 6.8, compared with an average for PCTs of 15.8. The number of staff needed to bridge the gap between PCG and PCT status and to perform the sort of detailed, enhanced functions that the Minister proposes raises a key concern. The numbers of staff employed or seconded have increased considerably during the past 12 months, but one in seven PCGs and PCTs still has no finance staff.

PCGs have extended efforts to involve key stakeholders, but the interests of local communities and voluntary organisations are still poorly represented in many PCGs and PCTs. The proportion developing locality groups—something on which the Minister places particular emphasis—is slightly more than one third. However, only seven have delegated budgets to that level.

That body of concerns has come out through the Government-supported tracker survey. Only one fifth of PCG and PCT budgets are in line with national resource allocation targets. Half are developing financial incentives related to clinical governance, but only one third were planning to link the financial incentives to notional practice budgets for hospitals and community services. Given the extent of the Minister's ambition for PCGs and PCTs, that is a long way off the mark.

The background is that responsible health professional bodies such as the BMA are proposing an "ambitious" timetable; as I said earlier, that is a bit like Sir Humphrey describing a Minister's decision as courageous. [*Interruption.*] I am happy to give way to the hon. Member for Weaver Vale (Mr. Hall) if he so wishes, or we could discuss the matter later. The hon. Gentleman may have been suggesting that my recollection of Sir Humphrey was poor, but I stand by it.

The *Health Service Journal* recently undertook a study of the views of chief executives of NHS bodies. Some 304 chief executives responded, which I would suggest is a very good sample. They produced a series of findings that make sobering reading. Some 45 per cent. of chief executives thought that the inabilities of PCTs to cope with enlarged responsibilities were due to the fact that they lack managerial capacity, resources and vision. A third—33 per cent.—thought that the time scale for the changes was unrealistic and dangerous. Some 29 per cent. thought that the changes were resulting in disruption to delivery and risks to the NHS plan. Almost a third of chief executives believe that the organisational changes involved in the Minister's great NHS plan, designed to deliver all the improvements that we hear so much about, will damage progress.

A fifth of executives—22 per cent.—had concerns about the future of many health authorities, regional office functions and the lack of detail in the proposals. Some 20 per cent. thought that the effect of changes on staff, the loss of key staff, the lack of continuity and the impact on morale were very important. One could go on and on listing the drawbacks that were found in the study. One chief executive was quoted in the survey as saying that

"many of the smaller PCTs and some of the newly appointed chief executives are not going to be able to deliver the new agenda. It is crucial to tackle this issue and not wait for these organisations and individuals to fail."

That is what we are saying. Why go forward with something half-baked, when allowing it a little extra time to evolve in the way it was originally intended might prevent the mess, which, under the present arrangements, will occur?

Another chief executive put it this way:

"Governments never learn that reorganisations disrupt delivery, demotivate staff and usually fail in their stated objectives. A programme of sustained development and performance management based around the NHS plan would have been far more likely to achieve the Government's stated objectives."

I have asked myself whether the implementation of the NHS plan would be delayed as a result. Three quarters of the chief executives asked said that it would. One said:

"policy making has been rushed and is inadequately informed by understanding of how the NHS ticks."

Another said that there was

"a need for a more measured pace if lasting, carefully thought-through reforms are to be achieved".

Will money be saved? Ministers say in "Shifting the Balance" that £100 million will be saved. The chief executives believe that the one-off costs involved in winding down health authorities and other organisations, setting up new ones, transferring staff, changing offices and so on—the sort of churning that occurs when one reorganises—will alone cost £200 million, dwarfing the saving of £100 million. Can the Minister name a single organisation in which change has not brought massive costs? He and I know from debating reorganisations of various sorts over the years that they cost money. If he says that there will be no costs, which is what the summary of the financial effect suggests, can he explain why that will be the case when there normally are?

We must consider the human cost of the reforms. A fifth of the chief executives surveyed were concerned that there would be a loss of experienced staff. Some 15 per cent. said that they planned a career move outside the NHS, and 14 per cent. said that they would retire early. That would be a substantial percentage of chief executives lost to the service. One said that the changes were

"the most ill-conceived, poorly thought through set of changes in decades. Is the plan to torpedo the implementation of the NHS plan? This is my sixth reorganisation in a 30-year career in the NHS. I have always responded positively to change previously. However, these proposals are a recipe for disaster—a blend of lack of insight, ineptitude and disregard from all staff at all levels."

Mr. Colin Challen (Morley and Rothwell): That person may have seen six changes in the past 30 years, but how many of them were brought about by Conservative Governments and what was the cost of them? Will the hon. Gentleman refer to some of the quotations—he may have them in his notes—from the majority of people, who have reacted positively to the proposals?

Mr. Heald: I shall answer the hon. Gentleman directly, as I like to do. I would vigorously defend the reforms of Lady Thatcher, of course, but he would not. I heard his colleagues criticise our changes year after year. They said that it was wrong to reorganise constantly and to use that as an alibi for not investing the money; they said that it was disruptive, the wrong approach and a waste of time. I heard that time after time, and I got sick of it. The hon. Gentleman will get sick of it this time. All the expert commentators who criticised Conservative reforms now say that what is taking place is exactly like the Thatcher days. How does he feel about that?

Labour Members have spent years building the myth that the wicked Conservatives were responsible for reorganisation, but now it is Labour who are reorganising, and its reorganisation is stupid, pointless, ill thought out, a waste of time, ludicrous and rushed through in the face of the objections of the BMA and the RCN.

7.15 pm

Mr. Challen: I asked whether the hon. Gentleman would provide quotations from those who support the changes; his figures relate to the 15 per cent. or 22 per cent. who do not, which is less than a third. Let us hear from the 66 per cent. of people who support the change.

Mr. Heald: The hon. Gentleman can give me some quotes when he makes his contribution to the debate. I have said it already, but I am happy to take interventions on this matter. The PCTs are something that can be built on; they are a good idea if they are done in the right way. The evolutionary change proposed by the Minister's predecessor is worth while. Why, then, should we settle for 408 targets? Why insist on rushing through the change, breaking commitments that were given only two years ago? Why ignore what doctors and the various nursing organisations are saying? It is stupid to put a political timetable above the interests of patients and patient carers.

Andy Burnham: The hon. Gentleman seems to have rewritten history. Does he not recall that the changes to the internal market, which he robustly defended, were rushed through in the teeth of opposition from the British Medical Association? However, the BMA has outlined its broad support for the Bill. The hon. Gentleman said that there was no difference between the reorganisation of the Conservative Government and that proposed by the present Government. The major difference is that the current reorganisation is accompanied by record investment in the NHS. It is a rather large difference.

Mr. Heald: Actually, Labour Members are being quite complimentary about the Thatcher reforms, saying at least that the process had led to the reforms and that the reforms lasted for an extended period. I commend an article, headed "Suits you, sir", which states:

"As Parliament prepares to enshrine in law the latest of a long line of NHS reorganisations, Laura Donnelly overcomes a sense of *déjà vu* and wonders what is so good about this year's model."

I commend the article to the hon. Gentleman; he will find the analogies in it deeply embarrassing.

Dr. Harris: We can have lengthy discussions about what opinion polls tell us and what focus groups say—which is what so-called interest groups are—but the key question in the modern NHS is whether the reforms have anything to offer. What evidence there is suggests that the primary care trusts are quite fragile, and that they are still coming to terms with their existing work load. The evidence suggests that imposing the reorganisation on them runs counter to what the Government presumably seek to achieve.

Mr. Heald: I do not always agree with the hon. Gentleman, as he knows, but I do on this occasion. Sometimes, the Government may want an alibi for reorganising everything because they got themselves into a mess, had a bad winter and so on; but they may still do the right thing, rather than the easy political thing. It is sometimes a good idea to behave like a Government, rather than like a spin merchant.

Andy Burnham: The hon. Member for Oxford, West and Abingdon has just attacked the very principle of primary care trusts. The hon. Member for North-East Hertfordshire needs to come clean; is he attacking the principle of bringing decision-making in the NHS closer to the patient, or is he pleading for more time? Which is it? If he agrees with the hon. Member for Oxford, West and Abingdon, is he also against the principle of PCTs?

Mr. Heald: The hon. Gentleman needs to listen, because I have made it clear time and again that PCTs are a good basis on which to progress. PCTs are a good idea. This is an evolutionary process, but it is wrong to coerce PCGs in the way suggested by clause 2. I am also saying that the time scale is wrong. It is not as if Conservative Members are saying something only for a political purpose. This is what the doctors and nurses are saying. It is what the professionals—the chief executives—are saying. The only people who do not understand that is the Minister and those Labour Members who want to support him, despite the evidence. It must be deeply wounding to some Labour Members to see parallels such as this:

"Margaret Thatcher had the inclination to kick the fridge when things were going wrong."

[Mr. Heald]

The behaviour of the present Prime Minister is being compared to that, and we are told that the measure is a sort of knee-jerk reorganisation. I do not accept that anything that Lady Thatcher did was a knee-jerk reaction. After all that criticism and complaint about the process when the Conservative party was last in office, how can Labour Ministers and Back Benchers support this approach?

Laura Moffatt: The hon. Gentleman needs to make his point of view much clearer. He is quoting a minority of people who do not want any change. Why does he quote people whose views he does not share? He has just told the Committee that he liked the idea of PCTs and of returning to a system in which people were in charge of their own communities. His only argument is about timing. Will he be clearer about his argument?

Mr. Heald: The hon. Lady cannot possibly maintain the point that she has just made. She says that the Royal College of Nursing and the British Medical Association support the changes, but those bodies say that the time scale is deeply worrying. Is it wrong for an Opposition spokesman to quote the evidence from the two leading representational bodies and to consider the tracker survey that the Government themselves fund? That cannot be wrong. What are we here for, if we are not allowed to scrutinise legislation by considering all the available evidence and the materials that are there for everyone to see, including important surveys and what chief executives and the important representational bodies think?

We must consider the evidence to see whether legislation holds water. The temptation is to accept what the Whips say, because that is how this whole place is organised. In Committee, we should try to do what the hon. Member for Leigh did earlier, in brokering a sensible middle position that would allow us to go forward. Forcing PCTs into an early change when they are not ready in the way that is proposed is obviously foolish.

Dr. Harris: I would like to set the record straight in respect of the intervention made by the hon. Member for Leigh. He said that an interest group opinion poll showed that there was a problem. I was talking about the academic evidence from people such as Doctors Walsh and Smith at Birmingham University, which suggests that no evidence is offered and that the proposals should take account of existing research. They said that in some areas—such as the plans for PCGs and PCTs—the proposals ran counter to some findings about the size and capacity of primary care organisation. They are simply not ready for the extra duties. The record will show that I never said that those organisations were bad.

Mr. Heald: That is reassuring, because I thought that that is what the hon. Gentleman said. I was slightly nonplussed when I was told that he had said something else. I wondered if I had misheard him.

It is foolish to describe someone such as David Hunt, professor of health, policy and management at Durham university, or Kieran Walsh of Birmingham university's health service management centre and a senior research fellow as if they were simply protagonists in a party-political battle. The hon. Member for Crawley (Laura Moffatt) knows that it is not sensible to describe an eminent professor or a research fellow in the field as if their views were like those of a party politician. They are not. Those people are saying that they, and others, are worried about what is being proposed. How can we ignore that?

On a more practical point, I want to ask the Minister about the powers contained in clause 2. The Secretary of State's role is enhanced by the duty to establish what are to be known as primary care trusts. Instead of simply deciding on a proposal put forward by a primary care group, he will have an enhanced role in the duty to impose PCTs in all areas of England. In addition, it seems that the Secretary of State will have all the powers in relation to strategic health authorities that he had in relation to health authorities. Given that it seems that PCTs will have the same role as that which health authorities used to have, how can the Minister describe clauses 1, 2 and 3 as decentralising?

Clause 2 enhances the power of the Secretary of State. Under the provisions of clause 1, he loses no powers and, if anything, gains a power in respect of the distribution of functions. Where is the decentralisation? If the Minister means that establishing PCTs is a decentralising move in itself—although the Secretary of State will continue to pull all the strings, has been given enhanced powers and will be able to act as he wishes and use the strategic health authorities to impose discipline on the PCTs in respect of targets and performance indicators—that is a funny sort of decentralisation. Perhaps he will explain how clause 2 supports his case on decentralisation. The proposals are ill thought out and rushed. Of course, the Minister could explain in detail how the powers will be used. He has chosen not to and he tells us that the documents are not ready, so it is difficult to agree to clause 2.

Debate adjourned.—[*Mr. Fitzpatrick.*]

Adjourned accordingly at twenty-eight minutes past Seven o'clock till Thursday 29 November at half-past Nine o'clock.

THE FOLLOWING MEMBERS ATTENDED THE COMMITTEE:

Widdecombe, Miss Ann (*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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