National Health Service reform and health care professions bill : third sitting, Thursday 29 November 2001 (morning) / Standing Committee A.

PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT

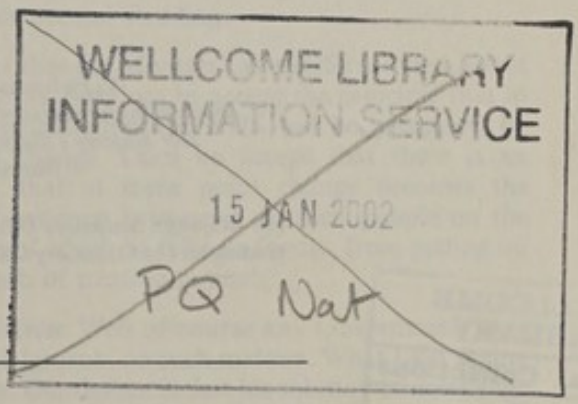
Standing Committee A

NATIONAL HEALTH SERVICE REFORM AND HEALTH CARE PROFESSIONS BILL

Third Sitting

Thursday 29 November 2001

(Morning)



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Standing Committee A

Thursday 29 November 2001

(Morning)

[MR. ALAN HURST *in the Chair*]

NHS Reform and Health Care Professions Bill

Clause 2

PRIMARY CARE TRUSTS

Question proposed [*27 November*], That the clause stand part of the Bill.

9.30 am

Question again proposed.

The Minister of State, Department of Health (Mr. John Hutton): We had an unexpectedly long debate on clause 2 on 27 November. As the hon. Member for West Chelmsford (Mr. Burns) said, the clause is an important part of the Bill. At times, the debate became acrimonious, which is regrettable. I am not sure why the hon. Member for North-East Hertfordshire (Mr. Heald) lost his usual equilibrium, but I hope that he recovered during the interregnum.

Mr. Oliver Heald (North-East Hertfordshire): I hope that the right hon. Gentleman will agree that I was polite and courteous as usual throughout the debate, but I was being provoked.

Mr. Hutton: That is a good plea in mitigation, and I will give it due consideration when I come to apply my sentence.

The debate was important, because the establishment of primary care trusts is an important part of the Government's reform agenda for shifting the balance of power and devolving more responsibilities to the front line of the national health service.

The hon. Member for Oxford, West and Abingdon (Dr. Harris) is concerned about whether the Audit Commission will assess the savings that the Government believe will accrue to the NHS as a result of the proposed changes. He also wondered whether I would allow the Audit Commission to make such a study. As he probably knows, Ministers do not decide what the Audit Commission examines. It has been given responsibility to perform the value for money audit of the NHS and can look into whatever aspect it chooses. That is not a matter for me to decide, nor should it be. I have no doubt that it will fully discharge its responsibility.

Dr. Evan Harris (Oxford, West and Abingdon): I thank the Minister for clarifying that issue. Will he confirm that the Audit Commission has neither confirmed nor denied the Government's claims that they have made savings in NHS management costs, because it has not looked into them?

Mr. Hutton: That is correct. The Audit Commission has not looked into the matter, as I said. We are confident that savings in the NHS will be made as a result of the proposed reforms. The money saved by the reforms will be reinvested in front-line health services, which is an important principle.

There was some discussion about whether the reforms have a different motive. The Government consider the reforms to be about empowering, and devolving power to, front-line health services. That is the most sensible way for any large organisation to conduct itself. Some Opposition Members attribute another motive to the reforms. The hon. Member for Oxford, West and Abingdon described that motive in a nutshell when he said that the reforms sought to shift blame, not redistribute the balance of power, in the NHS. The Liberal Democrats are making a false, but predictable, argument. They are the real conservatives on the subject of reform in the NHS: they oppose change, resist reforms that will empower the front line, and stick their heads firmly in the sand. We have always made it clear when we talk about the future of the NHS that there are two processes that need to go hand in hand. One is investment, and we are making sure that that the NHS has access to record amounts of new investment which will allow us to close the gap between public expectation and capacity in the NHS. That investment needs to go alongside reform; the money itself will not be sufficient. It is depressing that the Liberal Democrats, who would like to present themselves as a party with radical new ideas, are so deeply entrenched in their conservatism about the future of the NHS.

Dr. Harris: It is not my intention to return to matters that we have already discussed and the record will show that I did not repeat the extended allegations that I made on Second Reading because they were matters for Second Reading.

I accept that the Minister has a different view about these reforms, but does he accept the principle that in certain circumstances the NHS will be hampered by continual change. Does he accept that there is an argument that at some point change becomes the enemy of progress because it distracts people on the front line, of which he talks so fondly, from getting on with the job of treating patients?

Mr. Hutton: Well of course any Government have to make judgments on such matters. What I am saying to the hon. Gentleman is that his solution of no change is simply not compatible with the reality facing the NHS at the moment. That is why I say to him, the Committee and my hon. Friends that these reforms are essential if the extra investment is to work in the way that we envisage it working for the NHS.

The other point that emerged during our debate on clause 2 concerned the nature of the clause. There was a lot of rhetoric from the Opposition about imposing obligations to establish PCTs, and so on. We need to consider the issue in a more accurate way than we managed on Tuesday when Opposition Members were speaking about it.

One thing that Opposition Members have lost sight of in their concerns about clause 2 is that in the earlier debate on Tuesday I made it clear that by October 2002 we will have 100 per cent. coverage in England of PCTs. We will be practically there in April. Only a

[Mr. Hutton]

dozen or so primary care groups will not be constituted as trusts by that date.

What Opposition Members completely failed to pick up on was that that will be done under the existing voluntary provisions in the Health Act 1999. Throughout the debate on Tuesday it was suggested that we were using some power of compulsion to compel people to create PCTs. We have no such powers of legal compulsion at all. The process of moving from PCGs to PCTs is under way, and people will be aware of that in their own constituencies. Many hon. Members will be involved in the consultation process. But that process of moving from PCGs to PCTs is obviously being conducted outwith clause 2, because clause 2 is just that—a clause of a Bill that is not yet law. The argument that we were using some power of compulsion that we had said we would not use to establishment PCTs is simply not true.

Dr. Harris: Will the Minister give way on that point?

Mr. Hutton: No, let me finish my argument.

Clause 2 imposes a duty on the Secretary of State to ensure that PCT coverage remains comprehensive. That is essential because it is consistent with our "Shifting the Balance of Power" proposals.

The other point that needs to be clarified, which, unfortunately, I do not think was on Tuesday, is that it remains unclear to me whether Conservative Members support a shift in the balance of power; whether they believe that that is the right thing to do in relation to reforms in the NHS. I can quite understand their concerns about the speed with which the changes are being made, but on Tuesday I detected a more fundamental objection to the reforms themselves.

I hope that Conservative Members at least—Liberal Democrats will not because they are opposed to these reforms—understand that clause 2 is important because it will ensure that devolution to the front line becomes a reality. Without there being a statutory duty to ensure 100 per cent. coverage of PCTs, the new architecture of the NHS simply cannot be delivered.

Mr. Heald: We are getting into technical and legal areas, but I am trying to follow the Minister's argument. Is he seriously saying that the clause would impose a duty on the Secretary of State that he does not have the powers to achieve?

Mr. Hutton: It is true that, under the Health Act, the Secretary of State is not under a duty in law to establish PCTs. The Bill does impose such a duty, and necessarily so if shifting the balance of power is to work. My point was not so much a technical or legal one; it is a broader issue. The move to establish PCTs is not being done under any power of legal compulsion because the Secretary of State does not have that power of compulsion in primary legislation. He has an opportunity but not a duty to establish PCTs.

Dr. Harris: Does the Minister accept that if one says that someone has an option to do something and then says that if that option is not taken up it will happen anyway, that puts pressure on the person to take the optional route and they may as well prepare for the inevitable? An analogy, in terms of patient consent, is that consent is not valid if what is consented to will happen anyway.

Mr. Hutton: The concept of PCTs commands broad support in the NHS. I am not saying that everyone in the NHS supports the establishment of PCTs, they clearly do not—one hon. Member here does not—but there is a strong consensus in the NHS that this is the right way forward.

The argument on Tuesday was more about the speed of change. If one accepts the principle of devolution to the front line and the new role of PCTs, logically one must support clause 2. The argument about pace of change is a completely different from the fundamental argument about whether there should be PCTs in the NHS. That is a fundamental part of the shifting of the balance of power package. Without the duty to ensure that there is 100 per cent. PCT coverage there would be a hole at the centre.

Mr. Heald: It may be that I am not following the Minister's argument, in which case I apologise. We have always agreed that it is a good idea to develop PCTs in an evolutionary way and that they can form a good basis for the future. What we are objecting to is the fact that the Secretary of State will now be able, under clause 2, to establish PCTs without the sort of safeguards that Ministers had previously promised—that is, that they would emerge in an evolutionary way.

Mr. Hutton: I take issue with the hon. Gentleman because the safeguards will remain in place if clause 2 becomes law. The essential safeguard is consultation around any proposals to change PCTs, and that will be part of the new legislation. I can quite understand why the hon. Gentleman worked himself up into a lather on Tuesday. It is the responsibility of Opposition Front-Bench spokesmen to do that on occasions. I do not begrudge him that opportunity. He probably felt better for having done so. I am taking issue with the hon. Gentleman and his hon. Friends on their analysis of clause 2.

Throughout the debate on Tuesday, the impression was created by Opposition Members—I have read their remarks carefully—that we would be using powers that we would not have and would not take to compel the establishment of PCTs. That is not true. The hon. Gentleman supports the evolutionary progress of PCTs, and that is happening. The process to 100 per cent. PCT coverage, which will be established by October 2002, is an evolutionary process and has not been driven by any legal powers of compulsion because none will exist.

Mr. Heald: The hon. Gentleman says that consultation is the great protection. Community health councils are one of the statutory consultees. When they are abolished, what will replace that duty of consultation? Who will the consultation be with?

Mr. Hutton: That is already in the legislation: the hon. Gentleman should read it. The CHC role is being replaced. The consultation duties are clear. The consultative role will be changed owing to the abolition of CHCs. The right to object to service

reconfiguration—including PCTs—will transfer to local authorities, which have a democratic legitimacy that the CHCs never had. The hon. Gentleman's argument that we are loosening safeguards is without substance. I am sorry that I caused the hon. Gentleman confusion, but the clause does not compel PCGs to become PCTs. How can a clause impose compulsion on PCGs? It cannot.

Mr. John Baron (Billericay): Is the Minister saying that if some PCGs have not become PCTs by October 2002, the Secretary of State would have no power to enforce that, so the timetable would have to be put back?

Mr. Hutton: Clearly, once the Bill becomes law—

Mr. Simon Burns (West Chelmsford): Exactly.

Mr. Hutton: This is hardly a new constitutional principle. When the Bill becomes law, the Secretary of State will have a duty to establish PCTs, which are necessary to ensure devolution. Conservative Members spent Tuesday evening discussing the current process. The hon. Gentleman and the hon. Member for North-East Hertfordshire said that the existing evolutionary process was driven by some legal power of compulsion.

Mr. Heald: No.

Mr. Burns: No.

Mr. Hutton: They should both read their speeches because they made that point on Tuesday and they were absolutely—

Mr. Baron: Will the right hon. Gentleman give way?

Mr. Hutton: No, I must progress.

Both hon. Gentlemen were wrong. They raised other concerns—

Mr. Heald: On a point of order, Mr. Hurst. If the Minister has said on several occasions that he supports evolutionary progress and believes that PCTs are a good basis for it, but that he opposes compulsion, can he pretend that he said something different?

The Chairman: That is a matter for debate, not a point of order, but I am sure that the Minister hears the hon. Gentleman.

Mr. Hutton: I have certainly heard the hon. Gentleman, but that does not change the fundamentals of Tuesday's debate. In breach of an earlier pledge to my right hon. Friend the Member for Southampton, Itchen (Mr. Denham), the hon. Gentleman and other Conservative Members consistently described the process as driven by compulsion. The current process is not driven by compulsion; it is evolutionary and will result in 100 per cent. coverage by October 2002.

Ministers have to make a judgment on PCT applications. I do not dispute the obvious point that when the Bill becomes law, the Secretary of State will have a legal duty to require establishment. That is vital. The hon. Gentleman rails against that, but on Tuesday evening, he did not say whether he thought that compulsion was necessary to ensure delivery of the devolutionary proposals.

The hon. Members for Wyre Forest (Dr. Taylor) and for Oxford, West and Abingdon made good points about that. They described the possibility of a vacuum developing between the establishment of SHAs and PCTs. In that case, SHAs would exist everywhere in the country but not PCTs. That will not happen. We will not activate these proposals. We could not as it would not be logical if there were to be such a vacuum because the whole structure would be incomplete. The structure needs to be complete before the proposals can be fully implemented. As I have said on many occasions in Committee, that will happen by October 2002. That is when all the PCTs will be established and so the vacuum that rightly concerned the hon. Gentlemen will not happen.

Dr. Harris: I accept that I may not have followed this, so I should be grateful if the Minister could be gentle with me if I have missed something. Is he implying that if PCTs do not have full coverage by October 2002, health authorities will not be abolished? Is that throughout the country or just in the relevant areas? If so, has that been announced previously?

Mr. Hutton: No. We will undertake the reform in a sensible way so that it will happen throughout the country at the same time. That is what we have always said we would do and that is what we are currently planning to do from October 2002.

Some concern was expressed about the state of readiness for PCTs. I understand those arguments and they were well put. However, when hon. Members drew attention to the survey they did not point out that the comments were more than a year old. If we had taken no action to address concerns that had been expressed to us about the management capacity and capability of primary care groups as they move to PCT status, that would have been a perfectly valid criticism to raise today. But I referred earlier to measures that we have put in place to enhance and support managers working in PCTs. A national care programme of management support is now available to help PCTs and to help PCGs as they move to become PCTs. We also have a new national leadership centre in the NHS, which is helping managers to prepare for their new responsibilities.

There was a lot of concern about the new commissioning expertise of the PCTs and whether they would find that difficult to absorb as they move up from PCG status, and it was felt that somehow the NHS would lose the commissioning expertise that exists in health authorities. It is clear that as we move to the new model, we will not lose the commissioning expertise in the NHS. Many of the commissioning managers who are currently working in health authorities will want to work in PCTs too. There is strong case to be made for ensuring that we do not lose their commissioning expertise. The Government are committed to ensuring that, in line with the other changes that we are making to support and enhance the role of PCTs. Some of the criticisms that were aired on Tuesday need to be seen in that new and different light.

Andy Burnham (Leigh): Does my right hon. Friend agree that the Conservative Front-Bench spokesmen seem constantly to be contradicting themselves? On

[Andy Burnham]

Tuesday afternoon, the hon. Member for North-East Hertfordshire (Mr. Heald) said that Labour's

"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."—[*Official Report, Standing Committee A*, 27 November 2001; c. 87.]

This morning he has gone on at length about how he supports the principles of PCTs. Is my right hon. Friend as confused as I am?

Mr. Hutton: There will be a certain amount of rereading of speeches in the light of that comment.

Mr. Heald: Will the Minister give way?

Mr. Hutton: No. Let me at least finish my point and then I will give way to the hon. Gentleman.

Mr. Heald: This is a pointless exercise.

Mr. Hutton: It is not. What was a pointless exercise was much of the froth that we heard from the hon. Gentleman on Tuesday. He was clearly annoyed because his amendments were not selected because they were starred amendments and he felt sufficiently motivated to indulge in a bit of ranting about this without any notes or thought about the previous positions that his party had adopted. My hon. Friend is entirely right. On Tuesday Conservative Members contradicted their previous positions. That is why I wanted to open my remarks this morning by drawing the Committee's attention to that inconsistency.

Mr. Heald: Anyone can take one line out of context, but on Tuesday I made the point that I have made again this morning. I said:

"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."—[*Official Report, Standing Committee A*, 27 November 2001; c. 88.]

Mr. Hutton: The hon. Gentleman confirms the point that I was trying to make earlier, which is that he got it wrong on Tuesday. Clause 2 cannot be used to coerce PCGs, because that is not the law of this country. The hon. Gentleman is a lawyer, so he must know that no Government can use a clause in a Bill to coerce anyone to do anything. I do not need to labour the point.

Mr. Baron: Will the Minister give way?

Mr. Hutton: No, I have addressed the issues and do not want to detain the Committee much longer.

One concern raised by Opposition Members relates to finance directors and their role in PCTs. There was a misunderstanding about the quotation that said that one in seven do not have a finance director. It is a legal requirement for PCTs to have a finance director, whereas it is not a legal requirement for PCGs to have one because they are simply constituted as committees of health authorities. The health authority must have a finance director in that capacity, as well as in relation to the PCG. Opposition Members' analysis was wrong.

This long debate has become rather sour. I may have contributed to that with my remarks this morning, but it was important both to place on record some of the misconceptions in which hon. Members indulged themselves on Tuesday and to set out the argument in the correct context. Until Tuesday, we understood that the Conservatives supported the concept of primary care trusts but had arguments to make about the pace of change, just as they supported the principle of devolution but were concerned about the rapid progress towards it. Those concerns should be left to one side because they are not related directly to clause 2.

The clause simply puts the structure that we are designing for the NHS on a proper legal footing. Without a duty on the Secretary of State to require the establishment of primary care trusts, there would be a hole at the centre of the new NHS architecture. If the Opposition support the principle of primary care trusts and want to ensure that they can deliver their new commissioning responsibilities, their argument against clause 2 is inconsistent. An argument about the pace of change is one thing, but it is irrelevant to the clause. For those reasons, I commend clause 2 to the Committee.

Mr. Burns: As the Minister says, we have had a long and comprehensive debate on the clause. I do not intend to detain the Committee for long, except to clear up some of the misapprehensions that the Minister tried to spread in his remarks today. I do not understand his Minister's motivation—it may simply be a misunderstanding. I shall make the matter plain, so that he comprehends fully and there is no future misapprehension.

As my hon. Friend the Member for North-East Hertfordshire made clear at column 88, we as a party do not oppose the principle of PCTs. Our argument throughout the debate on clause 2 has focused on what we believe is a hasty rush towards implementation of the reforms, which haste will impose considerable strains on the health service. The Minister went off at a tangent and suggested that we do not understand that the Government currently have no statutory powers to force PCGs to become PCTs. That is self-evident; my hon. Friend and I have always understood that the Government have no such power. However, the purpose of clause 2 is to give them the power to ensure that there is 100 per cent. PCTs by the Minister's deadline of October 2002.

Mr. Hutton: I intervene to confirm that the transition from PCG to PCT status will be conducted and completed under the existing evolutionary provisions of the Health Act 1999, not under any powers of compulsion.

Mr. Burns: The Minister says that, but logically it is not possible for him to give a categorical assurance.

Mr. Heald: Are the changes not being made under the threat of compulsion?

10 am

Mr. Burns: My hon. Friend anticipates my argument. If he will forgive me, I shall finish putting my point to the Minister as he can clear up the matter once and for all. It is my understanding—of the Bill and the explanatory notes—that if in September next year a PCG is not evolving towards PCT status in time

for October 2002, the clause gives the Government the power to force the PCG to become a PCT. Yes or no? Am I right or wrong?

Mr. Hutton: As I have just said, the process will be completed by October 2002 and all the PCTs will be established under the evolutionary powers in the Health Act 1999.

Mr. Burns: It was a mistake to invite the Minister to intervene because, parrot-like, he has merely repeated what he has been saying for the past 20 minutes. He has not answered my question. In theory, a PCG might by September or October next year be nowhere near to becoming a PCT—for some quirky reason, it might not want to become one. In those circumstances, the Secretary of State will possess the clause 2 powers to make it become a PCT. That is my understanding of what might happen. The Minister says—events may prove him right in one respect—that although the Government will have that statutory power when the Bill becomes law, they will not need to use it because of the evolutionary process. My hon. Friend the Member for North-East Hertfordshire and I believe that the Government have sought powers under the clause to make PCGs become PCTs by 2002, and that they could use those powers to speed up the process if some PCGs were reluctant to acquire trust status.

Mr. Heald: Does my hon. Friend agree that the clause being unnecessary—because the process will happen anyway—gives even more reason to vote against it?

Mr. Burns: Absolutely. If it is unnecessary, there is no reason for the Government to include the clause in the Bill. The Government insist on including it because they need the reserve powers in case the evolutionary process does not materialise 100 per cent.

Since the Government's intentions were made clear, pressure has been applied to PCGs to rush towards PCT status. That is the nub of our argument and our concern about the undue haste. Our amendments ask—interestingly, in the light of the Minister's timetable—for a delay of only six months, to give PCGs and the embryonic PCTs a little more power to bed in and lay the foundations for their substantially increased and novel functions. The right level of health care might then be provided without any hiccoughs or hiatus. That is eminently reasonable, so I invite my hon. Friends to join me in opposing the clause.

So that there can be no misreading as Ministers and civil servants trawl through the debate over the weekend, we oppose the clause not because we oppose PCTs in principle, but simply because of what we regard as the haste with which we have reached that stage of the reforms and the damage that that haste will cause to the provision of health care throughout the country.

Dr. Harris: I have some brief some points to put to the Minister. First, I reiterate our concern about changes to the NHS that we believe are part of a strategy to make activity appear the same as action, so making it easier for the Government to blame the continuing failings of the health service on anyone but themselves. They are creating reforms in the NHS that appear helpful but are nothing of the kind.

A briefing paper from the NHS Confederation mentions management costs. Nigel Edwards, its acting chief executive, says about stripping away tiers of management that

> "Shifting the balance of power in the NHS"

—I assume that he is referring to the document—

> "actually requires more organisations not fewer. This will bring decisions close to the patient but the consequence is we have gone from 95 NHS management bodies to 307 with this latest reorganisation of the NHS."

The Government should accept as valid the fears that additional management and bureaucracy are being introduced and about the series of reorganisations. I am generally sceptical about such structural reforms when the urgent need is—as it was last year and four years ago—to give the NHS the resources it requires, not another reorganisation.

On the issue of compulsion, does the Minister accept the argument to which I alluded earlier, that if a person is given a clear option about whether to say yes or no to a proposition and he or she then says yes or no, and if that process is repeated with the threat that the person will have to accept the proposition in future, it is an invalid procedure in terms of the ethical gaining of consent? The choice is meaningless if the decision is to be compulsory anyway.

Will the Minister clarify his announcement today—and perhaps Tuesday, if one reads between the lines—that the go date for the changes is now October 2002 because he wants the process to occur simultaneously throughout the country? I understand why he wants to do that, but the necessity of getting PCTs across the country has put off the target date to a half-year point instead of his original target date of April 2002. Is it understood that people who seek new jobs will have to start them in October 2002 and not earlier?

Mr. Hutton: We have always said that April 2002 relates to the creation of the new strategic health authority. We will use our powers to make sure that health authorities merge by April 2002, but they will not be able to take on responsibilities or the new title of strategic health authorities until and unless the Bill becomes law.

Dr. Harris: I am still unclear. Is the Minister saying that he wants to create some form of shadow strategic health authority, getting the boundaries sorted out by April 2002? The key question is when functions of health authorities transfer to PCTs. If the Minister is saying that that will now happen in October 2002—that may have always been his plan but I was under the impression that it was going to be April 2002—it means that the shadow strategic health authorities will indeed be strategic health authorities in terms of boundaries, but in terms of functions they will for at least half way into the new financial year behave as health authorities. In other words, they will continue to have all the powers—to be discussed under another clause—that will transfer to PCTs. Will the Minister help me out by providing clarification?

Mr. Hutton: I have laid out the timetable many times. The hon. Gentleman's understanding of the timetable for establishing the health authorities is broadly correct. They will be established in shadow

[Mr. Hutton]

form using existing powers to merge health authorities to form larger groups; they will become authorities when the Bill becomes law. We are aiming for that to be done in 2002.

Dr. Harris: Is the Minister saying, in effect, that this section of the Act—as it will be, unless something dramatic happens during the parliamentary process—will come into force on October 2002, or that existing powers will be used to create the relevant geographical structures earlier than that?

Mr. Hutton: I am not in a position to give a precise date for when the provisions will be brought into force, but I will state honestly and openly that that is the broad timetable within which we are working. However, the legal transfer to PCTs of responsibilities and a host of functions cannot take place—I will not rerun the argument that we just had about the nature of clause 2—until the Bill becomes law.

Dr. Harris: To be consistent with the comments that I made on Second Reading, albeit not in this debate, about the reorganisation, I oppose the clause standing part of the Bill.

Question put, That the clause stand part of the Bill:—

The Committee divided: Ayes 10, Noes 5.

Division No. 4]

AYES

Burnham, Andy	Hutton, Mr. John
Challen, Mr. Colin	Moffatt, Laura
Fitzpatrick, Jim	Taylor, Dr. Richard
Hall, Mr. Mike	Touhig, Mr. Don
Havard, Mr. Dai	Ward, Ms Claire

NOES

Baron, Mr. John	Heald, Mr. Oliver
Burns, Mr. Simon	Murrison, Dr. Andrew
Harris, Dr. Evan	

Question accordingly agreed to.

Clause 2 ordered to stand part of the Bill.

The Chairman: For the convenience of the Committee, I should announce that I have called a meeting of the Programming Sub-Committee for 11.35 this morning. It will be held in this Room after the Committee rises.

Clause 7

Funding of strategic health authorities and health authorities

Mr. Heald: I beg to move amendment No. 134, in page 8, line 17, leave out 'not exceeding' and insert 'equal to'.

The purpose of this probing amendment is to ask why the Secretary of State should pay a sum "not exceeding" the amount allotted rather than a sum "equal to" it. It may be that the sum allotted is provisional and that, if the costs of an authority are lower, the Minister would want to pay less—as one would. However, he does not appear to have a duty to pay more if the costs are higher.

Let me give an example. Can the Minister explain what happened in connection with last year's underspend of £700 million? Some may find it hard to believe that there was a £700 million underspend, given pressures on the NHS such as waiting lists. What is the duty of the Secretary of State to health authorities? Why is it that he pays a "not exceeding" figure on part I expenditure of the sort dealt with here, but pays a sum equal to the expenditure under on part II? Is it because the amount that is recovered under part II has already been spent and is therefore quantified, whereas the allotted amount is a provisional sum? Can the Minister explain?

Mr. Hutton: I am grateful to the hon. Gentleman for spelling out the purpose of the amendment and so dispelling the confusion. The amendment would require the Secretary of State to pay the strategic health authority the full amount of its allocations, whether or not it requested the full payment of those allocations. That would not be sensible. The clause carries over the precise wording of previous legislation as it applies to the funding of the NHS organisations. It is not a device to allow financial subterfuge or the withholding of moneys that have been identified for NHS use and are needed for NHS patients.

The Government intend to fund the new strategic health authorities in precisely the same way as Labour and Conservative Governments have always funded health authorities. Strategic health authorities will be able to draw down funds up to the level of their allocation as they need them during the year, but it has never been the practice of any previous Administration to make their allocations before the money is needed. That is essentially what the provision would allow the Secretary of State to do.

It is true, as the hon. Gentleman says, that strategic health authorities might want to spend less money—perhaps to finance a project in a subsequent year. The Government intend to allow strategic health authorities the flexibility to carry forward such planned underspends into future, but if the strategic health authorities, rather than the Exchequer, had to hold the money themselves from the beginning of the year, it would not necessarily represent good value for money for the taxpayer. There is no subterfuge.

10.15 am

Mr. Heald: In relation to the underspend last year of £700 million, is that money allotted? I believe that it is. If so, is it available this year for the various health authorities and bodies in the NHS to spend? Is all of it available or only part of it? What would happen if there were an overspend and the allotment was not enough? Is there a power that is not in the Bill to make additional payments?

Mr. Hutton: The hon. Member for Oxford, West and Abingdon tabled several amendments that relate to deficits and underspends. I am not an accountant but, as I understand the position, the majority of the deficits that he referred to—I shall come to the point about underspends—are not deficits that involve repayment. That is the sort of deficit that I would like to have myself and I would need to speak to my bank manager about it. A large amount relates to the

way in which accounting rules require building values to be recorded on the balance sheet. They do not necessarily all give rise to an immediate call for repayment; they are not debts in that sense of the word.

The hon. Member for North-East Hertfordshire referred to underspends, and it might be helpful to try to explain one or two related matters. The total budget for the Department of Health last year—2000–01—was more than £45 billion, which was managed, as the hon. Gentleman knows, by more than 450 NHS bodies. The underspend to which he referred represents approximately 1.5 per cent. of total NHS expenditure. More than a third of that underspend was actually a planned contingency fund to meet costs that might arise or become due in the following year. There is always an element of that in any large organisation and provision needs to be made for it. On one level it looks like an underspend, but it has actually been put aside specifically to deal with expenditure that will arise in the following year. I make it clear to the hon. Gentleman that none of the money has been or will be wasted; it will all be spent on the provision of health care for the benefit of patients.

Substantial amounts were included in the underspend. For example, £250 million was deliberately held back and carried over to meet identified expenditure commitments arising in the current year, 2001–02. That would not have been counted in previous years, but a change in Treasury rules means that it is now counted as part of that underspend. There was some capital slippage of about £140 million, spread across approximately 450 trusts. NHS bodies manage a large capital programme, a significant proportion of which is devoted to building projects. Some delays are caused by planning problems; even for such basic reasons as bad weather. That money must be carried forward to the next year, and will not be lost. The hon. Gentleman rightly referred to the problems of underspend. I have tried to explain as best as I can—as a lawyer, and not as an accountant—how I understand those sums to be calculated.

The legislation is a continuation of the existing legal powers that apply to the funding of the new bodies, which will be called strategic health authorities, not health authorities. They will have a different role, but the funding arrangements will be the same as those applied by previous Governments. The hon. Member for North-East Hertfordshire was Member when his party was in government, and the hon. Member for West Chelmsford was a Health Minister. We do not plan to change the rules that satisfied both hon. Gentlemen and the Government then; the rules are a sensible way of funding the NHS and ensuring that the Exchequer does not lose out.

Mr. Burns: My hon. Friend the Member for North-East Hertfordshire raised the important issue of underspend, and I thank the Minister for a comprehensive response, even though he is not an accountant. However, the issue still concerns me. My hon. Friend talked about an underspend of £700 million. The Minister said that, for sound and common-sense reasons, a third of that figure—just over £200 million—would be a contingency fund. That reduces the underspend to approximately £0.5 billion. The Minister then identified £200 million that must be carried over to the current financial year. I can understand that, without knowing the budget items for which that figure must be carried over.

The Minister also mentioned £140 million for capital projects. If my mathematics are right, there is a remaining underspend in the NHS of approximately £110 million. That is a small amount of money in terms of Government public spending, but a considerable amount of money to me and you, Mr. Hurst, as we both represent constituencies in mid-Essex. We all know that the hospital waiting lists in mid-Essex have never been shorter than when the Government came to power in May 1997. You probably had the same experience as I did, Mr. Hurst, when you were canvassing in the streets of Braintree and villages in your constituency.

The Chairman: Order. I am not certain that the Chairman's position or activities are relevant to the progress of the Bill.

Mr. Burns: Please accept my apologies, Mr. Hurst. I will change the line of my argument by saying that I remember canvassing in Chelmsford and in villages that were part of the Braintree constituency before boundary changes. Because of the Labour party's rhetoric and the expectations that were raised, people on the doorstep believed that if a Labour Government were elected, when they turned up at Broomfield hospital—which is in my constituency but which serves mid-Essex—consultants would be waiting at the doors and fighting with each other to carry out operations of choice.

That was the level of expectation and the reason why people thought that there would be no underspend on health care by a Labour Government. In the past four and a half years, however, waiting lists have grown longer every day. Constituents in mid-Essex will be puzzled that the Government could have spent a lot of money in the current financial year to help to alleviate the problems that cause constituents so much suffering, misery and upset because more and more of them have to wait longer for their operations. That does not take into account the new phenomenon in health care provision; the waiting list to get on to a waiting list.

Mr. Hutton: The hon. Gentleman makes his remarks in the context of underspends. Will he remind us of the underspend in the final year of the last Conservative Government?

Mr. Burns: The context of my comments is the current underspend, which my hon. Friend the hon. Member for North-East Hertfordshire has identified. That is what concerns my constituents. Funnily enough, they do not live in a time warp where life was frozen in 1996–97. They are concerned about what is happening to them at the moment. Indeed, most people act on that basis. Many constituents, including those of the Minister, would be amazed to hear that despite all the pressures on financing health care, the Government actually underspent. My constituents will not be happy to know that more operations could have

[Mr. Burns]

been carried out—not only in mid-Essex, but throughout the country—and that what to most people are substantial amounts of money are not being used when there are so many demands on them.

Mr. Hutton: I did not want to intervene again, but I want to place some important facts on the record. The hon. Gentleman is obviously right that people do not live in a time warp, although Liberal Democrats might. However, he is wrong to suggest that there have been underspends in the national health service only from 1997. As a former Minister, he must know that every year there is an underspend margin. I apologise for not referring to all the figures. I did identify where £390 million was going and I want to explain where the rest goes.

The hon. Gentleman knows that health care providers—PCTs, NHS trusts and so on—have a statutory duty to break even year on year, and they carry a huge amount of money in their budgets. The NHS, like any other well-organised and efficient business, must carry a margin, because the organisations concerned cannot overspend as a result of their statutory obligations to break even. It is important to have a small underspend margin to comply with those duties. In this respect, the revenue underspend amounts to just over £200 million, but I want to make it clear that that money is not lost from the service, but carried forward.

Mr. Burns: I fully appreciate the Minister's point and I was not for one minute suggesting that the money was lost. However, the fact that it will be carried over to next year will not be much consolation to my constituents who need an operation now, but cannot have it because there is not enough money.

Mr. Hutton: As the hon. Gentleman knows, the system does not work in that way.

The other substantial element of the underspend to which I referred is the amount relating to lower-than-planned expenditure on demand-led services, where the resources are in the system, subject to the demand that is placed on them. Expenditure was lower than planned on some demand-led services, part of which was the consequence of the move from a cash to a resource-funded service, in line with recent legislative changes. I do not know the precise figures, but I shall write to the hon. Member for West Chelmsford. That underspend is not carried forward as such, but it can be spent in following years. If there is the demand, the expenditure is provided. In that respect, too, the hon. Gentleman is slightly wide of the mark.

Obviously, we want to ensure that all the money that we allocate to the NHS is spent on NHS patients. That is our priority and it applies equally to the amounts that the hon. Member for North-East Hertfordshire has discussed today. They are not lost to NHS patients; they will be spent on NHS patients.

Mr. Heald: I thank the Minister for his explanation of the way in which the funding system works and, on the basis of that, I shall seek the Committee's leave to withdraw this particular amendment. However, I could not close without making the observation that when the Minister was explaining to us about the underspend and got to the problems with the weather, it reminded me of the expression, "the wrong sort of snow". In fact, I was just waiting for, "Oh, there were leaves on the line." However, I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

10.30 am

Mr. Heald: I beg to move amendment No. 135, in page 8, line 20, after 'year', insert

'or any deficit inherited from a Health Authority'.

The Chairman: With this we may discuss the following amendments: No. 138, in clause 8, page 9, line 14, at end add

'and—

(c) any deficit inherited from a predecessor body.'.

No: 89, page 10, line 8, at end insert

'or—

(c) any deficit from a predecessor body.'.

No. 144, in clause 9, page 10, line 27, at end add

'and—

(c) any deficit inherited from a predecessor body.'.

Mr. Heald: I shall try to be relatively speedy because of the amount of business that we have to transact in the next hour.

Amendment No. 135 would enable the Secretary of State to pay the deficit that a strategic health authority may inherit from a health authority. I understand that many NHS trusts are overspent, and receive their funding from health authorities. Health authorities—in effect, the Secretary of State—have liabilities to the regions.

The Minister told us yesterday that only one health authority had a deficit. I am concerned about that. What does he mean by that? Could he explain it more fully? Many colleagues to whom I talk tell me that the NHS trust in their constituency is overspent. Certainly in Hertfordshire, we believe that the deficit, as we would describe it as laymen, is £30 million or thereabouts; at least, that is what the PCTs and health authorities tell me. Is that a deficit? Is Hertfordshire health authority the one about which the Minister was talking? What about East Surrey where, I am told, the trust was heavily overspent? What is the position there?

What is going to happen in respect of the liabilities? If a trust owes a health authority, does the debt pass to the strategic health authority, or to the PCT? If it passes to the strategic health authority, surely the Secretary of State should be able to provide for it in his allotment. Is the Minister saying that the amount must come out of the money that is provided for the following year for the health needs of the strategic health authority? Are all these new bodies going to start with a dowry of debt? What amount is to be given to strategic health authorities to deal with debt, and how is it to be calculated?

Amendment No. 138 would allow the Secretary of State to take account of any deficit inherited from a predecessor body in allotting money to a PCT. The

first amendment deals with the strategic health authority and the second in the group deals with PCTs. Amendment No. 89 would require the Secretary of State to pay to each PCT any deficit that it had inherited, while amendment No. 144 would allow the National Assembly for Wales to take account of deficits in funding each health board. This may sound like a rather technical matter.

Mr. Hutton: If I have understood the hon. Gentleman clearly, the amendment is calling upon the Government to make an additional amount of money available to the NHS over and above existing allocations to cover the deficits.

Mr. Heald: We are trying to understand. We are on a voyage of discovery in a way because—

Mr. Hutton: What is the hon. Gentleman proposing?

Mr. Heald: The Minister must let me finish. We want to know what the deficits are, where they are at the moment, who is to take responsibility for them and how are they to be provided for. If the Minister is suggesting that the Government are going to give strategic health authorities a dowry of debt by giving them the money for the health needs of the area and letting them get on with it, that is not responsible. The Minister may recall that when we were in government, he was always prepared to ask me plenty of questions.

Mr. Hutton: I am grateful to the hon. Gentleman for refreshing the memory of the Committee. My memory might prove to be wrong, but I do not ever remember asking the hon. Gentleman any question at all.

Mr. Heald: I would have to trawl through my memory to remember the exact occasion, but I remember debating at great length with the hon. Gentleman on numerous occasions. For example, there was the Committee stage of the Criminal Justice and Public Order Act 1994, when we crossed swords on numerous occasions.

The Chairman: Order. The Criminal Justice and Public Order Act 1994 is not before this Committee.

Mr. Heald: I was not a Minister at the time. When I have an idle moment, I may search through the archives to see what comes out. I commend the amendment.

Mr. Hutton: The amendments would require the Secretary of State to take into account inherited financial positions in determining allocations to primary care trusts and, because they relate also to Wales, to local health boards. It is difficult to avoid the conclusion that the hon. Gentleman is asking us to provide further resources to the NHS, over and above the existing allocations, to cover those deficits. I would be interested to hear what his right hon. Friend the shadow Chancellor makes of the amendments. Perhaps the hon. Gentleman will let us know.

The amendments might be based on the hon. Member for North-East Hertfordshire's concern about the consequences for PCTs and strategic health authorities of taking over part or all of the creditors of health authorities. This comment will not surprise him; the amendments are unnecessary. Funding for the national health service is allocated primarily in response to the identified health needs of communities; it should not be driven by other considerations, which would be the effect of the amendments. From the point of consistency, that has been the view of previous Conservative Administrations as well.

The financial position of the NHS has greatly improved from that which we inherited from the previous Government. I am reluctant to go into great detail, but it is important for the Committee to appreciate that health authorities and NHS trusts plan to achieve a balanced financial position this year, 2001–02. That is a massive improvement on the deficits of nearly £460 million that the NHS inherited, thanks to the stewardship of the previous Administration. I do not have an exact figure to mind, but the current level of deficit across the NHS is just over £120 million. That is substantial, but much better than it used to be.

Mr. Heald: Yesterday, the Minister said that only one health authority had a deficit. If so, that £120 million seems an awful lot of money.

Mr. Hutton: I was talking about health authority deficits, and there is only one health authority with a deficit. Clearly, NHS trusts have deficits; the hon. Gentleman knows that, because of problems in his constituency. I was talking about health authority deficits.

Mr. Burns: Which one?

Mr. Hutton: I will come to it, if the hon. Gentleman can bear with me for a second.

In the past financial year, only one health authority—Bexley and Greenwich—failed to achieve a balanced financial position. That health authority is a new one—it merged in April this year—and has taken on difficulties that it is trying to address. However, all health authorities plan to achieve a balanced financial position, which is a massive improvement on the deficits of £459 million that existed in NHS trusts in 1996–97. That is due in part to the financial stability that we have given the NHS, and it means that strategic health authorities have the best foundation on which to face the full challenges of their devolved responsibilities.

Amendment No. 144, which relates to provision in Wales, raises wider issues affecting the government of Wales and the devolution settlement. As part of its devolved functions, it is for the National Assembly for Wales to consider how debts arising from historical overspend are to be addressed. It is not a matter for primary legislation, and the Government do not intend to alter the terms of the devolution agreement. It is properly for the National Assembly to decide, and the amendment, inadvertently or not, would cut directly across that.

The debate has been primarily about deficits. It might be helpful to say a few words about those deficits that exist. The NHS has run up accumulated deficits during the years. An accumulated deficit is not necessarily indicative of either a poor financial position or a cash shortfall. It is a consequence of normal operations in any normal organisation. In any

[Mr. Hutton]

public or private sector body, amounts are due to be paid at the end of the year. In the case of health authorities, most sums will be moneys owed to and from other NHS bodies. It is not, as I said earlier, all a debt repayable on demand. As accounting rules require building values to be recorded on a balance sheet, the majority of sums do not involve repayment. I am not an accountant, but I wish that a set of accounting rules applied to my overdrafts in the same way as to these matters.

The hon. Gentleman explained the amendment well and we understand his point. Strategic authorities will not inherit the deficits of NHS trusts. Assets and liabilities relating to provider functions will be mainly retained by the NHS trusts themselves, not passed on to the new primary care trusts. We are dealing with important issues about deficits in the national health service. Significant extra resources will provide the NHS with the best possible financial platform for the future.

Mr. Heald: Is it correct that a health authority is responsible to the region for the debts of NHS trusts, as well as its own? If so, will PCTs acquire that liability under the new arrangements?

Mr. Hutton: I do not think so, but I hope that the hon. Gentleman will allow me to provide a more detailed answer later. I have tried to deal with his concerns about precisely where the deficits will go. As I understand it, they will mainly stay where they are. An NHS trust's deficit stays with the NHS trust. The health authority has an obligation to break even and maintain a sound financial position overall, but my understanding is that deficits of acute trusts, for example, will not become inherited deficits for the strategic health authorities. That is not how the new arrangements will work.

Mr. Heald: Will the Minister clarify whether the PCTs will inherit any deficits?

Mr. Hutton: Not unless it is a deficit of the PCT itself. They will not take over responsibility for deficits inherited or accrued over the years by acute trusts. I hope that that explains the position. If I am incorrect, I shall take the opportunity to clear it up later in the Committee or through correspondence.

Dr. Harris: If a PCT were heading for a deficit, would the Government's advice be to accept it and overspend, or to cut treatment provision? If a PCT cuts back because it has not been allocated enough money, who, if anyone, would be to blame?

Mr. Hutton: The hon. Gentleman is obsessed with blame, but I am not getting into that. I tried to explain earlier the nature of the deficits, not all of which give rise to a demand for immediate repayment. Some are bound up with accounting transactions and the recording of asset values on balance sheets. With record investment going into the NHS, trusts cutting back on services could never be justified. A growing financial resource is available for the NHS and we are not in the business of reducing health service expenditure.

We have dealt fully with the issues, but I suspect that we might have to return to some of them. If I can provide the Committee with further information—particularly about the questions asked by the hon. Member for North-East Hertfordshire—I shall do so.

Mr. Heald: We have had an informative and helpful debate. I am prepared not to press amendments Nos. 89 and 144. The Minister said that he would write to clarify whether PCTs would inherit liabilities for the debts of acute and other trusts. Given that there remains some doubt—I await the Minister's letter—it would be sensible to press amendment No. 138, which gives the Secretary of State the power to take account of any deficit inherited from a predecessor body in determining the amount to be allotted to a PCT. I would seek to divide the Committee on that amendment, unless there are procedural difficulties. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

10.45 am

Dr. Harris: I beg to move amendment No. 149, in page 8, line 21, leave out subsections (3), (4) and (5).

The Chairman: With this it will be convenient to take the following: Amendment No. 148, in page 9, line 7, at end insert—

'and sums paid under this subsection shall be disbursable at the sole discretion of the Primary Care Trust.'.

Amendment no. 150, in page 9, leave out lines 17 to 43.

Amendment no. 151, in page 9, line 46, leave out from 'year;' to end of line 2 on page 10.

Dr. Harris: I am grateful to members of the Committee for allowing the amendments to be taken today, when I am able to attend. I recognise that that involved inconvenience to other hon. Members and that it has disrupted the timetable. The hon. Member for Wyre Forest also wanted to participate in the debate, as he has done in others. Amendment No. 148 stands in his name as well as mine, although the other amendments do not. The hon. Gentleman is presently at the Health Select Committee; I understand that other hon. Members would have liked to attend the Select Committee but have chosen to be here. I shall be as brief as possible, because I know that we need to conclude these matters quickly.

The amendments are about the discretion for primary care trusts—strategic health authorities as well, but primary care trusts are the main recipients of funding—to choose how they spend their resources. What discretion do they have with respect to genuine deficits as opposed to accounting deficits, caused by some bills not being paid until the first quarter of the following year because they have not been received in time or by large bills, such as energy bills, being handled in that manner?

I accept that I was provocative in asking where the blame would go; I regret that, because I genuinely want to discuss the issue. However, in the Minister's response to my last point, he said that because of the generous growth settlement this year, no primary care trust—I suspect that he meant commissioning group—should be reducing current service levels. By

implication, that means that everything can be afforded and nothing has to be cut. That is either an astonishingly naïve assumption—I would not accuse the Minister of naivety—or spin.

I accept that this year growth has been high, relative to previous years, but surely the Minister accepts that pressures on commissioners are increasing. Only if the growth money exceeds the pressures will there be genuine growth and protection of existing services from cutbacks. That is a mathematical reality. Health authorities, which are currently the commissioners, and primary care trusts have told me that the growth of must-dos—we will not go into their merits—stemming from the Government with respect to national service framework requirements and rulings from the National Institute for Clinical Excellence have outstripped growth again this year, even though the growth has been more substantial than in previous years.

That is why many of our constituents are seeing cutbacks in service levels. Indeed, although the picture is variable, any increase in average waiting time is, by definition, a reduction in service and implies that resources were removed to meet must-do requirements.

The Government are concentrating on elective issues and, as a result, it is often areas outside of those favoured that end up having their funding reduced. Does the Minister wish to qualify his view that there is sufficient growth money this year, so no service provision needs to be cut? If hon. Members demonstrate that health authorities and PCT commissioners have had to reduce from the current level of service for financial reasons rather than for reasons of doubtful efficacy and rationalisation of service re-provision, will he, as he implies, say that they are responsible for that decision? They need not have made that decision on financial grounds, as there may have been enough money in the system.

If there is enough money in the system for the NHS to get better and never to get worse, how can the Minister explain his analysis when, the day before yesterday, we were told that the NHS needed much more money? Indeed, last week, his right hon. Friend the Member for Norwich, South (Mr. Clarke) accepted that, in some areas, some services had gone backwards because of the funding problem.

Amendment No. 149 seeks to leave out subsections (3), (4) and (5) of clause 7 which add strategic health authorities to the existing provisions in the amended 1977 Act. As I understand it, that will allow the Government to change the allocations based on performance measures of strategic health authorities.

Amendment 148 takes a slightly different tack, but was rightly selected in this group. The amendment proposes that the disbursement of funds paid under the subsection should be at the sole discretion of the PCT as opposed to the Government, or a Government agency directing how to spend those funds. This is an important point that I have made previously. If the Government are genuine about seeking to devolve budget and responsibility to a low level and to the front line, they cannot claim to have devolved responsibility while having multiple directions and lists of must-dos with which PCTs have to comply.

Amendment No. 150 leaves out the parts of clause 8 that set out these measures, specifically subsections (3), (4), (5) and (6). The further amendment in the group takes out the lines in subsection (7) that relate to the Secretary of State's power to change the allocation based on performance measures of some kind.

I said earlier that that is inconsistent with the maximum devolution of discretion and responsibility, and there is a question about whether it is appropriate for the Government to set targets, which will be political in nature, for managers and clinicians, who are supposed to be patient-driven rather than politics-driven.

The Government do a fantastic job in respect of the setting of political targets and expecting managers and clinicians to meet those, but does the Minister accept that if those targets are set for political purposes and are not clinically driven, that can distort clinical priorities in a way that impacts on the best interests of patients? An example is the Government's obsession with the numbers of people on a waiting list. The setting of a maximum waiting time—even if subdivided by clinical areas, as the Conservatives propose; a matter that I discussed at length with the Front-Bench predecessors of the hon. Member for North-East Hertfordshire—will mean that the patients that a PCT commissioner must get treated most urgently are not the most urgent in clinical terms but those that run the risk of exceeding the maximum waiting time. Is it ethical for doctors, whether managers or front-line clinicians, to accept a diktat to fulfil performance measures when that conflicts with what they consider to be appropriate clinical priority?

Although the Government have said that nothing in the targets should be seen to override patients' clinical priority, managers are clearly measured on their performance. The Government are angry when people exceed the waiting time limits because Opposition Members take them up on it. The Minister may realise that I have never, in my current role, attacked the Government for failing to meet an 18-month maximum waiting time limit. To do so would be to support the view that it is important to stay within the limits, when it may be appropriate for people to wait for what could be described an unacceptably long time if clinical priorities dictate that other patients are seen earlier.

Are the Government's likely targets reasonable? The record of the Government—and, probably, that of any Government—shows that the targets will be not evidence-based or patient-driven, but politically driven. Managers inevitably will feel obliged to ask doctors to work in line with the performance measures, rather than clinical need. Doctors, clinicians, nursing staff and other health care professionals may feel torn between their ethical duty and their employment duty to do the bidding of the Government and the managers. This part of the Bill creates that tension.

It is invidious to reward commissioners who are in the fortunate position of being able to implement

[Dr. Harris]

measures, regardless of their merit, by taking money from the general amount available—and, therefore, from other commissioning groups—while penalising commissioning bodies, PCTs and strategic health authorities who, because they have not had enough funding, have been unable to meet the targets. Taking money and resources from them creates more problems because it penalises the underfunded to pay those who, by a quirk, are better funded.

Mr. Hutton: I am trying to follow the hon. Gentleman's argument. On what does he base his argument that we are taking away money from other trusts to reward the good performers? As he knows, the performance fund is distributed on an entirely equitable and similar basis.

Dr. Harris: I am not sure what the Minister means by an entirely equitable and similar basis. My understanding is that a performance fund is a top-slice held centrally, rather than being dispersed in the weighted capitation allocations; perhaps the Minister will clarify that. If a performance fund is allocated to reward what the Government judge as good performance, it might be allocated according to the normal weighted capitation allocation formula. If it is allocated more variably to those trusts, in the case of PCTs, that the Government deem to be better performers, that funding will not be available to be allocated equitably—using that word to support my own argument—through weighted capitation allocations.

The money in the allocations is shifted towards those that are below target. I am not complaining about that, but I am concerned that the allocation of funding, however small or large, solely on the Government's judgment of performance is likely to be more politically motivated than clinically motivated and is, in any event, likely to relate significantly, if not entirely, to the resources of the PCT.

11 am

Mr. Hutton: To be honest, the hon. Gentleman has genuinely misunderstood the way that the performance fund works. I am following his argument carefully, but it might help if I pointed out that all organisations receive a fair share of the fund, regardless of their performance rating. Those shares are based on the national weighted capitation formula. The benefits that accrue depend on whether the trust has three stars or no stars. They can use those funds as they see fit. No one is penalised; everyone gets a fair share.

Dr. Harris: I am grateful to the Minister for his clarification. That was not my reading of either the explanatory notes or the Library briefing. I know that he is not responsible for the Library briefing, which are usually estimable. Paragraph 63 of the explanatory notes states:

"Section 97C (3)–(6) is a new provision to allow performance payments direct to Primary Care Trusts. The provision allows the Secretary of State to increase the allotments made to a Primary Care Trust if they have, over a period notified to the Primary Care Trust, satisfied objectives notified as objectives to be met, or performed well against criteria notified to them as criteria relevant to their satisfactory performance of functions. The additional sums"—

not the additional discretion over sums—

"may be subject to conditions. If those conditions are not met the Secretary of State may reduce the Primary Care Trust's allotment, in the current year or following years—in effect he can recover the additional sums paid, wholly or in part."

As I understand that, it supports what I said, rather than what the Minister said. I would be grateful if he could clarify whether the explanatory notes have misled me, however inadvertently. The Library briefing states that current provisions, rather than a new power

"which enable the Secretary of State to subject part of these allegations to performance criteria, and to claw back some or all of the performance-related part of the allocation if performance is unsatisfactory are retained, both for Strategic Health Authorities and for PCTs."

The difference is that these are retained powers rather than a new provision, as paragraph 63 of the explanatory notes implies. That may just be a quibble over words.

I think that I have made a substantive point here. If I have continued to misunderstand the Library briefing, the explanatory notes and what the Minister has just said, clearly it is just too early in the morning. I hope that the Minister will be able to explain why he believes that the concerns I am raising, regardless of their merit, are groundless.

Mr. Heald: We are sympathetic to the amendments, although we would not support them in a vote, as there are some drafting problems. The basic principle behind them must be right. PCTs have the freedom to spend their money in the interests of patients in their area. Although we think it necessary to have a small element of control—the words "sole discretion" might be further than we would want to go—the principle must be right.

On Second Reading, my hon. Friend the Member for Woodspring (Dr. Fox) said:

"The Bill will do nothing to stop the flow of centralised direction and instructions. It will strengthen the hand of the Secretary of State to interfere at local level. The Secretary of State will allocate the money to the PCTs so that he can determine what they will do. He can withhold money; he can set resource limits as well as cash limits; he sets performance rewards. It is micromanagement of policy, and it is folly."—[*Official Report*, 20 November 2001; Vol. 375, c. 209.]

Throughout the country, there will be complaints from PCTs that their funding is not adequate. Whitehall will decide what it should be. That cannot be anything other than a centralisation of power, and it is a silly one, because everyone knows that the Secretary of State in Whitehall is never any good at setting individual local figures, or at least not as good as a body closer to home. That will be a real rod for the Government's back in the long term. We sympathise with amendments Nos. 150 and 151, but again there are issues about the detail.

Mr. Hutton: I certainly will not advise my hon. Friends to support these amendments, for a number of important reasons. Amendments Nos. 149 and 150 would make it impossible for the Secretary of State to make additional payments, based on performance, to strategic health authorities or PCTs. However, it is important for him to have those powers to improve the

performance of the NHS as a whole. That is one of his primary responsibilities. It would be foolish to deny the Secretary of State the opportunity of delivering on the responsibilities that he owes to the House, patients and the public as a whole. I shall return to that point, because the hon. Member for Oxford, West and Abingdon clearly misunderstood the nature of the performance fund and how the money is disbursed.

Amendment No. 151 would limit the Secretary of State's powers to adjust a PCT's initial allocation during the year. That would be absurd. Equally, amendment No. 148 would prevent the Secretary of State from imposing conditions on any of the allocations, so that PCTs could spend them entirely as they chose. I understand the point about devolution, and we subscribe to it, but in some cases it will be important for the Secretary of State to have an influence on the use of funds. Ultimately, that is his accountability to the House.

The hon. Member for Oxford, West and Abingdon has always said that the Bill is about shifting the blame. However, the powers make it transparent and explicit that the Secretary of State has important responsibilities that he must discharge. The hon. Gentleman cannot have it both ways. He cannot claim that we are shifting the balance of power but then criticise the Secretary of State for exposing himself to criticism when he exercises those powers and responsibilities. That is a classic Liberal Democrat statement and position, but it is utterly contemptible. [HON. MEMBERS: Oh!] I enjoyed that.

Mr. Burns: Keep taking the pills.

Mr. Hutton: I will.

I know how much it sucks to be told by a Minister that an amendment has a technical deficiency, but I can also tell the Committee how much it pleases a Minister to identify one. There is a rather horrid technical deficiency in amendment No. 148. It would not have the effect that the hon. Gentleman has waxed lyrical about unless proposed new section 97C(8) were omitted from the Bill, and his amendment would not do that. The new section deals with the Secretary of State's power to give directions with respect to the applications of sums.

With a certain lack of conviction, the hon. Member for North-East Hertfordshire made a point about the acquisition of new powers and the stealth gain by the Secretary of State. However, we already have powers under section 2 of the Health and Social Care Act 2001 that enable us to make additional payments to health authorities based on their performance in previous years or during the same year. The measures in clause 7 to which both hon. Gentlemen take such exception simply extend existing powers to allow those payments to be made to strategic health authorities. That is perfectly logical and sensible, because they are broadly the successor bodies.

The Secretary of State has the power to determine how much to allot to each strategic health authority and, in doing so, he can consider a range of factors. It is open to him to pay more to a strategic health authority—I should have thought that the hon. Member for Oxford, West and Abingdon would like that to happen mid-year or at any other time after the initial allocations were made—if he takes the view that additional amounts will help to improve unsatisfactory performance. The hon. Gentleman has been banging on about some of those problems, but he wants to take away that power.

We have no current plans to allocate performance funds to strategic health authorities, but we wanted to retain the option to do so if we felt it to be necessary. For example, we might want to use the performance fund to give strategic health authorities money to incentivise performance on a local health economy basis. That could be a constructive use of the resources.

Subsections (3) to (6) of proposed new clause 97C will mirror for PCTs the existing powers to allow payments to be made to health authorities. That is necessary because of the way in which commissioning funds will be disbursed through the NHS to PCTs, not to health authorities. The measure is not, in the words of the hon. Member for Oxford, West and Abingdon, the acquisition of new powers, but the logical extension of existing powers to the new organisations that have commissioning responsibilities.

Dr. Harris: I direct the Minister to the explanatory note, which specifies that the extension is a new provision. That might mean "new" in the sense that everything in the Bill is new, but I am not sure why that would be so. I agree with the Minister's comment, and the Library briefing, that the proposal is a continuation of the health authority approach.

Mr. Hutton: The hon. Gentleman is right. The extension of powers is a new provision in a new Bill, but it represents a continuation of the powers that the Secretary of State already holds on health authorities, which are the commissioning bodies. PCTs will have that function and if we believe in the Secretary of State having the powers, it is logical to extend them to the new bodies. We believe that, and I am slightly puzzled that the hon. Gentleman does not. His party rightly wants to hold the Secretary of State to account, because that is the job of this House.

Mr. Heald: How can the Minister maintain that this is a devolutionary measure when he keeps on talking about extending the Secretary of State's powers? Why do we not reduce them? What happened to decentralisation and devolution?

Mr. Hutton: I will come to that point in a minute. The hon. Gentleman is falling into the same trap as the hon. Member for Oxford, West and Abingdon. We are devolving power and responsibility to the NHS.

Mr. Heald: No.

Mr. Hutton: We are, and that is the view of the British Medical Association and other organisations in the field. That is not the hon. Gentleman's view; even if we transferred every power—lock, stock and barrel—to the front line of the NHS, he would claim that it was a centralising measure. That is the political position that he and the hon. Member for Oxford, West and Abingdon wish to occupy.

The Secretary of State will take the power that he needs to determine how much to allot each PCT on its

[Mr. Hutton]

performance. He may consider a range of factors and he needs the discretion. It is important also for the Secretary of State to be able to vary an allocation during the course of a year, and I would have thought that the hon. Member for North-East Hertfordshire would have supported that provision. The Secretary of State should also be able to impose conditions, if he feels that they are necessary, on how the money allocated to PCTs is spent. The Secretary of State is accountable to Parliament for the way in which public money is used, and needs the powers to help him discharge the responsibility effectively. I do not agree with the hon. Member for North-East Hertfordshire that we cannot ensure proper parliamentary accountability—which, rightly, preoccupies every Member—and devolve responsibility to the NHS front line.

The hon. Members for North-East Hertfordshire and for Oxford, West and Abingdon both complained about ring fencing. We may want to ring-fence part of the allocation to ensure that funds are spent on the purposes for which they have been allocated. We are doing that, for example, for the development of out-of-hours GP services. It is important to develop those services, and earmarking funds is an effective way of ensuring that priorities are fulfilled. The services are not plucked out of a hat, but represent patients' priorities. The hon. Member for Oxford, West and Abingdon will know about the frustration that some patients and members of the public feel when they cannot access primary care services out of hours. Ring fencing is an important part of ensuring that all the NHS works effectively. We have proper out-of-hours primary care and accident and emergency cover, and they work intricately together. If we do not invest in out-of-hours services in primary care, we will have to soak up problems in accident and emergency departments. We must set our face against that.

In accordance with shifting the balance of power and the philosophy that underpins it, we aim to earmark funds only when necessary. Indeed, we are earmarking less in allocations to health authorities, and will do so to PCTs, than has been the case. This is a classic case of the Opposition trying to have their cake and eat it. They criticise the powers that the Secretary of State needs to have on the basis that they are centralising, but then rail that the Secretary of State is trying to evade his responsibilities and accountability to this House. On this occasion, they cannot have their cake and eat it.

Mr. Baron: The Bill introduces 58 specific instances in which the Secretary of State for Health's powers are enhanced. It introduces micromanagement for targets and performance rewards for individuals in primary care trusts; money can be withdrawn if the targets are not met. Will the Minister explain how it is a decentralising Bill?

11.15 am

Mr. Hutton: We will deal later with the provisions where those regulatory powers are discussed. Under the Bill, some of the Secretary of State's powers are intended to facilitate, for example, the establishment of the new UK council for health care regulators. That professional self-regulation will be a boost to patients' interests, which the hon. Gentleman should support.

In preparing legislation, material in the Bill must be balanced with the regulations. That process is subject to normal scrutiny: the hon. Gentleman may think that it is not sufficiently robust, but that is a separate argument. In drafting primary legislation, subject matter that is appropriate for regulations is distinct from what should be in the Bill. The hon. Gentleman and I may disagree where that balance should be struck. I will have to double check the hon. Gentleman's arithmetic, but it is not right for him to say—based on a crude headcount—that because the Bill contains 58 regulatory powers, it is a centralising measure. It is not as simple as that.

I want to conclude the debate by 11.25 and we have dealt robustly with the hon. Gentleman's arguments—though perhaps not to his satisfaction. His arguments are based on a misunderstanding of the performance fund's nature, purpose and intent. Most depressing of all is the failure of the hon. Gentleman and the hon. Member for North-East Hertfordshire to recognise that the Secretary of State has a role in incentivising and rewarding good performance in the NHS. It is entirely proper for the Secretary of State to have that responsibility, and it is his constitutional role to discharge it. The Bill will equip him with the powers to do so.

Mr. Baron: Will the hon. Gentleman give way?

Mr. Hutton: No.

The clause intends to give the Secretary of State those powers and the amendment would deny them. I cannot accept the amendment.

Dr. Harris: That answer was most unsatisfactory. It is not a case of having one's cake and eating it. Having heard the concept of a cake used in that way, I am sorry that I introduced it. The amendments will not prevent allocation of additional funding during the year, based on weighted capitation in the usual—as the Minister described it—equitable way. I cannot remember the other adjective that he used. It is welcome that the Government want to make allocations in advance, so it is regrettable that more money has to dribble in during the year. No one will complain about extra money, but they certainly would if it was withdrawn, which the Government have the power to do.

We are not debating the principle of additional allocation, but whether it is reasonable for the Government to set performance targets to incentivise staff financially. The Government's remarkable judgment of front-line health care staff is that they do their best only if offered additional money. To the Government, they are not inspired by vocation or by their duty of care to patients; they are inspired to work long, additional hours not on the basis of their wish to do what is best for their patients, in partnership with them, but by the fact that they will get a bit more money next year, either in their pay cheque or for their budgets. That is a remarkable analysis of people's motivation.

The Minister failed to explain the confusion that he caused by stating that there was not a performance fund separate from the general allocation, which is made available differentially to different commissioning groups on the basis of the Government's judgment of performance against Government-imposed targets. They may bear little relation to clinical priorities, or may be counter-productive in that they distort clinical priorities. The Minister did not respond to that allegation, nor did he clarify the issue.

Mr. Hutton: The hon. Gentleman is trying to have his cake and eat it, although it is more of a biscuit in this case. His party's manifesto was full of political commitments on targets for the national health service. What on earth is he talking about?

Dr. Harris: The Minister will have to be more specific. I accept his point that one cannot say that Governments should set maximum waiting time targets and not avoid being hung on them if they do not give health authorities the funding, regardless of clinical or other priorities. That is why our current policy rejects the concept of rigid performance-managed maximum waiting times; we favour using waiting times as a monitor of performance but not as the be-all and end-all, which will distort clinical priorities by making funding depend on them. The more funding there is in the system, the easier it is to drive down overall waiting, but arbitrary, politically driven maximum waiting times will distort clinical priorities. The earmarking of funds, which have to be dealt with on their individual merits, is a separate argument. The Bill may be so badly drafted that it would be impossible to amend it without covering earmarking, and the Government might want to think about that.

Mr. Heald: Does the hon. Gentleman agree that there is a role for incentivising individuals or even primary care trusts? What is wrong about it is the Secretary of State's control at a micro-level, with small clusters of GPs' practices throughout the country being run from Whitehall. Does the hon. Gentleman agree that it is micro-management that is so dreadful?

Dr. Harris: The Minister claims that I want to pin the blame on Ministers for underperformance and then take away their power to manage that performance. He thinks that that is having my cake and eating it. That is an accurate reflection of the position, but it is not I want. I want the NHS to be depoliticised except in terms of the funding settlement, because it is the Government who raise taxes. The best chief executives, health authority managers and PCT clinicians do not, off their own bat, have the power to raise extra resources in a fair and equitable way. That is what the discussion of Government performance should be about. But while the Government set performance targets, retain the interest in managing various issues and take credit for delivering them, it is right that that when they fail they should be held to account.

The Government are trying to ensure that the blame is devolved while the credit is centralised. They should not impose politically driven targets on health authorities. The hon. Member for North-East Hertfordshire should put himself in the position of a patient in an area that is defunded because it failed to meet the targets, perhaps because it did not have the money or the staff to do so, as the funding, which could be theirs if it was allocated fairly, will reward those who have done the Government's bidding, regardless of the impact on patients.

Mr. Heald: Does the hon. Gentleman understand that, because of time constraints, we shall not have the opportunity to debate my amendments, which deal with that matter?

Dr. Harris: If that is the case, I recognise it. I shall not press the amendments now. The Minister will probably point out their drafting problems, but I shall want to return to the same issues later in the Bill. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 7 ordered to stand part of the Bill.

Clause 8

FUNDING OF PRIMARY CARE TRUSTS

Amendment proposed: No. 138, in page 9, line 14, at end add

'and—

(c) any deficit inherited from a predecessor body.'.—[*Mr. Heald.*]

Question put, That the amendment be made:—

The Committee divided: Ayes 5, Noes 10.

Division No. 5]

AYES

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

NOES

Burnham, Andy	Havard, Mr. Dai
Challen, Mr. Colin	Hutton, Mr. John
Fitzpatrick, Jim	Moffatt, Laura
Hall, Mr. Mike	Touhig, Mr. Don
Harris, Dr. Evan	Ward, Ms Claire

Question accordingly negatived.

Motion made, and Question put, That the clause stand part of the Bill:—

The Committee divided: Ayes 9, Noes 6.

Division No. 6]

AYES

Burnham, Andy	Hutton, Mr. John
Challen, Mr. Colin	Moffatt, Laura
Fitzpatrick, Jim	Touhig, Mr. Don
Hall, Mr. Mike	Ward, Ms Claire
Havard, Mr. Dai	

NOES

Atkinson, Mr. Peter	Harris, Dr. Evan
Baron, Mr. John	Heald, Mr. Oliver
Burns, Mr. Simon	Murrison, Dr. Andrew

Question accordingly agreed to.

Clause 8 ordered to stand part of the Bill.

Mr. Burns: On a point of order, Mr. Hurst. I seek your guidance. I understand that a meeting of the Programming Sub-Committee will take place in this Room at 11.35. What will be the arrangements for members of the Committee who wish to leave their

[Mr. Burns]

papers here between now and 2.30 this afternoon when the Committee returns?

The Chairman: I can advise members of the Committee that the Room will be locked, so that will be a safe course to follow.

It being after twenty-five minutes past Eleven o'clock, THE CHAIRMAN *adjourned the Committee without Question put, pursuant to the Standing Order.*

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

THE FOLLOWING MEMBERS ATTENDED THE COMMITTEE:

Hurst, Mr. Alan *(Chairman)*
Atkinson, Mr. Peter
Baron, Mr.
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
Touhig, Mr.
Ward, Ms

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