UNIVERSITY OF BIRMINGHAM

School of Public Policy

Health Services Management Centre

Options for primary care trust provider services: an evidence-based policy analysis for NHS West Midlands

Judith Smith
Tim Freeman
Adrian Parker
Helen Parker

November 2006

Contents

The research team

Judith Smith

Judith Smith is Senior Lecturer and Joint Director of Research at the Health Services Management Centre at the University of Birmingham, with 12 years' experience of health services research and development. She has extensive experience of undertaking major policy-relevant research projects, including a three-year study of primary care organisations in the NHS published in a recent book (Smith and Goodwin, 2006), a review of the evidence on primary care-led commissioning (Smith et al, 2004) and an analysis of emerging NHS commissioning policy (Wade et al, 2006). Judith teaches and presents regularly in the UK and overseas and holds visiting fellowships in the School of Government at the Victoria University Wellington and in the Australian Primary Health Care Research Institute in Canberra.

Contact: j.a.smith.20@bham.ac.uk or 0121 414 7073

Tim Freeman

Dr. Tim Freeman is Lecturer in Health Policy at the Health Services Management Centre at the University of Birmingham. He joined HSMC in 1999, having previously worked as a researcher for Save the Children Fund and the Sainsbury Centre for Mental Health. His main research interests lie in governance, discourse and organisational theory, and in particular the governance of public sector partnerships and his recent work includes a dramaturgy of governance in a mental health partnership board. Palgrave-Macmillan published *Managing networks of twenty-first century organisations* in 2006, which he joint-authored with colleagues at HSMC. Within the department, he is Director of the Doctoral Programme and Joint Director of Research.

Contact: t.freeman@bham.ac.uk or 0121 414 3213

Adrian Parker

Adrian Parker is the head of the Health Sector Commercial team at Hempsons, a national law firm with a focus on the health sector. He provides advice on commercial, constitutional and statutory compliance issues and on commercial transactions. Adrian's experience has encompassed the broad commercial needs of health service bodies and outsourced service providers. His work involves meeting the specialist needs of NHS, social enterprise and private sector bodies operating within the restraints of statutory and health service regulation and in their increasingly complex interactions. Adrian's specialisms include: statutory powers and corporate governance; tendering procedures and European Public Procurement Law and advice on consultation requirements. Adrian lectures regularly within the health sector, including on HSMC programmes.

Contact: ap@hempsons.co.uk or 01423 724029

Helen Parker

Helen Parker is a Senior Fellow at the Health Services Management Centre with a background in primary care. She has had an NHS career spanning both clinical and senior management posts, her last post within a PCT. Subsequent work as an independent consultant provided her with extensive experience of working with a wide range of provider organisations across the public and independent sector focusing on organisational development and service improvement. Helen leads HSMC's Provider Programme and is currently working with individual organisations supporting the development of new provider models and is involved in a national evaluation of the shift of services from hospital to community settings. She is also leading learning networks of senior managers and clinicians exploring the options for future service provision and organisational models. Alongside her consultancy work, Helen has a teaching role as Programme Director for HSMC's MSc in Health Care Policy and Management.

Contact: h.parker.1@bham.ac.uk or 0121 414 2279

Foreword

Current health policy in England is placing a strong emphasis on the development of stronger commissioning and, as part of this, requires primary care trusts (PCTs) to make a robust and transparent assessment of their provider services, including how they are organised and governed. The intention is that there will be proper transparency and probity in the process of commissioning services that have been traditionally provided by PCTs, along with assurance of the continued development of high quality care that meets the needs of local populations.

This report has been commissioned by NHS West Midlands in order to make a contribution to what we see as an important local and national debate about how best these community health services, and other services provided by PCTs, should best be governed and organised in the future. It is intended as a resource to PCT boards, management teams and professional executive committees as they clarify plans for their provider services. We recognise that the Department of Health and many other bodies will contribute to this debate over the coming months, and hope that this report will add to that overall process of exploration and discussion.

NHS West Midlands has no preconceptions about the organisational and governance forms that will be appropriate for any particular PCT's provider services, but wishes to ensure that the process of reviewing options for the organisation of such services is able to draw on a range of advice and analysis, including that contained within this report. As such, we have been delighted to work with the Health Services Management Centre at the University of Birmingham, and Hempsons, in developing a research-based policy analysis that includes both health services research and legal expertise.

We must place on record our sincere thanks to all who have contributed to this project, including the people who attended a workshop to discuss emerging project findings in the summer of 2006, and the colleagues in the health and social care sector who have helped in the preparation of case study summaries that illustrate the practical experience of working with different governance and organisational models in health care.

Above all, we trust that this report will prove useful to PCTs as they strive to further develop their commissioning and provider functions, and that this in turn will result in ever higher quality services that are able to account properly to the people who fund and use them.

Cynthia Bower

Chief Executive, NHS West Midlands

November 2006

1. Introduction

The report

This report sets out the findings of a research project carried out by the Health Services Management Centre at the University of Birmingham and Hempsons (a national law firm focused on the health sector). It identifies, describes and analyses models of organisation and governance (legal entities) that could be adopted by primary care trusts (PCTs) for their provider services as they adapt to the current policy context of NHS systems reforms following Commissioning a Patient-Led NHS (Department of Health, 2005a), the NHS community services White Paper (Department of Health, 2006a), and the Government's open advocacy of third sector providers for statutory services. The report is intended as a practical, research-based resource for PCT boards and management teams to use as they consider their corporate response to a policy environment that appears to expect contestability and plurality of provision.

Related work from HSMC

This project builds upon and extends an earlier study carried out by HSMC in partnership with the NHS Alliance that explored the range of models of configuration being adopted by PCTs in early 2005 (Peck and Freeman, 2005) available at www.bham.ac.uk/hsmc. HSMC and the NHS Alliance have also collaborated on a project about the future shape of commissioning (Wade et al, 2006). Other related work includes policy analysis by HSMC and the King's Fund for the Health Policy Forum (Smith et al, 2006) about what constitutes 'effective commissioning' in the reformed NHS, and a project being carried out by HSMC for the Integrated Care Network exploring options available for adult care joint-ventures between the NHS and local government (Freeman and Peck, 2006).

Aim of the project

This project seeks to identify and assess actual and potential arrangements for PCT provider services being put in place as PCTs become organisations that focus more closely on commissioning (as opposed to provision). It sets out a series of possible models for the organisation and governance of community health services currently managed by PCTs, including an assessment of the risks and opportunities of each model. An analysis is also made of the issues facing commissioners as they seek to assess models of provision (and specific provider organisations) for a local area, for it is to PCTs as commissioners that the decision about the local mix of provider organisations will ultimately fall.

Parameters of the research and analysis

This project is aimed at supporting PCTs' decision making around local services currently provided by PCTs, within the bounds of policy and legal constraints on commissioning and procurement decisions. Consideration is given to what criteria a PCT might seek to apply when taking decisions that shape a local health care market and also when appraising specific health care providers. The project recognises the constraints that evolving developments in procurement and consultation law have on the freedom of operation of public sector commissioners. The project is concerned with those services currently provided directly by PCTs, and not the full range of NHS care.

2. Policy context

The Labour government has made clear its commitment to the use of market mechanisms as a way of bringing about changes to health services (Smith et al, 2005; Lewis and Dixon, 2005). This commitment is evident through developments such as: the use of private health care providers to deliver elective hospital care when reducing waiting times; the procurement of independent sector diagnostic and treatment centres; offering patients choice of private as well as NHS providers for elective care; and emphasising the importance of contestability of provision in recent guidance about commissioning (Department of Health, 2006b) and out of hospital care (Department of Health, 2006a).

The focus on contestability of provider services was given its most vivid expression in Commissioning a Patient-Led NHS (Department of Health, 2005a). This paper opened up what was first of all an apparent imperative, and latterly an optional direction of travel (see Department of Health, 2006a), for PCTs to divest themselves of provider services (or at least, demonstrate the robustness and appropriateness of in-house provision) and hence focus more clearly on their role as commissioners of services to enable local health improvement and health care.

One consequence of this policy has been that commissioning-side organisations (strategic health authorities and PCTs) have to spend time working out what principles or criteria they want to apply when making decisions about the model of organisation or governance for PCT provider services. Whilst the focus of this report is on the issue of assuring standards and governance of services that could transfer out of direct NHS PCT management into some other arrangement, it can be argued that the principles and criteria are equally applicable to NHS-provided services and hence to all services commissioned by the NHS and its partners (e.g local authorities). In this way the 'reach' of contestability can be considered to encompass potentially all provider services, and not just new services at the margin, which is where tendering and contestability have traditionally been employed.

PCTs, whilst being expected to demonstrate the contestability of provider services and a robust approach to local care market development, are also under a duty to work in partnership with local health and social care provider organisations. This tension between communitarian (partnership) values on the one hand, and contestable (market) values on the other, defines the complex and sophisticated nature of the task facing PCTs as new commissioning organisations. It is highly unlikely that commissioners will specify a particular model (or indeed be legally able to do so) for their provider services if such services cease to be provided in-house. PCTs have, in many cases, sought to reorganise internally over the last 12 months or so to create separate 'provider units' internally as part of the PCT.

As PCTs review the organisation and governance of their provider services, the emphasis is likely to be on fostering an awareness of the advantages and disadvantages of different potential organisational models, set within an analysis of local circumstances. Thus the organisational and governance model for services is likely to vary within and across PCT areas. This paper seeks to set out criteria that could be used by commissioners when making decisions about provider services, and to explore the different organisational and governance models that might be used as part of local NHS markets.

3. Criteria for assessing provider services

In this section, we set out criteria that PCTs could adopt when, as commissioners, they think about the strategic direction of their services, and in particular those services that have traditionally been directly provided by the PCT. In doing we make two distinctions.

Firstly, we set out criteria by which commissioners or purchasers can shape the local market and overall organisational models of provision for the local population.

Secondly, we suggest a set of criteria by which a PCT might appraise individual service providers, either in-house or external, in relation to their ability to deliver agreed strategic objectives and service specifications demonstrating value for money. For each criterion, tests can be applied to assess the level at which an organisational model or provider fulfils PCT requirements. These are summarised in tables 1 and 2 on pages 9 and 10.

Criteria for shaping the local market and models of provision

We set out here suggested 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. The criteria have been developed by the research team based on a review of the literature in this area and discussions within the research team.

Acceptability

PCTs will need to consider the level of acceptability of new models of provision to a wide range of stakeholders. New models will need to be tested against organisational, cultural and professional agendas as service reconfigurations could have an impact on current staff working arrangements, roles and responsibilities and service delivery. Equally, some models of provision such as private sector procurement may be politically sensitive. This has been vividly demonstrated recently in respect of the experience of the procurement of a private provider of primary care (an alternative provider of medical services or APMS) in North Eastern Derbyshire where the PCT's decision to appoint United Health Europe Limited as preferred bidder was challenged by a local patient in the High Court. The PCT's decision was eventually quashed at a Court of Appeal hearing and the PCT required to recommence the process of tendering, taking due account of the need for public consultation and involvement.

This case and the more recent case of Morris v Trafford Healthcare NHS Trust reinforce the importance of PCTs adopting consultation and engagement processes if service changes, improvements or developments are envisaged or proposed. PCTs will need to think about (and should consider taking legal advice on) the extent of consultation required under Section 11 of the Health and Social Care Act 2001 in the event the PCT considers or plans to consider any proposal to market test or re-provide services. This could also potentially apply to internal restructuring that does not entail an out-housing of services to an entity outside the PCT. PCTs should also discuss any such proposals with the relevant health overview and scrutiny committee (OSC) to determine whether the OSC regards any such development or variation as 'substantial' and requiring consultation with the OSC. In addition, requirements under employment law to consult staff will need to be taken into account.

To achieve the greatest level of acceptability, PCTs will need to ensure that where possible, they minimise the impact of change for staff and patients in areas such as employment terms and conditions and patient pathways. As part of a consultation process, the PCT will need to fully engage with some or all of the groups set out in box 1 opposite. The consultation with the local community and staff will be particularly important if another North Eastern Derbyshire scenario is to be avoided.

Demonstrates robust governance

PCTs will need to assess the extent to which new models of provision support the delivery of national and local priorities and support the strategic goals of the local health and social care economy. The delivery of national priorities will continue to be a crucial element in the governance and accountability of service providers, and a means by which PCTs as commissioners will be held to account. In managing and shaping the market PCTs need to test new or existing models to ensure that appropriate levels of governance and accountability can be maintained through effective performance management, communication, and information systems. For example, each model will need to demonstrate that is has systems in place to ensure that patients and carers are able to contribute to service redesign and service evaluation and that their feedback influences local commissioning and provision across the whole system.

Supports collaboration

The implementation of current health policy and the development of coherent strategic plans for the local economy rely heavily on collaboration between managers and clinicians, the PCT and partner organisations, and patients and the public. Models of provision should be assessed for their likely impact on existing networks and partnerships (e.g. cancer networks, coronary heart disease networks, emergency care networks, local strategic partnerships), with a view to working out how key relationships can be sustained and improved. Within a market environment, PCTs will need to demonstrate that any model of service provision facilitates rather than inhibits collaboration between new and existing providers, and that it will support continued service improvement, joint working and effective professional networks.

Box 1: stakeholders in a consultation about a provider market

- The public
- Patients forums (and for the future LINks)
- PCT board and professional executive committee;
- PCT staff
- Trade unions and staff associations
- Local independent contractors
- Local representative committees of primary care contractors
- The local authority – specifically, social care partners and the overview and scrutiny committee
- Local NHS and foundation trusts, including their patient forums and professional (e.g. medical staff) forums
- Local community associations
- Service users and carers related to the specific services facing a change of provider model
- Other partner organisations

Supports sustainable clinical engagement and leadership

Models of provision should demonstrate an ability to facilitate and support sustainable clinical engagement and leadership. Studies have shown a positive relationship between a high level of clinical engagement and support for innovation. Where clinicians are clear about their roles and objectives, there is a higher level of commitment to clinical quality and to improving services delivered (Borill et al 2001). Therefore PCTs will need to assess the potential mechanisms and opportunities to increase the level of clinical participation in strategic planning and service redesign and to maximise the input of all clinical professions. Developing mechanisms for engagement and leadership that include clinicians from different provider organisations in service redesign will encourage innovation and help reduce the potential for organisational protectionism. This will need to be done within a governance framework that avoids potential conflicts of interest, such as clinicians who may function as both commissioners and providers (Wade et al 2006).

For models that involve clinical staff working externally to statutory organisations, mechanisms will need to be in place that allow staff to contribute with equal authority (in relation to statutory sector colleagues) to pathway development, service improvement initiatives and strategic planning. For example, PCTs will need to ensure that any new models of provision do not inhibit the opportunity for clinicians from provider organisations to influence service development via formal committees and working groups.

Promotes innovation

PCTs will need to assess the extent to which new or existing models of provision have the ability to improve service delivery. Each model will need to be appraised for its potential to support a local organisational culture that allows innovation to flourish. New models should provide a framework of incentives for commissioners and providers to work together to develop locally sensitive services across the health and social care pathway. One test will be as to how new models support the shift of care closer to home outlined in Chapter Six of the White Paper (Department of Health 2006a). New models will need to demonstrate innovative service redesign that will contribute to shifting care in those areas identified as having the greatest potential such as outpatient follow ups, simple diagnostic testing and step-down care.

Patient focused

In line with the aims of the out of hospital care White Paper (Department of Health, 2006a), models of provision should be explicitly patient focused. PCTs will need to demonstrate that providers can support health and social care service integration to deliver individual packages of care within an agreed pathway. Any change to the model of service provision will need to be tested against the impact on existing patient pathways and its ability to manage changes in patient need and demand. For example, a change to community nursing service provision could impact on services delivered to housebound patients and these would need to be carefully appraised.

Improves clinical quality

Alongside promoting innovation, any model will need to support a framework for strong clinical governance to deliver safe and effective services. New models will need to sustain or improve existing levels of clinical quality, delivering services that are evidence-based and subject to ongoing evaluation. Models will need to be tested as to how they promote, support and ensure the delivery of national clinical standards such as the National Service Frameworks. Each model will also need to demonstrate an 'organisational fit' with the whole system in terms of clinical governance arrangements and processes such as recording and sharing patient information and clinical risks or incidents.

Promotes choice

PCTs will need to assess all models of provision against the requirement to deliver a degree of patient choice, ensuring that any new model does not reduce choice in terms of provider or service options. New models will need to be assessed within the context of the total provider spectrum across the wider health and social care economy to support contestability and responsiveness. In shaping the market, PCTs will need to ensure that models that may integrate community services with existing providers such as general practice and trusts do not create 'monopolies of care' that reduce choice in service model and location.

Promotes public health

Alongside demonstrating the ability to enhance local social capital, new models of provision will need to be assessed for their ability to address health inequalities and address local health needs. Standards for Better Health (Department of Health 2004a) calls for collaboration between communities and organisations to improve the population's health and therefore PCTs will need to test new models for their ability to deliver or contribute to local initiatives such as neighbourhood renewal plans and Local Area Agreements. New models will also need to be appraised within the context of targeting resources to the areas of greatest need and will therefore have to demonstrate that any changes to service provision, staff skill mix or care location do not increase the potential for health inequality.

Demonstrates economic viability

A significant test for any new model of provision will be the extent to which it is affordable and value for money within the PCT's financial framework. Specific metrics such as transaction and administration costs, critical mass and workforce costs will need to be measured to allow robust financial comparisons between existing and proposed models of provision. The test for model viability will be the extent to which it can support the productivity and efficiency indicators set out in the Operating Framework for 2006–07 (Department of Health 2006c). For example, each model will need to be tested as to how it will contribute to ensuring all referrals and admissions to hospitals are clinically appropriate.

Promotes capacity

The ability for an organisational model to sustain or increase management, clinical and facility capacity within the available resources will need to be assessed. Models will need to demonstrate how they can maximise the time and skills of the workforce for the benefit of services and patients, and how they could be scaled up or down in response to changes in patient demand. Models will also need to be assessed by efficiency measures in relation to their need for premises and equipment provision, delivering services within existing resources or agreed capital investment plans.

Criteria for appraising service providers

We set out here the suggested criteria that a PCT might apply when appraising specific service providers. Whilst it can be argued that it is not a commissioner's role to stipulate the *form* of provision e.g. for-profit organisation or a social enterprise and that there are, in addition, restraints to doing so in applicable procurement law, it is a commissioning responsibility to ensure providers are fit for purpose. This is particularly important in terms of governance for those PCTs who choose to retain direct provision of services.

These criteria may provide the basis of a 'provider scorecard' by which PCTs can judge the quality of a single provider (including existing in-house services) and compare providers who may be competing for a service contract. Additionally, the criteria may be used as a method for identifying areas for improvement of existing providers. The criteria have been developed by the research team based on our work nationally with a wide range of commissioners and providers, a review of the literature and discussions within the research team.

Provider credibility

PCTs will need to ensure that providers are able to demonstrate overall organisational and managerial competence with a history of high quality service provision or a sound business plan supported by references or professional accreditations. PCTs will also need to assess the legal soundness of the provider and ensure that it is a properly constituted organisation. A robust and transparent process for assessing credibility should provide a level playing field for newly established organisations and those with a track record of providing health care.

Service improvement

Providers will need to demonstrate robust mechanisms and positive approaches to service improvement and redesign. Any model will need the ability to engender a culture of development and innovation and demonstrate how they will contribute to the development of pathways, guidelines and protocols across provider organisations and influence service developments outside their own organisation.

Clinical leadership and governance

Providers will need to demonstrate that they are delivering care that is evidence-based, safe and organisationally competent. A significant element of this will be the ability to demonstrate that they can provide appropriate levels of clinical leadership within their workforce to facilitate organisational development as well as contributing to strategic service improvement across the local economy. Equally, clinical governance and reporting arrangements need to be robust, with agreement being in place to work to PCT protocols and standards.

Workforce viability

Providers will need to demonstrate that they are effective and supportive employers of staff and can provide and sustain a viable workforce. Without being prescriptive as to how services are delivered, commissioners will need to ascertain that providers have the critical mass of each clinical discipline to enable efficient service delivery and that the organisation has a robust workforce development and recruitment plan. Where numbers of a single profession are low, providers will need to demonstrate mechanisms for preventing clinical isolation. There should also be evidence of mechanisms in place to provide staff with human resource and occupational health services.

Training and development

PCTs will need to ensure that organisational models for provider services sustain or improve the existing training and development opportunities for staff. Providers will need to demonstrate a commitment to supporting professional education as a means of supporting strategic objectives, facilitating professional and individual career development and improving recruitment and retention where necessary.

Responsiveness

Providers will need to demonstrate the ability to respond efficiently and effectively to variable service and individual patient demands. Within their contractual framework, providers will need to have the ability to be flexible in relation to the location of service provision and to changing the clinical model of provision as required.

Patient and public involvement

Approaches and commitment to user involvement and public participation in service delivery and evaluation should be tested for appropriateness, effectiveness and congruency with the PCT's strategic programme.

Financial viability

Provider organisations will need to demonstrate long-term financial viability with the appropriate management competencies to manage budgets and financial risk. Within the context of contestability, PCTs retaining provision of services will need to demonstrate the true cost of those services in order to determine value for money.

Criteria for assessing provider services - summary

A key determinant of how successfully the new PCTs can demonstrate their fitness for purpose will be their ability to shape the local market through intelligent commissioning and the robust procurement of individual providers. This will require PCTs to actively develop a market that delivers a whole system model of care and appoint providers that can deliver the associated individual service specifications. A significant challenge will be for PCTs to focus on expressing clear desired outcomes and resisting the temptation to be prescriptive as to how providers should deliver those specifications. The transparent use of assessment criteria as part of a provider scorecard in supporting the commissioning function will enable PCTs to demonstrate their ability to deliver value for money and manage the market effectively. In addition, the use of such transparent assessment criteria is becoming an increasingly important part of the conduct of procurement processes in order to ensure that such processes are defensible.

Table1: Criteria and tests for shaping the local market and models for provision

Criteria for shaping the local market	Tests that may be applied
Acceptability	■ Fits with local system configuration ■ Minimises impact of change ■ Demonstrates positive change ■ Terms and conditions for staff are comparable with the NHS ■ Complies with statutory duties to consult
Demonstrates robust governance	■ 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	■ Facilitates existing or new clinical networks ■ Promotes clinical engagement in strategic planning and service improvement ■ Provides recognised clinical leadership positions within local economy
Promotes innovation	■ Incentives in place to support innovation ■ Supports the shift of care closer to home ■ Positive relationships are in place or can be developed with the PCT ■ Mechanisms in place to facilitate joint working across organisations
Patient focused	■ Supports service integration ■ Can respond to individual patient needs ■ Minimises impact on patient journey
Improves clinical quality	■ Robust framework for clinical governance ■ Robust monitoring and evaluation systems
Promotes public health	■ 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	■ Affordable ■ Value for money ■ Minimises transaction administration costs
Promotes capacity	■ Sustains or increases workforce capacity ■ Maximises capital resources

Table 2: Criteria and tests for appraising service providers

Criteria for appraising service providers	Tests that may be applied
Provider credibility	■ Track record of delivering quality services ■ Sound business plan ■ Robust legal status ■ Professional references ■ Sound national or local reputation ■ Demonstrates understanding of national policy
Service improvement	■ 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	■ Clinical governance plan ■ Clinical leadership framework in place ■ Sound reporting arrangements ■ Appropriate information systems ■ Risk management systems in place
Workforce viability	■ Robust workforce plan ■ Recruitment and retention plan ■ Staff support systems in place
Training and Development	■ Identified funding for training and development ■ Evidence to support professional and career development ■ Identified training providers
Responsiveness	■ History of managing change ■ Positive attitude to change ■ Mechanisms in place for monitoring any need to change
Patient and public involvement	■ Appropriate approaches to user involvement and public participation are in place ■ Evidence of commitment to and experience of patient and public involvement
Financial viability	■ Evidence of long-term financial viability ■ Evidence of ability to manage budgets and financial risk effectively ■ Value for money

4. Models of organisation and governance for PCT provider services

4.1 Identifying possible models of organisation and governance

At the time of writing, in autumn 2006, the Department of Health seems to be distancing itself from its earlier stated intention of removing directly managed PCT provision by 2008 (Department of Health 2005a) and appears to be in a permissive mode, which suggests scope for diversity of models of organisation and governance for services traditionally provided by PCTs. For example, children's services might be provided in partnership with the local authority by a children s trust; or general medical services provided under an APMS contract 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 (Department of Health, 2006b), and many PCTs are establishing 'provider arms' to create a greater degree of separation from their commissioning function.

What this illustrates is the importance of being clear about what is meant by the term 'provider model', a phrase that is often used in the current debate about the future of PCT provider services. It seems to us that there are three separate elements to be considered when examining the future of PCT provider services:

- the **sector** within which services will be located (state/NHS, private, or third/voluntary)
- the **legal entity** that will be used as the organisational and governance form (e.g. foundation trust, community interest company, arms-length management organisation)
- the **contracting methodology** that will be used to underpin the relationship between the PCT and the provider organisation (e.g. NHS contract, foundation trust contract, APMS, SPMS)

Given the diversity of possible organisational and governance forms across these three elements, it is inevitable that **hybrid models** of organisation and governance will emerge that are not easily distinguished as a specific 'provider model'. For example, a third sector community interest company might provide health services to a PCT under an SPMS contract, a private sector company limited by guarantee might deliver care under an APMS contract, and joint ventures might be created across organisations.

In this report, we address this complexity by focusing on making an assessment of the different **legal entities** that might be utilised or engaged with by PCTs when considering how to organise and govern their provider services. An assessment is made of the risks and benefits associated with each organisational option, and where possible, practical health and social care examples of each option and how it is being applied in the NHS are given.

The **analysis of risks and benefits** is in many ways inherently subjective, given the dynamic and emergent nature of organisational and governance models currently being discussed and put in place in the NHS. We have made our 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. Similarly, there is an inevitable tension in designating any facet as a benefit or risk. Increased regulation of a corporate form may be both a 'benefit' (as it gives greater surety of accountability) and a risk (as it gives less flexibility to innovate).

As noted above, whatever the legal entity adopted, a number of **different contracting routes** may be possible including specialist personal medical services (SPMS), alternative providers of medical services (APMS), NHS contracts, legally enforceable and contracts with foundation trust and non-NHS providers. There may therefore 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 European Commission 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.

We now examine the issues associated with different sectors in relation to care provision, and make a brief examination of the different contracting methodologies available within the NHS, before setting out our main analysis of the legal entities that might be used by PCTs when considering how best to organise and govern their provider services.

4.2 The sector within which services are located

In examining potential organisational models for services currently managed directly by PCTs, we group the available options into those within the NHS (often referred to in policy as the 'NHS family') and those outside the NHS (third or voluntary sector models, and those in the private sector). As will be seen from the analysis later in this section of the report, we focus on NHS family and those independent and third sector models associated with social enterprise approaches when assessing options for PCT services, given that we consider these to be the ones most likely to be adopted by new PCTs. We have made this judgement based on our examination of the likely acceptability and feasibility of non-NHS models of governance and organisation, and have taken into account factors such as the status of NHS staff pensions which we see as key enablers (or blocks if not resolved) to changing the organisational model of PCT provider services.

The private sector and the NHS

While much NHS health and social care provision remains publicly provided, it is important to note that 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. Nevertheless, the relevant question is not about the presence of the private sector but rather about its size and its scope.

The third sector and the NHS

There are alternatives to state/NHS and private provision in the form of 'third sector' providers. A wealth of terms is used to describe this sector, including non-profit, non-statutory, social economy, community organisation, and co-operative. The third sector offers a buffer between public and private provision - and assures some institutional stability during policy oscillations between free-market approaches on the one hand and social democratic state provision on the other. The third sector additionally provides a source of flexibility and expertise in partnerships with state agencies. There is an established voluntary sector in the UK and some voluntary organisations are both large and influential. Hudson (2004) provides a conceptual overview of the voluminous literature on third sector provision, schematically representing relationships between public, private and third-sector provision (figure 1).

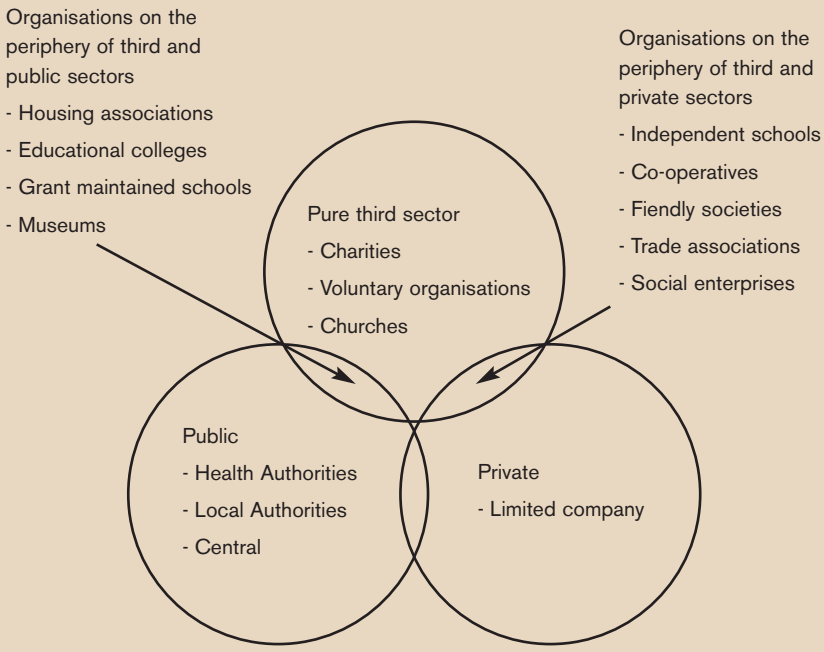
Hybrid organisations – social enterprises

Social enterprise is an umbrella term for a range of business models that promote the use of profits or 'surplus' for community benefit. Social enterprise models therefore 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 for social enterprises. 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 the Department of Health is now establishing a 'social enterprise unit', similar to that within the Department of Trade and Industry, together with pilot sites to encourage further development of social enterprise in health.

The benefits of provision beyond the NHS

Undifferentiated state provision may result in gaps between buyers' and users' agendas and third-sector entrepreneurship can act as a bridge to supply unmet user needs. 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 of primary care undertook: more community needs assessment and planning activity; more extensive use of 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). In the UK, social enterprises have also had a high profile in providing to under-served populations in regeneration areas. For example, 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 in areas such as childcare, credit unions and property for business start-ups.

Figure 1: The three sectors of society (Adapted from Hudson, 2004)



The rationale for considering private or third sector provision

While it would be simplistic to assume that changing the form of an organisation will axiomatically lead to substantial benefits, there may be circumstances which are better suited to particular organisational forms. Crampton and Starfield (2004) consider the strengths of public, private and third-sector provision, implicitly identifying the questions to which third sector providers may provide an answer (table 3).

Public providers produce public goods, may be held directly accountable to government, and are unlikely to exploit information asymmetries. However, 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 are 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.

Table 3: Summary of strengths and weaknesses of ownership (sector) **(Crampton & Starfield, 2004: 723)**

	Ownership		
Characteristic	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 (+++)

4.3 Contracting methodologies for PCT provider services

PCTs have a variety of contracting mechanisms open to them to commission services. We recognise that there is a degree of ambiguity, both in terms of service definition within the health service and legally between services classed as 'primary medical services' and other services. For the purposes of the following section we have adopted the assumption that PCT provider services are primary medical services in that term's widest sense, although where this is not the case other more general additional contracting mechanisms will be available to a PCT.

Extensions to PMS Agreements

In recent years, the Department of Health has developed a number of new contracting options for PCTs to use when commissioning primary care services (general practice and related services). The first alternative to the national General Medical Services (GMS) contract was the personal medical services (PMS) scheme that was initially piloted in 1998 and quickly expanded until some 40% of general practices were working under these locally negotiated and more flexible contracts by 2003. April 2004 also saw the introduction of permanent PMS Agreements.

PMS Plus contracts are variations to the core PMS Agreements that support new service development in primary care that go beyond standard 'GP' services. The opportunities for providing such services may include services aimed at a particular population with specific needs, eg the homeless, or wider community care.

Extensions to GMS Contracts

The new General Medical Services Contract, of which the PMS scheme was considered in many ways to be a trail blazer, was introduced in NHS general practice in April 2004, this being a new national contract that is managed locally and which is a 'pay for performance' contract that has a Quality and Outcomes Framework with clinical and organisational indicators that have to be achieved in order for practices to be paid additional quality incentive payments.

A further option is provided by enhanced services that are designed to provide a major opportunity to expand and develop primary care, and give practices greater flexibility and the ability to control their workload. These form additions to the GMS Contract. Services are provided under a number of different categories that include treating patients who are alcohol misusers or patients suffering from drug misuse. Enhanced services are intended to help PCTs release the demand on secondary care and ensure value for money and provide a mechanism for contracting for primary care services.

Alternative Providers of Medical Services (APMS)

Under Alternative Provider of Medical Services (APMS) contracts PCTs can contract with independent, voluntary, or not-for-profit, providers for the delivery of primary care services. The APMS contract option was introduced explicitly to address problems of poor access and under-provision of general practice in some areas and to secure innovative models of care, or in some cases, to relocate services from acute to community settings. APMS is being used by many PCTs as a route to contract with private sector providers of primary care and to introduce a new degree of contestability into the local primary care market but has a wider application to all primary care services. It forms the contracting mechanism for contracts engaging private and third party providers in provision of primary care services.

Specialist Personal Medical Services (SPMS)

Another new contract option available to PCTs is Specialist Personal Medical Services (SPMS). SPMS is designed as a way of contracting for care delivered in specific disease areas (e.g. mental health) or for particular patient care groups (e.g. care home residents), and the scheme does not require a registered list of patients, involvement of a GP, or provision of essential primary care services. It can only be provided by bodies that are entitled to hold PMS Agreements, however. A widely publicised example of SPMS being used as a contracting method to underpin a new model of organisation and governance of former PCT services is Central Surrey Healthcare where an SPMS contract has been used along with the establishment of a not-for-profit company limited by shares, a company that delivers services previously managed by the PCT. Nurses and therapists at East Elmbridge and Mid Surrey PCT have been transferred under TUPE arrangements into a new organisation that is owned by employees, and provides nursing and therapy services. The scheme promises increased integration and co-ordination for health promotion, self managed care, and care pathways. and became operational in October 2006 (see page 20 for more details). This would have been on the basis that the company was a "qualifying body" as defined in the PMS Agreements Regulations 2004.

What is clear is that these new contracting methodologies give PCTs additional flexibility in terms of how they commission primary

care services. These contracting options can be applied to contract with many of the legal entities (both NHS and non-NHS) explored below, although there are particular regulatory requirements in each case on which legal advice should be sought.

4.4 Models of organisation and governance for PCT provider services within the NHS – the 'NHS family'

In this section, we examine the different legal entities that might be used by PCTs when organising and governing their provider services within the NHS or statutory sector. We consider six organisational forms:

- managed practitioner networks
- horizontal integration (children's trusts, care trusts)
- vertical integration of primary and secondary care services
- provider units
- community foundation trusts
- arm's length management organisations

4.4.1 Managed practitioner networks

Managed practitioner networks are not a specific legal entity in themselves, but are an affiliation of health and social care organisations. These networks seek to ensure co-ordination of service responses around the needs of individuals by creating linkages between all relevant service provider agencies, providing a functional rather than a structural solution to managing complex service provision. Managed practitioner networks operate outside but alongside service provision structures and are principally concerned with the inter-activity of practitioners and how it provides better quality of life outcomes for service users. While care networks are nothing new to health and social care service professionals, and indeed such networks are widely established as the working model in cases of child protection and the management of services for adults and older people with mental health problems, it is possible that clinical pathways may form the basis either for specialist providers to contract for the entire pathway, or for joint ventures between providers for a similar purpose. The needs of an entire user group population are likely to be too broad to become the focus of such a network, and so particular groups with specific needs could be identified to form the focus of one or more networks. It is crucial that the group selected should present challenges to, or require support from, all the practitioners and agencies represented in the network. Possibilities include long-term conditions management and primary care services for young isolated males with mental health problems.

Case study of a managed practitioner network: Sussex cancer network

In April 2001 the Department of Health established a national cancer research network; Sussex was one of 34 such networks within the UK and is a managed clinical network within the former Surrey & Sussex Strategic Health Authority, charged with integrating cancer management across the county. This is achieved via a strategic service development plan against which PCTs commission services; identified local standards and pathways; agreed models of care; and flexible use of staff across boundaries to cover gaps in service

http://www.sussexcancer.net/professional/sussexcancerresearch.php

Assessment of managed practitioner networks

Benefits

- Patient focused
- As a functional, rather than structural solution, may be more readily realised
- Likely to be no procurement constraints, as an in-house or joint working arrangement

Risks

- No external drivers or challenge in relation to excellence
- Potential for service fragmentation as focus is on a clinical condition, not the whole patient
- Falls down for patients with multiple needs
- A piecemeal solution only
- Integration between health and social care may present challenges and some regulatory issues.

4.4.2 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 has been 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 with local authorities and health agencies being explicitly encouraged to develop models to address local conditions. An important potential vehicle for some children's services, a provision-only children's trust (as opposed to one that also commissions children's services) will be able to explore integrated forms of service delivery, such as multi-disciplinary organisations providing a wide range of services out of a single location. However, many of the national pathfinder pilots are commissioning (and not provider) entities.

In the first instance, children's trusts were piloted for three years with a view to ensuring best use of the powers already available for local authorities and health agencies to work together. Consequently, early children's trusts were based on the flexibilities of the 1999 Health Act bringing together local authority functions and health service functions delegated by PCTs. In 2004 the Children Act 2004 came into force and contains a number of powers and duties to help the development of children's trusts including a wide power to pool budgets and a duty on agencies to co-operate. There is, however, no duty to set up children's trusts in the Children Act 2004, which would have necessitated a prescriptive strategic model. Instead children's trusts are to be seen as a set of effective local arrangements, developing organically in response to local circumstances. The duties in Section 10 of the Children Act 2004 require local authorities and their 'relevant partners' to co-operate to improve children's well being, defined in subsection 10(2) as being "physical, mental and emotional well being; protection from harm and neglect; education, training and recreation; the contribution made by them to society and their social and economic well-being".

Subsection 10(6) allows the local authority and any of its relevant partners to provide staff, goods, services, accommodation or other resources and establish and maintain a pooled fund. The definition of a relevant partner for these purposes is wide and as well as encompassing strategic health authorities and primary care trusts includes police authorities, probation boards, youth offending teams and the learning and skills council.

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 (University of East Anglia 2005). While many pilot sites are testing common forms of assessment, these were typically yet to be fully operational at time of publication of the initial evaluation, with ongoing professional concerns expressed over data security and confidentiality. While some pilot sites were developing co-located services these remained in their infancy for 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 and joint commissioning arrangements.

Case study of horizontal integration: Bexley Children's Trust

Bexley Children's Trust aims to commission and, as relevant, provide services for children, in particular those with a combination of health, educational and social care needs.
Set in a context of successful prior partnership working between agencies, the trust is establishing children's centres and developing fully integrated information, referral and assessment systems for health, education and social services. Further details on terms of reference and progress are available on Bexley Council's web-pages

http://www.bexley.gov.uk/service/children/trust.html

Care trusts

Proposed in the *NHS Plan* (Department of Health 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 a PCT or on a NHS provider trust, to join up responsibility for health and social care for specified client groups. NHS and local authority functions are delegated to care trusts, who may, depending on the underlying Section 31 Agreement(s), 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 or older people.

Case study of horizontal integration: Torbay Care Trust

Torbay Care Trust seeks to both commission and supply adult services. Under the terms of their care trust application, the PCT has formed the basis of the care trust with an expanded board and the potential to transfer local authority staff contracts to the NHS. In the context of uncertainty over the future divestment of service delivery, the care trust has become the vehicle through which the local NHS, in an integrated fashion with the local authority, manages the future disposition of provider services (i.e. it may continue as the direct provider or facilitate their future divestment). In this way, the care trust can ensure a provider with a specific focus on, and overview of, provision across the locality during turbulent times.

http://www.torbay-pct.nhs.uk/

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. Indeed, it is interesting to note that several years on, there are still very few care trusts in place, mainly because many sites felt that the same outcomes could be achieved without the disruption that full organisational merger would entail (Glasby, 2006, personal communication). Where existing inter-agency relations are not good, the organisational and cultural challenges involved in merger risk making relations worse (Dickinson et al, 2006). 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 insecurity 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 organisational 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 organisational boundaries can preserve existing staff benefits, although secondment models have recently been called into question
- Established and flexible model suitable for a large number of different applications and situations

Risks

- Frictions from two-system approach (health and social services)
- Potential ambiguities over extent of responsibilities
- Can be constitutionally complex in practice

4.4.3 Vertical integration of acute and primary care services

The NHS and Social Care Long-Term Conditions model (Department of Health 2005b) is designed to help ensure that health and social care organisations take a systematic and structured approach to improving the care of those with long-term conditions. 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 from the United States 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 (considered above) 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 of organisations, virtual rather than vertical integration, will be the preferred model, and this is supported by US evidence which suggests difficulties in bringing primary and secondary services together in the same organisation.

Case study of vertical integration: Evercare

The 'Evercare' model combines nurse-led assessment with intensive case-management for frail elderly patients. Intensive evaluation of ten pilot-sites in the UK identified modest impact on emergency admissions.

http://www.natpact.nhs.uk/uploads/2005_Feb/Evercare_evaluation_interim_report.pdf

Assessment of vertical integration of acute and primary care services

Benefits

- Whole care pathway solution
- Financial incentives towards system efficiencies

Risks

- Potential for monopoly provider
- Largely untested in the UK
- Requires an accountability framework to be developed with the commissioning PCT
- Structural difficulties could be avoided by virtual integration

4.4.4 Provider units

Some PCTs are exploring or actively developing the concept of a 'provider unit' within the organisation to establish new governance arrangements that ensure a formal separation between their commissioning and provider functions. These typically comprise of a provider services unit that hosts all PCT provider services, led by a strategic provider board that is then accountable to the PCT board. It should be noted that a provider unit is not a separate legal entity – the PCT remains the formal statutory body, irrespective of mechanisms put in place to 'separate' out provider and commissioning functions. Provider services are formally commissioned by a separate PCT structure through service level agreements. Bury PCT has adopted this structure with a provider board comprising clinical staff alongside executive and non-executive members of the main PCT board. The new Wirral PCT is also adopting this model (see case study box) and is 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 an organisational and governance model in its own right for the future delivery of PCT provider services, or as a 'step-change' towards community foundation trust status or the establishment of a social enterprise.

Case study of a provider unit: Wirral PCT

Wirral PCT (a merger of Birkenhead and Wallasey PCT with Bebington and West Wirral PCT) is developing an 'arm's length' provider directorate overseeing three local health directorates that include all PCT-provided services, practice-based commissioning clusters, and GP provider services. The PCT has built its structure to achieve strong clinical engagement with local professionals, especially independent contractors such as GPs, pharmacists, optometrists and dentists. The PCT has three part-time primary care medical directors, each one responsible for a locality as well as having Wirral-wide service development roles. These three posts not only 'manage' a locality, they also sit on the high-level PCT commissioning group and thus this 'separates' them from a practice-based commissioning provider function, for each of Wirral's four practice-based commissioning clusters are led by an elected GP separate from the main PCT management organisation. The provider directorate management board (PDMB) will be accountable to the PCT board through the PCT's performance committee. To ensure a formal separation of commissioning and provision, the PCT's commissioning arm will commission services through service level agreements with the PDMB who will performance manage services to ensure effective delivery. The PCT is developing this structure as a potential step-change towards community foundation trust status.

http://www.bwwpct.nhs.uk/index.asp

Assessment of provider units

Benefits

- 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
- 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

Risks

- A service level agreement 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 claim to be 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

4.4.5 Community foundation trusts

In the commissioning framework published in July 2006, the Department of Health was explicit in its intention to 'explore the feasibility of community NHS Foundation Trust status' as another potential model for provider services (Department of Health, 2006b, paragraph 4.6). The decision to move forward with this as a firm policy direction will depend on the outcome of consultation on the commissioning framework. What is clear however is the intention to ensure that if proved to be feasible, the new community foundation trusts will be able to demonstrate a patient focus together with innovative models of providing community health services.

Community foundation trust status would afford community provider services the same freedoms already given to NHS foundation trusts, but also the same challenges in terms of working with new local accountability, public involvement and regulation arrangements. Organisational development to establish a shadow foundation trust for assessment by the regulator (Monitor), whilst services still remained an entity of the PCT, would need to be worked through, particularly in terms of allocation of management support. The community foundation trust model offers some of the benefits of social enterprise in enabling providers to become self-governing and more autonomous, with the ability to retain financial surpluses for developing services and the organisation. This may be an attractive option where there is local opposition to services moving outside NHS management. Community foundation trusts will be able to grow the business by expanding their services beyond existing PCT boundaries, merging current provider services to gain economies of scale and increasing the opportunity for greater efficiencies and innovation. Equally, it is possible that there could be a development of specialist community foundation trusts covering a much wider geographical area, bringing together those services where critical mass and professional isolation has been a historical barrier to service development, for example community rehabilitation services, rapid response nursing teams, and sexual health services. For commissioners, this may bring challenges in terms of monopoly of provision and restriction of patient choice.

Assessment of community foundation trust model

Benefits

- Existing legal form with separate legal entity (the public benefit corporation)
- Lock on public assets would be in place
- Regulation by Monitor would ensure financial rigour

Risks

- Complex public engagement model and constitution
- Regulation by Monitor restricts freedoms
- Potential for monopoly provision and restricted patient choice

4.4.6 Arm's-length management organisations (ALMOs)

The ALMO programme is an approach to organising and governing provider services in the local government sector that has potential application to the NHS. It concerns central government giving active encouragement to local authorities to develop new forms of service delivery while allowing councils to continue to maintain overall ownership and control of services at local level. ALMOs most frequently take the form of bodies set up by local councils to manage and improve local housing stock. Unlike large-scale voluntary transfer (LSVT), with ALMOs, housing 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 organisation of the company is at arm's length, but the stock and company are owned by the council. The core business of an ALMO is thus embedded in the 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 community 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.

Case study of an arm's-length management organisation: Sheffield Homes

Sheffield City Council (SCC) is a metropolitan council in South Yorkshire. The ALMO, Sheffield Homes Limited (SHL), was established in April 2004 and manages 53,500 council dwellings in ten housing management areas and has a delegated housing revenue account (HRA) budget from SCC of £44 million and capital budget of £114 million (2005/06). It also receives a management fee of £36.5 million (2005/06). In the five geographic areas under inspection there are 21,647 properties including 759 leaseholders managed from 11 local housing offices.

http://www.sheffieldhomes.org.uk/latest-news

Assessment of ALMOs in health

Benefits

- Would provide a focused delivery body
- Would retain ownership and control
- May retain pension entitlements for NHS staff

Risks

- Unlikely to be possible legally currently due to restrictions on creating separate legal entities to provide statutory functions
- Could be possible if the object was to generate 'profit' for the PCT, 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 in-house, the PCT would need to contract with the ALMO as an external body and the relationship could be exposed to competition

4.5 Models of organisation and governance for PCT provider services outside the NHS – the independent and third sectors

In this section, we examine the different legal entities that might be used by PCTs when organising and governing their provider services outside the NHS or statutory sector. We focus on those private and third sector organisational vehicles that are likely to be appropriate to social enterprise, for we consider that these are most likely to be acceptable to PCTs and their stakeholders (especially to staff). We consider five organisational forms:

- company limited by guarantee

- company limited by shares

- community interest company

- community benefit society

- co-operative

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 (some that are specific to the third sector and others that are taken from the private sector and applied within a social enterprise approach), including incorporated associations, trusts, community interest companies, charitable incorporated organisations (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 and that choice of legal structure reflects the needs and aspirations of the provider organisation. 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 place control in a small management committee without beneficiary members, the committee running the business to provide a service to the defined community. Any investments by stakeholders are nominal and profits reinvested are 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, all of which are currently being considered as forms of 'social enterprise'. For this reason, we set out a description of social enterprise before going onto examine the specific legal entities within which social enterprise objectives can most effectively be pursued.

The private sector itself is of course an option that PCTs could explore as an organisational and governance form for provider services. It is hard to envisage currently that a PCT would be able to pursue such an approach for transferring its existing community services, given the need to satisfy acceptability criteria as part of an evaluation of options. However, this sector is already part of the local care market in many areas (typically following a competitive tendering exercise) so it has to stand as an option available to PCTs. The logistics of such an option becoming acceptable to staff require significant further development, and it will be interesting to observe how far this is pursued by PCTs, and how far it is supported by policy makers.

Social enterprise

Social enterprise as a business model covers a wide range of industries and sectors. There are at least 55,000 UK social enterprises with a combined turnover of £27bn per year and social enterprises account for 5% of all businesses and contribute almost 1% of GDP (Department of Trade and Industry 2005). Social enterprise is defined by the government as:

"...a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners"

(Department of Trade and Industry 2002, p 13)

Citing Maltby (2003), Lewis, Hunt & Carson (2006) argue that mutual (i.e. social enterprise) providers may be particularly beneficial when one or more of the following conditions apply:

- If a monopoly of essential services exists
- If services are underpinned by a high level of public subsidy
- When contracting for complex public service, as contracts may themselves be insufficient to protect the public interest or deal with issues of safety
- Where a key policy aim is to increase 'social capital' and/or promote public co-operation

Public commissioners can therefore realise commissioning objectives such as '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 may well prove successful in procurement processes with assessment criteria that value such 'community benefits'. 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.

Social enterprise is increasingly being seen by PCTs as a solution to the formal separation of commissioning and existing provision functions and for new models of service organisation such as health and social care alliances and integrated provision between community health services and general practice. The Department of Health is actively supporting social enterprise as a business model for the provision of community health and social care services. The recent White Paper continues a policy direction of supporting and developing social enterprise and using 'business disciplines for social objectives' (Department of Health 2006a, p176) and as mentioned earlier, from April 2007 the Department will have established a Social Enterprise Unit supporting PCTs with set-up costs and professional advice in relation to social enterprise.

For NHS staff, social enterprise offers an alternative form of employment that is

closely aligned to public sector princples and values and as such is seen by many as a more professionally and culturally acceptable provider model than 'for-profit' models with stakeholder beneficiaries. As we note in this report, social enterprise models such as Central Surrey Healthcare and Rushcliffe Mutual are already emerging within primary care, demonstrating some of the perceived benefits and potential barriers outlined in this paper. Whilst there is national and local support for social enterprise provision, PCTs face the tricky issue of NHS pension rights when examining the feasibility of this legal entity. For example, social enterprises favour involvement of other professions, patients and the public in their governance structure and see this as central to their concept, but some putative NHS social enterprises have been advised that unless all its directors are medical practitioners, their staff will not be eligible for membership of the NHS pension scheme.

4.5.1 Companies limited by guarantee

Companies limited by guarantee are suitable for use with a non-profit distribution structure often combined with charitable status, comprising a two-tier management structure of a 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 electing the 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. Accountability arrangements can be costly however, and regulation is tight.

Case study of a company limited by guarantee used to develop a social enterprise: Rushcliffe Mutual

Rushcliffe Mutual is being established as a not-for-profit company limited by guarantee called 'Principia – Partners in Health' which aims to deliver practice based commissioning for a group of GP practices in Nottinghamshire, plus community health services. Its origins lie in the work of the Rushcliffe PCT Professional Executive Committee, which systematically reviewed practice referral activity (via a referral centre) and identified significant opportunities to redesign the patient pathway and release resources currently tied up in hospital activity. The challenge was seen as how to keep clinicians well-engaged in turning this opportunity into reality, and a model of mutuality was seen as the best way forward.

The Mutual involves GPs, other primary care contractors, such as pharmacists, nurses, and therapists. Principia has established a governance model that has all patients registered with the constituent practices as beneficiaries of the company. The mutual model creates opportunities for multi-practice collaboration on the provider side too, including sharing of back office functions and development of professional roles. Contractually, the company has an APMS contract from the PCT for the delivery of practice based commissioning, and in the short term will have a staff supply agreement with the PCT for the provision of community staffing. However, in the longer term the Mutual's leaders are clear that the company will wish to employ its own community staff.

The challenges faced in taking forward the mutual proposal have been both national and local. Involvement of other professions, patients and the public in the governance structure is central to the concept, but the company has been advised that unless all its directors are medical or nursing practitioners entitled to hold GMS contracts, its staff will not be eligible for membership of the NHS pension scheme. There are also problems with the mutual's eligibility for the Clinical Negligence Scheme for Trusts. Both these issues are being addressed by the Department of Health. Locally, the Mutual is aware that the principles of choice and contestability will need to be demonstrated in its approach to provider services, and it sees strong patient and public involvement in its governance as a mechanism for ensuring this. The structure of the NHS tariff, even with the changes for 2006/7, does not facilitate redesign of care pathway so the Mutual would like to push forward local agreements on unbundling.

Assessment of companies limited by guarantee

Benefits

- 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 members model with staff engaged as members
- Separate legal entity

Risks

- 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 with the commissioning PCT
- Regulation by Charity Commission will apply if charitable status is accorded

4.5.2 Companies limited by shares

This is the most common form of incorporated body offering limited liability for its shareholders. It is a well understood and flexible way for a business to be established as a legal entity with a view to its making profit for distribution to its shareholders. Shareholders' liability is limited to the unpaid value of their shares in the company. Ownership of shares usually gives voting rights on matters requiring a shareholder resolution as determined by the Memorandum and Articles of Association of the company and/or by company legislation, and there may be an agreement between shareholders as to how shares are dealt with.

Companies can attract investment by offering new shares for sale (in addition to contracting for debt finance – a finance raising route would be available in theory to all the corporate vehicles). Profits are paid to shareholders as dividends.

Companies are relatively inexpensive to set up, although there are various reporting requirements that must be fulfilled while the company is trading. Management control is in the hands of a board of directors. Company directors have a number of duties to their company relating to corporate governance and should take advice as to the extent of those duties and how to fulfill them. Directors can be held personally liable (in civil and criminal actions) for failing to perform their duties.

Case study of a company limited by shares: Central Surrey Health (CSH)

Central Surrey Health was established on 1 October 2006 as one of the first independent organisations to emerge to provide NHS community health services. Over 650 nursing and therapy staff transferred from the Surrey Primary Care Trust to the new organisation whilst retaining their NHS terms and conditions.

As a co-owned organisation, Central Surrey Health will operate within the philosophy of a social enterprise investing profits back into staff and service development. Established as a company limited by shares all staff own a single share in the company. This model is expected to foster a sense of staff ownership and empower clinical staff to create innovative services that are congruent with the priorities of the commissioning PCT.

The model was developed by staff over a 20-month period and was operational within the primary care trust for two months prior to establishing itself as a separate organisation.

Although its inception pre-dates Commissioning a Patient-led NHS, Central Surrey Health is supported by the PCT as a model that facilitates a clear separation between commissioning and provision while retaining core NHS values. The organisation has agreed a three year SPMS contract worth £20m with the PCT to deliver services within community and hospital settings.

Assessment of companies limited by shares

Benefits

- Well-known established and flexible model
- Limited liability for shareholders
- Incentive for generating efficiencies and innovation for personal profit
- Can be a members' model with staff engaged as shareholders
- Able to raise equity as well as debt finance
- Separate legal entity

Risks

- Not a social enterprise model
- Suspicion of for-profit models in health sector
- May be able to access NHS pension entitlements if structured as an APMS/SPMS provider with clinician-only shareholders
- Needs an accountability framework to be developed with commissioning PCT

4.5.3 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.

Assessment of community interest companies

Benefits

- 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 recognised publicly as a social enterprise model
- May be a Direction Status employer for NHS staff seeking to transfer their 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

Risks

- 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

4.5.4 Industrial and Provident Societies (IPS)

Two types of industrial and provident society are available as options for the organisation and governance of health services: community benefit societies and co-operatives.

Case Study of a community interest company: Gateway Family Services

Gateway Family Services offers training in health and social care to excluded communities across Birmingham. It helps people access work in the health sector and encourages community involvement in the delivery of public services. The new company was originally established as part of South Birmingham Primary Care Trust in 2004 specifically to address the health inequalities faced by people in disadvantaged areas and to tackle the under-representation of minority communities and other excluded groups in health and social care employment. Using the new legislation, the PCT converted the company into a CIC in 2006.

www.gatewayfs.org

(a) Community benefit societies (BenComms)

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). The Co-operative and Community Benefit Societies Act 2003 gives the Secretary of State power to make regulations allowing societies to provide that their assets are dedicated permanently for that purpose and connected purposes. The Community Benefit Societies (Restriction on use of assets) Regulations came into force in April 2006. They provide that where a society has a restriction on use of the assets, the assets may only be used in the ways allowed by the restriction – intended to stop conversion to company status ('carpet-bagging').

Case Study of a community benefit society: Growing Well

Growing Well was founded in 2003 in Cumbria with the aim of providing people recovering from mental health problems opportunities to develop their confidence and skills in the workplace. Their objective is to provide a sustainable therapeutic work environment that enables adults recovering from mental health problems to recover, grow and move nearer to the labour market. Growing Well achieve this by offering volunteering opportunities throughout the running of their Soil Association certified social enterprise. As an organisation, they grow and sell organic produce, provide accredited training in horticulture (NVQ) and run an educational programme aimed at increasing the connections between local school children and their food. A large proportion of the volunteers have placements at Growing Well funded through a spot purchasing contract with the local Council. The council and the founders of Growing Well identified a lack of service provision in this area and therefore saw this social enterprise as positive development for the area and complementary to existing services.

www.growingwell.co.uk

Assessment of community benefit societies (BenComms)

Benefits

- 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

Risks

- Less flexible than some other corporate forms, as constitutionally may only be changed with Financial Services Authority (FSA) 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.

Case study of a co-operative: Seldoc out-of-hours GP cover

Co-operatives have been used to provide out-of-hours GP cover rather than use duty rotas or commercial deputising services. One example is that of the South East London Doctors Co-operative (Seldoc), established in Lambeth, Lewisham and Southwark in 1996. Employing over 70 non-clinical staff and with an annual turnover in 2003 of £2m, the 120 GP members are each obliged to undertake 12 out-of-hours shifts a year. Profits are reinvested to provide additional services to members including a GP and practice nurse locum service.

http://www.seldoc.co.uk/

Assessment of co-operatives

Benefits

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

Risks

- 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

4.6 Considering options for organising and governing PCT provider services

This chapter has outlined and assessed a range of organisational and governance options available to those in PCTs seeking to transfer service provision from direct PCT management to some other NHS arrangement (managed practitioner networks, vertical integration, horizontal integration, provider unit, community foundation trust, arm's length management organisation), or when considering social enterprise, to a body outside the NHS (e.g. company limited by guarantee, company limited by shares, community interest company, community benefit society, co-operative). We set out on pages 22 and 23 tables that summarises the benefits and risks of the models of organisation and governance discussed above. In the final section of the report, we reflect on the analysis set out here, examining the issues likely to be faced by PCTs as they review their provider function, taking account of their current dual function as both commissioners and providers.

NHS family		
Organisational Form	**Benefit**	**Risk**
Managed practitioner network	■ Patient focused ■ As a functional rather than structural solution may be more readily realised ■ Likely to be no procurement constraints, as in-house	■ No external drivers or challenge in relation to excellence ■ Potential for service fragmentation as focus is on clinical condition not whole patient ■ Falls down for patients with multiple needs ■ A piecemeal solution only ■ Integration between health and social care may present challenges and some regulatory issues
Horizontal integration (Children's trust, care trust)	■ Integration across organisational boundaries can preserve existing staff benefits, although secondment models have been called into question ■ Established and flexible model suitable for a large number of different applications/situations	■ Frictions from two-system approach (health and social services) ■ Potential ambiguities over extent of responsibilities ■ Constitutionally complex in practice
Vertical integration of acute and primary care	■ Whole care pathway solution ■ Financial incentives towards system efficiencies	■ Potential for monopoly provider ■ Largely untested in UK ■ Requires an accountability framework to be developed with the commissioning PCT ■ Structural difficulties could be avoided by virtual integration
Provider unit	■ Provides continuity and stability ■ Removes need for consultation on forming a new body ■ Avoids contractual, employment, pensions, equipment and property issues associated with forming a new body ■ Allows informal and ad hoc arrangements ■ Maintains provider function access to PCT support services ■ Maintains NHS assets and goodwill in public ownership ■ Safeguards services for vulnerable groups that may not be best served by independent providers	■ A service level agreement imposed by PCT as commissioner would have no legal enforceability (PCT cannot contract with itself) ■ Unless leadership of the provider function had no links with commissioning arm, provider arm could not claim to be an independent body ■ Might be difficult to identify and segregate costs that are unique to the provider function ■ Legally, provider function is indistinguishable from the PCT and therefore PCT remains liable for its actions
Community foundation trust (Public benefit corporations)	■ Existing legal form with separate legal entity (public benefit corporation) ■ Lock on public assets would be in place ■ Regulation by Monitor ensures financial rigour	■ Complex public engagement model and constitution ■ Regulation by Monitor restricts freedoms ■ Potential for monopoly provider and restricted patient choice
Arm's length management organisation	■ Would provide a focused delivery body ■ Would retain ownership and control ■ May retain pension entitlements for NHS staff	■ Unlikely to be possible legally at present, due to restrictions on creating separate legal entities to provide statutory functions ■ Could be possible if object was to generate 'profit' for the PCT, but that is unlikely to be a viable service model ■ If in-house, procurement with third parties would be governed by EU procurement rules ■ If not in-house, PCT would have to contract with ALMO as an external body and the relationship could be exposed to competition

Non-NHS Bodies		
Organisation Form	**Benefit**	**Risk**
Company limited by guarantee	■ Well known established, and flexible model ■ Suitable for not-for-profit and charitable models ■ May achieve Direction Status for transferring NHS Staff pensions ■ Transparent legal form ■ Limited liability for members ■ Can drop limited designation in some circumstances ■ Can be a members model with staff engaged as members ■ Separate legal entity	■ 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 with the commissioning PCT ■ Regulation by Charity Commission if charitable status is accorded
Company limited by shares	■ Well-known established and flexible model ■ Limited liability for shareholders ■ Incentive for generating efficiencies and innovation for personal profit ■ Can be a members' model with staff engaged as shareholders ■ Able to raise equity as well as debt finance ■ Separate legal entity	Risks ■ Not a social enterprise model ■ Suspicion of for-profit models in health sector ■ May be able to access NHS pension entitlements if structured as an APMS/SPMS provider with clinician-only shareholders ■ Needs an accountability framework to be developed with commissioning PCT
Community interest company (CIC)	■ Social enterprise objectives hardwired into constitution – e.g. asset lock ■ Monitored by a regulator to ensure community interest test is satisfied ■ Limited liability for members ■ Will be recognised publicly as a social enterprise model ■ May be Direction Status employer for NHS staff in relation to pensions transfer ■ It may be more acceptable to NHS staff ■ There is less need for an accountability agreement ■ Can opt for not-for-profit and for-profit models ■ Separate legal entity	■ 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 and some other corporate forms ■ May be for-profit ■ Question mark over provision of core public services
Industrial & provident society (community benefit society)	■ Limited liability ■ Social enterprise – run for benefit of community rather than members ■ Capable of having charitable status ■ May achieve Direction status for NHS transferring staff pensions ■ Separate legal entity	■ Less flexible than some other corporate forms as constitutionally may only be changed with Financial Services Authority (FSA) approval ■ May not have open membership ■ Regulation by Charity Commission if charitable status
Industrial & provident society (co-operative)	■ Limited liability ■ Hybrid social enterprise/personal advantage model ■ Accountable – open membership policy ■ Separate legal entity	■ Will not qualify as an NHS pension provider and may not achieve Direction Status ■ Less flexible than some other corporate forms as constitution may only be changed with FSA approval ■ Not capable of achieving charitable status

5. Discussion and conclusions

5.1 Introduction

As set out in section 2 of this report (Policy Context), PCTs find themselves with two core functions, commissioning and provision, which can be viewed as either complementary (enabling a strong primary and community care base from which to plan, purchase and further develop acute care) or in conflict (preventing the PCT from focusing clearly on its role as a local commissioning body that plans, purchases and accounts for levels and quality of care to the local population).

In this section, we examine the issues facing PCTs as they review the services they currently provide (for example, community nursing, health visiting, community therapy services) and suggest the challenges that they are likely to face, along with possible approaches they might wish to consider for organising and governing these particular PCT services. We make our analysis in the same format as we adopted for the overall report: firstly from the perspective of the PCT as commissioner; and secondly from that of the PCT as a provider of services. We then go on to examine how a PCT could draw together these two perspectives as it makes its final decisions about the future organisation and management of its provider services, and set out the factors that will inevitably impact on such overall decisions.

5.2 The PCT as commissioner

PCTs are under significant policy and management pressure to 'up their game' as commissioners, given the widely held view that to date, PCT commissioning has not been sufficiently effective in bringing about desired change to NHS care (Bramley-Harker and Lewis, 2004; Smith et al, 2006). The NHS White Paper (Department of Health, 2006a) and the subsequent draft commissioning framework for the NHS (Department of Health, 2006b) made it quite clear that PCTs are expected to be commissioners that are able to properly assure both choice for local people about their health services and care, and also 'voice', that is proper involvement in local PCT decision making and accountability processes. In this way, PCTs are required to represent and meet the needs of people as individuals who will wish to exert consumer choices about care, and as collectives or communities whose voice should be properly heard within decision making processes. The PCT's role as commissioner has been described as follows in recent policy analysis carried out by HSMC and the King's Fund (Smith et al, 2006):

- the identification of need and demand;
- the shaping of local care markets;
- the holding of those markets to account; and
- the holding of commissioners to account.

The analysis of organisational and governance options for PCT provider services set out in this report is fundamental to the PCT's commissioning role as a **shaper of local care markets** and in relation to how it can **hold those markets to account**. It is our assertion that this role as shaper and manager of markets is one that is fundamentally different to what has gone before in PCTs, and on that basis we suggest that more robust assessment and challenge of the organisational form and governance arrangements for provider services is required.

We suggest that PCTs might use the criteria we set out on page 9 of this report as they explore the different organisational and governance forms for provider services that we have assessed in chapter 4. If making an assessment of organisational forms for their provider services (or as part of a procurement process where the PCT has tendered for a specific service), the PCT needs to have a transparent and auditable evaluation process for its provider service organisational options. That is, it needs to have a proper scoring system, possibly including some weighting of the different commissioning criteria that reflect the relevant importance of different criteria to the PCT and its objectives.

We suggest that this type of analysis of organisational forms in respect of specific commissioning criteria should be carried out by PCTs for different provider services, enabling them to explore the relative pros and cons of different options, taken from the perspective of the PCT as commissioner. It is likely that the demands of the PCT commissioner for robust governance, the promotion of innovation, economic viability and the development of public health (and the other commissioning criteria set out in chapter 3) will be best served by a mix of provider forms. In particular, views formed about a core service such as community nursing that involves often hundreds of staff, are likely to be different from those that emerge from an assessment of a small and specialist service. Analysis of provider forms might even vary between two examples of the same organisational form (e.g. two community benefit companies coming forward in a tendering exercise), for the scoring will ultimately be of an individual organisation and not just of the form or legal entity per se. As set out in chapter 3, an initial assessment can be made of the different legal entities/organisational forms available, followed by the application of criteria within an actual tendering or procurement exercise.

In its commissioning role, the PCT will be concerned with shaping a local market of care that will enable the PCT's wider commissioning strategy and priorities to be delivered (with a particular focus on health objectives and financial viability), and for robust organisation and governance to be demonstrated.

5.3 The PCT as provider

Almost all PCTs are currently providers of community health services, as well as having a core commissioning and public health role. The nature and range of service provision by PCTs varies enormously, and this in itself will have a significant impact on the decisions that PCTs will reach about appropriate organisation and governance for such services. As PCT commissioners demand assessment and review of provider services, they will look to the PCT's managers of provider services to consider different organisational and governance options, and to explore the feasibility and acceptability of such models with staff and other stakeholders. In making such considerations, we suggest that the analysis carried out in chapter 4 of this report could be useful as a way of highlighting potential benefits and risks associated with different options.

PCT provider service managers would also be wise to consider organisational and governance options according to the criteria that commissioners are likely to use when shaping a local market (see table one on page 9) and also according to the criteria that commissioners could apply as part of the evaluation of a service option within a tendering process (see table two on page 10).

It is likely that where PCT provider service providers are considering alternative structural forms that PCT managers will hold

meetings and workshops to explore possible future organisational arrangements with colleagues and other local stakeholders. The criteria and assessments set out in this report are intended to be aids to such processes.

5.4 Bringing together the two sets of assessment of PCT provider services

PCT boards will ultimately have to make the final decision as to the future organisational and governance arrangements for services that have to date been a core management responsibility of the PCT. In making such decisions, they will draw together their conclusions as a commissioner (shaper and manager of local care markets) with that as a service manager (responsibilities to staff, patients, carers and accountability to service commissioners).

The specific choice of organisational and governance forms finally chosen by a PCT for its provider services will depend on many factors including:

- The views of the PCT board about the role of the organisation (purely a commissioner, a commissioner rooted in the provision of community services, a health maintenance organisation that provides what is can and buys in the rest, etc.).
- The outcome of 'fitness for purpose' assessment of the PCT's provider services and recommendations made by the strategic health authority to the PCT.
- The nature of local clinical leadership, including desire to develop new organisational forms that are less closely tied to mainstream NHS management.
- The desire or otherwise of local NHS staff to move outside NHS line management.
- The nature of local service configuration and the degree to which there is competition.
- The extent to which vulnerable patient groups are excluded from or well served by current service provision.
- The existence or otherwise of effective partnership working across local care organisations (NHS and local authority).

Evidence from research into health care organisations would suggest that there will not be a 'one size fits all' solution to the dilemma facing PCTs as they review the organisational form of their provider services. The factors set out above are the main reason for inevitable variability.

What is crucial however is that PCTs will be able to demonstrate transparent and robust processes of assessment that have been carried out in reaching decisions about the future organisation of community health services. For even if the ultimate decision is to leave provider services as an arm of the PCT, as a commissioner acting within the spirit and requirements of the proposed new NHS commissioning framework, the PCT needs to be able to demonstrate that it has treated 'its own' services with the same degree of scrutiny and rigour as it would do when assessing tenders for services within a fully contestable procurement/ commissioning. At the time of writing, there seems to be particular interest within the NHS in the following options for the future organisation and governance of PCT provider services

- provider unit
- community foundation trust
- and to a lesser extent, forms of social enterprise such as the community interest company or company limited by guarantee

It may be that, as mentioned earlier in this report, the provider unit option will represent a step on the way to community foundation trust or a social enterprise model of organisation. The analysis set out in this report is intended to broaden the debate about organisational and governance models beyond the three examples set out above, and to serve as a reminder to PCT boards and managers that there are other options available. The community foundation trust offers what might at first sight seem a relatively familiar and 'comfortable' model for NHS managers, harking back to the community units of the 1980s and 1990s, although the markedly different accountability and governance arrangements as public benefit corporations are likely to be exacting, drawing on the experience of early foundation trusts. However, the application of foundation trust status to what will often be quite small organisations needs to be carefully thought through, as do the potential consequences in terms of restricting patient choice and 'locking up' models of service provision within a single (perhaps monopoly) local provider.

5.5 Conclusion

The PCT as local accountable NHS body will ultimately fund, plan and commission community services for its local population, and as such it will determine the future of services currently managed within the PCT. PCT boards face a daunting task as they develop a commissioning strategy for 2007 and beyond, operating within the new NHS commissioning framework and in a context that is clearly based on market principles at a time of increasingly constrained resource increases in the NHS.

The NHS community services White Paper and the new commissioning framework for the NHS make it clear that 'not to change is not an option'. There is a clear desire on the part of politicians and policy makers to push the NHS into a further phase of change and modernisation (aimed among other things at extending the degree of care available outside of hospitals) and to use competition and contestability as part of this process of system reform. This report has sought to help PCTs work out how they might develop provider services to meet such challenges. We conclude with the words of a recent HSMC thinkpiece on primary care markets:

'The health policy of the current government has been described as being one of trying to bring about 'creative discomfort' (Stevens, 2004) in an NHS in need of 'modernisation' if it is to deliver the degree of choice and access required by national plans (Department of Health, 2000, 2004b) ... Providers face some challenge to existing ways of working, and a need to explore ways in which they can better respond to patients' desire for greater responsiveness and choice... This does however depend on strong and effective commissioning of primary care and other services, perhaps the biggest challenge facing the NHS today.' (Smith et al, 2005, p8)

References

1. Borill, C.S., Carletta, J., Carter, A.J., Dawson, J.F., Garrod, S., Rees, A., Richards, A., Shapiro, D., & West, M.A. *The Effectiveness of Health Care Teams in the National Health Service: final report for the Department of Health.* Aston Centre for Health Service Organisational Research, University of Aston, Human Communications Research Centre, Universities of Glasgow and Edinburgh, Psychological Therapies Research Centre, University of Leeds, 2001
2. Bramley-Harker E. and Lewis D. *Commissioning in the NHS: challenges and opportunities.* London: NERA Economic Consulting, 2005
3. Central Surrey Healthcare. *Development of a limited company to provide nursing and therapy services under a Specialist PMS contract:* Outline business case 2005
4. Crampton, P., Davis, P., & Lay-Lee, R. Primary care teams: New Zealand's experience with community-governed non-profit primary health care. *Health Policy* 2005;**72**:233-243
5. Crampton, P., & Starfield, B. A case for government ownership of primary care services in New Zealand: weighing the arguments. *International Journal of Health Services* 2004;**4**:709-727
6. Department of Health. *The NHS Plan: a plan for investment, a plan for reform.* Cmnd 4818. London: Department of Health, 2000
7. Department of Health. *Standards for better health.* London: Department of Health, 2004a
8. Department of Health. *NHS improvement plans: putting people at the heart of public services*. Cmnd 6268. London: Department of Health, 2004b
9. Department of Health. *Commissioning a patient-led NHS.* London: Department of Health, 2005a
10. Department of Health. *Supporting people with long term conditions: Improving care, improving lives.* London: Department of Health, 2005b
11. Department of Health. *Our health our care our say.* Cmnd 6737. London: Department of Health, 2006a
12. Department of Health. *Health reform in England: update and commissioning framework.* London: Department of Health, 2006b
13. Department of Health. *The NHS in England: The operating framework for 2006/7.* London: Department of Health, 2006c
14. Department of Trade and Industry *Social enterprise: a strategy for success.* Department of Trade and Industry. London: 2002
15. Department of Trade and Industry. *Cracking open the public sector: It's happening, but how to scale up? Procurement: the social enterprise solution* London: Department of Trade and Industry, 2005
16. Dickinson H., Peck E. and Smith JA. *Leadership in organisational transition: what can we learn from the research evidence?* Birmingham: HSMC, 2006
17. Freeman T. and Peck E. *Adult care joint-ventures: aspirations, challenges and options.* HSMC and Integrated Care Network, 2006
18. Hudson, B. Integrated care trusts and structural change in England: the case of care trusts. *Policy Studies* 2002;**23**(2):77-95
19. Hudson M. *Managing without profit: the art of managing Third Sector Organisations, 2nd edition.* London: Director of Social Change, 2004
20. Lewis, R., and Dixon, J. *NHS market futures: exploring the impact of health service market reforms.* London: King's Fund, 2005
21. Lewis, R., Hunt, P., and Carson, D. *Social enterprise and community-based care: Is there a future for mutually owned organisations in community and primary care?* London: King's Fund, 2006
22. Maltby P. *In the public interest: assessing the potential of public interest companies.* London: IPPR, 2003
23. Peck, E., and Freeman, T. *Reconfiguring PCTs* Birmingham: HSMC, University of Birmingham, 2005
24. Smith, J., Ham, C., and Parker, H. *To market, to market: what future for primary health care?* Birmingham: HSMC, University of Birmingham, 2005
25. Smith J., Lewis R. and Harrison T. *Making commissioning effective in the reformed NHS.* London: the Health Policy Forum, 2006
26. Stevens S. Reform strategies for the English NHS. *Health Affiairs,* vol 23, no.3, pp37-44, 2004
27. University of East Anglia. *Realising Children's Trust Arrangements: National evaluation of children's trusts phase 1* report. Norwich: UEA, 2005
28. Wade, E., Smith, J., Peck, E. and Freeman T *Commissioning in the reformed NHS: policy into practice.* Birmingham: HSMC, University of Birmingham, 2006

UNIVERSITY OF BIRMINGHAM

School of Public Policy
Health Services Management Centre
University of Birmingham, Park House
40 Edgbaston Park Road
Birmingham B15 2RT

www.hsmc.bham.ac.uk