PCT accountability and the democratic deficit

Political debate is increasingly focusing on a perceived ‘democratic deficit’ in health and there is a growing challenge to the legitimacy of current PCT decision-making arrangements. Proposed solutions are likely to feature in the main political parties’ manifestos at the next General Election.

This Consultation outlines the current situation and invites your comments on seven options for PCT accountability.

**Key points**

- Political debate is increasingly focusing on the ‘democratic deficit’ in health.
- There has been considerable recent development of local accountability mechanisms for PCTs.
- The public is wary of the track record of the NHS in delivering local accountability.
- PCTs are aware of the difficulties and barriers to public engagement.
- The NHS Confederation suggests seven options for PCT accountability and welcomes your views to help influence the political debate.

**Background**

In giving evidence to the Health Select Committee in 2006, Dr Ed Mayo of the National Consumers Council said: “It is difficult to know what kind of accountability people want in relation to the NHS. Is it the accountability of a service provider, like Tesco, that is just responsive to what people want? Is it accountability that is, in some way, mutual and engages them as partners in health, or is it some democratic process that has parliamentary or local councillor scrutiny? Those are very different notions of accountability and I have never heard very clear answers either from patients we talk to or others in this field.”

The Government’s shift in emphasis from national targets towards local autonomy raises questions about the accountability of primary care trusts (PCTs). Lord Darzi has said recently that his review will “establish a stronger framework of responsibility, accountability and legitimacy for decision making within the service both nationally and locally”, and promises “an open and accountable process for arbitration and decision making where possible.”

Accountability of local services is a strong theme in the 2007 Comprehensive Spending Review, with a commitment to delivering on Darzi’s recommendations and proposals, including neighbourhood charters which allow local citizens to hold service providers to account.

PCTs will also soon have a statutory duty to be active partners in local arrangements for jointly commissioning services, particularly for long-term conditions, including mental health, children’s trust arrangements and wellbeing services.
The current position

PCT boards are currently accountable to the Secretary of State for Health and are performance managed by strategic health authorities (SHAs). SHAs hold PCTs to account for delivery of the local delivery plan (LDP) and their other responsibilities. PCT performance is also assessed by the Healthcare Commission and the Audit Commission.

Local accountability

Alongside this national accountability structure, there has been considerable recent development of local accountability mechanisms. Indeed, some systems put in place as part of the Government’s reforms are not yet fully implemented. Local mechanisms currently include:

- the local strategic partnership – comprising local government, health trusts and PCTs, local businesses and third sector organisations, the police and criminal justice services, supported by joint strategic needs assessment, undertaken between the PCT and local authority. Co-terminous PCTs and local authorities are advantageous – this currently applies to about 70 per cent of all partnerships in England
- a legal duty on NHS trusts to be part of a local area agreement (LAA), developing local improvement targets from a range of centrally and locally prescribed indicators, and a rigorous external assessment of this in the comprehensive area assessment (CAA). Both of these elements are still under development and the CAA will only be in place from 2009
- a strengthened duty on PCTs to involve and consult, backed up by statutory guidance, although the guidance has not yet been published and the Act has only recently been passed
- a requirement for PCTs to give an annual account of how they have consulted and involved the public, what they have heard and how they have responded to public views
- a requirement for PCTs to consult and involve patients, the public and other local stakeholders in the development of their prospectus. The prospectus will lay out the services the PCT wants to commission and will act as a procurement guide for both the public and potential providers, but has not yet been developed
- LINks (local involvement networks), which will be groupings of local networks and user groups, supported by the local authority. They will be consulted on key local decisions and have recourse to the local authority’s overview and scrutiny committee
- a strengthened local government overview and scrutiny committee, with the ability to proactively scrutinise new health services and redesigned provision and reactively investigate difficulties or challenges with particular areas of service provision. The right of recourse to the Secretary of State and the Independent Review Panel supports the work of these committees. We await further guidance on the strengthened overview and scrutiny committee function.

What the political parties say

Labour

In a recent speech, Ben Bradshaw outlined the areas where further work on local accountability is needed. PCTs, which increasingly will be responsible for spending money and commissioning services, are seen as having no direct democratic accountability. Labour argues that it is difficult for local people to make their voices heard and to make sure that changes are made. Managers need to communicate using simpler language, with healthcare terminology at present being “far too managerial and technical.”

The Conservatives

In their paper on NHS autonomy, the Conservatives claim there is a democratic deficit and a lack of accountability in health. They reject the idea of putting NHS commissioning in the hands of local authorities. They propose a national NHS watchdog (Health Watch) for patients and public. They would strengthen LINks and make them independent of local authorities, and believe that NHS accountability to local authorities needs strengthening. This would mean enhancing LAAs, which would define local priorities for NHS services. They agree with the pooling of budgets to ensure that people can have individual budgets, particularly for long-term conditions.

The Liberal Democrats

The Liberal Democrats propose two
options. Firstly, instead of the Health Board appointed nationally, there might be a board with a majority of directly elected members, supported by appointees who would provide financial and health expertise.

Alternatively, the work of the PCT could be transferred to a local authority, democratic accountability being secured through the normal council election process. Models for local authority-led healthcare commissioning might include: the local authority nominating the majority of members of a health board; the same arrangement but with significant levels of joint working between health and social care; or the PCT/health board becoming entirely integrated with the local authority. Different models may fit different circumstances; it would be for local people to decide via local referenda.

What the public says

In a MORI survey carried out for the NHS Confederation in 2006, respondents were asked who should make decisions about which medicines or treatments are funded by the local NHS. Seventy per cent believed that clinicians working in the local NHS should do so, with 33 per cent favouring patient representatives and 23 per cent local NHS managers. Only 9 per cent believed that decisions should be made by MPs and 6 per cent by local councillors.

However, there is evidence that people are wary of the track record of the NHS in delivering local accountability. The Health Select Committee’s report on public and patient involvement in the NHS found that: “Many of those most actively promoting public and patient involvement are concerned to tackle the ‘democratic deficit’ in the NHS. They hope that encouraging people to get actively involved in collective activity to reshape the NHS will reduce alienation and promote a new type of community engagement.”

Indeed, work by the Picker Institute states that PCT processes for patient and public involvement are “one of the least well developed components of clinical governance.” PCTs themselves are aware of difficulties and barriers to engagement, particularly those in “supporting, training and motivating the public to engage with commissioning issues.” Even where developed, patient and public consultation is rated by PCTs behind overview and scrutiny and local MPs in its influence in commissioning decisions.

Public perceptions of local government are not positive. Work undertaken by the Department for Communities and Local Government looked at people’s initial reactions when asked to discuss local authorities. Mainly, people did not know the identity of their local councillors and were cynical of their reasons for being in local politics: “Impressions of councillors… were fairly negative with councillors described as inaccessible, driven by their ego and desire for local recognition rather than a will to serve the people in their local area. Once residents become councillors they in some way lose their affinity with the people they are supposed to represent, becoming part of a council clique or local conspiracy.”

Another interesting finding was a deep-seated mistrust of politics and politicians and a belief that councils cannot be trusted to deliver value-for-money services or the promises they make at election time.

Options to be considered

The options outlined below are not mutually exclusive and may vary in their effectiveness from PCT to PCT.

Option 1: Retain the present accountabilities and allow the existing system to bed in, with specified evaluation points on overall performance

The mechanisms already in place are still, in some cases, being developed and therefore their effectiveness is unknown. This option should be seen in light of the Picker evidence, outlined above, that PCTs’ track record in involving the public is also, in the main, underdeveloped.

Pros
- the current system is not yet fully operational and has not been given an opportunity to bed in
- another reorganisation of PCT structures so soon after establishing the new PCTs in October 2006 is disruptive and at odds with the Government commitment to no new top-down reorganisations
- it is not clear that there is any serious public disquiet with the current system (see ‘What the public says’ section).

Cons
- the current system does not deliver a fully democratically accountable system for PCTs, particularly if their local autonomy is to increase
- this option might be interpreted as a lack of will on the part of the NHS
to really change the way in which it relates to the local population
• there is no real need for better performance evaluation if the system remains unchanged.

Option 2: Foundation trust style membership for PCTs
The principle of foundation trusts, which have been heralded as a step forward in local accountability for hospital services, could be rolled out to PCTs with similar membership and governance systems put in place. The Institute for Public Policy Research’s most recent major report suggests that: “Foundation PCTs… would reduce direct government involvement in PCT management and strengthen local accountability, legitimacy and ownership of decisions. The best PCTs should be given freedoms and flexibilities in exchange for stronger local accountability mechanisms.”

Pros
• foundation trusts have shown that it is possible to engage large numbers of local people in the governance of NHS organisations, including having elected governors on boards to improve local challenge
• this option provides a symbolically inclusive model with the national line of accountability to Monitor augmented by local membership arrangements.

Cons
• the overlap with foundation trust members might cause confusion and competing local accountability systems
• given the financial accountability required of PCTs, and their performance management in this respect by SHAs, would this mean that they would not be able to achieve the level of independent governance required for such authorisation?
• the ‘membership’ of a PCT should be all local people, not just those who volunteer to get involved
• how would membership be decided or would residence automatically bestow it?
• it is not clear yet what impact foundation trust members have had, so simply duplicating this approach may be premature
• this option does not enable greater integration with local authorities.

Option 3: Directly elect all or part of a non-executive body on the PCT board
Enabling local people to have the opportunity to stand for election onto the PCT board could give better accountability to local populations and enable local issues to be debated at board level.

Pros
• this option delivers democratic accountability into PCTs and deals with the argument of democratic deficit
• it strengthens the credibility of local consultation mechanisms and brings a wider range of views into the commissioning debate.

Cons
• there is no evidence of public appetite for more local elections – turnout at local government elections is low and is falling
• there is a danger of single issue politics dominating such elections, for example the closure of a local unit/hospital
• the impact of politicising the local health system is unknown but may lead to short termism
• fully-elected boards might be difficult to maintain as turnover of board members could cause delays in new developments whilst knowledge of the business was being gained following elections
• this option might exclude high quality potential non-executives where they are not politically active.

We should also consider local funding and local accountability. Local politicians have a direct impact on the extent to which services are funded locally through council tax. The local accountability is therefore about value for money in services funded in part directly (and which can be varied directly) through local taxation. The accountability for funding and the ability to vary this locally is not the same when considering the NHS unless (as the Liberal Democrats suggest) national funding can be augmented through local income tax.

Option 4: Appoint local authority members to PCT boards on a quota basis (either the lead cabinet member or representatives of the main local political parties)
Given that local authority members have already been elected by the local community, this could be a mechanism for linking local decisions to the political process particularly as local strategic partnerships develop as the key vehicles for planning health and social care.

Pros
• this option establishes a link between existing local elected
members and the local health system

- it supports partnerships to work together more effectively by giving a much clearer understanding of the pressures and issues within both health and local government. There would be influence but without some of the single issue politics that might derive from a directly elected board
- it doesn’t require local people to participate in additional elections.

**Cons**
- many of the disadvantages of Option 3 also apply here
- this option might be seen as tokenistic and unrepresentative of their views by the local community – this would be particularly relevant where there was a slender political majority or a hung council. To use appointment as a proxy for democratic involvement might not be acceptable in terms of public engagement
- it doesn’t deliver specific accountability for health services as it would be incorporated into the existing local government election.

**Option 5: Transfer NHS commissioning responsibility to local government**

This option would enable the partnership agenda to be linked to democratic structures and make the NHS a live issue for local authority elections.

**Pros**
- this option delivers democratic accountability for commissioning
- it integrates health and other local government to promote joined-up planning and decision-making on issues such as public health.

**Cons**
- another huge reorganisation for health services would be at odds with the Government commitment to no new top-down reorganisations
- more understanding of secondary care health service issues at local government level would be needed if services other than wellbeing and community services were to be commissioned in this way
- new mechanisms would have to be developed to link practice-based commissioning into local partnership arrangements
- many of the disadvantages of Option 3 also apply here.

**Option 6: Allow local government scrutiny of appointments of chairs or all non-executives on PCT boards (along the lines that the Government is proposing for some other public bodies)**

This would enable the suitability, competence and experience of PCT board members to be scrutinised with an indirect accountability through local councillors to the electorate.

**Pros**
- it would introduce some local accountability into the Appointments Commission process.

**Cons**
- it might dissuade good quality candidates from applying, particularly if the process was confrontational or overly inquisitive
- mechanisms would need to be developed both for candidates deemed unsuitable through scrutiny and, potentially, also for appeal procedures.

**Option 7: A new body sitting between the NHS and local government**

This option would involve setting up an authority with a mix of: elected councillors; key stakeholders (such as magistrates) and clinicians; and independent members selected following local advertisement and recruitment. The role of this new body would be to set the strategic direction and hold the PCT to account on behalf of local people.

**Pros**
- this option gives elected members and members of the public more influence in local healthcare
- it creates a joined-up approach.

**Cons**
- the new body could be seen as a committee of the local authority rather than being independent
- it is unclear what powers such a group would have and how accountability would be demonstrated.
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Points for consultation

We would welcome your views on the following questions to help us develop an NHS Confederation position and influence the political debate accordingly.

1. Are there any other ways of attaining local accountability that we have not considered?
2. Are there any different strengths and weaknesses to the options we have outlined above?
3. Should we have a preferred option around which we should draw our lines?
4. Should we choose one model or should we follow a broader line that would allow local variability?

Please email your comments to sam.hunt@nhsconfed.org by 16 November, or comment online at www.nhsconfed.org/primary-care-trusts/primary-care-tr-3007.cfm

References

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6. Lamb, N. 2007: Localism, fairness and empowerment in the NHS.
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12. Great expectations: achieving a sustainable health system. IPPR, September 2007

The NHS Confederation

The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS. We help our members improve patient care and public health, by:

• influencing policy, implementation and the public debate
• supporting leaders through networking, sharing information and learning
• promoting excellence in employment.

The Primary Care Trust Network is part of the NHS Confederation. For further details of the Primary Care Trust Network, please visit www.nhsconfed.org/pctnetwork or contact David Stout on 020 7074 3322 or at david.stout@nhsconfed.org