New Business Structures in Health and Social Care: Implications for Commissioning and Commissioners

A Briefing Paper for NHS Commissioners and Health Overview and Scrutiny Committees

April 2006

Preface – who is this paper for?

This briefing paper from The Moore Adamson Craig Partnership is for NHS commissioners, particularly PCT Board members and practice-based commissioners. It is also for members of Local Authority Health Overview and Scrutiny Committees. The focus is on England, but much of the information is also relevant to other parts of the UK.

The NHS and local government are moving closer together as commissioners of health and social care. That can only benefit the users of health and social care services. As a consequence health and social care commissioners will need to engage with a much wider range of service providers and they must understand new forms of business enterprise. This briefing paper aims to help them have a constructive dialogue between themselves and jointly with potential new business partners.

The two activities for commissioners to use at the end of the paper are designed to help PCT boards in particular think about their future as commissioning bodies, working in partnership with both practice-based commissioners and local authority commissioners.

We are grateful to board members of Wandsworth PCT for the opportunity to discuss an earlier version of this paper. The present paper has benefited from their feedback.

This briefing paper is freely accessible and can be downloaded from our website www.mooreadamsoncraig.co.uk

We invite feedback and comment from readers of this paper. Please send your thoughts to feedback@mooreadamsoncraig.co.uk We will post a selection of comments on our website as a contribution to the debate about new business structures in health and social care.

April 2006

Moore Adamson Craig Partnership Briefing Paper

New Business Structures in Health and Social Care: Implications for Commissioning and Commissioners

Introduction

This is a discussion paper to assist NHS bodies that commission services in England - Primary Care Trusts, Practice Based Commissioning Groups and individual primary care practices. It aims to aid them to engage in an informed and constructive consideration of the possible implications of new business structures in health and social care. A range of new providers could be part of the future organisation and delivery of these services. The content of the paper is also relevant for members of Local Authority Health Overview and Scrutiny Committees who are charged to monitor and challenge commissioning decisions on behalf of the public.

The paper discusses a range of health and social care enterprises and takes account of ***Our Health, Our Care, Our Say: a new direction for community services***, the White Paper on community health and social care published at the end of January 2006. A "future gazing" exercise and a discussion activity for commissioning boards are found at the end of the paper. These are designed to stimulate discussion about the future disposition of health and social services in specific geographical areas.

The national policy context

The ***Labour Party Manifesto 2005*** committed the incoming Government to work with "social enterprises" as a stimulus to the Third Sector* wherever possible*:"where services can be provided by mutuals, cooperatives or Community Interest Companies to the required standards of quality and value for money, they should be positively encouraged to develop and be included in procurement policies*."

> * "Third Sector" or Voluntary and Community Sector (VCS) is the preferred terminology for the diverse group of organisations often known as charities, not for profits, voluntary bodies and social enterprises. The organisations themselves are now collectively known as "VCOs"

In her policy speech on the next steps of NHS reform in England on 13 December 2005, Patricia Hewitt stated, *"I want to see more NHS social enterprises … we can build upon the work of the social enterprise unit that I created at the Department of Trade and Industry."*

The Secretary of State outlined the four main elements of NHS reform on 10 January 2006 in her Westminster Lecture for the NHS Confederation. These were:

1. more choice and a much stronger voice for patients, with patients' new rights to choose between hospitals transforming the way local services respond to the public

2. money following patients, rewarding the most efficient providers and giving the rest a real incentive to improve

3. more diverse providers, with more freedom to innovate

4. a framework of regulation and decision-making that guarantees quality, fairness, equity and value for money.

A meeting at Downing Street in early February 2006 between Chief Executives of 3rd Sector bodies, Home Office, Health and Treasury ministers and officials confirmed the bigger role the VCS will have in areas of public service delivery such as offender management, the NHS, schools and skills development. Both the CBI and the National Audit Office have signalled support for this. As one example, the "Pathways to Work" projects to get people back to work and off incapacity benefit will be delivered primarily by the private and voluntary sectors. Following this meeting the Prime Minister stated: "*It is clear that what matters to people is not who delivers public services, but that they are high quality and accessible to all."*

"More diverse providers, with more freedom to innovate"

Social enterprises, "mutuals", commercial "hybrids" and more conventional private sector business forms adapted for the public sector are likely to start populating the provision of primary and community health and social care as a result of Government policy about "contestability" of services. A task force has been established by Health Minister Liam Byrne to strengthen commercial links between the 3rd Sector and public sectors in health and social care.

The goal of not-for-profit enterprises taking over control of public assets in some cases has been identified. A new alliance of 3rd Sector organisations has been established for this purpose – the Voluntary Sector Management of Public Service Delivery Network. Historically, of course, education, health and care services were all provided by "voluntary" bodies before the State became involved.

Over time, working with these new businesses will become part of the matrix for both practice based commissioning (PbC) and for commissioning which remains at PCT level. PbC structures themselves are likely to change to reflect their need for more robust governance structures. The Londonwide Local Medical Committees are urging GPs to think creatively about alternative provider structures and business forms. They have identified one of the possibilities for who will take over the PCT's provider functions as *"organisations in which local PbC groups have a controlling interest as either for-profit, or not for profit, organisations".* The NHS Alliance has published ***The Nuts and Bolts of Primary Care Provision*** (January 2006) to guide thinking about new business models from small social enterprise companies to co-ops and mutual societies in order to ensure that primary care services can compete with large corporations and foundation trusts in future healthcare markets.

The recent White Paper identifies Foundation Trusts as potential players in primary care through the Alternative PMS arrangements. It is well known that some Foundation Trusts have significant aspirations in this direction and are intent on establishing primary care subsidiaries or acquiring existing primary care businesses to achieve "vertical integration" of their business.

For all of these new players, whether they are profit/surplus-making or not, the key questions to be answered before they can do business with the NHS will be around their fitness for purpose in terms of:

- corporate governance
- internal assurance and controls procedures
- compliance with healthcare standards
- regulators' requirements (Healthcare Commission, Commission for Social Care Inspection, Monitor for Foundation Trust expanded activities) and
- engagement with their customers/users who are funded NHS patients and social care users.

Divesting provider services from PCTs

Ministers made clear to the Health Select Committee that Government policy is still to divest provider services from PCTs, though no longer to the 2008 timescale announced in ***Commissioning a Patient Led NHS*** (July 2005)***.*** This longer-term objective has implications for staff employment and conditions as well as control of public resources and delivery of public services. Government has said that its objectives should be taken forward locally by agreement with PCTs.

The ***NHS Operating Framework 2006-07*** (the so-called "Managers Rulebook", January 2006) states: *"from 2007 each PCT will be expected to review formally and systematically whether local services are delivering high-quality, effective and efficient care, and whether they are tackling health inequalities. This applies both to directly-provided and contracted services, and will be a central part of each PCT's role as a commissioner. …/…. There is no requirement for PCTs to divest themselves of provision, and nor will there be in the future, but PCTs will also be free to make different arrangements where they believe these will continue to improve services, especially in relation to health inequalities."*

The implication is that PCTs which are not seen to seriously engage with the contestability process regarding their provider services will have to explain why not and justify their existing arrangements as providing the best solution.

The Health Select Committee report ***Changes to Primary Care Trusts*** (11 January 2006) spoke the feelings of many about the *"insecurity and distraction that has been caused within the NHS community"* by Government contestability policies. Against that must be placed the argument of well-placed observers such as Simon Stevens, former Downing Street adviser on health and now President of the European arm of United Health Group, that

"a search for constructive discomfort" is an essential part of achieving fundamental reform in health and social care.

The truth lies somewhere in between these polarities. But what matters is that changes are already happening and more seem to be in store. North Eastern Derbyshire PCT recently commissioned United Health Europe, from a shortlist of six bidders including local GPs, to provide primary care services on two sites as APMS practices in deprived former mining areas. However this change may not prove easy as the decision has been challenged through judicial review using Section 11 of the 2001 Health and Social Care Act alleging the PCT failed to consult properly with local people. Whether this is a bellwether or a one-off delay remains to be seen.

Despite somewhat mixed messages from the centre, it is timely for PCT Boards and practice-based commissioners to initiate a discussion about this whole area of national policy and its possible local implications. This paper identifies some of the possibilities for new business forms in local health and social care and points towards sources of more information.

Staffing new structures

The biggest practical issue with introducing any new business form which is outside traditional NHS direct employment is the status of national pay and conditions agreements for staff, especially pension entitlements. This is relevant both for NHS staff who will transfer to them and for staff engaged after they begin functioning.

This need not be the hurdle many have predicted. The Prime Minister stated on 22 November 2005 that TUPE protection entitled employees to "broadly comparable" pension arrangements, and that some employers, usually not-for-profit companies or charities, are able to operate the NHS pension scheme for their employees under a direction given by the Secretary of State**.** The Prime Minister's letter also stated that "*in general, NHS employees who are compulsorily transferred to a private sector employer cease to be entitled to membership of the NHS pension scheme*." The *Health Service Journal* reported on 23rd February 2006 that a workforce strategy to support White Paper changes would be ready by the end of this year *"to support new independent businesses taking on NHS primary care services."*

New thinking about employment is already occurring. The Royal College of Surgeons recently suggested that future consultants could be appointed to a network or a group of surgeons working together rather like lawyers in chambers to provide services in a given area rather than work for an individual hospital trust. The Royal College of Nursing has produced a policy briefing on ***Nurse Led Social Enterprise*** to encourage entrepreneurial nurses into new ways of working and service delivery. Confirming the necessity of this new thinking, the NHS National Leadership Network has argued in ***Strengthening Local Services: the future of the acute hospital*** (March 2006) that there must be much more creativity and flexibility in the way services are organised

and delivered including *"social enterprises or independent sector companies [who] could employ staff and contract with the NHS (and other IS providers)."*

"Social Enterprises"

The Social Enterprise Coalition representing more than 5,000 social enterprise businesses estimates there are 15,000 social enterprises in the UK. Among those delivering public services are more than 100 leisure trusts, 1,400 housing associations and a growing number of social care organisations.

Reflecting the Labour Manifesto commitment of 2005, the Coalition takes the view that the vitality and innovation of the social enterprise sector could and should be harnessed to improve the NHS. This would happen by reconfiguring NHS units into social enterprises, just as leisure trusts grew out of local authorities. There is an out-of-hours GP service in Yorkshire, for example, which is now a social enterprise with a £16m turnover. It is argued that social enterprises empower people to innovate and bring about change.

The Government's White Paper on community health and social care (January 2006) contained a commitment to a Social Enterprise Unit within the Department of Health and, in 2007, a Social Enterprise Fund *"to provide advice to social entrepreneurs who want to develop new models to deliver health and social care services. This fund will also address the problems of start-up, as well as current barriers to entry around access to finance, risk and skills, to develop viable business models."*

The intention in the White Paper is clear that such innovation will span the health and social care sectors. This implies much more joint commissioning between the NHS and Local Authorities as well as less direct provision by statutory authorities. In his Budget speech on 22 March 2006, the Chancellor Gordon Brown praised social enterprises and pledged to set up an Office for the Voluntary Sector within the Treasury to "*conduct a nationwide consultation with the voluntary sector to inform spending decisions"* that will feed into the public spending review. Conservative Leader David Cameron has also supported a level playing field for social businesses to enable them to compete more realistically for health and local government contracts. A new procurement guide aimed to help the NHS purchase services from social enterprises, ***More for your Money – a guide to procuring from social enterprises for the NHS***, was launched at the end of January 2006 by the Social Enterprise Coalition and the NHS Purchasing and Supply Agency. A similar initiative aimed at local authorities in 2005 has proved very successful.

Community Interest Companies (CICs)

Public interest companies, from July 2005 termed "community interest companies" (CICs), are a new, legally defined and regulated form of social enterprise. CICs have both official backing and considerable potential to expand into health and social care.

CICs have possibilities as a way forward for health where commissioning and a contract alone are not enough to secure the public interest and, more importantly, address health inequalities or other social purposes. Some of the governance and financial advantages of Foundation Trusts are available to CICs. Registered charities can own CICs and have any surpluses made by the CIC passed to them. CICs themselves can take several forms: private company limited by shares; private company limited by guarantee or a public limited company.

The Regulator of CICs defines them as *"limited companies with special additional features created for the use of people who want to conduct a business or other activity for community benefit, and not purely for private advantage. This is achieved by a "community interest test" and "asset lock", which ensure that the CIC is established for community purposes and the assets and profits are dedicated to these purposes. Registration of a company as a CIC has to be approved by the Regulator who also has a continuing monitoring and enforcement role."*

Some examples of CICs: Glas Cymru (the Welsh water utility), housing associations, the Local Education Authority in Hackney known as "The Learning Trust", and ex-local authority leisure services in areas such as Greenwich and Bristol

More information on CICs: www.dti.gov.uk/cics for fact sheets on forming and running a CIC; www.cicregulator.gov.uk Regulator for CICs

Mutuals

"Mutual" is an umbrella term for cooperative-type enterprises with a particular membership/usership/ownership governance arrangement. A range of legislation supports these forms, most recently the Industrial and Provident Societies Act 2002, and the Co-operatives and Community Benefit Societies Act 2003. Mutuals exist in many sectors – utilities, football supporters trusts, community housing, children's services.

Mutuals are surplus-making businesses, so any surplus that is created is returned to members, either equally or in proportion to the amount of use they have made of the business (the best known example is the famous Co-op dividend). They can also choose to have a 'community dividend' that benefits the group or the local community. Or they can choose not to distribute surpluses but to use them to lower prices in the future. The two principles of equal voting rights and right to the surpluses make up the minimum requirement for an organisation to be considered a mutual.

It has recently be argued that *"there is no reason in principle why those services currently provided by PCTs could not become locally-owned or mutual organisations, trading on a non profit-distributing basis for the benefit*

of the community, and providing services on a contractual basis to the PCT. Such organisations could be owned by public, patients and staff, and build into their governance arrangements role at strategic level for other statutory, local and voluntary bodies. This will only be possible where a robust and sustainable business plan can be produced for such services to be operated as a viable business. The sustainability will depend upon the commissioning policy of the PCT, and the ability of the new organisation to secure its income for a sufficient period into the future to weather the remaining years of major NHS reform." Mills, C. "NHS Reform: consumerism or citizenship?"

Some examples of mutuals: some building societies, insurance companies and provident associations (but "demutualisation" is increasingly occurring). The out of hours primary care service Harmoni is a mutual but describes itself as a GP cooperative. SELDOC (South East London Doctors' Cooperative) is a surplus-making cooperative business encompassing 430 GPs serving almost one million patients.

More information on mutuals: Mutuo www.mutuo.co.uk a trade body for mutuals which "brings together the different wings of the mutual sector to promote a common message of success and to encourage mutual approaches to business and public policy."

Industrial and Provident Societies (IPS) and Societies for the Benefit of the Community (BenComs)

An Industrial and Provident Society (IPS) is a particular form of mutual body, the other is a "bona fide cooperative", having its own specific legislation and regulatory processes. A Society for the Benefit of the Community (BenCom) is a specific type of IPS. Though not in the mainstream of the discussion about 3rd Sector alternatives thus far, these business forms have considerable potential both for provider services and for the future governance of practice-based commissioning clusters themselves.

A BenCom's membership can be diverse: people over the age of 16 living or working in the area of benefit (eg part of a borough, the whole borough or several boroughs), incorporated bodies like GP practices or VCOs, or "anyone who supports the objectives" if the rules are drawn in that fashion. Housing associations, large community voluntary groups and tax-exempt charitable organisations often use the BenCom governance model.

The biggest NHS development going down the BenCom route is **East London Integrated Care (ELIC)** based in Hackney which is bringing together health and social care across parts of East London. It is due to commence in spring 2006. ELIC's governance structure will be a Society of Benefit to the Community. GPs, nurses and managers will be members. The company will

be overseen by a council with both professional and patient interests and any surpluses will be reinvested to benefit patient care.

This BenCom's style of working to deliver health and care services could be through Alternative PMS. That arrangement would combine the flexibility of both forms to maximum benefit. We believe this will be attractive to commissioning clusters of primary care practices whether they cover parts or all of boroughs. They could even be multi-borough vehicles for delivering services which are in effect community owned by residents, patients and providers who are all voting and participating members of the Society. This would bring the democratic benefits of the Foundation Trust hospital governance model down to primary care level, where many now argue it should have begun life in the first place.

Cooperatives

Cooperatives are member-owned mutuals. "Members" could be consumers or employees. They are either "member only" or "semi-mutual" dealing with non-member customers/service users.

The best example in the NHS is **Central Surrey Health (CSH),** the first large scale transfer of staff to a company owned by NHS employees. In CSH over 700 community nurses, therapists and dieticians are seeking to win contracts to supply speech and occupational therapy services for stroke, back pain, disability services, and community nursing. CSH is due to start functioning in spring 2006.

It has been agreed that CSH staff will keep NHS conditions, though this has recently been criticised by the independent sector as an unfair incentive. CSH's business plan is sell services to local primary care commissioners and others on an SPMS basis. They want to use the freedom SPMS gives to innovate in how those services will be delivered. It is interesting to note that CSH considered using the CIC business structure, but felt CIC was "too new" in mid 2005 when they were forming, so went for SPMS in order to get the benefits of a limited company and also the perceived closeness to the NHS family. The private sector has criticised this arrangement on the grounds that such a large service should have been commercially tendered rather than kept as an NHS business.

Government has singled out Central Surrey Health for praise as an example of local innovation within the NHS family. Patricia Hewitt's speech on the next steps to NHS reform on 13 December 2005 stated:

"Some weeks ago, I met the social entrepreneurs Jo Pritchard and Tricia McGregor who, with the support of their PCT, are leading the creation of Central Surrey Health, a not-for-profit co-operative that would be owned by over 700 district nurses and other community staff to provide care within the NHS. They are very clear that, by combining the freedom and flexibility of an employee-owned organisation with the values of the NHS, they can match the care they give far more effectively to the personal needs of their users."

A commentary in ***The Guardian*** (25-1-06) gave this view of Central Surrey Health: *"The co-owners will have equal shares. They will not get dividends and cannot sell to make a profit if they leave. But, if all goes well, patients may benefit from the nurses' and therapists' greater freedom to organise services more intelligently. And the nurses and therapists may end up with a useful salary bonus. The object, say Pritchard and McGregor, is "to put the professionals back in charge", allowing them to innovate to streamline services, instead of leaving patients to struggle to assemble the care they need from separate organisational silos. "*

Registered charities, not-for-profit businesses and companies limited by guarantee

3rd Sector bodies of all types have made it clear, and Government has agreed in principle, that there must be new ways of doing business for them within the public sector. This includes, above all, "full cost recovery" on services they are contracted to provide including administrative and overhead costs, standard agreements running for five years rather than the one or two years often seen at present, and for 10-15 years where capital investment is required by the 3rd sector provider. This is a completely new way of operating that will demand significant attitudinal and organisational changes from both public sector commissioners and VCO providers. "Full cost recovery" is set out in the National Compact and its good practice code on funding and procurement.

The Charity Commission has stressed (June 2005) that trustees must make informed decisions about whether to engage in service delivery. Crucially when considering this, decisions must be based on whether *"charities are able to retain their independence, remain focused on their objects and properly meet the needs of their beneficiaries".* This points up the dilemma for some campaigning and advocacy charities: delivering public services may create conflicts of interest and mean that one part of the organisation is criticising the services delivered by another part. When agreeing contracts to deliver public services care will need to be taken that the terms of agreements do not interfere with the trustees' duty to act in the charity's interests. The governance aspects of this will need very careful handling. A charity which is serious about public services delivery may decide to establish a separate social enterprise such as a CIC to handle this aspect of its business.

In addition to the well known national voluntary bodies, there are a range of smaller and more specialised health-related bodies which might be well placed to adopt social enterprise models to contract with the NHS, for instance to provide both direct services and care pathway management for named patients with particularly complex needs. As the recent White Paper on community health and social care argued: *"such third-sector organisations can have advantages over the public sector in terms of better relations with particular groups (for instance mental health charities) or expert knowledge in*

a specific area (for instance single disease bodies such as Diabetes UK) or expertise in a type of care (for instance voluntary hospitals)."

This segment of the social enterprise world is highly varied. Below are three of its diverse examples:

1) Big Life Group of Companies - both a charity and a company limited by guarantee commissioned to provide primary care services on Moss Side, Manchester. www.thebiglifegroup.com/home/index.asp

2) Get Well UK - a not for profit company backed by Futurebuilders England whose business is to expand complementary and alternative therapies. It has contracts with several London PCTs.
www.futurebuilders-england.org.uk/investment/results2.asp?id=2

3) Trinity Community Partnership - established 1963 and based in Clitheroe, Lancashire, the Trinity Community Partnership is an independent community-based Development Trust, a registered charity and a company limited by guarantee. It provides "*opportunities for sustainable social, cultural, economic and environmental enterprise by empowering individuals and community groups to develop and improve quality of life, ensuring a high level of social inclusion.* www.trinitypartners.co.uk

Private sector healthcare – evolving to provide public services

The profit-making limited companies most likely to take advantage of the call for more diversity in health and care provision may not be the better known healthcare brands. The area of greatest innovation is likely to be around primary care, diagnostic and treatment centres and social care rather than "private hospitals". Here are some recent examples:

One APMS primary care provider, Chilvers McCrea Ltd, has 18 practices already commissioned by PCTs. It was commissioned by City and Hackney PCT to provide primary care services in an under-doctored part of Hackney after local GPs could not be persuaded to develop additional services. The company has recently established a partnership with Mercury Healthcare (see below).
www.chilversmccrea.co.uk

Mercury Health (part of Tribal Group plc) run diagnostic and treatment centres in the South East. In November 2005 Tribal Group formed a partnership and joint venture company with Chilvers McCrea to promote primary care developments and diagnostics.
www.mercuryhealth.co.uk

Capio Ltd (Sweden) run nine specialist treatment centres in NHS premises and free standing locations and actively market services to NHS commissioners.
www.capio.com

NHS Walk In Centres are being run by private sector companies. General Medical Clinics plc, a company running four private family doctor surgeries in London, is operating a “commuter clinic” close to Liverpool Street Station for City and Hackney PCT. Information technology services provider Atos Origin is responsible for a similar centre by Piccadilly Station in Manchester. Five more walk-in centre contracts are to be awarded.
www.genmed.org.uk www.atosorigin.co.uk

Eleven private sector organisations currently running between them 21 diagnostic and treatment centres have established a trade body called NHS Partners Network in order to promote the public image of this type of partnership with the NHS.
www.nhspartnersnetwork.org.uk

Care UK is a large private sector company that has previously operated in the residential and home care market and more recently in the development of independent sector treatment centres for elective and diagnostic care. The company is working with NHS commissioners to develop public/private partnerships in primary care with a focus on long-term conditions, prevention of disease and provision of primary care services.
www.careuk.com

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Commissioners face a diverse future

The following two exercises are meant to help commissioners at PCT and practice cluster level start to identify the many possible implications that working with new forms of health and social care business could bring about. This is an integral part of the "fit for purpose" exercise which all NHS commissioners are undergoing.

The only sure thing about the future role primary care and social care commissioners are moving towards is that it will be much more diverse than anything they have experienced in the past. That is undoubtedly a challenge, but it is also a unique opportunity to rethink what commissioning is about and who it is meant to benefit. Only then can commissioners begin to work effectively with a range of health and social care businesses to achieve improving health objectives for and with local people.

A Future Gazing Exercise for Commissioners.

What will the new health and social care landscape be like in your area? To start thinking about this, consider how the possible new business structures discussed in this paper might apply to the existing business of your PCT or practice-based commissioning cluster.

We have provided some indicative points in a possible diverse pattern of providers below.

<u>Possible changes in services currently provided by the PCT</u>

A free standing CIC or some other "special purpose vehicle" could be running community hospitals.

A charity-owned CIC could be commissioned jointly by the NHS and local authority to provide elderly care/special needs services (eg delivering parts of the Older Persons and Long Term Conditions NSFs). This could perhaps be combined with providing supported housing and social care services.

A local registered charity VCO could be contracted to provide health promotion services (eg falls prevention and chair-based exercise) to older people in their own homes, at social day centres and in care homes.

Employee owned cooperatives/mutuals could be commissioned by PbC clusters to provide community nursing and therapies, dentistry and dietetics

<u>Possible changes in services currently provided by local primary care organisations</u>

Foundation Trusts could create primary care outreach services or acquire existing primary care businesses ("vertical integration").

SPMS and APMS primary care practices could be run by private companies or NHS businesses, especially where existing GP practices are underperforming on their targets or there are chronic problems in “under doctored” areas.

PbC Clusters constituted as BenComs (Societies of Benefit to the Community) could be established with professional (staff) and public (patient) and practice (corporate|) members.

PbCs could be commissioning services for “Choosing Health” public health goals for specific target areas and populations delivered by open-market organisations like Weight Watchers (weight loss) or leisure centre commercial contractors (physical activity)

Possible changes in services in the wider health and social care economy

British or European PLCs and subsidiaries of multinationals could be running diagnostic and treatment centres as well as primary care practices.

VCOs could be providing services for entire care groups such as older people or children/young families.

What other things can you think of to add to this list for your area?

Questions for Discussion by Commissioning Board Members

1. What feelings and views do Board members have about new business forms being used as the basis for providing services under the NHS brand name?

2. Do Board members have any preferences for particular types of new business forms and if so why? What are the governance implications of these?

3. If a particular model of social enterprise is recommended or directed to be used by the Government, which one do Board members believe it is likely to be and why?

4. Would the Board consider that the PCT should be come an equity partner in new businesses with commercial organisations or VCOs?

5. What does the Board believe is the future role for the local authority in your area in these developments and what does that mean for joint commissioning?

6. What are the implications for PbC and PCT commissioning if services are divested to diverse providers?

7. Would addressing health inequalities be helped or hindered by commissioning services through diverse providers? How could this create new opportunities for commissioners to play a key role in designing patient pathways?

8. If the PCT had to start tomorrow on a specific objective to have some of its services provided differently, what area of services would it choose to focus on and what business form would it prefer to see developed?

9. What pieces of work need to be done – and by whom - to prepare the PCT, its partners, stakeholders and the public to think along these lines?

10. Do you know what views your local authority partners have about working with new business forms and enterprises? What process should you follow to start finding out what their views and experiences are in this area?

Further Information sources

Social Enterprise Coalition www.socialenterprise.org.uk "the voice of the UK social enterprise sector"

Futurebuilders England www.futurebuilders-england.org.uk Funded by the Home Office, Futurebuilders England is an "arms length" body investing £125M in schemes that involve the delivery of public services. They define public services as those where more than 50% of the required income flowing from the proposal once up and running will come, directly or indirectly, from the public purse.

Capacity Builders http://communities.homeoffice.gov.uk/activecomms/sup-vcs Also Home Office funded, Capacity Builders is an "arms length" initiative to invest £70M in 3rd sector organisations to develop their capacity as partners with statutory organisations and change relationships between government and the Voluntary Community Sector.

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