

# SHOULD PRIMARY CARE TRUSTS BE MADE MORE LOCALLY ACCOUNTABLE?

A King's Fund discussion paper

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*King's* **Fund**

Increasing the accountability of NHS organisations to local people has become a significant policy issue within the NHS. Until now, primary care trusts (PCTs), which spend the bulk of the NHS budget, have been largely accountable to the centre. There have been calls to review this as PCTs become more autonomous. This paper discusses a range of options for reforming the relationships between PCTs and their public. It explores the question of whether more responsive local services should be the main goal of better accountability or whether local accountability should be an end in itself.

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## Summary

Accountability can be seen as having three key components in relation to local communities:

- ‘taking into account’ the views of local people
- ‘giving an account’ to local people
- allowing local people to ‘hold to account’ (with the power to amend or even reverse decisions if necessary).

Primary care trusts (PCTs) have largely been accountable to the centre, but this is being challenged as the role of PCTs has evolved to become both complex and potentially powerful within the National Health Service (NHS) system in England. PCTs hold large budgets, they allocate resources, let contracts with providers, and make irreversible (at least in the short term) decisions about capital spending. They now have an additional role of market regulation, which includes deciding the degree of competition or co-operation within the local health care system.

Although PCTs’ upward accountability systems are still in place (and there is no plan to change them), the question is whether local accountability needs to be enhanced. It is argued that better services and more legitimate decisions will result from better engagement with local people.

The current mechanisms for engaging with local people (directly or through elected local council officials) have been subject to reform and have yet to bed in. Traditionally, in relation to the NHS, investment in local engagement has been justified on the grounds of producing better services.



Effective implementation of existing engagement and accountability structures, such as local involvement networks (LINKs), overview and scrutiny committees, and the numerous local authority joint working arrangements, would go a long way to improving accountability: services would be improved and PCT decisions would have more legitimacy. More thorough guidance for PCTs about the minimum standards of engagement and better regulation would assist this.

Even if this happens, however, the empirical evidence suggests that, to date, only a limited number of citizens will get involved in NHS decisions, and PCTs may not embed local engagement across all their activities.

There is an argument that the only way to change this would be to embrace radical systemic change, for example, through elected PCT boards or new governance structures such as a ‘foundation PCT’. However, these are potentially expensive and go beyond the justification of a means to better services: how much NHS money should be spent on these more political objectives, such as giving citizens control and revitalising democracy?

If taxpayers’ funds are to be deployed for this, then the following conditions would need to be met:

- PCTs would need to be guaranteed a much greater level of autonomy from government than is presently the case, otherwise new or enhanced democratic structures would be exercising only token control
- the public and government would need to accept the likelihood of substantial variation in the level and nature of PCT services and governance, which would mean abandoning the desire to maintain a uniform NHS.

One way forward might be for the government to specify much more clearly than it has done to date, which areas of a PCT's activities are subject to genuine local autonomy and therefore might be arenas for new experiments in local citizen engagement or accountability mechanisms. There could be learning from local government experience in this area.

## Introduction

How the National Health Service (NHS) in England should be better held to account by local people has become a policy issue of increasing significance. Although ‘local accountability’ is a term used in the debate with variable definitions, all the major political parties are now convinced that the NHS should be run much less (if it all) from Whitehall and much more by local organisations that are more responsive and accountable to the communities they serve. Of particular concern is the need for the main commissioners of health care – the primary care trusts (PCTs) – to be more locally accountable.

On the provider side, radical new forms of local accountability have been required for NHS foundation trusts since 2004. Foundation trusts recruit members from the public, patients and staff, and those members then elect governors with a range of powers over the management of the trust. The government expects all acute and mental health trusts to become foundation trusts over the next few years.

By contrast, PCT commissioners remain accountable largely upwards, via strategic health authorities to the Secretary of State for Health (and ultimately to parliament).

The absence of downward or outward accountability to local communities for PCTs is being called into question by a range of actors, including the current government. Prime Minister Gordon Brown signalled the government’s intention to look more closely at the local accountability of PCTs in a speech he gave early in 2008: ‘As we seek to devolve more responsibilities to the local level, we will also explore the ways of improving the legitimacy and accountability of primary care trusts and of the commissioning decisions they make on behalf of their local communities’ (Brown 2008).

This expands on earlier comments made by Ben Bradshaw, Minister for Health, who singled out PCTs as a particular area of concern for government in 2007.

*One of the things where I think we have a problem is that at local level there is still not very much democratic accountability. PCTs that increasingly will be responsible for spending vast sums of money and commissioning services don't have any direct democratic accountability. If people in their local area don't like what their PCT is doing it is quite difficult for them to make their voices heard and to make sure that changes are made.*

(Evans 2007)

Hazel Blears, now Secretary of State for Communities and Local Government, made a specific recommendation during her bid to become deputy leader of the Labour Party in 2007:

*Some bodies, for example primary care trusts (PCTs), hold a huge power over our lives, yet we have no direct say over them. We should introduce an element of direct representation on primary care trusts, with local elections to their boards.*

(Blears 2007).

A very similar conclusion has been reached by the two main opposition parties. The Liberal Democrats argue that local people have 'no effective control over their health services' and suggest directly elected PCT boards or a complete transfer of the work of PCTs to local authorities as options for consideration (Lamb 2007). The Conservative Party has proposed much closer links between PCTs and local government to address this gap (Conservative Party 2007).

In addition to the political parties, others have recently added their voices to the debate, calling, for example, for foundation trust PCTs

(Rankin *et al* 2007) or for local councils to have the power to dismiss NHS trust directors for poor performance (Milton 2007).

The Scottish parliament has taken the debate a step further by launching a public consultation, asking for views on how community involvement with the NHS can be improved. The consultation is asking if this can be done by strengthening existing consultation arrangements, or whether legislation is needed to require there to be locally elected NHS board members (Scottish Government 2008).

Against this background, it is perhaps not surprising that achieving a locally accountable NHS (including PCTs) is an important objective in the current government review of the NHS, *Our NHS, Our Future: NHS next stage review*, the final report of which is due in 2008. The interim report, published in 2007, promised in particular to look at how to ‘establish a stronger framework of responsibility, accountability and legitimacy for decision making within the service, both nationally and locally including in PCTs and NHS foundation trusts’ (Department of Health 2007c).

These calls for greater local accountability appear to be aimed at solving a range of problems, including a perceived lack of responsiveness of NHS services to the needs and views of local people, and a lack of legitimacy for PCTs in their decision-making. The debate in favour of enhanced local accountability is also intertwined with a parallel debate, over whether the NHS should be more independent from ministers, a debate that has also gained in intensity over the past year (Dixon and Alvarez-Rosete 2008). Some of the objectives put forward by proponents of greater independence, such as creating greater local freedom for the NHS from political interference by ministers, overlap with some of the objectives of those calling for greater local accountability, although the two issues are distinct.

The recent suggestions for reviewing the accountability of PCTs have also been influenced by a wider (and longer standing) debate about how to increase the scope of local engagement with local government and the services it provides. ‘New localism’ in this context argues for new methods of engagement with citizens locally for objectives that go beyond simply improving the quality of public services. These include modernising democracy by using new forms of participation that augment traditional elections, building social capital in local communities, and creating healthier communities through civil renewal (Stoker 2005). Viewed from this perspective, the relationship between citizens and their local health services represents an important and extensive new arena for the realisation of some of these other objectives.

The calls for greater local engagement with the NHS in general, and PCTs in particular, touch on two linked concepts – public involvement and public accountability. While the nature and objectives of these two concepts are essentially different, they are commonly conflated. This paper examines the meaning and functions of both in an attempt to bring more clarity to what is often a confused debate. We consider a number of questions.

- What problems are these calls for greater local accountability and public involvement intended to solve within the NHS?
- How is the public already currently engaged with the work of PCTs?
- Do the current NHS reforms present new accountability challenges?
- Are new local accountability mechanisms needed and if so, what might the costs and benefits be?

In this paper, we discuss a range of options for reforming the relationships of PCTs with their public. We conclude that both public involvement and accountability can be goals in their own right or means to achieve various ends. The purpose of local accountability

and public involvement will vary according to the perspective taken, the values held, and, ultimately, the structure of the NHS being planned. One distinction is between an instrumental and a political approach. In the former, local accountability and involvement are seen as a means to ensure that health services are better designed and executed and therefore more attuned to patients' needs. The latter sees accountability and involvement as important ends in themselves – inalienable rights of citizenship that should be exercised locally as well as nationally, possibly with greater levels of power and control over the commissioning of services ceded to local people.

In this paper, we have not favoured one approach over another (both might be considered legitimate), nor have we proposed a single structural solution. Rather, we have attempted an informed discussion that sheds light on the key question: should PCTs be made more accountable to the populations they serve, and if so, how?

## What do we mean by local accountability?

Discussions about the engagement of local people with their health services often confuse accountability and public involvement. This is perhaps understandable; effective local accountability might employ various public involvement mechanisms, but the presence of citizens' juries or holding deliberative events does not automatically bring accountability.

This report is concerned with the intersection of public involvement and accountability exercised at a local level, specifically the different ways in which local people might be engaged to improve or strengthen the accountability of primary care trusts (PCTs). We use the term 'local accountability' to describe this synthesis.

### Accountability

Accountability in the context of public services has been defined by the Organisation for Economic Co-operation and Development (OECD) as 'the obligation of those entrusted with particular responsibilities to present an account of, and answer for, their execution' (OECD 2005). Accountability is ensured through one or more systems of control. A system of control is 'a process designed to provide reasonable assurance regarding the effectiveness and efficiency of operations, reliability of reporting and compliance with applicable laws and regulations' (OECD 2005).

The two dimensions of accountability identified above (presenting an account of and answering for) have been expanded further by Ashworth and Skelcher (2005) in their review of local government modernisation. They identify four distinct components of accountability:



- taking into account: the shaping of activities and priorities (for example, through consultation with citizens and stakeholders)
- giving an account: explaining actions that have been taken (for example, through performance plans and reporting systems)
- holding to account: actions taken by citizens and service users once they have heard the account given (for example, a process of scrutiny with resulting action such as through the ballot box)
- redress: a right to redress when services have not been delivered to an appropriate standard.

An important feature of ‘holding to account’ is an assumption about a degree of control or power being exercised over the account giver. Klein and New have described this as one end of a spectrum. At the ‘soft’ end of the accountability spectrum lies transparency, justification and explanation, while at the ‘strong’ end are sanctions, such as the power to dismiss or challenge decisions (Klein and New 1998). To fully qualify as accountability, the process must be able to result in some sort of action that can impact on the decisions and direction of those delivering the service. Redress in this sense is at a community rather than an individual level, as suggested by the fourth component.

## Public involvement

Public involvement can be defined as ‘all forms of institutional and professional engagements with lay people (patients, carers, local people and local communities) other than through the individual professional–patient relationship’ (Anderson *et al* 2002).

As with accountability, the degree of power being exercised by the involved public can vary. The classic analytical framework describing how power may be differentially shared with users is provided by Arnstein’s ladder of participation (Arnstein 1969). This ladder

describes the continuum of power sharing between decision-makers and service recipients or the public. At one extreme, participation is, in fact, illusory – a mechanism for manipulation not involvement. At the other extreme, power is shared.

A simpler categorisation of power-sharing is provided by Charles and DeMaio (1993), who identify three distinct categories of citizen involvement:

- consultation
- partnership
- lay control.

These categories take place within different decision-making domains:

- macro-level policy issues
- decisions about service design and resources
- matters relating to individual treatment.

This report is concerned with the first two domains. It is a matter of value judgement as to which is the ‘right’ intensity of involvement (that is, how much power should be shared).

## **Definition of accountability in this report**

For the purposes of this discussion paper, the definition of local accountability will use three components of the definition described above (Ashworth and Skelcher 2005). For a PCT to be ‘locally accountable’ it would need to:

- ‘take into account’ the views and needs of local people, through public involvement mechanisms and other techniques
- ‘give an account’ of its actions and decisions at a local level

- ‘be held to account’ at local level, with some degree of power being exercised by local people or their representatives to challenge the decisions of the PCT.

What this definition leaves unresolved is the scope of local accountability (do all PCT decisions need to be locally accountable?) and the degree of power to be exercised in the third category (should ‘holding to account’ include the right to dismiss PCT chief executives or overturn PCT decisions?).

## **Where is accountability located?**

In theory, accountability and public involvement could happen at different levels or be discharged by different bodies within a national structure. Public involvement could be local, regional or national, for instance government-led national consultations and focus groups or citizens’ juries residing within national bodies.

Accountability could be upwards to a higher authority, underwritten by national democratic structures (where elected politicians face the sanction of being voted out of office), or downwards (to local people or service users, either through local government or some other form of governance arrangements that might allow the exercise of power).

In practice, in the case of the NHS, many of these forms of accountability (particularly giving an account and holding to account) have been located centrally – with government and regulators. Upward accountability for health organisations has traditionally been exercised through performance management arrangements where national or intermediate administrative tiers hold to account (for example, for public service agreement targets negotiated between the Department of Health and the Treasury), with overarching scrutiny of the executive coming from parliament.

Some downward accountability of the NHS also exists currently, for example NHS trusts' duty to consult service users and the public (taking into account), or the accountability of executive staff to local non-executive members of a board or local government scrutiny (holding to account). The information collected by national regulators is also broken down so that the performance of one area can be compared with that of others. Overall, with the exception of foundation trusts (see p 25) the balance of accountability is, however, still weighted towards the centre. In the case of the NHS, this location and direction of accountability originates from the funding arrangements of the NHS: centrally raised taxes bring national government responsibility for, and control over, the expenditure of those funds. Accountability has followed this central line of control (Klein and New 1998).

Although the tax-funded status of the NHS has not changed, belief in the appropriateness of the centralised accountability that evolved with it has begun to erode. The long-held notion that nationally elected representatives hold all public servants to account, including those at a local level, has become less convincing over time both as a descriptive and, for some, a normative account (Day and Klein 1987). Similarly over the past two decades, reforms in the public sector have challenged the efficacy of central government control over services delivered locally, with increased delegation of decisions closer to clients and the use of entities outside direct governmental control to deliver public services (OECD 2005).

Despite this, it is striking that none of the protagonists for greater local accountability are arguing for a change in the way the NHS is funded or for parliament to cede its accountability function to another body. Nor is there a challenge to the government's right to involve the public in national or regional consultations over questions of policy. What is under discussion is whether to strengthen accountability at a local level for PCTs.

## What is the overall purpose of local accountability?

Strengthening local accountability has been justified on a number of grounds. These can be divided into instrumental and political objectives.

On the one hand, strengthened local accountability could be seen as a means to secure better public services: involving people in the planning and review of services could (in theory) make them more responsive to at least some of the community's needs. We call this an instrumental understanding of local accountability, and its value lies in a contribution to improved service quality.

Instrumental objectives of increased local accountability include achieving the right mix and volume of services to:

- meet local health needs (by taking into account when performing needs assessment)
- ensure that services are delivered in a way that is more attuned to people's demands and preferences locally (by taking into account when commissioning)
- ensure the appropriate use of health services through better public understanding of the range and purpose of services provided locally (giving an account)
- impose sanctions on poor performance in delivery and commissioning (holding to account).

On the other hand, in these debates about greater local accountability there is also a more political understanding of accountability that is presented as a value in its own right: the exercise of local accountability is inextricably linked to democratic values such as control and legitimacy (and even though there might be some positive side-effects for service quality, this is not the primary aim). Here the purpose of local accountability is, above all, to generate

some legitimacy for local NHS decisions by giving people the right to be involved in local decision-making and permitting local people to hold to account by challenging and reversing decisions that are perceived to be illegitimate. Whereas an instrumental approach sees local people primarily as users of services (and needs to tap into their expertise and knowledge of services), a political approach is more likely to involve people because of their status as citizens (and taxpayers).

These definitions of local accountability are not mutually exclusive, but they might have different implications for the mechanisms used to engage people: an instrumental approach implies, perhaps, a more focused engagement policy to target those people most affected by or needing the service in question (though this could be quite wide if big changes to institutions such as local hospitals were under discussion). The more political approach is aiming to generate legitimacy for PCT decisions and would, therefore, need to be underpinned by mechanisms to ensure engagement with as many local people as possible, which might include traditional elections or other forms of participatory techniques.

Both definitions of accountability could imply differing degrees of power to be exercised by local people. Some sort of challenge is clearly needed for an instrumental objective, to act as a sanction on NHS organisations if the quality of their engagement or explanation of their activities is poor. However, a more political definition of local accountability could imply a much greater devolution of power to local people and their representatives.

As we have noted, these two separate but linked objectives are often mixed up and conflated in the debate on NHS accountability. As we discuss in the next section, recent NHS policy has tended to emphasise the instrumental benefits of local public involvement. However, changes are being discussed that are implicitly calling for

a shift in the location of power in the NHS towards local NHS organisations *and* their local communities – essentially a political objective.

Any reform of the lines of accountability towards local communities provides an opportunity to pursue both instrumental and political objectives. Yet, while both objectives can be pursued, different approaches may be more effective in one domain than another (for example, better public involvement in service redesign may improve services but not hold commissioners effectively to account). In the next section, we discuss the extent to which reforms should seek to address instrumental or political objectives will depend on exactly what problem is to be solved.

## How do PCTs work?

This section describes the main features of primary care trusts (PCTs) as organisations, their functions and current lines of accountability. It then describes the recent reforms to local public involvement structures, local scrutiny arrangements and other relevant reforms to PCTs working in partnership with local authorities, and offers some analysis of the objectives behind these reforms.

### Size and structure

The first PCTs were set up in 2000. They were reorganised from 2005 in a process that involved halving their numbers plus a radical overhaul of the senior management of the new organisations. This was completed in October 2006 (although some appointments may have taken longer). Similar changes took place in strategic health authorities, which manage the performance of PCTs.

There are now 152 PCTs, and they are nearly all ‘new’, having been created from merging former PCTs. They serve an average population of 330,000, ranging from 90,000 to 1,253,000 (Department of Health 2005a). Many PCTs are coterminous with local authorities. Each PCT is governed by a board comprised of non-executive directors and a chair (appointed by the Secretary of State), plus executive staff drawn from the paid employees of the PCT. Many PCTs still also employ staff who deliver community services on their behalf.

A total of just over £70 billion was allocated to England’s PCTs for 2007/8, representing more than 80 per cent of the total NHS budget. This represents an average budget per PCT of £230 million (ranging from £90 million to more than £400 million) (Department of Health



2005a). The size of the allocation to each PCT is calculated by the Department of Health (with input from an independent advisory committee) using a complex formula based on population size, estimated health needs (related to factors such as age) and adjustments for local variations in pay and cost of land or property (Department of Health 2005d). Data derived from local patterns of morbidity and mortality is fed into the formula that calculates the allocations, but the allocations process does not specify how the money should be spent within each PCT.

## Functions

There is no single document that explains the overall function of a PCT. We have therefore based our description of the functions of a PCT on recent Department of Health guidance (Department of Health 2007e, 2007f; Department of Health 2007d; Department of Health 2005c).

The functions of PCTs can be broken down into four key domains.

- **Needs assessment** PCTs are expected to assess patterns of ill health locally and calculate expected levels of need for services, including preventive care (identifying those who might be at risk of illness), primary care (including dentistry and general practitioner services), secondary care and specialist care.
- **Devising a strategy for the local health care system** PCTs are expected to decide on the appropriate providers of services to meet needs, the appropriate level of competition and co-operation between those providers, the appropriate configuration of buildings and their function (to meet policy objectives such as specialisation, care closer to home or new types of general practice) and to monitor the output of the system to ensure choice, equity, quality and value.
- **Commissioning** PCTs are expected to draw up contracts with providers that specify the volume, quality and timeliness of services provided and to monitor the delivery of services as specified in the contract.

- **Direct provision of services** PCTs also supply services themselves, for instance, district nursing or community hospitals.

## Role within the health system

PCTs lie at the intersection of several different reform strands initiated by government policy. They have seen a huge increase in both the scope and importance of their functions since they were created in 2000. When the first PCTs were set up there was a modest emphasis on improving aspects of local service delivery by, according to the NHS Plan, ‘giving local health professionals more freedom to develop new services by bringing together in a single organisation primary and community care services’ (Department of Health 2000b).

Since then their role has not only grown hugely in scale, but it has also become pivotal to the successful delivery of many of the government’s recent targets and strategies for NHS reform. These include implementing patient choice, Payment by Results (PbR), practice-based commissioning, and improving overall health, while reducing health inequalities (Department of Health 2005c; Department of Health 2007d). Some of these are summarised below.

Even though the Department of Health guidance to the NHS for the current year (2008/9) contains many additional detailed instructions about the provision of cancer, stroke, maternity and other services, PCTs are also expected to set their own local priorities and monitor their progress in delivering these priorities against local targets called ‘vital signs’. This process is to be underpinned in the future by a detailed analysis of health needs and utilisation of health services (some of it provided by the private sector (Department of Health 2007b)), and a new mandatory duty to co-operate with local authorities in ‘joint strategic needs assessment’, which comes into force in 2008 (Department of Health 2007d).

## THE MAIN ROLE OF PCTS

### Acute (hospital sector)

- Ensure delivery of access targets by providers (18-week referral-to-treatment target)
- Ensure delivery of hospital-acquired infection targets
- Contain demand for elective hospital services
- Ensure patients have choice of provider
- Ensure competition for elective services/allow new entrants into the market
- Ensure appropriate use of emergency and other non-elective services

### Primary care

- Ensure roll-out of practice-based commissioning
- Ensure delivery of access targets (such as extended hours)
- Ensure delivery of government priorities of more general practices in some areas and more care outside hospital
- Ensure delivery of targets to reduce health inequalities through smoking cessation programmes and other interventions

Source: Department of Health (2007d).

Recent guidance also makes it clear that PCTs are to consult patients and the public in this process, especially to ‘proactively identify and seek out communities that experience the worst health outcomes’ (Department of Health 2007e).

The government’s vision for PCT commissioning in the future could make PCTs engage in a much more explicit process of resource allocation and rationing than in the past. After assessing needs, PCTs are expected to commission services to meet those needs, supported by a much richer supply of data and analytical skills to

establish whether treatments improve health and to avoid unexplained variations in care. This process will mean taking decisions that involve trade-offs or rationing, given the fixed budgets within which PCTs operate. For example, there is historical variation in PCT spending on key disease areas that is not always explained by need (King's Fund 2006) and PCTs are expected in the future to reduce unexplained variation and ensure that spending results in measurable improvements in health and reduced health inequalities.

The process of reducing variation might mean reducing higher than average referral rates for some procedures (thereby denying some people who might historically have received it), or it might mean that PCTs decide to spend less on one disease area (where outcomes are better) and more on another. It might mean that PCTs decide to target more resources on those living in deprived areas or on a particularly vulnerable group, such as those at risk of frequent admission to hospital, possibly at the expense of other groups. A focus on cost-effectiveness might also mean a PCT deciding whether to invest in particular treatments at all (where there is no national guidance), or deciding to apply thresholds for treatments or interventions.

PCTs have always made decisions of these kind. Some of them have been controversial, for example whether to provide Herceptin in advance of national guidance, or setting thresholds for patients' eligibility for surgery, such as being below a certain body mass index or being a non-smoker (British Medical Journal 2005). If the government's vision for PCTs is realised, it will mean more of these decisions being taken more frequently and more explicitly.

PCTs will also make decisions that impact on organisations within the local health care system, whether to stimulate the market by allowing in new competitors or make decommissioning decisions where quality is not provided at a suitable level, and prioritising investment, which could mean redesigning services (Department of

Health 2007e). The government has made it clear that there will not be any further centrally led commissioning of independent sector treatment centres (beyond the first two waves), and it will be a matter for local decision in the future (Department of Health 2007a).

Letting contracts with private sector providers have generated controversy in the recent past (for instance, the local opposition to United Healthcare providing a new GP service in Derbyshire (British Medical Journal 2006)), as have both major and minor service redesigns (such as closing community hospitals (BBC News Online 2006; BBC News Online 2007)).

The latest guidance from the Department of Health adds a market regulatory role to the commissioning functions of PCTs. In addition to deciding how much competition there should be and for which services, PCTs should be monitoring potential collusion between providers, monitoring the promotional activity of providers for fairness, monitoring the impact of competition on the quality of care and deciding when mergers, de-mergers and acquisitions between providers are in the interests of patients and taxpayers (Department of Health 2007d).

It should be noted that the above describes the government's vision for PCTs, a vision that sees PCTs becoming more autonomous over time and choosing more of their own targets, or 'vital signs', according David Nicholson, Chief Executive of the NHS:

*I want to be clear that this is the beginning of this journey. The list of vital signs will by no means be exhaustive and will be fluid, to reflect the local and national direction of travel. Throughout this [CSR] period, I would expect that we will be able to shift even more autonomy over local target setting towards PCTs.*

(Department of Health 2007d).

Some commentators have pointed out that, although the scope for PCT autonomy is wide on paper, in practice the agenda for most PCTs is currently dominated by directives from the centre and is likely to remain so in the near future (HSJ 2007), a point to which we will return later.

## **Accountability**

Historically, the lines of accountability for NHS bodies (as opposed to individual professionals) have been firmly upwards to the Department of Health rather than downwards to local populations because of the source of funding of the NHS. A PCT is directly accountable to the strategic health authority within the boundaries of which it sits, and the strategic health authority is in turn directly accountable for performance through the Department of Health to the Secretary of State. The Secretary of State is held accountable for the delivery of public service agreements negotiated with the Treasury and for overall performance by parliament.

PCTs are also accountable to the Healthcare Commission (for the quality of care commissioned and provided) and to the Audit Commission (for financial management and accounts). Individual clinicians working within PCTs are also directly accountable for their clinical practice to professional bodies such as the General Medical Council and the Royal Colleges.

Locally, each PCT is accountable through its publicly appointed board, the members of which are drawn from the local community, and through the oversight and scrutiny committee of the local authority, to which it must provide information when requested. More indirect accountability exists via the partnership duties with local government, and the relationship with the new public and patient involvement mechanisms, known as 'local involvement networks' or LINKs.

## Boards

The Labour government inherited a system of boards for NHS hospital trusts, which it applied to PCTs on their creation in 1999. NHS boards were established in 1991, modelled on the private sector. The White Paper that proposed the reform, which overturned the power of local authorities to nominate health authority members, envisaged non-executive board members chosen for ‘the strength of the skills and experience they can bring to an authority’s work’ rather than for their ability to represent a wider community (Klein 2006). Accountability was upwards, to the Secretary of State.

The idea that non-executive board members might also have an accountability role in relation to the wider public and local community has been introduced more recently. According to the latest guidance issued to non-executive directors by the Appointments Commission:

*Non-executive directors are appointed by the NHS Appointments Commission on behalf of the local community. They therefore have a responsibility to ensure the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.*

(Department of Health 2003a)

Quite what this responsibility means in relation to local accountability is not clear. Department of Health guidance to NHS staff on public consultation emphasises that non-executive directors should not be seen as ‘representative’ of their local communities: ‘Non-executive directors do not “represent” the public. They are there to govern the organisation, by using their experiences in other fields and as residents in the areas they serve’ (Department of Health 2004).

The role and capabilities of NHS trust board governance have been subject to a considerable amount of development, reflecting parallel

efforts in the private sector to improve the scrutiny powers of boards. Much of the energy in the NHS has been focused on improving standards of clinical governance, and, more recently, the financial competence of boards.

For PCTs, non-executive board members do, in theory, represent a form of concentrated local accountability (particularly in giving an account and holding to account) by virtue of their status as local people. There is currently, however, no role for local communities in the selection of those individuals. This contrasts with foundation trusts, in which there was a deliberate attempt to connect trust governance more directly with the local community, although stronger local public accountability was a secondary objective of foundation trusts, which were set up primarily to reap the benefits in terms of service improvements (such as greater efficiency and improved quality) that would flow from autonomy from Whitehall.

At the time foundation trusts were created, accountability was largely seen to flow in an upwards direction: 'They will be held to account through agreements and cash for performance contracts they negotiate with PCTs and other commissioners as well as through independent inspection' (Milburn 2002). Nevertheless, in creating the new governance structures, the government also articulated an essentially political justification for greater local engagement by arguing that control needed to be exercised at a local level because it was being devolved from the centre: 'As national control over day to day management of these NHS hospitals ceases so local community input will need to be strengthened' (Milburn 2002).

The new machinery for greater local public accountability created for foundation trusts is based on membership, and is open to all local people including patients and carers. Members can put themselves forward as governors, non-executive directors or chairs (although appointment to these board posts is still controlled by government).



Members also elect governors to represent their interests within the formal governance structures of the trust. The board of governors has a number of rights, including the right to be consulted on plans for the future, to appoint and remove the chair and non-executive directors and to approve the appointment of the chief executive. These changes resulted in an increased emphasis on recruiting non-executive directors for their specific skills rather than for the strength of their local links, which is now considered to be an important quality of governors (Healthcare Commission 2005; Lewis and Hinton 2005).

### ***Overview and scrutiny committees***

The creation of the NHS in 1948 was an act of centralisation that brought a sudden end to a variety of local government and other forms of locally controlled health services (Gorsky 2006; Klein 2006). Local government control of all health services, and by implication local accountability through local democracy, was initially discussed prior to the original White Paper of 1944. It was abandoned partly to reach a compromise with the medical profession – which was hostile, among other things, to the idea of control by local councillors (Klein 2006) – and partly because of more general concern about the wisdom of allowing local government full control over resources raised through central rather than local taxation (Timmins 2001).

The result was an NHS where hospitals were run by people appointed by the Minister of Health, general practitioners were administered by separate bodies, and the local authorities were left to provide a rump of community services such as district nursing, which they lost completely in 1974 (Hudson 1998).

There have been no subsequent attempts to reintroduce *direct* local government control of NHS services, although there has been considerable effort put into partnership working between the NHS and local authorities. It is only recently that local government

councillors, using the vehicle of overview and scrutiny committees, have been given a more formal opportunity to question and, most importantly, *influence* the decisions of local NHS bodies. In relation to the typology of accountability developed previously (see p 12), overview and scrutiny falls most clearly into the category of holding to account, although questions remain about the degree of power with which it does this, which we will examine in the next section.

Overview and scrutiny was set up in local authorities under the terms of the Local Government Act 2000. This Act abolished the pre-existing committee system and set up a Westminster-style separation between executive and scrutiny roles. The scrutiny provided by the overview and scrutiny committee is led by elected non-executive councillors. Powers were given to them to scrutinise and hold to account the executive by obliging it to offer an explanation of its decisions in public.

In 2001, the Health and Social Care Act extended the scope of scrutiny to include health services ‘to review any matter relating to the planning, provision and operation of health services in the area of its local authority’ (Department of Health 2003c).

Committees are made up of non-executive councillors and are able to choose a wide variety of topics to scrutinise. According to the guidance, committees have discretion on topics: they might look at matters relating to an individual trust, or at thematic issues, such as winter pressures on services or tooth decay (Department of Health 2003b). One area is mandatory: under the terms of the 2001 Health and Social Care Act, any substantial variation or development planned by NHS trusts should be referred to the committee.

Although the committees have the power to request information from NHS organisations and summon NHS staff, the power relating to the *outcome* of the scrutiny process is less strong. According to the

Department of Health's guidance, the scrutiny process is expected to conclude in a report and recommendations, following which 'the executives of all key stakeholder organisations are *encouraged* to implement recommendations or provide reasons why no action is taken' (Department of Health 2003b).

Both the political and instrumental objectives are reflected in the justifications by government for this enhancement of overview and scrutiny. On the one hand, government is keen to emphasise how: 'For the first time, democratically elected, community representatives have the right to scrutinise how local health services are provided and developed for their constituents' (Department of Health 2003c). On the other hand, a high priority still seems to be securing improvements in health and health services: 'The Health and Social Care Act 2001 provides explicit powers for local authority overview and scrutiny committees to scrutinise health services within the authority's area as part of their wider role in health improvement and in reducing health inequalities for their area and its inhabitants' (Department of Health 2002b).

### ***Other links between the NHS and local authorities***

Overview and scrutiny is only one element of an evolving relationship between local government and the NHS. Numerous partnership arrangements now exist in which NHS bodies, particularly PCTs, work with local government using a variety of models. Although not designed primarily to improve local accountability, they are worth analysis here. The justification for these reforms has been instrumental and is described in the latest White Paper as a 'new framework for local authorities to work with other public service providers, with new duties for them to work together to meet local needs and drive up service standards' (Department for Communities and Local Government 2006).

However, by virtue of the democratically elected status of local government, it might be argued that closer working with local authorities automatically builds an element of local accountability into any partnerships, if only by proxy. In reality, the evidence on this is mixed, as we shall explore in the next section.

NHS bodies were enabled to work more closely with local authorities under the provisions of section 31 of the Health Act 1999. This Act allowed three new ‘flexibilities’:

- it allowed partners to pool budgets
- to delegate commissioning to one lead organisation
- to integrate staff from different organisations to work under a single management structure (Department of Health 2000b).

The scope of local partnerships was soon widened by the Local Government Act of 2000, which placed a duty on local authorities to set up a local strategic partnership, drawing together a range of bodies including the NHS in order to create strategies to improve the well-being of a local area. Following this, the Health and Social Care Act of 2001 placed a further ‘duty of partnership’ on PCTs to co-operate with social services departments.

The government signalled its intention to forge even closer ties between local government and health services in two White Papers: *Our Health, Our Care, Our Say* (Department of Health 2006a) and *Strong and Prosperous Communities* (Department for Communities and Local Government 2006). Some of those proposals have now become legislation: a requirement for PCTs and local authorities to co-operate through a ‘joint strategic needs assessment’, and a duty on local authorities to draw up a ‘local area agreement’ with partners including PCTs. These agreements, which include performance targets agreed with central government, will come into force in June 2008 (Department of Health 2007d).

### ***Public involvement structures: LINKs***

The machinery for direct public and patient involvement in NHS organisations has undergone substantial change during Labour's term in office. In 1997, Labour inherited a public involvement structure that had, unlike other areas of the NHS, remained relatively stable in form for more than two decades.

Community health councils were set up in 1974. One-third of their members were local councillors, one-third were elected by local voluntary sector organisations, and one-third were appointed by the Department of Health. Community health councils had a statutory duty to represent the interests of the public, to monitor the local operation of the health service and to be consulted by (and give advice to) local health authorities. They had a power of veto over health authority decisions that involved service redesigns (such as ward closures) and could refer issues to the Secretary of State.

Pressure to reform the community health councils grew out of concerns about how well they were able to discharge their multiple functions (delivering advice, advocacy *and* representation), a lack of representativeness, particularly with respect to younger people and ethnic minorities, and gaps in covering the scrutiny of primary care (Hinchcliffe 2003).

Amid some controversy at the time, the Health and Social Care Act 2001 abolished community health councils and placed on the NHS a new duty to involve the public. The old functions of the community health councils were split up: advocacy now belonged to the new Patient Advice and Liaison Service, designed to provide on-the-spot help and advice from within trusts, and the Independent Complaints Advocacy Service to pursue formal complaints (Department of Health 2003c).

The representation of patients (and citizens) was replaced by patient and public involvement forums, co-ordinated by an arm's length body, the Commission for Patient and Public Involvement in Health. The forums began work in 2003, and were given specific powers including the right to visit NHS premises, to request written information from trusts and to refer matters to local overview and scrutiny committees.

In 2004, less than six months after many had begun operating, a major review of patient and public involvement forums was announced. This resulted in more legislative change, which was completed in the Local Government and Public Involvement in Health Act 2007. The new Act abolished patient and public involvement forums, and established 'local involvement networks' or LINKs. Under the new system, funds will be given to local authorities to commission an organisation to act as a local involvement network. The new body will no longer be attached to individual NHS institutions, as the forums were, but will operate over a geographic area, usually equivalent to a local authority or PCT boundary. LINKs are described in the legislation as having responsibility for:

- 2 (a) promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services;*
- (b) enabling people to monitor for the purposes of their consideration of matters mentioned in subsection (3), and to review for those purposes, the commissioning and provision of local care services;*
- (c) obtaining the views of people about their needs for, and their experiences of, local care services; and*
- (d) making –
  - i. views such as are mentioned in paragraph (c) known, and**

*ii. reports and recommendations about how local care services could or ought to be improved, to persons responsible for commissioning, providing, managing or scrutinising local care services.*

*3 The matters referred to in subsection (2)(b) are –*

*(a) the standard of provision of local care services;*

*(b) whether, and how, local care services could be improved;*

*(c) whether, and how, local care services ought to be improved.*

(Section 221 Local Government and Public Involvement in Health Act 2007)

In addition to the legal requirements on local government to set up a local involvement network, the 2007 Act retains the duty on NHS trusts to consult users of their services, either directly or through representatives on:

*(a) the planning of the provision of those services,*

*(b) the development and consideration of significant proposals for changes in the way those services are provided, and*

*(c) significant decisions to be made by that body affecting the operation of those services.*

(Section 233(1B) Local Government and Public Involvement in Health Act 2007)

It also requires PCTs to ‘prepare a report (a) on the consultation it has carried out, or proposes to carry out, before making commissioning decisions, and (b) on the influence that the results of consultation have on its commissioning decisions’.

### ***Rationale for reform to patient and public involvement structures***

Both the patient and public involvement forums and the successor organisations, LINKs, fall most clearly into the category of taking into account.

Prior to the latest reforms to patient and public involvement forums, the duty to consult has largely been promoted to the NHS by the Department of Health in broadly *instrumental* terms, in other words better services will flow from better consultation. Trusts were issued with extensive and detailed practical guidance from the centre on a variety of different techniques to get information from patients and the public (Department of Health 2003c).

The rationale for the latest reforms to patient and public involvement was published in July 2006 (Department of Health 2006d). The document sets out similar instrumental arguments, but with the refinement that LINKs should provide trusts with the means to access the views of a much more representative sample of the local population than the old patient and public involvement forums, which relied on a small number of volunteer members of the public and were not subject to any requirement to be representative of their locality.

But the same document also includes recognition that some of the objectives for reforming the system might extend beyond the instrumental to include some of the more political objectives possible under the umbrella of accountability. So, on the one hand, the reforms will mean that ‘people are encouraged and given opportunities to have their say in how providers improve their services’, but, on the other hand, they will mean that ‘NHS trusts and PCTs are accountable to their local populations, that the organisations are held to account; and commissioners engage with, respond to and are accountable to the communities and groups within their populations’ (Department of Health 2006d).

The reforms to patient and public involvement are being enacted alongside another round of changes to local government, much of it designed to improve the quality of service delivery and accountability of locally elected councils. In the White Paper that preceded the



Local Government and Public Involvement in Health Act 2007, the government elaborated a theme very similar to that for health: that local government needs to be given more freedom from central targets and control (Department for Communities and Local Government 2006). As with the NHS, much of the argument for doing this is framed in terms of improving services (more freedom to engage better with local citizens for better services). Within this, there are references in the White Paper to examples of ‘lay control’ (the top rung of Arnstein’s ladder), for example participatory budgeting (an idea from Brazil, where citizens decide budgetary priorities through some sort of representative forum), or even lay *delivery* of services. The White Paper also puts forward more political arguments for greater local autonomy, including building stronger communities and establishing more vibrant local democracy (Department for Communities and Local Government 2006).

## Why might the system need to change?

Before addressing the question of *how* primary care trusts (PCTs) should be made more locally accountable, it is perhaps worthwhile considering *why* the current accountability arrangements might need to change.

Is there a gap in the current local accountability arrangements of PCTs? This is a difficult question to answer, partly because the reforms are still being implemented to both the public involvement arrangements and the duties to co-operate with local authorities, and partly because an acceptable or minimum standard of engagement has not been clearly specified. In addition, as we have demonstrated, the overall goal or goals of local public accountability and engagement have not been clearly laid out, while the mission of PCTs has changed (and expanded considerably) since they were set up.

One simple way of approaching the question is to map the planned local accountability and involvement mechanisms on to the different PCT functions, as defined earlier, using the three-fold breakdown of accountability set out in a previous section (see pp 11–2). Although reforms to public involvement, scrutiny and local authority partnership are not yet complete, according to what is proposed, PCTs *should* face the prospect of some sort of local public involvement in, or scrutiny of, all elements of their functions as we have defined them (see Box overleaf).

But even though there might be some sort of local accountability in place on paper, it might not be effective in practice. Are there any lessons from the past experience of the NHS? Because the objectives of local accountability have not been made clear, assessing future

## IS THE PUBLIC INVOLVED IN THE ACCOUNTABILITY OF PCTs?

| PCT function                           | Taking into account?                                  | Giving an account?   | Holding to account?             |
|--|---|--|---------------------------------|
| Needs assessment                       | Joint strategic needs assessment with local authority | Publishing PCT prospectus/board papers/ meetings in public<br>LINKs* | Overview and scrutiny<br>LINKs* |
|  | Duty to consult LINKs*                                | Local authority partnerships   |                                 |
| Strategic direction/ system management | Duty to consult LINKs*                                | Publishing PCT prospectus/board papers/ meetings in public           | Overview and scrutiny           |
|  | Local area agreement/ local strategic partnerships    | LINKs*<br>Local authority partnerships                               | LINKs*                          |
| Commissioning                          | Local area agreements                                 | Publishing PCT prospectus/board papers/ meetings in public           | Overview and scrutiny           |
|  | Duty to consult LINKs*                                | LINKs*<br>Local authority partnerships                               | LINKs*                          |
| Provision                              | Duty to consult LINKs*                                | Publishing PCT prospectus/board papers/ meetings in public           | Overview and scrutiny           |
|  |   | LINKs*   | LINKs*                          |

\*LINKs = local involvement networks.

effectiveness against past performance is difficult. Nevertheless, despite the lack of clarity about objectives, there is evidence from existing experience that would be relevant regardless of whether a more instrumental or more political approach was favoured: namely, the extent to which all sections of a local community have engaged or are inclined to engage with some element of their local PCT and the extent to which the PCT responds to that engagement, either by reviewing decisions or changing plans.

In the previous section, we reviewed the existing local accountability mechanisms: boards, overview and scrutiny committees, other local authority partnerships and patient and public involvement (PPI). What is the evidence from these?

## **Boards**

There is no direct evidence on how the presence on PCT boards of non-executive directors drawn from the local community has impacted on accountability. There is, however, some limited evidence about the performance of the new accountability arrangements that were designed to complement and enhance foundation trust boards.

A report by the Healthcare Commission in 2005 concluded that, while there was evidence of foundation trusts engaging well with the public and other local stakeholders, there was still room for improvement, particularly with ‘hard to reach’ groups, engaging staff and delivering greater clarity to the role of governors (elected by members) (Healthcare Commission 2005). A study of the governance arrangements of the first 20 foundation trusts found a great deal of variation in the style of engagement with the public and the numbers involved in each trust, and suggested that more thought might be given to evaluating the effectiveness of these governance arrangements (Day and Klein 2005). A case study of one foundation trust found little evidence of any impact by the elected governors on the working of the hospital over the short term, but that expectations continued to be high that

better local accountability was still an achievable goal (Lewis and Hinton 2005).

## Overview and scrutiny committees

There is a slightly clearer picture on the efficacy of overview and scrutiny committees in relation to the NHS as a result of more formal evaluation by the Centre for Public Scrutiny, funded by the Department of Health. The most recent evaluation is based on an in-depth study of eight sites between 2004 and 2007 (Centre for Public Scrutiny 2007). This concludes that there has been some impact, albeit small, in terms of changes to services and plans as a result of the work of overview and scrutiny committees. However, it is not clear how much routine scrutiny there is of PCT commissioning (or other functions) specifically. The evaluation uses a typology of styles of democratic accountability in practice, including ‘collaborative’, ‘corporate’, ‘challenge’ and ‘campaign’. It finds that there is more evidence of collaborative working than challenge, suggesting that instrumental objectives are being pursued (collaboration to secure better services) rather than the more political objectives implicit in ‘challenge’, where the process of challenging is an end in itself.

This study built on an earlier evaluation that provided some insight into the process and volume of overview and scrutiny committee work (Centre for Public Scrutiny 2005). In 2005, 92 per cent of local authorities reported having conducted some sort of health scrutiny in the previous 12 months. Of those officials surveyed from local authorities, 11 per cent mentioned improved services as an outcome; 13 per cent mentioned greater accountability; and 16 per cent felt that there was greater public involvement as a result.

By comparison, 45 per cent of NHS respondents said that their organisation had changed policies, procedures or services as a result of overview and scrutiny committee review, which is only slightly lower than local government perceptions of overview and scrutiny

committee activity in a more general sense, where it is perceived to have had an impact by 49 per cent.

The latest evaluation confirms earlier concerns about the balance of subject matter that comes up for review: NHS trusts are obliged to consult their overview and scrutiny committees on substantial changes to their services, and such consultations can often limit an overview and scrutiny committee's ability to scrutinise other topics. It also reported that direct public engagement in the work of the committees is an area in need of further development (Centre for Public Scrutiny 2007).

### **Joint working with local authorities: partnerships**

An early evaluation of how section 31 was being used in practice was published in 2002 (Hudson *et al* 2002). By April 2002, 130 partnerships had been notified to the Department of Health. The evaluation found that pooled budgets were the most popular flexibility, being used by three-quarters of partnerships, and that they tended to cover services for older people, adults with learning disabilities, adult mental health services, and adults with physical disabilities. The evaluation also noted that the partnerships improved efficiency through shared commissioning and other functions, but that considerable work was often required to set up legal frameworks to make sure that accountabilities were clear.

The Audit Commission published an overview of all such partnerships (which number more than 5,500 across the public sector) in 2005 (Audit Commission 2005). The Audit Commission points out that, although such partnerships are generally designed to improve service delivery (and many do register tangible improvements), greater public accountability is not guaranteed and can often be made worse as a result of poorly set up partnerships. The Audit Commission found that by 2003/4, 66 per cent of PCTs had set up some kind of partnership arrangement under section 31 of the 1999 Act, but that

one-third of them had experienced problems with governance arrangements.

More generally, the Audit Commission noted that, on paper, most corporate bodies (including the PCTs as currently constituted) already had much better local accountability when compared with partnerships.

## **Local strategic partnerships**

A government-commissioned evaluation of local strategic partnerships (Office of the Deputy Prime Minister/Department of Transport 2006) found that some of those involved believe that a clear benefit of the partnerships, beyond improved services, is improved accountability in the form of greater openness between organisations: ‘...through effective partnership working, and integrating/aligning plans, targets, performance management regimes and budgets all result in considerable scrutiny of individual agencies’ actions and resources by stakeholders (public, private, voluntary and community alike)’ (Office of the Deputy Prime Minister/Department of Transport 2006).

Nevertheless, in practice, the same evaluation noted: ‘substantial numbers of local strategic partnerships identify accountability as an area that needs strengthening. There is a lack of clarity on a number of aspects including the accountability of the local strategic partnership to partners, and the accountability of partners to the local strategic partnership, as well as wider public accountability’ (Office of the Deputy Prime Minister/Department of Transport 2006).

## **Local area agreements**

These have not yet been implemented in their latest form. Evaluation has been published on the process of negotiation (Office of the Deputy Prime Minister 2005), and there has been an evaluation of their impact drawn from case studies of early adopters (Department for Communities and Local Government 2007).

The first evaluation notes that, while the main objective of local area agreements was delivering better services through joined-up working, a secondary objective could be seen as ‘greater horizontal accountability for local government spending’. This is accountability understood (primarily) as giving an account: ‘The fact that the agreements will be public documents, with outcomes to which partners are formally committed, supported (eventually) by clear targets, should help to make partners more accountable to local people’ (Office of the Deputy Prime Minister 2005).

The more recent evaluation reinforced the view that local authorities regard local area agreements as having the potential to improve services, but that it is too soon to identify measurable outcomes from the process (Department for Communities and Local Government 2007).

Underlying the efficacy of scrutiny by, or partnership with, local government is a more fundamental question: how accountable is local government itself to the local community? The most recent White Paper proposing reform for local government acknowledges that the democratic credentials of local government are far from robust in some cases:

*Too often the political parties are struggling to find enough good candidates to stand for election. Non-executive councillors feel unable to make a real difference. Local leaders have short mandates – frequently only one year – limiting their ability to take tough, but essential, decisions. Responsibility for decisions can be unclear and accountability mechanisms often remain weak, along with low levels of citizen participation.*

(Department for Communities and Local Government 2006)

The White Paper also reproduces the low turnout figures for local elections (30 per cent), with 41 per cent of those not voting because they believe it ‘will not make a difference’.



## Public involvement: a duty to consult

An accurate and comprehensive picture of the overall volume and impact of the various forms of public and patient consultation and involvement generated by all NHS trusts, including PCTs, is hard to obtain. These activities are, however, subject to inspection by the Healthcare Commission under core standard C17 ('The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services'). The actions required to comply with this standard are not clearly specified, which makes the finding in the annual health check ratings for 2006/7 of 90 per cent of PCTs meeting the standard difficult to interpret.

The Commission for Health Improvement (the predecessor to the Healthcare Commission) has published one review on the experiences of PPI within all NHS organisations (not just PCTs). They found some improvements in the willingness of NHS trusts to consult patients and the public, for example to get feedback on services or to help design new kinds of patient information. But they found much less evidence of routine involvement of the public in decision-making on service delivery or setting strategy, and no measurable impact of any PPI activity on policy and practice (Commission for Health Improvement 2004).

In proposing the reforms to PPI forums in 2006, the government conceded that there had been a 'lack of meaningful engagement' with public and patients on the part of NHS trusts in the delivery and commissioning of services (Department of Health 2006d).

There is also limited empirical work on the attitudes of NHS managers or senior clinicians to public involvement. A recent survey of PCT staff found that, although most PCTs had allocated staff and budgets for PPI, there was 'evidence of considerable and widespread barriers' to achieving greater involvement in *commissioning per se* (Chisholm

2007). Two-thirds felt that the public's lack of comprehension of the commissioning process was a barrier, and half reported difficulty in securing attendance at public meetings.

## **Public involvement: PPI forums**

There has been a dearth of formal evaluation of PPI forums in general, and in relation to PCTs in particular. The most recent Department of Health Annual Report to mention PPI (Department of Health 2005b) stated that PPI forums had more than 5,000 members in total and reported that they were 'carrying out their functions'.

According to the most recent figures available from the Commission for Patient and Public Involvement in Health, the number of people serving on forums stands at 4,250, with 84 per cent of forum members classifying themselves as white (British), 3 per cent as white (other), 6 per cent as Asian, and 4 per cent as black or African, figures that are broadly representative of England as a whole (Commission for Patient and Public Involvement in Health 2007).

Some evidence about the performance of forums was recently collected by the House of Commons Select Committee on Health (Barron 2007). PPI forums were perceived by a range of witnesses to be unrepresentative of the local communities served (particularly in respect of working adults, people with young families, and people from ethnic minority backgrounds). They were also described by forum members as bureaucratic and tending to rely too much on a small number of volunteers. PPI forums were also described as focused on individual institutions that neglected the importance of commissioning at PCT and practice level (Barron 2007).

The past performance of the forums might be a poor indicator of the likely success of local involvement networks. These new structures were designed, according to the government, to overcome some of the limitations experienced by patient forums, particularly their

failure to involve anything like a representative sample of the public. Local involvement networks should, in theory, provide a range of different ways for local people to have a say by better links with local voluntary sector organisations and by using different techniques for engaging the public, such as *ad hoc* focus groups or surveys. Evaluation of local involvement network pilots, known as early adopter sites, was published by the NHS National Centre for Involvement (2007). The evaluation found it was too early in the life of most local involvement networks to report much change, either in terms of local public involvement or in the response of NHS organisations.

Much now rests on the evidence of public enthusiasm to get involved in the NHS on a larger scale. Over the past year, there has been evidence of substantial public concern over specific controversial issues, notably the reconfiguration of services, which has resulted in a variety of manifestations from petitions to public demonstrations. Whether this activism extends to a demand for an ongoing and active role in the work of PCTs is less clear.

This is probably because the question is infrequently asked, or, if it is, it is asked at a very general level, leading to predictable responses. For example, some research by the Department of Health in 2006 found that 90 per cent of the public felt that they ‘ought to have a say in how local health services are run’ (Department of Health 2006b). A similar response was elicited when the government consulted the public prior to the White Paper *Our Health, Our Care, Our Say*: 91 per cent of people felt it was important or very important to consult the public about changes to services, and 92 per cent felt it was important or very important to consult locally ‘when deciding about the future priorities of health or social care’ (Department of Health 2006e).

Away from health, there is evidence from *ad hoc* surveys and polls into public engagement with local public services in general. A MORI

poll conducted for the Cabinet Office found that there is an appetite for some sort of input: 80 per cent of people agreed or strongly agreed with the statement ‘I would get more involved in shaping how public services were provided if I knew more about the opportunities available and was given help and advice on how to’ (MORI 2007). However, MORI notes that people are split on the level of involvement: roughly equal proportions of people agree with the two contrasting statements ‘The experts and people who provide the services know best – they should find out what we want and get on with it’ (50 per cent agree) and ‘The general public should be much more actively involved in shaping public services, through, for example, people deciding on priorities’ (48 per cent agree) (MORI 2007).

There may be a gap between intention and practice here. The government’s citizenship survey measured civic activism, defined as involvement in decision-making structures: 9 per cent reported involvement in the past 12 months, and a further 20 per cent reported responding to a consultation (by filling out a questionnaire or going to a meeting in the previous year) (Department for Communities and Local Government 2006a). Other research has suggested that the real level of activism is much lower – nearer 1 per cent of the population – and that imaginative solutions are needed if both reform of local public services and democratic renewal hinge on constructive engagement with a larger proportion of people (Skidmore *et al* 2006).

## **Conclusion: is there case for strengthening local accountability ?**

Evidence of an actual accountability gap relating to the current structures is ambiguous. The half-implemented state of reforms to key elements, such as the new public involvement networks for the NHS and joint working with local authorities, makes it premature to conclude that the systems are inadequate. The available evidence that relates to the complexities of delivering widespread public

engagement with services or institutions suggests that delivering local accountability will be very challenging. From the discussion above, there are two main reasons for this: the unwillingness of enough members of the public to be involved in decision-making and to mount a significant challenge; and the unwillingness of NHS institutions to change in response to challenge.

Other arguments can be added to this evidence. First, the role of PCTs has expanded considerably since much of the accountability mechanisms such as boards, overview and scrutiny committees and even LINKs were designed. As NHS reform has been implemented, a steadily growing proportion of the NHS budget is now allocated locally by PCTs, and the government's vision for commissioning means PCTs will take many more explicit rationing and allocation decisions, which calls for stronger accountability in all dimensions – taking into account, giving an account and holding to account. PCTs also oversee practice-based commissioning. Should a further tier of public accountability be built into this system? A recent survey has shown that 71 per cent of PCTs with active practice-based commissioning in their localities say that there is little or no public involvement in it (NHS Alliance 2006).

Second, and allied to this, is the argument that if PCTs dispose of similar amounts of public money and make decisions on a similar scale as does local government, should they not be subject to some of the democratic accountability that exists for local councils? (This is clearly a matter of concern for government since it is mentioned explicitly as a factor in the arguments for reforming PPI forums (Department of Health 2006d).)

Third, it might also be argued that an implicit anomaly arises from the findings of the routine surveys of people in local authority areas: in 82 per cent of local authorities, the public ranks health services as the first or second most important factor in making somewhere a

nice place to live (Lyons Inquiry 2006), and yet, because of the way the NHS is currently run, local people have very little direct leverage over the quality and volume of health services delivered locally.

A fourth argument concerns the precedent set by the governance arrangements of foundation trusts in the NHS system. As foundation trusts increase in number, their comparatively elaborate local public accountability arrangements will look increasingly odd when compared with the much bigger budgets and wider scope of decisions being made by PCTs. Even if there are unanswered questions about the efficacy of foundation trust governors, as foundation status is extended across the NHS, it will become increasingly anomalous that PCTs are not required to build a local membership and elect a board of governors to shape the activities of the trust.

When coupled with the evidence of indifferent performance on local accountability to date, these latter arguments tend to support the view that new accountability mechanisms need to be considered. The options for changes to local public accountability are considered next.

## Strengthening local accountability of PCTs

There is a wide array of potential arguments for strengthening the local accountability of primary care trusts (PCTs). A range of options has also been identified (see Box below). These can be divided into those that propose systemic change (that is, that fundamentally alter the governance of all PCT functions) and those that imply only incremental change (that is, they build on current governance structures and can be targeted, if desired, to some rather than all PCT functions).

### OPTIONS TO STRENGTHEN LOCAL ACCOUNTABILITY

|             |  |
|-------------|--|
| Systemic    | Direct election of PCT board by PCT residents  |
|             | Foundation PCT with membership that elects governors                                     |
|             | Cross-representation of local authority councillors on PCT boards                        |
|             | Transfer of PCT responsibilities to local authorities                                    |
| Incremental | Fully functioning patient local involvement networks (LINKs)                             |
|             | Enhanced overview and scrutiny committees and boosted responsibility of ward councillors |
|             | Health plebiscites   |
|             | Enhanced PCT intelligence functions  |

We examine the detail of each option below, and then assess them critically in Tables 1 and 2 (see pp 54–57).

## **Options for systemic change**

### ***Direct elections to the PCT board by PCT residents***

The PCT chair (and non-executive directors if desired) could be subject to direct elections. Voting for these posts could be organised separately or alongside elections for local councils, and would provide, in part at least, a direct democratic mandate and legitimacy to the PCT. To ensure that elected representatives had the appropriate skills to run a PCT, a pre-qualification assessment could be held under the aegis of the Appointments Commission. Thus candidates wishing to stand for election would first have to satisfy the Appointments Commission that they were suitably qualified (though such a stipulation is not made for elections to local councils).

### ***Foundation PCTs***

Membership of the PCT would be offered to the population of the PCT (arranged via general practice registration with an option for unregistered patients). Members would enjoy ‘social ownership’ of the PCT in a similar way to foundation hospital trusts, and would likewise elect governors to represent their interests. A council of governors would be established with a role broadly similar to that of the National Health Service (NHS) foundation trust board of governors, including:

- to advise on the strategic direction of the PCT
- to appoint and remove the chair and non-executive directors
- to confirm the appointment of the chief executive officer.

### ***Cross-representation of local authority councillors on PCT boards***

A number of options is available. The council post with the designated role within the cabinet for health could enjoy automatic membership of the PCT board, perhaps even as chair. This could go further with



the replacement of appointed non-executives by other local authority cabinet members. These arrangements would provide a formal connection between the governance of the PCT and the democratically elected local council, providing greater democratic legitimacy. However, the democratic mandate would be attenuated, as a degree of upward accountability to the Secretary of State for the performance of the PCT would remain.

### ***Transfer of health responsibilities to local authorities***

The council cabinet would exercise the powers currently within the remit of the PCT board and would integrate these with its existing responsibilities. In essence, the PCT board would be replaced by the elected local cabinet, and accountability would flow downwards to the electorate, although central government would be likely to retain powers to intervene as it does, for example, in education. The independent organisational structure of the PCT could remain unreformed or be subsumed by local authorities in their entirety.

## **Options for incremental change**

### ***Fully functioning patient LINKs***

Patient LINKs could be created as free-standing entities with leadership from a mix of voluntary sector stakeholders and leaders drawn from the population of the PCT. LINKs could provide an effective portal for NHS organisations to access a wide variety of patient and public views, but could also act as a conduit for bottom-up views on health from patients and the local public. LINKs, according to current government proposals, will also have some powers of inspection.

### ***Enhanced overview and scrutiny committees and boosted responsibility of ward councillors***

The last two options for systemic change (above) imply an executive and an increased scrutiny role for non-executive councillors. Even without such a radical reform of PCT governance, an enhanced role could be envisaged for current overview and scrutiny committees. This might involve one councillor per ward having a specific remit to investigate health and represent the views of his or her constituents. Overview and scrutiny committees would also routinely scrutinise the commissioning function of PCTs and could be provided with routine financial/performance data, alongside expertise from an independent adviser or advisers drawn from the local academic community (similar to the expert advice given to the clerks of the select committees). Non-executive councillors could take a more active interest in health and could also initiate plebiscites (see below) or calls for action, if they were sufficiently concerned about the quality of local services.

### ***Health plebiscites***

The public's view could be assessed directly on a range of issues through plebiscites. Rather than seeking to involve patients continuously or across the full range of PCT functions, plebiscites are a method of targeting involvement. For example, the acceptability of the proposed strategic commissioning plan, or the adequacy of current service performance could be tested. The areas that would be reserved for local plebiscites, which could be either binding or advisory, could be established in advance or triggered according to agreed rules, such as the gathering of a certain number of signatures or a vote in the local authority. Regulation of the framing of questions would be required. This option is similar to the proposal for calls to action outlined in the White Paper *Our Health, Our Care, Our Say* (Department of Health 2006c) but which, so far at least, has not been actioned.

### ***Enhanced PCT intelligence functions***

PCTs could be given an obligation to maintain a citizens' jury comprising people drawn at random from general practitioners' lists and reimbursed for their time, as are jurors in the legal system. This would allow a wider representation than the traditional volunteer base and the jurors could be used as lay experts to determine key rationing decisions, each jury serving for a short period of time only. Or they could follow the example set by the National Institute of Health and Clinical Excellence where a citizens' panel builds up expertise and deliberates over a period of time.

### **Assessing the various options**

Each option can be assessed for its likely efficiency in delivering a set of outcomes.

The following criteria will be used to examine the viability of each option.

- What is the likely impact if instrumental objectives are paramount?
  - Will the options deliver better, more responsive, local services?
  - Will there be enough reach into the local community to explore all user perspectives?
  - Will NHS organisations be obliged to take these views into account?
- What is the likely impact if political objectives are most important?
  - Will most or all citizens be enabled to have their say in decision-making through direct elections or other democratic vehicles?
  - Will the NHS be obliged to respond to this citizen voice?
- What is the likely cost?
  - Will the mechanism imply significant extra cost?
  - Does it represent a considerable amount of change?

The viability of the options for systemic and incremental change are assessed in Tables 1 and 2 (see pp 54–57), respectively.

## Discussion

The options for change are numerous. The critical appraisal in Tables 1 and 2 demonstrates that performance against the criteria varies – no one option meets all the criteria equally.

The current local accountability arrangements for PCTs are relatively undeveloped – PCTs remain primarily accountable upwards. However, we have found little evidence of sustained public opinion in favour of greater local accountability for PCTs. This lack of evidence should not, however, be taken as proof of the adequacy of the current arrangements.

Whether local accountability needs strengthening depends on the objectives of accountability. If an instrumental goal – improving services – is paramount, it might be argued that the current system simply requires fleshing out.

Patient and public views can be taken into account with regard to PCT priorities through newly formed LINKs. Further, locally elected councillors will soon have a more substantive role in setting strategic commissioning priorities through joint strategic needs assessments and the nascent local area agreements. These will link PCTs into a much wider set of local stakeholders, who can help to take into account a broader set of views about need. PCTs will have to publicly give an account of their shared local priorities with local government. Local strategic partnerships could evolve to become more universally effective, tying PCTs' performance firmly to local representative politics, thus enhancing the holding to account aspect.

PCTs are already held to account locally through overview and scrutiny committees, and our report suggests ways in which such arrangements could be made stronger.

**TABLE 1 SYSTEMIC STRATEGIES TO ENHANCE THE LOCAL PUBLIC ACCOUNTABILITY OF PCTS**

| Option  | Impact on instrumental objectives: better services  |
|---|---|
| <b>Direct election to board</b>                                 | <p>Likely to increase the impact of public representatives on the work of the PCT, particularly if the whole board is to be directly elected, but they may not be any better informed about local health needs than existing PCT board members or executive officers.</p> <p>In addition, elected members may lack the skills to handle the complex business of the PCT. However, a relatively long tenure of office could increase skills and experience. Some form of pre-qualification criteria could be used to improve skill-sets and/or post-election training.</p> |
| <b>Foundation PCT</b>   | <p>The impact of governors on improved services may be limited in practice as a result of lack of time and expertise.</p> <p>In theory, the larger number of governors should permit more 'reach' to different elements of the community.</p> <p>Clear roles, powers and support would be needed for the governing body if it is not to become merely a 'rubber stamp', especially given the complexity of PCT commissioning and system management roles.</p>   |
| <b>Cross-representation of councillors on PCT boards</b>        | <p>Cabinet members on the PCT board are likely to wield significant power over the broad strategy of the PCT. Cabinet members would need to develop a new knowledge base, if a positive impact on services is to be achieved.</p>   |
| <b>Transfer of health responsibilities to local authorities</b> | <p>Very significant shift in the taking into account part of accountability, with a high degree of local feel permeating PCT functions, but the impact on service responsiveness would still depend on the quality of local government public engagement strategies.</p>  |

| Impact on political objectives: legitimacy  | Cost/degree of change  |
|---|--|
| <p>This form of public accountability will be familiar to the public from local government and should prove credible, but legitimacy would be undermined by low voter turnout or if candidates were focused on single issues.</p>   | <p>There will be costs associated with direct elections, although many could be largely subsumed within the existing electoral machinery for local government (assuming alignment between electoral cycles).</p> <p>This system would save on the current costs of appointment (particularly if there were no pre-qualification criteria).</p> <p>This represents a very significant change to current accountability, and has the potential for a high degree of variability across the country. There is likely to be hostility from managerial and professional stakeholders to the potential politicisation of health, especially if political parties were allowed to field candidates.</p> |
| <p>The legitimacy of this approach as perceived by stakeholders will depend on the size of the membership (particularly relative to foundation hospital trusts). There may be competition for membership with hospitals.</p> <p>The perception of legitimacy among professionals is likely to be relatively high because of the precedent of foundation trusts.</p> | <p>There are likely to be significant financial costs associated with maintaining an active membership, as well as a time burden on the board associated with supporting and developing governors.</p> <p>In theory, this would represent significant change. In practice, the PCT board might continue much as before if membership were small and inert and the governors were unchallenging.</p>  |
| <p>This option might be seen as ‘tokenistic’ if strong lines of accountability continue to flow upwards to strategic health authorities.</p> <p>There might be conflict over strategy if different parties control the council and the national government.</p>   | <p>Minimal costs.</p> <p>Structurally only modest change.</p>  |
| <p>This could lead to perceptions of high legitimacy among citizens (subject to the local government election turnout caveat, see above).</p>   | <p>There would be minimal costs plus the potential for cost-savings on overheads as a result of greater economies of scale.</p> <p>However, there could be hostility from managerial and professional stakeholders to the potential politicisation of health.</p> <p>There is the potential for conflict between national and local government policy.</p>   |

**TABLE 2 INCREMENTAL STRATEGIES TO ENHANCE THE LOCAL PUBLIC ACCOUNTABILITY OF PCTS**

| Option   | Impact on instrumental objectives: better services  |
|--|---|
| <b>Fully functioning LINKs</b>                   | With more resources to conduct consultation and engagement, diverse communities are more likely to be included than under the current model.  |
| <b>Enhanced overview and scrutiny committees</b> | <p>Better scrutiny is theoretically possible, but is contingent on the professionalism and energy of councillors.</p> <p>Overview and scrutiny committees can boost their membership/support functions to overcome any shortcomings.</p>  |
| <b>Health plebiscites</b>                        | <p>Single-issue plebiscites are likely to result in 'lowest common denominator' participation and accountability. They are unlikely to represent the view of diverse populations.</p> <p>This option is likely to impact strongly on decision-making, but only in relation to the relatively few areas subject to plebiscite.</p> |
| <b>Enhanced PCT intelligence functions</b>       | This would involve the use of varied and effective means of understanding the views of patients and the general public.   |

| Impact on political objectives: legitimacy   | Cost/degree of change  |
|--|--|
| <p>Contingent on the degree to which LINKs actively engages a cross-section of the local community.</p>  | <p>Potentially large if a wide variety of deliberative events, citizens' juries or patient surveys were held on a regular basis. Who would pay?</p> <p>LINKs are already in place, so minimal organisational disruption.</p>   |
| <p>The legitimacy of overview and scrutiny rests on the existing democratic mandate of local government, but low voter turnout could undermine legitimacy.</p> | <p>More resources would be needed to give overview and scrutiny committees the expertise to conduct effective scrutiny of all PCT functions.</p> <p>Overview and scrutiny committees are already in place, so disruption would be minimal.</p>   |
| <p>Legitimacy will depend on voter turnout, which may be low for single health issues.</p>   | <p>This option is likely to involve significantly higher transaction costs than other forms of public accountability.</p> <p>No structural change is implied, though direct canvassing of public opinion in this way represents a significant challenge to the established governance of PCTs.</p> |
| <p>Legitimacy could be high among professional bodies if the methods of consultation and research were robust.</p>   | <p>Could be costly (eg, surveys, focus groups, etc).</p> <p>No structural change is implied, but new skills and approaches would need to be developed at PCT level.</p>  |



Lastly, PCTs will soon have to give an account to local people through the comprehensive area assessment and a new health and social care outcomes framework. PCTs will also give an account more effectively in future (in addition to the publication of board papers and strategic plans) as a result of the existing requirement to publish patient prospectuses and the new legislative duty to give an account of how they have consulted the public locally.

One might conclude, therefore, that with a will and a fair wind, PCTs are already on their way to greater local accountability. However, sceptics will point to evidence of poor public and patient engagement in the past, as an indication of the effort that might be required to engage the public in any comprehensive way in the future, especially given what we know about levels of local participation and activism.

How much NHS money should be spent on better consultation? The government's own public consultation process in developing the White Paper *Our Health, Our Care, Our Say* cost £1.39 million (Hansard 2007), and, according to the evaluation report, 'a large element' of those costs went on the logistics of bringing nearly 1,000 members of the public together for one deliberative event in Birmingham (Department of Health 2006a).

Even if all sections of the community could be reached, will PCTs really take the views of the public and local councils into account, or will they still march to the drum of the strategic health authority to which they are primarily accountable? Put another way, what will make them look out rather than up?

In the light of these concerns, a more radical approach may be required that pushes the argument beyond the instrumental, towards a more political objective – genuine local power over services. One way to make PCTs responsive to local people would be

to put representatives of those people into positions of authority within the trust. This could be done using the machinery of local government, such as the systemic options to bring elected councillors on to the PCT board, as members or as chair, or to transfer PCT functions in their entirety to local authorities.

The options for systemic change involving shared leadership between local authorities and PCTs have some historical resonance within the NHS, resembling arrangements prior to 1990 when local authorities had rights to appoint health authority members as well as some role in co-ordinating the direct delivery of services. The arguments in favour of increasing the role of local authorities in health are relatively powerful: it is a minimally expensive option (as the democratic machinery is in place), there is a degree of public legitimacy, and it does not imply the creation of parallel democratic structures.

However, passing all PCT responsibilities over to local authorities would open up old debates about the desirability of local government and locally elected politicians spending money that has not been raised locally. These concerns would be only partly palliated by arguments about precedents in other services areas – such as education, where about 80 per cent of local spending is funded through national grants – or even arguments about national devolution (the Scottish Executive disposing of funds not directly raised by that body).

This option is also unlikely to be popular in the NHS, because of the potential for local party politics to impinge on NHS business. PCTs could find themselves mired in national–local disputes if the political complexion of central and local authorities differed. They could also suffer from discontinuities of leadership due to political turbulence, or a lack of clear leadership if councils were hung.

A way round this would be to set up direct elections for PCT boards by PCT residents, as is being suggested in Scotland. A decision would have to be made formally whether to exclude political parties from these elections, which would raise important questions about how candidates should be selected and what competencies (if any) they would need to have.

Both the local government option and the direct election option would also need to consider the problem of low turnout and the related risk that there would be only limited ‘reach’ into all sections of the community, given the tendency for not everyone to vote.

How would councillors or elected PCT board members represent patients in any meaningful way? Although a democratic vote-based system would clearly create a form of legitimacy, it would not solve the problem of reach, which would be critical if PCTs intend to reduce inequalities by commissioning services for more vulnerable people, who might be less politically active or vocal.

It might, therefore, be tempting to consider alternative, more direct solutions for engaging local people. The proposals for PCT governance discussed so far mostly use only indirect means of involving the public, such as via elected representatives. Does this matter? If the overriding objective is simply to ensure that the views of patients and the public imbue the work of the PCT and that it is effectively held to account for its performance, the answer may be no. However, at least part of the government’s agenda aims to reinvigorate local communities with a sense of local *direct* control over community assets. From this perspective, elected boards or local government-dominated boards may fall prey to the same lassitude that caused government to wish to augment established local democratic structures in the first place.

Following this logic, more direct models of local accountability may be preferred, in which case the notion of a foundation PCT may appear attractive. Indeed, it can be argued that stronger local involvement and control based on membership is far more suitable for commissioners than it is for providers. Setting local health priorities seems a task well suited to local members and governors, rather more so than becoming involved in the management of a trust that they may or may not choose to use.

However, it is not clear whether PCTs will be able successfully to attract active members, as they are far less visible than hospitals. In addition, the same caveats about the representativeness of councillors (or PCT board electees) must apply to the elected governors of foundation trusts. In addition, the experience of foundation trusts to date suggests a large degree of variability in the knowledge and skill base of governors elected by members. In the case of PCTs, low membership and unfocused governing bodies would strike at their legitimacy.

One form of direct involvement that does not rely on such sustained interest would be the use of plebiscites. If carefully targeted, such an approach might generate significant public interest and engagement over key strategic issues, and more legitimacy than simple polling, although, of course, commissioners could find themselves inheriting decisions that they simply do not like.

However, these options for direct accountability involve establishing a parallel democracy, and are likely to generate potentially significant costs. Experience of foundation hospital trusts demonstrates that the creation and administration of a membership base is time-consuming and expensive.

Expenditure on public accountability structures that brought no obvious service delivery benefits would be perceived by NHS staff, if

not the public itself, as being unacceptable in terms of the health services forgone. It is not clear how much the public is willing to pay simply to feel in charge.

So, we arrive back at the need to pin down the primary objectives of greater local accountability. What is it for? Even if a service improvement goal is uppermost and an incremental approach to change is favoured, improving local accountability will be costly: systematically to take into account the views of the relevant sections of patients or the public, or to give an account of all the various budgetary and allocation decisions made by PCTs, or to support overview and scrutiny committees to spend more time holding to account their local PCTs, will require more expenditure than now.

If a more political goal is in sight to generate some legitimacy for local PCTs, it will alter the balance between upward and downward accountability in favour of the latter. It would depend on the willingness of central government to cede power – genuine power – to local areas. It is noteworthy that the consultation on directly elected boards in Scotland encourages views on what the consequences of a local, alternative power source might be for the status of national targets and standards for the NHS. Would national targets have to become legally enforceable? What would happen if a local area voted to opt out of a key government reform strategy, for example competition and the increased use of the independent sector?

Such a move would have implications for the national nature of the health service. It needs to be acknowledged that a shift in power might lead to variations in local services, possibly on a substantial scale. Could local accountability and engagement mechanisms be sufficiently robust to overcome challenges from those members of the public unwilling to accept local variations? It might also have implications for the accountability of the Secretary of State to

parliament in relation to the use of resources voted to the Department of Health. And it could potentially undermine the legitimacy of the national regulators: if local areas had genuine control over the use of resources, what would it mean for the legitimacy of rulings from the National Institute for Health and Clinical Excellence? Or the actions of a national regulator?

If significant powers to determine the nature of health service activity and accountability for performance are really delegated locally, it will need to be within a national framework that is sufficient to ensure that national accountability requirements are adequately fulfilled. This suggests that some form of regulation will be required to set parameters for local action. This could continue to be by strategic health authorities, although their relationship with PCTs would need to change significantly if local public accountability were to be meaningful rather than tokenistic.

## Conclusions

This paper has considered the scope for enhancing the local accountability of primary care trusts (PCTs). PCT accountability is currently highly centralised: with prime accountability being to the Department of Health and national regulators and auditors, rather than to local people.

However, it is by no means clear that this current situation is problematic. We have found no compelling evidence that the population seeks greater local accountability of PCTs, nor that patients and the public would necessarily engage in any reformed local accountability structures any more than they have in the past. And nor have we found any compelling evidence that outcomes are clearly better with greater rather than less public engagement. Furthermore, the criteria for an effective local accountability have not been clearly specified.

The case for enhanced local accountability, and what form that should take, depends largely on its objectives. Where local accountability is intended to deliver a political outcome (such as increased legitimacy via additional direct democratic control over the health service, or ongoing local engagement in decision-making), then a range of systemic changes to the governance of PCTs has been proposed. From past experience, solutions that rely on active engagement of greater numbers of local people run up against the difficulty of ensuring a 'representative' sample of the population. Attracting people to engage as citizens (rather than patients) in the routine business of the NHS has proved hard, despite significant efforts and investment to do so over several years. In our view, those that rely on greater links between the NHS and local authorities, such as

using elected councillors more effectively, have a greater chance of success and could be seen as more legitimate. They would, however, still be open to the charge of under-representation, particularly of the more vulnerable and less vocal users of the NHS.

Where enhanced local accountability has been motivated by a desire to improve the effectiveness of PCTs in discharging their functions (an instrumental outcome), a different conclusion might be reached. Here, we suggest that a more incremental approach might be preferred. Such an approach would apply differentially to PCT functions. For instance, citizens' juries might be more appropriate for resource allocation decisions or large deliberative events underpinned by large scale surveys for decisions about reconfiguring services. This approach could include pilots of targeted initiatives rather than impose any radical overhaul of PCT governance.

To be successful, the government must specify, more clearly than it has to date, the overall purpose of enhanced local accountability. If local 'legitimacy' is the ultimate goal, then clarity is needed about the scope of decisions over which PCTs have guaranteed autonomy so local accountability mechanisms appropriate to the scope of these decision rights can be designed. If more responsive services are the primary aim, then there needs to be greater clarity about the minimum acceptable levels of public involvement and a recognition that trusts will need to devote a larger proportion of their budgets to this task in the future.



## References

Anderson W, Florin D, Gillam S, Mountford L (2002). *Every Voice Counts*. London: King's Fund.

Arnstein S (1969). 'A ladder of citizen participation'. *Journal of the American Institute of Planners*, vol 35, no 4, pp 216–23.

Ashworth R, Skelcher, C (2005). *Meta-Evaluation of the Local Government Modernisation Agenda: Progress report on accountability in local government*. London: Office of the Deputy Prime Minister. Available at: [www.communities.gov.uk/publications/localgovernment/metaevaluation2](http://www.communities.gov.uk/publications/localgovernment/metaevaluation2) (accessed on 14 January 2008).

Audit Commission (2005). *Governing Partnerships: Bridging the accountability gap*. London: Audit Commission.

Barron K (Chair) (2007). *Patient and Public Involvement in the NHS: Third report of session 2006–07*. HC 278 (March 2007). London: House of Commons, Health Committee. Available at: [www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/278/278i.pdf](http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/278/278i.pdf) (accessed on 6 February 2008).

BBC News Online (2007). 'Reprieve on hospital closure plan'. 18 October 2007. Available at: <http://news.bbc.co.uk/1/hi/england/norfolk/7051622.stm> (accessed on 6 February 2008).

BBC News Online (2006). 'Hospital closure plan dropped'. 24 March 2006. Available at: <http://news.bbc.co.uk/1/hi/england/shropshire/4840630.stm> (accessed on 6 February 2008).

Blears H (2007). *Building On Success: A programme for the deputy leadership* [online]. Available at: [www.hazelblears.com/downloads/Hazel\\_Blears\\_Policy\\_document.pdf](http://www.hazelblears.com/downloads/Hazel_Blears_Policy_document.pdf) (accessed on 8 January 2008).

British Medical Journal (2006). 'News roundup: Derbyshire Village wins court battle'. *British Medical Journal*, vol 333, no 7566. Available at: [www.bmj.com/cgi/content/full/333/7566/461-a?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Derbyshire+United&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT](http://www.bmj.com/cgi/content/full/333/7566/461-a?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Derbyshire+United&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT) (accessed on 15 February 2008).

British Medical Journal (2005). 'News roundup: Rationing of joint replacements raises fears of further cuts'. *British Medical Journal*, vol 331, no 7528, p 1290. Available at: [www.bmj.com/cgi/content/full/331/7528/1290?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Suffolk&searchid=1&FIRSTINDEX=0&fdate=1/1/1994&tdate=2/29/2008&resourcetype=HWCIT](http://www.bmj.com/cgi/content/full/331/7528/1290?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Suffolk&searchid=1&FIRSTINDEX=0&fdate=1/1/1994&tdate=2/29/2008&resourcetype=HWCIT) (accessed on 6 February 2008).

Brown G (2008). Speech on the National Health Service, 7 January 2008. Available at: [www.number10.gov.uk/output/Page14171.asp](http://www.number10.gov.uk/output/Page14171.asp) (accessed on 3 February 2008).

Centre for Public Scrutiny (2007). *Scrutinising for Health: Health scrutiny evaluative research project*. Available at: [www.cfps.org.uk/publications/item.php?itemid=69](http://www.cfps.org.uk/publications/item.php?itemid=69) (accessed on 19 February 2008).

Centre for Public Scrutiny (2005). *Process, Progress and Making it Work*. London: Centre for Public Scrutiny.

Charles C, DeMaio S (1993). 'Lay participation in health care decision making: a conceptual framework'. *Journal of Health Politics, Policy and Law*, vol 18, no 4, pp 881–904.

Chisholm A (2007). *Patient and Public Involvement in PCT commissioning: A survey of primary care trusts*. Oxford: Picker Institute. Available at: [www.pickereurope.org/Filestore/News/PCT\\_commissioning\\_survey\\_report\\_FINAL\\_for\\_web.pdf](http://www.pickereurope.org/Filestore/News/PCT_commissioning_survey_report_FINAL_for_web.pdf) (accessed on 15 February 2008).

Commission for Health Improvement (2004). *Sharing the Learning on Patient and Public Involvement from CHI's Work. 2i Involvement to Improvement*. London: Commission for Health Improvement. Available at:

[www.healthcarecommission.org.uk/\\_db/\\_documents/04010188.pdf](http://www.healthcarecommission.org.uk/_db/_documents/04010188.pdf) (accessed on 14 January 2008).

Commission for Patient and Public Involvement in Health (2007). *Patient and Public Involvement Forums' Annual Report 2006–07 National Summary*. Birmingham: Commission for Patient and Public Involvement. Available at: [www.cppih.org/documents/PPIForumsAnnualReport-NationalSummary\\_000.pdf](http://www.cppih.org/documents/PPIForumsAnnualReport-NationalSummary_000.pdf) (accessed on 14 January 2008).

Conservative Party (2007). *NHS Autonomy and Accountability: proposals for legislation*. Available at: [www.conservatives.com/pdf/NHSAutonomyandaccountability.pdf](http://www.conservatives.com/pdf/NHSAutonomyandaccountability.pdf) (accessed on 19 February 2008).

Day P, Klein R (2005). *Governance of Foundation Trusts: Dilemmas of diversity*, p 37. London: Nuffield Trust.

Day P, Klein R (1987). *Accountabilities in Five Public Services*. London: Tavistock Publications.

Department for Communities and Local Government (2007). *Evidence of Savings, Improved Outcomes, and Good Practice Attributed to Local Area Agreements*. Available at: [www.communities.gov.uk/documents/localgovernment/pdf/381390](http://www.communities.gov.uk/documents/localgovernment/pdf/381390) (accessed on 19 February 2008).

Department for Communities and Local Government (2006). *Strong and Prosperous Communities: The Local Government White Paper*. Cm 6939. London: HMSO. Available at: (Vol 1) [www.communities.gov.uk/documents/localgovernment/pdf/152456](http://www.communities.gov.uk/documents/localgovernment/pdf/152456); (Vol 2) [www.communities.gov.uk/documents/localgovernment/pdf/154067](http://www.communities.gov.uk/documents/localgovernment/pdf/154067) (accessed on 19 February 2008).

Department of Health (2007a). 'Johnson outlines new measures to deliver more choice and faster treatment to patients'. Press release, 15 November. Available at: [www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=330913&NewsAreaID=2&NavigatedFromDepartment=True](http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=330913&NewsAreaID=2&NavigatedFromDepartment=True) (accessed on 12 December 2007).

Department of Health (2007b). 'New framework to help PCTs deliver services locally'. Press release, 5 October. Available at: [www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=320042&NewsAreaID=2&NavigatedFromDepartment=False](http://www.gnn.gov.uk/environment/fullDetail.asp?ReleaseID=320042&NewsAreaID=2&NavigatedFromDepartment=False) (accessed on 14 January 2008).

Department of Health (2007c). *Our NHS, Our Future: NHS next stage review – interim report*. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_079077](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079077) (accessed on 6 January 2008).

Department of Health (2007d). *The NHS in England: The operating framework for 2008/9. Annexe D – Principles and rules for co-operation and competition*. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081098](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098) (accessed on 14 January 2008).

Department of Health (2007e) *World Class Commissioning: Competencies*. London: Department of Health. Available at : [www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Competencies/index.htm](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Competencies/index.htm) (accessed on 8 January 2008).

Department of Health (2007f) *World Class Commissioning: Vision*. London: Department of Health. Available at: [www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Vision/index.htm](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Vision/index.htm) (accessed on 8 January 2008).

Department of Health (2006a). *Evaluation of 'Your Health, Your Care, Your Say'*. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4138622](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138622) (accessed on 14 January 2008).

Department of Health (2006b). *NHS Users: The silent majority*. Developing Patient Partnerships press release, 30 March. Available at: [www.dpp.org.uk/en/1/prthesilent.qml](http://www.dpp.org.uk/en/1/prthesilent.qml) (accessed on 19 February 2008).

Department of Health (2006c). *Our Health, Our Care, Our Say: a New direction for community services*. Cm 6737. London: The Stationery Office. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/)

PublicationsPolicyAndGuidance/DH\_4127453 (accessed on 14 January 2008).

Department of Health (2006d). *A Stronger Local Voice: A framework for creating a stronger local voice in the development of health and social care services*. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4137040](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137040) (accessed on 19 February 2008).

Department of Health (2006e). *Your Health, Your Care, Your Say: Research report*. Available at: [www.dh.gov.uk/assetRoot/04/12/74/64/04127464.pdf](http://www.dh.gov.uk/assetRoot/04/12/74/64/04127464.pdf) (accessed 6 February 2008).

Department of Health (2005a). *2006–07 and 2007–08 Primary Care Trust Initial Revenue Resource Limits*. Table 3.1. Available at: [www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/Allocations/DH\\_4104471](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Financeandplanning/Allocations/DH_4104471) (accessed on 6 February 2008).

Department of Health (2005b). *Departmental Report 2005*. Cm 6524. London: The Stationery Office. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH\\_4113725](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_4113725) (accessed on 6 February 2008).

Department of Health (2005c). *Health Reform in England: Update and next steps*. Annexe D, Commissioning for a patient-led NHS [online]. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4124723](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4124723) (accessed on 6 February 2008).

Department of Health (2005d). *Resource Allocation: Weighted capitation formula – 2005*, 5th ed. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4112065](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4112065) (accessed on 6 February 2008).

Department of Health (2004). *Getting Over the Wall: How the NHS is improving the patient's experience*. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4090841](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090841) (accessed on 6 February 2008).

Department of Health (2003a). *Governing the NHS: A guide for NHS boards*. London: Department of Health. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4082638](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4082638) (accessed on 6 February 2008).

Department of Health (2003b). *Overview and Scrutiny of Health – Guidance*. Available at: [www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH\\_4093409](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH_4093409) (accessed on 6 February 2008).

Department of Health (2003c). *Strengthening Accountability: Involving patients and the public: Policy guidance. Section 11 of the Health and Social Care Act 2001*. London: HMSO. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4008005](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008005) (accessed on 6 February 2008).

Department of Health (2002a). *Delivering the NHS Plan: Next steps on investment, next steps on reform*. Cm 5503. London: HMSO. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4005818](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005818) (accessed on 6 February 2008).

Department of Health (2002b). *The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2003: A consultation*. Available at: [www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_4016952](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4016952) (accessed on 6 February 2008).

Department of Health (2000a). *Implementation of Health Act Partnership Arrangements*. Health Service Circular 2000/010. 27 March. Available at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH\\_4004753](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004753) (accessed on 6 February 2008).

Department of Health (2000b). *The NHS Plan: A plan for investment, a plan for reform*. Cm 4818-I. London: HMSO. Available at: [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4002960](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960) (accessed on 6 February 2008).

Dixon A, Alvarez-Rosete A (2008). *Governing the NHS London: Alternatives to an independent board*. London: King's Fund. Available at: [www.kingsfund.org.uk](http://www.kingsfund.org.uk)

kingsfund.org.uk/publications/kings\_fund\_publications/governing\_the.html (accessed on 6 February 2008).

Evans O (2007). 'Bradshaw calls for action to fix primary care democratic deficit'. *Health Service Journal*. Available at: [www.hsj.co.uk/primarycare/news/bradshaw.html](http://www.hsj.co.uk/primarycare/news/bradshaw.html) (accessed on 19 February 2008).

Gorsky M (2006). *Hospital Governance and Community Involvement in Britain: Evidence from before the National Health Service*. History & Policy: paper 40. Available at: [www.historyandpolicy.org/papers/policy-paper-40.html](http://www.historyandpolicy.org/papers/policy-paper-40.html) (accessed on 14 January 2007).

Hansard (House of Commons Debates) (2007). 30 Oct 2007 col 1219W. Available at: [www.publications.parliament.uk/pa/cm200607/cmhansrd/cm071030/text/71030w0035.htm#07110121008467](http://www.publications.parliament.uk/pa/cm200607/cmhansrd/cm071030/text/71030w0035.htm#07110121008467) (accessed on 6 February 2008).

Healthcare Commission (2005). *The Healthcare Commission's Review of NHS Foundation Trusts*. London: Healthcare Commission. Available at: [www.healthcarecommission.org.uk/\\_db/\\_documents/04018494.pdf](http://www.healthcarecommission.org.uk/_db/_documents/04018494.pdf) (accessed on 6 February 2008).

Health Service Journal (2007). 'Nicholson's Operating Framework gets mixed review' [online]. Available at: [www.hsj.co.uk/Intelligence/news/2007/12/nicholson\\_s\\_operating\\_framework\\_gets\\_mixed\\_review.html](http://www.hsj.co.uk/Intelligence/news/2007/12/nicholson_s_operating_framework_gets_mixed_review.html) (accessed on 6 February 2008).

Hinchliffe D (Chair) (2003). *Patient and Public Involvement in the NHS: Seventh report of session 2002–03* HC 697 (July 2003). London: House of Commons, Health Committee. Available at: [www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/cmhealth.htm](http://www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/cmhealth.htm) (accessed on 6 February 2008).

Hudson B (1998). 'Circumstances change cases: local government and the NHS'. *Social Policy and Administration*, vol 32, no 1, pp 71–86.

Hudson B, Young R, Hardy B and Glendinning C (2002). *National Evaluation of Notifications for the Use of the Section 31, Partnership Flexibilities in the*

*Health Act 1999*. Manchester: National Primary Care Research and Development Centre. Available at: [www.npcrdc.ac.uk/PublicationDetail.cfm?ID=62](http://www.npcrdc.ac.uk/PublicationDetail.cfm?ID=62) (accessed on 12 March 2008).

King's Fund (2006). *Local Variations in NHS Spending Priorities*. Briefing paper. London: King's Fund. Available at: [www.kingsfund.org.uk/publications/briefings/local\\_variations.html](http://www.kingsfund.org.uk/publications/briefings/local_variations.html) (accessed on 15 February 2008).

Klein R (2006). *The New Politics of the NHS. From creation to reinvention*, 5th ed. Oxford: Radcliffe Publishing.

Klein R, New B (1998). *Two Cheers? Reflections on the health of NHS democracy*. London: King's Fund.

Lamb N (2007). *Empowerment, Fairness and Quality in Health Care*. Liberal Democrat policy paper. Available at: [www.libdems.org.uk/party/policy/paperlist.html](http://www.libdems.org.uk/party/policy/paperlist.html) (accessed on 6 February 2008).

Lewis R, Hinton L (2005). *Putting Health in Local Hands*. London: King's Fund. Available at: [www.kingsfund.org.uk/publications/kings\\_fund\\_publications/putting\\_health.html](http://www.kingsfund.org.uk/publications/kings_fund_publications/putting_health.html) (accessed on 6 February 2008).

Local Government and Public Involvement in Health Act 2007 (c 28) (section 221 onwards). London: The Stationery Office. Available at: [www.opsi.gov.uk/acts/acts2007/ukpga\\_20070028\\_en\\_21#pt14-pb1](http://www.opsi.gov.uk/acts/acts2007/ukpga_20070028_en_21#pt14-pb1) (accessed on 12 March 2008).

Lyons Inquiry (2006). *Lyons Inquiry into Local Government: Place-shaping: a shared ambition for the future of local government*. London: The Stationery Office. Available at: [www.webarchive.org.uk/pan/15454/20070329/www.lyonsinquiry.org.uk/docs/final-exec.pdf](http://www.webarchive.org.uk/pan/15454/20070329/www.lyonsinquiry.org.uk/docs/final-exec.pdf) (accessed on 12 March 2008).  
Milburn A (2002). Speech to UK and European health service managers on NHS Foundation Hospitals, 22 May 2002. Available at: [www.dh.gov.uk/en/News/Speeches/Speecheslist/DH\\_4000768](http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_4000768) (accessed on 6 February 2008).



Milton, Sir S (2007). *Reconnecting the citizen and the state*. Address to the LGA General Assembly, London, 12 December 2007. Available at: [www.lga.gov.uk/Documents/Sir\\_Simon\\_speechtoLGA%20General%20Assembly121207.pdf](http://www.lga.gov.uk/Documents/Sir_Simon_speechtoLGA%20General%20Assembly121207.pdf) (accessed on 11 January 2007).

MORI (2007). *Public Services Policy Review: The public view for HM Government*. London: MORI. Available at: [http://archive.cabinetoffice.gov.uk/policy\\_review/documents/ipsos\\_technical\\_report.pdf](http://archive.cabinetoffice.gov.uk/policy_review/documents/ipsos_technical_report.pdf) (accessed on 12 March 2008).

NHS Alliance (2006). *Developing Patient Partnerships: Effective practice-based commissioning: Engaging with local people*. Retford: NHS Alliance.

NHS National Centre for Involvement (2007). *Learning from the Early Adopter Programme: Interim report*. Coventry: NHS National Centre for Involvement. Available at: [www.nhscentreforinvolvement.nhs.uk/docs/EAPS%20interim%20report%20Final.pdf](http://www.nhscentreforinvolvement.nhs.uk/docs/EAPS%20interim%20report%20Final.pdf) (accessed on 12 March 2008).

Office of the Deputy Prime Minister (2005). *A Process Evaluation of the Negotiation of Pilot Local Area Agreements*. London: Office of the Deputy Prime Minister. Available at: [www.communities.gov.uk/documents/localgovernment/pdf/381276](http://www.communities.gov.uk/documents/localgovernment/pdf/381276) (accessed on 12 March 2008).

Office of the Deputy Prime Minister/Department of Transport (2006). *National Evaluation of Local Strategic Partnerships: Formative evaluation and action research programme 2002–2005*. London: Office of the Deputy Prime Minister. Available at: [www.communities.gov.uk/documents/localgovernment/pdf/143384](http://www.communities.gov.uk/documents/localgovernment/pdf/143384) (accessed on 12 March 2008).

Organisation for Economic Cooperation and Development (2005). *Modernising Government: The way forward*. Paris: OECD.

Rankin J, Allen J, Brooks R (2007). *Great Expectations: Achieving a sustainable health system*. London: Institute of Public Policy Research. Scottish Government (2008). *Consultation Document Local Healthcare Bill*. Edinburgh: The Scottish Government. Available at: [www.scotland.gov.uk/Resource/Doc/208149/0055207.pdf](http://www.scotland.gov.uk/Resource/Doc/208149/0055207.pdf) (accessed on 12 March 2008).

Skidmore P, Bound K, Lownsbrough H (2006). *Community Participation: Who benefits?* York: Joseph Rowntree Foundation. Available at: [www.jrf.org.uk/bookshop/details.asp?pubID=838](http://www.jrf.org.uk/bookshop/details.asp?pubID=838) (accessed on 12 March 2008).

Stoker G (2005). 'New localism, participation and networked community governance'. Paper presented at the UN's 6th Global Forum on Reinventing Government, Seoul, South Korea, 25 May. Available at: [www.ipeg.org.uk/papers/ngcnewloc.pdf?PHPSESSID=08ce65b1865ad9d371770327b9b20278](http://www.ipeg.org.uk/papers/ngcnewloc.pdf?PHPSESSID=08ce65b1865ad9d371770327b9b20278) (accessed on 12 March 2008).

Timmins N (2001). *The Five Giants: A Biography of the Welfare State*, 2nd ed. London: Harper Collins.