

School of Public Policy

Health Services Management Centre

**Adult care joint-ventures:
Aspirations, challenges and options**

A report prepared for the Integrated Care Network

by

Dr Tim Freeman
Professor Edward Peck

In collaboration with members of the health and social care communities
of Barnsley, Milton Keynes Portsmouth and Wolverhampton

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HSMC
University of Birmingham
40 Edgbaston Park Road
Birmingham B15 2RT

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1) Executive summary

Background

This report concludes the second stage of a commission from HSMC at the University of Birmingham by four local health and social care communities – Portsmouth, Wolverhampton, Barnsley and Milton Keynes – and the ICN. During 2006, two workshops were held to inform the further development of these communities' plans for the commissioning and provision of adult care services, by providing a community of interest in which aspirations, challenges and emerging solutions may be exchanged and explored. This report, prepared for the Integrated Care Network (ICN) captures transferable learning from those workshops for the broader community of interest.

Report structure

The report outlines and considers the possibilities for adult care provision raised by recent developments in:

- partnership working and contestability in service provision;
- commissioning and procurement of health care services; and
- new localism, or the ability of local government to take responsibility for the well-being of an area and the people who live there and to promote their interests and their future.

While the national policy contexts of service provision, commissioning and local jurisdiction remain the same regardless of locale, the history of partnership working and service aspirations within any given area will be unique, with implications for strategic choices. For example, the desire to avoid divestment of services to a 'rival' provider agency with a broader geographical focus is likely to manifest as an aspiration for integrated local health and social care provision. Similarly, the desire to position provision so that it is consistent with both contestability and integration will manifest in an aspiration to explore alternative (plural) provider models.

PCTs and Local Authorities (LAs) may respond to the policy context in a number of ways. They may seek to develop joint structures for health and social care services in commissioning and / or provision, and additionally consider criteria important in shaping local provider markets (commissioning), appraising potential providers (procurement) and assessing the strengths and weakness associated with different types of providers.

Regardless of their response, a central concern of Primary Care Trusts (PCTs) and Local Authorities (LAs) is the ability to assert their legitimacy to make decisions over local service provision – in other words, the claim

to jurisdiction. This report raises the possibility of PCTs and LAs positioning themselves as the guarantors of services appropriate for their local communities (potentially against the demands of central government agencies) through 'place-shaping'. We additionally present a conceptual framework for provision, consider a range of single provider models including care trusts and ALMOs, outline a range of social enterprise legal forms, and present criteria that may be considered in attempts to shape local provider markets and appraise rival options during procurement.

Policy context

UK health care policy documents have sought to establish the benefits of a mixed economy of autonomous service providers in increasing efficiency and responsiveness to patient need; *Commissioning a patient-led NHS* (2005) constituting the high water mark of this approach. *Health reform in England: update and next steps* (2005) emphasised continued supply-side reforms ensuring diverse provider organisations while softening the prescription that all PCTs should cease direct provision of services by 2008. This sparked considerable debate in the academic community over the extent to which the current reforms will be pursued in primary and community care and a number of possibilities are plausible, ranging from markets in both commissioning and provision (with light tough regulation to ensure essential 'core' services) to a differentiated strategy in which contestability is pursued in some sectors (elective care) while partnership and planning are pursued in others (such as primary care and mental health).

The situation became clearer on publication of the awaited White Paper on out of hospital care - *Our health, our care, our Say* (2006) - which incorporated proposals for adult social care where there is the potential for further extension of consumer choice through individualised budgets in the context of an existing market (with around 25,000 providers) underpinned by the regime of Best Value. The subsequent health commissioning guidance issued by the DH in July 2006, together with the Joint Commissioning Framework for Health and Wellbeing expected in early 2007, focuses attention of effective service commissioning as a vehicle for service delivery and improvement. Commissioners specify services required based on needs assessment and a vision for local provision; they may then either directly provide or seek to procure such services, judging options against transparent criteria. Despite policy aspirations for divestment and plurality of provision, local markets for provision of services (vertical supply chains) will be strongly influenced by: the market interests and behaviours of commissioners and their suppliers; the nature of existing relationships between providers; and their future ambitions. It is in this context that possible provider models need to be considered.

While commissioning and diversity of provision have held the attention of health care managers, rather less attention has been paid to contemporary trends in governance, particularly developments associated with the new localism, comprising the development of place identity, participation and community and collaborative partnerships. The Lyons Review promises further dispersal of accountabilities from central to local government, and in this context it is likely that PCTs and LAs may seek to act symbiotically, so that LAs are in a better position to place-shape and PCTs gain enhanced legitimacy and community engagement. Possible institutional reforms include: taking NHS commissioning into local government; bringing direct accountability into local organisations via elections to NHS bodies; or developing a new locally-accountable commissioning body (Glasby *et al* 2006) – or combinations of joint-ventures and robust commissioning criteria. The Local Government White Paper, *Strong and prosperous communities* (2006) outlines an intention to legislate for new statutory partnerships for health and well-being and strengthens the role of Local Area Agreements (LAAs) by making them central to the performance framework - under the new regime, LAAs become the framework for reaching agreement between local partners and central government on priorities, the site for striking a balance between national priorities and local flexibility to respond to local circumstance (Lorimer 2006).

In this context, the anticipated Joint Commissioning Framework for Health and Wellbeing may be seen as strengthening the link between commissioning and governance strands.

Providers: public; private and third sector

While UK health care provision remains predominantly public, significant pockets of private provision are discernable, and provider options include myriad forms of third-sector (not-for-profit) agencies and hybrids. This sector is receiving much support and encouragement from the DTI and DH, and provides a number of potential benefits in addition to the political advantages to the current government of offering contestability without expanding private provision. While it would be naive to consider social enterprise as a panacea, it offers considerable potential advantages, including: meeting currently unmet needs occasioned by undifferentiated public provision; enhanced (direct) user involvement in service development; and innovative approaches to service delivery.

Single providers

These are a particular partnership form in which multiple organisations set up an arms-length structure in order to pursue a common endeavour, remaining accountable to parent organisations through shared governance arrangements. Examples include:

- Horizontal integration (children's trusts / care trusts);
- ALMOs; and

- Community Foundation Trusts

Social enterprise legal forms

Stimulated by publication of *Creating a patient-led NHS* (2005), a wide range of alternatives for service provision may be discerned. While a concerned service reaction subsequently led to a more accommodating public stance from the DH, the general direction of travel remains towards plurality of provision, underpinned by a strengthening of commissioning, contracting and performance management. A diverse range of legal forms of social enterprise are available, and it is important that form follows function. These include as follows:

- Incorporated forms are suitable for primary care services provision, given the limited liability of members
- Companies limited by guarantee are relatively simple structures with transparent accountability arrangements
- Community Interest Companies (CICs) are specifically designed for the pursuit of community benefits and additionally provide the assurance of an 'asset lock' which debars future reversion to for-profit status
- Similar to co-operatives, Community Benefit Societies (BenComms) distribute profits to the wider community and are run by members (one member, one vote), ensuring democratic community involvement, with the option of an asset lock, and finally
- Charitable Incorporated Organisations (CIOs) receive the tax benefits of charitable status with the limited liability benefits of incorporation, and are the first 'off-the-peg' corporate structure specifically designed for charities.

Far from being mutually exclusive, many of these approaches may be combined in hybrid arrangements, developing a wide variety of local services in response to patient need.

Commissioning

Commissioning is perhaps best viewed as a heterogeneous function containing multiple elements:

- Assessing and articulating need;
- Defining service standards and specifications ('service plans'); and
- Procuring, contract setting and monitoring, in which the requirements of commissioners detailed in the above plans are negotiated with providers

Given the likelihood of market consolidation and possible DH interventions over time, commissioners may seek initially to apply criteria or to craft

local provider markets that weight particular elements (acceptability, collaboration, patient focus) in order to shape the application of subsequent procurement criteria. Such criteria are likely to reflect characteristics of effective commissioning to improve health and wellbeing contained within the Joint Commissioning Framework – trailed in the Commissioning Framework (2006) as whole-systems approaches to service transformation, improving preventive and early intervention services, and promoting equity.

Considering options

The report concludes that, ultimately, the choice of the appropriate provider option(s) requires careful judgement and political skill at a local level. While there is no advantage to be conferred by simply transferring service providers for the sake of it, where services are considered sub-optimal contestability may provide opportunities for alternatives. Of course, as in any market, it may be that the future shape of provision is driven as much by the entrepreneurial ambitions of providers (including current NHS staff) as by the strategic planning of commissioners. Clear statements of general aims and principles, requirements from providers and evaluation criteria are required. Commissioners clearly need to understand the provider options that are likely to emerge and their known strengths and weaknesses. In this regard, careful commissioning and procurement criteria may prove vitally important in shaping provision while avoiding legal challenge. The 'developing practice case studies' detailed in CSIP's Commissioning eBook may be of help in illustrating these issues. Further information available from:

www.cat.csip.org.uk/commissioningebook

2. Background

This report concludes the second stage of a commission from HSMC at the University of Birmingham by four local health and social care communities – Portsmouth, Wolverhampton, Barnsley and Milton Keynes – and the ICN. During 2006, two workshops were held to inform the further development of these communities' plans for the commissioning and provision of adult care services, by providing a community of interest in which aspirations, challenges and emerging solutions may be exchanged and explored. This report, prepared for the Integrated Care Network (ICN), captures transferable learning from those workshops for the broader community of interest.

3. Report structure

The report outlines, and considers the possibilities raised by, recent developments in three policy arenas: partnership working & contestability in service provision, commissioning and procurement, and new localism. The balance of forces shaping joint-ventures is dynamic, comprising combinations of the legacy of the past (existing institutional forms and relationships); forces of the present (broader policy contexts); and the shadow of the future (aspirations of participants in the context of available models).

While the national policy contexts of service provision, commissioning and local jurisdiction remain the same regardless of locale, the history of partnership working and service aspirations within any given area will be unique, with implications for strategic choices. For example, the desire to avoid divestment of services to a rival provider agency with a broader geographical focus is likely to manifest as an aspiration for integrated local health and social care provision. Similarly, the desire to position provision so that it is consistent with both contestability and integration will manifest in as an aspiration to explore alternative (plural) provider models. PCTs and Local Authorities (LAs) may respond to the policy context by seeking to develop joint structures for health and social care services in commissioning and / or provision, by considering criteria important in shaping local provider markets (commissioning), appraising potential providers (procurement), and the strengths and weakness associated with different types of providers in combinations suited to particular local contours.

Regardless of their response, a central concern of Primary Care Trusts (PCTs) and Local Authorities (LAs) is the ability to assert their legitimacy to make decisions over local service provision – in other words, the claim to jurisdiction. The report:

- raises the possibility of PCTs and LAs positioning themselves as the guarantors of services appropriate for their local communities against the demands of central government agencies through 'place-shaping';
- presents a conceptual framework for provision, consider a range of single provider models including care trusts and Arm's Length Management Organisations;
- outlines a range of social enterprise legal forms for providers that may be contracted under Alternative provider of medical services (APMS) / Specialist Personal Medical Services (SPMS) arrangements; and
- presents criteria that may be considered in shaping local provider markets and appraising rival options during procurement.

4. The policy context: provision, commissioning & local jurisdiction

While this paper concerns possible joint-ventures between health and social care, it makes little sense to consider options without attending to wider policy contexts. Of particular importance are policy developments in plurality and collaboration in service provision; the extended role of commissioning and procurement; and trends in local governance. While local governance has typically received far less of managers' attention than the other two, particularly in health care, a successful claim to jurisdiction – the assertion of the right to make such decisions, in the face of opposition (actual or potential) from national government agencies – is a crucial factor in the ability of local agencies to shape service provision in a manner that they consider to be consistent with local need. These policy contexts are considered in turn.

(a) Provision

The medium-term strategic objectives for the NHS as identified in the NHS Plan (2000) have been further elaborated and developed in a range of subsequent DH publications, including *Delivering the NHS Plan* (2002), *the NHS Improvement Plan* (2004), *Creating a Patient-Led NHS* (2005), *Commissioning a Patient Led NHS* (2005) and *Our Health, Our Care, Our Say* (2006), and these more recent reforms have potentially wide-ranging implications for both commissioning and provision (box 1).

Arguably the most significant policy developments relate to encouragement of a mixed economy of autonomous providers, a commitment to which *Health reform in England: update and next steps* (DH 2005c) provided continued support. On this characterisation, the NHS is in a state of transition from public monopoly insurer and provider to being an insurer with devolved commissioners buying services from a

mixed market of providers (Lewis & Dixon 2005), with economic regulation to remedy market failure (DH 2005c). The reforms are intended to improve access and increase efficiency through rival providers (competition), or the fear of market entry by alternative providers (contestability).

Yet, it should be noted that there has been considerable debate over the extent to which the current reforms will be pursued and a number of outcomes are possible reflecting political and practical exigencies. At one extreme, they may lead to a market in both provision and commissioning with light-touch regulation to ensure competitive practices and safeguard essential 'core' services. Alternatively, a more tightly regulated market with incentives for inter-organisational collaboration and regulatory activity focused on service quality improvement might emerge. On a third scenario, a differentiated strategy, in which contestability is pursued in certain sectors (e.g. elective care) while collaboration and planning are pursued in others (e.g. primary care; mental health), is conceivable.

Box 1: Elements of the current NHS reform agenda

Payment by results (PbR)

More properly payment by activity, PbR involves a move away from block contract funding to charging for work undertaken according to national tariffs based on average costs. It creates strong incentives for acute providers to increase efficiency and activity, and in doing so may give rise to 'winner' and 'loser' trusts with risk of financial failure..

Plurality of provision

The provision of multiple, competing providers is designed to provide incentives to increase the quality of patient experience.

Patient choice

Allows patients to choose from a range of service providers, and provides incentives for providers to improve patient experience. Critics are concerned that patients' capacity for exercising choice may vary, raising fears of reduced equity.

Practice-based commissioning

Designed to strengthen commissioning, and likely to combine devolution of some commissioning functions to practices and groups of practices and centralisation of activities such as contract management arrangements to regional levels, either private sector or PCT clusters. The degree of interest by practices is currently highly variable.

While much attention has been focused on the increased use of quasi-market incentive systems such as Payment by Results (PbR) and plurality of provision, recent policy also contains countervailing messages for collaboration and integration between providers and sectors within elements of care provision. For example: *Choosing Health* reiterates the

need for effective partnerships between sectors, communities and organisations; *Supporting people with long term conditions: Improving care, improving lives* (2005) emphasises a need for local engagement in service redesign; the DH continues to promote the integration of health, targeted educational and social care services for children in Children's Trusts under Local Authority Chief Officers; the recent Green Paper on social care *Independence, well-being and choice* (2005) sets out a vision of integration between health, social care, voluntary and independent sectors in planning services to meet diverse needs; and the White Paper *Our Health, Our care, Our Say* (2006) promotes greater joint commissioning between health and social care. It is clear that, as currently constituted, the rhetoric of patient choice contains shades of both economic individualism (competition) and communitarian endeavour (partnership) in tension.

The extension of choice and contestability from elective care and its full incorporation into primary and community services would lead to PCTs becoming primarily commissioning-led organisations, charged with managing an emergent more or less genuine market. This is the clear intention of *Commissioning a patient-led NHS* [CPLNHS] (2005). Yet, while Minister of State for Health's annual health and social care lecture (2005) outlined the importance of plurality in care provision, there was also an emphasis on the need for planning and co-operation. The White Paper *Our Health, Our care, Our Say* (2006) addresses the balance between plurality of provision and partnership, treading a fine line between promoting partnership between patients and statutory services, and developing multiple models of provision in response to unmet or poorly met patient need. It also incorporates proposals for adult social care where there is the potential for further extension of consumer choice through individualised budgets in the context of an existing market underpinned by the regime of Best Value. Given the significant degree of health and social care integration at a local level, the political and managerial response of local government may also be a key influence in many localities.

(b) Commissioning

In the context of health care provision, Smith and Mays (2005) conceptualise commissioning as a combination of **conscience** (elements relating to stewardship, quality and public safety) and **brain** (activities concerned with resource allocation, planning and service design). Wade *et al.* (2006) extend the metaphor in a post-CPLNHS context to include **eyes and ears** (tasks related to keeping close to patient experience, and framing messages for action by brain and conscience). Their argument is that the reforms position commissioning bodies as the guarantors of the principle of publicly funded services, free at the point of delivery, available

according to need: they are 'NHS local' and, by extension, joint-commissioning arrangements are the embodiment of 'care local'. The responsibilities of these elements may be summarised as:

- Conscience – setting out 'how things should be' - what the system aims to achieve, and how;
- Eyes and ears – observing and reporting 'how things are' – what the system is currently delivering;
- Brain (having processed the information from both sources) – identifying and implementing the optimal solutions for delivering objectives.

These functions imply a series of activities, including needs assessment, service specification, procurement against specification from providers, contracting and monitoring, and the relative importance and nature of these tasks is highly context dependent. Where commissioning has traditionally been conducted within internal markets of statutory providers, the emphasis has been on funding services in response to usage (purchasing), rather than on stimulation and identification of suppliers through transparent competitive tendering (procurement).

The reforms thus potentially open new territory for many NHS commissioners, who are typically less used to strategic commissioning from non-statutory providers than their Local Authority colleagues. New required skills include those of market management and development, competitive tendering and contract law, management of supply chains and strategic partnering (Wade *et al.* 2006). It is perhaps the last of these, in which commissioners seek to develop long-term, risk-sharing relationships with suppliers and partners ('relational contracting') that may be helpful in reducing the transaction costs associated with procurement markets. Local authority experience may be particularly helpful here, practices including accreditation onto approved supplier lists; procurement compacts, where a framework for the local role of the voluntary sector in public service delivery is agreed, and procurement is shaped by this agreement; and framework agreements / 'open' contracts, where contracts negotiated by one commissioning body are made open to others. Crucially, these practices reveal that crude text-book distinctions between 'competitive markets' and 'collaborative networks' are difficult to uphold empirically; rather, markets may contain embedded relationships (ties) between multiple commissioners (horizontal ties); and between commissioners and their main providers / main providers and their sub-contractors (vertical ties). The nature of the ties in any given market sets limits on the market behaviours available to both commissioners and providers (6 *et al.* 2006).

(c) Local Jurisdiction

Contemporary public sector reform processes are multidimensional. In this new paradigm, and despite pressures towards the fragmentation of service delivery, problems are recast as requiring the management of cross-system goals, necessitating collaborative action across multiple agencies, professional groups and active citizens (Clarke & Stewart 1997). At the risk of oversimplification, three broad aspects of the new governance may be discerned (Sterling 2005):

- *jurisdiction*, or the development of place identity as a site for mobilising interests (Healey *et al* 2002) and integrating organisational activity in geographically based communities;
- *participation & community*, exemplified in user involvement, active citizenship and democratic renewal, embracing concepts such as communities of interest, empowerment and social capital; and
- *collaboration (partnerships)*, or the development of inter-agency approaches to service commissioning and / or delivery

Each of these elements may sit in tension, so that while collaborative governance may be aligned with participatory governance, it is also the case that many demands for collaboration arise from managerial imperatives; indeed, rather than opening up decision-making, collaborative ventures may run counter to the stated preferences of wider stakeholder groups. While 'active citizenship' may be used to subtly discipline citizens, encouraging the formation of identities congruent with policy aims (Rose & Miller 1992), the optimistic reading is that the diverse, fragmented and emerging institutional forms associated with the new governance have the potential to develop a more democratic local order (Bennington, 2001; Hirst, 1994); a 'politics of the commons' capable of extending and re-energising local democracy (Amin & Thrift 2002).

Associated with discourses of local partnership, community participation and consumer choice, the new localism is embodied in a wide range of initiatives and structures, most notably Local Strategic Partnerships (LSPs) and more latterly Local Area Agreements (LAAs). These initiatives signal a move away from short-term, area-based spending programmes towards coordination of mainstream structures under a National Strategy for Neighbourhood Renewal (NSNR). Initially targeted on the 88 most deprived local authorities, each of which were required to develop LSPs involving public, private and voluntary sectors, the logic was subsequently expanded to include all local authorities, who must develop LAAs in partnership. New localism has received a further boost in the recommendations of the Lyons Inquiry, which attributes the role of 'place-shaping' to local agencies.

Commissioned in July 2004, the Lyons Inquiry was charged with considering the case for changes to local government funding in England and making recommendations. Following initial work, in which it became clear that a sustainable solution to the problems of local government finance required clarity on the future direction of central–local relations, the Inquiry’s terms of reference were expanded to include clarification of the roles of central and local government on the basis of function; and at the heart of the matter lay considerations of the division of responsibility for public services.

The Lyons Inquiry report, (*‘national prosperity, local choice and civic engagement’*), urges further dispersal of accountabilities from central to local government, setting out a strategic role for local government in the context of fewer (more focused) central targets and reduced central supervision. Perhaps most importantly, the report suggests that local authorities should be given a responsibility for promoting local choice and acting as the voice of a whole community – in other words, an agent of place:

*‘... the ultimate purpose of local government should not be solely to manage a collection of public services that take place within an area, but rather **to take responsibility for the well-being of an area and the people who live there, and to promote their interests and their future.** Place-shaping should both reflect the distinctive identity and aspirations of the people and area, and function as a means of safeguarding and promoting their well-being and prosperity.’* (Lyons 2006: p.39) [emphasis not in original]

Comprising many elements (see box), it is clear that ‘place-shaping’ implies new accountabilities. The line of argument is that while local government is best placed to understand and meet local preferences, in order to respond to them it requires the ability to direct resources to where they are most needed. Indeed, the inability to do so gives rise to an accountability gap, in which local government is held accountable by local people for spending choices over which it has little control.

Glasby *et al* (2006) outline a potential symbiotic relationship between PCTs and LAs, in which local authorities need PCTs to help them place-shape, and PCTs need LAs for legitimacy and community engagement. They consider a number of options for institutional reform that might buttress the ‘NHS local’ claim, including taking NHS commissioning into Local Government; bringing local legitimacy into NHS commissioning through direct elections; or developing a new single, locally-accountable commissioning body. In the absence of such institutional developments, LAs and PCTs may still seek to represent the interests of their localities through combinations of joint-ventures and robust commissioning criteria which include issues such as economic development, continuity of care and public confidence. Indeed, to the extent that they become

recognised as the guarantors of the NHS and its local manifestation – ‘NHS local’ (Wade *et al* 2006) - claims to jurisdiction may provide a language with which localities may seek to challenge future central prescriptions for service reorganisation.

Box 2: *Place-shaping*

1. building and shaping local identity
2. representing the community
3. regulating harmful and disruptive behaviours
4. maintaining the cohesiveness of the community and supporting debate within it, ensuring smaller voices are heard
5. helping to resolve disagreements such as how to prioritise resources between services and areas, or where new housing and development should be located
6. working to make the local economy more successful, to support the creation of new businesses and jobs
7. understanding local needs and preferences and making sure that the right services are provided to local people through a variety of arrangements including collective purchasing, commissioning from suppliers in the public, private and voluntary sectors, contracts or partnerships and direct delivery; and
8. working with other bodies to respond to complex challenges such as natural disasters and other emergencies

(Lyons 2006: p. 39)

The Local Government White Paper, *Strong and prosperous communities* (2006), reiterates the Lyons Inquiry's findings on place-shaping, outlines an intention to legislate for new statutory partnerships for health and well-being under the LSP, and strengthens the role of LAAs by making them central to the performance framework. Under the new regime, LAAs become the framework for reaching agreement between local partners and central government on priorities—intended to strike a balance between national priorities and local flexibility to respond to local circumstance.

These developments will be further developed and outlined in the forthcoming *Joint Commissioning Framework*, anticipated in early 2007

and designed to deliver both the commitments to partnership working outlined in *Our health, our care, our say* (2006) and, more fundamentally, the outcomes in *Independence, wellbeing and choice*. While the detail has yet to be published, the guidance will elaborate on the characteristics of effective joint commissioning raised in *Health reform in England: update and commissioning framework* (2006). The diagnosis on which the guidance is being developed is that difficulties are due to a combination of lack of alignment between incentive systems; lack of clarity around accountability mechanisms of joint commissioning; limited commissioning capability; and a focus on services rather than outcomes for users. Its solutions will thus be framed around provision of joint needs assessment criteria; market development; clarification of commissioner accountabilities; alignment of incentives (including performance frameworks) to support partnerships; and a common framework linked to the Local Government White Paper.

Options for commissioners

The above analysis suggests that LA and PCT commissioners might consider a number of options. The first would be to set up a joint-venture for commissioning (and possibly also providing) all such services within a defined geographical area, defended on the grounds of local jurisdiction. This would require an appraisal and selection from the range of joint available venture vehicles, on the basis of local considerations and a consideration of the their known strengths and weaknesses. Where commissioners wish to stimulate local provider markets, they would be wise to consider the likelihood of market consolidation over time and the possibility of subsequent DH intervention; local joint commissioners will only have one 'shot' at setting up local criteria (i.e. in addition to national standards) for shaping local provider markets (commissioning) and appraising potential service providers (procurement).

The following sections outline known strengths of public, private and third sector providers, considering available options for joint-ventures and other provider vehicles before drawing on recent literature to assess what criteria might be important for shaping local markets (commissioning) and appraising service providers (procurement), over and above statutory requirements.

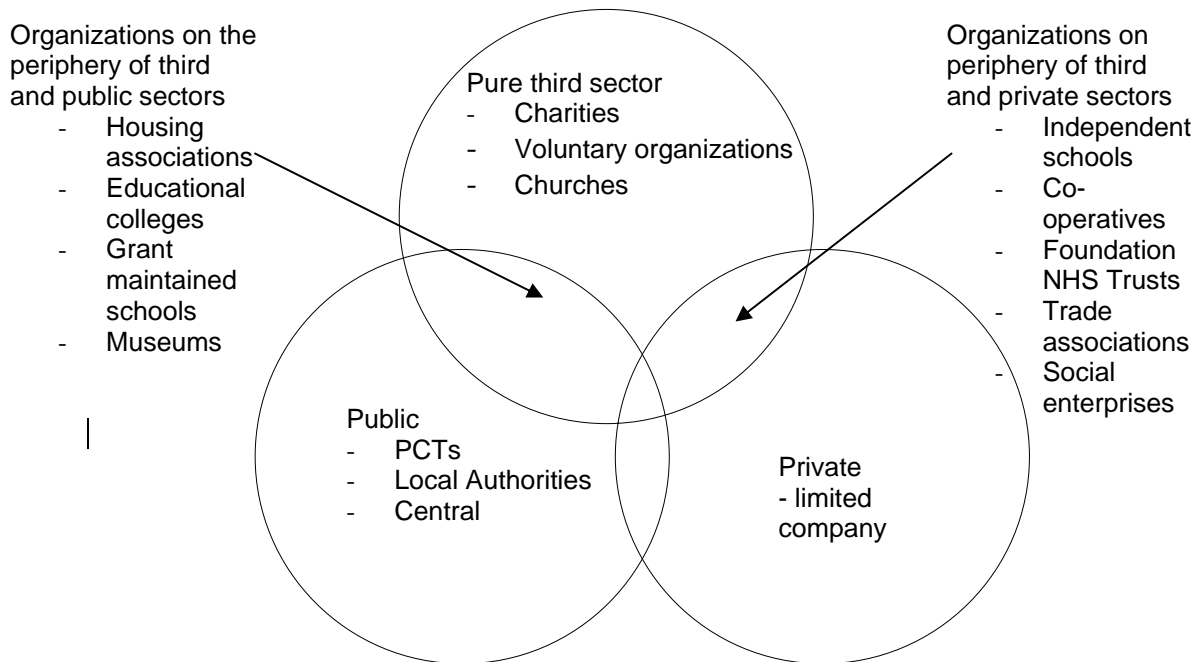
5. Providers: public; private; and third sector

While much UK health and social care provision remains publicly provided, there is already a substantial private sector including over 9,000 GP practices, 10,000 pharmacists, and some 25,000 independent social care providers. A significant proportion of the NHS budget is spent on the

pharmaceuticals supplied by multi-national companies. Private providers are already commissioned by PCTs to provide elective care and long-term services for people with acquired brain injury, mental illness, learning disability and nursing care needs in old age. Of course, it should not be assumed that the growth of these private services means that they offer best value. Nonetheless, the relevant question is not about the presence of the private sector but rather about its size and its scope.

The debate around plural provision is centred on state monopoly and competitive private provision. Yet, there are alternatives in the form of 'third sector' providers. A wealth of competing terminologies is available for the sector, including non-profit, non-statutory, social economy, community organization, and co-operative. Offering a buffer between public and private provision - and providing institutional stability during oscillations between free-market economic liberalism and social democratic state provision in public policy - the sector additionally provides a source of flexibility and expertise in partnerships with state agencies. There is an established voluntary sector in the UK, some voluntary organizations being both large and influential. For example, Turning Point, a social care organisation providing mental health, substance misuse and learning disability services, has a turnover of over £60m, national reach, centralised support systems, focused on growth in service provision and active in lobbying for a level playing field with the private sector. Dickinson *et al* (2005) provide a conceptual overview of the voluminous literature on third sector provision, schematically representing relationships between public, private and third-sector provision (figure 1).

Figure 1: The three sectors of society



(Adapted from Dickinson et al 2005)

Social enterprises form one hybrid of private and third sector provision, combining responsiveness to markets with a strong social value system, and the government has identified the public sector as a major market growth area; the recent government review of the Role of the Voluntary and Community Sector in Service Delivery led to increased funding to increase the scope of such provision, and there is a DH proposal to establish a 'social enterprise unit', similar to that within the Department of Trade and Industry, together with seven pilot sites to encourage its further development.

There are many potential benefits of social enterprises, beyond the obvious political ones afforded to the present administration by an approach promising contestability while simultaneously avoiding any increase in private sector provision. On the demand side, consumers may prefer third sector to for-profit providers in conditions where they are unable to accurately evaluate the quality of service and fear being taken advantage of by for-profit providers (contract failure theory) or where third sector organizations provide 'collective goods' both for their own benefit and that of non-controlling stakeholders, so that consumers identify with the coalition of demanders-suppliers, recognising the latter's self-interest in ensuring high quality provision (stakeholder theory). Consequently, social enterprises may provide means for improved user involvement and

may be experienced as empowering when run by members for their own benefit.

On the supply side, the distinction between users and buyers in the public sector market has important consequences. Public commissioning agencies are buyers with their own criteria and priorities, the service user paying little or no direct fee for the service. Undifferentiated state provision may result in gaps between buyers' and users' agendas and third-sector entrepreneurship may act as a bridge to supply unmet user needs (pluralism). Enterprise may thus be harnessed for a social purpose, of benefit to a defined community of either geography or interest (Allan, 2004). Empirical support for this is provided by a study conducted in New Zealand which found that in comparison to private primary care provision, non-profit providers undertook: more community needs assessment and planning activity; community nursing (including midwifery care); and public health functions. Overall, they ended up effectively 'filling the gap' in provision to meet the needs of poor communities (Crampton, Davis and Lay-Lee 2005, cited in Dickinson *et al* 2005). In the UK, social enterprises have also had a high profile in providing to under-served markets in regeneration areas - neighbourhood renewal programmes such as Single Regeneration Budget (SRB) and New Deal for Communities (NDC) have targeted the most deprived wards to meet unmet need for childcare, credit unions and property for business start-ups.

While it would be simplistic to assume that changing the form of an organization *axiomatically* led to substantial benefits, there may be circumstances which are better suited to particular organizational forms. Dickinson *et al* (2005) consider the strengths of public, private and third-sector provision, their analysis implicitly identifying the questions to which third sector providers may provide an answer (table 3). None of the sectors is a panacea; public, private and third-sector provision each have distinctive attributes, which may be considered either strengths or weaknesses depending on the viewpoint of the observer. Public providers produce public goods, may be held directly accountable to government, and are unlikely to exploit information asymmetries; yet, they experience difficulty in catering for diversity, responding quickly to fluctuations in service demand, or experimenting with new policy options – they provide uniform services and are typically not focused on innovation. In contrast, private providers are likely to respond well to increases in demand and be innovative in response to effective demand; yet prone to exploit information asymmetries, ignore diversity unless profitable and do not produce public goods - they respond well to profit incentives at the expense of public goods. Third sector providers are able to provide public goods, are innovative and capable to catering to diversity; yet, less able to respond to fluctuations in demand and are less directly accountable to government than public sector providers- they cater for diverse needs, but are less easy for government to control.

Public commissioners may thus seek to realise community benefits through their procurement activities by funding social enterprise endeavours that combine: the direct provision of services to a market with social aims; direct accountability to members and the wider community; and ownership structures based on participation by stakeholder groups. By being rooted in the local community social enterprises may possess a detailed knowledge of their consumers and this may be reciprocated so that the provider's (good) reputation may in turn confer competitive advantage. There are clear governance issues involved with the transfer of service accountability from government to local community representatives, strengthening social cohesion within the particular community at the potential cost of common standards of provision. Whether this increases or decreases equity depends upon whether the arrangement meets previously unmet need.

Table 1: *Summary of strengths and weaknesses of ownership (sector)*

Characteristic	Ownership		
	Non-profit	Private	Public
Direct accountability to government	+	+	+++
Willingness to cater to diversity	+++	+	+
Likelihood of producing public goods	+++	+	+++
Able to experiment with new policy options	+++	++	+
Likelihood of exploiting information asymmetries	+	+++	+
Likelihood of disguised profit distribution	+++	+	+
Responsiveness to increases in demand	+	+++	+
Likelihood of blunting more extensive policy development	+++	+++	+

Key: Strengths or weaknesses ranging from small (+) to large (+++)

(Dickinson et al 2005: based on Crampton & Starfield, 2004: 723)

For NHS staff, social enterprise offers an alternative form of employment that is closely aligned to public sector principles and values and as such is seen by some as a more professionally and culturally acceptable provider model than 'for-profit' models with stakeholder beneficiaries. HSMC is currently hosting a learning set of PCT senior managers exploring the potential for social enterprise and one of the emerging drivers for pursuing this route is the ability to combine a model that will be acceptable to PCT staff with a more 'business-style' approach to service

delivery that social enterprise offers. Recognising the diversity of business models within the social enterprise umbrella there is a consensus that accepting the calculated risk, managing expectations and engaging with all stakeholders will be key issues for successful transition.

Locally, there are challenges and opportunities. The mutual is aware that the principles of choice and contestability will need to be demonstrated in its approach to provider services, and sees strong patient and public involvement in its governance as a mechanism for ensuring this. The structure of the tariff, even with the changes for 2006/7, does not facilitate redesign of the pathway so the mutual would like to establish local agreements on unbundling the tariff. The initial response of PCT provider staff to the mutual has been mixed but is now moving forward positively. The development of a service level agreement between the mutual and the PCT for community health services is being seen as the first stage in the process of divestment and an opportunity to develop relationships and involve nurses and therapists in the development of the mutual as a multi-professional organization for the future.

Established and emerging options

Given the diversity of possible organizational forms across the three sectors, what are the available, established and emerging options for primary care provision? A wide range of innovative approaches are being pursued. Some are informed by horizontal integration between existing health and social care public providers or vertical integration of acute and primary care services between statutory, private and/or voluntary providers. Others directly transfer services to either independent or third-sector providers under alternative provider of medical services (APMS) or specialist provider of medical services (SPMS) contracts, or integrate provision through joint ventures. At the time of writing - in early 2007 - the Department of Health seems to be still publicly distancing itself from its earlier stated intention of removing direct PCT provision by 2008; it appears to be in a permissive mode, which suggests scope for diversity in models of provision between service areas. For example, children's services may be provided in partnership with the local authority by a children's trust; or general medical services provided under APMS by a multi-disciplinary team constituted as either a community interest company or a private firm, dependent upon local circumstances. The concept of a "Community Foundation Trust" built on current legislation for Foundation Trusts (Public Benefit Corporations) is also being actively explored.

While our earlier report *Reconfiguring PCTs: influences and options* (Peck & Freeman 2005) identified a number of options for primary care provision, the focus was on commissioning arrangements. The remainder of this chapter updates our earlier work to take account of recent

opportunities and developments for provision, with an assessment of the pros and cons associated with different legal forms of third sector provision.

The analysis of risks and benefits is in many ways inherently subjective in this type of debate. We have adopted an analysis from the viewpoint of PCT commissioners, but with an eye to the conflicting drivers of personal profit, the desire for public sector/social enterprise values, and the likely necessity of preserving NHS pension rights for any transferring staff groups. We make no value judgment as to the benefits attaching to any of the three sectors (statutory, private or voluntary). Applying a fitness for purpose test to existing services inevitably raises the question of whether alternative forms would provide a better alternative.

There is an inevitable tension in designating any facet as a benefit or risk. Increased regulation of a corporate form may be both a 'pro' (as it gives greater surety of accountability) and a con (as it gives less flexibility to innovate). A number of different contracting routes are possible (SPMS, APMS, NHS contracts, contract with foundation trust), and it is likely that a transition of existing in-house provision to any form of external body (whether within or outside the health service) could not now be accomplished without some form of contestable and advertised procurement process.

6. Single provider models

a) Horizontal Integration – e.g. children's trusts; care trusts

Children's Trusts

Unlike care trusts, children's trusts are hosted within local authorities. The government is keen to encourage children's trust pilots as a means to improving service integration, strategic coherence and improved user access to children's services in health, social care and education (and also those provided by SureStart and Connexions). There is little prescription in terms of structure; indeed, local authorities and health agencies are explicitly encouraged to develop models to address local conditions. An important potential vehicle for some children's services, a provision only children's trust will be able to explore integrated forms of service delivery, such as multi-disciplinary organizations providing a wide range of services out of a single location, such as a neighbourhood office; however, many of the pathfinder pilots are commissioning entities.

In the first instance, children's trusts are being piloted with a view to ensuring best use of the powers already available for local authorities and health agencies to work together. Consequently, children's trusts utilise

the 1999 Health Act Section 31 Partnership Arrangements to bring together local authority and health services delegated by PCTs. Thus, they will not be separate legal entities and will initially operate under existing legislation. Thirty-five successful pilot sites were announced in July 2003. Phase 1 evaluation findings report strong support for the national vision of integrated services from professionals, parents and young people, while acknowledging that children with complex social care needs are perceived to be under-supported across the case study sites (UEA 2005). While many pilot sites are testing common assessment forms, they were typically yet to be operational at time of publication, with ongoing professional concerns expressed over data security and confidentiality. While some pilot sites were developing co-located services these remained in their infancy; only 8% of schools were working with their children's trust and only a further 10% were planning future involvement.

The discussion of children's trusts is – in many localities – giving renewed energy to consideration of care trusts (especially where mental health services are in some form of partnership trust and joint commissioning arrangements and the local authority starts to question the ongoing viability of social services departments as merely a commissioner – and to a limited extent a provider - of services for older people and those with a physical and sensory impairment; to a certain extent the recent green paper on social care for adults (Independence, Well Being and Choice HMSO 2005) has its origins in these sorts of debates).

Care trusts

Proposed in the *NHS Plan* (DH 2000) and conceived as a further step on the journey towards integration started by the Health Act (1999), care trusts are intended to build on existing partnership working under Section 31 flexibilities. They are multi-purpose legal bodies, based either on primary care organizations or on NHS provider trusts, to commission and be responsible for all local health and social care for specified client groups. NHS and local authority functions are delegated to care trusts, which may commission and/or provide services. Care trusts typically cover client groups in need of complex, integrated packages of care, such as those with mental health problems.

While seemingly a natural progression of increased integration, the weight of evidence suggests that care trusts work only where there are existing good relations between sectors; where existing inter-agency relations are not good, the organizational and cultural challenges involved in organizational merger risk making relations worse. Even where existing relations are good, the adoption of care trusts may lead to significant tensions particularly related to staff conditions of service and perceived job security necessitated by transfer of employment. Indeed, Hudson (2002) outlines a number of difficulties with the approach including

financial dilemmas, narrowness of remit and limited human resource capacity. Consequently, the decision whether to opt for a care trust or to increase integration by pursuing Section 31 flexibilities under the Health Act (1999) should be taken carefully and serious consideration should be given to the organizational and cultural integration necessary to support pooled budgets and shared targets with effective governance arrangements.

Assessment of horizontal integration (e.g. children's trusts, care trusts)

Benefits

- Integration across organizational boundaries can preserve existing staff benefits
- Established and flexible model suitable for a large number of different applications and situations

Risks

- Frictions from two-system approach (health and social services)
- Ambiguities over extent of responsibilities
- Constitutionally complex in practice

b) Arm's-length management organizations (ALMOs)

The ALMO programme is a particular example of active central government encouragement of local authorities to develop new forms of service delivery while allowing councils to continue to maintain overall ownership and control at local level. ALMOs are bodies set up by local councils to manage and improve local housing stock. Unlike large-scale voluntary transfer (LSVT), stock remains in the ownership of the local authority; the local authority remains the legal landlord; and both existing and new tenants remain secure council tenants. In short, the structure, management and organization of the company are at arm's length, but the stock and company are owned by the council. The core business of an ALMO is embedded in the local community, and focused on meeting local needs. Equally, ALMOs must contribute to local authority corporate objectives.

A logical development of this concept would be to develop broader, neighbourhood-based vehicles for the delivery of a variety of local services, while freeing up local authorities (potentially in partnership with health service agencies) to determine strategy, identify and commit resources to achieving local priorities, and monitoring service quality.

Assessment of ALMOs in Health

Pros

- would provide a focused delivery body
- would retain control
- may retain pension entitlements for NHS staff

Cons

- unlikely to be possible legally currently due to restrictions creating separate legal entities to provide statutory functions
- could be possible if object was to generate "profit" for the Trust, but that is unlikely to be a viable service model.
- if "in house" its procurement with third parties would be governed by EU Procurement Rules. If not the PCT would need to contract with it as an external body and the relationship could be exposed to competition.

c) Community Foundation Trust

The Department of Health commissioning framework (2006) raises the possibility of community foundation trust status for primary care trusts' provider roles. The document states that the government is 'attracted' to the community foundation trust model as a way of making community services stronger, while keeping them completely within the NHS and protecting staff terms and conditions, including pensions. Staff, patients and other members of the public would be able to become members of community foundation trusts, and have a role in their governance. The DH is in discussions with foundation trust regulator Monitor about how the model would.

Assessment of community foundation trust model

Pros

- Existing legal form with separate legal entity
- Lock on public assets
- Regulation by Monitor ensures financial rigour

Cons

- Complex public engagement model and constitution
- Regulation by Monitor restricts freedoms
- Potential for monopoly provider

d) Vertical integration of acute and primary care services

The NHS and Social Care Long-Term Conditions model (DH 2005d) is designed to help ensure that health and social care organizations take a systematic and structured approach to improving the care of those with long-term conditions in primary care. It aims to bring significant benefits for patients in terms of improved outcomes, derived from a combination of financial incentives for higher quality care for a number of long term conditions under the Quality and Outcomes Framework, but also from integration of service provision between primary and secondary care. Predicated on clinical collaboration and managed patient pathways, models such as Kaiser Permanente encourage integration between prevention, treatment and care, centred on multi-disciplinary community teams with community-based core diagnostic services. Three potential approaches to ending the primary – secondary division may be discerned:

- *upwards* vertical integration, in which primary care providers reach into hospitals to relocate some services to the community;
- *downwards* vertical integration, in which hospital providers expand outwards and downwards to manage primary care and community services; and
- managed practitioner networks with groups of clinicians delivering care via contracts with hospitals and other providers.

Structural integration is only one way of developing these approaches, and it may be that alliances – virtual rather than vertical integration – will be the preferred model.

Assessment of vertical integration of acute and primary care services

Pros

- Whole care pathway solution
- Financial incentives towards system efficiencies

Cons

- Potential for monopoly provider
- Untested in the UK
- Requires an accountability framework
- Structural difficulties could be avoided by virtual integration

e) Provider units

Some PCTs are exploring or actively developing the concept of a 'provider unit' within the organization to establish new governance arrangements that ensure a formal separation between their commissioning and

provision functions. These typically comprise of a provider services unit that hosts all PCT provider services, strategically led by a provider board that is then accountable to the PCT board. Provider services are formally commissioned by a separate PCT structure through service level agreements. Bury PCT has adopted this structure with a board comprising of clinical staff alongside executive and non-executive members of the PCT board. The proposed new Wirral PCT is adopting this model but is also incorporating the provider functions of the PCT with those of general practice within locality directorate groups.

Within the current policy context, this approach of retaining PCT directly provided services could be viewed as a model in its own right for the future delivery of PCT provider services or as a 'step-change' to community foundation trust status or social enterprise development.

Assessment of Provider Units

Pros

- provide continuity and stability
- remove the need for consultation on forming a new body
- avoid contractual, employment, pensions, equipment and property issues associated with forming a new body (as outlined later in Section 5 of this report.
- allow arrangements to be informal and ad hoc where necessary, maintaining flexibility.
- maintain the provider function's access to administrative support services.
- maintain NHS assets and goodwill in public ownership.
- safeguard services for vulnerable groups that may not be best served by independent providers

Cons

- any SLA imposed by a PCT's commissioning arm on its own provider arm would have no legal enforceability, as the PCT cannot contract with itself.
- unless the leadership of the provider function had no links with the commissioning function, the provider arm could not hold itself out as an independent body.
- it might be difficult to identify and segregate costs that are unique to the provider function.
- legally, the provider function is indistinguishable from the PCT and therefore the PCT remains liable for its actions.

7. Contractual forms

A number of different contracting routes are possible (SPMS, APMS, NHS contracts, legally enforceable contract with Foundation Trust and other non NHS providers; there may be additional areas of regulation to consider in relation to such contracts but this topic falls outside the scope of this report). The transition of existing in-house provision to any form of external body (whether within or outside the health service) could now require some form of contestable and advertised procurement process in order to comply with EC Treaty obligations. The requirements of Procurement Law will require attention (and legal input) at the planning stages of any intention to out-house any PCT provider functions.

a) *Alternative provider of medical services (APMS)*

Under APMS general medical services no longer have to be run as small businesses owned and managed by GPs. Introduced explicitly to address problems of poor access and under-provision and secure innovative care models, or re-provision (i.e. transfer of services from acute to community settings) (DH 2004), APMS allows PCTs to contract with either independent, voluntary, not-for-profit, foundation trust or PCT providers. Detailed guidance was updated in December 2005 (DH 2005), and the NHS Purchasing and Supply Agency have published a toolkit to aid in the APMS procurement process (NHS PSA 2005).

b) *Specialist Provider Medical Services (SPMS)*

Designed for care deliver in specific disease areas (e.g. mental health) or particular patient / client care groups (e.g. care home residents), the scheme does not require a registered list of patients, involvement of a GP, or provision of essential primary care services. SPMS agreements are PMS agreements, which means that an SPMS contract can only be entered into by those who would otherwise qualify to hold a PMS agreement – as specified in Section 28D of the 1977 Act and Part 2 of the PMS Regulations. An SPMS provider could be, for example, an existing or new nurse-led PMS provider, a group of clinical practitioners (secondary or primary care), an NHS Trust or NHS Foundation Trust, or existing or new GPs who provide specialist care to patients (DH Guidance 2006). While required to be provided by an NHS body, elements of the contract may be subcontracted to non-statutory providers: while unable to contract directly with non-statutory providers under SPMS, they may do so *indirectly* via sub-contacting arrangements.

c) *Joint ventures*

A particular form of partnership arrangement in which multiple organizations set up a separate structure, a joint venture, in order to pursue a particular strand of common endeavour while maintaining their

separate organizational identity. While comparatively new in the context of collaborations between PCTs and their co-terminus local authorities, they are relatively common in private sector markets, most successful when they are established to control a particular aspect of the partners' interests. Organizationally they have a distinct identity and clear purpose, yet remain accountable to their parent organizations through shared governance arrangements. Such arrangements avoid the costs (both financial and human resources) associated with merger or new organizational forms; are relatively quick to put in place; and are flexible in the sense that they may be easily altered to suit new contingencies – for example, they could pursue social enterprise forms, or incorporate elements of provision from other organizations, be they statutory, private or voluntary.

The idea is hardly novel, having its precursors in both PCT shared services agencies, some PCT/local authority joint commissioning teams (albeit on a smaller scale), and it could be argued that the ambitions for children's trusts are similar. And while the organizational fluidity considered above is for the medium-term and beyond, in the short term the approach offers two advantages in the context of current policy. It offers the prospect of placing PCT provider services at a distance from commissioning without incurring direct management costs, while retaining PCT(s) ability to shape the strategic direction of the local health economy and safeguarding continued health and social care integration.

8. Social enterprise legal forms

As previously outlined, diversity is one of the third sector's strengths and this heterogeneity is reflected in the complex array of legal forms available, including incorporated associations, trusts, community interest companies, charitable incorporated organizations (CIOs), and community benefit societies (BenComm) or co-operatives, as well as more established forms such as registered charities and limited companies. This provides flexibility and choice depending on whether the purpose of the enterprise is charitable, commercial or community based, and choice of form will be heavily influenced by the nature of activities undertaken, requirements of key stakeholders, appropriate governance structures and ability to access finance. It is therefore vital that form follows function – that choice of legal structure reflects the needs of the social enterprise. Choice of legal ownership is likely to be closely related to who is considered to be the 'community' who will benefit; and how participation and benefits are to be distributed. Typically, service models rest control in a small management committee without beneficiary members, who run the business to provide a service to the defined community (Social Enterprise London 2005). Investments by stakeholders are nominal and profits reinvested into the business.

While a number of unincorporated forms are available including trusts and unincorporated associations, their unlimited liability makes them inappropriate for the purposes explored in this paper. A number of incorporated forms are introduced below, and a summary overview of available legal structures for social enterprises, covering typical features, governance arrangements and eligibility for charitable status is provided in table 4.

(i) Company limited by guarantee

A non-profit distribution structure often combined with charitable status, comprising a two-tier management structure of board of elected directors and members with limited liability. There are no shares, but there are members with limited liability who play a similar role to shareholders in attending an annual meeting, approving accounts, and election of directors. Profits are put back into the company. Constitutions must be filed, the external functions detailed in a memorandum of association and internal procedures in articles of association. This is a relatively simple structure with transparent accountability arrangements via registered annual accounts. These latter can be costly however, and regulation is tight.

Assessment of company limited by guarantee

Pros

- Well-known, established and flexible model
- Suitable for not-for-profit and charitable models
- May achieve NHS Direction status for transferring NHS staff pensions
- Transparent legal form
- Limited liability for members
- Can drop limited designation in some circumstances
- Can be a member's model with staff engaged as members
- Separate legal entity

Cons

- Reporting and regulatory requirements are potentially onerous
- No NHS pension body status currently
- No incentive to excel for personal profit
- Will need an accountability framework to be developed
- Regulation by Charity Commission will apply if charitable status is accorded

(ii) Community Interest Companies (CICs)

Created under the Companies (Audit, Investigations and Community Enterprises) Act 2004, CICs are designed for pursuit of community benefits. As with companies limited by guarantee they are registered with Companies House, but are additionally required to satisfy a community

interest test ('whether a reasonable person could consider the CIC activities to benefit the community'), outlining the proposed benefits and assuring that benefits will not serve an unduly restricted community. They also have an asset lock, to ensure that assets may not be re-distributed. An annual public report is required, detailing activities undertaken to pursue the interest, and involvement, of stakeholders (DTI 2004).

Assessment of community interest companies

Pros

- Social enterprise objectives hardwired into the constitution – e.g. asset lock
 - Monitored by a regulator to ensure that community interest test is satisfied
 - Limited liability for members
 - Will be recognized publicly as a social enterprise model
 - May be a Direction Status employer for NHS staff transferring re. pensions
 - It may be more acceptable to staff
 - There is less need for an accountability agreement
 - Can opt for not-for-profit and profit models
- Separate legal entity

Cons

- Largely untested model
- Constraints on action constitutionally
- Cannot be a charity
- Not an NHS pension body at present
- Potentially more complex regulation than some other models
- Therefore potentially less flexible
- May be less able to raise finance than some other corporate forms
- May be for-profit
- Question mark over provision of core public services

(iii) Industrial and Provident Societies (IPS)

Two types of industrial and provident society are available:

(a) Community benefit societies (BenComm)

BenComms are incorporated co-operatives run by members (one member – one vote) in which profits are distributed to the wider community, rather than to members (as with co-operatives) or to external shareholders (as with companies). Proposed secondary legislation under the Co-operatives and Community Benefit Societies Act 2003 gives BenComms an asset lock option, to forever prevent them from distributing assets other than for community benefit – intended to stop conversion to company status ('carpet-bagging').

Assessment of community benefit societies

Pros

- Limited liability
- Social enterprise – run for the benefit of community rather than members
- Capable of having charitable status
- May achieve NHS Direction Status for NHS transferring staff pensions
- Separate legal entity

Cons

- Less flexible than some other corporate forms, as constitutionally may only be changed with Financial Services Authority approval
- May not have open membership
- Regulation by Charity Commission if has charitable status

(b) Co-operatives

These are participatory societies, conducting business through direct member participation for mutual benefit. Joined and run democratically, they are required to have an open membership policy and rules must reflect co-operative principles. As with companies there is a written constitution, members have limited liability and there is an elected board. Regulation is via the Financial Services Authority (FSA), rather than the Registrar of Companies.

Assessment of co-operatives

Pros

- Limited liability
- Hybrid social enterprise/personal advantage model
- Accountable – open membership policy
- Separate legal entity

Cons

- Will not qualify as an NHS pension provider and may not achieve Direction Status
- Less flexible than some other forms as constitution may only be changed with FSA approval
- Not capable of achieving charitable status

9. Commissioning

Commissioning is perhaps best viewed as a heterogeneous function, containing multiple elements:

- Assessing and articulating need
- Defining service standards and specifications ('service plans'), which provide a menu for practices to draw from and ensure clinical and organisational assurance of care; and
- Procurement, contract setting and monitoring, in which the requirements of commissioners detailed in the above plans are negotiated with providers

A number of possibilities follow. While local commissioners have a role in protecting local integrated provision and defining and representing local needs, it may be argued that the service standards and contract negotiation and performance monitoring are functions that could be provided by commercial procurement agents. Arguably of most importance is local determination of need in which patient, clinician and local organisational viewpoints are represented to derive an arbitrated menu reviewed with local stakeholders and against available evidence. Smith *et al.* (2004) identify the importance of *values* as well as the technical in all considerations of the 'correct' approach to commissioning. They urge health economies to consider a series of assessments in order to determine the most effective combination of approaches for its local area:

- Analyse the service(s) to be commissioned – is it simple or complex; are commissioners likely to be well or poorly informed of its content and effectiveness; is the service potentially contestable?
- Analyses the context and environment – is there already a choice of providers of this service or not; are patients likely to be willing and able to travel if local providers are unsuitable?
- Analyse the proposed commissioning model in the light of the assessment criteria

Practical resources for exploring issues related to strategic commissioning are available electronically from CSIP's Better Commissioning Network'. Resources include the Strategic Moves workbook detailing the work of CSIP's Local Improvement Network, and the commissioning e-book which provides a wealth of information and examples practical examples.

<http://www.cat.csip.org.uk>

a) shaping local provider markets

In an extension and elaboration of the earlier work of Wade *et al* (2006), Smith *et al* (2006) identify criteria that a PCT might apply when shaping a local market of care and determining which configuration or combination of models of provision it wishes to procure within that market, deriving their criteria from a review of the literature.

Table 2: *Criteria and tests for shaping the local market and models for provision*

Shaping the Local Market	Tests that may be applied
Acceptability	<ul style="list-style-type: none"> • Fits with local culture and whole system configuration • Minimizes impact of change • Demonstrates positive change • Terms and conditions for staff are comparative with the NHS
Demonstrates robust governance	<ul style="list-style-type: none"> • Supports delivery of national and local priorities • Underpinned by effective communication and information systems • Clear separation between commissioning and provision functions
Supports collaboration and engagement	<ul style="list-style-type: none"> • Facilitates existing or new clinical networks • Promotes clinical engagement in strategic planning and service improvement • Provides recognized clinical leadership positions within local economy
Promotes innovation	<ul style="list-style-type: none"> • Incentives in place to support innovation • Supports the shift of care closer to home • Positive relationships between PCT and provider • Mechanisms in place to facilitate joint working across organizations
Patient focused	<ul style="list-style-type: none"> • Supports service integration • Can respond to individual patient needs • Minimizes impact on patient journey
Improves clinical quality	<ul style="list-style-type: none"> • Robust framework for clinical governance in place • Robust monitoring and evaluation systems in place
Promotes public health	<ul style="list-style-type: none"> • Potential to enhance local social capital • Addresses local health inequalities • Promotes equity in service provision • Targets resources to greatest need • Supports local initiatives
Demonstrates economic viability	<ul style="list-style-type: none"> • Affordable • Value for money • Minimizes transaction administration costs

Promotes capacity	<ul style="list-style-type: none"> • Sustains or increases workforce capacity • Maximizes capital resources
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Smith *et al* (2006)

Applying the analysis of local jurisdiction outlined above, commissioners may seek to weight the importance of particular criteria and defend them on the basis of local jurisdiction: thus considerations of public health, collaboration and local acceptability may be required of any provider. Under this system, any procurement decisions based on the criteria in table 3 (below) would be filtered through the earlier commissioning criteria.

Table 3: *Criteria and tests for appraising service providers*

Appraising service providers	Tests that may be applied
Provider credibility	<ul style="list-style-type: none"> • Track record of delivering quality services • Sound business plan • Legal status • Professional references • Sound national or local reputation • Demonstrates understanding of national policy
Service improvement	<ul style="list-style-type: none"> • History of service redesign • Understanding of relevant tools and techniques for service redesign • Appropriately trained managers and clinicians • Evidence of partnership working
Clinical leadership and governance	<ul style="list-style-type: none"> • Clinical governance plan • Clinical leadership framework in place • Sound reporting arrangements • Appropriate information systems • Risk management systems in place
Workforce viability	<ul style="list-style-type: none"> • Robust workforce plan • Recruitment and retention plan • Staff support systems in place
Training and Development	<ul style="list-style-type: none"> • Identified funding for T&D • Evidence to support professional and career development • Identified training providers
Responsiveness	<ul style="list-style-type: none"> • History of managing change • Positive attitude to change • Mechanisms for monitoring need to change in place

Smith *et al* (2006)

10. Considering the options

What is to be done about adult care services provision? There is certainly no lack of policy guidance to inform decision-making. Lack of information

is certainly not the issue, rather there are multiple policy developments, and tensions between elements of the prescription are plain to see. For example, requirements for contestability in service provision and robust commissioning & procurement suggest increased plurality of provision, while at the same time there are pressures for service integration exemplified in the recent Local Government White Paper which identifies increased scope for health and social care partnerships under the Local Area Agreement (LAA) umbrella. As if this were not complex enough, implementation takes place within a context of financial recovery in which any service option must be shown to be financially viable - the agenda is certainly a demanding one.

In such a complex policy environment, it is entirely understandable that those charged with implementation should respond by turning to 'off the shelf' models, be they care trusts or community foundation trusts. Yet, however understandable this response, it contains dangers. Research and experience both suggest that policy implementation is fundamentally an interpretive process – successful changes are not so much 'delivered' fully formed, regardless of context, as made sense of and agreed within local settings, taking account of local contours. While national policy contexts remain the same regardless of locale, the history of partnership working and service aspirations within any given area will be unique, and have implications for possible strategic choices (Glasby & Peck, 2006). The reality is that unless policy implementation takes account of and engages with local contexts it risks losing all of its possible benefits, with negative consequences for citizens, managers and policy champions. Potential options will require evaluation against specific (and agreed) 'success' criteria which may include the potential benefits; the degree of support for the proposal; and the 'fitness for purpose' to deliver the agenda. Possible criteria for selection are likely to include commercial consideration of viability; local and national political acceptability; and commissioning agendas (Table 4).

Table 4: *Criteria informing local decision-making*

Criteria
Commercial viability of possible models
Response to commissioner agenda
New forms of staff engagement (e.g. third-sector models)
Political acceptability (local and national)
Local Authority engagement and sense-making

Pragmatism
Flexibility of response
Market-shaping and marketing of provision
Pursuit of horizontal / vertical integration across health / housing / social care

In the context of the related area of organisational mergers, Fulop *et al* (2002) distinguish between stated drivers – those set out in formal consultation documents ('espoused theory') – and unstated drivers – those privately held by stakeholders ('theories in use'). Both are important to understand, as together they set the context for decision-making processes, particularly when the two are in conflict. Participants need to consider:

- Clarifying the *real* reasons underpinning the thrust for change
- Provision of adequate organisational development support for organisations and individuals most involved in reconfigurations
- Matching actions closely to intentions, to reduce cynicism among key staff groups whose support will be crucial in realising the intended benefits

The recent judgement relating to a challenge in procurement decisions over primary care services provision in Derbyshire indicates the importance of ensuring due process. Commissioners are not able to simply 'pick options' from types of provider (private, public or third-sector) – rather what is required is a clear statement of general aims and principles; what is required from providers and how options will be evaluated to demonstrate fair selection (procurement); with an eye to the likely provider options likely to emerge and their known strengths and weaknesses (provider models). In this regard, careful commissioning and procurement criteria may prove vitally important in shaping provision while avoiding legal challenge. Ultimately, the choice of appropriate options will require both local judgement and compromise.

While the new localism and Lyons agenda provide an important language in which the jurisdiction of local agencies may be asserted, a number of tensions remain and require attention. Ellison & Ellison (2006) identify three tensions within new localism requiring careful attention: control; participation; and social closure.

- *Control*: Paradoxically, new localist approaches privilege national standards and priorities, the centre stressing particular policy outcomes while recognising the primacy of local governance institutions in service delivery. Pratchett (2004) indicates an inherent

tension concerning the ultimate location of control and claims to jurisdiction; the balance of power is not straightforward, and there are real difficulties engendered by the paradox of seeking to achieve national outcomes by means of local autonomy. The danger is that the centre may view this development as delegation of the responsibility for administering national priorities – administrative, rather than political, devolution. Much will depend upon the ability of local governance structures to act in the interests of their localities where such perceived local priorities run counter to the national agenda.

- *Participation*: active participation offers a means of building civic engagement and increasing self-confidence in abilities to take up opportunities, in a 'virtuous circle' of engagement. Yet, recent experience of engagement within LSPs indicates the potential for new governance arrangements to threaten councillors' self-perception a legitimate and accountable community leaders (Aspden & Birch, 2005). Further, participation and involvement are ambiguous goods; participants may feel empowered, but there is scope for disempowerment and alienation too, as power and interests surrounding decision-making processes are revealed (Dinham, 2005).
- *Social closure*: It may not be possible to successfully pursue social inclusion through targeted policies and localism alone. The potential downside of social capital building needs to be considered (Parkin, 1979; Butler 2004; 2005); in particular, the existence of exclusive social networks which negate attempts at inclusion means that the distribution of social capital may also need to be addressed.

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12. Related electronic resources from the Integrated Care Network (ICN) and Case Services Improvement Partnership (CSIP)

- CSIP Commissioning eBook: an electronic resource to improve commissioning of community services. Contains over 30 'good practice' articles aimed at assisting thinking among social care, health, and housing commissioners, as well as independent sector providers. Includes papers on developing commissioning skills; managing markets; workforce development; the purchasing process; and monitoring and improvement

<http://www.cat.csip.org.uk/index.cfm?pid=359>

- ICN: Strategic Moves: Strategic commissioning for older people's services -Better Commissioning Learning and Improvement Network. This practical guide explores strategic approaches to service commissioning using case studies and exercises

http://www.changeagentteam.org.uk/_library/docs/Housing/Strategic_moves_130105.pdf

- ICN briefing: We have to stop meeting like this: the governance of interagency partnerships

http://www.integratedcarenetwork.gov.uk/_library%2FICN_Governance_final_3_11_06.pdf

- ICN discussion paper: Strengthening service user and care involvement: a guide for partnerships

http://www.integratedcarenetwork.gov.uk/_library%2FICN_Involvement_final_3_11_06.pdf

- ICN discussion paper: Whole systems Working: a guide and discussion paper

http://icn.csip.org.uk/_library/ICN_Whole_Systems.pdf