Principles for accountability

Putting the public at the heart of the NHS
The voice of NHS leadership

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
Local accountability and the need to strengthen the transparency of decision making within the NHS are hot political topics.

With unprecedented investment in health coupled with high-profile reports of failures in some NHS organisations, there is a feeling among the national political parties that the local decision making of NHS commissioners needs to be more transparent. Reconfiguration controversies (albeit that a major hospital has not closed since 1997) have spawned the belief that existing accountability mechanisms are not sufficiently robust for primary care trusts (PCTs) to demonstrate a mandate for major service changes such as closing emergency departments.

This culminated in the Prime Minister’s recent speech (Jan 7 2008), with the statement that:

“We will explore ways of improving the legitimacy and accountability of primary care trusts and the commissioning decisions they make.”

The NHS Confederation, through its PCT Network, has embarked on a work programme to explore what local accountability is and what we need it for. As well as wide-ranging discussions with our members at regional and other meetings, the Confederation has undertaken an online consultation and held an expert seminar of leading academics, government advisers and a range of PCT and NHS provider executives, non-executives and chairs.

This report presents our findings and is intended to open up debate. We hope it will also help PCTs develop their arrangements with councils, partners, local citizens, patients and communities.
What is local accountability?

In theory, the principle of local accountability appears simple. In practice, however, PCTs operate in a complex system and deal with several different and not always mutually supportive dimensions to their governance and accountability. A study in 2002 found that 68 per cent of the public wanted involvement in decision making at the health system level, for example in local choices between different kinds of emergency care. Half favoured involvement at programme level, like in choosing where to allocate funds for cancer or mental health. Only 20 per cent in this study favoured involvement at the level of the individual patient. Indeed the study participants regarded the consultation itself as a way of improving the decision and its acceptability – a concept described by the authors as “accountable consultation”.

Our work suggests that there are three pairings of accountabilities that need to be considered:

- local and national accountability
- strategic and operational accountability
- consumer and taxpayer accountability.

Local and national accountability
PCTs need to be accountable outwards to their local community. At the same time they are also accountable upwards in the NHS through the strategic health authority (SHA), to the Department of Health (DH) through which they are performance managed, and accountable to the electorate.

Strategic and operational accountability
PCTs have to demonstrate they have a clear and well-evidenced long-term plan. At the same time they have to show transparency in their day-to-day operational decisions, for example which high cost treatments are made available locally. The difficult nature of some of these operational decisions may, at times, put the PCT at odds with local or national politicians.

Consumer and taxpayer accountability
PCTs must be accountable to local people as consumers to provide the services they need to the highest standards of quality and safety including, for example, investing in improved infection control standards or reducing local mixed sex hospital accommodation. At the same time, PCTs have responsibilities to the same people – in their role as taxpayers – to balance the books, to deliver efficiency savings and value for money, using best value principles.

The tensions between these pairings are considerable. What works best for one dimension may not always be positive for another.

How are PCTs accountable now?

Accountability and governance mechanisms already exist within local health and social care systems. PCTs are accountable to a board including independently appointed local residents as non-executive directors and a chair who has responsibility for overseeing the performance of the chief executive. PCTs are also accountable to the local council through the overview and scrutiny committee. The wider range of existing governance mechanisms are shown in Table 1 on page 4.

Some elements of the existing system are yet to be implemented, for example establishing public and patient involvement bodies, called LINks, set up in the Local Government and Public Involvement in Health Act 2007. It is not surprising therefore that 80 per cent of the responses to our online consultation were in favour of retaining the existing system to enable it to at least be fully implemented before considering more change. Many responses made the point that the system is still under development. However, 57 per cent were opposed to the prescription of one model nationally, believing that different local structures might be needed to reflect the requirements of different geographies or local circumstances.
### Table 1 Existing accountability system

<table>
<thead>
<tr>
<th>Accountability dimension</th>
<th>For</th>
<th>Through</th>
<th>By what</th>
<th>How assessed</th>
<th>What assessed</th>
<th>Public involvement</th>
<th>Elected representative involvement</th>
<th>How reported</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National</strong></td>
<td>National targets</td>
<td>Strategic Health Authority (SHA)</td>
<td>Local delivery plan</td>
<td>Regular performance monitoring</td>
<td>Trajectories for targets</td>
<td>No</td>
<td>Yes, through Secretary of State. Health Select Committee can also investigate</td>
<td>Quarterly and annual statistics – aggregated data</td>
</tr>
<tr>
<td><strong>Local</strong></td>
<td>Local targets</td>
<td>Local strategic partnership</td>
<td>Local area agreement and sustainable communities strategy</td>
<td>Comprehensive area assessment</td>
<td>35+ stretch targets from a menu of 200 national indicators plus local targets</td>
<td>Yes, through joint strategic needs assessment and LINks</td>
<td>Yes, through local council. Overview and Scrutiny Committee (OSC) can also scrutinise</td>
<td>Published annually</td>
</tr>
<tr>
<td><strong>Strategic</strong></td>
<td>Long-term plans/service changes</td>
<td>OSC</td>
<td>Sustainable Communities Strategy/Local Delivery Plan/ PCT Prospectus</td>
<td>OSC reports</td>
<td>Capacity of plans to meet findings of Joint Strategic Needs Assessment/local public opinion</td>
<td>Yes, through Joint Strategic Needs Assessment/LINks/ direct petition (Community Call for Action)</td>
<td>Yes through local council</td>
<td>Published reports. Evidence sessions held in public. PCT annual report/reports on consultation processes</td>
</tr>
<tr>
<td><strong>Operational</strong></td>
<td>Quality and safety of service delivery/activity levels</td>
<td>Healthcare Commission</td>
<td>Self Assessment with random checks. Range of plans including clinical governance</td>
<td>Annual Health Check</td>
<td>Nationally prescribed core standards/staff and patient surveys</td>
<td>Yes, through surveys and complaints</td>
<td>The Healthcare Commission is accountable to parliament. Health Select Committee can also scrutinise</td>
<td>Published annually</td>
</tr>
<tr>
<td><strong>Consumer focused</strong></td>
<td>Satisfaction with services</td>
<td>Healthcare Commission</td>
<td>Annual Patient Survey</td>
<td>Annual Patient Survey (part of Annual Health Check as well)</td>
<td>Survey findings from national set of questions</td>
<td>Yes</td>
<td>The Healthcare Commission is accountable to parliament. Health Select Committee can also scrutinise</td>
<td>Published annually</td>
</tr>
<tr>
<td><strong>Taxpayer-focused</strong></td>
<td>Value for money and probity</td>
<td>Audit Commission</td>
<td>Annual audits</td>
<td>Auditors Local Evaluation</td>
<td>Five domains in a nationally prescribed framework, nationally moderated</td>
<td>No</td>
<td>The Audit Commission is accountable to parliament. Select committees can also scrutinise</td>
<td>Published annually as part of Annual Health Check</td>
</tr>
</tbody>
</table>
What needs to be improved?

Lack of legitimacy – real and perceived

Perhaps because of the complexity of the existing accountability framework, it is not easily understood. PCTs are only a few years old and have only just been through a major reorganisation. They are on occasions, therefore, seen as not yet fully capable of delivering within the new system.

While there are clear forums where people can put forward their views and influence decisions, these are not generally well known. The NHS is often not good at demonstrating how views have been heard or how they impact on decisions. It is not clear where decisions are made, where the points of influence are or where ‘the buck stops’. This lack of transparency means that, for the public, it appears that local variations in services and decisions occur without reason. Equally politicians can feel that the NHS keeps doing things at odds with the policies of the political parties.

However, the public do not believe that MPs and local councillors should be involved in decisions about which treatments should be funded by the NHS. Only 9% think MPs should be part of the decision making process and only 6% think councillors should have a say (IPSO-MORI poll of 1000 people, Dec 2006).

Quality of relationships

The quality of relationships between the NHS and the public is variable, and not helped by the short intervals between NHS reorganisations. Constant change within the NHS also affects other local partnerships, notably with local government. In some organisations, relationships are in constant flux, leading to a lack of trust and preventing the development of a shared culture and vision. Added to this investment in communications in the NHS has historically been lower than in other sectors such as local government.

Public and staff perception

While several recent reports have highlighted improvements in the NHS, this is not the focus of media attention. The public have a lower expectation of the NHS than patients. So, while only 62 per cent of the public rate public involvement in the NHS as good or very good, 74 per cent of patients respond with the same ratings. Coupled with this are staff perceptions of the service which are similarly negative, with 19 per cent of staff critical of the NHS by comparison with a private sector average of 8 per cent.

The NHS not listening to public opinion

Recent reports on dignity and on cleanliness in individual trusts have highlighted the strength of public opinion about some issues where the NHS is seen to be complacent. A lack of trust in areas of basic care has a wider impact in the way in which the public perceive the motivations of senior managers and professionals.
What are the principles on which local accountability should be based?

Daniels and Sabin (1998)6 in their work on accountability in managed care systems in the USA argued there were two distinct notions of public accountability: ‘market accountability’ and ‘accountability for reasonableness’, and that both were necessary in a mixed public/private health system. Market accountability casts the individual patient as consumer and focuses providers on improving quality of care and being responsive to patient needs and wants.

However, ‘accountability for reasonableness’ sets four conditions which must be present for a decision to be acceptable to the ‘reasonable person’, and is more applicable to the priority-setting decisions that are made by PCTs on behalf of their local communities.

• **Publicity** – ‘limit-setting’ decisions (i.e. those which could be construed as rationing) and the reasons behind them must be publicly accessible.

• **Relevance** – the decisions must rest on information and arguments that people can agree are relevant to deciding how to meet a range of needs within available resources.

• **Appeals** – there is a mechanism for challenge and dispute resolution, including the opportunity to revise decisions in light of further evidence or arguments.

• **Enforcement** – there is either voluntary or public regulation of the process to ensure that the first three principles are met.

(Gibson et al, 20027)

Our work supports this and recognises that both forms of accountability will continue to be necessary in the NHS.
Principles for accountability

Our member consultation proposed seven potential options for strengthening local accountability:

- retain the present accountabilities and allow the existing system to bed in, with specified evaluation points on overall performance
- foundation trust style membership for PCTs
- directly elect all or part of a non-executive body on the PCT board
- appoint local authority members to PCT boards on a quota basis (either the lead cabinet member or representatives of the main local political parties)
- transfer NHS commissioning responsibility to local government
- 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)
- a new body sitting between the NHS and local government.

Responses were varied with all of the options having some supporters although, unsurprisingly, the largest proportion was in favour of the first option, leaving the present system to bed in. However, having also asked whether a single national option should be imposed, more than half of the respondents showed a preference for allowing some local flexibility in the model, albeit with mechanisms in place to show the outcomes in annual performance assessment systems.

Therefore, rather than recommend a single national model at this time, we believe that it is of more relevance to clarify some clear principles which local accountability systems should be able to demonstrate. These principles are intended to support good governance and decision making and the engagement of local people.

Engaging local people

Local systems should be:

- **clear, accessible and transparent**
  If systems are complex and difficult to explain, the public are likely to feel excluded from those ‘in the know.’ Transparency must be a core part of any local system and it must be easy to access not only the decisions but the reasoning behind them.

- **inclusive**
  Systems need to avoid sectional interests and enable as wide a range of views as possible to be taken into account when decisions are made.

- **responsive**
  Accountability systems should be responsive to the concerns of local people and able to demonstrate openly how these have been considered and addressed in the decisions made.

- **sustainable**
  The aim should be to develop relationships over a period of time with continuity on both a personal and organisational level. This builds trust.

- **pro-active**
  It is important to be pro-active and comprehensive in the approach to engagement and consultation. Systems should be up front about difficulties that may need to be addressed. This enables all interested parties to be involved.
in finding solutions. It has been shown in national deliberative events that, when the potential trade-offs are explained, difficult decisions can be made pro-actively and with community consent.8

Enable good decision making

Local systems should:

• **be able to deliver difficult decisions**
  Accountability systems need to be able to deliver difficult decisions. This includes decisions around investment and disinvestment where delays in decision making can appear as a reluctance to change in the face of public concerns.

• **be cost effective**
  Accountability systems should be cost effective with investment of resources in line with the benefits and bureaucratic approaches avoided. Systems should be designed for the probable and not for the extreme situation.

• **promote a reduction in health inequalities**
  While systems should be inclusive, they should also be able to demonstrate that decisions are designed to bring reductions in health inequality. This supports the underlying aim of the NHS to improve health.
Conclusion

The NHS Confederation believes that any local accountability structures must meet the principles set out within this report, but that there is not one single model that should apply across the country. The NHS is too complex a structure for a ‘one size fits all’ model of accountability.

We hope that this report will enable the debate on local, transparent and responsive accountability systems to be grounded in reason. NHS organisations and PCTs in particular are keen to debate how legitimacy can be improved.

To deliver true local accountability will require a shared view of the way forward from the NHS, local and national politicians and the local communities that they all serve. We hope that this report will contribute to moving the debate forwards.

To comment further on the issues covered in this report or for further information, contact Jo Webber at jo.webber@nhsconfed.org

References

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