Liberating the NHS: local democratic legitimacy in health

Summary

- The White Paper aims to develop a NHS that is more responsive to local people. There are at least two broad routes to this goal: devolving power to localities to shape health services locally; and increasing consumer power through market-based mechanisms such as competition and choice. Both routes are pursued in the White Paper − this response focuses on the former.
- The need for local legitimacy and accountability in the NHS is growing as the provision of NHS-funded care becomes more diverse, as there is significant restraint on funding, and as patients at present have effectively no choice of commissioner. Even as GP Consortia develop, patients will still have limited choice of commissioner. GPs as service providers, coupled with the expansion of Foundation Trusts and the increased use of private and third sector creates local health economies with multiple competing providers. It underlines the need to have an impartial local body to 'hold the ring' and take decisions on behalf of local patients.
- It has proved very difficult in the past to achieve local legitimacy and accountability in the NHS, as strong lines of accountability reach upwards to the Secretary of State and to parliament, not locally. There have been numerous attempts over the past ten years to improve local accountability and legitimacy (for example the creation of Foundation Trust governors, Local Involvement Networks and Overview and Scrutiny Committees) but their impact overall has been questionable. (House of Commons 2009, Picker Institute 2009, Lewis and Hinton 2008).

Consultation response

31 March 2011

- 'Strong' accountability and legitimacy is needed to set mandatory standards, or to veto/reverse decisions. In relation to commissioning, this has historically been highly centralised in the NHS. If there is to be a transfer of power over NHS commissioning decisions from the centre to localities under Liberating the NHS GP consortia will have to have suitable arrangements to secure both accountability and legitimacy.
- The proposed accountability arrangements for GP commissioners currently appear to be highly centralised (upwards towards the NHS commissioning board) and the loss of a non-executive director tier (with the abolition of PCTs)risks making GP consortia even less locally accountable or legitimate than PCTs have been. The government needs to clarify its proposals for GP governance and accountability, particularly whether there will be mandatory requirements for local representation in the governance of GP consortia.
- The proposals to create Health and Well Being boards go some way towards creating a multi-stakeholder local body to help shape local commissioning decisions. However, while the proposals are clear about the importance of needs assessment, the boards lack the power to intervene in commissioning decisions for example by enforcing joint or integrated working if it seems to be in the best interest of local patients. This includes joint working between social care and health but also integration between NHS organisations.
- We welcome the proposed expansion of HealthWatch, which has the potential to enhance patient voice locally. However, there is not enough detail on how HealthWatch itself will be representative of local communities.
- If it is the government's intention to have centrally defined standards and regulation as the primary driver of local commissioning and configuration of services, then, by the same logic, they must also pass muster as 'legitimate', particularly at a local level. This would apply to decisions made by the proposed NHS Commissioning Board, the economic regulator Monitor, the Care Quality Commission. This issue is also not addressed fully in the White Paper.

1. Is the aim to enhance democratic legitimacy or accountability?

We would urge the government to be more precise in its use of language to clarify the underlying objective for these reforms. Previous reform proposals put forward by both coalition members while in opposition called for greater local accountability. This consultation calls primarily for greater local 'democratic legitimacy'. Accountability and legitimacy, although related, are not the same thing.

Accountability involves those in authority (directly or indirectly) receiving an account of the performance of a publicly funded body and exercising the power of redress when performance is poor. Democratic legitimacy usually implies that decisions are demonstrably legitimate from the perspective of citizens (implying suitable consultation and, if appropriate, popular endorsement of policies) or that decisions have followed some democratic process in their making. Strong accountability might enhance legitimacy, but democratic legitimacy does not equate to the precise functions needed for effective accountability for public services.

2. Where should legitimacy and accountability be exercised?

The need for both accountability and legitimacy in publicly funded health care is important. Raising taxes from the public requires it; so does the rationing that accompanies the disposition of these scarce resources at many levels of the system. Ideally mechanisms for accountability and legitimacy related to a population should be built into a system at the level at which autonomous decisions about that population are taken.

Traditionally, lines of accountability in the NHS have been upwards to the centre (with the exception of Foundation Trusts), while democratic legitimacy has been pursued at a national level, with the NHS a critical battleground in general elections. This centralised form of accountability and legitimacy reflects the centralised nature of tax funding and control of the NHS, as power has been concentrated in the hands of ministers.

This government, like its predecessor, has recognised that a centrally driven NHS cannot be fully responsive to local needs. The previous government attempted to redress this through greater consumer choice and enhanced 'voice', particularly for NHS trusts and Foundation Trusts. While in opposition, both coalition parties drew attention to the weakness of local public involvement with commissioning, with no opportunity for local people to choose their commissioner, or challenge or participate in decisions in how the NHS budget was spent on their behalf.

We think that the proposals in the White Paper *Liberating the NHS: Equity and Excellence*, with its vision of devolved commissioning via GP consortia and central NHS Commissioning Board so far fail to resolve this deficit. The consultation paper states that the national NHS Commissioning Board will hold the consortia to account and strongly implies that accountability for commissioning stays at a national level.

Does this mean that there is to be no further development of accountability or local control over commissioning at a local level? Our observation of the proposed reforms set out in this consultation paper, including Health and Well Being Boards and HealthWatch, is that no local body appears to hold any power of accountability (to scrutinise *and* potentially intervene) over the decisions being made by GP consortia.

From a legitimacy perspective, the locally elected councillors will have 'influence' over GP consortia but no meaningful control over their commissioning decisions. The abolition of PCTs will also mean the removal of a tier of non-executive directors, some of whom, as members of the local community, were a form of concentrated local accountability.

We would urge the government therefore to develop their ideas on GP consortia governance and clarify the role of local public and patients within those governance structures. This is in addition to any duties imposed on consortia to involve patients and the public in their work. The experience of PCT involvement with patients and the public suggests that resources and support will be needed in order for GP consortia to fulfil these duties effectively.

3. Are national commissioning standards and regulation also sufficiently accountable and legitimate?

This absence of local power may be appropriate if the centre plans to closely control the commissioning decisions of consortia. But, if GP consortia really will be taking autonomous decisions about resources in essence rationing decisions - with very little oversight or management from the centre, then local accountability and legitimacy will need to be strengthened. The consultation document is ambiguous on this point: it argues that decision making will be pushed "much closer to patients" at the same time as emphasising the pivotal role of the national NHS Commissioning Board in setting standards and performance managing consortia against those standards.

There is a risk of inadequate accountability and legitimacy at either national or local level. If control and accountability over commissioners is intended to be exercised at a national level, it raises a further question about the legitimacy and accountability of the NHS Commissioning Board itself, as well as the decisions made by the economic regulator, Monitor. What arrangements will be put in place to ensure accountability of both bodies to parliament and the wider public? There may be lessons from the example of the National Institute for Health and Clinical Excellence (NICE) which has used a citizen's council since its inception to help inform decision making.

4. Local Health and Wellbeing Boards

We support the greater role being envisaged for local government and elected councillors, particularly in relation to their involvement in local health and wellbeing boards. The strategic needs assessment is a key function that has been recognised in these proposals. However, it is important that these boards are able to ensure that those needs are being met by GP consortia and local providers of care. Both these functions require the collection and analysis of large amounts of data, and it is questionable whether local government will be able to do this under future budgetary constraints.

As mentioned above, we would encourage the government to clarify what degree of control the boards have in relation to GP consortia and commissioning decisions. In the proposals, the health and wellbeing boards are described as having "influence"[para 31] over commissioning decisions. Local scrutiny will be particularly important if consortia inherit the sort of rationing decisions currently being carried out by PCTs, for example whether to fund certain drugs that do not have NICE approval or the provision of services as in vitro fertilisation (IVF). The alternative is for GP consortia themselves to

have greater public involvement in their governance structures and to have clear requirements to consult and involve local people in their decisions.

We welcome the prospect of a proposed statutory duty for GP consortia to "act in partnership" with local partners. Under the totality of reforms being proposed in *Liberating the NHS*, the creation of more autonomous and diverse providers (including primary care services via GP consortia), underlines the importance of a local body to monitor the configuration and quality of local services.

We endorse the proposal that the board has a role in ensuring integrated services. We would go further than the current definition of integration of health and social care to include integration between NHS providers where appropriate.

We would urge the government to recognise the complexity of assessing whether services are, or should be, integrated. It will require, alongside needs assessment, a sophisticated use of linked health and social care data sets (Ham 2009) and imaginative approaches to measuring patient experiences as they move between providers. It will also require coordination with the evolving rules on the regulation of competition, particularly where vertical integration (between primary and secondary care in particular) is concerned (Ham and Smith 2010). Development of networks of clinicians crossing both primary and secondary care offers the prospect of significant gains in efficiency and quality of care: this is particularly important for the care of older people, people with long term conditions, and those requiring preventive, supportive, rehabilitative and palliative care that cross organisational boundaries (Ham 2009).

5. Overview and Scrutiny Committees

While there is a potential overlap between the work of the proposed Health and Wellbeing Boards and the existing overview and scrutiny committees, it may not be desirable to fully subsume the functions of the overview committees into the Health and Wellbeing Boards. The Health and Wellbeing Boards will be shaping services through their joint decisions and therefore need to be subject to some sort of local external scrutiny about the quality of their own decision making.

6. HealthWatch

If HealthWatch is to play a pivotal role in delivering greater democratic legitimacy, outlined in these proposals, it needs to have some guidance about the processes through which it can claim to be genuinely representative of local patients, or it risks bringing a potentially skewed local picture of patient needs and preferences. This is particularly important if HealthWatch is included on the Health and Wellbeing Boards as vehicle for patients offer 'scrutiny and patient voice' [para 44]. Local authorities need to be able to monitor and enforce this.

The expansion of HealthWatch duties to include complaints advocacy and acting as a local signposting body for patients potentially brings greater clarity for local people about a single source of information and help relating to the NHS, but the government must recognise the need for adequate resources if this is to be done effectively and be available to all patients, particularly those who are at risk of exclusion because of age or disability.

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