



‘In principle, we can see no reason why most aspects of local health and policing should not become the responsibility of local government.’

Extract from the House of Commons Communities and Local Government Committee Report - The Balance of Power: Central and Local Government (Pages 30 - 36)

The delivery of local police, health and healthcare services: the role of local government

67. During the course of our inquiry, we asked whether local government’s role and influence needed to be strengthened in relation to local policing and health services. The answer from local government, and local government think-tanks, was “yes”. Sir Richard Leese, told us that “we can scrutinise, so we can call in people from the PCT and ask them what they are doing and say ‘that is not very good’, et cetera. What we cannot do is then effectively say, ‘No, you are going to have to change what you are doing because you are not meeting the objectives for, in our case, Manchester.” Birmingham, Gateshead and Kent similarly pressed for the ability to direct the local delivery of primary healthcare. With regard to local policing, Westminster was adamant that there was an accountability gap with regard to local policing, “a pretty disconnected picture” even though “they have come a long way in the Met.” Camden highlighted instances where the council and police were working to competing targets, such as entrance into the youth justice system where “our target is to get it down and the police’s target is to get it up.”

68. Similarly, the think tanks Local Government information Unit (LGiU) and New Local Government Network (NLGN) argued that both the police and primary care trusts (PCTs) are insufficiently accountable to local people, the LGiU stating in its written evidence that: ‘In practice, services such as police and PCTs are primarily accountable to Whitehall; this lack of direct accountability has an immediate impact on the ability of these services to respond to local priorities and meet local concerns. In oral evidence, Andy Sawford, Chief Executive of the LGiU, further observed that in polls they had commissioned “both the public and councillors feel that there should be stronger accountability at a local level

around policing and healthcare. Policing comes out as the number one issue that people want a say over in their community, and one where there is least opportunity for them to do it.”

69. There was a similar amount of consensus as regards how to improve the situation, with a number of different local government and think-tank witnesses advocating a model where local authorities would commission local health and policing services from the local NHS or police authority. For example, in oral evidence Cllr Merrick Cockell, Chair of the local authority representative body London Councils, explained that: We think the way ahead is for commissioning to be carried out along with the budget for level one policing, particularly neighbourhood policing, in other words to be joined to the budget that local authorities spend, which is often quite substantial these days, pool those together and then for the local authority to commission the borough commander to deliver level one policing in our area. He also confirmed that “the same would apply to health. Certainly the London Councils model is that it would apply to PCTs, that we would be the commissioners for local health services in our area.” Andy Sawford observed at the same oral evidence session that “we developed a similar model. [...] commissioning is the key and how you use local commissioning, what an opportunity that presents. It is the key to innovating, to getting people involved.” In written evidence, the Association of North East Councils felt that a commissioning model “under which the local authority would hold the budget for, and be responsible for the commissioning of, local health and policing services” would “be a bold innovation but it would take us a long way forward in securing democratic accountability”, and suggested that the model be trialled “in the first instance in a few authorities.”

70. Advocates of the commissioning model recognised that its implementation would be challenging, not least because local authority boundaries did not always match local health and policing boundaries. They felt though that, given the potential benefits for local service delivery and local democracy, any obstacles could and should be overcome. With regard to the boundaries issue, it was suggested that local authorities working in partnership, possibly within a Multiple Area Agreement (MAA), would offer a potential solution. Cllr Merrick Cockell observed that: we would from our own free choice agree to form groupings to do it [commissioning]. It may not be necessary or ideal to have 33 of everything in the case of London. There may be very good reasons, again without changing the structure of local government, to ally together with neighbours or others to achieve certain things better. Anna Turley similarly emphasised the need to “think about the appropriate level for all the kinds of services we deliver”, and felt “really encouraged” by the multi-area agreement process.

71. Finally, advocates of the commissioning model stressed its advantages over an alternative model whereby commissioners of local health or policing services would be directly elected by the local people. At the time of our inquiry, this model was being floated in a Home Office policing

Green Paper, From the neighbourhood to the national: policing our communities together. Published in July 2008, it proposed the establishment of locally elected Crime and Policing representatives (CPRs), who would be responsible for ensuring that the police were tackling the priorities that concerned local people most. Our local government and think-tank witnesses were more or less unanimous in arguing that such a model would actually undermine local democracy. The LGiU, in its written evidence, was clear that the model as articulated in the Green Paper “has the potential to undermine the progress in joined up government that have been made within local strategic partnerships.” The LGA, in its published response to the Green Paper, argued that directly elected crime and policing representatives would: undermine partnership working between police and councils make it more difficult for local people to decide who is responsible for reducing local crime and anti-social behaviour—in effect councils would no longer have a significant role in holding the police to account. waste scarce resources and create substantial new financial and administrative burdens for police authorities. have no more flexibility to address local crime priorities than police authorities currently do. remove a significant amount of local spending from local authority influence. Similarly, in oral evidence Anna Turley felt that the principle of a local say in local policing was not best served by “the creation of a new elected representative on an authority which most people have very little awareness of, and which perhaps not only duplicates some of the role of the local authority but may start to fragment policing from the wider place shaping agenda.” Lancashire County Council observed that “recent suggestions that policing or health should adopt separate democratic mechanisms to ensure public accountability are misguided,” adding “In addition to creating wasteful taxpayer expense, directly-elected health or police boards could confuse voters, especially in three-tier areas like Lancashire.” It is clear from the above that it is not just the specific Green Paper example that the local government family is opposed to; it is opposed in principle to directly elected policing and health representatives because they believe they would undermine local government and hence local democracy.

72. We put the local government case for increasing their powers over local policing and health to the Home Office and the Department of Health, and were struck by the extent to which they were opposed to it. Local councillors do currently serve on Crime and Disorder Reduction Partnerships (CDRPs) and on police authorities (commonly 9 out of 17 members of a police authority are councillors). They do, therefore, have input into local policing priorities. They are not, however, the leading voice, lacking as they do control over local policing resources. As well as the contentious CPRs proposal discussed above, which the Government has since announced it will not proceed with at this time, the Policing Green Paper also advocates more partnership working, bringing together local policing with the broad range of local services—provided by local councils, housing associations and others—that contribute to community safety. Whilst it sees a leading role for local government in crime prevention as part of its wider responsibility to support communities, this is still some distance from the leading role in many aspects of local policing advocated

by many of our local government witnesses. It was therefore unsurprising that the Minister of State (Policing, Crime and Security), Mr Vernon Coaker appeared somewhat taken aback when we asked for his response to the proposal that neighbourhood policing should move to local authorities, who would become commissioners for these police services, responding: I do not know about local councils controlling the police but certainly what we would want to see is the strengthening of the partnerships that already exist. He appeared more comfortable envisaging local authorities in purely supportive crime prevention roles, observing that:

we see the involvement of local authorities in a crime reduction role, a role which includes all the various aspects that lead to communities feeling safer and indeed tackling crime. This is particularly important if you look at local councils in terms of what they do with respect to graffiti, with respect to litter, with respect to lighting, with respect to council housing. All of those matters are fundamental to the importance of delivering safer communities, but on their own are not necessarily connected strictly with policing. Later on in the evidence session, he commented that “I think local councillors, local authorities, have a very real role to play through the CDRPs with respect to the broad community safety agenda, of which policing is a part.”

73. The implication of his comments, we felt, was that most aspects of local policing needed to remain firmly under the control of the Home Office and the police themselves, that local policing ultimately needed to be left to the professionals—albeit with the proviso that the professionals were willing to negotiate local priorities under the Local Area Agreement process. The difference—subtle, but profound—is that whereas under current arrangements the professionals have the whip hand at the negotiating table, were local government to have commissioning powers, the balance of power would move substantially in their favour.

74. Under current arrangements, local authorities have even less influence over local health priorities than they do over local policing. Whereas councillors are at least guaranteed a place on policing authorities and DRPs, they have no equivalent automatic right as councillors to sit on the local NHS equivalent structure, the Primary Care Trust (PCT). Under the terms of the Health and Social Care Act 2012, local authorities have the power to scrutinise local health services, and local NHS bodies are required to co-operate with local authorities. However, this still places local authorities at some distance from the decision-making process for the delivery of local health needs and health care services. The Department of Health and CLG published a joint document in December 2012—*Delivering health and well-being in partnership: the crucial role of the new local performance framework*—which did place further emphasis on PCTs working in partnership with local authorities to determine the health and well-being needs of the local community, and reflect them in the LAA. In some areas, local authorities and PCTs have agreed locally to pool budgets and commission some health services jointly. However, PCTs have a range of priorities to meet, and local government witnesses have suggested that

in the main the NHS remains likely to prioritise national targets over locally agreed targets.

75. Our oral evidence session with the Under Secretary of State (Health Services), Ann Keen MP certainly provided evidence of the ‘centre over local’ attitude of the Department of Health. We asked whether there were any circumstances where the Department of Health would be willing to drop national targets in favour of other locally-set priorities, and were told very firmly “no”. Whilst the Under Secretary was quite prepared to encourage greater local consultation by the PCT, and to support scrutiny of the PCT by the local authority, she saw no need for any more fundamental change, arguing that “the NHS does not need further reorganisation. It needs a period of stability [...]”. When we suggested that replacing the current members of the PCT with elected councillors would not require a change of structure or organisation, she argued that “people want Parliament to be accountable for the health spending of their local area”, echoing one of the key challenges to changing the balance of power between central and local government (public perceptions) that we identified earlier in this report. This does however lead to a situation where the centre becomes accountable for every local health decision, which is not a comfortable position for a Minister to be in. When put under pressure, such centralism cannot hold. Unsurprisingly, the Minister shied away from the implications of her stance, asserting that “people have to take that responsibility locally as well.” When pressed on how an appointed PCT could in practice be held accountable locally, she had to accept that the main line of accountability actually led to the Chief Executive of the NHS.

76. Jo Webber, Deputy Director of the senior managers’ representative body the NHS Confederation, provided a further glimpse of the NHS’s centralist mentality, which is clearly not limited to Whitehall. We asked whether she would feel comfortable with a model where local councillors had the responsibility to commission health services at local level instead of the current arrangements through PCTs. She replied that “what we would be comfortable with is, to a certain extent, what we have already.”⁹⁹ She did see further opportunities for joint commissioning at the preventative end of the health spectrum, but argued that “maybe local authorities might not want to get involved in commissioning very specialist, heavy end, regional or national specialty services”,¹⁰⁰ and did not accept the arguments in favour of sole commissioning by local authorities. We were left with the impression that, as with the Home Office and police, the Department of Health and the NHS felt that, ultimately, the professionals knew best and should be left to make the most important local health decisions.

77. We are concerned that neither the Home Office nor the Department of Health, on the evidence put before us, are ready to allow local authorities a real role in local policing and health and healthcare services. Despite recent changes that have brought in greater transparency and more consultation,

the balance of power remains very firmly in favour of Ministers and the policing and health professionals over locally elected politicians. Whilst we acknowledge that there is much useful joined-up working going on in some aspects of local policing and health services, involving some joint commissioning, it is by no means sufficient to alter the overall balance of power. The picture is particularly stark with regard to the NHS, where it is not even standard practice for local councillors to sit on PCT Boards. Moreover, hospitals, particularly where they have Foundation Trust status, also remain powerful brokers whose Boards have no requirement to include local authority representation. Our concern is twofold. First, local policing and health care services remain insufficiently accountable to their local populations. If local councils commissioned these local services, local accountability through the ballot box would be much stronger. Second, at present, local councils are unable fully to assimilate local policing and health and healthcare services into their strategic vision for the locality. So long as two such important local services—arguably the most important for most local people—remain outside its scope, the full benefits of an empowered, autonomous local government cannot be realised.

78. On balance, we are convinced by the local government case of the potential for local people to benefit if local authorities were able to set local priorities for local policing and health matters. In principle, we can see no reason why most aspects of local health and policing should not become the responsibility of local government. We can see merit in local authorities or sub-regional partnerships taking on sole responsibility for many local health commissioning priorities and, via sub-regional partnerships, for many local policing priorities. We recommend, therefore, that the Department of Health and Home Office work with CLG to establish a local authority commissioning model for local policing and health and health care. As a first step, we recommend bringing forward pilot projects in localities where there are matching boundaries and where some joint commissioning already takes place.

Extract compiled June 2009