

# Creating 'NHS local': a new relationship between PCTs and local government

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## Introduction

In recent months, partnership working between health and social care has had a bad press. Although the health and social care White Paper (Department of Health, 2006a) sets a clear strategic direction for community health and social services, PCT reorganisation and NHS financial difficulties have inevitably focused health care management attention on internal NHS issues. In academic circles, a number of researchers are increasingly wondering if the evidence really exists to support the assumption that partnerships lead to better outcomes for service users (see, for example, Dowling *et al.*, 2005; Glasby *et al.*, 2006), with one set of commentator describing partnership as "the indefinable in pursuit of the unachievable" (Powell and Dowling, 2006, p.305).

In terms of the governance of partnerships, the Audit Commission (2005) has raised significant concerns about issues of accountability, risk and value for money. While recognising that partnerships can be essential to deliver improvements in local services, the Commission warned that they can also bring risks - weakening accountability and not necessarily delivering value for money. In particular, a third of partnerships are reported by auditors as experiencing problems, often due to weak accountability and governance - for the Audit Commission (2005, p.3):

*"leadership, decision-making, scrutiny and systems and processes such as risk management are all under-developed in partnerships."*

With regard to financial issues, research in both public and private sectors increasingly suggests that partnership working may not lead to cost-savings and that, at best, integration may 'cost before it pays' (Peck and Freeman, 2005; Leutz, 1999). To make

matters worse, recent events in Wiltshire - with a high profile and public falling out in an area with longstanding positive relationships (O'Hara, 2006) - has given further food for thought. Increasingly, partnership is (perhaps rightly) being viewed more critically, with questions being asked about the extent to which this way of working 'adds value' or allows us to achieve things that would not be possible via single agency approaches.

And yet, this discussion paper argues that to date these debates have focused on the wrong things or, at least, that there is scope for different and more fundamental approaches to partnerships which go beyond current priorities and concerns. While much previous discussion has explored topics such as joint commissioning, integrated provision, pooled budgets and joint appointments, this paper focuses more on the overall relationship between PCTs and local government. With current priorities and with increasing co-terminosity, there is now - arguably more than ever before - an opportunity to rethink the fundamental nature of this relationship. In particular, we argue that health and local government are now so important to each other that the nature of their relationship will have to change if either or both are to be successful. Crucially, these two partner agencies have scope to benefit each other in two main ways:

- Health services are so important to local people and to people's sense of place and identity that local government must be able to influence and work with PCTs if they are to be effective community leaders and 'place-shapers' (Lyons, 2006). This is arguably already fundamental to local authorities' duty to promote the well-being of the local population, but becomes even more crucial following the Lyons Review of local government.
- New PCTs must move beyond traditional NHS notions of corporate governance to

become embedded in and fundamental to their local communities, thus enabling them to fulfil their 'voice' function in reflecting the views and demands of local people within their funding and commissioning decisions (Department of Health, 2006a). This is both about their future stability and survival (we would never merge Devon and Cornwall County Councils, and yet it would be perfectly possible to merge PCTs in these local authorities) and also about gaining local accountability and legitimacy for the decisions they take (for example, when allocating scarce resources and rationing access to some treatments). In doing this, they need to learn from the best of local government and tackle what is often described as the 'democratic deficit' in health care.

Thus, local authorities need PCTs to help them 'place-shape', while PCTs need local government for legitimacy and community engagement. To date, we are not convinced that recent developments (such as practice-based commissioning, Local Strategic Partnerships or health scrutiny) are sufficient to achieve this broader relationship (see, for example, Coleman and Harrison, 2006; ODPM, 2005; Wade *et al.*, 2006), but instead argue that a more fundamental and new approach is required.

Against this background, this discussion paper explores three key elements of a potential new relationship between PCTs and local government:

1. The importance of health (services) to people's sense of place.
2. The need for PCTs to find better ways of assuring legitimacy and public engagement, especially in relation to how they manage scarcity and prioritise resources.
3. The available models of how the relationship between PCTs and local government could be different and beneficial to both organisations.

## 1. The importance of health (services) to local people

### Place-shaping

Central to the Lyons Review of local government (Lyons, 2006) is the notion of local authorities as 'place-shapers' – building and shaping local identity, representing the community, regulating harmful and disruptive behaviours, maintaining the cohesiveness of the community, helping to resolve disagreements, working to make the local economy more successful, understanding and meeting local needs and working with others on complex challenges (p.8). In many ways, this builds on previous ideas such as the notion of local authorities as 'community leaders', but develops these into a more explicit and fundamental recognition that local government is the main body responsible for (and potentially capable of) taking responsibility for the well-being of an area, reflecting its distinctive identity, and promoting its interests and future prosperity (p.8). In pursuit of these aims, the Review makes a number of recommendations about issues such as targets and local priorities, resources, and the balance between central and local powers.

However, early in the Lyons Review, there is a crucial recognition that this involves services beyond those under the remit of current local government and, in particular, must involve health services. When asked which services were most important in making somewhere a good place to live, people in 82 per cent of local authorities rank health services as the first or second most important factor (Lyons, 2006, p.22). In many ways, this is hardly surprising, as the NHS touches the lives of everybody in ways that specific local authority services may not. For some people, health services are provided in an emergency, and the rapid availability of high quality ambulance, hospital and surgical services can quite literally be a matter of life and death. For others, contact with services is life-changing – whether it be through the birth of a new baby, an accident or the onset of illness, the death of a partner or family member, or increasing frailty in older age. For another group of people, the existence of a chronic or long-term condition means that health care becomes a fundamental part of their everyday lives – crucial to whether they are able to live chosen lifestyles or not. As a result of this, health care (and the services that embody health care at a local level) is a key aspect of all our lives. Although the rest of this section of the paper focuses on the importance of health services to local people in their role as service users, many health services can

also be crucial to local areas as a major source of employment (particularly large district general hospitals in small or medium sized towns) and are sometimes considered to be an important source of upward social mobility for local people.

### The NHS as a British institution

On an even deeper level, some of these services may even be of central importance to us as a nation and in terms of our identity. In a rapidly changing world, it is hard to find things that help to define us and to sum up who we are and what we value about our society. In the wake of the July 7<sup>th</sup> London bombings, Gordon Brown discussed the concept of Britishness and what it means within a modern context. In an address to the Fabian Society, Brown (2006) suggested "*shared values – not colour, nor unchanging and unchangeable institutions define what it means to be British in the modern world*". In other words, it is not institutions (such as the NHS or BBC) which define Britishness, but the values which underlie their creation. In 2005 YouGov conducted an online poll asking people throughout Britain which characteristics define Britishness. The results indicated that 90 per cent thought that a sense of fairness or fairplay was very or fairly important in defining Britishness. Given that the NHS was founded on a core value of fairness - universal access to health care founded on need, not ability to pay – we might suggest that the NHS is the institutionalisation of this British value. Thus, if we asked the average man or woman on the street what made them proud about their country or what makes them British, the National Health Service is likely to figure highly (despite the fact that the NHS is actually quite different in England, Scotland and Wales); it is characterised as British by its appeal to the underpinning value of fairness. Regardless of whether one subscribes to this concept, the importance of the NHS has been reflected by the value placed on it by all major political parties - from Margaret Thatcher's 'the NHS is safe with us', to Tony Blair taking personal responsibility for NHS reform.

In terms of people's stated priorities, we know that health services are crucial. At a national level, health care is the single issue identified by most of the public as being very important in helping them decide how to vote. In 2005, for example, 67 per cent of people said that this was very important in deciding how to vote, with education (61 per cent) and law and order (56 per cent) ranked second and third (MORI, 2005). At a local level too, health services are paramount to people, and those local

authority surveys that explore people's priorities in relation to both council and non-council services find that health is frequently top of the list. In Lewisham, for example, a regular residents' survey found that people were concerned about crime, levels of council tax and congestion, but that the two specific services that were most important to local people were health (21 per cent said it was one of three areas of most concern) and education (21 per cent). This was significantly ahead of other services, such as public transport (11 per cent) and provision for older people (9 per cent) (Taylor Nelson Sofres, 2006).

### The importance of hospitals to local people

Nowhere is the importance of health services more clearly apparent than in Kidderminster, where proposals to downgrade the local hospital led to fierce protests and, ultimately, to the formation of a new political party, control of the local council and the election of a new independent MP (Raftery and Harris, 2005) (see figure 1).

Hospitals occupy an important symbolic role within British public life. This is illustrated in the Kidderminster example, and also by the quotes from government sources in figure 2. Hospitals are much more than buildings where healthcare is delivered, but the physical incarnation of the NHS and its values within a particular locality. Under New Labour the NHS has undergone its biggest ever programme of hospital building, with more than £10 billion spent since 1997 (Carvel, 2006). *The NHS Plan* (Department of Health, 2000) suggested that a third of hospitals being used by the NHS were built before it was created, and many showed the effects of neglect. For most people, healthcare means hospitals – they are the establishments within an area which people most associate with the NHS. Therefore, the symbolic role of hospitals means that this neglect is amplified to illustrate a system-wide lack of investment within the NHS. Thus, building new state-of-the-art hospitals sends a strong message to local populations that the NHS is being invested in within their area. Although this would suggest a strong healthcare symbol which could be mobilised in place-shaping, this also highlights the problem that PCTs encounter with this process. Healthcare is synonymised with identifiable local hospitals, rather than the more anonymous and ever-changing PCT. Moreover, this means that health, for much of the population, is symbolised by the provider (and especially hospital, as opposed to community provider), rather than the commissioner.

**Figure 1 - The power of public protest**

*"When campaigners fighting to save Kidderminster Hospital swept all before them at the 1999 local elections their critics said it would never last. A year later the good people of Wyre Forest went back to the ballot box and instead of returning to their traditional allegiances the electorate made the Health Concern group the most powerful in the district. The group, which is fighting for a complete return of accident and emergency services at Kidderminster Hospital, now boasts 19 seats on Wyre Forest District Council and is the largest member of the ruling Rainbow Alliance."*

(Thorne, 2001)

*"It used to be perceived wisdom that independent candidates, deprived of the clout of a national political machine, could not win under the British political system... Now in Worcestershire's Wyre Forest, a traditionally Conservative seat turned into a Labour marginal, there is a growing possibility that the underdog may ... have his day. Dr Richard Taylor, a 66-year-old retired consultant physician at Kidderminster general hospital is making all the running in his local campaign. His issue is the local hospital and it is every health planner's and party politician's nightmare. Last September, Kidderminster lost its accident and emergency department and 192 acute beds... Kidderminster... was much-loved. It has just received millions in what is now wasted new investment and its planned down-grading coincided with controversial plans for a privately financed new hospital at Worcester, some 18 miles but often a 40-minute journey away on busy roads. The constituency erupted."*

(Timmins, 2001)

**Figure 2 The importance of hospitals**

*"One hundred years ago public buildings were often the pride of Britain's towns and cities. We need to rediscover in this generation a renewed sense of community and civic pride. I believe that we in Britain find focus for it in the values of fairness and decency that are at the heart of the National Health Service. Today our country's hospital building programme gives us the opportunity to find a new way of giving lasting expression to our pride in those values."*

(Alan Milburn, in Department of Health, 2001c, p.1)

*"Hospitals are public monuments and are important sources of civic and community pride as well as practical buildings for the delivery of health care. So the appearance and design of the building should enhance, rather than blight, the locality. New NHS buildings should not be anonymous and utilitarian concrete blocks, but should express the value that the community place in them."*

(Department of Health, 2001b, p.12)

**2. Engaging local people**

**Public involvement in priority setting**

The value of involving the public in decisions about setting priorities for health funding is well documented in the research literature. For example, Ham and Coulter (2001) assert that *"in an era of ever-increasing medical possibilities, publicly financed health care systems face the challenge of determining what services should be covered for the insured population"* (p.163). They examine some of the international experience of seeking to develop more systematic approaches to determining health funding priorities (Oregon, The Netherlands, New Zealand) and note that (p.164):

*"An important motivation in this context is that choices in health care involve making judgements about the relative priority to be attached to different objectives and services. It follows that these choices need to be informed by an understanding of community preferences if they are to gain acceptance among those affected."*

The importance ascribed by Ham and Coulter to gaining an understanding of community preferences is at the heart of our discussion here, about the need for the NHS to develop more effective ways of taking decisions about health funding that are legitimate (and indeed comprehensible) in the eyes of the general public. Ham and Coulter develop their arguments further by drawing on the work of Klein (1998), who asserted that in debates about priority setting, there was a need to strengthen the institutional basis of decision-making. Klein viewed priority setting as "inescapably a political process" (p.959) in which debate among divergent interests was inevitable. Holm (1998), in an analysis of experience of priority setting in the Nordic countries, shows how policy makers have increasingly turned their attention to ways of strengthening decision-making processes to generate legitimacy for health funding decisions, arguing that this was necessary as more technical approaches proved to be limited.

**NHS policy making**

Throughout its history, the NHS has struggled to find meaningful ways to engage with patients and the public. Known internationally as one of the most centrally managed and controlled health systems in the developed world (Ham, 2004), the NHS has traditionally been much better at developing and implementing national approaches to the organisation and delivery of care than it has in relation to ensuring that services meet the specific needs and priorities of local communities. Policy making in the NHS reflects this tendency to a central approach and continues to be largely the responsibility of the Department of Health. It is instructive that even an attempt in the 1990s to relocate many Department of Health functions away from London to Leeds has, over time, retracted back to a situation where the majority of 'significant' directorates of the department are firmly based back in London. This concentration of policy development within the capital was also lent weight by the abolition of regional health authorities (RHAs) in 1996. RHAs had an explicit role in the interpretation and implementation of national policy, taking account of regional circumstances, and their removal and replacement with regional

offices of the Department of Health confirmed that policy making and priority setting for the NHS was a clearly more national than regional or local activity. This national focus is consistent with the Labour government's desire to 'modernise' the NHS and improve its performance (Department of Health, 2000) and with their use of a large number of central targets and sanctions as a way of concentrating NHS attention on a specific set of national priorities (such as waiting times in accident and emergency departments, waiting times for hospital admission, access to a GP, offering patients choice of time and place of care, etc.). Ironically, this central and target-driven approach to service improvement took place at a time when the declared policy direction was one of 'shifting the balance of power' towards 'frontline' NHS staff and local people (Department of Health, 2001a). In the opening section of *Shifting the Balance of Power*, the following statement was made:

*"Reform in the NHS has to come from within the NHS. The balance of power must be shifted towards frontline staff who understand patients' needs and concerns. A shift in the balance towards local communities so that they reconnect with their services and have real influence over their development"* (Department of Health, 2001a, p.5).

### Patient and public input to NHS decision-making

In terms of the ways in which local people and patients have been able to influence NHS decision-making, there have been relatively few changes over the past three decades. Following the NHS reorganisation of 1974, community health councils (CHCs) were created as the main mechanisms for providing the 'patient's voice' within the NHS; having a dual role as patient advocate in relation to making complaints about NHS care, and as providing the patient voice and challenge to NHS planning and decision-making. CHCs were abolished (in England – they still exist in Wales, as do their equivalents in Scotland and Northern Ireland) in 2002 and replaced by patient forums, there being one forum for each NHS provider and members having a remit in relation to commenting on services provided by that trust or PCT.

Critical commentary of patient forums is characterised by a sense that they are a pale imitation of the CHCs they partly replaced, and that the CHC role as a

challenger of plans and decisions has largely been lost within the NHS. Indeed, some commentators have pointed to the need for greater clarity and co-ordination of the whole area of user involvement in the NHS (Florin and Dixon, 2004). Within the theme of public involvement in the NHS there has long been a debate as to whether individuals should be involved as consumers (i.e. service recipients) or citizens. Clearly, both conceptualise different roles and rights for the user. Yet, this distinction has been somewhat blurred by the "Third Way" approach of New Labour, which perceives greater choice and improved "customer service" as compatible with, and complementary to, a stronger voice in public services (Baggott, 2005). Thus, within the user involvement agenda, there are currently a number of involvement strategies which serve to undermine each other, with some serving the consumer and others the citizen. At the time of writing it remains to be seen whether new proposals for LINKS (Local Involvement Networks) will be any more successful with respect to user involvement.

### Developing a stronger public voice in commissioning

NHS commissioning is a much discussed and debated function, but a particularly helpful definition is set out below:

*"Commissioning...tends to denote a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. A commissioner decides which services or health care interventions should be provided, who should provide them, and how they should be paid for, and may work closely with the provider in implementing changes"*

(Woodin, 2006, p.203).

The role of commissioning as the activity that is concerned with deciding what health care should be funded (and hence provided) or not, is central to the discussion in this paper. Since the inception of the NHS market in 1991 (Department of Health and Social Security, 1989), there has been a division within the NHS between the payers (initially referred to as 'purchasers' and now termed 'commissioners') and the providers. There has been regular reform of the payer (or demand) side of the NHS since 1991, with major organisational reform taking place in 1991 (creation of health authorities and GP fundholders), 1994 (merger of family

health service authorities and health authorities), 1996 (health authority mergers and abolition of regional health authorities), 1999 (creation of primary care groups), 2000 (initial development of PCTs), 2002 (abolition of health authorities and creation of strategic health authorities [SHAs] and PCTs) and 2006 (mergers of SHAs, mergers of PCTs). This periodic organisational turmoil has made it very difficult for NHS commissioners to prove effective (Walshe *et al.*, 2004; Smith *et al.*, 2004; Bramley-Harker and Lewis, 2005; Smith *et al.*, 2006).

This lack of effectiveness of NHS commissioning has, among other things, been due to the difficulty faced by health authorities and PCTs in developing and sustaining necessary relationships with provider organisations, partner agencies, local people and their representatives. Interestingly, in parallel to the watering down of patient and public engagement in NHS decision-making, there has been an emerging and strengthening discourse about the need for greater public 'voice' within commissioning. However, this interest is not new; the NHS changes of 1991 and the publication of *Local Voices* (Department of Health, 1992) precipitated a flurry of interest from district health authorities in how they could consult the public to ensure that, "*their decisions reflect, as far as practical, what people want, their preferences, concerns and values*" (Department of Health, 1992, p.3). Brian Mawhinney - then Minister for Health - conducted a series of speeches during 1993 in which he stated that by April 1994 every health authority should be able to demonstrate that it was taking systematic action to seek and act on the views of CHCs, voluntary bodies, the wider public and their representatives. Yet, despite this pledge, by 1994 only 21 per cent of health authorities were deemed good, 57 per cent acceptable and the remaining 22 per cent unsatisfactory in the performance of this role (Mawhinney, 1994). Thus, public involvement in commissioning decisions is not a new concept; there has been sustained, but largely unfulfilled, rhetoric surrounding this issue for much of the past decade.

The periodic reorganisation of the bodies that are charged with making fundamental decisions about NHS funding priorities and investment, along with the scaling down of public and patient involvement mechanisms, has resulted in an ever more noticeable 'democratic deficit' in NHS decision-making. Nowhere has more vividly demonstrated than in Kidderminster where local people resorted to the use of the local and national ballot box as a way of registering their

protest at what they perceived as a lack of attention to their views by NHS managers and boards. What Kidderminster points to is a lack of faith on the part of the general public in the decision-making processes in place within the NHS, processes that are caricatured in the media as being in the hands of 'unaccountable NHS bureaucrats'.

**PCT governance and public involvement**

The accountable body for local NHS decisions is the PCT board. This is comprised of NHS executive directors (chief executive, finance director, director of public health, etc.) and non-executive directors, the latter being six or seven members of the local community who have been recruited (by the NHS Appointments Commission) to help plan for the future of local health services, ensure that the management team meets its targets, ensure the proper management of finances, and assist the board to work properly in the public interest and keep the public and patients properly informed. This corporate board model was introduced along with hospital trusts in the White Paper *Working for Patients* (Department of Health and Social Security, 1989). These self-governing trusts were introduced with the expectation that they would “earn revenue from the services they provide. They will therefore have an incentive to attract patients, so they will make sure that the service they offer is what patients want” (Department of Health, 1989, p.4) - i.e. they would become more corporate along “business lines” (p. 5). In the Government’s eyes this would make trusts more responsive to consumer preferences, and create much more space for a user voice within them. Yet, most hospital trusts would not be characterised by their high levels of public involvement and in this sense the role of the PCT corporate board seems somewhat anachronistic.

Indeed, the use of the corporate board model of governance for NHS commissioning bodies has been called into question in recent NHS Alliance and HSMC research. This has highlighted the inadequacy of a board as a means of ensuring public ‘voice’ within NHS decision-making and its consequent problems in terms of PCTs’ inability to demonstrate proper local legitimacy in respect of the decisions they make (Wade *et al.*, 2006). The researchers note (p.19):

*“Securing appropriate ‘voice’ within NHS commissioning ... requires the consideration of a new approach to PCT governance, that is, of how PCTs can properly act as and claim to be the ‘NHS Local’. In statutory terms, the representation of the public in healthcare decision making is currently through the non-executive directors on the boards of PCTs, and through patient forums. The extent to which these are seen by the public as effective mechanisms for exerting influence is extremely questionable, however, and to achieve a real and sustainable form of public engagement, alternative models need to be explored.”*

This paper seeks to do what Wade *et al* called for – explore alternative models for public engagement in healthcare decision-making, focusing explicitly on what the NHS could learn from the development of a closer and different relationship with local government, and hence create an ‘NHS Local’. The need for PCTs to have effective processes of engagement with the public is underlined in the recently published *NHS Commissioning Framework* (Department of Health, 2006b, p.4, annexe to commissioning framework):

*“Effective commissioning means effective engagement of patients and local communities. Patients, through greater choice will drive improvements in many services. For services where wide choice may not always be possible, the views of patients and carers and families, groups of service users and their communities should still substantially influence service provision.”*

**Re-examining what we mean by public involvement**

Underpinning our analysis is the need for a re-examination of the institutional basis of local health decision-making. The specific roles that can be played by the public within such health decision-making have been explored by Lomas (1997) in what is considered a seminal paper about public input to health care priorities. Lomas asserted that the public can adopt any one of at least three roles when providing input to public decision-making:

- Taxpayer
- Collective community decision-maker
- Patient

He suggested that each of these potential roles could be mapped onto three areas of public policy decision-making in health care: funding levels and organisation for the system; the services we choose to offer under public funding; and the characteristics of those who should receive services. In this paper, we are primarily concerned with public input to health decision-making within the role of taxpayer and collective community-decision maker, and more specifically, how PCTs can secure such input. Lomas, having reviewed the range of methods of public involvement typically used by health decision-makers, suggests that:

*“There appears to be no best method for obtaining public input that overcomes the common problems of poor information on which to base priorities, difficulty in arriving at consensus, poor representativeness of participants, and lack of opportunity for informed discussion prior to declaring priorities”*

(Lomas, 1997, p.103).

Lomas goes on to suggest that panels of citizens or patients, convened on an ongoing basis, offer the most promising way forward. What is interesting is that Lomas, having examined the wider roles of the public in decision-making about health care, reverted to techniques that are to be used by those with the technocratic or political power to make such decisions, rather than suggesting specific institutional arrangements that might lend a certain level of legitimacy or transparency to decisions.

We now set out some suggestions about how institutional arrangements for decision-making within healthcare might be changed within England in order to bring a greater degree of legitimacy and democracy into what is currently largely a technocratic process carried out by managers and appointed board members. In short, we use experience from overseas, other parts of the UK, and sectors beyond health to explore how PCTs can develop arrangements for commissioning and decision-making that properly enable the development of ‘NHS Local’.

### 3. What needs to change?

Having argued that health services are crucial to local authorities' ability to 'place-shape', and that PCTs need to learn from the best of local government in order to develop more local accountability and legitimacy, we now set out some broad ideas about how things could be different in the future. In particular, this leads us to examine a number of different models for developing a new relationship between local government and the NHS which would have the potential of assuring a greater degree of ownership of health issues by local government and more legitimacy for decisions taken about health funding priorities. In choosing which options to explore in more detail, we are conscious of three different approaches that could be taken:

- 1) A local authority-led approach (that is, taking NHS commissioning and bringing it to local legitimacy).
- 2) Changing current NHS approaches to make them more locally accountable (that is, bringing local legitimacy to NHS commissioning).
- 3) Developing a new single and locally accountable commissioning body in between the NHS and local government.

#### Option 1: A local government led approach

Key strengths	Key limitations
<ul style="list-style-type: none"> <li>■ Creates a single health and social care body locally and democratically accountable.</li> <li>■ NHS responsibilities could boost turnout for local elections and help to reinvigorate local politics.</li> <li>■ Scope to view health in its broadest sense (health as well-being) rather than focusing on illness and acute care.</li> <li>■ Removes some of the current tensions in the NHS reform agenda (for example, where GPs are both commissioners and providers of services).</li> </ul>	<ul style="list-style-type: none"> <li>■ Elected members may need considerable support and development to take on this new role.</li> <li>■ Would need a different balance between central control and local autonomy so that this did not become <i>local administration</i> rather than <i>local government</i>, with sufficient flexibility to do things differently. This might remove ministers from direct responsibility for local adverse events, but they might find the lack of direct control difficult.</li> <li>■ Local government has a different approach to the NHS to the split between provision and commissioning – while this might also be a strength, it would need detailed exploration.</li> </ul>

Of course, each of these approaches has potential strengths and limitations, and some may be more politically feasible than others in the current context. However, our thoughts about possible models are set out below, less as a proposed blueprint for the way forward than as an illustration of what the world could be like if we were to engage seriously with the analysis put forward in this discussion paper.

#### A local government-led approach

With the current emphasis on separating NHS commissioning and provision, one way forward would be to transfer health care commissioning to local government, leaving PCTs as NHS provider organisations. A local government-led system would give local legitimacy and might be more responsive to local priorities. Social services departments also have substantial experience of managing cash-limited budgets and of managing a mixed economy of care (both current issues in the NHS), and a local government-led system might also offer greater opportunities to focus on health inequalities and public health (arguably overshadowed by acute concerns in the current NHS). Despite these potential benefits, some local authorities might require substantial support and development in order for elected members to be able to engage effectively with such new responsibilities.

#### Changing NHS structures to make them more locally accountable

While previous approaches (for example, elected members represented on district health authorities, Joint Consultative Committees, health scrutiny etc.) have attempted to make the NHS more locally accountable, two more fundamental models that could be explored are direct elections to NHS boards and a foundation commissioning trust:

##### a) Direct elections to NHS boards

In New Zealand, a country that is regarded as a pioneer in applying some of the technical approaches to health priority setting such as the use of clinical scoring, there has been a move to address the public nature of the institutional basis of health decision-making. This has taken the form of having a proportion of the membership of district health boards determined through direct public elections. New Zealand has 21 district health boards (DHBs) that have responsibility for planning, funding and purchasing services for their local population, for managing local hospital and community health services, and for contracting with primary health organisations whose responsibility it is to improve health and develop primary care. DHBs are governed by a board of up to 11 members, the majority of which are elected. Central government appoints up to 4 members of the DHB. There is upwards accountability to the Minister of Health, but significant emphasis is placed on local, co-operative and collaborative arrangements (Cumming *et al.*, 2003).



**Option 2: Direct elections to NHS boards**

Key strengths	Key limitations
<ul style="list-style-type: none"> <li>■ Introduces a degree of local democracy into the NHS.</li> <li>■ Could introduce a broader range of views and experiences into the decision-making process.</li> <li>■ Could be symbolically important (but also runs the risk of tokenism).</li> </ul>	<ul style="list-style-type: none"> <li>■ Current NHS non-executives are appointed for their skills and experience, and can be very high calibre people – would such people be deterred from standing in an election, and are there sufficient high calibre people to fulfil the range of local public roles that now exist (councillor, school governor, magistrate etc)?</li> <li>■ Would this be subject to the political party system or would candidates be independent?</li> <li>■ Elections would be complex to administer (although could be held at the same time as local authority elections).</li> <li>■ Would successful candidates be executive or non-executive?</li> <li>■ If people are elected on an individual basis, is there a danger of competing legitimacies and a reduction in corporate responsibility?</li> <li>■ Might need significant development to enable some local communities to engage in this process in an informed way.</li> <li>■ Retains a split between local government and the NHS.</li> </ul>

**b) Foundation trust (for commissioning bodies)**

Foundation trust status has been introduced in the NHS in England as a new form of governance that is open to NHS provider organisations (NHS trusts). Foundation trust status takes the legal form of a public benefit corporation, a separate legal entity for the provision of public services that includes features such as a lock on public assets (meaning that these assets can never be sold outside the public sector) and a requirement for external regulation by a new foundation trust regulator, Monitor. Foundation trusts are considered to be more autonomous than NHS trusts, being at arm's length from the usual NHS/Department of Health performance management arrangements, and having a governance structure that is based first and foremost on a membership of local people, staff and patients. This membership elects governors of the trust who in turn appoint the trust board. In this way, the trust accounts to its members and not directly to NHS line management. The relationship of the foundation trust with the NHS is dealt with through a contract that the trust holds with the regulator, Monitor, and it is considered that this form of accountability to the

regulator is both more locally sensitive (due to the new governance arrangements) and potentially more robust (with the likelihood of some protection from centrally imposed reorganisations) than might traditionally be the case with NHS trusts (Walshe, 2003).

Foundation trust status is now being explored for PCT provider services (community foundation trusts), as was explained in the publication of the recent

**Option 3: Foundation trust for commissioning bodies**

Key strengths	Key limitations
<ul style="list-style-type: none"> <li>■ Symbolically inclusive with a potential for meaningful local involvement and accountability.</li> <li>■ Makes commissioning as accountable to local people as providers are meant to be (in theory).</li> </ul>	<ul style="list-style-type: none"> <li>■ Questions over who is a member and who can vote/stand in elections.</li> <li>■ Doubts remain about the local legitimacy and accountability conferred by foundation status.</li> <li>■ Scope for competing legitimacies between foundation trust providers and foundation trust commissioners.</li> <li>■ Concerns that current foundation trusts may be more accountable to a national regulator than to local people.</li> <li>■ Retains a split between local government and the NHS.</li> </ul>

commissioning framework for the NHS (Department of Health, 2006b). What has not yet been discussed is the potential of using the foundation trust model for NHS commissioning bodies (PCTs or practice-based commissioning clusters). This is surprising, for arguably, it is commissioning bodies that most need to have a strong public 'voice' function and a close connection with the views, aspirations and priorities of local people. That the NHS has, in recent times, paid more attention to the development of stronger community governance for provider organisations than for its commissioning and funding bodies is a reflection of the general lack of attention that has typically been paid to the development of commissioning in the NHS. As now would seem to be the time to address this issue, consideration of stronger and more effective governance of PCTs beyond the traditional corporate board/report to the Department of Health model is an urgent priority.

**A new entity in between the NHS and local government**

If local authority-led health care or democratised health commissioning are not the best way forward, could some other entity in between health and local government help to cement relationships? Here we have reflected on models such as the university council (universities operate relatively independently under a Royal Charter and are governed by a council which typically includes a range of nominated lay people, staff and students) or the potential for local strategic partnerships to co-ordinate cross-cutting issues. However, an interesting example of an entity between the NHS and local government is derived from the policy authority model - police authorities are made up of a mix of

elected members (nominated by relevant local authorities), magistrates and independent members selected following local advertisement and recruitment. The role of police authorities is to set the strategic direction of the police force and to hold the chief constable to account on behalf of local people. This involves setting a precept on the council tax, setting the annual police budget, appointing the chief constable, setting local priorities and

consulting local people. In a health and social care context, such an approach might entail a combination of elected members, clinicians and independent members fulfilling similar functions with regards to the local NHS. Despite their important functions, important questions remain about the capacity of some police authorities to engage fully with local people and to balance national and local priorities.

**Option 4: A police authority type model**

Key strengths	Key limitations
<ul style="list-style-type: none"> <li>■ Could give elected members and lay people more influence in local health care than at present.</li> <li>■ Creates an expectation of a joined-up approach.</li> </ul>	<ul style="list-style-type: none"> <li>■ Police authorities may be seen by local people as being a committee of the local authority, rather than as an independent entity.</li> <li>■ How executive or non-executive is this body, should members be elected or appointed and what powers should they have?</li> <li>■ Similar in nature to elected member representation on former district health authorities (which was perceived as not delivering the democratic accountability or the new relationship discussed in this paper).</li> <li>■ How would such a body relate to current local government?</li> </ul>



**Conclusions**

Having called for a new and deeper relationship between local government and PCTs, our preferred model is for a system of local government-led health care commissioning. For us, this model creates a single and locally accountable commissioning body for both health and social care, which democratises the NHS as well as holding the potential to increase engagement with local democratic processes. In practical terms, such an arrangement might also bring scope to shift resources towards 'care closer to home' and public health, as well as to learn from local government approaches to managing cash-limited budgets and a mixed economy of care. Nevertheless, this might only work if there was sufficient local autonomy and flexibility to do things differently – giving local government responsibility for administering a centrally planned and managed health service would not be attractive to elected members and would achieve little more than the current system. Such an approach would also depend on the ongoing modernisation of local government, with elected members and officers capable of taking up this new role.

However, what is at stake here is not so much our preferred model, as the diagnosis on which this is based. Essentially, we argue that local government needs the NHS to be a successful place-shaper, and that the NHS needs local government for local legitimacy and accountability. Whether we bring NHS commissioning to local legitimacy (a local authority-led approach) or bring local legitimacy to commissioning (democratising NHS structures), a new relationship between local government and PCTs is crucial. With new PCTs about to get up and running and with the final report of the Lyons Review due, the time is right for a much more radical reassessment of the relationship between local government and the local NHS.

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