ALTERNATIVE GOVERNANCE FOR PUBLIC SERVICE DELIVERY?

THE ROLE OF COMMUNITY INTEREST COMPANIES IN THE ENGLISH NHS.

A thesis submitted to The University of Manchester for the degree of Doctor of Philosophy in the Faculty of Humanities

2018

Jolanta Monika Shields
Politics, School of Social Sciences
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ABSTRACT

The aim of this thesis is to explore the role and nature of Community Interest Companies (CICs) in the delivery of health care services in the English NHS. CICs are a hybrid form of organisation insofar as they exist to generate wider social impact through their commercial practices. The thesis draws on theories of New Public Management and Governance to trace the changing role of the state in the context of public service delivery and highlights how these shifts facilitate the growth of alternative providers like CICs in publicly funded health care.

To achieve this aim the thesis explores a number of connected questions analysing whether CICs are a new form of governance in health service delivery or the Emperor’s New Clothes? Is the claim to a wider social mission and greater accountability exclusive to CICs? Or could other providers of health care, both private and public, make a similar claim by virtue of what they do rather than their legal status? To this end the study examines three distinct areas which politicians and policy makers identified as most likely to benefit from the CIC model in the delivery of health care services. These are: 1) innovation 2) organisational governance and 3) accountability. The study adopts an exploratory and qualitative mixed–methods approach that includes semi–structured interviews and document analysis. Through this the thesis contributes to important debates on the role of CICs beyond the narrow confines of organisational governance and situates the phenomenon at the intersection of political, social and economic preoccupations with public service delivery.

The thesis bridges the gap between the macro, meso and micro dimensions arguing that no matter how innovative CIC are, they are managed by contractual arrangements in a quasi-market system and regulated by the state. This means CICs face tensions and contradictions as they seek to balance multiple expectations and demands associated with their distinct institutional form as well as the wider context of the NHS. The thesis finds that a drive towards greater efficiency and shifting priorities in the policy environment play a crucial role in shaping conditions for innovation and change.
DECLARATION

I hereby declare that this thesis is my own work and that it has not been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning. Where other sources of information have been used, they have been acknowledged.

____________________________________

Jolanta Shields

December 2018
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Finally, this research would not be accomplished if not for the support of the individuals who kindly took part in the interviews and provided documents and information during the fieldwork. I am indebted to them.
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<td>APMS</td>
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<td>AQP</td>
<td>Any Qualified Provider</td>
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<td>Department for Business, Energy and Industrial Strategy</td>
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Chapter One: Community Interest Companies (CICs) in the NHS.

1.1 Introduction

In 2008 following the recommendations of the High Quality Care for All - NHS Next Stage Review (DH, 2008a), the government launched a programme called Right to Request (RtR). The RtR offered staff working in community health care the opportunity to ‘leave’ (spin-out) the National Health Service (NHS) and set up an independent social enterprise. The reform would allow staff greater ‘flexibility [...] to innovate and improve services and outcomes for patients’ leading to a more responsive and accountable service (ibid 9). At the time, nearly 152 Primary Care Trusts (PCT) in charge of approximately 200,000 staff and £10 billion worth of contracts were eligible to apply (DH, 2010a). By 2011 it was estimated that 10% of NHS staff would be employed by social enterprises delivering nearly £1 billion of public services (National Audit Office, 2011). According to the study carried out by Miller et al., nearly 90% of organisations that spun out of the NHS decided to adopt a CIC model (Miller et al, 2012: 277). The CIC is a new type of private company established under Audit, Investigation and Community Enterprise Act (2004) in 2005 to allow organisations to trade for profit and generate social value simultaneously. Justification from policymakers for introducing CICs into public service delivery lay in purported claims that the unique governance of these organisations would generate higher levels of innovation, autonomy and empowerment resulting in an efficient and responsive service with an increased accountability to both staff and patients. These assumptions have in recent years attracted attention amongst academics who sought to explore these new models of governance by concentrating upon specific aspects of social enterprises, for instance hybridity (Doherty et al., 2014) or by focusing on various

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1 PCTs were created in 2001 in the National Health Service in England and until 2013 were responsible for commissioning primary, community and secondary health services. Until 31 May 2011 they also provided community health services directly. Collectively PCTs were responsible for spending around 80 per cent of the total NHS budget. The expectation was that by devolving power and responsibility to PCTs this would ensure a clinically driven and locally responsive service (DH, 2001a).
areas of operation with individual case studies serving as an illustration of the distinct potential of social enterprises to generate innovation and change (Tracey and Scott, 2017). The growing salience of the topic has also led to critical reflections on the subject challenging the existing conceptualisations of the phenomenon of social enterprises (Bull, 2008).

The aim of this thesis is to explore the role and nature of CICs in the delivery of health care services in England. The research argues that existing analyses tend to overemphasise the normative aspect of these organisations and therefore ignore the relevance of the wider political and institutional frames in which these organisations operate. In doing so the process of transforming the delivery of publicly funded health care tends to be problematised as an evolutionary phenomenon predicated on the narrative of choice and affected by changing needs and wants of society. In this sense, the transfer of responsibility for the delivery of health care provision to alternative providers including CICs has become an unproblematic end point in itself. The research offers a more nuanced and critical analysis of CICs in the NHS cognisant of the wider political, social and institutional context. To this end the study adopts a qualitative, exploratory case study methodology (Yin 2003) to examine the nature of these organisations and specifically their role in stimulating 1) innovation and bringing about change in 2) governance and 3) accountability in public health care delivery. The thesis draws upon a research design with eight case studies that emerged in the English NHS through the RtR process and assesses how these organisations impact on the governance of the health care delivery. Since political devolution in the UK in 1998, four distinct health systems have been created: England, Scotland, Wales and Northern Ireland with health policy and management specific to these four countries. This research concerns CICs that operate in the NHS in England and consequently the studied policies and programmes of reform reflect this distinction. The choice of research methods reflects an epistemological standpoint (discussed in detail in chapter five) defined here as broadly critical realist whereby the phenomena of CICs is considered to be closely
related and influenced by a wider set of contextual factors and instruments be it political, historical, social or organisational (Sayer, 2000).

This chapter is organised as follows. It begins by setting out the research context and the rationale for undertaking this research and then identifies the main research questions before offering a brief outline of the thesis.

1.2 Research aim and context

To better understand the role and impact of CICs in the English NHS, it is important to consider the context in which these organisations emerged. The total of 15,275\(^2\) registered CICs in the UK must experience seemingly different tensions depending on the area of work rather than legal status \textit{per se}. For instance, it is reasonable to expect that a small CIC, which runs a theatre company will face different challenges and opportunities to the CIC that provides publicly funded health care, irrespective of the fact that both share the same governance structure. The narrow focus on governance, therefore, neglects the presence of macro level factors, for example historical, organisational and political, which play a role in how CICs develop and operate in the English NHS.

With this in mind, this research maps the key periods in the organisation of the NHS delineated as three distinct mode of co-ordination: 1) hierarchical bureaucracy 2) market and 3) networks. Drawing on theories of New Public Management (NPM) and Governance, the research traces the changing role of the state specifically in the context of public service delivery and highlights how these shifts facilitate the growth of alternative providers in publicly funded health care (Hood, 1991; Osborne, & Gaebler, 1993; Hood & Peters, 2004; Rhodes, 2007). In this sense, the thesis aims to bridge the gap between the macro, meso and the micro dimensions suggesting that no matter how innovative the CIC’s governance is, it necessarily emerged from and is affected by the environments.

\(^2\)There is no central database for CICs as these are all registered with the Companies House. The CIC Regulator official Twitter feed, however, regularly updates the information on the publicly registered CICs and on 10th of December 2018 it reported there were just over 15,000 recorded CICs.
in which it operates. For instance, attending to social concerns and contractual obligations is challenging in the competitive markets of the NHS and requires trade-offs and concessions. This is further reflected in the government’s own contradictory position on social enterprises with rhetoric that does not necessarily keep pace with practice. On one hand, governments have advocated the role of these new organisations as a better alternative to public and private service delivery. At the same time, none had legislated for change, particularly in the area of public procurement that would ensure more public sector contracts went to these providers (Addicott, 2011). The Tussell–SE UK Index (2018:2), for instance, recently estimated that in the first quarter of 2018 only 0.4% of public sector contracts were awarded to CICs although this represented an overall increase of 6% since 2016.

Insufficient knowledge about CICs in the English NHS invites some important questions. Are CICs a case of new governance in service delivery or the Emperor’s New Clothes, a fad that like any other will in time be superseded with something else, for instance the recently proposed Accountable Care Systems (NHS England, 2017)? Is the claim to the wider social mission exclusive to CICs’ governance? Or could other providers of health care both private and public make a similar claim by virtue of what they do rather than necessarily their legal status? And lastly, how does the new approach in service delivery offered by CICs ensure greater accountability to staff and service users? In this context, the aim of this thesis is to extend the debate on the role of CICs beyond the narrow confines of organisational governance and situate this phenomenon at the intersection of political, social and economic preoccupations with public service delivery.

1.3 Positioning of the Research

Much knowledge about social enterprises, including CICs, in the delivery of public services comes directly from the sector itself as well as politicians and policy makers (for instance, inter alia Social Enterprise UK; Cabinet Office; DH; Mutuals Task Force). These actors were influential in
advancing a particular understanding of new models of delivery based on the assertion that innovation make health care services more responsive and accountable to service users and staff.

For instance, Tony Blair (2002:5) in the forward to the Report by Social Enterprise Unit stated:

Social Enterprise offers radical new ways of operating for public benefit. By combining strong public service ethos with business acumen, [...] highly responsive to customers and with the freedom of the private sector – but [...] driven by a commitment to public benefit rather than purely maximising profits for shareholders.

Similarly, David Cameron (2007) described social enterprise as ‘the great institutional innovation of our times’.

In contrast, the academic literature has focused on the potential of social enterprises from multiple vintage points (Sepulveda et al., 2018; Vickers et al, 2017; Hall et al., 2016; Cabrelli, 2016; Low, 2006; Nicholls, 2009). For example, in one study CICs were conceived as a policy construct that governments implemented to diversify the way public services were delivered (Sepulveda, 2014). In this sense, CICs were seen as a form of ‘social entreprization’ rather than outright privatisation (Sepulveda, 2014; cf. Farrell, 2015). For Sepulveda, the rise of a social enterprise as a distinct policy field can be traced to the critical juncture of the 1980s–1990s albeit these practices have a long history with principles akin to the 19th century voluntary action (Sepulveda, 2015: 845; Bull, 2018). Much attention here is on the evolving role of the voluntary and third sector vis-à-vis New Labour’s policies that promoted the growth of the sector (see chapter 4). However, the approach appears one sided insofar as it conceives social enterprises as passive recipients of governmental policies and thus having no agency in charting their own destiny. As a result, the potential impact of these organisations to affect change rather than be solely affected by it is necessarily neglected particularly in terms of the English NHS.

Similarly, Haugh and Paredo (2011) theorised the emergence of CICs through four conflicting meta-narratives. A political narrative of Conservative neoliberalism was contrasted with New Labour’s agenda of democratic renewal. Here, CICs were an inevitable outcome of the New Right’s
focus on private property rights that gave rise to New Labour’s counter-discourse on civil responsibility, empowerment and engagement. Second, ideological narrative juxtaposed the individualism of the New Right with community, localism and social benefit promoted by New Labour. A third narrative implicated the emergence of CICs in the process of adaptation that relied on new techniques to address wicked problems, most notably through means of collective action and social accountability rather than individual self-interest. And finally, an economic narrative that contrasted Conservative neoliberalism and the role of free markets with the New Labour’s commitment to social justice (*ibid*, 19-22).

These four narratives make a useful contribution to thinking about CICs, however, there is an implicit assumption that a ‘bad’ policy triggers development of a new improved policy. By juxtaposing two seemingly opposing political agendas as a definitional yardstick neglects similarities and continuities between the two parties and fails to appreciate the policy convergence particularly in the area of market reforms in the NHS (Greener, 2002).

The policy environment that has been created as a result raises questions about the suitability of present classification of CICs as social enterprises (Jones & Keogh, 2006; Whitfield, 2013). The umbrella term encompasses a variety of legal structures as if these were static and homogenous entities thus neglecting the context, most notably the NHS, and the evolved character of CICs. Subsequently, this lack of clarity has given rise to claims by some private providers about their social enterprise status. Bupa, for instance, made the following point:

> As for social enterprises, I also believe that we are close to this description. Bupa has no shareholders and pays no dividends. Any surpluses are reinvested to provide our customers and residents with better services; while our mission remains the same as when we were set up in 1947: to help people enjoy longer, healthier, happier lives. Our status allows us to invest for the long term, whether that is staff training, refurbishments or building new care homes. We also own our own freeholds so we are not subject to the market pressures affecting some other operators. (Bupa cited in Gosling, 2009)
Similarly, Circle Health a private company that in 2011 won a contract to run the Hinchinbrook Hospital under a franchisee arrangement was described as a social enterprise and as having a partnership model resembling the governance structure of John Lewis (for critical review see McKee, 2011; Hawkes, 2011). It is possible to see why such confusion could arise on the basis that there are no shareholders with restrictions on profit redistribution characteristic of social enterprises. However, what this example illustrates is the importance of considering the wider context in trying to better understand the role of CICs in the English NHS.

To this end, some studies have focused on the increasingly porous sectoral boundaries to explain the rise of alternative, hybrid forms of organisation such as CICs. According to these perspectives the new legal structure allows for multiple institutional logics and identities to be successfully combined in order to achieve financial and social objectives simultaneously (see Battilana and Lee, 2014; Besharov & Smith, 2014; Billis, 2010). In this context, CICs are problematised as an ideal type of a hybrid form of organisation insofar as these exist to generate wider social impact albeit through the established commercial practices. However, as demonstrated later in chapter nine this seemingly novel practice is both complex and contested as the logics these organisations seek to blend are neither pure nor neutral themselves suggesting quasi-outcomes are more likely to follow.

An interesting contribution to this theme comes from Hall et al. (2016) who drew on publicness theory to explore the attitudes of staff who left the NHS to establish independent CICs. The research found that staff were able to associate ‘themselves with the public, private or third sector as they saw most relevant for different challenges and opportunities’ enabling certain features to be preserved, rejected and exploited simultaneously (ibid, 553). Subsequently, the authors proposed that since the ‘organizations can take on elements of all three sectors and even potentially move between’ them, the current conceptions of publicness and privateness needed to be re-evaluated to encompass the increasing involvement of the third sector in public service delivery (ibid, 554). However, such a perspective implies that institutional boundaries no longer matter and can be
readily incorporated under the single, conceptual roof of hybridity. While NPM successfully introduced a series of reforms that resulted in significant convergence and thus made the distinction between public, private and third sector seemingly blurred, the practice also sought to distinguish between the sectors by way of contrast emphasising individual strengths and weaknesses (Christensen & Lægreid, 2007). As a result, it is customary to view the private sector as innovative, risk taking and profit seeking while the public sector as inertial and bureaucratic (Mazzucato, 2015). Likewise, the third sector including social enterprise continues to be depicted as a responsive and altruistic. In this sense, CICs may be perceived as a Janus-faced phenomenon in which both benefits and negatives of three sectors are side of one coin, which helps to legitimise and delegitimise the distinct approaches adopted by CICs.

The development of CICs in the English NHS has invariably brought attention to the role of governance as an effective tool to bring about change by altering the behaviour and attitudes of staff. Ham et al. (2012), for instance, suggested that improving engagement with staff led to reduced levels of absenteeism and turnover generating better outcomes for patients and staff simultaneously. Recently, Le Grand and Roberts (2018) proposed that policy makers should pay more attention to employee-led public service mutuals as a better alternative to a traditional bureaucracy, private company or the non-profit organisation. By drawing on economic and psychological theory, the authors argued that giving staff greater autonomy and control rights boosts morale and improves motivation enabling organisational and staff objectives to be better aligned. A similar justification has been adopted in respect of CICs, however, as chapters seven and eight demonstrate the extent to which these organisations are able to engage their staff and exercise their organisational autonomy remains contested.

While existing studies form an important source of knowledge in respect of CICs and thus constitute a relevant backdrop to the analysis developed in this research, there is still not enough
known about the variety of ways in which CICs operate and the impact these organisations have on the governance of the delivery of health care services in the English NHS.

1.4 Research questions

The gap identified above has led to the development of the main research question:

What is the role of CICs in the English NHS and how does the introduction of CICs impact on the governance of health care delivery?

In trying to address this primary question, there are a number of smaller, nested questions set out below:

a. What is the relationship between CICs and the wider agenda of transformation of health care delivery in England?

b. What mechanisms have been employed in legitimising the activation of CICs in the NHS?

c. What type of innovation is promoted by CICs and does this innovation transform the way healthcare is delivered and managed?

d. What is the nature of CICs governance and how does it allow for greater autonomy, and responsiveness to staff and service users?

e. What are the mechanisms of accountability in CICs?

The intention transmitted through these questions is to make sense of the role and nature of CICs in English NHS and to understand better how these organisations affect greater organisational autonomy, improve staff engagement, generate innovation and enhance accountability in public service delivery.

1.5 Thesis structure
In attending to these concerns the thesis has been divided into nine chapters inclusive of this introduction. The remaining eight are outlined below.

**Chapter two** describes the historical and policy context of the English NHS in which CICs developed and now operate in. More specifically, it illustrates how changes in the mechanisms of co-ordination, understood as shifts from bureaucratic hierarchy to markets and networks, have altered the governance of the public health care delivery. The chapter focuses on New Public Management (NPM) and Governance as a broader theoretical framework to help illuminate the way in which formulations of a problem generates a specific solution. As a result, three emerging themes of innovation, governance and accountability are identified and then discussed in greater detail in **chapter three**.

**Chapter four** provides a short overview of different conceptualisations of the third sector and illustrates how the distinct features of innovation, governance and accountability became important pillars in the policy agenda of New Labour and later the Coalition government. The chapter provides a brief overview of the policy and legislative context as backdrop to understanding CICs in the English NHS.

**Chapter five** outlines the methodological approach taken and the rationale for choosing it. The case study strategy is set out alongside the detailed discussion of the qualitative methods of data collection. The chapter reflects on ethical considerations and limitations involved in this type of research and provides information on steps undertaken by the researcher to overcome them. The next three chapters, **chapter six, seven and eight**, seek to empirically analyse how the three previously identified themes of innovation, organisational governance and accountability have been enacted by the studied CICs. As indicated in chapter five, these chapters consist of data that comes primarily but not exclusively (documents and observations are also included) from the interviews.
**Chapter six** is the first of the three empirical chapters. The aim here is to present individual views and opinions of participants concerning the type and nature of innovations that the studied CICs pursued and adopted. Specifically, the chapter provides a detailed and descriptive account of innovation with different drivers identified across the eight studied CICs.

In **chapter seven** the governance of CICs is analysed from a perspective of their staff and examines how this blended governance model operates in the context of health care delivery in the English NHS. Attention is paid to how assertions of flexibility, ownership and autotomy works in practice and what impact this has on staff working across the eight studied CICs.

**Chapter eight** explores different aspects of accountability. The purpose of this chapter is to examine how CICs achieve greater accountability in the delivery of health care services and what mechanisms they employ to do that. In this sense, the chapter seeks to establish whether there is any link between CICs governance and the impact it makes in the area of accountability.

**Chapter nine** draws together the analysis of the empirical data. It seeks to critically evaluate and engage with the findings. The chapter then draws conclusions from the theoretical and empirical debates presented in this thesis and offers reflections in relation to the main research questions about the role and impact of CICs on the governance of health care delivery in the English NHS. Finally, suggestions are made about possible lines of future research that directly emerge from this thesis.
Chapter Two: The UK Healthcare System

2.1 Introduction

Since this thesis is concerned with a group of CICs that developed from within the English NHS and which currently deliver services on its behalf, an overview of the NHS is useful to understand the wider context for the study. In obtaining answers to the main research question about the impact of CICs on the governance of health care delivery, this chapter explores the evolving nature of three modes of co-ordination within the NHS: bureaucratic hierarchy, markets and networks. The greater focus on shifts in governance takes place against New Public Management and Governance, highlighting the intellectual basis in support of alternative providers in public service delivery. It is important to note that while the discussion proceeds in a specific order implying a linear shift from one mode to another, in reality the three modes tend to co-exist and overlap rather than neatly supplant each other. This view is in line with Exworthy et al. who reject ‘the chronological paradigm change from hierarchies to markets and then to networks’ (1999: 17). It is also shared in the empirical findings from this research presented in chapter nine.

3 In this chapter as well as throughout this thesis, I distinguish between organisational, operational function of governance and the specific theory by using the capital letter when referring to the letter. As it is discussed later in this chapter, the multifaceted nature of the concept means it can be applied to different things to denote different understanding and hence the adopted distinction in this thesis.
This chapter is organised as follows. The first section provides a brief introduction to the NHS followed by a discussion of the distinct modes of co-ordination. In elaborating on the shifting values in the public service delivery, the section draws on NPM and Governance theories to make better sense of the changes implemented as a result. The chapter concludes by providing a short summary of key points and introduces the next chapter.

2.2 The Overview of the NHS: The emergence of the welfare state

A greater role for the state in areas of social policy can be traced back to the Second World War, which according to Thane (1996:13) created an important precedent for implicating the government in the direct provision of social goods for ‘the mass of its citizens’. The social and economic inequality at the start of the 20th century, exacerbated by the earlier experience of industrialism and the stigmatising effect of the Poor Law, exposed problems associated with free markets and paternalistic support based on kinship and charity (Briggs, 1961; Kerr et al, 1960).

By the mid-1940s poverty was increasingly linked to social and economic conditions such as poor education, income, labour and wage inequality (Glennerster, 2000). The shift of attention from the individual to the collective nature of the problem emphasised the structural inequalities that needed to be addressed through state intervention (Jones and Novak, 1999). As a result, traditional forms of social support associated with the Poor Law (self-help, family, charity, trade union or friendly society) were slowly superseded by institutional structures of welfare, moving the residual welfare state towards a centralised institutional model (Fraser, 1973; Titmuss, 1974).\(^4\) Arguably, the

\(^4\)Wilensky and Lebeaux were the first to make the distinction between residual and institutional models of welfare state (Wilensky and Lebeaux, 1958). However, later other social scientists used the model to develop their own typologies. For instance, Titmuss built on the distinction and created a framework of the welfare state that he defined as: the residual model (available on a short term basis and only if standard channels of welfare via family had been exhausted); ‘the Handmaiden model’ (work performance and productivity-based) and finally institutional redistributive model (an integrated model based on ‘command-over-resources through time’) (Titmuss, 1974:30-31).
involvement of the state had consequences for the voluntary sector that was traditionally seen as a ‘buffer’ organisation in charge of delivering essential welfare services. Since the introduction of the Old Age Pensions Act (1908) and National Insurance Act (1911)\(^5\) this relationship began to evolve with the voluntary sector increasingly compensated for the delivery of services on behalf of the state rather than expected to provide it out of moral duty and obligation (Lewis, 1995). According to Penn (2011:24) these Acts also contributed to the greater inclusion of profit seeking societies in the delivery of welfare. Initially only non-profit and democratically run societies were allowed to register as Approved Societies to administer social benefits. However, due to pressure from powerful lobbying groups, the terms were modified to include business–orientated societies with private companies increasingly involved through separately created entities \(^{ibid}\). These changes in the state–voluntary relations were further documented in the special report commissioned by the National Deposit Friendly Society in 1948, the *Voluntary Action*.\(^6\) The Report prepared by William Beveridge presented an historical account of the sector but significantly clarified its position in the context of reforms implemented as a result of the emerging welfare state. It committed the government to providing this sector with the necessary ‘room, opportunity, and encouragement’ to grow in order to be able to offer ‘new ways of social advance’ (Beveridge, 1948:10). A similar narrative can be found in the policy documents produced by successive governments and in particular New Labour, which advocated the role of the sector in the delivery of public services in the English NHS. Chapter four explains this further.

Similarly, the development of social policy in post war Britain was significantly influenced by the findings from the better-known Beveridge publication, the *Social Insurance and Allied Services* (1942).\(^7\) In this landmark document, Beveridge identified five ‘giant evils’ in the society: want (poverty and

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\(^5\) For the detailed analysis of these Acts as well as social policy more generally see Gilbert, (1966).


\(^7\) Better known as the Beveridge Report, considered to be the ‘main blueprint for the creation of the post-war welfare state and [a] “scheme” [that] affected the development of British social policy for a generation after 1945’ (Harris 2004: 289).
lack of basic provision for health and employment), ignorance (poor educational standards), disease (lack of available universal healthcare), squalor (poor housing) and idleness (unemployment) that needed to be confronted to make social progress in post-war Britain. The Beveridge Report set out a number of key proposals for social security services ‘from the cradle to the grave’ and extended the provision of the 1911 Insurance Act to include all groups by imposing a statutory scheme of compulsory contribution (the weekly payment of a National Insurance Contribution paid by working age group of people). To ensure individuals continued to seek employment rather than depend on the state for support, the Report also established a ‘social minimum’ and a ‘flat rate’ of subsistence (Lynes, 1984).

The reforms promoted a new ‘social compact’ between labour, the state and the market that required a new mechanism of co-ordination (O’Brien and Penna, 1998:37). The next three sections discuss this development through the distinct phases in the organisation of the NHS: bureaucratic hierarchy, markets and networks.

2.3 Co-ordination via Hierarchy in the NHS from 1948 – 1974

On 5th of July 1948, Aneurin Bevan, the then health secretary officially launched the NHS in what is now Trafford General Hospital. The newly created health service was a tripartite system of hospitals, general practitioners and associated services (dentists, opticians and pharmacists) and local authority health services.8 It was designed as a universal service, meaning the standard and quality of provision of health care was expected to be the same across the country, comprehensive insofar as it was covering all health needs and free to all citizens who needed it rather than who

8 The establishment of NHS refers to the creation of the public health services in England, Northern Ireland, Scotland and Wales. However, there are some differences to be noted. For example, The National Health Service (NHS) officially came to life through the decree of National Health Service Act 1946. In Scotland, the NHS was established through the National Health Service (Scotland) Act 1947 and subsequently repealed by the National Health Service (Scotland) Act 1978. Since 1998 the UK Parliament passed the law (Act 1998) which devolved powers to Scotland, Wales and Norther Ireland subsequently establishing four distinct health systems in England (for in-depth studies see, Greer, 2004, 2016; Timmins, 2013; Birrell, 2012).
were able to afford it (Powell, 1997; Klein, 2010). The earlier scheme of mixed social and private voluntary insurance was replaced with a compulsory tax contribution and the administrative structure of the NHS was centralised under the Ministry of Health with the appointed Minister accountable to Parliament for all spending in the NHS (Webster, 1998; Rivett, 1998). Public accountability was maintained through the system of general taxation with the NHS becoming a ‘centralised and heavily regulated’ structure (Klein, 2019:2).

As part of Bevan plan all hospitals, voluntary and municipal, were nationalised and organised under 14 (and later 15) regional hospital boards managed by hospital committee boards with the family doctors and allied services overseen by executive council (Webb, 2002). The hospital services were taken out of local government control because Bevan feared they would be inclined to provide ‘a better service in the richer areas, a worse service in the poorer’ (Bevan, 1945: point 1; see also Klein, 2019). Universalising hospital provision was difficult and required considerable adjustments on the part of hospitals that came with different organisational cultures, traditions and values (Rivett, 2008). For instance, voluntary hospitals were used to working in partnership while municipals did not share the same local autonomy and thus had to report via medical superintendent to the Minister of Health (Rivett, 2008). In seeking to bring the balance between the national responsibility and the responsiveness to a local need, Bevan sought to provide ‘for delegation to existing persons and agencies for doing the day to day job’ within the NHS (Bevan, 1945:4). The introduction of the Hospital Plan for England and Wales in 1962 by the Conservative Minister, Enoch Powell, represented a ‘technocratic intervention’ that aimed to impose ‘a national hierarchy of district general hospitals and subsidiary centres for defined populations’ while providing the

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9 In 1968, the Ministry was replaced by the Department of Health and Security (DHSS).
10 Teaching hospitals were exempt from the State exercising the same power, e.g. ownership. In addition, teaching hospitals were granted a special status with their own governing bodies and not integrated into the administrative structure of hospitals but sat directly under the Minister of Health.
largest construction and modernisation of hospitals, backed by a substantial capital programme for new building (Gorsky, 2008:444).

The management in the post–war NHS was conducted within the province of experts and medical professionals who in the period leading up to the establishment of the NHS won considerable concessions on pay. In rejecting salaried service doctors were able to maintain their professional autonomy and authority (Webster, 1990; Ham, 2009). While the state claimed a control over the budget for health and the wider policy framework, the doctors had a responsibility of how these resources should be spent.\(^\text{11}\) In the October Memorandum (1945:3), Bevan conceded that whilst ‘the full principle of direct public responsibility must […] be maintained, […] we can – and must – afford to bring the voice of the expert right into direct participation in the planning and running of the service’. Admittedly, who the experts were, was centrally determined meaning some health professionals were left out from the process. In the letter to the TUC’s General Secretary Bevan (1946) justified the decision in the following terms:

‘[…] the difficulty here would be to draw any line which would keep membership of the Boards and Committees down to reasonable numbers. If nurses were to be consulted, why not also the hospital domestics? the radiotherapists? the physiotherapists? and so on’. (Bevan cited in Klein, 2010:16)

Since, much of the responsibility was delegated to the medical profession the quality and standards had to be regulated and this took place via established bodies of the General Medical Council (GMC) and royal colleges (Davies, 2007). Under this model, accountability was served through professional and hierarchical channels and thus it followed that doctors assumed authority which meant care was dispensed according to professional judgement and within a fixed budget. Even though patients exercised a right to register with a practice, it was the doctor’s discretion to

\(^\text{11}\) For Klein (1990, 2018:1), this mutual dependency, dubbed as ‘the politics of the double bed’ created conflict and tension that had to be manage throughout the history of the NHS with successive reforms seeking to ‘square the circle’.
prescribe a treatment as ‘a technically competent person whose [...] specific judgement [...] [could not] be competently judged by the laymen’ (Parsons, 1951:463; Lipsky, 1983). The doctor–patient relationship was ‘one of clientism’ with patients considered as a homogenous group and passive recipients of planned care (Sullivan, 1994:118).\textsuperscript{12} The accountability was grounded in the universal ethos of the NHS and sustained by the ‘internal adherence to agreed ethical codes of conduct’ and shared values (Rowe & Calnan, 2006:382). The governance was based on ‘consensus management’ between health professionals and administrators and delivered through a ‘command and control’ style of management (Harrison et al.,1992). Significantly, though, it was a system of quasi-hierarchy ‘with authority relationships based not [...] on line management but professional status, coordinative competence and resource control’ (Rowe & Calnan, 2006:382).

In the first three decades progress was made in clinical research, use of controlled trials and technological and pharmaceutical breakthroughs (Timmermann, 2008). The 1960s were also characterised by ‘innovative intellectual currents’ such as Balint’s study of the doctor-patient relationship and Tudor Hart’s work on social determinants of morbidity, which were sparked by a renewed focus on primary care and in particular the launch of a new Family Doctor Charter in 1966 (Gorsky, 2008: 444). These scientific and medical advances played an important role in raising standards and the health of the population in post–war Britain (Shapiro, 2010). However, growing welfare expenditure and the onset of the economic crisis at the start of 1970s drew attention to the management of the NHS and questioned the cost effectiveness and sustainability of the governance model based on bureaucratic hierarchy.

2.4 Co-ordination via Markets

\textsuperscript{12}There is no such thing as ‘homogeneity’ with Bivins (2016:84) reflecting on the period in which the NHS was established that almost exactly coincided with the post-war movement to Britain of once-colonial populations from the ‘New Commonwealth’.
Until 1974, the NHS had not experienced much structural change and thus the first three decades are commonly regarded as a relatively stable period in the organisational history of the NHS (Timmins, 2012). Concerns about affordability of the national system were raised as soon as the NHS became operational but the principle of collectivism on which NHS was founded meant that the responsibility for health care remained with a state bureaucracy.\textsuperscript{13}

Since the mid 1970s, however, the NHS has undergone numerous ‘organisation, re-organisation and re-disorganisation’ which inevitably altered the nature of governance of public health care delivery (Timmins, 2012:16).\textsuperscript{14} In 1974 the first major reorganisation of the NHS took place intended to bring ‘balance of services-hospital and community-throughout the country’ and to put an end to the fragmentation of the national health system (DHSS, 1972:1). The NHS Reorganisation Act (1973) replaced the tripartite structure of the NHS with a unitary model based on Regional Health Authorities (RHAs) and Area Health Authorities (AHAs) coterminous with local government. The responsibility for some of the public health services such as food hygiene and environmental services were retained by the local authority while preventative health services were transferred to the NHS where they remained until 2012.

Since the 1980s attention has turned to efficiency (Ham, 2009: 30). The weakening of the national economy, high levels of unemployment and global recession undermined the belief in the Keynesian model of economic governance and had cast doubt over the capacity of a nation state to act ‘alone’ in the globalised and highly competitive world (Jessop 1995, 2006; Steger & Roy, 2010). By the late 1970s the Organisation for Economic Cooperation and Development (OECD) began to advance a view whereby the free market rather than hierarchical bureaucracy was regarded

\textsuperscript{13} The Committee of Enquiry into The Cost of the National Health Service under Claude Guillebaud in 1956, found that the NHS was not too expensive and performed well relative to the low level of funding in relation to the GDP, for the detailed analysis of this study, see Abel-Smith and Titmuss (1956).

\textsuperscript{14} Timmins (2012) estimates that since 1970s the NHS has undergone 20 reorganisations, approximately one every two years.
as more efficient form of co-ordination in public service delivery (Crouch, 2011:16). The conventional wisdom at that time was that competition between providers would act as an incentive to run services more efficiently leading to improved quality and better choice for consumers (Mohan, 1996). In other words, the administrative order of hierarchies was to be modified by ‘price competition […] [with the] central co-ordinating mechanism of the market’ (Thompson et al., 1991:15). For Crouch (2011:16) this new type of governance was delivered through the ‘privatisation of publicly owned industries and services, the imitation of private business methods in public services […] and attraction of private capital into the ownership of public infrastructure facilities’. Together these reforms represented a wider trend in public administration, known as New Public Management (NPM). As noted in the introduction to this thesis, NPM constitutes the relevant backdrop to any study of health care reforms and created a unique environment in which CICs emerged and developed. To this effect, the next section provides a brief outline of this trend.

2.4.1 New Public Management

NPM is a ‘loose term’ that Hood (1991) characterised by seven distinct categories:

hands–on professional management’ in the public sector, explicit standards and measures of performance, greater emphasis on output controls, shift to disaggregation of units in the public sector, shift to greater competition in public sector, stress on private sector styles of management practice and greater discipline and parsimony in resources application. (ibid:3-5).

While Hood believed that not all aspects were needed simultaneously, he thought identifying each was helpful in recognising the trend albeit not sufficient to provide answers to the concerns it raised (ibid, 3). Thus, Dunleavy (1997) and Pollitt (1993, 2016) developed an approach in which NPM was studied at two-levels of abstraction.

On the higher level, NPM was considered a doctrine and a general theory with its intellectual basis in neo-classical economics and public choice theory. Individuals were assumed to be rational
subjects who exercised freedoms and choice in the way that benefitted and met their preference (Buchanan, 1986; Niskanen, 1971; Osborne 2006; Simonet 2013; see also McLaughlin et al., 2009; Thomas, 2012). In contrast, Barzelay (2000:209) drew on Hood and Jackson’s (1991) early discussion of NPM and defined the phenomena as characterised by ‘two qualitatively different conceptions of NPM’: an administrative argument that provided a reason and an administrative philosophy that justified it and forced it onto the policy agenda. Similarly, for Aucoin (1990:115) NPM entailed two distinct ideas; one that emanated from the public choice theory and concerned ‘the primacy of representative government over bureaucracy’ and the second that came from the ‘managerialist’ school of thought and sought to re-instate ‘the primacy of managerial principles over bureaucracy’ (Aucoin, 1990:115). The coupling of these two seemingly contradictory approaches caused tensions but at the same time influenced the way governments were organised ‘for the purposes of administering public affairs’ (ibid, 115). Lane (2000:8), defined NPM as ‘a new theory about governance in the public sector’ that helped to make sense of how the government deliver services. The emergence of NPM during the Conservative administration of Thatcher and Reagan in the US, linked the trend to liberal ideology and laissez faire economics promoted at the time (Bevir, 2010; Boston, 2010; Lorenz, 2012; Peck, 2010).

At the lower level of analysis, NPM referred to a wide range of managerial reforms that appeared to break from the traditional public administration. According to Reed and Anthony (2003: 189) NPM involved ‘a series of policy initiatives aimed at realizing the widespread inculcation of a customer-focused and performance- driven culture supporting a much ‘leaner and flatter’ organizational delivery system’ and effectively responding to market pressures. The general thrust of NPM involved the professionalisation of the public space, performance measurement and output control, disaggregation, competition, privatisation and finally discipline and parsimony in resource allocation and use (Hood 1991).
This emphasis on performance focused attention on the role of audit tools creating a culture of indicators that became repeatedly created and re-created (Coleman et al, 2013). Central to this was the notion of the public sector as wasteful and represented by civil servants who were ‘inefficient in their use of public resources and display[ed] excessive conservatism’ (Gruening, 2001:6). In this context, NPM called for re-invention and modernisation of an unresponsive and monolithic structure of the government. Routines, norms and customs were considered constraining and crowding out the innovative and creative potential of managers (Osborne & Gabler, 1993; Lane, 2000; Pollitt, 1995, 2016). Ashburner et al. (1996) suggested that NPM was a ‘management hybrid’ which allowed for old public values to be conveyed via new methods. Similarly, Christensen and Lægreid (2002), considered NPM as an umbrella term for many different trends that could be found in public administration.

Common to the rhetoric of NPM reform was the important contribution of the private sector in stimulating competition and choice for consumers in public service. Likewise, NPM also advocated restoring trust and enhancing local democracy by involving citizens ‘in the governing of public services […] [via] new governing structures based on dialogue’ and participation (Sehested, 2002: 1524). Directly related to this was the changing relationship between the state and society with citizens increasingly portrayed as customers of public goods and services (Le Grand, 2007). Other themes to emerge through the NPM rhetoric included: customer sovereignty (Aberbach & Christensen, 2005), value (Peters & Pierre, 1998) and empowerment (Clifton et al., 2005; Dent, 2006). But together these narratives created an understanding whereby solutions to the structural problems of the NHS could be found in governing arrangements and resolved by business like mechanisms rather than redistributive policies alone.

Despite some proclaiming NPM dead (Dunleavy et. al., 2006), the logic and practice associated with it has proved resilient and hard to substitute. Lapsley (2008:77) suggests that the recurring NPM
reforms render the phenomena a ‘Back to the Future’ characteristics. The 1980s and 1990s became known as an era of management with markets conceived as a better mode of co-ordination than public bureaucracy. The next section provides a brief outline of the key reforms that took place during that time in the NHS and which were crucial in altering the landscape of public service delivery and its governance.

2.4.2 Health Care Reforms: 1980s – 1990s

The 1980s and 1990s illustrate a period in which NPM became a useful framework within which governments sought to operationalise and justify administrative reforms aimed at overhauling public service delivery and the welfare system more generally. These reforms helped to establish conditions in which markets obtained a greater role in the delivery of public services. Without these ‘enablers’ organisations like CICs would probably not have emerged in the English NHS.

The initial reforms introduced under the Thatcher government (1979-1990) aimed to simplify the structure of the NHS and reduce state bureaucracy. In the consultative document *Patients First* (DHSS, 1979) the government proposed a series of changes to make health services more responsive and closer to the point of delivery. This was to be realised by the ‘maximum delegation of responsibility to managers in each hospital and in local communality services […] and […] by strengthening’ the role of management practices (BMJ, 1979:1605). The government abolished the AHAs and replaced them with District Health Authorities (DHAs) responsible to the RHAs. According to Klein (1995:123-125), the 1982 reorganisation of the NHS involved ‘a new emphasis on localism, and a reaction against expertise’ albeit the medical influence was preserved and further institutionalised. In ensuring efficiency gains, the government introduced *The Health Services Act* (1980) that set cash limits that spending authorities could not exceed. The Act also established new powers to the health authorities to enable them to use the Treasury monies to raise additional
revenue via philanthropic activities (DHSS, 1980). The voluntary sector saw this new approach as blurring the boundaries between sectors and questioned the legitimacy of these arrangements (Mohan, 1995; Fitzherbert, 1992). The increasing emphasis on efficiency also prompted the government to instruct the health authorities to put auxiliary services such as laundry, catering and hospital cleaning out to competitive tender (DHSS, 1983a). By 1987, outsourcing extended to other parts of the NHS including portering and transport.

The Roy Griffiths Report (DHSS, 1983b) marked another important phase in the development of the new model of co-ordination in the NHS. The Report (ibid:12) identified a persistent lack of leadership and well-defined roles in the NHS that led to no one taking ‘direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievements’. As a solution, Griffiths proposed a ‘general management’ style in place of ‘consensus management’, which was distinctly fashioned on the practices found in the commercial sector and then conveyed to the public sector as a better framework for administration (Pettigrew et al., 1988:299). Under this model, one person had responsibility (chief executive or general manager) at different levels of the organisation (regional authority, district authority and hospital) and was in charge of implementing and monitoring work programmes (DHSS: 1983). The ‘general management’ was consequently extended to clinical staff, with hospital doctors expected to take

15 Until the introduction of The Health Services Act 1980, the NHS hospitals were not allowed to fundraise and were restricted in the use of charitable donations. However, the Act changed this and so the appeals became a popular form of ‘subsidy’ and income generation. For instance, Jimmy Savile, until discredited posthumously, was a prominent figure in this area. He famously raised £10mln in 1979 for building works in Mandeville Hospital. The budget for the entire Oxfordshire Regional Health Authority at that time was £40mln (Lampard and Marsden, 2015).

16 According to the commissioned by UNISON Report, Hospital Contract Cleaning and Infection Control, around 51% of contracted out auxiliary services was held by four companies, ISS, Compass, Sodexho and Rentokil Initial, which were themselves an outcome of acquisitions in 1980s/1990s that resulted in fewer but significantly larger companies (Davies, 2005).

17 The Report on NHS Management Inquiry (1983) led by Roy Griffiths, the managing director of the supermarket chain Sainsbury’s and three other businessmen: Jim Blyth, Group Finance Director of United Biscuits; Michael Bett, Board member for Personnel at British Telecom and Brian Bailey, Chairman of Television South West
this managerial responsibility alongside ‘clinical freedom’ (*ibid*:18). The shift meant that doctors and nurses were increasingly involved in the management of budgets and other resources (Packwood et al., 1991). In addition, the Report recommended simplifying and strengthening the administration of the NHS by creating a Health Services Supervisory Board and NHS Management Boards which were overseen by a non-NHS chair. These changes had implicit consequences for accountability shifting the emphasis from collective responsibility to a managerial chain of command (Kettl, 2010; Ferlie et al., 1996). In addition, the Griffiths Report facilitated the introduction of the internal market in the NHS (Ham, 2005).

The idea of the internal market was first proposed by an American ‘policy entrepreneur’, Alain Enthoven (1985:10) who declared NHS to be in the permanent ‘gridlock’ with cosmetic rather than substantial reforms implemented as a result.\(^{18}\) Enthoven recommended that DHAs should take the role of purchasers of services in charge of procuring best services for their populations and from whomever supplied it within the NHS (*ibid*). Subsequently, the White Paper, *Working for Patients* (1989a) published the plans for reform including the purchaser–provider split and legislated for them in the *National Health Service Community Care Act 1990*. Kenneth Clarke (1989:1013) the Secretary of State for Health at the time, introduced the legislation stating that it was vital to ensuring ‘choice, a more responsive health service, better value for money and an even better standard of health care for the decade to come’. The Act also made provision for independent, corporate and self-governing trusts and established a GP fundholding scheme, using the Health Maintenance Organisations (HMO) as a model.\(^{19}\) GPs and DHAs were assumed to negotiate the

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18 Alain Enthoven is an American economist and a graduate from Stanford University to which he returned later in his life as a Marriner S Eccles Professor of Public and Private Management. During the Vietnam War he served as a Deputy Assistant Secretary of Defence and then an Assistant Secretary of Defence for Systems Analysis. The role provided him with a potent ground for research which resulted in the publication of the book ‘Shaping the Defense Programme: 1961-1969’. However, Enthoven is better known both in the US and in the UK, for his role in promoting market-based economics in the area of financing and delivering health care.

19 In the government’s discussion paper, *Primary Health Care: An Agenda for Discussion* (DHSS, 1986:55) HMOs were described as ‘competing with each other to provide a quality product at a reasonable price. This is
contract with the NHS and commission care for their population (Le Grand, 1999). It was envisaged that the arrangement would stimulate competition between providers securing better outcomes for patients. The inclusion of markets into the realm of public sphere meant that there was now a greater emphasis on direct accountability ‘to their users through more market like mechanisms, more choice’ (Ferlie, 2001:135). Consequently, the *Caring For People — Community Care In The Next Decade And Beyond* (1989b), made a necessary progress toward inclusion of the voluntary and private sector and by encouraging competition between them to tender for public sector contracts. To this effect, the state was increasingly expected to forfeit its role as a sole provider of welfare services and to assume a position of an enabler, facilitator and regulator of new arrangements (Deakin & Walsh, 1996; Pollitt and Talbot, 2004).

In the White Paper *Promoting better health* (1987: 1497), the government set out to strengthen the role of primary care by drawing up plans ‘to raise standards of care; to promote health and prevent illness; to increase competition and give the public greater choice [and] to improve value for money’.\(^\text{20}\) Patients were increasingly regarded as consumers of health care with health portrayed as a commodity that like any other was subject to pressures from price and competition. Related to this, was the launch of *The Citizen Charter* (1991), a national initiative under John Major’s government, which established the framework for standards in the public service delivery. By placing an emphasis on individual needs and customer satisfaction the document helped to transcend the collective interests and values characteristic of the public sector (Aberbach and Christensen, 2005). *The Patient’s Charter* (DH, 1991) and the successive policy document by NHS Management Executive *Local Voices* (1992) issued further guidelines specifically in relation to the

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NHS and placed obligations on local authorities to involve patients in consultations so that services were delivered in a responsive way.

NPM inspired reforms introduced deregulation, delegation and decentralisation as means of achieving efficiency, competition and responsiveness in public service delivery. At the same time, the reforms strengthened the central role of the government by imposing new performance targets, regulation and other audit mechanisms. Robinson and Le Grand (1994) argue that the managerial culture of ‘command and obedience’ opened the NHS to further political interference and successive change. Simultaneously, decision-making in the NHS remained located at the management executive level with the implementation of policy initiatives coming from the top down (Klein, 1995). The introduction of the internal market in the NHS while not resulting in outright privatisation, it nonetheless had created an environment with quasi–market conditions and with a wide range of providers competing with one another.

What these examples illustrate is that CICs emerged into a diversified, politicised and complex environment in which old and new modes of co-ordination generated challenges as well as specific arrangements and governance structures that privileged certain ways of thinking and doing things. NPM also facilitated the rise of certain expectations and assumptions that shaped and normalised the successive programmes of reforms, most notably efficiency savings, choice, empowerment and innovation. Arguably, the introduction of ‘general management’ into the NHS led to ‘a constant search for major change and cost improvement’ with new reforms delivered under similar objectives, namely innovation, empowerment and choice (DHSS, 1983:13). While the public bureaucracy remained strong albeit changed, the question persisted, what was the ideal model of co-ordination in the NHS? The next section explores the networked form of co-ordination commonly associated with the New Labour government. In drawing on broad conceptions of
Governance to make sense of these reforms the section highlights the key changes in the governance of health care delivery in the NHS.

2.5 Networked form of Co-ordination in the NHS

As mentioned above, the health care reforms adopted during the 1980s and 1990s emanated from a narrow concern with efficiency that was implicitly linked to an ‘axiomatic assumption of the ubiquity of organisational inefficiency’ of the public sector (Robinson and Le Grand, 1994:14). Adopting NPM as an analytical lens, helped to map the key reforms illustrating how markets rather than hierarchies became regarded as a better form of co-ordination in the NHS. Since the late 1990s, public service delivery became increasingly differentiated and complex and so attention turned to a networked model of co-ordination. The transition, commonly depicted as a shift from ‘government to governance’, is briefly discussed here and then followed up by the specific examples of health care reforms in the NHS that were implemented under New Labour and then in the early years of the Coalition government.

2.5.1 From Government to Governance

Governance developed as a new way of thinking about ‘governing styles in which boundaries between and within public and private sectors have become blurred’ and hybridised (Stoker, 1998:18). Governance, however, is a multifaceted concept, both explanans and explanandum, a theory, organisational structure and framework of analysis that has the ability to obfuscate but also to interpret a changing political order (Peters, 2016; Jessop, 1995). It means different things to different people. It is an essentially a contested concept (Gallie 1956).

The dominant account of Governance, the society-centred approach, conceives the change in interactions as ‘a new process of governing; or the new method by which society is governed’ (Rhodes, 1996:652). The focus here is on societal steering and coordination within networks and
partnerships (Kooiman 2003). For Treib et al. (2007:3) the shift ‘denotes a process of governing which departs from the traditional [hierarchical] model’ and is cognisant of societal actors who are increasingly involved in the formulation and implementation of policies. Put differently, governance is ‘an elaborate system of third party government’ in which some part of public administration is shared with a wider range of new organisations, both for profit and non-profit (Salamon, 2002:2). Similar accounts suggest that public management is increasingly conducted through pluricentric negotiations, which are based on ‘trust and jointly developed [via] rules, norms and discourses’ (Sorensen & Torfing, 2009:236). The important theme here is on the ‘governing mechanisms which do not rest on recourse to the authority and sanctions of government’ (Stoker, 1998:17). At the same time, the diversity of interactions between state, market and civil society are seen to contribute to hollowng out the state (Rhodes, 1994). The dispersal of power, as some suggest, means that the ‘government is not actually the cockpit from which society is governed’ (Klijn & Koppenjan, 2000:136).

By contrast the state centric perspective rejects the notion of governance as the zero-sum game and thus conceives the government as ‘the key political actor […] and the predominant expression of collective interests’ (Pierre & Peters, 2000:25). The ‘state-centric relational’ account, on the other hand, proposes a view by which the governments ‘expand their governing capacities not only by strengthening central state institutions but by forging new governance partnerships with a range of social actors’ (Bell & Hindmoor, 2009:2). Similarly, Crawford (2006:455) argues that the government continues to intervene and ‘micro-manage’ all aspects of social life albeit by different governing methods. Thus, the state-centric relational perspective conceptualises governance as ‘the tools, strategies and relationships used by governments to help govern’ the expanding areas of its influence (Bell & Hindmoor, 2009:2). For Newman (2005:1), the dual logic of governance can be observed in the power of the government that ‘is […] retreating – with state institution being slimmed down, hollowed out, de-centred and marketised – and expanding, reaching out to non-
governable terrains like health’. Likewise, the state continues to play an important role in the ‘supply of welfare but also […] in subsidising the welfare activities of other sectors (including voluntary and commercial sectors […] and regulating welfare activities by means of an increasingly complex and controlling systems of governance’ (Le Grand & Robinson: 1984:3-5). In this sense, the ‘old’ forms of hierarchical control are ‘naturally’ displaced by new complex sets of networks, which can be steered but ostensibly not governed (Newman, 2004a). The shift signifies the development of a new ‘social contract’ based on partnerships, networks and trust rather than hierarchical rule of law (Stoker, 1998). At the management level, the paradigm can be translated into the expansion of new flexible and innovative organisations that are ‘lean […] working as networks with a multitude of participants, organising work in the form of teams or projects, intent on customer satisfaction’ but importantly organised around a common vision (Boltanski & Chiapello, 2005:73).

In analysing Governance it is possible to note similarities and overlaps with NPM, which led some to argue that Governance represents a ‘natural’ transition from the Progressive Public Administration (PPA), to NPM and finally to the New Public Governance (NPG). Under this model, citizens acquire a new status of co-producers of public services (Denhardt & Denhardt, 2015; Osborne, 2006; Koppenjan, 2012). While public space becomes hybridised and the governing is increasingly shared and delivered by multiple diverse actors (Wiesel & Modell, 2014).

### 2.5.2 Networked Governance

The hybrid form of networked governance, therefore, represents a new way of addressing a ‘wicked problems […] which lie beyond the jurisdiction of any one agency’ (Ferlie et al., 2013: 2). It is essentially a mechanism for governing the hollow state that became fragmented because of marketisation in the 1980s and 1990s (Provan & Milward, 2000). In practical terms, networked governance represents an expanding role for partnerships as a ‘strategic consensus for joint action’ and collaboration (Kickert et al.,1997:167). For Newman (2004:71), the phenomenon constitutes
an alternative paradigm to markets and hierarchy whereby the state ‘can no longer assume a monopoly of expertise or resources necessary to govern, and must look to a plurality or interdependent institutions drawn from the public, private and voluntary sectors’. (Newman, 2004b: 71). In this context, the co-ordination is relational and horizontal. Peters (1994), for instance, attributes the emergence of the trend to the policies aimed at rolling back the state in the 1980s vis-à-vis the societal expectations that were created by the post war welfare state. Thus, the networked governance is seen as a reconciling route to bring greater accountability and responsiveness while at the same time deliver ‘efficient, non-bureaucratized public services (ibid, 743).

Rhodes and Marsh (1992:182), draw attention to the role of policy networks defined as ‘a cluster or complex of organisations connected to each other by resource dependencies’ and thus increasing the ability of states to govern by sharing limited resources and expertise. Bevir and Waring (2018) find that such a portrayal of networks grants them special power to generate innovative solutions, which became stifled under public bureaucracy. At the same time, it exposes the ‘inward-looking cultures and operational models’ of the hierarchy that become outdated in twenty first century (Goldsmith and Eggers, 2004:8). So, for Goldsmith and Eggers (ibid, 9-10) the networked governance represents ‘the confluence of four influential trends that are altering the shape of public sectors worldwide’. These trends can be summarised as ‘third party government’ involving a wide range of profit and non-profit providers; ‘joined–up government’ meaning an integrated approach to problem solving; ‘the digital revolution’ that facilitates collaboration at levels previously unattainable and finally, ‘consumer demand’ whereby citizens are increasingly calling for more control and choices over their own lives.

The popularity of the network paradigm has generated many interpretations and identified different types of networks, e.g. environmental, global. What the above conceptions necessarily have in common is the apparent appeal of the networked approach to co-ordinating complex
independencies in delegated health care systems in the way that on one hand, satisfies growing customer expectations while on the other delivers necessary cost savings. In this way, networked governance assumes a position as an ideal type of co-ordination insofar as it ‘allow[s] innovators to fashion creative responses’ to ‘wicked’ problems (Goldsmith and Eggers, 2005: 8; for a critical review of ‘wicked’ problems see Turnbull & Hoppe, 2018).

Having reviewed this new mode of governing the next section explores how it was implemented and instituted as the preferred vehicle for service delivery in the NHS. As in the previous sections of this chapter, a summary of key reforms is intended to illustrate rather than critique the specific policy context from which CICs emerged and in which they subsequently developed.

### 2.5.3 Health care reforms under New Labour

The first wave of reforms of the NHS at this time took place under New Labour’s Health Secretary, Frank Dobson (1997-1999). The intention and vision for change was laid out in New Labour’s White Paper: *The New NHS: modern, dependable* (1997). The document set out a plan to replace the internal market and GP fundholding with a system of ‘integrated care’ based on ‘partnership and driven by performance’ (DH, 1997:1.3). It was envisaged that by retaining what worked (purchaser-provider split) and discarding what had failed (internal market) the government would ‘improve the NHS through evolutionary change rather than organisational upheaval’ (*ibid*). Underpinning the reform agenda was ‘a new model for a new century’, the Third Way, that had emerged as an alternative to ‘an old centralised command control system of the 1970s’ and the ‘divisive internal market system of the 1990s’ (DH, 1997:10-11). The Third Way offered a consensual framework to legitimise and reconcile the ideological tensions arising from the assimilation of neo-liberal policies with the economic gains of the last administration amid problems stemming from governing a ‘differentiated society’ (Newman, 2001: vii, Giddens, 1998).
Under this new social contract, the government prioritised policy that sought to forge partnerships with local communities, individuals and other stakeholders (including the private sector) to improve both quality and efficiency in the NHS (Glendinning, 2002; Glendinning et al, 2005; Clarke and Glendinning, 2002; Powell and Dowling, 2006). The approach, therefore, emphasised the role of networks and partnerships as the preferred method in modernising all aspects and sectors of public policy. The shift signalled a departure from traditional hierarchical and market-based systems of care towards a devolved model that was founded on trust, co-operation and negotiation (Dickinson, 2007). The move had ‘clear links […] with ‘governance’, ‘self-organising and ‘inter-organisational networks’ that defined the new ‘rules of the game’ but also became a ‘vogue word for reforming public sector’ (Rhodes, 1997:15; Rhodes, 1996:652; Kickert et al., 1997). In the 1997 White Paper the Government introduced a series of reforms aimed at restructuring the supply side of the NHS. This involved removing the responsibility for commissioning of health from fundholders,21 health authorities (HAs) and purchasing pilots and slowly phasing in smaller entities called Primary Care Groups (PCGs) (Greener, 2008). The White Paper, *The New NHS: Modern, dependable* (DH, 1997) announced that PCGs led by GPs and involving other health care professionals such as nurses would have significant freedoms to allocate resources and be responsible for commissioning of care. PCGs were expected to gradually develop into freestanding Primary Care Trusts (PCTs). The main goal of this policy was to bring the primary and community health close to patients and to ensure that services were responsive and delivered according to the needs of local population. For Wilkin and Coleman (2001) the establishment of PCTs signified an important change ‘in the funding, organisation and governance of health care provision in the NHS’ that had long term implications for governing. At the same time, HAs (latterly named Strategic Health Authority, SHA) were given new remit for monitoring, regulation, priority settings and developing targeted

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21 Under the National Health Service and Community Care Act (1990), GPs were able to apply for fundholding status, which meant having a responsibility for budget and purchasing of care for their population.
programmes for local services. In line with the overarching agenda of partnership, SHAs and trusts were supposed to collaborate with one another as well as with other local agencies, voluntary organisations, PCG/Ts and local authorities (Dixon and Mays, 1997; DH, 1997).

The perverse effects of earlier, short-term contracts that ‘turned partners into adversaries’ pitted against one another were subsequently replaced with longer-term arrangements based on ‘co-operative service agreements’ (Exworthy et al, 1999:17). Simultaneously, the ‘self governing’ and quasi-independent trusts introduced by the previous administration became a subject of greater scrutiny with an obligation to open up their ‘business’ to the public and act in a more transparent manner (DH 1997, para. 2.23). The reforms were intended to consolidate and modernise the fragmented service by placing ‘the traditional values of the NHS into a modern setting’ (DH, 1997: para 2.24). To this end, an alternative vision of state as facilitator and partner keen to foster community values and economic success was promoted (Bevir et al, 2001). The government recognised that social justice and a competitive economy are two sides of one coin and needed to be achieved in tandem (Crouch, 1997:359). New Labour, thus, remained committed to expanding the Private Finance Initiatives (PFI), a controversial scheme introduced by the previous Conservative government with critics warning that the cost of ‘partnership’ significantly exceeded the benefits and distorted the priorities of the service by privileging private interests (Gaffney et al., 1999; Pollock et al, 2002). On the other hand, PFIs were seen to represent a new model for service delivery that was built around commercial synergy and trust (Driver & Martell, 2002).

In keeping with New Labour’s approach to modernising ‘the old culture of paternalism and inwardness’, the government abolished the Compulsory Competitive Tendering (CCT) regime, which it argued was skewed in favour of private sector and market principles (DETR, 1998a:5).

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22 The PFI is a type of project finance where the private sector provides capital finance, infrastructure, building and servicing while the public sector pays for the use of facilities. For the evaluation of PFI see for instance Broadbent and Laughlin, 2003.
Instead, the government introduced a new framework of Best Value (BV) for local authorities, which was focused on quality of services that ‘should be provided through the sector best placed to provide those services’ (DETR, 1998b: 33). For New Labour this meant any provider public, private or third sector as long as it showed commitment to achieving efficiency and meeting performance targets (Boyne, 1998). As with other reforms introduced by the government, the BV regime built on and expanded the requirements of the earlier model of CCT subsequently increasing the bureaucratic controls and administration. At the same time, the BV reforms in local government contributed to the growth of alternative providers and thus instead of reducing the competition it further intensified it (Martin, 2000). The BV regime was intended to improve local government’s procurement practices, and it was envisaged that the similar model would soon develop in the NHS (Bovaird, 2006). However, it was not until the Coalition Government when the idea remerged again in the consultative document, *Securing the Best Value for patients*, which laid out proposal for commissioning health care services (DH, 2013a).

The idea of networks promoted by New Labour extended beyond the organisational structures and their management and was increasingly aimed at involving staff and patients in deciding and planning how services should be run and delivered. In the *NHS Plan: a plan for investment, a plan for reform*, the Health Secretary set out a vision for modernising the NHS over the following 10 years by introducing a ‘radical change at all levels’ (DH, 2000). The *NHS Plan*, was formulated in a true spirit of partnership working with ‘teams of NHS professionals and others analysing each part of [the] healthcare system and how it [could] be improved’ (DH, 2000:9). The reforms promised an increase in funding for the NHS, new and revised ‘modern’ contracts for GPs and hospital doctors as well as more opportunities for staff to develop clinical and managerial leadership (*ibid*).

The interlinking components of the government reform programme continued to include competition, choice and private and civil society involvement. The *NHS Plan* embraced the needs of patients and promised to give them more power and voice to influence decisions about their
own care (DH, 2000). The government passed legislation that abolished Community Health Councils that since 1974 had provided a voice to public and patients in the NHS (*ibid*). In their place, it created a number of new bodies such as the Commission for Patient and Public Involvement in Health (CPPIH), the Patients Advice and Liaison Service (PALS) and the Independent Complaints and Advocacy Service (ICAS). The overriding concern was to extend patient choice by introducing reforms that would result in the NHS being ‘less monopolistic [and] more diverse [with] greater plurality [and with] greater sense of local ownership within the system’ (Timmins, 2002:130). Assisting this transformation was the pledge to form a concordat with the private sector to ensure the NHS could make a better use of private facilities (DH, 2000).

The emphasis on the role of the private for-profit and non-profit voluntary sector suggested potential for a revised version of the internal market albeit one that was achieved through partnership and regulated by national frameworks. The patient choice a leitmotif of New Labour NHS reforms, was the centrepiece of the discussion document *Extending Choice for Patients* in which the government set out the conditions for the improved care of patients’ awaiting heart surgery by allowing them to choose an alternative provider from public or private sector (DH, 2001a). The proposal attempted to address the inefficiencies of the system (waiting lists, backlogs in the referral systems) by introducing a series of structural reforms to the supply side including diversity of provider and consequently improving demand aspects. The approach was seen by some as the basis for expanding the principles of internal market by adopting a neoliberal prescription in which competition amongst providers leads to a greater choice for consumers (patients) and increases productivity of the system (Greener and Mannion, 2009; Chernichovsky, 1995).

However, New Labour argued that the demand for choice and quality came directly from patients themselves whose experiences and expectations were increasingly shaped by the new dominant consumer culture (Vidler & Clarke, 2005). In delivering the objectives of the *NHS Plan* (2000), the government published a new framework, *Shifting the Balance of Power*, to devolve ‘greater power to
frontline staff and local communities’, galvanising their skills and knowledge in order to improve and innovate the service (DH, 2001b:12). Under the theme of ‘culture change’, the government seemingly tried to shift the locus of control from the top to the bottom by empowering staff and giving them more autonomy over the decisions of how to design and deliver services. Initiatives such as the National Taskforce on Staff Involvement in the NHS found that ‘involvement can improve patient care, enable the efficient management of change and lead to a healthier, better motivated workforce with reduced staff turnover’ (DH, 1999:3-4).

While staff was freed to make decisions about how best to deliver care to patients, the latter were increasingly expected to take responsibility for own health. The 2004 White Paper Choosing Health: Making healthy choices easier argued that ‘new opportunities’ created a ‘new’ type of public that was now ‘used to consuming a range of goods and services’ and thus the Government had to act by developing approaches that reflected this change (DH, 2004a). The White Paper elaborated on the individual freedoms and choice implicitly making patients more responsible for sharing risks connected to health management (Clarke, 2005). For example, lifestyle choices such as smoking, or exercise became important factors in determining the worthiness of a patient in regard to granting treatment. In this sense, the shift in emphasis helped to redefine not only the expectations and rights of patients but also implicated them in the complex web of conditions and assumptions on the basis of which access to health care was granted.

Despite introducing a number of important changes, the approach adopted by New Labour, particularly in the first term of office, continued to resemble a traditional command and control model (Timmins, 2012:18). Their ambition conceived of the state ‘as an enabler acting in partnership [and] … delivering services through networks’ was necessarily delivered through a system of performance targets and regulation. Critics argued that the institutional architecture served as a Trojan Horse through which to import neo-liberal ideals of deregulation and liberalisation (Jessop, 2003:2). While others pointed to the NPM roots in the successive policy
innovations such as the National Institute of Health and Clinical Excellence (NICE), the Commission for Health Improvement (CHI), a National Framework for Assessing Performance, and a National Survey of Patient and User Experience highlighting the technocratic and prescriptive nature of these developments (Walker et al, 2007).

From 2000, and under new Health Secretary Alan Millburn, the emphasis on health care reforms significantly changed. Whilst the commitment to quality, efficiency and responsiveness of the service retained its political kudos, the strategy of how to deliver on these commitments had shifted. In 2003, the government introduced the Health and Social Care (Community Health and Standards) Act, which made provision for commercial contracting for mainstream hospital service and established a new body, the NHS Foundation Trust (FTs). FTs were non-profit companies, independent of government and enjoyed greater autonomy than the earlier NHS trusts established in 1991 under the Conservative government. These were formed on a voluntary basis and regulated by a new arms-length body, Monitor. The purpose of FTs was to create structures that ‘mimic aspects of TSOs [Third Sector Organisations] and to increase the diversity of provision at local level’ making the service delivery more responsive to local needs (Allen, 2009:380). However, Dixon et al. (2010:1) argued that despite the rhetoric, the foundations trusts continued to take direction from the DH rather than seeking approval from local communities.

The introduction of FTs was accompanied by a programme of commercial contracting for elective care under the Independent Sector Treatment Centre programme (ISTC). The ISTCs emerged at a time when the NHS was struggling with long waiting lists that put pressure on clinicians to separate

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23Monitor was originally established in 2004 as an Independent Regulator of the Foundation Trusts. The Health and Social Care Act 2012 extended its remit to include the role ‘as sector regulator for health services in England’ and to promote ‘the provision of healthcare services that is economic, efficient and effective, and maintains or improves their quality’ (Monitor, 2014:4). In 2016, the Monitor became part of NHS improvement.
acute and elective work from one another (Hughes & Vincent-Jones, 2007:405). In 2004, primary care was also opened to more competition. Under the Alternative Provider Medical Services (APMS) framework, new providers from private and third sectors were encouraged to bid for contacts and secure a place in the primary health care market (Ellins et al., 2009). The government introduced a range of provisions to lower the barriers to entry for third sector organisations encouraging them to play a bigger part in the delivery of public services (see chapter four). The inclusion of alternative providers was central to New Labour’s plan of modernising the delivery of public services and was driven by the assumption that a plurality of providers would necessarily bring greater choice for patients while at the same time produce improvements in the quality of care. However, Coleman et al. (2013) found that procurement under the APMS contract model in primary care in England, proved to be expensive and time consuming and resulted in mixed outcomes in relation to quality and patient care.

Along with alternative providers and the reformed status of hospitals came another change, the reform of hospital finance and the introduction of payment systems. Since 2003/04 the government phased in a national tariff system in a form of Payment by Results (PbR), which was supposed to inform providers of costs and incentives they were likely to incur for their work. Under the PbR purchasers of care, typically PCTs, were expected to pay a fixed price for every patient that was treated by a provider of primary and community care. It was expected that this new approach would help to control demand and keep the health care costs down. In addition to reducing admission and cutting the waiting list, the policy was designed to facilitate a culture change whereby managers were more able to convince clinicians to perform care in the cheaper setting and on a day case basis (Street & Maynard, 2007:421). Albertson et al. (2018) argue that the theoretical antecedents of this innovation can be found in NPM with the emphasis it placed on incentives, targets and performance. Moreover, they suggested that this outcome–based commissioning could be seen as a way of dealing with complexity in the social world whereby policy makers ‘seek to facilitate and
develop new and existing philanthropic activity and social enterprise’ (ibid, 14). Put differently, the framework was intended to generate innovative and creative responses in service delivery by giving sufficient flexibility over the choice of methods coupled with financial incentives. The approach is not dissimilar to the one adopted in the pre-war NHS and under the market model of co-ordination with the growing interest in the sector but also in its varied forms to deliver services on behalf of the state.

The government’s attempts at improving health care services continued with the publication of the report by Lord Darzi, the High Quality Care for All: NHS Next Stage Review (DH, 2008a). The Report endorsed the reforms introduced by the NHS Plan (2000) and set out key objectives for the NHS for the next ten years. Although the themes, patient choice, competition, community services and personalisation remained unchanged, the proposed mechanisms for their delivery differed. Instead of a centralised and target driven approach, Lord Darzi (DH, 2008a) advocated a system that was informed by locally produced indicators and underpinned by quality as an important driver for change. To this effect, from April 2010 all providers NHS, private and third sector were required to publish Quality Accounts, which were then made publicly available. The Report encouraged PCTs to commission a wide range of services from a diverse range of providers and in partnership with local authorities. Alongside staff freedoms, the Report endorsed a greater autonomy for ‘local decisions on the best governance and organisational models to support the development of flexible, responsive community services’ (ibid, 62). It emphasised the role of innovation and proposed introduction of a ‘right to request’ for staff who wished to establish an independent social enterprise to deliver health care services.
Subsequently, the document placed an obligation on PCTs to consider staff’s request and as long as the business case was approved, the new social enterprises were to be awarded with a contract for an initial term of three years with staff upholding a right to the NHS Pension Scheme. The *NHS in England: the Operating Framework for 2008/09* (DH, 2007a) set out specific arrangements for implementing the proposed changes. It committed all NHS trusts to become FTs and extended the freedoms and local accountabilities to other providers in the NHS. The Framework also clarified the process that needed to ensure it was transparent and based on ‘genuine partnership working between PCTs, local authorities and other partners (public, private and third sector – including social enterprise)’ to jointly address and appreciate local needs (*ibid*, 4). The Transforming Community Services (TCS) (DH, 2009) detailed provision for the mentioned RtR programme which at the time was regarded as a novel policy vehicle for ensuring high quality in community services. The assumption was that ‘through innovation and redesigning services in flexible new ways in independent organisations such as social enterprises’ it would be possible to achieve higher standards as well as achieve necessary efficiency (DH, 2009:32). The TCS provided a comprehensive list of legal structures for social enterprises and highlighted both challenges and opportunities stemming from adopting a specific model, for example VAT, corporation tax. *The Primary and Community Care Strategy* (DH, 2008b) further encouraged staff to consider forming an independent social enterprise and to ‘produce proposals through a right to request to reform themselves into entities that can be recognised in the market place (*ibid*). To this effect, the Department of Health together with the SEU issued a list of publications such as for instance ‘Social Enterprise – Making a Difference: a guide to the Right to Request’ (DH, 2008c), detailing how the process worked but importantly explaining what a social enterprise was. Out of all the legal models and despite the relative newness, CICs became the most popular organisational platform that was

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24 During the interviews, some participant observed that the process was in practice arbitrary with some PCT Boards showing prejudice to the applicants. In other cases, the positive relationship with commissioners resulted in favourable terms obtained during the spin out phase.
adopted by staff. CICs were originally intended to ‘meet the needs of local communities, complement [...] core government services in areas such as childcare provision, social housing, leisure and community transport’ rather than ‘deliver essential public services in core sectors such as hospitals and schools’, which might explain why the government did not at first recognise CICs ‘to be in the public sector’ (DTI, 2003a:3). Nonetheless, nearly 60% of the CICs were established in the health and social care market, with Bristol Community Health CIC, for instance, recording a turnover of £48 million (The CIC Regulator, 2015:14).

2.5.4 The NHS under the Coalition government.

Since 2010 and under the leadership of the Conservative–Liberal coalition government, the NHS underwent significant further transformations. There was a degree of convergence with the previous reforms albeit implemented under the new discourse of Big Society. There was a fundamental shift in the scope and pace of change that some regarded as unprecedented in the NHS (Timmins, 2012). To begin with, the Coalition government continued with reforms that intended to generate more patient choice, increase competition and improve clinician and staff autonomy. To this effect, *Equity and excellence: Liberating the NHS* (DH, 2010a:25) outlined a five year vision committing government to achieving greater accountability by adopting a ‘transparent regime of economic regulation and quality inspection to hold providers to account for the results they deliver’. Quality and high standards, therefore, remained central to the proposed reforms with specific emphasis on the bottom up approach to their implementation. In this context, the commissioning practices were to be devolved to health care professionals who were perceived closer and more responsive to patients’ needs. Much like New Labour, the Coalition government sought to expand the role of non-profit providers by creating the ‘largest and most vibrant social enterprise sector in the world’ (DH, 2010a:36). This was to be achieved by giving the NHS ‘staff

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25 Presumably this was because some of the hospitals were already run as semi-autonomous, non-profit organisations, e.g. Foundation Trusts.
the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises’ (ibid, 5). As a result, in March 2011, the Department of Health announced Right to Provide (RtP)\(^{26}\), which extended the right of staff ‘to provide services as staff-led enterprises and bid to take over the services they deliver’ (DH, 2011:3). In introducing the new programme, Francis Maude (2010), drew on the renewed relationship between the state and citizens, which marked the departure from Big Government toward the model based on the Big Society. Maude (ibid) highlighted the role social enterprises and employee-led mutuals played as important platforms for enabling frontline staff to have ‘a real stake in the ownership and governance of the organisations they work for’ and significantly ‘in reforming public services’. The White Paper, *Open Public Services* (2011:42) subsequently set out the policy framework underpinned by five key principles for modernising public services: choice, decentralisation, involvement of a wide range of providers, fair access to public services and accountability to users and to taxpayers.

Despite an earlier pledge to end top down reorganisation of the NHS, the Coalition government introduced one of the most debated and controversial pieces of legislation, the *Health and Social Care Act* (HSCA)\(^{2012}\) (see also Timmins, 2012). The Act abolished the Secretary of State for Health’s duty to provide a national health service and replaced it with a duty to promote it. The change while appearing relatively small had important and long-term implications with the subject becoming a central theme in parliamentary and academic debates (Pollock & Price, 2011). As part of the legislation, the authority for purchasing of health care services was removed from SHAs and PCTs and transferred to the newly established NHS Commissioning Board (CB) (later to be known as NHS England) and the Clinical Commissioning Groups. The existing 10 SHAs and 152 PCTs were replaced by 211 CCGs, area teams, clinical support units, clinical senates, local education and

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\(^{26}\) The 2017 Labour Manifesto also showed interest in developing a similar scheme if the party won the election. According to the Manifesto (2017:19), ‘Labour would give more people a stake – and a say – in our economy by doubling the size of the co-operative sector and introducing a “right to own,” making employees the buyer of first refusal when the company they work for is up for sale.
training boards as well as Health and Wellbeing Boards (HWBs) (HSCA, 2012). Under the new scheme, all GP practices had to enrol with the CCGs, which were set up as ‘membership’ organisations maintaining responsibility to their members as well as to the newly created NHS England (Checkland, 2018). The CCGs were given responsibility for purchasing acute and community health care services from ‘any qualified provider’ (AQP) and through competitive tendering overseen by the newly appointed body of the Monitor. According to Checkland (ibid: 59), the establishment of CCGs constituted a new paradigm in governance arrangements which involved ‘setting conditions in which actors are incentivised to behave in ways consonant with policy objectives, whilst perceiving themselves to be acting autonomously’. For Speed and Gabe (2013), the new system embodied the continued dominance of NPM logic, which despite the rhetoric on empowerment had eroded public trust and professional autonomy.

In 2014, the government introduced another significant document, the *Five Year Forward View* (FYFV, 2014) that signalled a shift in the policy direction. The FYFV contained plans for improving preventative and public health provision by empowering and involving patients, engaging communities through programmes like *NHS Citizen* and building stronger partnership with the voluntary and charitable sector. The document drew attention to the development of new care models (NCMs), which would ensure better integration of primary care, community services, and hospitals. Central to this vision was the shift towards new population–based models, Multispecialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS). Both models share the same objective of better integration of health and social care delivery but differ in scope and scale. For instance, MCPs allow networks, federations and larger partnerships to operate on the scale delivering a wide range of community–based services including those that were previously

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27 Established and hosted by local authorities, HWBs bring together the NHS, public health, adult social care and children’s services, including elected representatives, to plan how best to meet the needs of their local population and tackle local inequalities in health. They do not have formal powers, instead they influence commissioning through effective partnership working and pooling of budgets.

28 NHSE is an arms’ length, non-departmental body.
provided in hospital settings (FYFV, 2014:18). PACS, on the other hand, apart from primary, community, mental health and social care also include most hospital services in addition and therefore offers the potential to transform an entire hospital business model, across inpatient, outpatient, medical and surgical pathways. The proposed changes inevitably will impact on the existing providers of health and social care services including CICs although to what extent this is still unclear.

The rapidly imposed place-based Sustainability and Transformation Plans (STPs), the special mechanisms to deliver the FYFV, have been consistently mentioned by the participants as a significant development in the health care economy in England. The STPs were initially set out in the NHS shared planning guidance 2016/17 - 2020/21 requiring ‘every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the FYFV (NHS England, 2015:4)

These strategic plans represented a shift in focus from competition to cooperation mandating organisations to develop a combined approach to planning and delivery of health and social care services. However, The King’s Fund (2017) warned that this might be difficult to achieve under the current conditions with the legacy of conflict and rivalry created by the HSCA (2012). Likewise, the expectation of the NHS that STPs plans would be developed in a short timespan meant that areas did not have enough time to organise and formulate realistic plans let alone to consult in the meaningful way with the public, local organisations (e.g. local authorities and primary care), their own staff who were ultimately to be affected by the proposed changes. The plans were also designed to reduce debt while continue to deliver services under financial constraint. The initial lack of transparency and engagement with these plans and the implication of service cuts impeded progress eroding public trust and support for them. However, despite mentioned difficulties, there is a consensus that integrating health and social care would bring positive outcomes for patients, with
a number of studied CICs suggesting they were already delivering a similar model of care prior to the introduction of STPs.

This brief reflection on STPs in this concluding section relates to the concerns raised by CICs during the interviews. At the time, the plans were still underdeveloped and therefore it was difficult to ascertain their impact. Nonetheless, participating CICs expressed both apprehension and frustration with the programme claiming that STPs were effectively pushing them back in the direction from which they only recently emerged, most notably larger acute–based models of care which policymakers and politicians described as not conducive to innovation and staff engagement.

2.6 Summary

This chapter provided an outline of health care reforms understood as the shift between three modes of co-ordination: bureaucratic hierarchy, market and network. From the outset, the chapter recognised that such a chronological representation conflates a more nuanced reality whereby governing arrangements are increasingly interconnected through the specific institutional and historical adaptations and thus are more quasi rather than ideal types. As Ham (2009) pointed out markets in the 1990s co-existed alongside hierarchies and networks and indeed hierarchy played an important role in the first term of Blair’s administration. Likewise, the Conservative-Lib Dem Coalition government was seen to champion markets while the current Conservative government appears to be reverting to managed networks if not networked – hierarchy (Jones, 2018).

This resonates with the view of the NHS as a ‘zig-zag between different governance mechanism (hierarchy, markets and networks)’ where different policy streams and reforms have not necessarily ‘replaced each other but have accumulated over time, or ‘sedimented’, producing complex mix’ rather than ideal type of governance (Jones, 2018:18). Nevertheless, the typology served a useful purpose to synthesise an understanding of the significant body of NHS reforms and at the same time to contextualise the evolving and increasingly complex governance arrangements in health care.
delivery. In exploring these wider historical and organisational aspects the chapter sought to reconnect CICs to the wider process of the transformation of health care delivery in England.

The chapter attended to the first nested questions proposed in the introduction to this thesis (see p.9) namely: **What is the relationship between CICs and the wider agenda of transformation of health care delivery in England?** In this respect, rather than thinking of CICs as a unique phenomenon or a countermovement to hierarchies or markets, it is possible to problematise their role from a wider, macro perspective that indicates deeper roots and pedigrees. In adopting NPM and Governance as an explanatory account of changes to the steering mechanisms, the chapter illuminated the specific logics and values that influence and shape the direction of successive policy streams and narratives. Moreover, the trends are useful in identifying shared themes in public sector reforms, most notably innovation, governance and accountability that play an important role in guiding and legitimising policy choices. The next chapter analyses these three categories to then test them in the successive three empirical chapters of this thesis (see chapters, six to eight).

**Chapter Three: Key themes in the delivery of publicly funded health care**

### 3.1 Introduction

In examining the macro context in chapter two, a series of common themes began to emerge. While many other concepts are explicitly and implicitly related to health care policy, in this thesis the focus has been narrowed to the three broad categories: innovation, organisational governance and accountability. As chapter two explored, the pressure to deliver an efficient, responsive and accountable health service has led governments to experiment with novel mechanisms for coordination in service delivery. Moreover, the chapter illustrated how NPM and Governance were useful in legitimising these new modes of governing by establishing a set of expectations and assumptions specifically around innovation, flexibility and autonomy as well as new forms of accountability. The development of CICs in the NHS is directly related to this broader agenda and
therefore these key concepts merit attention. To this end, the chapter has been divided into three parts, each providing a brief overview of the terminology.

3.2 Innovation

In the last three decades innovation has become a popular catchphrase, a panacea to complex problems (Abbasi, 2013) and synonym of progress and growth (Romer, 1990). As Godin (2016:527) asserts, innovation is a term that ‘everyone spontaneously understands or thinks they understand; that every theorist talks about; that every government espouses to’ and indeed legislates for. Yet, despite the abundance of labels and descriptions innovation remains a vague term (see for instance review by Ville, 2011 and Maskell, 2000). To be innovative is commonly considered desirable although it is not always clear how, why and for whom (Holt, 1971). For Rogers (1995:100) this results in ‘pro-innovation bias’ defined as ‘the implication . . . that an innovation should be diffused and adopted by all members of a social system, that it should be diffused more rapidly, and that the innovation should be neither reinvented nor rejected’. Similarly, Knight (1967) proposes that innovation involves value judgements that give an implicit expectation of something positive to happen without necessarily raising questions about impact including negative consequences. But what is innovation?

3.2.1 Definitions of innovation

Innovation concerns many areas and can be studied from various perspectives such as a specific sector (e.g. public, private), area (e.g. technical, organisational) or process (e.g. adoption, diffusion). For Schumpeter (1939:87-88) innovation was intrinsically linked to economic growth and involved ‘new commodity as well as those of a new form of organization or a merger, or the opening up of new markets’. Drucker (2007:17), on the other hand, saw innovation as ‘the specific tool of entrepreneurs, […] [to] exploit change as an opportunity for a different business’ while Damanpour (1991) recognised that organisations had to innovate in order to survive in a constantly changing
and competitive environment. A similar definition was proposed by Bessant et al. (2005: 1366) for whom ‘innovation represent[ed] the core renewal process in any organization. Unless it change[ed] what it offer[ed] the world and the way in which it create[ed] and deliver[ed] those offerings it risk[ed] its survival and growth prospects’. Central to these views is the role of an entrepreneur and a charismatic leader who is endowed with special qualities that enable him or her to foster change and innovate (Petrakis et al. 2015; Dodge et al. 2017).

From these perspectives, creativity is positively associated with innovation and is believed to emerge where the relationship between staff and leaders is supportive and where the former has a degree of freedom and ownership (Ohly et al., 2006). The implied changes in all these cases, however, do not need to be big nor do the ideas have to be novel (O’Sullivan & Dooley, 2009: 5). As Nayak and Ketteringham (1986:344) argued, ‘innovation [was] the art of doing the same thing you [were] doing’ but in the better way. In contrast, Barnett (1953:7) suggested that innovation was ‘any thought, behaviour, or thing that [was] new because it [was] qualitatively different from existing forms’. Eco-innovation, for example, might involve radical shifts (Fussler and James, 1996) in knowledge and practice while technological advances (Betz, 2003) could lead to breakthroughs and disruptions (Christensen, 1997). Hence innovation encompasses new and old ideas, products as well as new organisations and administrative structure (Damanpour, 1996: 694). Consistent with extant literature, the Organisation for Economic Co-operation and Development (OECD), Frascati Manual (2015) defined four types of innovation: product, process, marketing and organisational innovation which involves implementation of new methods and business practices. Hartley (2005:28) extended this taxonomy to embrace: service innovation (new ways in which services are provided), strategic innovation (new goals or purposes), governance innovation (new forms of citizen engagement), position innovation (new contexts or users) and rhetorical innovation (new language and new concepts).
Innovation in services has increasingly become popular with public sector seeking new approaches to deal with growing demand vis-à-vis limited resources. The focus, thus, is on enhancing public value through activities and services that serve wider social value enhancing the wellbeing of society as well as its capacity to act (The Young Foundation, 2012). The dominance of Western notion of innovation has recently been challenged by Jugaad Innovation (Radjou et al., 2012, Bobel, 2012) and ‘frugal innovations’, defined by George et al. (2012:662) as ‘low - cost and high - quality products and business models originating in developing countries and exportable to other developing countries or even the developed world’. This model is particularly resonant with politicians and policy makers who in the era of austerity are searching for ideas that could help to contain cost while meeting social obligations. Lord Darzi (2017), for instance, suggested that governments should look to the developing world for solutions and inexpensive innovations to secure the best value for the NHS. However, Gallouj and Zanfei, (2013:91) observed that ‘innovation in public services has long been envisaged in terms of a cost-cutting trajectory at the expense of other performance trajectories’ narrowing the scope for innovation to necessarily NPM solutions. While Lord Darzi might be right about the sources of high costs in the NHS, e.g. pharmaceutical, interest rates on Private Finance Initiatives (PFIs), innovation on its own is unlikely to resolve these issues as the problem is as much economic as it is political.

In considering the concept further, the next section narrows the field of innovation to the case of the public sector.

3.2.2 Innovation in the Public Sector

In the last three decades and under the influence of NPM, innovation has become an important concept in public sector reforms (Windrum, 2008). Rising consumer expectations on one hand and financial austerity on the other are believed to have created need for alternative and cost-effective solutions to public service delivery (Osborne & Brown, 2013). The systematic review on innovation,
for instance, found that the second largest field in the study of the subject came from the government and was closely followed by healthcare (de Vries et al., 2016). Likewise, administrative and managerial innovations were shown to be the most popular categories for innovation (ibid). In line with Benington and Hartley’s (2001:29) argument that the three competing paradigms of bureaucratic hierarchy, markets and networks are ‘conducive to particular ways in which innovation is both generated and adopted’ the following sections focus on the nature of innovations under the three dominant modes of co-ordination.

3.2.3 Innovation under Bureaucratic hierarchy

The model of public governance is said to be conducive to administrative type of innovations with scale intensive and publicly funded projects. In the postwar period and under the influence of strong bureaucracy, innovations tended to be based on legislative rule and command approaches. The wider socio–economic context facilitated the rise of innovations that had a universal appeal (e.g. penicillin, vaccinations) and were produced and delivered at large scale (mass production) via new and emerging technologies. Research was not intended to deliver cost efficiencies rather it was focused on effectiveness by embracing scientific and technological innovations (Farchi & Salge, 2017). The National Health Service Act made the Minister of Health (1946:19) responsible for conducting or instructing others to ‘conduct research into any matters relating to the causation, prevention, diagnosis or treatment’ with health departments in charge of all clinical facilities. Research and training was supported by established bodies such as the National Institute of Medical Research (NIMR) as well through the charitable donations from the Wellcome Trust. According to Hartley (2005), the economies of scale and the central control over resources helped the government to implement changes relatively quickly and for innovations to become evident and widespread.
Under bureaucratic hierarchy, innovation is necessarily likened to technocratic processes in which policy makers (‘commanders’) are in charge of innovations with public managers acting as ‘impasive officials [martyrs] implementing political will’ without necessarily questioning the validity of such decisions (Hartley, 2005: 30). Arguably, the large institutional context intrinsically encourages administrative and managerial innovations to help deal with problems of control and co-ordinations including support for scientific innovations. In 1971, Rothschild’s Report recommended for ‘each government department […] [to become] a customer of government-financed R&D’ with an appointed Chief Scientist closely involved in the customer decision-making process (Duffy, 1986:70).

3.2.4 Innovation under market mode of co-ordination

The next phase in the NHS discussed in chapter two as market mode of co-ordination is characterised by medical and scientific advances but also by a shift towards organisational and managerial forms of innovations with an enhanced emphasis on customer value. Under this model, innovation involves significant restructures, new business practices and the development of novel organisational forms and financial arrangements most notably PFIs. Efficiency rather than effectiveness is considered to drive innovations in accounting practices, service design and delivery. Innovations while still incremental are perceived dynamic, managed rather than planned, resulting in novel organisational structures (hospital trusts), practices (contracting out, internal markets) and other instruments such as privatisation. While the technology under markets plays a vital role in stimulating innovation this tends to take place under the NPM requirements of cost containment, generating value for money and enhancing business performance. Likewise, innovation appears to be skewed towards practices that ensure greater choice resulting in improving the supply side without necessarily altering the content of public service delivery per se (Hartley, 2005). In this context, managerial innovations (Hamel, 2006) are seen to shape the way managers perform and account for their task prioritising innovations that are ‘oriented toward the efficiency and […]
management processes’ (Damanpour & Aravind, 2011:428). Whilst the science–driven research remains important, the idea that it is exclusively dominated by scientists and science related concerns has shifted. Farchi and Salge (2017:148) argue that while professionals might be seen to maintain autonomy, ‘the traditional curiosity-led approach [becomes] deemphasized’ and steered towards cost effective solutions.

### 3.2.5 Innovation under networks

The shift towards a new mode of governance opened up opportunities for collaboration considered more conducive to new types of innovation based on intrinsic social value creation, so-called social innovation (Adams & Hess, 2010). The new approach was predicted upon multi-level governance in which distributive and trust-based leadership leads to bottom up experimentation (Hartley et al., 2013). Phillips et al. (2013) propose an analytical framework to conceive social innovation as part of a system, in which a wide range of institutions and organisations support one another to influence change and meet a social need. The service users, clinical and managerial staff and other stakeholders are increasingly regarded as potential sources of innovative ideas and solutions. As the former Health Secretary, Jeremy Hunt (2014) noted ‘the most powerful driving force for innovation we have: the power of individual citizens who care about their own health’. Innovation is thus typified by a larger involvement of diverse range of actors and institutions from public, private and third sector with citizens actively performing a role of co-producers of innovations. At the same time, managers are seen to be ‘commissioned […] to search for public value [and] […] expected to use their initiative and imagination [and] […] be responsive to more or less constant political guidance and feedback (Moore, 1995: 299). Innovation is thus wedded to political, social and an economic sphere underpinned by the NPM logic of efficiency and customer satisfaction. In the NHS, this is articulated by novel procurement practices, e.g. Commissioning for Quality and Innovation (CQUIN), which promote innovations by offering financial incentives. In addition, all CCGs have a legal duty to promote innovation through the Section 26 of the Health and Social
Care Act 2012 (p.40), which states ‘in the exercise of [CCGs] functions, promote innovation in the provision of health services (including innovation in the arrangements made for their provision)’.

3.3 Organisational governance

One of the central themes to emerge from the discussion in chapter two, has been the role of alternative forms of governance in public service delivery. The NPM rhetoric that the ‘state is too big, that the public sector hinders economic development’ resulted in the policy aimed at decentralising, disaggregating and delegating some of the state functions to a diverse range of providers (Flynn, 2002:58; Peckham et al., 2008). According to Rhodes (2007:1245), this fragmentation led to the formation of new networks but significantly in increasing the membership and composition of existing networks, integrating both the private and voluntary sectors. Central to the transformation, as chapter two illustrates, was imbedding of alternative and innovative governing structures to act as important conduits through which to deliver change and provide public services. In this context, Governance was conceived as a broad intellectual current that helped to shape and make sense of the new and emerging relationships and interactions between the formal institution of the state and its citizens. Stoker (1998:18) synthesised Governance as a theory of five complementary propositions, which aimed to identify 1) a set of institutions and actors from but also beyond government, 2) the blurring of boundaries and responsibilities 3) the interdependence between institutions involved in collective action, 4) autonomy of self-governing networks and finally 5) the capacity to get things done which does not require the government intervention through the traditional channels of authority and command. In this sense, Governance was useful in illuminating the meso level changes taking place in the public policy and linking them to the shifting macro-level context of politics.

In this chapter, however, governance is used to mean specific albeit narrow practices, structures, mechanisms as well as processes involving different aspects of decision making. This is deliberate
and intended to bring the focus from macro to the micro level concerns with governance. The term governance has evolved from the broad method of management to the narrow understanding of the role and responsibilities of board of directors and function of organisational relationships (Forbes & Milliken, 1999). Carver (2010:150) argues that the concept is still in flux and because it is a ‘social construct rather than a natural phenomenon, theory must be driven by and anchored in the purpose of boards’ rather than reproduced by studying existing practices. In this sense, governance is a multi-faceted concept that can be used and understood differently depending on the context and frame of analysis. In this chapter as well as in the empirical assessment of CIC governance in chapter seven, the term has been defined from an organisational perspective that encompasses public, corporate and non-profit (participatory) governance. This is because the legal structure of the CIC has developed in the way that incorporates, to greater or lesser extent, all these three institutional logics and practices. Significantly though it is to illuminate the fluidity between public, corporate and participatory governance that can no longer be defined by the sector boundary of the organisations.

### 3.3.1 Public governance

For Stone and Ostrower (2007, p. 418), public governance involves fixed ‘constitutional and statutory arrangements among executive, legislative, and judicial branches, with the executive branch’ overseeing the design and implementation of public policy. Carver (2001:54), on the other hand, equates public governance with ‘microcosms of the state’. However, the concept is ambiguous and can take a variety of forms depending on the jurisdiction. For instance, the public sector has been defined as the section of the economy traditionally owned and controlled by government where public sector organisations were in charge of providing services and utilities that were essential to society and therefore funded by the state (Broadbent & Guthrie, 1992). Broadbent and Guthrie (2008) subsequently revised this definition suggesting that the public sector was
necessarily superseded by public services. The modification was justified on the basis of public sector reforms that resulted in public services being organised in different ways and controlled by variety of means and organisations including regulation. While public organisations could retain an ‘element of government funding, ownership, public direction or regulation’ there was no longer a requirement for the government to be directly involved in the delivery of these services (ibid, 134). This shift significantly normalised the view that it was ‘the provision of services that matter[ed], rather than who provide[d] them (ibid, 138).

From another perspective, ‘governance comprises the arrangements [political, economic, environmental, legal, and administrative structures and processes]’, which are implemented to ensure that defined outcomes are delivered to stakeholders (CIPFA, 2014:8). Thus, public sector governance broadly conceived concerns the way in which the state assumes the authority to provide and to delegate the responsibility for public goods and services. It describes the complex relationship between different actors, citizens, politicians, policy makers and bureaucracy, involved in the production, co-production and consumption of public goods and services. Co-production is understood here as a mix of activities including public services where different stakeholders are seen to make a ‘better use of each other’s assets and resources to achieve better outcomes or improved efficiency’ (Loeffler & Bovaird, 2016:1006). In practice, public sector governance is delivered by traditional mechanisms of regulation, procurement and by setting overall policy objectives and direction. As indicated in chapter two, the introduction of managerial ideologies into the public sector shifted the foci of public sector governance from delivery towards improvements in service delivery, promoting greater engagement of diverse stakeholders. The emphasis was on an accountable public sector that was responsive and capable of brokering a new relationship with civil society (Haque, 2000). In identifying the public sector, a concept of ethos is often deployed to draw on a specific characteristic of the sector. As a subjective term it involves both positive and negative
interpretations with the latter used in the context of an unresponsive and bureaucratic sector while the former draws on altruistic and special qualities of the sector and its staff (Lethbridge, 2011).

3.3.2 Corporate governance

The OECD defines corporate governance as a ‘set of relationships between a company’s management, its board, its shareholders and other stakeholders’ along with ‘the structure through which the objectives of the company are set, and the means of attaining those objectives and monitoring performance are determined’ (OECD, 2004:11). Essentially, corporate governance concerns the practices and processes by which organisations are governed and how the rights and responsibilities are distributed amongst the different stakeholders, e.g. board of directors, members and managers. Its key aim is to ‘facilitate effective, entrepreneurial and prudent management that can deliver the long-term success of the company’ (Financial Reporting Council, 2016:1). The board is given the power by members (shareholders) who delegate the responsibility for the running of the organisations to the directors. In addition, the board of directors manages and oversees the disclosure of information in annual reports of the company (Gibbins et al., 1990). For Gibbins et al. (1990:143), ‘organizations may disclose information to support the efficiency […] of production, but they also disclose information to establish their compliance with the social values reflected in regulations and informal norms’ for instance via social corporate reporting.

Armour et al. (2003:2), draw on a typology of corporate governance based on outsider-arm’s length and insider-control-oriented distinction. This differentiation allows the illumination of the level of activity and influence shareholders exhibit based on the concentration of share ownership. In other words, the more dispersed the ownership, the less active the members are since ‘shareholder has only a small amount at stake, they have little incentive to intervene in the running’ of the company.29

29 For instance, in the UK the prevalent model of ownership is dispersed with shareholders of 85% of the listed companies, not ‘even controlling a blocking minority (of 25% or more)’ (Crespi-Cladera and Renneboog, 2003: 3).
This links to the central issue in corporate governance, that of shareholder primacy. The philosophy stipulates that a director of the company has a duty first and foremost to the shareholder. Following a government review, the UK Companies Act 2006 provided an alternative approach by introducing an ‘enlightened shareholder value’ by placing an obligation on the director to ‘act at in the way he considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole and in doing so have regard (amongst other matters)’ to employee interest, customers, impact on the community and the environment and the company’s ethical reputation (Section 172 of the Companies Act, 2006). The change sought to institutionalise the value creation that moved beyond the financial constraints toward a wider social impact.

3.3.3 Non-profit Governance

The common problematisation of non-profit governance concerns the role of boards in managing the dual objectives of organisation, that ensures social mission and financial viability (Brody, 2002). This dichotomy in non-profit governance is commonly managed by a constraint on profit distribution that prevents directors making claims on residual income and for the surplus to be retained in the organisation for the benefit of wider community of interest (Glaeser, 2002). According to this account the restriction provided non–profit governance with a distinctive quality that significantly increased their trustworthiness amongst wider members of society (Hansmann, 1980; cf. Evers & Laville, 2004).

Traditional conceptions of non-profit governance distinguish on the basis of board composition (Callen et al., 2004; Cornforth, C. & Brown, W, Moore & Whitt, 2000) and the relationship between the board, directors and staff (Bradshaw, & Wolpin, 1992). The effectiveness of boards in terms of ensuring organisational performance was seen through the lens of stakeholder engagement and judged by its independence and autonym. Non–profit governance is therefore concerned with the analysis of fiduciary responsibilities of members in meeting legal, financial and management
obligations (Ostrower & Stone, 2006). As a result, much attention has been paid to different models of non-profit governance based on stakeholder, volunteer and service user representation, which developed in conjunction with theories of agency, stewardship and resource dependency (Miller-Millesen, 2003).

Critical to such understandings is the concept of accountability, discussed in more depth below, that similarly to corporate and non-profit governance concerns the delegation of responsibility from shareholders (stakeholders) to managers and Chief Executive Officer (CEO). In criticisms of this narrow conception, Cornforth (2012) proposed an augmented framework cognisant of external factors such as regulation, audit and inspection.

These wider contextual conditions are seen to have a bearing on the design and enactment of non-profit governance, for instance through isomorphic pressures that lead to mimicking behaviours and practices (DiMaggio and Powell, 1983). For instance, the shift towards contractual arrangements is seen to have altered the non-profit governance by importing private sector practices while attending to public sector reporting requirements. As The Home Office stated (2004:19) ‘these [third sector] organisations have to concern themselves with strategic planning and budgeting, staff recruitment and development, quality management, statutory reporting requirements, public relations, membership systems, more formal management of relationships with stakeholders.’ At the same time, Rochester (2003) brought attention to the complex interactions between staff and boards which might become blurred particularly in smaller organisations or where there is insufficient knowledge resulting in chairs of boards taking greater control over operational matters.

For some the governance goes beyond the role of boards and includes a wide range of activities performed by executive directors, management of the organisation, informal and advisory groups etc. (Middleton, 1989; Saidel, 1998). Harris (1999:105), on the other hand, observed that non-profit
governance is not a neutral or static phenomenon rather it consists of relationships that are in constant flux and need to be ‘negotiated and renegotiated as circumstances and personalities change’. Non-profit governance as noted above is also subject to external pressures that result in hybrid structures and combinations. This trend has become more salient since the introduction of NPM type reforms but as chapter two indicated it has already been visible with some benefit societies experimenting with non-profit structures to gain right to deliver government sponsored programmes. In the US, for instance, where non-profits are more established in the health care sector, the fluidity of relationships has led non-profits to establish for-profit enterprises and joint ventures while for–profits tend to set up non-profit foundations in order to distribute grants to other non-profits (Weisbrod, 1988). As findings from this research suggests (see chapter nine), such practices are increasingly becoming popular with third sector and CICs in particular in the UK. According to Weisbrod, the confusion and lack of knowledge of non-profits presents significant challenges for policy making (ibid, 2-3). For example, tax collecting agencies face administrative burdens, courts a numerous litigation cases while private and for-profit firms view the sector as a ‘source of subsidised, unfair competition’.

Chait et al., (2005:3), on the other hand, focus on the role of chief of executives who ‘articulate clearly and persuasively the organisation’s mission, belief, values, and culture’ subsequently confining non-profit governance to ‘leadership’. Defined like this, the non-profit governance shows resemblance with innovative entrepreneur and ‘leaderism’ that has emerged as a distinct trend in organisational managerial practice via hybridisation and progression of NPM and NPG (O’Reilly & Reed, 2010: 960). Underpinning the issue of governance broadly conceived is the concept of

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30 According to The American Hospital Association (AHA) Survey (2016), nearly 59% of community hospitals (e.g. non-federal, short-term general and special hospitals such as obstetrics and gynaecology, orthopaedic, etc.) were non-profit compared with 21% for-profit and 19% governmental.
accountability. The final section in this chapter provides an overview of different aspects and understanding of this concept.

3.4 Accountability

The growing interest with different forms of accountability in the NHS can be attributed to the programme of reforms that in the last three decades has been underpinned by the rhetoric of greater choice and flexibility in the delivery of public services. The key aim has been to liberate the NHS from the constraints of state bureaucracy by granting more autonomy to private and third sector organisations to deliver services. This shift has brought attention to the role of accountability and its mechanisms in overseeing these increasingly complex relationships between the state, service users and new providers of health care services.

There are many definitions of accountability and the concept can be viewed from multiple standpoints, for example from the top down, ‘upwards’ and ‘downwards’ as well as from internal and external positions (Humphrey et al., 1993; Gray & Jenkins, 1993; Bovens, 2007, 2010; Romzek, 2000; Romzek and Dubnick, 1987). Accountability covers multiple and diverse stakeholders and actors and thus questions like accountability ‘to whom’ and ‘for what’ are important in establishing the appropriate lines of responsibility and ownership for action (Fox and Brown, 1998: 12; Checkland et al., 2013). Mulgan (2000:555), for instance, defines accountability as the ‘process of ‘being called to account by some authority for one’s actions’ whereas Bovens views accountability as ‘a relationship between an actor and a forum in which the actor has an obligation to explain and justify his or her conduct’ (2007:447). From another perspective, accountability is tied to legitimacy and control which was traditionally achieved via public bureaucracies (Bevir 2006: 426; also see Abels, 2007). For Pollitt & Hupe (2011:643) accountability has acquired the status of a ‘magical
concept\textsuperscript{31} that is ‘broad, normatively charged and lay[ing] claim to universal or near universal-application’ that cannot be easily denied and challenged. It is a buzzword of governance (Bovens et al., 2014:1) that is prone to conceptual stretching (Collier & Mahon, 1993). Significantly, it is a contentious concept to which Sinclair (1995: 219) referred as the ‘chameleon of accountability’, a ‘cherished concept, sought after but elusive’.

3.4.1 Traditional views of accountability

Accountability concerns ‘giving and demanding of reasons for conduct’ implying a right to demand and an obligation to supply the requested information (Roberts and Scapens, 1985; Smyth, 2012). Historically, the term was associated with the practice of accounting and specifically book – keeping (Bovens, 2005). In this sense, accountability was rooted in a routine and repetitive procedure, which was intended to maintain order and fulfil a set of expectations and therefore was suited to big bureaucratic models. Day and Klein (1987) further distinguish between ‘strong’ and ‘soft’ accountability where the former refers to sanctions and involves redress while the latter signifies justification and advice. Leat (1988) on the other hand, offered a fourfold classification focused on expenditure and financial probity (fiscal accountability); exploring the adequacy of procedures for decision making (process accountability); providing justification for the way in which an organisation has focused its activities (accountability for priorities); and finally, the way an actor is held to account for the outcomes of their activity (programme accountability).

The common thread underpinning this taxonomy is the notion of responsibilities and consequences. For instance, under the political accountability the issue of ‘answerability’ is tightly coupled with ‘enforcement’ implying sanctions will follow if there is non-compliance (Schedler, 1999). Likewise, the managerial accountability imposes a duty on managers to account, for instance

\textsuperscript{31} Pollitt and Hupe (2011) also view innovation, participation and performance as one of the ‘magical concepts’.
for meeting agreed tasks which were delegated to them, under similar condition of injunctions (Day and Klein, 1987). This type of accountability concerns inputs, outputs and outcomes some of which may be financial or political. Under the traditional public bureaucracy, accountability was delivered via audits, monitoring and legislative measures. However, Paul (1992:1047-48) argues that ‘public service accountability will be sustained only when the “hierarchical control” […] over service providers is reinforced by the public’s willingness and ability to exit [i.e., marketization] or to use voice [i.e., direct participation]’. Similarly, Heald (1983) suggests that the growth of the public sector both in terms of its size and level of activity has changed traditional conceptions of accountability.

### 3.4.2 New forms of accountability

The shift from ‘government to governance’ has created a new demand for accountability. As the OECD (2005: 100) observed ‘new technologies, privatisation and new forms of management have changed the way governments operate’ and therefore ‘created a need for new ways of making governments accountable for what they do’. For Evans (1996:1131) the ability of public bureaucracies to assume a role of ‘co-producer’ was ‘the best way to increase effectiveness and ultimately the best way to preserve the integrity of increasingly besieged public institutions’. Choudhury and Ahmed (2002:563) argue that in the case of third sector, public accountability was traditionally achieved via means of ‘legal recognition (legitimacy), instrumental efficacy (service effectives) and economic benefits (comparative advantage)’. However, the introduction of managerial measures as well as the rise of networked form of governance resulted in new methods including political, organisational and social (e.g. partnerships, participation, consultation). Thus, Kearns (1996:26) asserts that accountability is increasingly linked to ‘the emerging themes of customer service and responsive entrepreneurship’ which can find themselves at odds with the traditional reporting mechanisms.
In this context, accountability ‘refers to a wide spectrum of public expectations dealing with organizational performance, responsiveness, and even morality […]’ with organisations facing demands internally and externally having to account for their actions to ‘the general public, the news media, peer agencies, donors, and many other stake-holders’ (ibid, 9). On the other hand, the increasing emphasis on horizontal modes of co-ordination that replaced hierarchical authority by legal agreements and contracts had further muddied the traditional forms of accountability (Kettle, 2000). The transformation of the public service into a more responsive model has shifted the focus from the legal process toward a system of participatory accountability that is considered to have greater democratic value and function (Bovaird, T., 2007, Newman & Tonkens). According to Fox (2015), the trend is associated with institutional innovations that are designed to encourage citizens empowerment and to bring about a social change and new responsibility. While the concept of social accountability is applied in reference to the developing countries, it nonetheless has a broader claim with public services that pursue policies to ensure accountability to ‘individuals and local communities rather than to Whitehall’ (Brown & Gash, 2011:2). Rubin (2006) traces this shift to a growing anti-establishment, anti-bureaucratic and anti-administrative movement with the emergence of focus on localised mechanism of accountability. Arguably, accountability under the networked form of governance requires co-ordination and compromise as it bring diverse range of actors, interests and issues that while complimentary are also competing (Denhardt & Denhardt, 2000). In this context, the traditional mechanisms of accountability such as audit, performance and regulations are no longer considered fully apt to capture the complex and nuanced relations between the state and the society. Rather than reject them altogether policy makers seek to combine the old and new and subsequently introduce a mixed or hybrid models of accountability (Goetz & Jenkins, 2001).

3.4.3 Alternative mechanisms for accountability
The increasing emphasis on participation and empowerment created a need for a series of new measures. These consisted of approaches that were of both qualitative (surveys, social capital) and quantitative in nature (performance and contract targets) and involved elements of *ex ante* (NPM related performance measures, contract) and *ex post* (self-reporting, self-reflection and self-evaluations) forms of accountability (Ebrahim, 2010). According to Ebrahim (2003), non-profits adopt five distinct categories of accountability: reports and disclosure statements; performance assessments and evaluations; participation; self-regulation; and social audits. Introduction of soft targets, such as Social Value, while aimed at enhancing the depth of accountability proved difficult to measure, particularly in area of procurement, subsequently triggering the rise of NPM-like language to deal with this dilemma. As a result, familiar concepts of accounting, capital and investment became attached to ‘social’, producing new understanding of the term albeit within the prescribed boundaries of classical economics. For instance, Social Return on Investment (SROI) provides a framework for economic evaluation of social value through a financial ratio of social value created for every £1 invested in the activity (Nicholls et al., 2009; Heady & Keen, 2010). In 2012, the European Commission set up a working Groupe d'Experts de la Commission sur l'Entrepreneuriat Social (GECES), to agree a shared methodology, which could be applied across other European social economy cases. Two years later the GECES produced a report, in which it highlighted the need for transparency in the area of social impact and suggested five stages to facilitate this process: identification of objectives; stakeholders; setting relevant measurement; measure, validate and improve; and finally report, learn and improve. By instituting financial methods and management logics in social spheres extends the government's remit of influence and control implying social claims and aims can be verified by traditional means rendering claimants a necessary legitimacy and trust. For instance, the Department of Health (2010b:1) published a booklet based on the experience of five social enterprises to assist other ‘social enterprises and commissioners to better understand the wider impacts of service delivery and quantify the value in monetary terms’. In this sense, defining ‘social’ by quantifiable measures necessarily limited the
development of alternative forms producing a ‘thin conception of a social’ and possibly the reinforcement for a new ‘governable terrain’ (Newman, 2009:1).

### 3.4.4 Other aspects of accountability

The principle of accountability is interconnected with the standard of legitimacy. The relationship between these two concepts is important and illuminates the ways by which organisations and institution construct and maintain their authority. Bovens (2005:183), for instance, argues that accountability has been transformed into ‘a rhetorical device serving as a synonym for many loosely defined political desiderata, such as transparency, equity, democracy, efficiency and integrity’ making legitimacy difficult to define and verify. Thus, legitimacy, from this perspective, resides in the socially constructed reality that is subjectively applied to an organisation’s activity (Palazzo and Scherer, 2006). Adopting such a focus implies that organisations pursue legitimacy by different means including language and for various purposes, for instance symbolic and strategic (Beelitz and Merkl-Davies, 2012). From another perspective, legitimacy is conceived as an ‘appraisal of action of shared or common values in the context of […] the social system’ (Parsons, 1960:175). Arguably, such a system is prone to change and thus legitimacy must be constantly mediated and re-evaluated. It may also need to be re-enforced to ensure that an organisation can effectively function.

There are numerous sources of accountability that cannot be addressed here but it is worth noting that central to the concept of legitimacy and particularly relevant to accountability, is expectation. In this sense, legitimacy plays an important role in creating an expectation that certain behaviour should be expected on the basis of the legitimate status of the company. Suchman (1995:574), for instance, proposes that legitimacy involves ‘a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions’. However, the social accounting perspective is cautious in this respect claiming for instance that sustainability reporting is prevalent amongst those companies
which display poor environmental record and standards (Brown & Deegan, 1998). In other words, ‘industrial, more “polluting” sectors have been the most active reporters’ (Higgins and Larrinaga, 2014). For Nicholls (2010a), legitimacy in the field of social entrepreneurship exists as a consequence of dynamic interactions and exchanges between macro-level organisational structure and the micro-level context of individual actors. Legitimacy matters but like accountability it is a normative concept that requires careful consideration and an understanding of the context to which it is applied and from which it is derived.

3.5 Summary

This chapter has provided an overview the key concepts: innovation, organisational governance and accountability central to the rest of the thesis. It drew on different accounts to construct a backdrop against which the later discussion unfolds. This was considered pertinent as these concepts are not only enduring themes in public management but also important heuristic tools with which this thesis studies the role and nature of CICs in the English NHS as illustrated in chapter seven, eight and nine. Moreover, these concepts were shown to be normative and to carry weight and thus deemed important to shaping expectations and perceptions that underpin the relationship between the state and the wider public. Put slightly differently, innovation, organisational governance and accountability are deeply entrenched conventions that have a bearing on what we think the public service delivery should look like and involve. Paying attention to these different conceptualisations reveals that an abundance of meanings and interpretations can be problematic (see non-profits, for instance) and while they do explain they also have a tendency to obfuscate. For instance, the emphasis on targets, reporting and compliance does not necessarily secure better outcomes or ensure accountability, whilst innovative and entrepreneurial approaches do not necessarily lead to fairness and improved welfare provision (Haque, 2000). Likewise, in the context of health care where information might be difficult to obtain or make sense of ‘it might be difficult to discharge the function of accountability’ on this basis (Dixon et al, 2010: 83). Admittedly,
this does not suggest that innovation, good organisational governance and accountability do not matter or are not important standards rather that these values need to be understood in context and not assumed or deduced from the narrative of public sector reforms. Hence, the next chapter examines the policy and legislative backdrop for the development of CICs in the delivery of health care services.

Chapter Four: Policy Context

4.1 Introduction

This chapter provides an overview of the policy and legislative context against which CICs have emerged and developed in the NHS. An appreciation of this context matters if we want to better
understand the role and nature of CICs in the delivery of publicly funded health care in England. To this end the chapter offers different understandings of the voluntary and third sector\(^{32}\) and illustrates how the emergence of CICs has been supported by these narratives. A narrative is understood here in a broad sense and refers to what it is rather than what it ought to be describing rather than prescribing specific action. A narrative provides an account of ‘relations (between citizens, between citizens and the state, between states etc.) in politically selective ways (Schram & Neisser, 1997:2). Nonetheless, the enactment of policy takes place through the construction of convincing narratives that invariably influence the blueprint of a political agenda and frame a problem ‘with an objective of getting their hearers to assume or do something’ (Roe, 1994: 32). In this context, the argument developed here is that justification for involving CICs in public service delivery was explicitly and implicitly based on the knowledge derived from the different conceptualisations of the sector rather than necessarily empirically driven. This is particularly significant given New Labour’s insistence on ‘what works’ and the evidence – based policy making (EBPM) in public sector (Parkhurst, 2017).

The chapter begins by providing an overview of different understandings of the ‘third sector’. It then offers a summary of key definitions of a social enterprise including its specific legal structure, the CIC. In examining various conceptualisations, it draws attention to the use of the third sector in public policy ‘to effect and legitimate change, including the establishment of new types of institutions and organizations’ (Motion & Leitch, 2009:1047). More specifically, by adopting Kingdon’s (1995) model the chapter seeks to account for how CICs entered the policy agenda despite being relatively new and unknown entity. Finally, the chapter examines the series of reforms introduced under New Labour government to create an enabling environment for social enterprises

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\(^{32}\) Throughout this thesis, I use terms third and voluntary sector interchangeably to mean a wide range of non-profit organisations that are separate from the government. While, I am aware of on-going debates that has produced different, often conflicting, interpretations in respect of these labels (see this chapter), it is not my aim to critically engage with them but rather to use them in descriptive way to highlight their relevance to the public policy discourse.
in the NHS. It then briefly references initiatives adopted by the Lib-Dem-Conservative government.

4.2 Third Sector in academic debate

The term ‘third sector’ encompasses a diverse and broad range of descriptions and organisational structures that Kendall and Knapp (1994: 66) refer to as a ‘loose and baggy monster’. It comprises charities, voluntary and community groups, co-operatives and other social enterprises. These organisations differ in the design, legal status and purpose albeit they are frequently grouped together under an umbrella term of non-profits, not-for-profit or the Voluntary and Community Sector (VCS) (Billis, 2010; Evers & Laville, 2004).

The ‘third sector’ can be defined as ‘the largely uncharted social space beyond the market, the state, and the household’ (Salamon & Sokolowski, 2016:1517). It constitutes, ‘an enormous residuum’ with a ‘bewildering variety’ of organisations beyond the private and public sphere (Levitt, 1973: 48-9). According to Etzioni (1973:315) the concept combines ‘the best of two worlds, efficiency and expertise from the business world, with public interest, accountability and broader planning from government’. For Mulgan and Landry (1995:3) the third sector is ‘the other invisible hand’ guided by a moral commitment rather than the market’s material self-interest or governmental coercion.

In contrast, Brandsen et al. (2005:750) suggest that it is ‘far easier to find arrangements that are hybrid or “fuzzy” than those approximating ideal types’. For Evers (1995:160) the term reflects a diversity of organisations, public, private and kinship associations that come together and ‘act as hybrids, intermeshing different resources and connecting different areas’. Similarly, Billis (1989) conceives the sector as a space that emerges as a result of increasingly overlapping and blurred institutional boundaries.
From another perspective the third sector is problematised as a distinct paradigm (Anheier & Kendall 2002). Hansman (1980), for instance, argues that a constraint on profit and surplus distribution means that third sector does not have owners and therefore has a ‘comparative advantage’ that gives a certain level of assurance to the public and signals trust (Billis & Glennester 1998; Billis 2001). In this context, the third sector is voluntary, private (institutionally separate from the government) and serves a common good. Alternative typology uses state or market’s failures as explanatory variables to illuminate the emergence of third sector. It emphasises the capacity of the sector to address seemingly complex issues that have been neglected by private and public sector organisations (Ortmann, 1996; Steinberg, 1997). The comparative and cross-national study by John’s Hopkins Institute in the US (Salamon et al., 1999) on the other hand, developed a ‘structural-operational definition’, of five common characteristics: formal, private, voluntary, non-profit distributing and self-governing (independent).

These different conceptualisations reflect distinct social, political and philanthropic traditions across different countries. Alcock (2010a:8) argues that in the UK the concept emerged as a result of ‘a particular constellation of political and cultural forces’. While Perry and Leat (1997) point out that it was not until the Wolfenden Report (1957) that the concept of the voluntary sector emerged as standalone field. Harris et al. (2001:2) describe this process of invention as politically motivated and constituting ‘intellectual segues into the radical social welfare reforms’ in the mixed economy of welfare.

4.2.1 Third sector in policy debate

The election of New Labour in May 1997 significantly expanded the use of the term ‘third sector’. The political philosophy of the Third Way (Giddens, 1998) sought to revive the relationship
between the state and society by advancing a view that ‘a strong economy and strong society […] were closely interconnected’ themes (Haugh & Kitson, 2007:983). These ideals helped to endorse a role of the voluntary and third sector as alternative providers in the delivery of public services. Alcock (2010b) shows how the policy debate under New Labour was dominated by the language of partnerships with a concept of the third sector finally making a discursive shift towards the language of social entrepreneurship.

In promoting the role of the third sector in public policy debate, the government sought to define it by drawing on its distinct qualities. For instance, in the discussion document the government defined the sector as ‘a superior alternative to both the private and public sectors […] particularly […] when government failures exist and neither the state nor the market can respond and deliver in an equitable or efficient manner’ (HM Treasury, 2005:3). It comprised of voluntary and community organisations, charities, social enterprises, cooperatives and mutuals. These organisations shared common characteristics most notably they were non-governmental, value driven and reinvested financial surpluses to further social, environmental or cultural objectives (ibid, 8).

In contrast, the Coalition government found the concept too narrow and sought to expand it by promoting the importance of civil society. While still in opposition, the Conservative government published a green paper A Stronger Society: Voluntary Action in the 21st Century (Conservative Party, 2008:6) in which it promoted a new ‘post-bureaucratic’ order where the government was ‘more open to being driven by a vibrant civil society’. The same paper, rejected the term third sector claiming it inaccurately described the voluntary sector and instead proposed to think of the sector as ‘the first sector; not just in recognition of the historical origin of the public services and institutions we rely on today – but as the first place we should look for the answers that neither the state nor the market can provide’ (ibid, p.4).
Despite rhetorical and ideological differences, both New Labour and the coalition governments aimed to expand the role of the third sector in the area of public service delivery. At the same time, the NPM type reforms (see chapter 2), introduced since the 1980s across the public sector, began to reshape the relationship between the government and third sector organisations. Increasingly, the focus of attention was on earned income rather than traditional grants to reduce dependence on government funding. This led to third sector organisations to develop novel albeit commercial strategies in order to pursue their social mission (Kerlin & Pollak, 2010; Kerlin, 2012).

4.2.2 Social Enterprise

Since the 1990s the term social enterprise has gained much traction in academic and policy debates both in the UK and abroad. In the US, the concept has been traditionally associated with social entrepreneurship, a commercial activity of non-profits that seek to achieve a social objective. According to one school of thought, social entrepreneurs are important innovators and game-changers who pioneer new solutions or introduce new services and techniques (Dees & Anderson, 2006). From this normative dimension, social enterprises are conceived as a catalyst for transforming society and alleviating social problems (Alvord et al., 2004; Ashoka Innovators, 2000). According to Dees (1998a) a social entrepreneur can be defined by a wide range of qualities, most notably:

- playing the role of change agents in the social sector by adopting a mission to create and sustain social value, recognizing and relentlessly pursuing new opportunities to serve that mission, engaging in a process of continuous innovation, adaptation and learning, acting boldly without being limited by resources currently in hand, and finally exhibiting a heightened sense of accountability to the constituencies served and for the outcomes created. (ibid, 4).

According to this perspective, individuals possess special qualities that allow them to learn and adapt quickly to new situations. In this context, two terms ‘social’ and ‘entrepreneurship’ become self-reinforcing, engendering ‘an uncontested win-win situation’ (Dey & Stryaert, 2012: 97).
As mentioned earlier, the importance of earned income is emphasised in place of philanthropic donations or government grants. For instance, in the late 1990s the Social Enterprise Alliance formulated a definition of the sector ‘as any earned - income business or strategy undertaken by a non-profit to generate revenue in support of its charitable mission’ (Social Enterprise Alliance cited in Defourny and Nyssens, 2010). This definition was later modified to ‘organizations that address a basic unmet need or solve a social problem through a market-driven approach (Social Enterprise Alliance, 2018).

In Europe, the concept ‘social enterprise’ initially emerged in the early 1990s via the Italian journal Impresa Sociale, launched at the time when the cooperative movement was gaining momentum. Later, International Research Network EMES developed the first theoretical and empirical framework for the analysis of social enterprises (Borzaga & Defourny 2001). It proposed a working definition based on a set of economic and social indicators that describe ‘ideal-type’ of social enterprise. The economic values in this classification involved: a continuous activity producing goods and/or selling services; a high degree of autonomy; a significant level of economic risk; a minimum amount of paid work. On the other hand, the social dimension focused on: explicit aim to benefit the community; an initiative launched by a group of citizens; a decision-making power not based on capital ownership; a participatory nature, which involves various parties affected by the activity; a limited profit distribution (Defourny 2001: 16-18). Defourny and Nyssens (2008, p. 204) summarised this approach as follows:

Social enterprises are not-for-profit private organizations providing goods or services directly related to their explicit aim to benefit the community. They generally rely on a collective dynamic involving various types of stakeholders in their governing bodies, they place a high value on their autonomy and they bear economic risks related to their activity. In the UK, the term was first adopted in reference to worker co-operatives. In 1979, the Social Audit: A Management Tool for Co-operative Working (Spreckley, 1981:4) published a definition of social enterprise as:

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An enterprise that is owned by those who work in it and/or reside in a given locality, is governed by registered social as well as commercial aims and objectives and run co-operatively may be termed a social enterprise. Traditionally, ‘capital hires labour’ with the overriding emphasis on making a ‘profit’ over and above any benefit either to the business itself or the workforce. Contrasted to this is the social enterprise where ‘labour hires capital’ with the emphasis on personal and social benefit.

In 1999 a new body formed by the coalition of co-operatives, Social Enterprise London (SEL), offered a slightly shorter version defining social enterprise as ‘businesses that do more than make money; they have social as well as economic aims and form the heart of what is now coming to be known as the “Social Economy”. Aims include the creation of employment, stable jobs, access to work for disadvantaged groups, the provision of locally based services and training and personal development opportunities’ (SEL, 1999, cited in Brown, 2003:10).

New Labour recognised that ‘while some social enterprises start off as businesses, most [were] in transition from their beginnings as voluntary sector organisations, dependent largely on grants and volunteers, and working to increase traded income’ (DTI, 2002:13). The definition drew on the resource dependency theory, problematising the emergence of social enterprises as a result of diminishing funding streams from the traditional sources, notably government (Dees, 1998). By extension, ‘many charities would class themselves as social enterprises on the basis that they generate their own income and rely on little or no grant aid […] becoming increasingly entrepreneurial in response to funding pressures and […] develop[ing] trading ventures (Cabinet Office, 2002: 14). To this effect, the Department for Trade and Industry (DTI:2002) adopted a pragmatic approach and defined social enterprise as ‘a business trading for a social purpose whose surpluses are principally reinvested for that purpose, or in the community, rather than established to maximize profits for shareholders and owners’.

The OTS (2009:1), elaborated further and offered a definition in which it highlighted a number of areas that distinguish social enterprises from other sectors:
They are innovative; entrepreneurial; concerned with aligning the needs of the individual with those of society; and social justice [...]. They offer joined-up, personalised services by [...] enabling users to make informed choices. They enable access to public services by taking the service to the citizen, empowering dispersed communities to work together. They improve outcomes for those “hardest to help” by developing innovative solutions. [...]. They influence individual choices by using role models within the community and giving people a stake in protecting their future.

The coalition government later widened the definition by including key indicators to help business determine whether or not it was a social enterprise (Cabinet Office, 2013:1). According to this classification a social enterprise:

- should not pay more than 50 per cent of profit or surplus to owners or shareholders;
- should not generate more than 75 per cent of income from grants and donations;
- should not generate less than 25 per cent of income from trading;
- should think itself ‘a very good fit’ with the following statement: ‘A business with primarily social/environmental objectives, whose surpluses are principally reinvested for that purpose in the business or community rather than mainly being paid to shareholders and owners’.

As a result, a number of small and medium enterprises (SME) recognised themselves as social enterprise raising question about the robustness of the data generated in terms of the scale of social enterprise sector (see Teasdale et al., 2013). Haugh & Kitson (2007), noted that in 2005, the first national census of social enterprisers in the UK estimated that there were 15,000 active social enterprises commonly registered as a company limited by guarantee or an industrial and provident society. This assessment was based on a narrow definition of the sector as criterion for selection. However, in 2006 the DTI reviewed this figure and put the number of social enterprises much higher at 55,000, accounting for 5% of all businesses in the UK (ibid, 978). The definitional confusion and the difficulty to easily quantify social enterprises may be explained to some extent by the lack of legal structure for social enterprise. In 2002 the Government sought to remedy the situation by launching a consultation, *Private Action, Public Benefit*, to review the legal provision for
charities and the wider not-for-profit sector. In the forward to the report, Tony Blair (Cabinet Office, 2002:6), acknowledged that there was ‘insufficient recognition in the legal system of the particular needs of social enterprises’ despite the emerging new groups of organisations delivering a range of activities aimed to benefit wider communities rather than seeking to satisfy individual interests. It is at this point that the chapter briefly turns to Kingdon’s (1995) model of multiple streams to better understand how CICs developed and entered the policy agenda.

4.3 Multiple streams approach (MSA) and CICs

Policymaking is traditionally understood as a result of politics with some ideas catching on while others being rejected (Hajer & Wagenaar, 2003). The question then arises what makes a good policy idea? Kingdon (1995) provides a valuable analytical framework that aims to facilitate understanding of how certain issues become dominant and policies endure and change within complicated, politicised, and sometimes ambiguous contexts. This is necessarily done through the lens of three distinct ‘streams’: the problem stream, the policy stream and the politics stream. The first refers to an issue that has become to be viewed as a problem due to some dramatic events and therefore necessitating a government response. The policy stream, on the other hand, relates to the development of policy solutions upon the examination of the problem. Finally, the politics stream involves factors that influence nature of politics, for instance the prevailing mood, election results, pressure exerted by interest groups, and changes of government.

These three streams while independent of each other when they come together create an opening - a policy window - that brings focus upon and support for the issue and subsequently leads to policy change. This tends to happen when a problem, for instance, suddenly receives attention (due to statistical evidence, new framing, ideology or specific circumstances), is assigned with resources (means and mechanisms) and accompanied by a political will to implement the change (public opinion, pressure groups). Parsons (1995:193) explained this approach as ‘a function of the mix of
problems, participants and resources. Just as organisations do not rationally relate problems and solutions, so the agenda process may be conceived...as composed of three separate and distinct streams: problems, policies, and politics’. Central to this, is the role of a policy entrepreneur who actively promotes and advocates for a specific issue or a solution. Notwithstanding, the policy window is short-lived and so the interest might quickly fade or be lost altogether with politicians and policymakers presuming the problem has either been resolved or no longer requires their attention. The development of CICs as a policy idea and solution can be better understood through the application of Kingdon’s model.

### 4.3.1 CICs and the Problem Stream

Stephen Lloyd, who established the CIC model, fits Kingdon’s (1995:122) description of the policy entrepreneur; he was willing ‘to invest [...] resources—time, energy, reputation, and sometimes money—in the hope of a future return’. Lloyd (2010: 32) identified a gap in the provision of a legal structure ‘for a public purpose organization that was not a charity’ but for social benefit. While he regarded the charity law generous in terms of tax incentives, he found its traditional governance model too constraining for the emerging group of social entrepreneurs. As he recalled ‘in a charity you [entrepreneur] are accountable to a board of trustee [...] the majority of the people with authority, the people who can sack you, are the trustees’ (ibid, 33). He saw that such a model was not aligned with the interest of his clients (social entrepreneurs) who wanted to ‘have a complete control’ while ‘doing this thing that is good for society’ (ibid). The lack of simple and easy to use legal entity, which was not an old-fashioned provident society, prompted Lloyd to experiment with the company law to create a novel type of public interest company (PIC)\(^{33}\). The company was intended to serve its social objectives in perpetuity and have a statutory asset lock that would protect the company from any future risks of privatisation or de-mutualisation. At the same time, New

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\(^{33}\) The PIC acronym was eventually abandoned and replaced with the CIC as the government was also interested in promoting this new legal vehicle for the delivery of public services.
Labour was advancing a policy of Third Way and was looking for new models in service delivery that would sit ‘between the free market and state control’ (Amin et al., 2002). However, the government recognised that ‘[mu]ch of the legal context for charity and voluntary action [was] now outdated’ (Blair, 2002:5).

4.3.2 CICs and the Policy Stream

Soon after New Labour came to power, the government instructed the Treasury to conduct the Charity Tax Review (1997). The review finally led to the publication of Private Action Public Benefit, which set out a series of measures to modernise the law (Cabinet Office, 2002). In 2002, the Social Enterprise Coalition was formed ‘of third sector organisations that were very successful at putting social enterprise on the political agenda’ (Richardson cited in Ainsworth, 2011). In the same year, the Social Enterprise Unit was set up followed up by the Social Enterprise Investment Fund and Social Enterprise Pathfinders Programme. Lloyd also (2010: 34) continued to promote the new concept of the CIC holding a workshop in the House of Lords and one at the School of Economics before ‘getting lucky’. As Lloyd (ibid) described himself ‘it was really me that got lucky in that then Prime Minister, Tony Blair, set up his strategy unit. He wanted to investigate the way that the whole charity and social enterprise sector worked’. He then went on to say:

I got even luckier when I was asked to send one of my own employees to work there; I had a mole sitting inside the strategy unit office. Hence, I decided to write a paper for them and got lucky again because I was on the board of an organization that funded me to write the paper that convinced the strategy unit that this was a good idea! (Lloyd, 2010:34)

It is possible to see how the specific idea emerged from the ‘primordial soup of ideas’ and began to take shape (Kingdon, 1995).

4.3.3 CICs and the Politics Stream

By 2006 efforts to mainstream the third sector and specifically social enterprises into various policy areas in the UK became well defined. As noted by Gordon Brown (2006):
The truth is that much of the best work in communities takes place through third sector organisations and their alliances with you, including social enterprise—a term not widely recognised five years ago. Fifty-five thousand social enterprises founded for a social purpose, united by a commitment to social innovation and today finding new ways to tackle existing social challenges with . . .—a major role to play in environment, jobs and investment. (Brown, 2006 cited in Haugh and Kitson, 2007:986)

A year earlier, as Lloyd noted ‘eight civil servants came to my office, all at taxpayers expense […]. That is the way government sometimes wastes its money. Anyway, the drafting team drafted the bill, and the act came into force in July of 2005’. In 2008, ‘High Quality Care for All – NHS next stage review final report’ (DH, 2008a) introduced the Right to Request (RtR) programme encouraging staff to set up a social enterprise to deliver services. The programme, as previously indicated, resulted in staff leaving the NHS (spinning out) and adopting relatively unknown model of the CIC.

According to Kingdon’s model (1995) once the problem, policy and politics streams become realigned a policy window opens up allowing an opportunity for change to emerge. While this is a useful way of explaining how the social enterprises and in particular the CIC entered the policy agenda, this account should not be misread as a case of serendipity rather as a messy political process which involved combinations of factors including historical (see chapter 2) as well as exercising of power and choice by policymakers. The next section offers a brief overview of the organisational aspects of the CIC.

4.4 Community Interest Company

A community interest company (CIC) is a type of limited company that was established in April 2005 by the Companies (Audit Investigation and Community Enterprise) Act 2004 (Ch.27 to provide a new legal structure for non-charitable social enterprises. The same legislation also created the Regulator of Community Interest Companies (‘the Regulator’) to oversee, supervise and to ‘maintain public confidence in the CIC model’ (Edmonds, 2014: 4). CICs like any other private company can be limited by guarantee (CLG) without share capital or limited by shares (CLS). As CLGs they do not
have shareholders and therefore no obligation to pay dividends on shares. If CICs decide to set themselves up as a CLS they must adopt the Articles either of Schedule 2 or Schedule 3, which specify how dividends and capital would be paid. For example, if a CLS decides to adopt Schedule 2, it will ‘only be able to pay dividends, and otherwise transfer assets for less than full consideration, to other asset-locked bodies or otherwise for the benefit of the community’ (BEIS, 2016a:6). On the other hand, if a CLS chooses Schedule 3 it will have more freedom and to pay dividends (the maximum aggregate dividend cap is 35% of annual profits) to shareholders who are not asset-locked bodies, including private investors.

CICs are established to produce goods and deliver services that have a social purpose. In other words, the activities need to bring benefit to a wider community other than members and shareholders. CICs are a commercial entity that needs to ensure that it is solvent and profit making. It needs to make return to its investors (if constituted as limited by shares) and generate sustainable level of income that can be enhanced by charitable grants and donations (BEIS, 2016a).

CICs are meant to be flexible, easy and inexpensive to set up with a ‘light touch’ framework of regulation (BEIS, 2013). As a limited company CICs must adhere to the rules established by the Companies Act 2004 as well as additional guidelines as set out by the Regulator. To this effect, CICs need to register with Companies House by paying a £35 fee and submit the required by law documentation such as Memorandum of association followed by Annual Accounts and Reports and the CIC34 Report, produced annually as an evidence that the CIC is satisfying the community interest test (see appendix 8). In addition, CICs must submit CIC36 when incorporating into a new CIC, or a CIC37 when converting from an existing company (see appendix 7).

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34 Formerly the Department for Business, Innovation & Skills (BIS). In 2016, BIS and the Department of Energy and Climate Change (DECC) merged to form the Department for Business, Energy and Industrial Strategy (BEIS)
All CICs must ‘pass’ a ‘community interest test’ that confirms the ‘motivation or underlying purposes of a CICs activities’ and provide a brief overview of how these activities will benefit a community (BEIS, 2016b:17). The Regulator must be satisfied that the CIC is not party-political or involved in campaigning actions and that the intended activities will have a wider impact beyond the immediate employees of the organisation. For instance, a CIC that manufactures a product can satisfy a community interest test ‘by virtue of the fact that the profits from its sales are to be devoted to charitable or other community benefit purposes’ (ibid, 18).

The governance structure of a CIC requires it to have a statutory asset lock meaning any surplus or profits generated by CICs is permanently locked within that CIC or used for the benefit of the community (BEIS, 2016a). The assets are locked in perpetuity in the organisation unless the full market value can be obtained from selling them or if the assets are moved to another asset-locked organisation (e.g. a charity, another CIC or non-UK based equivalents). Much like other private limited companies CICs can issue shares but they must adhere to the Regulator’s conditions, notably the ‘dividend cap’, which protects profits and surpluses from being redistributed to other parties other than a community itself. It is important to note that CICs are considered first and foremost as companies and as such they must operate within normal trading conditions (BEIS, 2016a: 4). This means that they need to generate income, be competitive and provide value for money. In the case of CICs that emerged as a result of RtR programmes, this proviso has often been difficult to achieve. The lack of asset base and insufficient infrastructure in terms of lending for social enterprises means that CICs in NHS rely primarily on public sector contracts as their main income source.

In this context, the significance of an asset lock as an underwriter of social purpose may be weakened if CICs need to use it as collateral to secure commercial loans. In addition, any surplus CICs generate rather than being used to achieve social purpose may become used as a financial leverage to meet CICs demand for debt. During the annual OECD meeting on Public Private
Partnerships (2011), the NAO delivered a presentation called ‘PPP, Social Enterprises and lessons from the Private Finance Initiative’, in which it highlighted the barriers CICs face when considering the growth and scaling up their innovation. It suggested that the government sought to address this by allowing the ‘established enterprises […] retain[ed] their profits as a source of capital’ (NAO, 2011). The risks associated with this financial dimension of CICs have also been addressed by the Regulator who stated that ‘a CIC may take on a commercial venture with the purpose of generating profits to support its objects. If the venture fails and makes losses the CIC must still meet its contractual obligations in regard to the venture even if this means depleting its assets or selling some of them to meet its debts’ (BEIS, 2016a: 4). Unlike charities, CICs do not have trustees and can remunerate the founders and directors including non-executive directors. According to the Regulator, the ability to pay salaries is important to attracting the best quality of managers (BEIS, 2016b). In addition, the familiar structure of shareholders and directors as an easily recognisable corporate governance framework meant that the potential funders, lenders and customers did not find it difficult to understand.

4.5 Overarching public policy context

The New Labour Government endorsement of social enterprises resulted in the most developed governmental support and portfolio of social entrepreneurship than any other administration in the world had created (Nicholls, 2010b). Understanding this policy context helps to illuminate a political nature of this phenomena. To this effect, this section examines the key documents that were crucial in creating and enabling a suitable environment for the establishment of social enterprises in the area of public service delivery. The table 1 below provides a summary of the key documents and

<table>
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<tr>
<th>Year</th>
<th>Key Policy Initiative</th>
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<tr>
<td>2001</td>
<td><strong>Social Enterprise Unit</strong> is created within the Department of Trade and Industry to advocate and support the role of social enterprise in public service delivery</td>
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<tr>
<td>Year</td>
<td>Initiatives</td>
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<td>------</td>
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<tr>
<td>2001-2006</td>
<td>Initiatives between 2001-2006 that helped to pave the way for social enterprises and to create an enabling environment for social enterprises to emerge in the public sector and health care more specifically. These policy initiatives are then discussed in greater detail in the sections that follow.</td>
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2. *Private Action, Public Benefit*—A review of the charitable and not for profit sector by The Strategy Unit (Cabinet Office).
3. Social Enterprise:
4. *A Strategy for Success* (DTI) sets out key government vision and policy for social enterprises.
5. A Review by the government into The Role of the Voluntary and Community Sector in Service Delivery.

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<th>Year</th>
<th>Initiatives</th>
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<tr>
<td>2005</td>
<td>9. Home Office launches <em>Futurebuilders</em> fund to improve the capacity of the third sector to engage in delivering public services.</td>
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<td>2006</td>
<td>10. <em>NHS Foundation Trusts</em> are established as independent, not-for-profit public benefit organizations, with accountability to their local communities.</td>
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<th>Year</th>
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<tr>
<td>2005</td>
<td>11. NHS Networks creates the first <em>Social Enterprise Network</em> a first and the only network for people interested in social enterprise in health care.</td>
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<tr>
<td>2006</td>
<td>12. <em>The Third Sector Commissioning Task Force</em> is set up to further encourage involvement of the third sector including social enterprises in the provision of primary and social care.</td>
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<th>Year</th>
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<tr>
<td>2005</td>
<td>14. <em>The Office of the Third Sector</em> (OTS) is within the Cabinet Office, consolidating the Active Communities Unit (Home Office) and the Social Enterprise Unit (DTI).</td>
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<td>2006</td>
<td>15. <em>The Social Enterprise Unit</em> (SEU) is created within the Department of Health with an appointed Director of Social Enterprise working closely with the OTS.</td>
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<td>2006</td>
<td>16. The guide <em>More for your Money: a guide to procuring from social enterprises for the NHS</em> is produced by the Social Enterprise Coalition and supported by the NHS Purchasing and Supply Agency.</td>
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<tr>
<td>2006</td>
<td>17. The White Paper <em>Our Health, Our Care, Our Say</em> provides support for social enterprises and community interest companies.</td>
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<tr>
<td>2006</td>
<td>18. <em>No excuses. Embrace Partnerships now. Step towards change!</em> by the Third Sector Commissioning Task Force (DH) provides guidance and encourages PCTs to consider third sector and social enterprise organizations when commissioning health and social care services.</td>
</tr>
<tr>
<td>2006</td>
<td>20. The Social Enterprise Investment Fund (SEIF), is established to facilitate access to finance for social enterprises and to provide support for business start-ups. The SEIF is by the Department of Health.</td>
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</table>
4.5.1 Creating an enabling environment for social enterprises: New Labour (1997-2010)

In 2001, New Labour set up the Social Enterprise Unit (SEU), in the Department of Trade (DTI)\textsuperscript{35} to support and co-ordinate policy making on social enterprises. The following year the department published the *Social Enterprise: A strategy for Success*, which set out the government’s plans and ambitions for the sector:

‘Our vision is bold: social enterprise offers radical new ways of operating for public benefit. By combining strong public service ethos with business acumen, we can open up the possibility of entrepreneurial organisations - highly responsive to customers and with the freedom of the private sector - but which are driven by a commitment to public benefit rather than purely maximising profits for shareholders.’ (Blair, 2002:5)

In recognising the benefits of the sector, the *Strategy* also identified a number of areas that the government needed to address in order to create an enabling environment for social enterprises to develop within. These were: access to finance, business and training advice and improving the existing knowledge base in respect of social enterprises. Consequently, SEU together with Regional Development Agencies (RDA), local authorities and devolved administrations, embarked on the process of data collection. The evidence was supposed to inform future policy, raise awareness and build trust among the wider public and mainstream lenders. Furthermore, the *Strategy* also recognised that the dual mission, e.g. attending to social via commercial means of social enterprises presented a potential risk and therefore these organisations needed to prove themselves to gain public trust. It was proposed that a system of accreditation might be a one way to achieve this (DTI, 2002:9). In 2002 the government announced additional support through the ‘Futurebuilders’ Fund to assist the sector to build capacity to deliver public services. The funding was also supposed to help remove barriers, modernise and increase the scale and scope of third sector in public service delivery.

\textsuperscript{35} Replaced in 2007 by the Department of Innovation, Universities and Skills and the Department for Business, Enterprise and Regulatory Reform that merged into Department for Business, Innovation and Skills, to finally become the Department for Business, Energy and Industrial Strategy (BEIS). SEU was later integrated with the Cabinet Office
4.5.2 Commissioning

The government’s ambition to include social enterprises in the delivery of public services required changes to the commissioning practices. While there was a general consensus of the potential of social enterprises to drive innovation and improve participation, in practice the social value added by the sector tended to be overlooked by commissioners. As a result, DTI (2003:6) published a procurement guide, *Public Procurement: A Toolkit for Social Enterprises*, ‘to give social enterprises across the UK access to the best possible information and advice on how to win government or public sector business’. Similarly, the *National Procurement Strategy for Local Government 2003-2006* highlighted the need for mixed service provision with social enterprises playing a bigger part (ODPM, 2003). The Strategy (*ibid*, 17) also mentioned that work was under way to ‘facilitate asset transfers from the public sector, taking account of the development of the CICs’.

In 2005 the government established the Third Sector Commissioning Task Force (TSCO) to ‘promote a sound commercial relationship between the Third Sector and the public sector’ and to ensure the sector could be fully involved in public services by identifying and removing barriers to such a relationship (DH, 2006b:26). In addition, the TSCO was expected to ‘encourage innovation in the way services [were] provided to meet patient needs and wants’ by galvanising the desirable characteristics of the Third Sector around responsiveness to service users’ (*ibid* 26) needs, special relationship with communities and innovation. In the report, *No excuses. Embrace partnership now. Step towards change!* set out steps of how to achieve better ‘working and business relationships between public sector, commissioners of health and social care and the third sector’ and turn them into effective providers of health care services (DH, 2006b: 20). Consequently, the Department of Health’s Social Enterprise Unit (SEU) was tasked with providing support to social enterprises of how to involve staff and service users in designing and delivering services. In meeting the commitment made in *Our health, our care, our say* (2006a) a special investment fund for social
enterprise was created by 2007. In *No excuses. Embrace partnership now. Step towards change!* not only laid the practical plans for ensuring the sector was actively involved in delivering public services but also that it could ‘play a full role in public services reform’ (2006b: 3). For the TSCO the involvement of the sector was regarded as seemingly positive with innovative providers bringing a mix of skills and strengths: ‘public service values, strong governance and accountability from the public sector, commercial discipline and customer focus from the private sector and the unique strengths of the third sector embodied in its independence from government and shareholders’ (DH 2006b: 4). At the same time, the benefits derived from this flexible, responsive and innovative provision for service users meant that ‘the quality of care [would] matter more than which organisation provides it’ (*ibid*).

### 4.5.3 Added Value of Social Enterprise: Innovation

In 2002, The Cross-Cutting Review (HM Treasury, 2002), *The Role of the Voluntary and Community Sector in Service Delivery*, endorsed TSCO action plan by emphasising the potential of the sector to drive improvements in public service delivery. The Review referenced research including Knapp’s et al. (1990) typology of the third sector based on distinct qualities around ‘provision of […] specialised services; cost-effectiveness; flexibility and innovation; advocacy; and citizen participation’ albeit recognised academics own reservations about the limited evidence in support of these claims (HM Treasury, 2002). Nonetheless, a special table was inserted into the document to match ‘public service requirements with third sector organisations’ distinct strengths and specific organisational characteristics (see appendix). However, the approach itself was based on a normative assumption rather than evidence as the ‘data problems [meant] that comprehensive, accurate, consistent and comparable information [was] not readily available’ (HM Treasury, 2002: 13).
4.5.4 A new System of Accountability

In 2006 the government published, *Partnership in Public Services*, an action plan for involving third sector organisations in trying to resolve complex societal problems. The document set out four main areas: commissioning, procurement, learning from the third sector and accountability that the government identified as requiring improvements to facilitate better engagement with the third sector. Specifically, in relation to accountability the government believed the third sector could play an important role ‘in helping communities [...] hold public service providers to account for the approach they take to delivery’ (OTS, 2006:31).

It was envisaged that third sector would be a catalyst for citizens’ engagement and empowerment, involving them from the early stages of the service design, through the implementation and finally delivery. The government also aimed to transform public service delivery into a system that was based on a diverse range of providers from private and voluntary sectors delivering services in the innovative and responsive to local needs ways. In the forward to the guide *How to Step Out* (Dearden-Phillips & Griffiths, 2011) the Chief Executive of the National Endowment for Science, Technology and the Arts (NESTA), Geoff Mulgan, proposed that there was emerging evidence that new organisational structures could play an important role in transforming staff attitude and improving workplace productivity. Whilst he warned that changing the structure alone was not sufficient enough, he also suggested that the new developing models based on ‘strong public service ethos with commercial nous’ could ‘encourage staff to deepen their sense of accountability downward to citizens and users rather than only upwards’ (Mulgan, 2011: IX). Moreover, the criticism of an unresponsive public sector advanced by the NPM discourse has proven an important lever for introducing social enterprises into the NHS in England.

At the same time, in highlighting the wider benefits of the third sector, the government referred to the unique governance that rendered these organisations an independent status. This supposed
autonomy was believed to generate trust and accountability based on the participation of wider
groups.

4.5.5 Social enterprises and health care reforms under New Labour (1997-2010)

Since the 1980s the plurality of actors in the delivery of public services has gained momentum. The 1990 NHS and Community Care Act (DH, 1990) saw the introduction of purchaser-provider split creating necessary conditions for trade, competition and outsourcing to take place in health care. The use of Private Public Initiatives or Public Finance Initiatives in the health sector introduced under the Conservative government were widely adopted and promoted by New Labour (Broadbent & Laughlin 2005). The government was keen to stimulate choice not through outright competition but by partnering with private, third sector and social enterprises organisations. Instead of relying on hierarchy or market alone, New Labour sought to develop a ‘third way’ approach with the third sector as ‘a key partner delivering government policies’ and services (HM Treasury, 2002:5).

In 2000, The NHS Plan: A Plan for Investment, a Plan for Reform (DH, 2000) as well as the subsequent policy documents Delivering the NHS Plan: next steps on investment and reform (DH, 2002a) and NHS Improvement Plan (DH, 2004b) laid ‘the foundation for the complete transformation of health care delivery [...] moving away from an integrated system, in which the National Health Service provided virtually all care, to a much more mixed one (Timmins 2005). In such a permissive environment, social enterprises became idealised as the most appropriate model for delivering efficiency and innovation through increasingly participatory democratic structures. In the document Social Enterprise in Primary and Community Care (Hewitt, 2006), the government detailed its ambition to reform the NHS in a manner that would modernise the sector while at the same time protect its values by ‘unleashing the potential of new providers in the third sector and social enterprises’ (Hewitt 2006a: 14). The White Paper, Our Health, Our Care, Our Say: a new direction for community services,
published in 2006 emphasised the role of personalised care that could be effectively provided by the new type of social enterprise set up by existing NHS staff. According to the Department of Health consultation less than 10% of public considered it important for new organisations to set up local health centres whilst the majority of respondents regarded access to a regular and universal health check as a main concern and priority (DH, 2006a: 32).

In 2005 the Department of Health published *Creating Patient-led NHS* (DH, 2005a) closely followed by *Commissioning Patient-led NHS* (DH, 2005b), in which the Department laid out the key steps necessary to achieving the vision. In short, it proposed that the reconfiguration of the NHS should include a progressive move towards greater use of other providers, including those from the independent sector in order to secure £250mln of savings in overheads costs (DH, 2005b:1). In 2006, *Our Health, Our Care, Our Say* (DH, 2006a), built on the earlier recommendations and set out the direction for change by focusing on local innovation, particularly where this meant the introduction of new providers. The same year, New Labour piloted a programme called *The Social Enterprise Pathfinder*, in which 26 social enterprises were identified and given assistance to deliver health and social care services to a total value of £9million over a period of two years (DH, 2010b). The main aim of the programme was to learn what made a social enterprise successful in delivering healthcare provision. The evaluation of this Pathfinder programme indicated a series of factors such as commissioning support, granting contracts to social enterprises and resources that were said to be early predictors of success of social enterprises and on this basis made recommendations stating that the organisational model was fit for purpose as it produced some notable successes and achievements, with many of the Pathfinders exceeding their expectations (DH, 2010b).

Despite attracting criticism particularly around areas of research strategy and methodology and the fact that the report was produced by the same company that was also involved in consulting NHS organisations to develop the social enterprise model, clearly a potential conflict of interest, seven
‘Pathfinder’ social enterprises were spun out from the NHS before 2008 (for detailed analysis see Peckham, 2011).

High Quality Care for All (DH, 2008a:60-61) introduced the RtR scheme, which was seen as central to achieving a broader vision set out in the document under the following proposals:

1. To give front line staff including commissioners a greater freedom to use ‘their expertise, creativity and skill to find innovative ways to improve quality of care for patients’;
2. To create a new accountability that is ‘rooted in the people’ NHS serves;
3. To work in partnership;
4. To empower staff, patients and to foster leadership.

The intention was to strengthen the bottom up approach by devolving responsibility and autonomy to the local level within the centralised model of health care regulation. Since the ‘NHS [was] a national system, funded by taxpayers for the benefit of all patients’ the government needed to resolve this tension by maintaining its position in overseeing that ‘there [were] national standards’ and that these standards were met (DH, 2008a:11). It was therefore important to create not only an enabling environment for the sector to develop in the NHS but also to develop the very infrastructure of the sector.

Prior to the RtR being formally launched in 2008, the Department of Health produced a resource pack for social enterprises and commissioners to help them ‘understand and maximise the very real and growing opportunities in health and social care’ (DH, 2007a:1). The pack acknowledged social enterprises ‘robust reputation for transforming many sectors […] through its innovative, flexible and non-bureaucratic’ approach and offered practical guidance in terms of finance, workforce, commissioning and regulation (ibid, 1-2). Congruent, with New Labour’s commitment to partnership working and within the broader context of networked governance, in 2005 a dedicated resource was created within the Department of Health, the Social Enterprise Network (SEN).
Network’s key focus was on promoting and disseminating information on social enterprises, providing guidance on legal forms and directing towards funding streams. In 2006 SEN held a conference with politicians, policy makers and practitioners to further raise the awareness of new governance models in health care delivery. The presentations given during the day covered subjects such as ‘involving community’, ‘opening up the channels for new leaders’ and ‘Primary Care Practices - alternatives to the private sector’ (SEN, 2006). The Network ceased to exist in 2009 but a considerable effort and information had gone into creating a knowledge base of social enterprise sector that was crucial for RtR programme to proceed.

4.5.7 Social Enterprises under the Coalition Government (2010-2015)

In order to differentiate its approach to the third sector, the Coalition government formulated the policy around the idea of Big Society as opposed to the Big State that was seen to characterise New Labour’s administration (Alcock, 2012). The shift was taking place under a consideration that had to do with post–financial crisis and the considerable budget deficit (HM Treasury, 2010). In this context, the government sought policies that would reduce rather than expand public spending across all areas. A key theme of the Big Society was useful in constructing an image of the two-party coalition government capable of blending different commitments in the way that it encouraged social responsibility (Conservative) on one hand and protected civil liberty from the interference of the state (Lib-Dem) on the other (HM Government, 2010). Significantly, though, where the strength of the coalition government became most prominent it was in their commitment to NHS. As Clegg and Cameron stated in The Coalition: our programme for government:

For example, in the NHS, take Conservative thinking on markets, choice and competition and add to it the Liberal Democrat belief in advancing democracy at a much more local level, and you have a united vision for the NHS that is truly radical: GPs with authority over commissioning; patients with much more control; elections for your local NHS health board. Together, our ideas will bring an emphatic end to the bureaucracy, top-down control and centralisation that has so diminished our NHS. (HM Government, 2010: 8).
The OTS was subsequently replaced with the Office for Civil Society which according to Alcock (2010:10) deliberately incorporated ‘the potentially wider notion of an arena of social relations’. Under the new government the support for social enterprise was also actively promoted and pursued by key policy entrepreneurs. Jess Norman (2010), for instance, embraced the notion of Big Society as a symbol of long established tradition in political philosophy that could be traced to Oakeshott and Hobbes (Norman, 2010). Blond (2009:8), on the other hand, advocated the model of ‘shared ownership’ in order to ‘unleash the energies of frontline staff and citizens and scale up their impact through the power of shared ownership’ (Blond, 2009:8). While, Singh (2010:78) proposed a model of ‘diverse ownership’ where social entrepreneurship represents ‘not simply a policy idea [but] a way of thinking about business, community, personal motivation and association that is informing and revolutionising every aspect of our lives’. Recently, Singh (2018) proposed that social enterprises should take over the running of public services following the collapse of the private company Carillion (House of Commons, 2018). However, some commentators observed that the ‘rhetorical power’ of Big Society rested in its neo-liberal articulation of state–society relation at the time of fiscal austerity and public cuts stressing the potential of enterprise and self-improvement as a solution to the structural problem (South et al., 2013).

The policy and practice under the coalition government in regard to social enterprises showed both continuity and change with the last administration. The 2010-2015 government policy: social enterprise (Cabinet Office, 2013) noted that social enterprise and other voluntary and third sector

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36 Jess Norman is a Conservative MP for Hereford and South Herefordshire and according to his own website, campaigner and writer. He is a supporter of Adam Smith’s free-market economic theories. In Parliament, he consistently voted for reduction to welfare benefits (44 votes for reduction in spending in welfare benefits) (www.theyworkforyou).

37 Philip Blond, on the other hand, is director of a right-wing think tank ResPublica, proponent of ‘Red Torism’ that ‘sought to redefine the centre ground of British politics around the ideas of civil association, mutual ownership and social enterprise’ (Taylor, 2012).

38 Asheem Singh is a former interim Chief Executive of an umbrella organisation for third sector and social enterprises ACEVO. He is a writer (The Moral Market Place, Social Entrepreneurs are Changing Our World), journalist and campaigner, former staff at ResPublica and a director of economy at Royal Society for the Arts (RSA).

39 The date when the policy was last updated.
organisations were ‘sometimes frustrated by red tape or other problems, or because they [didn’t] have the support they need[ed] to do their work’. In responding to these problems, the government outlined a number of areas where action was either needed or already took place. These included: addressing barriers and dealing with bureaucracy, the introduction of a new legal structure for charities, improving access to funding and finance, the introduction of right to challenge for local communities to take over unused council buildings and other initiatives aimed at building skills and capacity base of the sector. Where the government, however, showed to diverge was in making the third sector organisations’ income and funding dependent on achieving results. For instance, social impact bonds (SIBs) were introduced as a new ‘commissioning tool’ that linked payment for the delivered services to successfully meeting contractual targets. Nick Hurd, then Minister for Civil Society, defined this new model as ‘opening up serious resources to tackle social problems in new and innovative ways’ (2011). Critics saw this practice as being constructed on a false premise (e.g. to offset welfare cuts rather than improve social entitlements), applying perverse incentives and thus likely to distort ‘activity within the third sector’ leading them ‘away from activities that are most needed towards activities that are most measurable’ (McHugh et al., 2013:250).

The approach adopted by policy makers in respect of third sector and social enterprises in the NHS did not significantly change although the focus had subsequently shifted towards a new agenda of mutualisation. In 2011, the government published a White Paper, *Open Public Services* (HM Government, 2011) setting out future plans for opening public services to a diverse range of providers in order to improve the quality and bring choice to patients. In 2012, the government introduced the Public Services Act (Social Value) 2012 (HM Government, 2012), which required commissioners to consider the wider social, economic and environmental impact of services purchased by them. It was expected that this Act would encourage greater participation from a mixed range of providers, including CICs, and would subsequently ‘deliver better services for less money, improve public service productivity and stimulate innovation’ at the time of public sector
cuts (HM Government, 2011: 6). The effectiveness of the Act, however, in this respect is mixed and remains to be selectively applied by commissioners with critics arguing it had no or little impact in public procurement.

The key objectives of the Open Public Services (2011) programme of reform were not dissimilar to those promoted by New Labour and thus concerned familiar themes of empowerment, cost efficiency, inclusion of new providers in public service delivery and innovation. At the same time, the coalition government while indicating the ‘huge respect for the public service ethos’ also noted that public services needed to change to ‘free its staff from the bureaucracy and central instruction’ (HM Government, 2011:9). This was to be facilitated through the earlier adopted reform of the community services (see TCS), which gave staff a right to establish an independent organisation.

Under the new coalition government, the programme was renamed to Right to Provide (RtP) and aimed at extending rights to already granted under the RtR to new staff enabling them to take over the running of public services as employee-led mutuals (DH,2011). The scheme was part of the government’s ‘bigger vision’ for public services and ‘a cornerstone of the Big Society’ that sought to grant front line staff ‘freedom to personalise and improve service delivery to the public, particularly to individuals and communities at the margins of society’ (ibid, 7). According to Miller et al. (2012: 234), despite a relatively small number of social enterprises emerging as a result, the RtR and subsequently RtP the shift was ‘a radical development in that it sought to transfer core NHS community health services out of public ownership’. The RtP was supported by Social Enterprise Coalition, which provided guidance and information for public sector staff considering

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40 According to the National Audit Office (2011) at the start of the programme there were 60 applications with 38 successfully launching. However, there has been no further study that I am aware of that attempted to evaluate the size of the CIC sector in health care and public services more generally. Miller et al (2012: 234) estimated that at the time ‘the Social Enterprise Investment Fund invested in 51 right to request proposals at a total cost of £8,333,385 which gives an indication of the set-up cost for these organizations’.
setting a mutual or social enterprise model (Social Enterprise Coalition, 2011). For instance, the Coalition produced a list of benefits, which although not exclusive to the sector were nonetheless typically found there. Table 2 below illustrates how the narrative around the programme was constructed and supported around normative principles rather than necessarily practical considerations. It was the latter, e.g. the NHS that became an important source of challenge and resistance and one that could explain the lower than expected uptake of this scheme.

### Table 2. Summary of benefits based on different approaches (source: Social Enterprise Coalition, 2011:9)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>...of commercial approach (which public sector can struggle with)</th>
<th>...of social mission (which private sector can lack)</th>
<th>...unique to social enterprise?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>Financial incentives and flexibility around terms and conditions</td>
<td>Staff empowerment in decision making and governance</td>
<td>Reduced absenteeism</td>
</tr>
<tr>
<td></td>
<td>Lighter administrative burdens</td>
<td>Commitment to social mission</td>
<td>Lower staff turnover</td>
</tr>
<tr>
<td></td>
<td>Greater autonomy and flexibility to innovate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customers</td>
<td>Nimbleness and entrepreneurial culture to respond to market opportunities and emerging needs and wishes of customers</td>
<td>More engagement through governance and ownership models</td>
<td>Focused on social need</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service user involvement in design of services Greater levels of trust</td>
<td>Customers become supportive advocates for the organisation</td>
</tr>
<tr>
<td>Resources</td>
<td>Flexibility and incentives to create surplus</td>
<td>Safeguards on assets and surpluses reinvested for community benefit</td>
<td>Independence to access and join up alternative funding streams</td>
</tr>
</tbody>
</table>

### 4.6 Summary

This chapter has provided an overview of the key policies and government initiatives concerning new providers and the governance arrangements that were based on alternative models of
ownership in health care delivery. The chapter drew attention to different representations and conceptions of third sector and social enterprises and how these became embedded in the language of public sector reform. In doing so, the chapter used the Kingdon model to help account for policy change specifically in relation to CICs. While, it was noted that such a framing might be necessarily narrow and thus not fully appreciative of other factors, most notably power relations, it nonetheless illuminated the important role of policy entrepreneurs in advancing specific issues and solutions. Likewise, the broad claims behind the policy were shown to bear a close resemblance with NPM conventions suggesting that the third sector was not immune to but rather part of the wider trend of marketisation. The next chapter outlines the rational, method, strategy and tools that have been adopted in this research.

Chapter Five: Research design and methods

5.1 Introduction
The purpose of this chapter is to outline the methodological strategy that was adopted for this research to obtain answers to the main research question, namely: **what is the role of CICs in the English NHS and how the introduction of CICs impact on the governance of health care delivery?** Hakim (2000) suggests that questions raised in theoretical or policy debates need to be converted into research design that is feasible and will generate answers to the questions and problems posed.

In reviewing the research topic from a wider theoretical and policy perspectives I was confronted with a wide range of possible areas of enquiry. To help me identify appropriate methods and to avoid future ‘false starts, confusions, re-evaluations’ (Burnham et al., 2008:45) at a later stage of the study, I followed a series of interconnected steps as shown in Figure 1.

![Figure 1. A linear model of the research process (adapted from Burnham et al., 2008:46)](image)

The following chapter is organised to reflect, in general, the steps of this research process.

### 5.2 Research idea: preliminary considerations

There are a number of reasons to conduct social research. Essentially, they concern ‘an aspect of our understanding of what goes on in society’ that remains unresolved or unknown and thus merits attention and further investigation (Bryman, 2016:3). The basis from which these research interests develop vary and may include historical, political and social events as well as personal experiences. Silverman (2013) argues that biographical factors play an important role in how students and social researchers plan and approach their research subject. Likewise, Merriam (2009) notes that ‘research topics most often come from observing and asking questions about […] everyday activities’ and practices (2009:57). In the case of this study there were two noteworthy sources of inspiration.
Firstly, the subject area concerns third and public-sector organisations in which I worked between 2000-2003 and 2003-2011 respectively. This period represented an important phase in public policy where the interest and support for third sector organisations to deliver public services significantly expanded. It also typified a shift in the state-third sector relationship with an emphasis on partnerships and the subsequent mainstreaming of the sector into the social policy domain.

My professional involvement in third and public sector activity led me to appreciate the challenges of policy making in the ‘real world’ and specifically how the implementation of national and local objectives sometimes leads to unintended consequences. For instance, the Best Value Review of Voluntary Sector Policy and Funding in 2002 proposed that any ‘future investment in voluntary sector work and activity must be led by corporate objectives, moving from traditional grant-aid to a commissioning based funding approach’ (Manchester City Council, 2006:2). I found that in practice the shift tended to have a disproportionate effect on small scale, Black and Minority Ethnic (BME) community and volunteer-led organisations in comparison to established charities. This was partly due to the fact that these groups were providing services that were traditionally outside of mainstream provision and therefore unlikely to be part of an established procurement process.

Another crucial influence came in 2011 when I left the public sector to set up my own Community Interest Company (CIC) to help professional women find quality, part time employment. I chose the model because it was simple and inexpensive to set up with light touch regulation and unlike a charity, allowed founders like myself to draw income and retain significant control in the business. Moreover, CICs like any other third sector organisations were able to access grants. While I enjoyed some aspects of running a CIC I also learnt two things. First of all, the social impact I insisted I was making as a CIC would probably have taken place irrespective of its legal structure. Indeed, as many companies I approached for business pointed out, the social value and social impact were essential parts of any successful and sustainable private business and therefore not exclusive to
CICs. Secondly, I noticed that the process began to generate interesting ideas and difficult questions, which I could no longer answer or make sense of. My practical knowledge had stimulated an academic interest that I felt I needed to explore further. In 2013 I went back to University to study public policy and governance.

The second source of inspiration, thus, is directly related to the period of postgraduate study where I had time to develop necessary research skills. I was challenged by my course tutors to read widely and think more analytically and critically. I was able to examine the wide range of issues that I had experienced first-hand, for instance specific institutional cultures, working practices, partnerships and so on, but from different theoretical perspectives, traditions and literatures.

My interest in CICs continued to expand, with my MA dissertation focused on the role of CICs in privatising welfare provision. The next section looks how the research proposal for this thesis developed.

5.3 Research proposal

The preliminary considerations led me to formulate a project proposal for my doctoral thesis. The original title: ‘A Trojan Horse for the Marketisation of the National Health Service? The Emergence of Community Interest Companies in the Delivery and Governance of Health and Social Care’ was replaced with a slightly shorter title ‘A case of new governance in public sector provision? The role of Community Interest Companies in the English NHS’. The original intention was to emphasise the role of governance as a multifaceted concept and a category. I felt that the narrow focus on marketisation with the suggestive title of the Trojan horse would unnecessarily conjure theme of privatisation and thus considerably limit the scope of analysis. Likewise, my aim was to move beyond the research topic of my MA dissertation and include areas that were intellectually puzzling at the time but could not be properly studied.
As part of the research process and literature review in the introduction to this thesis, I identified an analytical and empirical knowledge gap in understanding the role of CICs within the English NHS. The existing conceptualisation of CICs tended to be limited to the analysis of their management and the governance structure as if it were a static and homogenous construct. Consequently, existing research neglected the diversity and dynamism of CICs but also lacked the appreciation of the importance of applying wider frames that were necessarily political, ideological, historical and organisational. In this sense, this research aimed to explain the role of CICs as an evolving process in the governing arrangements that involved continuity as well as change and incorporated considerations for power and legitimacy (Thelen, 1999).

The overarching objective of this thesis is a thorough exploration of the role and nature of CICs in the English NHS and the simultaneous enquiry into broader theoretical issues in which I propose the emergence and development of CICs is embedded. This connects a number of different disciplinary areas that include analytical, theoretical and empirical, referred to later in this chapter as three levels of analysis (see table 3). In the course of the thesis, I engage with a number of relevant literatures (chapter 1 and chapter 4) and problematics (chapter 3) that relate to: governance, organisation, policy and politics. What underpins these responses is the critical analysis of the role and nature of CICs in the English NHS that has ontological (i.e. the way we think the world is) and epistemological (i.e. what can be known) foundations that can be defined as a broadly critical realist position. In relation to this, Blaikie (1993) argues how social enquiry that focuses on ‘what exists, what it looks like, what units make it up and how these units interact with one another’ (p.6) lends itself to exploratory study like this thesis.

In the introductory chapter I propose that the existing research on CICs is either positivist and narrowly focused on the specific forms of these organisations’ governance or ideational in respect to their potential to stimulate innovation and improve accountability in public service delivery. In accepting prima facie that CICs exist primarily to produce social benefits neglects, I argue, the role
of contextual factors e.g. the political, social, and institutional, that have deeper structural influence over the trajectory of these organisations. At the same time, while recognising the value of the wider frameworks in which CICs develop and operate, the thesis acknowledges that CICs are themselves active agents that affect their environment as well as being affected by it. Traditional positivist epistemology continues to be dominant within health service management theories and practices in the NHS (see chapter 3 on NPM) which do not fully reflect the reality of NHS as a politically-charged, complex and constantly changing context. In order to respond to this historical, socio-political and intuitional complexity, the research offers an analysis from a broadly critical realist perspective.

### 5.3.1 Critical realist perspective

The critical realist perspective is closely associated with the work of Bhaskar (1979, 1989) and others in this tradition (Archer, 1995; Sayer, 2000; Gorski, 2013). It represents a heterogeneous series of positions (meta-theoretical, reflexive philosophical stance) that offer a philosophically rich account which in turn inform empirical investigations. The key ideas of critical realism flow from the ontological assumption that there is a reality ‘out there’ independent of observers’ views. This world while socially constructed is not completely so. As Sayer (2000:17) argues ‘meaning has to be understood, it cannot be measured or counted, and hence there is always an interpretative or hermeneutic element in social science’. In this respect, critical realism provides a useful lens to conceive of CICs not only as ideational constructs but as a legitimising vehicle for transforming the way health care services and welfare more generally is delivered.

In brief, critical realists distinguish between three different ontological modes of reality: empirical (experienced explicitly or implicitly); actual (out there but not necessarily experienced); and real comprising mechanisms and ‘deep’ structures that generate phenomena (Bhaskar, 1979). This ontological layering is particularly useful in qualitative research such as the thesis in that it allows to
develop deeper levels of understanding and explore why things are rather than that they are. Put differently, rather than seek to produce generalisable outcomes (positivism) or identify the experience of social actors (interpretivism), critical realism facilitates gaining knowledge that derives from unpacking casual mechanisms (Fleetwood, 2005). Put simply the thesis is interested in the social and political content of the reforms associated with CICs rather than just their institutional form. The next section outlines how the overall research design.

5.4 Overall Research design

Since the main research question sought to examine the role and impact of CICs rather than to quantify the phenomena \textit{per se} (how many, location etc.), it was considered useful to adopt a qualitative methodology. With this in mind, the approach was based on multiple case studies. Yin (1984: 23) explains that ‘a case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used’. Such a method was particularly suited to the study of organisations such as CICs, to closely inspect the complex relationships and conditions in which these organisations developed. The aim was to learn and gain insight from the interviewees in the selected eight CICs. Hartley (2004) argues that case studies can be useful in uncovering behaviours and identifying factors that influence social processes that can only be better understood in the wider context of historical, social and contemporary forces. An additional benefit of this type of research was that it permitted the use of a variety of methods including interviews, observations and document analysis (Crang & Cook, 2007; Hammersley & Atkinson, 2007).

However, a case study approach is not without problems. For instance, Segar et al. (2015:102) warn that the rapidly shifting policy environment in the NHS context makes defining organisations as ‘a case’ problematic and suggest that rather than to perceive them as neatly bound units of analysis to
acknowledge that these are ‘complex, multi-layered contexts’. Likewise, criticisms have been raised over ‘a lack of rigor, a lack of basis for generalisation, and the suggestion that they are too time consuming and unwieldy to analyse and present’ from a case study approach (Yin, 1994:10-11). Qualitative unlike quantitative experiments cannot be easily controlled and thus are not necessarily replicable raising further concerns about the validity of findings. However, Stake (2000:22) contends that although generalization may not be all that despicable, particularization does deserve praise. To know particulars fleetingly of course is to know next to nothing. What becomes useful understanding is a full and thorough knowledge of the particular, recognizing it also in new and foreign contexts (ibid).

In this research, the multiple cases comprising eight CICs are studied as a single unit of analysis that can be interpreted in their own right (as individual organisations) as well as in relation to wider processes and contexts (historical, political, policy, etc.). As Segar et al. noted by ‘tolerating fuzzy boundaries and regarding the interpretation of “national level policy” not as a “contextual variable” but as an integral part of the cases’ (ibid, 89) helps to provide depth and nuance to the understanding of the issue being studied.

5.4.1 Three-level framework of analysis

In order to attend to the multiple concerns identified in the introductory chapter, the research proposed an analysis that was cognisant of macro, meso and micro levels of analysis. These three levels provided a useful conceptual, analytical and empirical basis that would better explain the role of CICs in the delivery of health care.

Firstly, the research adopted a historical perspective and situated the discussion on the health service in the context of its own history (macro). The analysis of CICs was then developed by reviewing the theoretical foundations of health care reforms in the English NHS. It was found that NPM and Governance were useful to interrogate the shifts in the modes of governing that took place in the
English NHS. Together with the historical perspective, these frameworks enabled teasing out the possible consequences and contradictions in the provision and the delivery of health care services in England. In particular, three important themes impacting on health care delivery began to emerge from this review: innovation, governance (broadly conceived) and accountability.

Next, at the meso-level the main area of interest was with the wider role of policy in enabling CICs to develop in the primary and community health care markets. The aim was to build on the earlier discussion (macro) and to illustrate how theories and historical trends became entrenched and mediated through the policy process. Another reason for approaching the subject from the meso-level perspective was to illuminate the deliberate nature of the policy in activating and legitimising the role of CICs in the English NHS. These aspects were addressed by focusing on the distinct narratives of the third sector and in particular around key themes of innovation, governance and accountability. Finally, at the micro-level, the research dealt with a wide range of issues and concerns experienced at the individual and organisational level. This provided insight into organisational practices, cultures, leadership and management and how these were enacted but also shaped by the identified macro and meso-level factors. Again, the focus here was on the three primary areas of study: innovation, governance and accountability. The research sought to gauge how individual actors perceived the role CICs played in generating new forms of governance, innovation and accountability and how these were implemented at the micro-level? And finally, how these concepts that took place under the macro and meso-level conditions affected the types of governance, innovation and accountability that CICs were able to generate at the micro-level? The approach adopted in this research is set out in Table 3.

<table>
<thead>
<tr>
<th>Research Design</th>
<th>Macro-level</th>
<th>Meso-level</th>
<th>Micro-level</th>
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Table 3. A three-level framework of analysis
### Research Questions

1. What is the relationship between CICs and the wider agenda of transformation of health care delivery in England?
2. What mechanisms have been employed in legitimising the activation of CICs in the NHS?
3. What type of innovation is promoted by CICs and does this innovation transform the way healthcare is delivered and managed?
4. In what way CICs governance allows for greater autonomy, empowerment and responsiveness to staff and service users?? What are the mechanisms of accountability in CICs?

<table>
<thead>
<tr>
<th>Theoretical framework</th>
<th>Historical context.</th>
<th>Policy context.</th>
<th>Organisational context.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Public Management (NPM) and Governance–guiding theories to make sense of health care reforms and the shifts in the modes of coordination: hierarchies, markets and networks.</td>
<td>Qualitative Research: Interpretative Approach involving the overview of key themes and policy in respect of CICs and social enterprises in health care.</td>
<td>Qualitative Research: A Case study approach adopting an inductive and deductive approach to data analysis.</td>
</tr>
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<table>
<thead>
<tr>
<th>Method</th>
<th>Literature review.</th>
<th>Literature review and document analysis.</th>
<th>Interviews, observation of meetings and analysis of organisations' documents.</th>
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<table>
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<tr>
<th>Where in the thesis?</th>
<th>Chapter 2</th>
<th>Chapter 3 and 4</th>
<th>Chapters 6, 7 and 8</th>
</tr>
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### 5.4.2 Choice of (case) sites

A systematic review of the existing data sources, listed in Table 4 below, was initially conducted to identify organisations that emerged in England as part of the Department of Health’s RtR programmes. The information was drawn from the three specific lists published by the following bodies:

1. House of Commons Hansard Written Answers that provided names of 45 staff–led social enterprises under the RtR;
2. DH’s first and second wave of RtR projects announced in 2009/2010 including 14 existing and 30 new organisations respectively;
3. Cabinet’s Office, *Pipeline of Public Service Mutuals* (2012) containing 100 established and developing
projects that fell within the department’s definition of public sector mutual.\textsuperscript{41}

Table 4. Data Sources

<table>
<thead>
<tr>
<th>No.</th>
<th>DATA SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The Department of Health</td>
</tr>
<tr>
<td>2.</td>
<td>The National Audit Office</td>
</tr>
<tr>
<td>3.</td>
<td>Cabinet Office</td>
</tr>
<tr>
<td>4.</td>
<td>The RBS SE100</td>
</tr>
<tr>
<td>5.</td>
<td>The Employee Ownership Top 50</td>
</tr>
</tbody>
</table>

The mapping exercise employed a set of criteria (see below) to identify suitable organisations for the study. In addition, both practical and time considerations were taken into account to determine the pool and spread of the sample.

i. Location.

ii. Launch date & scheme (e.g. RtR) under which it emerged

iii. Company status (e.g. limited by shares/guarantee)

iv. Governance structure (e.g. employee led/owned)

v. Size: number of employees

vi. Size: Turnover

vii. Contract: type of service

As a result, 10 CICs were purposively selected and their Chief Executives invited by e-mail to take part in the study at the beginning of September 2016 with 8 finally agreeing to participate. The sample was purposefully chosen to reflect diversity of the identified criteria defined above. Details of the 8 case study sites by selection criteria are set out below in Table 5.

\textsuperscript{41} A public service mutual – an organisation that has left the public sector which continues to provide public services (under contract) and in which employee control plays a significant role in its operation (DCMS, 2018).
<table>
<thead>
<tr>
<th>ID</th>
<th>Site</th>
<th>Region</th>
<th>Programme</th>
<th>Status</th>
<th>Structure</th>
<th>Staff no.</th>
<th>Turn-over (mln)</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>North West</td>
<td>North West</td>
<td>Established under Right to Request programme: 1st August 2011.</td>
<td>Ltd by shares</td>
<td>Employee led with staff representative on the Board</td>
<td>40</td>
<td>£1.2</td>
<td>IAPT, mental health services, support to work and dementia programmes.</td>
</tr>
<tr>
<td>2</td>
<td>North East</td>
<td>North East</td>
<td>Established under Right to Request programme: April 2011</td>
<td>Ltd with Share Capital</td>
<td>100% employee owned</td>
<td>550</td>
<td>£24</td>
<td>Community health and care services. Specifically, mental health services, services for older people, eating disorder services and employment services.</td>
</tr>
<tr>
<td>3</td>
<td>North West</td>
<td>North West</td>
<td>Established under Right to Request: April 2012.</td>
<td>Ltd by guarantee without share capital</td>
<td>80% employee owned/average</td>
<td>49</td>
<td>£1.4</td>
<td>A nurse led rehabilitation centre. Intermediate Care, Nursing Home for Life and Neurological Physiotherapy.</td>
</tr>
</tbody>
</table>
5.5 Selection of Research Method

Data for this research came from a variety of sources and employed a number of different strategies to allow methodological triangulation of the data. For instance, concepts, ideas and themes that emerged during the literature review were followed up with interviews and informal conversations. The data from internal sources (agenda, minutes, reports) was used to qualify issues, identify relationship and at times point out discrepancies between the various data sources reflected further application of methodological triangulation. The use of a number of data sources was intended to strengthen the case study from the methodological point of view but also enabled to gain a detailed understanding of the wider and complex environments within the organisation and in the context of the national policy.
5.5.1 Semi-Structured interviews

Atkinson & Silverman note that we are currently living in the time of the ‘interview society’ in which interviews seem central to making sense of our lives’ (Silverman, 1993:13). Despite their prevalence, interviews are not the same as conversations. The practice of interviewing involves a clear goal, ‘the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena’ (Kvale & Brinkmann, 2008:3).

Interviews can be divided into structured and semi-structured. In this research, the primary data came from semi-structured interviews, which were constructed to reflect the main research interests and questions (see appendix 1 for the interview schedule). The approach was deliberately flexible to allow participants to digress and be spontaneous. Shiner and Newburn (1997:520) advocate the use of semi-structured interviews because it helps participants ‘to raise issues that were important to them […] to discover respondents’ own meanings and interpretations’. The process invited interesting and relevant responses to the questions posed and allowed for consistency in the themes of data being collected from the individuals. At the same time, the semi-structured nature of this process created opportunities for participants to offer a wide range of views and remarks that I did not anticipate or account for in my interview schedule.

The initial participants for the study were selected on the basis of the position held within the organisation. This typically meant Chief Executive or another senior member of staff. These people were asked to identify suitable candidates for the study. There was limited scope to influence the decision, however, the process was preceded by an exchange of e-mails, which clearly set out the key purpose for the study and highlighted specific areas of interest, notably knowledge of the CIC and its development and staff representation. In some cases, secretarial staff acted as gatekeepers in an organisation, and requested a copy of the interview questions to be presented upfront to help
determine the organisation’s suitability for the study. Table 6, below, includes the breakdown by site, the position the interviewee held within the organisation and duration of the recorded data.

Another way to identify participants for this study was via a “snowballing” technique, which essentially involved using an earlier selected participant to ‘locate other persons having necessary characteristics making them eligible for the sample’ (Bailey, 1994, p. 438). Likewise, desk top research involving website searches identified four key actors, outside of the studied CICs, whose experience and knowledge were considered relevant to this project. Their participation was solicited by sending e-mails and was subsequently followed up by four interviews held via Skype and phone.

Table 7, below, lists the areas of expertise as well as the rational for seeking the views of the identified participants.

<table>
<thead>
<tr>
<th>No</th>
<th>ID</th>
<th>Interviewee ID</th>
<th>Interviewee Role</th>
<th>Type of record</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Site1</td>
<td>ID1.1</td>
<td>Staff Rep</td>
<td>Audio (45:53)</td>
</tr>
<tr>
<td>2</td>
<td>Site1</td>
<td>ID1.2</td>
<td>Chief Exec</td>
<td>2x Audio (1:17 &amp; 52: 23)</td>
</tr>
<tr>
<td>3</td>
<td>Site1</td>
<td>ID1.3</td>
<td>Chair</td>
<td>Audio (37:29)</td>
</tr>
<tr>
<td>4</td>
<td>Site2</td>
<td>ID2.1</td>
<td>Chief Exec</td>
<td>Audio (57:45)</td>
</tr>
<tr>
<td>5</td>
<td>Site2</td>
<td>ID2.2</td>
<td>Ass Director Operations</td>
<td>Audio (49:05)</td>
</tr>
<tr>
<td>6</td>
<td>Site2</td>
<td>ID2.3</td>
<td>Medical Director</td>
<td>Audio (40:02)</td>
</tr>
<tr>
<td>7</td>
<td>Site2</td>
<td>ID2.4</td>
<td>Manager</td>
<td>Audio (56:20)</td>
</tr>
<tr>
<td>8</td>
<td>Site2</td>
<td>ID2.5</td>
<td>Clinical Lead</td>
<td>Audio (29:50)</td>
</tr>
<tr>
<td>9</td>
<td>Site2</td>
<td>ID2.6</td>
<td>Staff Rep</td>
<td>Audio (40:35)</td>
</tr>
<tr>
<td>10</td>
<td>Site2</td>
<td>ID2.7</td>
<td>Staff Nurse</td>
<td>Audio (34:16)</td>
</tr>
<tr>
<td>11</td>
<td>Site2</td>
<td>ID2.8</td>
<td>PA</td>
<td>Audio (24:44)</td>
</tr>
<tr>
<td>ID</td>
<td>Role</td>
<td>Expertise</td>
<td>Rationale</td>
<td>Interview</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>ID0</td>
<td>Social Enterprise UK/Head of Policy</td>
<td>Support for social enterprises, CICs/spin outs.</td>
<td>To seek views of policy makers and those involved in the process of promoting the agenda on social enterprises.</td>
<td>Skype Interview: audio</td>
</tr>
<tr>
<td>ID1</td>
<td>B Corp UK/Executive Director B Lab UK</td>
<td>Social investment, social responsible business in the UK via certification of B-Corps, social enterprises.</td>
<td>To seek views of people involved in promoting initiatives that are part of the movement towards more responsible capitalism, ‘shared capitalism’, etc.</td>
<td>Skype Interview: notes</td>
</tr>
</tbody>
</table>

**Table 7. Interview breakdown with key stakeholders**
The interview schedule consisted of a list of questions that were grouped under three main thematic areas: innovation, governance and accountability. There were no other interview schedules produced in this study, but the nature and process of the interviews meant that new questions developed spontaneously and directly in response to new information or a comment made by participants. As a result, a new question was added to the interview schedule asking which sectors’ characteristics, notably public, private and thirds sector best reflected the type and nature of their organisation. The transcripts generated from interviews, alongside written up notes from observation, were analysed (see section 5.7) in the way that it corresponded with the above identified themes. Verbatim quotations are considered an integral part of qualitative research and are typically used to support the main argument or a particular account within it in the way that it makes sense and is convincing to the reader (Mason, 2002). There is a general consensus that verbatim quotations play a role in driving final conclusions in the research insofar as the ‘excerpts from transcripts help to clarify links between data, interpretation and conclusions’ (Corden & Sainsbury, 2006). In chapter, six, seven and eight verbatim quotations from interviews were used to illustrate the point being made. Occasionally quotations from the specified documents or observations were also included but these were boxed in to differentiate them from verbatim quotations.
5.5.2 Observations

Much like interviews there are different types of observation (see discussion in Gains, 2014). However, unlike interviews they are considered ‘unobtrusive measures’ to gaining new knowledge (Webb et al, 1966). In this study, I used a non-participatory method to collect additional data. I attended two Annual General Meetings (AGMs) held at two separate CICs’ sites, took part in the organised visit to the inpatient facility and sat at the staff meeting in another CIC. I took part in informal discussions that happened immediately after these meetings but also when traveling to them with other members of staff who were not participants in this research. These encounters differed from interviews insofar as they were spontaneous, unsolicited and unrecorded. They created opportunities for alternative opinions and views to be expressed and shared with the researcher.

This experience offered rich and unpredictable data sources. I was able to immerse myself in the social setting and to gain empirical and subjective knowledge that contrasted the type of data obtained from document analysis and semi-structured interviews. For instance, when visiting a ward at a mental health facility, I was followed by one of its patients. The staff quickly recognised that the patient’s intention was likely to cause harm and took immediate action. The situation allowed me to observe first hand, how the ‘non-restraint’ practice advocated by the organisation was enacted and how their ethical and policy considerations were implemented in real world with real people. Table 8 shows the observations undertaken by site.

Table 8. Observations undertaken by site

<table>
<thead>
<tr>
<th>No</th>
<th>ID</th>
<th>Interviewee ID</th>
<th>Interviewee ID Role</th>
<th>Type of record</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Site1</td>
<td>ID1.4</td>
<td>AGM (attendance)</td>
<td>Written notes</td>
</tr>
<tr>
<td>2</td>
<td>Site2</td>
<td>ID2.9</td>
<td>Site visit to acute inpatient facility</td>
<td>Written notes</td>
</tr>
<tr>
<td>3</td>
<td>Site4</td>
<td>ID4.5</td>
<td>Staff Forum (attendance)</td>
<td>Written notes</td>
</tr>
<tr>
<td>4</td>
<td>Site7</td>
<td>ID7.</td>
<td>AGM, Site 7/Participation</td>
<td>Written notes</td>
</tr>
</tbody>
</table>
5.5.3 Documentary sources

The data came from a wide range of documents (see below) and was collected at various points of the study, enabling me to be reflexive, spontaneous and deliberate in seeking new channels of information. Atkinson and Coffey (1997:47) view documents as “social facts’, in that they are produced, shared and used in socially organized ways’. In my research, documents were an important albeit supplementary source of information. Unlike interviews and observations they are not constrained by the time unless they are subject to specific rules and regulations such as for example, Freedom of Information Act (2000). Nonetheless, the analysis of documents requires a considerable time investment on the part of a researcher as the process relies on ‘a systematic procedure for reviewing or evaluating documents - both printed and electronic (computer-based and Internet-transmitted) material’ (Bowen, 2009:27).

The documentary data for this study came from multiple and varied sources. For example:

- Policy Documents (White and Green Papers)
- Reports (CICs’ Annual, Financial & Social Reports)
- Online information including CICs’ own website
- Press Releases and radio broadcasts available online
- Application forms to Primary Care Trust to set up a CIC
- Official statistical data sources including DH, data.gov.uk, MORI
- Public records (CIC Regulator, Companies House, DH, Care Quality Commission (CQC)
- Staff & Patients Surveys
- CICs own publicity (brochures, websites, meeting agendas)

5.6 Sampling Strategies & Methods of data collection
Sampling allows researchers to identify what, who, where, and how (many) to sample. The process is informed by practical, theoretical and research questions’ considerations and involves developing a certain type of selection criteria (Creswell, 2013).

5.6.1 One to One Interviews

The initial sampling decision (site) was made prior to the start of the fieldwork and as soon as the focus of the research enquiry became clear. The selection continued to evolve and change during the process, as some participants were no longer able to commit, or new informants were identified and recruited until data saturation was reached.

The sampling strategy adopted within sites focused on selecting members of staff who had relevant knowledge about the subject under investigation and who were willing and able to talk about it. Initially, I contacted Chief Executives of the potential case study sites to acquire their consent and through them obtain access to additional participants at a later stage. As already mentioned, an introductory e-mail (see appendix 2) was sent to PAs who then made a decision whether or not the e-mail should be forwarded to their Chief Executives. Where I had not received any response, I followed it with a telephone call.

In every case, the Chief Executive assumed a role of authority in the selection process of the staff and was the ultimate decision-maker in terms of who was chosen to participate in the research. However, snowball sampling was also used when new participants were invited to take part to replace a previously identified informant who was not present or available at the time of my visits. In one site, for example, an additional participant was identified following a spontaneous, interaction during a site visit. The final sample represented a varied group of people in respect of roles held in the organisation and reflected the research areas of interest, most notably in innovation, governance and accountability.
5.6.2 Observations

The request to take part in meetings, events or any other social gatherings was not solicited at an early stage. I felt it was important to establish a relationship with individual organisations and build necessary rapport and trust before asking for access to meetings. I was also mindful of the wider context of health care and the implications in respect of staff’s time and confidentiality. However, I was invited to a series of events that provided me with a valuable insight of how staff behaved, interacted with one another, and senior colleagues. This situation was useful as a contextual backdrop to observe how the rhetoric of CICs governance around staff engagement, participation etc. worked in practice and how in some cases there were contradiction between the perceptions of senior and junior members of staff regarding the same topic. Such data would not have been easily gained from interviews or document analysis alone. The observations also brought a real-life aspect to the research.

5.6.3 Documents

Atkinson and Coffey (2004:58) suggest that ‘documents construct particular kinds of representations’ but that they should be treated as an important data in its own right.

There are many ways in which data can be obtained and analysed. My previous knowledge of the research topic gained through the MA programme was useful in choosing documents for this research. As my thesis sought to embed knowledge on the role of CICs in the English NHS in the wider context of analysis, I divided the documentation into two groups: primary and secondary material.

Primary data refers to a type of evidence that relates to a topic that was produced at the time CICs were created (Burnham et al, 2008:187). This type of data constituted a small but nevertheless significant element in the research.
The documents (see section 5.5.3) came from newspaper articles, audio recordings, Cabinet and research reports and were selected on the merit of making a reference to CICs, spin outs, RtR and RtP programmes, and mutuals. The primary data sources provided me with an important insight into first-hand and immediate accounts of a wide range of stakeholders involved in the roll out of CICs into the English NHS at the very early stage. As my research was limited to interviewing staff nominated by Chief Executives it was useful to establish a broader understanding of the issue. For example, during the course of interviews staff frequently referred to the period when CICs were transitioning from PCTs and what type of emotions this generated.

The secondary source refers essentially to the material, which was produced as a direct result of the topic or event reported in the primary source. Much of the academic writing, for instance books, journal articles, are defined as secondary sources. In this research, the secondary material was used to inform the literature review (chapter one). The process involved a careful review of past and recent academic writing on the research topic in order to determine blind spots in the literature as well as to establish connections within the existing theories and traditions (see chapter two).

Documents from both sources were used critically and analytically to verify and corroborate the findings. Likewise, the utility and quality of documents was subject to questions such as why it is important and why the information exists in the first place? (see for example Scott, 1990). As Bowen advises, documents are context-specific and require careful evaluation against other sources of knowledge and information (Bowen 2009:33).

5.7 Qualitative Data analysis

There were 27 recorded semi structured interviews. Twenty-one of these took place at the site where participants were able to give their answers in person. In five instances, it was not possible to arrange a convenient time and therefore interviews were conducted over the phone and Skype. A total of 21 hours and 24 minutes of interviews were recorded and transcribed with further written
notes that came from unrecorded interviews. All the interviews took place between December 2015 and November 2016.

The first step in the research process involved a literature review, which established a theoretical direction for the research and identified three core themes, innovation, governance and accountability as relevant to providing answers to the main research question. The chosen areas were then presented and discussed with two supervisors and following their suggestions, a research template was created to ensure the necessary rigour and to manage a large quantity of qualitative data from the empirical case studies. In addition, the template was used to lend structure to the overall thesis as well as to develop an interview schedule that was used at a later stage.

The next phase, consisted of systematically going through the documents and organising them according to the three main categories. To this effect, Annual and Quality Reports of individual CICs alongside published staff surveys, material on the general governance and leadership of CICs, data from the website were all examined for relevance and electronically filed under the established themes and within the folders pertaining to the specific CICs. In some cases, the documents had to be copied and filed under all of the three themes illustrating a high degree of overlap between the concepts. The above process took place early on in the study and continued throughout the research with new data being added as and when it became available to the researcher.

As soon as the sites were recruited and the timetable for the visits and interviews drafted and agreed, the process of empirical data collection began. When interviews took place over the phone, I relied on note taking which was then followed up by a brief summary of the key points. It was not always possible to replicate the exact words or complete sentences and so to ensure transparency I differentiated between interviews being recorded and transcribed or if hand written notes were taken instead (please see table four and five). The tape recorded interviews where transcribed as soon as it was practically possible. The transcripts were then read and re-read a number of times to
help me familiarise myself with the data before I began to group it into different categories. In reviewing the notes, transcripts and other material including grey literature I paid attention to any possible patterns and relationships emerging between and across the data.

My initial intention was to code material into NVivo and so I drafted a provisional set of guidelines for selection and coding. Unfortunately, I experienced a number of setbacks both technical and practical and after discussing the problem with my supervisors I decided not to pursue this option. I felt that the time and lack of experience in using the software would cause delay in completing my PhD. Therefore, to ensure that the data analysis was conducted in the systematic manner, I decided to follow a straightforward framework proposed by Srivastava and Hopwood (2009) which is summarised in Table 9, below.

Table 9. Questions that served as the framework for the data analysis

| Q1: What are the data telling me? (Explicitly engaging with theoretical, subjective, ontological, epistemological, and field understandings) |
| Q2: What is it I want to know? (According to research objectives, questions, and theoretical points of interest) |
| Q3: What is the dialectical relationship between what the data are telling me and what I want to know? (refining the focus and linking back to research questions) |

In undertaking the data analysis, I used the above template for each of the participating CICs and for each of the identified three categories. I then created a ‘card’ based on the proposed by Srivastava and Hopwood model for the eight participating CICs. An example of how this looked is shown in Table 10.

Table 10. Framework for narrowing the focus.

| The overarching research question: What is the role and impact of CICs in the English NHS? |
| Main category for investigation: Innovation |
| CIC Site X |
By cross referencing what I already knew about the subject from the literature review with what I learnt helped me to identify common areas as well as highlight discrepancies between, for instance, practice and the wider policy. The developed cards were further used to compare against the eight CICs and in doing so to establish any possible patterns and relationships, e.g. size of the CIC versus the ability to innovate. In addition, the literature review conducted at the early stage in the process and the led me to identify a number of sub-categories within the core three themes, for example innovation became identified as pertaining to managerial, social and technological group.

The overall process to analysis was iterative and inductive. According to Patton (1980:306), the inductive analysis ‘means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis’. However, Srivastava and Hopwood (2009) suggest that themes tend to develop ‘according to subscribed theoretical frameworks, subjective perspectives, ontological and epistemological positions, and intuitive field understandings’ (ibid:77). In this research the themes of innovation, governance and accountability were identified during the early process of the literature review and thus were already predetermined when the collection of data began. At the same time, interpreting
participants’ own views and opinions was carried out to take into account macro and meso level considerations that were identified by an early literature review. The process thus involved cross-referencing the obtained data with already identified themes and allowing for sub-categories to develop both from within the field of data collection as well as being informed by an early theoretical structure developed in chapter two. To this end, both broader heading as well as sub-headers in chapters six, seven and eight broadly reflect the presentation of the data.

5.8 Ethical Issues

To determine the ethical requirements for my research I read the School of Social Sciences (University of Manchester) guidance on ethics and completed the ethics decision tool. Based on this information I was able to decide on the appropriate route for my application. As my research did not involve vulnerable groups or patients I was only required to seek the formal approval from the School of Social Science Ethics Panel. In addition, as part of the application process, I was expected to undertake and submit a complete risk assessment in respect of the research. I did not encounter any significant problems and in July 2015 I was granted ethical approval from the School’s panel to conduct my research (see appendix 3).

As part of the commitment to maintaining high ethical standards, individual participants were given an information sheet outlining the nature the main objectives of the project and an explanation why they had been chosen? (see appendix 4). In addition, at the start of each interview, all participants were made aware that they could leave the process at any point in the process if they no longer wanted to participate and that their data would be removed if requested. All participants who took part in one-to-one interviews, including Skype and phone, were asked to read through and sign a consent form (see appendix 5). In order to ensure confidentiality, audio transcriptions were assigned a specific ID code with verbatim quotations following the same pattern to maintain anonymity.
The nature of qualitative research requires a careful ethical consideration and close attention to the practices and techniques employed during the course of a study. Bulmer (1992:45) defines ethics as ‘…a matter of principled sensitivity to the right of others’ to ensure that researchers pursue their interests in a way that does not cause harm to participants. Iphofen (2011:5) argues that social researchers are obliged ‘to maintain a climate of trust in the practice and outcomes of social research’ by establishing ‘effective system of ethical review, clear lines of responsibility and a manageable degree of independent overview’. In this research, these considerations have been addressed through adherence to the ethical approval system at the University of Manchester.

5.9 Limitations of the research

All research designs carry a degree of uncertainty of what we would find once we start collecting data. In this sense, social science research has relative advantages and limitations. In this section I will briefly outline a series of limitations encountered in this research.

5.9.1 Sample Size

Qualitative research, more so than quantitative, involves a certain degree of ambiguity when it comes to a sample size. It appears that there is no general agreement in the research community of what constitute and ideal and reasonable sample size (Bryman, 2016:18). As a novice in social science methods I found this issue particularly troubling and challenging. While the small sample allowed me to explore in greater depth the practices of individual CICs, the claim to generalisability was nevertheless an issue. However, Yin (2009:6) argues that ‘a single case study can be the basis for significant explanations and generalisation’ and therefore should not be dismissed as evidence. The validity of the findings, however, was not assumed from a single source, for instance interviews, rather from a careful sequencing of research process and triangulation of methods and data.
5.9.2 Site Selection

Closely related to the above point, is the site selection and the possible limitations involved in this process. As noted in section 5.7, I chose the case study sites according to seven distinct criteria. The sites were recruited purposively mainly because they were enthusiastic and willing to participate, which meant I did not experience problems with access. However, this might be problematic for two reasons. First of all, the participants’ motivation to take part in the study may involve bias insofar as the sites that volunteered can potentially have their own agenda (e.g. endorsement of the brand, grievances that can be channelled via seemingly independent research, etc.), which is hidden from the view of the researcher. And secondly, site selection while practical and necessary to complete thesis on time may not go far enough to allow for important variations across and between sites to be identified, affecting the potential generalisability of the findings. However, as Segar et al. (2015:103) eloquently argue the purpose of case studies is not to generalise but ‘to provide a powerful way to illuminate how policy is enacted’ with case studies being ‘heuristic devices - shortcuts or strategies for coming to grips with messy reality’.

5.9.3 Documents

The multiple sources from which I obtained information, presented a series of practical and analytical challenges. This included the considerable amount of time needed to critically evaluate the suitability, quality and reliability of sources of the written material. The issue of partiality and professional bias also needed to be acknowledged. While reviewing the documents, I tried to address this problem by asking questions such as who commissioned and paid for the report? What was the purpose of this report? Arguably, in making decisions about which documents to include in the research study, what qualifies or not, I was myself exercising bias. Furthermore, the documents obtained from individual sites suggested a ‘biased selectivity’ insofar as the content in these documents was strictly aligned with organisations own corporate aims and policies (Yin,
1994:80). However, the potential conflict of interest was overcome by narrowing the criteria to identified concepts and words, for instance *spin-outs*.

### 5.9.4 Interviews and Observations

As mentioned in section 5.5.1 the decision about who else should be included in the study rested predominantly with senior managers of the organisations. The recruitment of participants had undoubtedly introduced a potential for bias, although, the findings from interviews suggest considerable variations in responses amongst participants. In addition, the research setting meant that I was operating within the context, which was unfamiliar to me and was fully controlled by the participants’ organisational rules and norms. It is possible to speculate, then, that the context might have played a role in influencing responses and interactions between participants and myself. Fontana and Frey (1994: 361 - 374) also recognise that interviewing has other limitations, claiming that ‘the spoken or written word has always a residue of ambiguity, no matter how carefully we word the questions and report or code the answers’.

### 5.9.5 Resources

As a single researcher conducting a study that involved multiple sites selected on the basis of geographical spread had considerable time implications. In addition, being solely responsible for transcribing the recorded data put me under considerable pressure. It was mentally challenging to listen and transcribe at the same time, continually making sure it was accurate. This was further complicated by the fact that I was confronted with memories of individual interviewees where participants communicated in more tacit way most notably using facial expressions, laugh, irony etc. To capture the richness of such interactions was difficult and subsequently a unique dimension was lost as a result.
In carrying out the research on my own I was also aware of biases and perceptions I was bringing to the process. After all, as Smith and Noble (2014:100) noted, research ‘bias exists in all research’ and it ‘is difficult to eliminate’. I was also aware of the implications related to that fact that I acted alone and was not part of a team to consult with and verify my findings. Therefore, throughout the research I actively pursued opportunities to disseminate the findings from my research and share my ideas with wider research community. I attended and presented at national and international conferences as well as the Comparative Public Policy and Institutions (CPPI) cluster, where I received useful feedback from other PhD peers and senior academic colleagues. In mitigating the negative impact of the single researcher bias I sought the advice of my supervisory team and followed their suggestions in selecting the methods and strategies while articulating the rational of my choice.

5.10 Summary

This chapter outlined the research strategy and discussed the methods employed in the data collection process. It illustrated how a multiple case study strategy based on a mixed methods approach involving interviewing, document analysis and observations was useful to operationalise the theoretical framework presented in chapter three. The chapter concluded with a discussion of research ethics paying attention to the limitations of the type of research conducted.

The main aim of the following three chapters, six, seven and eight will be to present the empirical data obtained during this research with the concluding chapter offering a discussion on the key findings. The next chapter looks at the role of governance in the individual CICs.
Chapter 6    Innovation

6.1    Introduction

Chapter three highlighted how CICs entered the policy agenda as an alternative provider for publicly funded health care. Facilitating this development was a narrative underpinned by the assertion that the governance structure of the CIC would generate innovation in public service delivery. More specifically it has been argued that social enterprises are good at harnessing
innovation through staff and patients’ engagement leading to service improvements and efficiency gains (DH, 2010). The aim of this chapter, therefore, is to offer an analysis of participants own opinions and understandings of innovation. In doing so, the chapter attends to the third (nested) research question (see introduction), namely: **what type of innovation is promoted by CICs and does this innovation transform the way healthcare is delivered and managed?**

This chapter is divided into three sections. First, a range of views and explanations is presented of what CICs consider to be innovation. Next, the section identifies three broad categories of innovation that emerge as a result: managerial, social and research including technological innovations. This is in line with the broad classification of innovation identified in chapter three. The chapter concludes by briefly examining the impact of these innovations on different stakeholder groups including CICs.

### 6.2 What is innovation: different views on the same subject

As part of the research process (see chapter 5), six broad questions have been developed under the theme of innovation and all participants were asked to provide answers to these questions, for instance what innovation meant to them, how would they define it, etc. (see interview schedule in appendix 1). The responses varied across the eight CICs and some interviewees found it difficult to come up with one single definition. The ambiguity, however, seemed to arise from the fact that innovation was perceived as a common-sense conception, a ubiquitous phenomenon that did not require much elaboration or clarification. For instance, one interviewee suggested:

> I think we innovate a lot, and I think people probably then do not recognise they innovate all the time. I think particularly people on the front line… they adopt new ways of working almost as an organic process and then they do not recognise the fact they have changed the way, in which to be either more effective, more efficient. So, I think there’s a lack of recognition particularly at the front line for innovation, because people think it has to be a new device or something, which it does not necessarily need to be. (ID6.3)
For the above respondent innovation was seen as a tacit and ‘natural’ act that took place spontaneously and continually. It was an organic process that enabled front line staff to adopt and implement new ways of working in order to be more effective and efficient. In this context, innovation did not need to be inventive or involve something new, e.g. ‘a new device’. This interpretation has resonance with a traditional approach found in business studies where innovation is problematised as a continuous albeit incremental process that leads to better or improved outcomes (see chapter 3). From another perspective innovation was equated with a process or ‘a long-term strategy, which then leads to innovation; [innovation] is being able to do things’ (ID5.1).

In this example, innovation was part of a managerial toolkit, an approach that allowed freedom to ‘do things’. The focus, then, was not so much on the final outcome, although this was important too, as much as on the process itself. In this context, innovation meant careful planning and management albeit in a way that did not stifle individual efforts to try new things.

Innovation was also considered to be a concept, an umbrella term for a range of activities and ideas that involved adopting new and old techniques simultaneously.

Innovation is a pretty broad concept, you can innovate in a host of things inasmuch as you can come up with a new concept or you can come up with a new approach to the old concept and probably in most instances you deal with a bit of both. I don’t see it much more than that. (ID1.2)

Here innovation was seemingly abstract and tied to the idea of a familiar concept that was constructed and deconstructed in the way that blended new and old approaches and understandings. The proposed definition implied simplicity, which did not need to be complicated. It suggested there was a limit beyond which it was futile to discuss the subject any further e.g. ‘I don’t see it much more than that’, (ID1.2).

Another respondent described innovation as a process that ‘means ability to think creatively, to think differently and to put in place some of these innovations, new ways of working, new models
of care’ into practice (ID4.4). Likewise, innovation was also considered to involve ‘thinking outside
the box’ and being able to experiment with ideas (ID2.7). One interviewee proposed a definition
by which innovation was seen as behaviours that transcend traditional structures because they focus
on clients’ rather than bureaucrats’ needs (ID5.3). There was a general consensus that innovation
was a good thing and the concept was closely associated with change that was beneficial albeit
unavoidable. A Chief Executive of a small CIC noted that innovation and change were essential to
the survival of CICs.

One of the things I say to the staff is that I never apologise for changing things because
we are going to constantly change things because if we don’t keep changing things,
innovating, we won’t be here in two years’ time, we won’t be here in two months’ time.
So, we are going to be constantly changing. (ID3.2)

There was a palpable sense of urgency that innovation was inescapable suggesting there was no
alternative but to change and innovate. From this perspective innovation emerged as an approach
that organisations had to adopt in order to survive and maintain the newly acquired status quo of a
private company. In this sense, innovation was associated with adaptability caused by the exposure
to exogenous pressures most notably competition and commissioning framework in the health care
sector. A similar view was proposed by another interviewee who noted that innovation was crucial
to address the inherent problems of finite resources in health care.

The only way we survive in health care is if we are innovative and do things differently
because there’s just not enough money and the resources to go around. (ID6.2).

In this sense, the pursuit of innovation was coupled with search for efficiency. It was about building
an organisational resilience to deal with deep structural problems in health care economies
particularly in respect of financial and human capital constraints. Innovation was seen as rational
and utilitarian behaviour that organisations had to develop in order to adapt to the challenging
environments. This type of innovation closely resembled what was described in chapter three as
frugal innovation, an approach that turns adversarial conditions such as resource limitations into opportunities to innovate.

Innovation was also connected and developed according to the requirements and expectations of the funder, most notably, the government. As one interviewee explained:

Innovation is important to CICs because the government says so and the government is the funder in the end of the day so if we are not cognisant of the central political agenda then we are naïve and the survivability of CICs will be threatened. (ID8.1)

This perspective emphasised the interdependence and hinted at the political conditions that facilitate the growth of innovation. In this sense, innovation was part of a wider operational framework to deliver innovative health care services. In specifying this seemingly covert dimension, the participant offered an insight into the power relations that exist between the CIC and the government that should not be overlooked.

The concept of innovation also came up as a tool or mechanism with which organisations sought to address the constantly evolving demands of the population. For instance, a Chief Executive of a large, award-winning CIC made the following observation:

Innovation is finding new ways of doing things that meet the changing demand and needs of population...because they are. So, innovation is often the mother of invention in terms of needs being mother of invention and we have to find solutions. (ID6.1)

Innovation here was considered as a rational and a direct response to the changing expectations of the population. The term was equated with invention placing the emphasis on technology as a route to achieving necessary and desirable outcomes. In this example innovation was predicted upon the model that relied on developing technological solutions and new behaviours simultaneously. Thus, innovation was closely linked to the culture change. This aspect was particularly pertinent since all
studied CICs emerged from the public sector and there was an explicit expectation that the new governance of CICs would unleash previously stifled entrepreneurial spirit of staff.

So, innovation has to be alongside a cultural and organisational and change management process that allows them [staff] to see the benefits of what it is they are about to get involved and reconnect them back with why they got involved in the first place, e.g. you are going to feel better about yourself. (ID6.1)

The definition also suggested that change and innovation enabled staff to ‘reconnect’ with their original motivation for working in the health care sector. The tacit assumption was that people who choose to work in this area did so as they were seemingly more compassionate and therefore the benefits they drew were not merely financial. The assertion also links to the wider policy objective, mentioned in chapter four, which promoted staff engagement as means of fostering new behaviours facilitating innovative responses that were person centred. In this context, CICs unique governance was seen to offer an alternative model predicted upon staff ability to think creatively and experiment with new ways of doing things. As the former Health Secretary, Andrew Lansley, asserted:

I’ve heard from many NHS staff over the years that they could run their services better if they were given room to breathe and felt their voices were heard. I want as many of them as possible to come forward now and take more control of the NHS and care services they provide. (Lansley, cited in Taylor, 2011)

Effective staff engagement was, therefore, considered to be an important driver for innovation. The interviewees perceived the CIC model as an enabling structure that allowed staff to experiment and to some extent take risks. There was a tendency, therefore, to define innovation by way of contrast whereby progressive CICs were juxtaposed against the inertial and bureaucratic model of the NHS. Put differently, it was far easier for participants to explain what innovation was not rather than what it was. The approach also lent itself to a conception of innovation as borne from the inherent failures of the state. This was reflected in a response given by a member of staff who
transferred from the NHS and in attempting to describe what innovation meant, reflected on the personal experience:

We have seen it time and time again in the public sector, in the bureaucratic system, the layers and layers of hurdles to get there [to innovate]. NHS is very bureaucratic, very much led by meetings, by people with little front-line experience, geared around finances, and performance indicators. (ID2.2)

Likewise, a similar view was proposed by a different participant who although had never worked in the NHS, based an opinion on what would appear to be a prevailing view of the sector, notably:

I didn’t work for the NHS. When I started here it was already a social enterprise. What I have heard from my colleagues working for the NHS, when they tried to develop any new project or focus on something more specific, the procedures behind and the length of time it takes for anything to happen is enormous. When I think in here [within the CIC] it happens quite quickly. So, whatever we want to achieve we just think about how we can do that, and we just go ahead and do that and there is nothing that can [stop] us …apart from funding. (ID1.1)

Here innovation was understood from an implementation standpoint. For this participant, the governance structure granted CICs an ability to respond and adopt new ideas quickly in contrast to the NHS organisations. A similar account was presented in a separate interview, where innovation was coupled with the organisational autonomy.

[Innovation] from the social enterprise perspective is…well; I think the world is your oyster because we are not bound by ‘you can’t do that’. We treat NHS patients but we ‘can do that’ as long as we keep patients or clients at the centre…then why wouldn’t you? (ID6.2)

From this perspective, it was the governing structure that created a thriving environment in which to challenge established norms and rules and encourage risk taking initiatives. The statement echoed NPM’s traditional preoccupation with ‘what matters is what works’ in the delivery of public services. As long as the customers’ needs were continually met there were no limits or barriers to innovation.
In this respect, the concept drew a distinction between old values typically associated with the bureaucracy notably hierarchy, standardisation and collectivism with the modern, flexible and entrepreneurial model of the CIC. Unlike the earlier meanings, here innovation was seemingly concerned with the end result suggesting managers and staff knew best and therefore would make right decisions in respect of patients’ care.

From another perspective, innovation was coupled with invention, which seemed to fit more closely with a conventional view of innovation.

Innovation is often about introducing a new product or a way of working that is not researched that is not tested. So, it is about being willing to cross the accepted cultural boundaries in the interest of developing this culture of practice. (ID2.3)

Similar to the earlier conception, the definition suggested that crossing boundaries and breaking rules was desirable in order to progress and develop new culture and find innovative solutions to complex problems. It is easy to see, however, why such a conceptualisation might be problematic in the context of NHS in terms of ethical considerations but also in regard to clinical practice that tends to be routinised for safety reasons and statutory compliance.

Innovation in general, then, was seen to play a role in improving standards in the delivery of public services taking into consideration both social and economic factors. For CICs, unlike conventional private sector, innovation was about ‘what we do best that no one else does’ (ID2.7) rather than necessarily creating competitive advantage to advance the economic position of an organisation. In this sense, innovation for CICs was about maintaining ethos, quality and customer satisfaction simultaneously,

Most people come to the health service to improve the care of individuals. I would measure innovation on our ability to meet that target to provide care you would expect for yourself and your own family in whatever form it means. (ID2.2)
Consequently, the studied CICs applied specific tools such as the ‘Friends and Family Test’ alongside staff surveys to measure employees and patients’ levels of satisfaction. Likewise, in order to promote and encourage innovations outside of the organisation, CICs typically showcased their achievements by entering into national award programmes such as Health Services Journal Awards and through professional affiliation and accreditation with Investor in People, Living Wage Foundation and Social Enterprise Gold Mark.

The examples presented in this section illustrate that innovation held different meanings to different participants in this study. The narratives revealed how specific conditions and motivations (financial constraints, anticipated reforms or new opportunities created by technology) influenced the scope and nature of innovation that CICs sought to develop and adopt. Based on the above responses, it was possible to attempt a simplified classification of innovation using three broad categories: social, managerial and research driven including technology (see table 11). Admittedly, these clusters reflect prevailing theoretical positions in the longstanding debates on innovation that were presented in chapter three.

Table 11. Three types of innovation

<table>
<thead>
<tr>
<th>Managerial</th>
<th>Social</th>
<th>Research &amp; Science</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New (Changed) Practice</td>
<td>• Value based</td>
<td>• Digitalisation</td>
</tr>
<tr>
<td>• New (Changed) Culture</td>
<td>• Patient/Staff-led</td>
<td>• Research</td>
</tr>
<tr>
<td>• Lean (unbureaucratic)</td>
<td>• Responsive and engaging</td>
<td>• Creative</td>
</tr>
</tbody>
</table>
‘An organisational innovation is the implementation of a new organisational method in the firm’s business practices, workplace organisation or external relations’ (OECD, 2005).

‘The creation and implementation of new solutions to social problems, with the benefits of these solutions shared beyond the confines of the innovators’ (Tracey & Stott, 2016:1).

Technological innovations comprise new products and processes and significant technological changes of products and processes. (OECD, 2001).

The following sections will unpick this classification further.

### 6.3 Managerial and organisational innovation

The pressure to deliver clinical services in the way that met both social and economic objectives simultaneously led CICs to develop innovative approaches to how these services could be managed in an efficient way. In some cases, the resource constraint stimulated responses to develop management practices which participants viewed as innovative.

#### 6.3.1 Resource implications

In order to meet the requirements of the contract and to deliver required efficiency, the studied CICs looked at different ways by which these could be achieved. As one interviewee put it,

> A lot of the drive [to innovate] comes from the financial position or the financial climate that we’re operating within. So, we are trying to do more with less and maintaining the same standards of safety and quality that we are aspiring to in addition to our contractual outcomes. (ID6.3)

In a separate interview, a Chief Executive of another CIC implemented changes to the service model based on the successful pilot project which resulted in considerable reduction in patient waiting times. The success, according to the Chief Executive was mainly due to the fact that:

> we had a little bit of extra resources, we used a care model, which was really well thought through, we knew what we were doing, what we were about, and we had a will to make it work. (ID1.2)
However, these outcomes were also able to be achieved because the model considerably reduced
the time and frequency of interventions that subsequently led to improved access to treatment. The
participant described the model as follows:

In our model, people would…, say they do one to one work, it will be typically be more like
half hour session. [In traditional model] Fifteen sessions and people come for an hour
appointment and then basically the psychologist sees them as long as they feel it is necessary
in the clinical opinion, which could be almost forever for some people. You do not get any
flow through, do you? If you then say for people who can still benefit, benefit from
intervention which might be eighty per cent of people who come through you adopt a high
flow model where people almost […] kind of bar code the stuff and negotiate the checkout
for themselves – low intensity customer service versus somebody does all the meeting and
greeting and talks about how lovely it is and like wrap it all up individually and puts it like
dicky bow and everything, and then puts it in the box and carry it out in the carrier bag.
Which is going to be the most resource efficient? Which is going to manage the volume? It
is no brainer. (ID1.2)

The approach in all its simplicity, according to the Chief Executive, worked and was effective in
managing both the volume of patients as well as the cost. In addition, the new model was considered
to be safe and delivering clinical results.

[…] These models have been tried out and shown to be effective with a good enough
proportion of the overall patient population to make it worthwhile. Right? Not everybody
needs Harrods, that’s all it was. That was our model. We didn’t overstate what we were
going to do. It was [Chief Executive’ name] no frill model of care. Staff used to go mad
when I used to say it! Putting down the expectations, you will be chuffed. So, no frill model
of care, think: Aldi, Lidl, looks like it might be good enough for your weekly shop…that’s
what we’re doing. And the model has been tried and shown to work. (ID 1.2)

It could be argued, that the comparison with the supermarket is indicative of how deeply entrenched
market values are with health care construed as part of a ‘high street’ experience. Nonetheless, the
innovation was considered to be clinically sound as well as economically robust and therefore
championed as a model with which to secure the required cost savings.
Some of the examples of innovation the participants mentioned involved modifying existing organisational structures and practices to be leaner, efficient and thus more adaptable to changing conditions in which these organisations operated. In some cases, this involved changing the supply side.

We cannot decide upon the external influences, but it is our choice in terms of how we react to those. [...] I prefer are ones that are actually staff – driven. I look after [...] the estates and so they [staff] have come and spoke to me and said: “you know we currently get our services through the NHS negotiated contract, food and veg and things like that; can we do something locally?” and I said as long as the cost is comparable and we have got some policy measures. So, what they did is [...] they said: we can speak to a local farm that can deliver it cheaper. And actually that’s what they did. They also spoke to big firms [name] that we work with and they said to them: actually we need something a bit different from you [...] so they renegotiated the reduction of cost; and the other thing we have managed to do was we got them to deliver when we needed the food not when it was convenient for them. And so [...] switched off half of our freezers because we were carrying so much food. And that is what the team did and that saved us, I think, £25K of pounds or something like that, which in a £500mln organisation is not actually huge but it is much more important that they did it. So, our Chief Executive went out with a gift voucher that sort of thing, thank you for idea it worked really well. (ID4.3)

In line with assertions that CICs governance provided employees with opportunities to propose changes and innovate, the example illustrated how the managerial innovation was perceived to create value other than just financial both for the company as well as staff simultaneously.

Another example of innovation concerned the change of uniforms to help new staff (TUPE’d from a statutory service) to quickly assimilate within the new organisation. The aim of this relatively simple innovation was to create a distinct identity for all staff in order to foster universal culture and values of the CIC. Despite a series of consultations that took place prior to the implementation of the policy, there were some unintended consequences that emerged as a result, for instance the perceived loss of status associated with a specific colour of the uniform (also see section 6.6 for further discussion).
CICs also explored ways by which to take advantage of commercial opportunities typically through making purchases of dental services, pharmacy, care homes or in one case a garden centre. These initiatives were considered important to ensure CICs diversified their income streams as well as complemented and enhanced the contracted services. For instance, the garden centre was intended to provide additional revenue as well as to offer training and employment facilitates for vulnerable adults with mental health problems.

6.3.2 New approach

A different approach to innovation was offered by a provider of rehabilitation services, in which a hand-washing programme was transformed from a routine scheme into a project that had wider appeal. The programme was developed in addition to the contract and was designed to improve hand hygiene amongst primary school age children. As a result, the organisation developed an educational programme that unlike the existing provision was regarded as fun and age specific. While the CIC believed the scheme was innovative, the idea behind it was not.

There’s not anything new in the message. There is nothing mothers have not taught, or fathers have not taught to their children for the last 100 years or so. What we have done is we did it in a different way that appeals to the audience and makes it fun for them and they may be learning while having some fun. So, we just applied it differently but added in skills and knowledge of nurses and health care assistance with education and combined them in a positive way. (ID3.1)

This particular innovation was simple, cost effective and importantly tailored to the specific needs of the (young) recipients. It was based on the conception of innovation that matched old concepts with new techniques and approaches to make it more relevant to the service users. However, this particular innovation also faced a number of challenges (see section 6.6), which significantly affected CIC’s capacity to scale it up.
The studied CICs implemented innovations by directly responding to the national framework, Commissioning for Quality and Innovation (CQUIN) that the Department of Health introduced in 2009. The CQUIN framework made the proportion of providers’ income conditional on achieving locally agreed outcomes in respect of innovation and quality standards (DH, 2008). Whilst there was a provision for local providers to contribute to setting CQUIN goals, it was ultimately the commissioner who determined what areas should be given priority and focus indicating that CCGs retained significant control of what should be awarded the status of innovation. As reported by one of the CIC:

Service Managers and staff work hard to achieve CQUIN targets set by Commissioners to encourage delivery of effective service provision. (Quality Accounts, Site2: p.31)

It could be argued therefore that the national framework was also a source of innovation as well as an incentive for CIC’s to develop its strategies accordingly. At the same time, ‘clinical commissioners have themselves been incentivised with payment of a Quality Premium on achievement of their quality priorities’ suggesting that this innovation played an important role indirectly influencing the new modes of working (Horrocks et al., 2018:9). The implications of this relationship are briefly discussed in the final section of this chapter that deals with consequences generated by CICs’ innovations.

6.3.3 Lean Structure, New Culture

The lean governing structure of the CIC was considered by participants to be beneficial to fostering innovation. Greater visibility of the senior staff showed to have a positive impact on empowering employees to come up with new and creative ideas of how to change and improve the service.
It [the CIC] has allowed us to be more radical, make bigger decisions […]. Big thing for me looking at other providers is that we have got a very small board, we got small executive team and we have got Chief Executive who is very much people person. His main interest […] is around what is best for people who use our services and how to support staff. I think this is a view that is very much shared across the executive team, so we are out and about. People know who we are. (ID4.4)

At the same time the leaner structure of the CIC was seen to enable managers to use their discretion to implement change quickly. Thus, innovation was seen ‘to free some of my teams to focus on added benefit’. (ID4.3)

However, adopting new approaches and implementing alternative solutions required in some cases making changes to the existing staff roles.

In our wheelchair services rather than recruiting a therapist to enable people to use and adapt to wheelchairs we employed a technician. As it turns out he is a very caring person but actually it’s mechanical work […]. He’d never thought of getting into this role, but we have broadened the idea of whom we’re trying to attract. We couldn’t attract a therapist into the role. (ID6.1)

For this interviewee, the changes needed to be extended beyond the realm of staff. In his next response, the Chief Executive, highlighted how the behaviour of service users also needed to be altered to accommodate and to engage with the emerging new technologies.

Harnessing technology that is out there being used for the whole range of other things that can be used but more importantly used alongside techniques that are probably quite old fashioned in the sense that things like behaviour change. So, my belief is that an awful lot of health care related issues are about behaviour. And those innovation particularly digital innovations can be of use alongside the techniques that are around behaviour change. (ID 6.1)
In this context innovation positively linked to the organisational structure resulted in new opportunities being created for learning. Technology in this respect was facilitating change in practices that were strictly operational as well as contributing to the change in patients’ attitude.

6.4 Social Innovation

As the earlier section illustrated the participants believed their organisations played an important role in generating innovative solutions that led to both more efficient and more responsive ways of delivering health care services. According to the CIC Regulator (2015:32) CICs were:

diversifying in service delivery according to the needs of their community and providing services that have been long missed or which [were] completely innovative as well as contributing financially to local third sector organisations.

This perception reverberated throughout the interviews and dominated much of the literature published by the studied CICs, such as for instance Quality Accounts, Website, newsletters, etc.

[...] we strive to ensure our patients receive high standards of clinical care, delivered by caring, compassionate staff. We believe and commit to Putting the Patient First by making patient safety and experience our number one priority every day, in other words Quality care closer to you. (ID7, Quality Accounts, 2012-13:2)

Our services are delivered with respect and dignity in a professional and personal way by empowering our clients and pushing the boundaries, challenging stigma and exclusion in our communities. (ID8, website)

Our Mission: To make a positive different to peoples’ lives on a daily basis [...] by delivering innovation and developing partnerships [and] by increasing social value. (ID3, Annual Report, 2016-17:10)

These assertions were not necessarily unexpected since all studied CICs were delivering community health, a ‘cradle-to-grave’ service which by definition involves supporting a wide range of people with complex needs both at home and in the local community. However, where CICs sought to make a difference was by developing novel approaches and by actively involving different stakeholders in co-production of their own outcomes.
The proposed meanings of innovation revealed the co-existence of individual, value-laden judgements with practical and organisational considerations. All participants raised the importance of customer and patient-value in driving innovation. One CIC in particular decided to choose innovation as ‘one of our core [organisation] values’ (ID6). In this sense, ‘value’ became germane to social innovation encouraging activities that sought to explore opportunities for change that had a wider social impact.

For a Chief Executive in one of the studied CICs services had to be based on reciprocity rather than charity if these were to create sustainable and social impact. He explained his approach as follows:

You can invite older people and give them free lunch because they are lonely. At the same time if it was me I’d be thinking ‘thank you for giving me free lunch’ but ‘why you’re giving me free lunch and what can I do for you’. So, if you want to give those people lunch and you want them to enjoy the company then give them dignity by taking something from them either as payment or labour or their ideas or at least make them feel that they’re contributing. (ID2.1)

This account was reflected in the wider ethos of the organisation that had won a number of awards and was recognised for its successful approach to mental health. The innovations developed by this CIC aimed to challenge the established attitudes, behaviours and approaches to better reflect values of dignity and fairness.

[Name of the Chief Executive given but not disclosed] has been the biggest national advocate for years around the use of restraint. If you are disturbed, 98% of organisations including Police including the NHS would inflict pain on you to stop you being disturbed. Two percent would use the technique that does not inflict pain, but it has the same effect. It is not a rocket science thing. [Chief Executive] says that it is wrong, and it is. But this is a national model that is out there. (ID2.2)

This example illustrated the important contribution the Chief Executive played in stimulating interest and support for the above noted innovation. More specifically, the account indicated how
the professional background of the Chief Executive, notably in mental health, as well as his personal qualities were influential factors in the decision to take up specific innovations.

I’ve always admired [the Chief Executive], the levels of energy…he just feels he is the CIC [name of the organisation]. You know he is energetic, he is loud, strong leader and these will be big shoes to fill. (ID2.5)

The strong relationship between the leader’s personal qualities and innovation were also reported by other participants at different sites in this study. As ID6.3 noted the ‘[named leader] is a really strong innovator. He is always challenging us to do things in new and different ways’ (ID6.3).

Another participant implied that institutional culture was also an influential factor.

It’s partly culture and it comes down from the top. Our Chief Executive came from the Charity sector. When we initially spun out our Chief Executive moved on quite quickly and at that stage we made decision ‘we don’t want someone from the NHS, we want someone from third sector’. And so, we recruited former Chief Executive of X [name of a large, national charity] who came with that ethos. (ID7.2)

This is in line with the conception of innovation that positively links the role of an entrepreneur or charismatic leader with organisational innovation and change (see chapter three). Much like the examples here, the literature stresses the subjective aspect involved in the process of innovation that typically originates at the individual level but then becomes delivered through the collective effort successfully mobilised and overseen by the leader.

However, the close relationship between a chief executive and an innovation meant that there was a risk that good ideas would be lost or not advanced if he or she left. This was the case in one of the visited CICs, with staff reporting [name of Chief Executive] ‘will be a great loss. […] and I really believe there will be big changes. I feel saddened’. (ID2.5)
The sentiment continued after the appointment was made with one participant suggesting ‘we’ve got a new Chief Executive so now which direction the new one wants to go?’ (ID2.2)

In this example a plan to establish a community supermarket previously supported by the former Chief Executive was abandoned by the new one. While change in government’s priorities for mental health in the Five Year Forward View (2014) was cited as the main reason for this decision, the professional background of the new Chief Executive as a commissioner, could also be considered as a factor. This was in line with the view expressed by another commissioner who acted as a Chair of different CIC. The interviewee suggested that national policy, most notably the devolution of health care budgets and the development of STPs, meant that CICs were under pressure to converge and to become ‘like anybody else but smaller’ (ID1.3).

6.4.1 Service user and Staff-led Innovations

Central to social innovation was the role of stakeholder engagement and participation. Much attention, thus, was on creating novel approaches based on involving service users and staff in co-production and co-design of services. From the research perspective as well as from interviews it was evident that ‘the innovative process [was] not simply a matter of someone coming up with a good idea, putting it in a suggestion box, and the organization implementing it through its normal channels’ rather than as an activity that was driven from the bottom up (Borins, 2002:469).

We are trying to encourage our staff to think out of the box, to think differently about how you can deliver care differently than to what has been done in the past. (ID4.1)

For participants, the CIC model was by virtue of its governance conducive to staff experimenting with new ways of working and introducing changes to improve the delivery of services. Staff were encouraged to make a business case to the management team, who would then make the decision whether or not to support the proposed project and innovation. As a result, a number of schemes were piloted and subsequently implemented including mobile therapy rooms to run outreach
activities for the local community, a garden centre and support programmes to help people with dementia live independent lives. Following the inspection in 2016, CQC reported that the organisation

had embraced the concept of patient involvement to its utmost […].
They also through their X employment scheme work actively to engage patients to maximise their working potential to re-integrate patients with mental health problems back into the local community. (CQC, 2016)

The innovative scheme, however, preceded the establishment of the CIC and according to the manager of the above service it helped the CIC ‘in a massive way because of what we were already doing in the community’ (ID2.4). Significantly, innovative service began while the organisation was still in the NHS and was supported by EU funding to deliver the New Labour agenda on the welfare to work programme. The service led to the transformation of a traditional day service for mental health patients into an alternative model of service provision.

Slowly but surely all of the people who attended day hospital would come in and work in the café. So, this café became really, really popular. […] But the thing was your bacon sandwich was cooked and served by somebody with the mental health problem. So, all of a sudden, the barrier that was once there shifted […]. They were trainee or could be seen as employee of a really nice café that everybody enjoyed going to so attitude on the general hospital site completely changed. (ID2.4)

The case of social innovation was seemingly influenced by external, contextual factors such as New Labour’s programme of reform and reflected a wider political shift towards the model of service delivery that incorporated markets to create new forms of accountability and well-being. In this sense, the transfer of services to the CIC was logical step to integrating economic and social concerns under one organisational roof. In a different CIC, the Chief Executive drew a similar example pointing out the delay in taking up innovation while still in the NHS.

We developed a model of care from within the NHS. In the NHS I was part of the working group that was looking at primary care and mental health and probably was feeding these
ideas, working them out and probably getting them to know more about it probably for about five years before I got anywhere. (ID1.2)

Cases of social innovation were reported to take place across eight studied CICs with both individuals and discrete teams leading the process. It was suggested that although the majority of staff who transferred to CICs under the TUPE arrangements were long-term employees of the NHS with seemingly entrenched public sector culture, innovation was thriving. For instance, a Chief Executive of one of the larger CIC with a workforce close to retiring age, shared an example in which staff was seen to embrace opportunities presented by the CIC model.

They [the staff] said ‘ok, you know we think we could put some leadership into the local health and social care community. We’ve got the experience, we can offer it up and we can change how people are being treated and seen’. So, our Continence Team had done this huge piece of work about reduction of the number of urinary tract infections with people with catheter. They just came to us with the concept: ‘we’d like to do it; can we go ahead and do it’. And we said yes, absolutely fine. (ID4.1)

Likewise, individual members of staff were also developing new and innovative products that championed the traditional ways in which services were delivered. For instance, in one CIC a nurse developed a unique product to address the issue of dehydration amongst older and vulnerable adults.

One of our member of staff, I say the word, invented a feeding cup. We patented that cup [and] got the Intellectual Property Rights. And so, we have got two or three examples like that where the staff thought about doing things differently where it worked on the clinical level. Where I think the innovation does not work is on the financial model going forward. (ID7.2)

The loss of the main contract to deliver community health services, the above CIC decided to create a subsidiary company and provide it with a non-repayable grant of £260,000. The new organisation effectively became a trading arm of the parent company, which was then in charge of developing existing and future innovations. In 2017 the company ceased to exist with the subsidiary company
continuing its operation albeit reporting no trade. It was not possible to determine what happened to the other two innovations, but the example illustrates the difficulty involved in managing innovations under short–term contracts with a potential loss of benefits from the investment made to develop it. It also shows that the difficulty in determining ownership as well as line of accountability in regard to this innovative product once the company folded and the service transferred to the new provider.

In a separate CIC, the staff involvement in implementing an innovative project created a vital sense of ownership with staff using their own initiative to ensure that the project would continue further. From the staff point of view that was their idea. They love it. You know they would say: “we had an idea, we were given permission to go through with it and we did, and it works”. And so much so that we bought those iPads five years ago, so I was thinking they were probably up for renewal, so I asked them. And they said: “do not worry about it we have raised £20K to buy our own, the service had gone out and done all sorts of things to buy new iPads. You give people opportunity to be innovative allow them to do what they want to do. You support them doing it and lo and behold they take control and power and go off and do it. (ID6.1)

Thus, trust and empowerment were positively linked to innovation. Along implementing new products and techniques, CICs were looking for ways by which they could transform the service delivery to better respond to the local needs and wants of communities.

### 6.4.2 Responsive Innovation

The elicited responses revealed that innovation was crucial in changing the way services were delivered making them more responsive to patients’ needs rather than the NHS targets. This thread was common and repeated throughout the interviews and was important to making a clear distinction between the CIC and the traditional NHS service from which CICs emerged. As one interviewee explained:
Somehow NHS got bogged down in standards and targets. And if you got this disease this is what you need to do to cure it, this step, this step...And we stopped listening to people. In fact, I do not think we ever really listened properly to people. And said just because you have got, say a condition, maybe you do not mind living with pins or needles down your left side for the rest of your life; so why if that's the case do you take four tablets a day for it. You know that kind of thing. And yet, I think it is so entrenched in old medical model that is if you have got diabetes, it is A, B, C, D and then we can say we have done our best. But I do not think it is always best because [...] we always forget to say: is that what you want? (ID6.2)

For the participant the services needed to be designed and delivered in such a way as to reflect the views of individuals rather than professionals alone. Undoubtedly, this theme is not new and has been central to health care reforms in the last three decades (see for instance Working for Patients, 1989a). Nonetheless, as the extract below illustrates, the interviewee believed that the shift in the relationship could be achieved through the unique governance of CICs.

I'm in quality and safety so we have got hundreds of rules and regulations and rightly so because it is health, you know, so you can't be messing about; you've got to be doing it in a certain way in some case. But I think the difference [...] I have worked in some massive acute trusts where you just a cog. It is very different here. They are all sat here. People out from services come here for meetings, they see the people who can actually listen and help them make change. (ID6.2)

While this account seems to slightly contradict the previous one, the point made here suggests that the health care delivered by the CIC unlike in the NHS was informed and built around individual patients’ needs. This was because the front-line staff had direct access to the decision makers and thus was able to influence how the care was designed and delivered. In this sense, innovation was linked to the locally co-produced knowledge that was then integrated into the work programme with greater speed and accuracy.

A similar principle was behind the innovative project which was developed by another CIC. Responding to the funded by the Department of Health initiative, ‘NHS Patient Feedback Challenge’, the CIC in partnership with public, private and third sector led the development of a
specialist toolkit that sought to capture quantitative patient feedback ‘metrics’ in the real time. The CIC was able to engage with patients who were previously underrepresented in similar surveys, most notably dementia patients, by applying sector specific qualities and knowledge. The model was seen to successfully enhance the patient experience as well as create opportunities for staff to be involved in championing the new ways the information was gathered. As a result, the principles behind the innovative toolkit were spread across three NHS Trusts and were further embedded in the organisation and within different community health services.

6.5 Technological Innovation and clinical research

Adopting new technology as a way of innovating the service delivery varied across the CICs. While clinical research was not mentioned by every CIC in this study those who did showed a good and well-developed practice in this area despite experiencing notable barriers (see 7.4). Embracing research and technology was considered vital to improving the evidence base and making the delivery of health care targeted and specific to the local communities’ needs rather than nationally set targets. The examples that CICs provided ranged from clinical interventions, electronic data storage, mobile software as well as more traditional research involving clinical trials and academic and organisational collaboration. Below, are a few illustrations of these innovations.

6.5.1 Therapeutic technology

One of the case study CICs specialised in the application of Transcranial Magnetic Stimulation (TMS) to treat depression and low moods. This technology is regarded safe and helpful to improving symptoms without the need for medication or painful intervention. The CIC was the only centre in the country, however, to offer TMS in the way that was ‘targeted’ to the specific needs of individual patients. The service was provided in addition to the main contract and people were able to access the service via GP referral or privately. However, the latter came at the cost of
over £3000 for a course of ten sessions and thus uptake through the private route remained low at the time of interview.

In another example, a Chief Executive considered new technology as essential. According to him, such innovation developed to meet the changing expectations of consumers and patients. In this sense, the technology facilitated unique exchanges that while unconventional resulted in innovations that were responsive to the needs of patients and allowed them self-manage their long-term conditions.

In 10 years’ time most, long-term conditions will be managed through this [participant pointed at the mobile phone]. It’s undoubtedly the case. In fact, people in particular younger people, but also people in their 20s, 30s and 40s with diabetes have created systems that manage their care that are completely unauthorised but they’re sharing it online. So, disruption will change the way we provide care. We can either fight that or we can embrace. So, my view is we embrace it and we allow people to self-manage care in the way that they want to do. (ID6.1)

In this example, innovation was linked to the disruptive influences of new technology that challenged the traditional ways in which health care was delivered and importantly was understood. Innovation, therefore, took place because of the changing conditions that necessitated adjustments that extended beyond the institutional context towards individual behaviours. In this sense, the nature of innovation was two-fold. On one hand it facilitated creation of new knowledge and experience in relation to healthcare, while on the other it emphasised the central role of patients in self-care and management of their own conditions.

6.5.2 Process–focused technology

In some cases, technological innovations were adopted in order to improve the administrative practices of individual CICs. For instance, one CIC planned to introduce a series of cost–effective technological solutions to improve the day to day management of the clinical service.
We have electronic white boards; we don’t have [old] boards with all people’s names. We are looking at phones and apps. We are going to get rid of paper instead of writing a check list we will do it on the iPad. (ID2.7)

At the same time, CICs indicated research readiness with half of the studied CICs forming a part of a research alliance, which was established to support social enterprises delivering health care. The main objectives of the Alliance (2017:1) were identified as follows:

- Construction and delivery of research drawing on our combined patient populations
- Research opportunities that look at the social value of what we do

In addition, the Alliance developed a work plan (see below) to embed research as an important agenda for CICs. The strategy was implicitly intended to raise the awareness of funding public bodies of the considerable potential of the sector to generate and disseminate data, particularly through locally acquired and co-produced knowledge.

- A research governance infrastructure framework for organisations who seek to benefit from involvement in nationally funded NHS research
- Funding of a PhD studentship exploring the unique potential of social enterprises to contribute to the research agenda
- Develop links with the National Institute for Health Research Clinical Research Networks
- Support for member organisations to develop research projects within their service
- Support in responding to requests to conduct research in member organisations from stakeholder groups
- Support in writing papers for publications in peer reviewed literature.

Individually, CICs were undertaking research that was closely related to the main activities delivered as part of their contract. However, the emphasis as mentioned earlier was on focusing on individuals rather than necessarily claimed targets. For instance, according to the CIC’s official website:

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42 One of the studied CICs subsequently resigned.
The research [was] to ensure the services provided by X originate from evidence-based practice and are of the highest quality. [...] Our research aims to improve patient care by gaining better understandings that can positively inform healthcare practice and policies on a wider scale. ID3.Site0

In another CIC, clinical research was embedded alongside the culture in the organisation with the organisations at the time conducting over 40 studies that spanned service areas from the end of life, stroke, falls prevention, physiotherapy to health visiting. However, there were notable difficulties relating to research activity by CICs.

One of the challenges for CICs is that we have not been recognised so those studies have not been recognised at the national level. So, all of our studies at the moment are assigned to the CCG. We have actually just managed to get that changed, which is brilliant for us regionally with the NIHR [National Institute for Health Research]. So, we have got an agreement now from our strategic lead regarding that we can have a seat on the provider research network which is fantastic. (ID5.1)

The other important change that the CIC was able to influence in respect of the research was:

We have just agreed that we will actually now have our own code created. Cannot be nationally but will be regionally and we will be shown in all the reports at the national level for the research that we were undertaking. (ID 5.1)

Closely related to the above examples, was the view that research could play an important part in raising awareness about the benefits of CICs as a new governance model in health care delivery granting them political clout.

Our primary aim is to enhance the reputation of CICs. I think to have more political influence I suppose through the research we do rather than trying to grow finance of the organisation. (ID8.1)

Questions about the nature and different types of innovation aimed to elicit responses that would help make better sense of how this concept was understood and operationalised by the studied CICs. The intention was not to evaluate and measure the effectiveness of the above approaches.
Nonetheless, innovation is consequential. The final section of this chapter provides a brief overview of examples where innovation was considered by participants to generate unintended consequences.

6.6 Unintended consequences of innovation

Although the participants considered innovation important to the operation of CICs some unintended consequences were also noted alongside. The strong emphasis on change generated an expectation of an employee who would be entrepreneurial and engaged in the process of creative thinking. For staff who transferred from the NHS, a context that traditionally provided them with a sense of stability and routine, this proved challenging. Likewise, attempting to implement, on one hand standardised and uniform care, and on the other respond to ‘personalisation’ and empowerment agendas created dilemmas that were not easy to resolve (DH, 2006a). As one Chief Executive recalled:

“There were a group of staff who were saying ‘you know actually I really don’t feel comfortable with this and as soon as I can retire I’ll retire.’ (ID 4.1)

The staff, in the above example, were reacting to an innovative approach that was developed by a group of employees. It was not clear whether it was the actual method that was causing unease to the staff or a change itself which could generated an adverse effect on staff’s well-being.

“I think if you know peoples’ views are that [to retire] then we need to be supportive to them as we want to make sure they feel comfortable. There’s no pressure to retire but if that’s suit you then we can support that. (ID 4.1)

Similarly, in another CIC, an innovation that was introduced by the management of the organisation was met with considerable resistance.

“We decided that, there were a certain type of eye drops that were not requiring a nurse to administer and that a carer could do it or indeed a patient could do it. So, we instructed our nurses that those were the reasons why they should be doing it. And this was a kind of
behavioural change innovation rather than a specific technological innovation and the nurses were very reluctant to do it because it was a job, this is what she did, and the patient and the carer were quite upset about the whole thing. But we were adamant that we could not keep doing these things; we couldn’t keep doing just because the doctor or somebody had said: oh, the nurse would do it. We can’t keep doing it. So, what we encouraged the nurses was either work with the carer or somebody from Age UK or some other voluntary organisation to come around once a day and do that.

Now that requires a completely different mindset that requires you thinking slightly outside the box and going beyond just going in and doing a simple task. It also requires a patient and the carer of the patient to be comfortable about the idea that this can be done. And I got lots of complaints, lots of complaints about one bloody eye drop situation. When we first started doing it, I got nurse writing to me telling me it was wrong thing to do, I got patient and carer writing to me…yeah everybody. (ID6.1)

Innovation no matter how simple has consequences that are not necessarily evenly distributed. It affects different groups in different ways and thus the supposed benefits generated by new models might not be uniformly received, understood and appreciated. In this particular example, innovation was seemingly implemented in the top–down manner implying staff and stakeholders were not involved in the process from the start leading to conflict and resistance at the later stage.

In a separate case, innovation introduced by the CIC caused tensions with another service, which was seemingly delivering a similar provision.

Interestingly we got backlash from school nurses and Public Health. They had a little moan at us, so we sat down with them and said ‘you know, you’re not happy with us doing even though we told them we were doing what we were doing’ […] but they were not very happy with us until we explained what it was…still the same: ‘you’re doing our job’. Yes, we’re doing your job, we’re doing it a little bit better and the outcomes are actually better. (ID3.1)

However, this participant admitted that the outcomes from this innovative project were based on anecdotal evidence. The organisation did not have sufficient level of resources including expertise to adequately evaluate the programme and acknowledged that research was the ‘Achilles hill’ of the organisation. The CIC had however, enlisted the support of volunteers from a local Business School
but their lack of experience and understanding of the wider context of the health care economy proved problematic.

The downside is they were first year students who not really had a grasp of a business so did the cost model but they didn’t include VAT, so they did it at full retail price also they didn’t look what if you buy from a supplier, what reductions you could get. So, they kind of missed out all the pricing. […] ‘So, we have got the ideas, but we do not have the backing. (ID 3.1)

The tension was caused by a relatively straightforward innovation that aimed to integrate staff from two distinct services by adopting a new uniform policy. The staff reported that the change created unintended consequences with elderly patients questioning their professionalism and suitability to perform medical procedures. Likewise, for staff, the innovation resulted in blurring occupational boundaries that reflected their clinical status.

Significantly, the managerial innovations that sought to make necessary savings in the delivery of health care services led to some unintended outcomes as the following examples shows – in contractual terms:

As a result of us being productive and making savings the commissioners of our services can see what our bottom line is. They can see what we make and if they think that we are making extraordinary savings they can try to extract some for themselves. That’s the nature of the business we are in…unfortunately. (ID6.1)

### 6.7 Summary

This chapter has offered an insight into different understandings and applications of innovation obtained through this study. It has illustrated a wide range of approaches adopted by the CICs and distinguished between three broad types of innovation: social, managerial and technological. In discussing the role of innovation, the chapter drew attention to distinct drivers and barriers that impacted CICs. Specifically, it highlighted how some of these innovations had undesirable effects
on certain groups. Likewise, the examples illustrated the close relationship between governance and innovation. Put slightly differently, for participants the unique governance of CICs was innovation and vice versa. The next chapter focuses on the specific characteristics of governance and how it is operationalised in practice. To some extent, topics of engagement, empowerment and responsiveness once more play an important role suggesting the three themes of innovation, governance and accountability are self-reinforcing and continually reproduced features of CICs.

Chapter 7  Organisational Governance

7.1  Introduction

The previous chapter set out the different understandings and approaches to innovation from the empirical research. It found that governance of CICs played an important role in stimulating it and that participants regarded governance as central to creating an environment in which to innovate
and try new approaches to health care delivery. The aim of this chapter then is to appraise some general outcomes observed, discussed and learnt from visiting the case study sites and from the documents obtained during these visits in respect of CICs governance. In doing so, the chapter attempts to answer one of the sub research questions (see introduction, p. 9), namely: **what is the nature of CICs governance and how does it allow for greater autonomy and responsiveness to staff and service users?**

Chapter two and three introduced the concept as a distinct theoretical perspective as well as a practical framework that organisations adopt. In this chapter governance is understood from a narrow perspective of public, corporate and non-profit (community) governance as discussed in chapter three. The detailed governance structure of the studied CICs is included in appendix 6.

### 7.2 Types of governance

The starting point for the discussion is an adapted chart that synthesises different approaches to organisational governance identified in chapter three. Figure 2 shows the distinct models of organisational governance and highlights the form of relationship and intersections between them. The aim here is to draw attention to the hybrid nature of CICs that to a lesser or greater extent display characteristics cognate to these three institutional logics. It also examines the potential areas of challenge and opportunity that stem directly from this mix. For instance, during the site visits the interviewees were asked to locate their organisation according to the sector that they felt the CIC represented, public, corporate (private) and social (voluntary) (see figure 2). The findings from this exercise indicated that only two participants felt that CICs intersected all three sectors despite all of them reporting commercial, community–based and public sector concerns to be present in the CIC.
This chapter has been organised according to the three types of governance shown in Figure 2 to illustrate the embeddness of different logics in the CIC structures and how this is operationalised in practice.

### 7.3 Corporate governance

As the analysis in chapter three illustrated, corporate governance involves practices and processes by which organisations are governed and concerns the distribution of rights and responsibilities amongst the different stakeholders, e.g., board of directors, members and managers. The corporate governance of the CIC is rooted in the company law, which requires the CIC to abide by its rules and regulations and to establish procedures and practices according to that law (see chapter eight). In this way, it offers assurance to the public that corporate governance is achieved and meets the standards expected from internal actors. The CICs’ Articles of Association provide a detailed list of these requirements including a suitably adapted code of compliance with corporate good practice. In addition to this, CICs have to register with the statutory body, the Office of the
The Regulator applies a light touch control over CICs’ governance and ensures these organisations are provided with the necessary guidance and advice. In practice, then, CICs operate within two institutional and regulatory frameworks. As the officer at the Regulator pointed out:

CICs are essentially private companies but with an added advantage of being able to generate social value, too. In terms of governance, the model is subject to greater scrutiny via two-tiered level checks, e.g. from the Companies House and the Regulator. (ID3.Site0)

The fundamental difference, however, is that unlike other limited companies, CICs exist to benefit the community of interest rather than act to benefit shareholders and members alone. As one of the interviewed Chief Executives observed, 'I think, for us it is the sense of working on behalf of the community and … [being] connected with the community in a different way (ID5.2).

But equally having a clear understanding of business purpose and dynamics insofar as the interest of customers is concerned. Therefore, as the interviewee noted:

The big difference is that we've always taken a customer focused approach to our commissioners. (ID5.2)

The governance and accountability of CICs, therefore, relies on the effective management and the involvement of a wide range of stakeholders. Specifically, the board of directors plays an important part in the day-to-day running of the organisation and in ensuring that both the mission statement and the community test is continually met.

We don’t have a large management committee. We have people who keep an eye on the bits of the jigsaw and then we have a structure within the management, which is very much to try and look at the strategic avenues, things that would improve quality of care that we give. (ID.2.2)

An important addition to the corporate governance is the compulsory requirement for companies to notify the Companies House of so-called Person with Significant Control (PSC). The PSC provides information in terms of the control and ownership rights of individuals in the company.
and has been created to improve transparency as well as to help future investors make informed decisions. This law applies to all companies including CICs and failure to comply with this requirement is considered a criminal offence which can result in a fine and/or prison sentence up to two years for the company directors. Consequently, all CICs provided information in this respect with four registering no PSC while 4 others listing between 1 to 4 PSC within the CIC. Two CICs reported to have PSCs with more than 25% but less than 50% of shares and voting rights while the other two stated a significant influence and control held within the organisation. All PSCs were Chief Executives and non-executive directors of the company. The CIC structure is not necessarily a guarantor of democratic and equal rights with a hierarchy as a dominant corporate model.

7.3.1 Organisational hierarchy

The governance of CICs is enshrined in company law that specifies the key responsibilities for company directors. It imposes on them a set of statutory duties and obligations, which need to be met and holds them personally liable (limited liability) for any defaults with a potential risk of prosecution. One of the interviewed directors, explained:

If a CIC runs at a deficit, then the directors can be held to be personally liable for any shortfall by virtue of the provisions of the Insolvency Act 1986. NHS organisations can and do run at a deficit with no personal liability implications for their directors. (ID8.1)

This is particularly challenging for CICs that have taken on the staffing and pension liabilities as a result of TUPE arrangements under the RtR programme, which all of the interviewed CICs did. Moreover, plans to expand a business beyond the strict confines of public sector procurement can also be hampered by the probability of personal liability. Only 2 out of 8 interviewed sites had registered charges (loans) with the Companies House, with site 2 having 4 separate liabilities and site 5 only 1 suggesting that the main source of income came predominantly from existing public sector contracts leading to a high level of dependence on a public procurement.
The organisational governance of CICs involves boards that consist of the Executive and Non-Executive Directors and may include staff/community and service user members. The directors are fiduciaries and are required to perform supervisory and management tasks with due diligence and care. They hold a position of trust and therefore they must avoid any conflict of interest. The day-to-day running of the organisation is necessarily delegated to them and they must ensure that they deliver their responsibilities. In some cases, tasks are delegated further to specific directors who have particular sets of skills and expertise. For example, the financial management and planning might be delegated to Director of Finance whilst clinical governance would be more suited to the Director of Health. In one site (6) the Corporate Governance Manual (ID6, 2016:5) clearly outlined the principle and lines of delegation within the organisation:

The Board is delegated the authority to manage the affairs of [Site 6] and to exercise all of its powers for any purposes connected with the affairs of [Site 6] and to establish requirements in the form of codes of conduct, standing orders, terms of references or otherwise as it thinks fit for the management and governance of [Site 6].

On average, the majority of case study CICs had boards comprising of 7 to 8 directors, except for one that had only 5 active directors, with majority of directors holding executive roles. As expected, the responsibilities of individual directors across all sites included areas of finance, operations, human resources and clinical governance. In Site 2 the board included members who were acting as staff and community members, however, staff representatives were usually invited to attend board of directors’ meetings. In site 8, the Board of Directors was supported by the Board of Trustees with the Chief Executive sitting on both. The board of directors across all eight sites included individuals with a similar range of skills and experience of private, public and third sector. The members’ professional background converged around accounting and finance; business management and commissioning; professional and clinical skills (nurses and doctors) as well as human resources and organisational practice. In some sites, it would appear that considerable weight was given to business and commercial acumen. On the whole, however, there was a suitable match between the individual directors’ level of expertise and the position they held. In general, the
case study CICs appeared successful in attracting the right level of skills and experience. The directors across all sites were remunerated, with non-executive directors receiving an honorarium or consultancy fee in place of salary. In one site, the Chief Executive noted ‘we do pay our non-executives as well; […] it’s a monthly amount. Generally, it works in our favour more than their favour if I’m honest’ (ID3.2).

The terms and conditions varied slightly across the sites but generally followed the rules of company law in respect of directors’ remuneration and the advice of the Regulator, which stated:

| I want CICs to be able to attract high quality wealth creators as directors, paying them reasonable salaries, giving them immense job satisfaction, and the opportunity to put their talents to making profits for the public good. (BIS, 2013) |

It is worth noting, that unlike other limited private companies, CICs are required to disclose information regarding the directors’ pay.

As mentioned the size of boards of the studied CICs was relatively small. There was a noticeable high level of resignations registered with the Companies House since the CICs became live. The total number of notices stood at 74 in total across the eight sites. It is difficult to tell why exactly this was the case and whether or not this was significant but some interviewees’ listed changes in personal circumstances, loss of contracts and reorganisations as one of the potential causes. For instance, in one site (ID2) the changes were mainly due to internal decisions and reflected the emphasis on lean and flexible structure in contrast to public bureaucracies. As one interviewee observed ‘over the year the management structure has been trimmed down massively’ (ID2.2).

For some participants, however, the changes presented a risk and challenge. As the interviewee ID1.3 observed:

She’s moving on…For that type of organisation to keep going it just needs some stability. I’m just a little bit nervous that [gives the name] is going as well from the board. And I’m just thinking [the organisation] is going through the change and we have to make sure that it’s still stable.
This is an interesting observation particularly in respect of proposed understandings of innovation in chapter six where change was positively linked to innovation. In this case, however, the loss of a member was perceived as a potential and unwelcome risk.

In another CIC, a concern was raised about some of the new senior appointments that showed bias towards commercial set of skills and backgrounds. It was felt that such a practice was likely to move attention away from social values towards more commercial goals crowding out the social ethos of the company in the long run. However, the micro changes appeared to have macro foundations resulting from constantly evolving health care markets and competition. For example, most of the case study CICs admitted that whilst reluctant they felt compelled to pursue new strategies that would allow them to generate income to subsidise the shortfall in the value of public sector contracts.

Yes, definitely, we have to. [...] we will end up with people paying privately and people statutory referred. What we've actually said about this is that the principle will be whether you're statutory or privately funded you will not get a different standard of treatment because we can offer the same. I think it's the way the world is. (ID3.1)

In site 6, the participant was positive that a new source of funding would enable the organisation to have greater autonomy over resources and make it more sustainable.

So, from our perspective, what we’ve decided to do, what we’re doing is to create a private company, separate to the CIC that does private business. With that we'll extract considerable we hope income which will then be ploughed back to the CIC because it will be wholly owned company and it'll all go back to CIC which will then go back to community. So we’re finding other ways of supplementing the fact that LA/NHS is cutting. (ID6.1)

Essentially, then, CICs were developing business instruments to ensure their services continue to be delivered by their organisations and as they all pointed out, to the high quality standard. It was not always clear, whether or not these plans had support and input from the wider group of members as some interviewees admitted there was not always a consensus about the future plans.
of the organisation. Likewise, the senior management felt it was their responsibility to protect staff from uncertainties of funding in the future and the insecurity this may cause.

The next section briefly outlines the governance implication for members in the CIC model.

7.3.2 Membership

According to the guidelines on Corporate Governance of CICs, the Office of the Regulator, states that ‘the ultimate control of the CIC and responsibility for major policy and other decisions rests with the members’ (BEIS, 2013:4). The members have statutory rights to call a meeting once a year during which they can exercise their decision-making powers. Specifically, the members can appoint and dismiss the directors, make amendments to the governing and policy documents and agree dividends and other transactions. Essentially than, members are regarded to possess a significant amount of power. In reality, however, most responsibilities and control over the day-to-day management of company is necessarily delegated to the company’s directors. This is not to say that members do not matter rather that the sphere of influence and control may not be as great as the official guidelines suggest. For instance, interviewee ID2.2 implied that whilst it is a popular belief that members have overriding power in the organisation, it is a rather idealised view that does not necessarily work in practice. As they explained:

the beauty of [the CIC] is that they [staff] can vote [the Chief Executive] in and vote him off; the chance of that ever happening is absolutely zilch because if anyone who was ever to put up their hand would know that their future in [the organisation] would be very short. So, it is a bit naïve position. (ID2.2).

Another, participant cautioned that the ownership rights should not be seen as an end in themselves rather than as a condition that needs to be carefully managed to prevent any potential misuse of company’s interests. As they put it:

In my pragmatic way I worked out what we don’t want to do is to let that kind of potential institutional mechanism where it could be a coup where basically I had to spend three years putting so much work into planning to ensure that we do this [spin out] just for somebody
with selfish motives that I don’t agree with [pause] to kind of edge me out and take control as a vehicle for wrong gain. So, there are limits. (ID1.1)

The above points highlight the complexity of relationships that exists in any type of organisation but in particular in the employee owned models and suggests that it is important to consider the both risks and advantages of such systems. According to the study conducted by the Employee Ownership Association over 30% of mangers, who worked in an employee-owned company reported that they were less free to manage and 65% of respondents thought that the model led to the slower decision making (Burns, 2006). However, it is worth noting that 78% of companies thought that the employee-owned status of their organisations was attractive to customers (ibid).

There were notable variations across the sites in terms of practices relating to staff engagement and representation. One of the reasons might be the size of the organisation or the level of experience of individual Chief Executives in that area. For instance, this Chief Executive reflected on their own experience of recruiting the board at the early stage of setting up the CIC. As he put it himself ‘nobody told me how to do that [to recruit the members/board] so I just went and recruited them myself” (ID1.1).

In the discussion in chapter three, it was mentioned that whilst the RtR programme was prescriptive in some areas, it was quite ambiguous in others, suggesting that actors had considerable ‘freedom’ to develop their own individual business proposals. For instance, as the director of one the CICs pointed out:

There were no rules whatsoever…you come from the NHS organisation where there’s rules for everything, everything is tightly scrutinised that sort of thing and you’re moving into somewhere where there were no rules and you think such as Community Interest Company only need Company House who were very kind of…it was very easy to set up the company, £15 and you get it done and the regulation is very light touch, there’s CIC Regulator but [pause]. So, very, very different. (ID4.3)

This account, however, is in line with the advice issued by the Department of Health’s guide to the Right to Provide programme where it stated that ‘there [was] no single correct formula for the
governance of staff–led enterprise’ and it was up to individual organisations to decide on what type of governance practice to adopt, for instance whether to elect the board rather than appoint it (DH, 2011:2).

The lack of understanding and clear guidelines on the part of policy makers but also at the commissioners’ level presented further opportunities and challenges simultaneously. As the interviewee explained:

Also, with the particular type of service that we’re providing something which is a real challenge because the government might have put in the policy but not really understood what that means. So, I spent a lot of my time having to tell somebody that there was a problem and having to work with them to solve that problem. (ID4.3)

In another CIC, the Chief Executive reflected on the journey of the CIC throughout the spinning out process and referred to a lack of clarity and direction.

It was a very challenging time, it was very difficult, and I took on the leadership of the organisations as all of the TCSs were happening. Being part of the PCT there wasn’t much clarity over what the organisation wanted to do in the future. It fell with the previous leadership and it felt that this was very much what the CCG wanted to happen to the provider services. There was no sense of control. I didn’t feel there was a clear strategy. The previous leader had looked at social enterprise and then dismissed it fairly quickly. So when, I came… I wasn’t the Chief Executive before, I hadn’t been a director so when I took on the leadership role, so, it was me coming into a brand new role with an organisation that I didn’t really know the board very well and felt that we had no control’. (ID5.2).

Similar to the previous experience, here as well the Chief Executive played an important part in shaping not only the relationship with the board but also in shaping the future model of service delivery.

So, the first thing to really look at what did the board and the Executive…you know, what did people feel they wanted the future to be. And, we all felt that we we’d been a good arm’s length, if you like, part of the PCT and that we had something to offer, an independent organisation that we wanted to take control. I knew I had an agreement from the board and the senior leaders to try and become an independent organisation. So, when I spoke with the Chief Executive of the PCT, it was really clear that they were not going to let us be a community foundation trust. They felt we were too small and that there was not an option
and that they were going to put our services on to the open market, which they did. And they put them into eight different bundles and I was told that if I wanted to be independent then the services were mine to lose. Go for it or [pause]. But they were going out to the market. (ID 5.2)

This meant that some governance arrangements had to develop rapidly in order to meet the deadline of the RtR or the procurement process, with changes being implemented overtime or rectified in retrospect. However, the responsibility for setting objectives and future strategy for the organisation was commonly formulated by the board and delegated for implementation to the CICs management team. The board also played a role in deciding policy, budgets and procedures ensuring the long-term stability and sustainability of the organisation. These plans typically involved monitoring of performance targets, risk analysis and evaluation of impacts made by the organisation. Moreover, interviewees highlighted the important role of Chief Executives in their organisation in influencing and shaping the process at the time and after CICs where established through the RtR programme. The next section focuses on the nature of leadership and its relationship with the wider philosophy of the organisation.

7.3.3 Leadership & Culture

Essential to the effective governance of CICs was the leadership and culture within the organisation. The board is commonly expected to facilitate the conditions in which leadership, alongside staff and patient engagement generate innovative solutions to health care delivery that lead to service improvements. In all of the case study sites, there was a genuine sense of trust in the ability of the executive team, with the majority of participants feeling positive and confident about the way the organisation was run.

[The Chief Executive] has grown it [the organisation], encouraged, chosen people he believed in and said: come on, go on this journey with me. It’s more than your salary. It’s about success, it’s about achievement, so we strive harder and we achieve greater and you are admired. (ID2.5)
In addition, where participants where directly involved in the delivery of front line services, they felt encouraged to express their views. The idea that their opinions mattered, and they would be listened to was an important and indeed a distinguishing feature of the organisation. It was generally considered that the staff not only knew who the management team was but more importantly that they themselves were known to the senior management. As the chief executive of one of the CICs pointed out ‘personally, I know that I know a lot of individual things about individual people’ (ID3.1).

A number of other examples demonstrate further the emphasis the interviewees placed on the role of the Chief Executive:

I clearly remember when [the CEO] said to me: if I’m not in the meeting, my office door is always open. I have an open door policy – anybody can walk in. (ID2.8) I think the big [thing] for me that really stands out is the approachability of our senior board members, you know, the Chair, the Chief Executive, the Assistant Chief [Executive]. You know, you could easily knock on the door and say: I’ve got a thought, I’ve got an idea and they’ll pull out the chair and say ‘let’s talk about it’ (ID2.5)

During the site visit to one of the sites (ID2), I was able to observe first-hand the interactions amongst staff and senior members of management team. It was noticeable that staff, and in some cases the service users, felt relaxed and were confident to approach the chief executive with various questions. For example, during the tour of one of the acute facilities the member of a domestic team came up to the chief executive to ask for help with trying to arrange a doctor’s appointment for a relative. The request was met with a suitably sympathetic response.

It was also evident that much thought went into the planning and design of facilities from which the services were run so that they were conducive to social interactions. It was interesting to observe the chief executive who during the tour stopped to collect litter or took notes of items that were showing signs of wear and tear and needed replacement. There was a sense of pride and personal connection with the physical space that was also reflected in the behaviour of some staff. Naturally,
it is not possible to generalise or predict from one single case, however, the experience has a
different value insofar as it captures the capacity of organisations to generate soft outcomes that
nevertheless remain difficult to report and measure. One of the key leitmotivs in the narratives
stound CICs is the propensity to affect a culture shift that improves service performance and
achieves greater quality in health care. The examples, in which the change in staff’s thinking led to
innovative solutions has already been discussed in chapter six therefore this section focuses mainly
on change in the organisational context.

7.3.4 Governance and organisational culture

Throughout the interviews, the participants reflected on distinct organisational culture of CICs. For
instance, the director of one of the CIC noted that:

The culture is what makes the difference. The structure of [site 2] is not a huge managerial
bureaucratic structure. The whole beauty of it is that everybody who in [named site] is
prepared and does get involved in front line service level care. If they don’t want to see
service users then they shouldn’t be working…It doesn’t matter if they work in finance or
any part of the service. We expect everyone to be able to communicate and work we think
the culture that delivers good quality care. (ID2.2)

The example directly relates to the earlier discussion whereby visibility and approachability of
management staff created special conditions for engagement and participation. In some instances,
the uniqueness of culture within the CIC was attributed to the personal and professional qualities
of the chief executive. For instance, one interviewee referred to the special nature of leadership in
his organisation:

We’ve got the Chief Executive who is very much a peoples’ person so his main interest […]
is what’s best for people that use our services and how to support staff. (ID4.2)

In a separate interview, this participant explained that the culture in the CIC he worked in came
partly ‘down from the top, our Chief Executive, [who] came from the charity sector […] and he
came with that ethos’ (ID7.1).
The interviewee also acknowledged that the appointment was deliberate and the decision to employ someone from the third sector was made after the resignation of the original chief executive who came through the spin out process. As the interviewee recalled:

> When we initially spun out, we have spun out with the Chief Executive who moved on quite quickly and at that stage we made a decision we didn’t want someone from the NHS and so we recruited former Chief Executive from [named a large national charity]. (ID7.1)

Another understanding of culture change arose from slightly different perspectives that came from adopting the right mind set rather than necessarily the unique model of the CIC itself. As one interviewee relayed

> I think a lot of is about the general attitude of the senior team. So, for example, under the previous Chief Executive on induction they would play a dvd recording of him saying ‘welcome to the organisation, and this is what I believe’ and the rest of it. And so for me when we became our own organisation and they asked ‘when are you coming down to be recorded’, I said: Never. It’s easy enough to slot that into the diary over 12 months when the inductions sessions are. So, for me it’s a mindset change. (ID4.1)

However, the leadership’s expectations of culture and what it should entail had at times negative effects. For instance, one participant noted that at times the implementation of innovative systems might be perceived negatively and be an unpopular development amongst the employees. However, the interviewee argued that the process could not be avoided and had to at times be implemented to address the external pressures from competition in health care markets.

> So, we took over some of the staff there and then we had to get rid of some of the staff and we’ve changed some of the staff’s job, we moved them around. [...] you don’t want to make anybody unemployed or redundant but inevitably people would have to get an understanding that with change comes different jobs and you don’t want different jobs, if you don’t want to be part of that then we’ll have to find something somewhere else. I do believe jobs will change. If we don’t do it Virgin will. (ID6.1)

At the same time, the flexible structure of the CIC was seen to offer managers a greater freedom and discretion to make decisions.
Because we had a freedom to make our own decisions […] we didn’t have to support the bureaucracy of the NHS but we could use our time to reduce our overheads considerably and we made a lot of savings by not having people feeding the machine. Secondly, people could actually focus on adding value as opposed to filling in useless forms; and they are useless. For instance, ERIC that stands for Estates Returns Information Collection. (ID6.2)

ERIC is managed by Health & Social Care Information Centre (HSCIC) and requires all health care providers to report on various aspects associated with equipping the NHS estate, for example food, laundry, car parking facility as well as on non-financial costs such as meeting the carbon reduction targets (NHS Digital, 2017). The HSCIC maintains that the data is essential to ensure that health care is delivered from safe and good quality premises. However, in the publication ‘Challenging Bureaucracy’ (2013), the NHS Confederation found that reports such as ERIC gave no assurance about safe and responsible use of resources and therefore should be abolished. Although, there has been no change in policy regarding this issue, the interviewed CIC decided to discontinue its publication as they felt the type of data they were asked to provide would give a misleading account of the situation. As the interviewee put it:

Nobody came back to me, nobody shouted at me or anything like that but more fundamentally it was that it added no value whatsoever to what they were trying to get? But it was the centre, the NHS Information Centre [now NHS Digital]. It was just pointless, absolutely pointless but it was that. (ID6.2)

For example, during the staff forum meeting, I observed that staff frequently raised the issue of access and availability of parking spaces across the sites. From the discussion, it became apparent that this was an on-going problem, which some staff found very challenging. In some cases, it was reported to significantly affect staff’s capacity to move freely around the sites or to respond quickly to the appointments held in the community. No one really knew who was responsible for dealing with this issue. The problem, however, is much more complicated. Almost all CICs are leaseholders and as such do not have ownership rights to the NHS estate. This significantly affects their ability to resolve matters such as this as remain dependent on the good will, and information of the owner

43 A body that represents all organisations that commission and provide NHS services.
to act. In this respect, the value of data collected under ERIC may be redundant for other reasons entirely, notably that it no longer fits with the changing context of health care provision that is increasingly fragmented and delegated to different providers.

There was also an interesting irony in some of the responses. For example, one interviewee was resistant to accept that the CIC may be regarded as a private business. They felt that such an open admission might be harmful to the public ethos and values of the organisation.

> We’re a proper business but I don’t allow my staff to talk business […] because I think it erodes people [trust]. I think the issue here is first and foremost to serve people and the closer we are to them the better we understand them. (ID2.1)

The last point leads neatly to the next section on non-profit (community) governance, which as it was suggested earlier constitutes an important part of the organisational blend of the CIC model.

### 7.4 Non-profit (community) governance

Community governance reflects a closer association with concepts such as citizenship participation and legitimacy (Newman et al., 2004). It highlights the role of collaboration and decentralisation that necessarily gives way to greater citizen and community empowerment. As indicated in figure 2, non-profit (community) governance is seen to coexist alongside corporate and public sector logics within the CIC model. It provides a common objective to transform the institutional landscape so that it is more responsive to the changing needs and expectations of patients in the increasingly pluralist health care systems. The staff-led, and staff-owned CICs present an interesting example of non-profit (community) governance that is enacted by building ‘more trusting relationships with service users and developing services specifically designed to meet their needs’ and by becoming an independent provider of social goods (DH, 2013). The next section discusses the role of mission statements in embedding the social values of CICs.
The Community Interest statement in the governance of CICs

In order to become a CIC, organisations need to pass a community interest test. This is to ensure that CICs carry out activities that focus on achieving social goals and benefits for the wider community.

The social benefits that the case study CICs included in the CIC 36 and 37 forms was comparable across all sites and as expected related to health and well-being of patients and carers. Two of the CICs entered the same information in their declarations, however, this may be explained by the fact that they were both advised at the early stage of the spin out process by the same law firm. The other common factor in all the forms was a strong emphasis on communities of place rather than interest. For example, in the majority of cases, the locality was used to define the beneficiaries implying that it was important where the patients lived and came from rather than that they were necessarily patients *per se*. The locality played an important role and tended to correspond with the CCG boundaries with one case alluding to 'potential' nation-wide reach. However, most interviewees felt that it was essential for the service to be based in the local area so that decisions could be taken closer to the population it served.

Things happen more quickly than they used to. Things remain local; everything is very much focused on local services for local people. (ID2.6)

Everybody who works here cares for the community; a lot of people come from the community, live within the community they work in. (ID1.3)

For the majority of participants, a locally run, non-profit and responsive service was what distinguished their organisations from both public and private sector. The significance of this type of governance resided in the asserted ability to democratise and legitimise public service provision. One interviewee saw this as being achieved by ‘local services for local people’ (ID2.8). The emphasis on a locally provided public service, however, has been a common theme in many of the recent reforms in the NHS (e.g. STPs, ICSs, devolution etc.), which claimed to liberate the centralised resources in order to make them locally responsive and accountable (DH, 2010a).
The CIC 36 form is considered by the Regulator to represent the company’s mission statement. In essence, the statement declares the organisation’s commitment to social values and states its overall purpose. This message is typically communicated via various outlets including websites, published Quality and Annual Accounts, leaflets and other media. The mission statement is often the most visible and recognisable part of the company’s strategy and in the case of CICs it sets them apart from other for-profit organisation. It can be argued, therefore, that one of the main roles of the mission statement is to inform and create expectations amongst the stakeholders in respect of the organisation’s commitment to meeting its social obligations. In the majority of the studied cases, it was easy to identify from the website what the mission statement and the vision of the organisation were. The statements concerned a range of topics from delivering ‘high quality care’, ‘building resilient communities’, ‘supporting people to be well’ to ‘building healthier communities’ and ‘providing outstanding and empowering services’. For all the case study CICs, the mission statement was utilised as an important tool to establish a market presence and gain a necessary legitimacy and trust as a new alternative provider of health care. However, as one of the interviewees observed, the process was at times more complicated than it was generally appreciated.

Some of new, emerging CICs and new organisational forms they are not doing it with the ethos and the values that we want to put back into our community. They want it [the non-profit model] as a mechanism to win contracts. I suppose if I was really hard on us that’s what we did, that’s exactly what we did in the first place not really understanding what it was or what it was doing but I think we became a lot more comfortable in the shoes of this different model. (ID5.2)

In all of the cases there was a clear effort particularly on the part of the senior management team to establish a unique identity for the organisation. As the discussion around the RtR process highlighted, the initial apprehension and in some cases discontent of staff and local communities, meant that a carefully planned response was required.
7.5 Public Sector Governance

Public sector governance, broadly conceived, refers to the way the state assumes the authority to provide, and as chapter three illustrated, increasingly delegate some of its functions and responsibilities to other non-state actors. Here, the public sector governance refers to the regulatory and statutory practices that CICs incorporate into their operation but also reflects broadly both the origin of the CIC as well as the environment in which it now operates. At the same time, public governance also involves relationships and how these need to be constantly re-evaluated and negotiated. For instance, the commissioning framework under which CICs operate means that to ensure operational sustainability CICs must work within these structures meaning it may not always be possible to be attending to the needs of service users that were not identified by the contract unless CICs could use the surplus achieved from the contract. At the same time, it might be difficult to preserve an autonomous and unique character in light of statutory demands that might require to adopt similar practices and behaviours as a result.

7.5.1 CICs, ethics and public sector ethos

Public sector governance has been considered to have some positive and negative implications for the newly established CICs. On the one hand, it provided new organisations with necessary legitimacy and recognition, on the other it meant that practices had to be aligned with the national commissioning framework, which was not always easy or fully desirable. As one interviewee described it.

I think that the thing that matters most is if the core ethic is right, then you tend to make other decisions right. But then, you get to the contract decision with CCGs and the urge to compromise too far … well it should never override your essential ethics but to get the balance right between that is a difficult one. (ID2.1)

Another interviewee indicated that in the end the ‘resources come with political will within the NHS so when there is political will the resources will follow’ (ID1.2).
CICs sought to adopt approaches that would enable them to meet their social purpose. This tended to take place by aligning their mission statements with the public sector ethos reinforcing the notion of the CIC as a distinct model to a private for-profit company. To this effect, statements such as ‘we build on the best NHS principles’, we ‘build on the successes of the NHS’ were frequently mentioned in the official publicity across all of the studied CICs.

In another interview a participant suggested that CIC governance enabled staff to reconnect with a traditional public sector purpose. As the Chief Executive of a larger CIC observed:

I love Bevan healthcare⁴⁴ cause they’re the ones who used the phrase like getting back to NHS values. I love that. I like that as a kind of concept and it was easy to say to our staff ‘that’s what we’re trying do here guys! (ID2.1)

The interviewee is referring here to the period when the organisation was leaving the NHS amidst much criticisms from the unions and uncertainty amongst the staff. The idea that staff would be able to ‘get back to’ the lost values of the national service, therefore, was important to reassure the staff and the general public that the CIC was not, as it was portrayed by the media, a backdoor privatisation of the NHS. Similarly, another interviewee noted ‘we [CICs] are now more public than the public sector itself or I see us as true NHS and I see the rest as the political straitjacket’ (ID2.2).

In this sense, while there was a clear separation from the private sector by association with the public sector ethos, CICs also ensured that they were not seen as a bureaucratic model associated with the public sector. However, the shared foundations of the NHS also suggest that the new governance and its mechanisms developed if not parallel then alongside the existing cultures and practices.

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⁴⁴ Bevan Healthcare CIC provides NHS general practice services for people who are homeless, refugees, asylum seekers or in unstable accommodation.
7.5.2 Legal and commissioning context

CICs like any other non-state health care provider must register their services with CQC and with Monitor (latterly part of NHS Improvement). They also have a statutory duty to seek quality improvement via a clinical governance framework. Since June 2010 NHS healthcare providers also need to submit an annual report about the quality of their services.

In addition, CICs need to meet their responsibility for service delivery and associated liabilities including employment contracts and TUPE arrangements in accordance with statutory legal requirements. Since leaving the NHS CICs have acquired new businesses, secured new contracts recruited new members as well as TUPE’ed public sector staff from and to another service. All these changes and transformations bring new liabilities and obligations which have to be met and resourced. Together with attending to social objectives and commercial requirements this means that CICs have to constantly try to reconcile these competing demands.

We spend a lot of time justifying and evidencing what we provide […]. We have regular discussions with our commissioners about funding and monies that we get to provide and we provide a lot of services that we are not specifically funded for and again this is because of being creative with the monies that we’ve got. (ID2.8).

One CIC, for instance, had a large portfolio of contracts with a total of 56 services, 14 of them were subsequently sub-contracted. As the interviewee noted this required careful planning and carried a significant level of responsibility and risk but was still the most cost-efficient option.

We’re commissioned by the City to provide care home beds so we have gone out to the market and again as a social enterprise very different relationship with care home market. So again, people were going what is this £50m just being plopped into the middle of this landscape of the city. So, we held couple of engagement events with the care home sector to say, come and speak to us, let us know. For them, it was one size fits all, this and this tariff, actually nothing in between. Whereas we can actually look at this and make changes in a very tailored to individual way. So, we’ve got contracts but we are able to flex when the system was under pressure. But again, different way of engaging with home care market. We have a lot of pharmacies that deliver our smoke cessation contract for us. But actually,
still more cost effective to sub-contract and to build these relationships with the local GPs who deliver on their patch for us. (ID5.1)

While sub-contracting might be a cost–efficient way to deliver health care, it does nevertheless pose questions about accountability. It also raises problems in respect of a social mission of CICs that might not be aligned with that of other partners that deliver services on behalf of the CIC.

The commissioning framework model was frequently cited as a source of problems or a priority that needed to be constantly attended to. For instance, one interviewee, who was the chair of one of the CIC boards mentioned:

‘The most important people they are trying to keep sweet [the management of CIC], sweet is the wrong word, is - the commissioners. And that is all around delivery so that it is about identifying what the commissioners are getting for their investment…and that’s absolutely the key’. (ID1.3)

At the same time, the interviewee noted:

They are a small organisation that has to do exactly the same as big organisation. We talked about whether we should have a governance person, somebody who has ‘clinical’ as part of its job description and it is very, very difficult because you don’t have the infrastructure that a large organisation has got but part of being who you’re – ‘the niceness’, it is about being close to everything. (ID1.3)

In other words, there was a compromise and a trade-off that came with being responsive and CICs had to acknowledge if they were to continue delivering publicly funded health care services. Consequently, commissioners were considered a crucial part in this arrangement, albeit not always welcome to the operation of CICs. One of the studied CICs sought to resolve this tension by defining its approach in the following terms:

Central to our approach is the commitment to work closely with those who commission our services, GPs and clinicians to ensure that we deliver the prescribed outcomes in the communities in which we work. Care, Quality and Cost efficiency are our watchwords and these are reflected in the five elements of our […] care model. (ID1, website)
A different approach was adopted by another CIC that decided to pursue its own ideas and implemented a new model for mental health facilities, which was considered innovative and importantly developed in consultation with service users but nonetheless risked not being commissioned.

We designed a bespoke model with service users; designed to mitigate against all that (10 bed units all that). When we were about a year or maybe six months before we finished, the CQC and the SHA [...] our master, they asked me a couple of questions. One, who gave you permission to do this. And two, why haven't you got seclusion rooms. The seclusion rooms, I’ve spent a lot of time saying [...] there’s no therapy value in them and most people are less safe, and we can have this discussion if you want. And then after a year when it was all safe, a lot of people said: yes we were involved in that design, it’s good isn’t it. (ID2.1).

Admittedly, it is difficult to ascertain if and to what extent risk and own initiative should be taken in health care as well as who should be overseeing this arrangement. In this sense, it might be that it is not the governance that stands in the way of innovation but rather incompatibility with wider policy frameworks. To this effect, a director from another CIC pointed out that whilst CICs were seen as independent businesses they remained locked into a cycle of dependence with the state who continued to be the main funder and regulator of this relationship and who ultimately define the terms and conditions.

The assets that transferred from the PCT to the CIC were the staff, they were the IT assets, they were stock and there was stationery so all the assets you would need to run a business apart from property. Property transferred from PCT to NHS Property Service that in turn was supposed to grant the lease, which equal the length of contract to the provider. (ID7.1)

The governance of CICs, however, was supposed to facilitate a greater engagement with the wider group of stakeholders including patients who would be involved in the design and delivery of services.
7.5.3 Stakeholder Engagement

The case study sites operated varying policy and practice in terms of stakeholder engagement. For instance, a Chief Executive of one of the larger CICs suggested that within their organisation there were a number of ways for staff to get involved.

It all depends how you measure engagement. So, we have governors who you’d be probably say are the most engaged. We have a volunteer force who are staff who do wellbeing in the organisations; actively going out and supporting staff to become active, get fitter. We have staff that regularly attend social event. We have Christmas parties, summer parties, we have charitable events. We have staff who attend that and they’re not the same staff. And we have staff that attend quality awards summit and staff who attends clinical summit. And they’re not the same staff. And then we have staff actively engaged with each other in the teams, with their teams, doing stuff together. And then we have those who do their own thing. For example, a consultant would attend probably the clinical summit and the quality summit because he’d think that the rest of the thing is beneath him. And I don’t have problem with that, and that’s fine. So, I think the staff finds different ways of engaging. And, of course we hold workshops, which are specific like for managers and the rest of it, we have a pretty good take up. One size doesn’t fit all. (ID6.1)

Significantly, for this interviewee the engagement represented an essential part of the CIC.

And we don’t have a choice but to engage them. That’s our raison d'etre. So, some organisations like NHS bodies will engage them by having an event once a year, twice a year. We almost have one every bloody month! (ID6.1)

However, despite variety and frequency of opportunities available to staff there was also a sense of disconnect between those who worked in the community and those who were based in the main office in administrative and managerial roles. As another interviewee observed, ‘there definitely is ‘them’ and ‘us’, with –‘you in your ivory tower’, etc. […] I think it always will be’ (ID6.2).

The availability and access to information about potential engagement opportunities for other stakeholders rather than members of the organisations varied from site to site. For instance, two CICs (ID1 & ID3) did not provide any information on their website regarding possible engagement or ways by which service users could become involved in the design of the service. However, ID3 did refer to its twitter account as a main source of communication. Given that the service was
providing care homes and nurse-led units for elderly and vulnerable patients, it was not quite clear how many of them would be regular users of social media. Nonetheless, it is possible that the advice was aimed at a wider group including carers. Alternatively, one CIC offered easy to find information on its website including times, dates and venues when different events and meeting were taking place. At the same time, the CIC (ID2) provided copies of minutes and a named contact person who would provide further support and information. In addition, this CIC provide an interactive ‘social’ diary with a list community events taking place in the area. Admittedly, this was the only CIC that I visited, who had service users present in the main building of the office. In another sites (ID8 and ID6), while the information was listed on the website, the onus remained on a service user, prospective partner, volunteer and a customer (ID6) to get in touch. For instance, one CIC (ID8) encouraged ‘don’t wait for us to contact you […] please get in touch’ (ID8) while the other suggested ‘if you would be interested in taking part or would like further information please contact our customer service team’ (ID8). Other examples included a list with a brief description of the two main activates, most notably patients experience groups and member panels. While the first was a regular activity that offered an opportunity to meet and exchange ideas the latter did not have any official assemblies and thus members where instead encouraged ‘to take part in surveys, consultations and meetings to help develop services’ (ID5). All CICs used patient feedback and staff surveys to demonstrate engagement and show levels of satisfaction with their services. These mechanisms were popular across the eight CICs with outcomes reported in the official publicity, Annual and Quality Accounts. It was not possible to determine if all of the mentioned by CICs fora and meetings were well attended but when asked participants suggested that there was still room for improvements. For instance, a chair of one of the CIC (ID1.3) suggested that the organisation could ‘do a little bit more’ of patients’ engagement. The answer to this might be that social media and reliance on social media is not necessarily conducive to engaging and capturing different groups’ attention, especially those classed as ‘hard to
reach’. The organisational capacity of CICs may also present challenges as highlighted by the interviewee.

Having [large number] of staff and across [large number] odd bases and different territories, geographies…it’s really difficult and it is art to trying keep those folks engaged. (ID5.1)

At the same time the assumption that people want to be engaged and via conventional methods, most notably meetings might be built on a false premise and thus requiring re-evaluation. The last point to make is that apart from one of the visited CICs, all non-clinical sites where designed on the call-centre basis which again might not be helpful to encouraging people to visit or get involved.

7.6 Summary

In this chapter, three models of governance, corporate, non-profit and public where proposed as a useful framework to organise and analyse the material obtained from interviews, documents and observations within this research. Specifically, the chapter focused attention on different aspects of CIC governance and how these enabled CICs to provide health care in a more responsive, flexible and innovative way. At the same time, the chapter illustrated how these different institutional logics created specific demands that were not easy to reconcile. The chapter suggested that while hybridisation is a useful concept that can help to make sense of the increasingly blurred health care arrangements in the NHS, it is not something that can be in practice easily delivered. Moreover, system of mixed logics has consequences not only on the governance of health care delivery but importantly the accountability. The next chapter, therefore, focuses on how CICs ensure they are accountable to different groups of stakeholders.
Chapter 8  Accountability

8.1  Introduction

This chapter represents the final segment of a three-fold empirical analysis of CICs. Like chapters six and seven on innovation and governance, this chapter seeks to respond to a specific research question, namely what are the mechanisms of accountability in CICs? In searching for an
answer, the chapter draws on data from interviews as well as documents to illustrate a wide range of approaches and mechanisms adopted by CICs.

As chapter three illustrated because CICs embody aspects of public, private and third sector institutional logics accountability is contested. The concept is understood to entail responses to the key questions: accountability to whom, what and how. The first, to whom? refers to the loci of accountability, for instance the board of directors, members and commissioners. The second, what for? relates to the CICs social mission, which is closely linked to the governance. While the latter, how? concerns specific procedures and mechanisms that ensure compliance.

The chapter is organised according to this broad classification. However, before it proceeds the chapter briefly reflects on some important influences that participants mentioned in relation to accountability that could not be easily ascribed to any of the above categories but were nonetheless considered relevant to the discussion.

8.2 Accountability versus Autonomy

During the initial phase of the spin out, the staff appeared to be attracted to the idea of organisational autonomy and independence. As one interviewee commented:

The health care spin-outs that spun out to be social enterprises that I know [...] the thing that was interesting to them was independence, freedom, flexibility...those kinds of words. (ID0, Site0)

The interviewee suggested that it was not until Francis Maud’s mutualisation agenda (see chapter four) that succeeded the RtR programme that terms such as mutuality, collective and accountability began to enter the wider policy narrative. Other forms for social enterprises, such as Industrial and Provident Societies (IPS) were not actively promoted even though they did represent a close fit with the narrative on accountability and staff engagement. As one interviewee observed:
The vast majority chose CICs I think because they thought that societies were probably complicated and old fashioned but there are lots of reasons why societies have become more interesting over the past 4-5 years around things like community share, issues around governance, accountability and transparency. (ID0, Site0)

Subsequently, as figure 3. shows, the first wave of spin outs in the NHS largely adopted a CIC structure with only four deciding to adopt the IPS and the conventional charity model respectively.

**Figure 3. Breakdown of spin outs by the legal structure**

<table>
<thead>
<tr>
<th>Legal Structure</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity</td>
<td>1</td>
</tr>
<tr>
<td>IPS</td>
<td>2</td>
</tr>
<tr>
<td>CICs</td>
<td>40</td>
</tr>
<tr>
<td>Dissolved: charity</td>
<td>1</td>
</tr>
</tbody>
</table>

These findings resonate with another view whereby new spin outs were not necessarily offered a choice, as noted by the participant, ‘I find it really difficult when we were pushed down that route [the adoption of the CIC model] when we come out of the NHS’ (ID4.4).

At the same time, a different interviewee observed that adopting the social enterprise and the CIC model more specifically was considered to represent the ‘best’ option available:

There were probably three messages that came out [referring to the consultation proceeding the spin out process]. First one, was we don’t want companies such as Virgin, Bupa or anyone else coming to take us over. The second was, certainly from our […] community services that they didn’t want to be, I think the phrase used at the time was ‘to be taken over by the Acute Trust’ because they saw that as an opportunity for asset stripping potentially to take place. And I think the other option of becoming social enterprise was probably the best of the group of worst deals to be honest with you. In that it was if we’re going to do anything we’ll go for this route because at least it’ll give us a bit of a say in our own destiny. And this is how we led the process. And our commitment to staff, our ongoing
commitment is actually you’ll have an opportunity to shape the delivery of services. But it was very much probably the lesser of the group of evils. (ID4.1)

This led some participants to question the real motivation behind the programme suggesting that the drivers for change were implicitly linked to advancing a specific political agenda of which accountability was just one of many facets.

Politicians can be your best friend one day and your worst enemy the next. I probably didn’t expect a huge amount of support from anywhere, anyway, but I think […] some spinouts actually thought that politicians would help them on the way. I didn’t expect that. I expected to be against the grain, really. (ID2.1)

On the other hand, a different participant pointed out that the changing landscape in health care meant different policy windows (Kingdon, 1995, see chapter four, section 4.3) were constantly being opened up facilitating the development of new initiatives before the existing ones had time to establish themselves. In such an environment it was difficult to implement practices that would ensure greater accountability as well as measures to evaluate the effectiveness of these new mechanisms.

When I look at new models emerging within STPs […] suddenly [CICs] are getting forgotten politically along the line. We’re all doing this great work, we’re doing well but where’s the support? We had Norman Lamb and we had all these people and things changed and suddenly what you see is […] these STPs. (ID5.2)

This assertion echoes Coleman’s (2017) observation of new models of care, which were introduced at considerable pace that did not allow time for reflection or for lessons to be drawn from the ‘immediate past’.

Underlying these responses was the sense that while the rhetoric on staff engagement and greater accountability to service users was strong, the process was fundamentally led from the centre and in a top down manner. For instance, the implementation of the RtR was in places determined by idiosyncratic and subjective considerations raising a question about the expediency of concepts such as accountability and staff freedoms under which the scheme was delivered.
Generally speaking PCTs and health spin-outs came into the CIC [model] especially in the South West. I think what you find is X who was then the Chair of the Strategic Health Authority led on this and that’s why we have a cluster of them in the South West. (ID7.2)

A similar observation was made during a different interview where a participant commented on how leaders of new CICs were recruited into the roles.

A lot of the spin-outs are in the South West. It was almost unintended, something to do with the leadership of the South West Strategic Health Authority. When the six or seven big ones spun out, they were recruiting board members and leadership through the appointment commission. I think that’s what it was called. They insisted on these interviews, that was sort of mass recruitment process. [Pause]

And it was complete opposite of what [we] and others saw as Right to Request agenda; of the team of people saying we want to do this differently. The ‘we’ was kind of cut off. (ID0, Site0)

In this sense, CICs might be seen as a symptom of the wider trend in public sector reforms rather than necessarily a solution or as some policy entrepreneurs proposed a social movement, which sought to rectify the unresponsiveness of the public and the inequity of the market (see chapter four).

In practice, the central principles of the RtR programme were seemingly overlooked highlighting the discrepancy between the policy narrative and its implementation,

Because of that… it’s another example of how [CICs] were not necessarily led by one leader who [span out] wanted to take this appointment. They were led by someone who happened to be appointed following the process. (ID0, Site0)

Despite, the provision in the Articles of Association that gave members (staff with voting rights) a mandate to elect a new Chief Executive, all sites but two decided to retain the same person who was in charge of the spin out process.

While the motivation for transforming the public health care delivery might have political and economic roots, the interviewed CICs by virtue of the model adopted a wide range of approaches
and mechanisms with which to safeguard and ensure increased accountability. The next section focuses on different groups to which CICs were accountable to.

8.3 Accountability to whom?

The dual purpose of CICs means that the organisations need to balance the demands arising from corporate governance with those of meeting a wider community benefit. Boards need to have well developed strategies and plans that enhance both aims simultaneously. To do this they need to build effective relationships with the organisations as well as a wide range of stakeholders.

8.3.1 Boards

The accounts of how Boards performed the roles varied across the sites. In some cases, past experience played an important role in influencing and shaping how the structures and relationships developed. As the Chief Executive of a small CIC recalled:

I didn’t have any Board experience to start with. The Board [under the former structure] was part and parcel of window dressing where they went through the motions. […] A lot of times you’d be able to work out that the positions have been agreed prior to the Board meeting and we were allowed to influence, you know, minor issues. So, we don’t run like that. At the Board we have a proper talk through, a proper debate. I’d say like a professional, corporate […] presenting governance reports, clinical governance, and organisational governance. (ID1.1)

It is possible to suggest that the performance of the CIC’s Board, at least in this case, emanated not so much from the governance itself but rather from the subjective experience of the executive member who was then able to influence the conduct of the meetings once in a position of authority. In another example, the Board was deemed not as a static model of good governance but as a complex and evolving process that involved challenge (so-called critical friend), and which over time led to better outcomes and relationships.

We’ve worked very hard with our Board to get to the point where I think there’s really mutual, beneficial relationship if you like. [Initially] neither of us knew what actual roles
were really. So, over the years we’ve now come to the point where we work very closely together, to the point where there’s governor on the Board so it’s…I truly feel that they listened to what people were telling them in the organisation. (ID6.2)

For the CIC Regulator, this was an important area that boards were encouraged to develop in order to build trust, confidence and become more transparent, open and accountable to staff, commissioners and other stakeholders.

‘The idea was to give staff a status and a voice and enshrined it in the constitution, so it can be used but not do anything that unhinge or destabilises the situation’. (ID1.1)

Boards were also expected to promote and protect the social mission of the organisation and as one Chief Executive noted to ‘hold us to account [and] ask difficult questions… so that we don’t sit on our won laurels and are just happy with what we do’ (ID1.1).

Likewise, there was a strong sense that Boards should exercise powers and discretion in order to protect staff and service users and to act in their best interest. For example, at the time of the site visits, two CICs were in dispute with local commissioners, which was likely to result in the loss of the contract. The members of the executive team decided that the issue should not be subject of discussion in the staff open forum until it was absolutely necessary.

We don’t want them unduly worried. At the same time, we have to balance this; we’ve got to tell them, we have to be open, transparent with them so what’ve done is we’ve been open and transparent about finances but the day to day firefighting if I can put it that way we reserve to the Board. […] We do have transparency there but where we don’t involve members are the nitty-gritty of the negotiation with for example, commissioners. (ID7.2)

Likewise, in another site the interviewee expressed a similar attitude suggesting ‘we don’t want our service users to have this awareness. They don’t need to have that awareness. Sadly, of late it became a bit more public’ (ID2.8).

Whether or not the financial challenges should render the right for the organisation to withhold the information is not an easy question to answer. The approach might be viewed as necessary to
achieve strategic and operational goals particularly at the time of organisational instability. At the same time, it raises questions of the quality and meaningfulness of interactions suggesting that the process of deliberation is limited to items that are set and controlled by the management subsequently lacking transparency. The dilemma necessarily draws attention to the second topic in relation to governance practice that is the role of membership in CICs.

8.3.2 Members

As chapter seven indicated membership in CICs was conditional and based on entitlement notably by a proxy of either being a full-time member of staff, a £1 shareholder or an employee on a permanent contract. To become a member those who were eligible to apply had to complete an application form and have it approved by a Director or other authorised by the Articles of Association person. Essentially, the membership in CICs was defined by a formal set of rules meaning it was granted rather than assumed.

Unless these articles otherwise provide, every person who wishes to become a member shall deliver to the Company an application for membership in such form (and containing such information) as the Director require and executed by him or her.

And:

No person shall be admitted a Member of the Company unless he or she is approved by Directors.

In site two, the membership appeared to be more inclusive and focused on achieving accountability via the increased involvement of community and staff members. The organisation claimed to be unique insofar as its membership was open to all service users and carers and based on equal rights to those of staff. There were four community members who sat on the CIC’s Membership Board with one of them sitting on the CIC Board. Recently, the CIC amended its Articles of Association (ID2, 2018) by stipulating that three seats would be reserved for service users who had experience of secondary mental health services or existing carers of mental health services. The members were invited to vote for instance on how the surplus should be allocated and encouraged to provide
feedback about the service directly to the senior management team or via representatives. Furthermore, the organisation was keen to ensure that membership in the organisation remained active and was meaningful.

It does actually provide some level of ownership to the people and we don’t just have it like this. We keep reviewing it, we go back looking to where the membership has become a bit passive, finding out if there is anything that has been less attractive to them, if circumstances have changed. And we actually invite them to consider withdrawing the membership if they are no longer actively looking into that. (ID2.3)

Likewise, there were four elected staff representatives, the highest number amongst all the case study CICs, who were responsible for ensuring that the voice of staff members was heard and listened to. However, despite significant provision for staff to get involved, some did not take up these opportunities.

You give people a chance to vote. You give people a chance to have their say, you give people a chance to shape the service – it’s so frustrating, they just want to come and go. (ID2.5)

And while commenting on experience of being the first serving staff rep, the interviewee noted.

I’m gonna offer people this [reference to £1 share] and I’m going to give them this incentive and you think WHAT? What’ up with people, why aren’t they excited, and they are not! (ID2.5)

In another site, the interviewee highlighted the importance of the employee led model in ensuring not only accountability to staff and users but crucially improving sustainability of the organisation.

For me this has always been the most important in order to guarantee our survival. We need to get the staff to feel that and use their own influence or care for the organisation. If only we can do that we’ll be successful. (ID4.3)

There was a degree of frustration noted during the interview that the existing structures of staff engagement have not developed as well as hoped for.
One of my big frustrations is that we haven’t developed enough. So [staff forum] is an example where it’s been very difficult because I can’t go along to them and say you need to develop the membership structure to understand what your voting rights are because that’s not employee-led that’s management-led and if they don’t think that’s important why am I saying it to them. (ID4.3)

A similar observation was made during a separate interview where participant commented that holding a £1 share did not automatically mean that staff felt more compelled to be involved in the organisation.

Symbolically £1 represents something important. Sometimes staff had to be reminded of this. So, I think ‘do you really want to have a staff rep on the board?’ and I’d put out this to them and just think so the opportunities are there. It’s not for me to force it. But think what you could lose for yourself and your colleagues in the future if you let go of that. It’s your constitutional right to express your opinion; you may want to articulate your voice. […] Amazingly not everyone signs up for it […] but I’m absolutely gobsmacked that it was like this. It’s open and all you have to do is fill in the form. (ID1.2)

It is difficult to tell which factor was to blame for the apparent lack of enthusiasm. It is possible to speculate that the process which required a staff to fill an application form acted as a deterrent. It might also be that the right culture has not had sufficient time to develop. However, during a staff forum at another site it was suggested that it was not the unwillingness of staff to participate rather that they were not always able to get permission from senior managers to attend meetings. Some pointed out that even when they were released from duties they had to make up for the lost time.

There was also some scepticism as to what extent decisions could be influenced by staff despite granting them certain constitutional rights. As chapter seven already demonstrated the ability to vote the Chief Executive in or off was regarded as ‘a bit naïve’ (ID2.2). Making such a provision in the governing document seemed to flow from the assumption that staff feel safe and empowered by the fact that they can get rid of the leader should they prove unsuitable. At the same time, the leader is afforded power and support by being elected by a popular vote rather than appointed in office.
8.3.3 Other stakeholders

In the official guidelines for setting up CICs, the Regulator (2016:3) advised that ‘the involvement of stakeholders should [therefore] be integrated in the corporate governance of the CIC’. Much of the debate on the role of CICs in the NHS has been focused on the capacity of these organisations to improve accountability via wider stakeholder involvement. The ‘Enterprise for Communities: Proposals for a Community Interest Company’ promoted a view that CICs involved in the delivery of health care services would need to have a strong stakeholder engagement in the governance of the organisation to meet requirements for democratic accountability (DTI, 2003a). The assumption behind this proposal was that firstly, staff and the wider community would innately want to be involved in the design and running of the organisations and secondly, that as long there was a wider stakeholder engagement the obligation towards public accountability would be fulfilled and expanded. However, as the examples above illustrated in practice the results were mixed. Despite the government’s efforts to provide legal and financial assistance to new CICs many organisations struggled to understand what the new governance structure required them to do. The lack of clarity around the legal form was evident in some of the interview responses but also in the reading of the official documents of the interviewed CICs particularly from the early days of the spin-out process.

It’s almost impossible if you don’t come from company law background to understand what you are doing. We couldn’t get the same benefits if we were limited by guarantee. I can’t remember what they were now. […] We didn’t know what we were doing, we didn’t even issue shares even though this was in the constitution. (ID1.1)

In many cases the implementation of various standards of accountability was part of the learning process that involved alignment and adaptation with previous institutional logics and cultures. In this sense, accountability, as Newman (2004) proposes, concerned social and cultural practice that took place within formal institutional structures and power relations. In the section of CIC34 document that asks organisations to provide information on consultation with stakeholders, CICs reported the following stakeholder groups.
The organisations stakeholders are many, including: our Staff Members (shareholders) and Community Members […], Staff, Service Users and Carers who are not Members of the organisations, the general public, our main funders […], NHS England, NHS Property Services Limited/Department of Health […]. (CIC34, ID2, 2016)

We have a wide variety of Stakeholders, including staff (members), customers (patients) and our commissioners (including GPs). (CIC34, ID6, 2016)

The Company’s stakeholders are service users and carers, our commissioners and community beneficiaries. (CIC34, ID8, 2016)

Apart from the already mentioned activities, the studied CICs ensured that they were accountable to these groups by conducting regular staff surveys, patient surveys and the NHS Friends and Family Test. The results were published in the CICs’ Annual Accounts as well as in other official publicity including websites.

8.3.4 Commissioners & other public bodies

As indicated above, commissioners were considered an important group to whom CICs were accountable. For instance, one interviewee, chair of one of the CICs board mentioned:

The most important people they are trying to keep sweet [the management of CIC], sweet is the wrong word, is - the commissioners. And that is all around delivery so that it is about identifying what the commissioners are getting for their investment…and that’s absolutely the key. (ID1.3)

For all of the studied CICs the NHS contract was the substantial element of their revenue and thus a good relationship with commissioners was deemed important. The approach was reflected in the published Annual Reports with CICs providing the following statements:

The group’s primary income stream is under block contract with [name given] CCG. [name of the CIC] will continue to work with its commissioners and other stakeholders to develop its services in line with the national direction for NHS funded healthcare in the future. (ID4, Annual Accounts 2016, p.5)

Our strategic objectives are […] to deliver services that are responsive to the needs of our local communities and commissioners. (ID5, Quality Accounts, 2016, p.7)
In this sense CICs were accountable to commissioners for meeting contractual obligations including agreed performance targets and achieving required savings. In practice, however, being accountable and successful was not enough to ensure that the contract would be awarded in the future.

[name given] Teaching hospitals gave us notice on our contracts, even though they were the ones that made us happen. They took the contracts back in-house and made the provisions for the services to be provided in-house. (ID3.2)

Another interviewee referred to professional jealousy that played a role in shaping the relationship between the purchaser and the provider. In this context, achieving accountability was considered a mandatory obligation rather than part of a collaborative process.

It’s this human factor of envy. We are successful, and the CCG is a failure. They may not like it, but it is true. They fail on many of the targets, etc, etc. When we were with them we were less successful, and it probably just rubs in how lazy you they were as mangers and that they probably shouldn’t be running the services. There is a risk. And I actually don’t say things like this in this way to them in case you’re wondering if it’s me who gets up their nose. (ID2.1)

It was evident that the relationship was not based on mutual respect and trust but rather shaped by historical resentment and rivalry. This begs the question to what extent accountability should serve as a hallmark of quality to be aspired to if in achieving one sets of targets (information relating to performance targets) it invalidates the others, e.g. competition rather than collaboration.

Like any other independent provider in the NHS CICs also have a statutory duty to ensure accountability to regulators (CQC), above mentioned commissioners, and other public scrutiny bodies such as Well Being Boards, Scrutiny Committees and Health Watch. As one of the CICs stated:

Governance is about making sure that we meet all our obligations as an organisation, both legally and to our service users. Our governance team work with specific agencies, such as the Care Quality Commission to monitor and improve standards of patient care. (ID8, website)
CICs as private companies need to ensure they are accountable to the Companies House as well as to the CIC Regulator.

8.3.5 The CIC Regulator

The scrutiny of CICs resides with the Office of the Community Interest Company Regulator. The CIC Regulator is an independent office holder based in the Department for Business, Energy and Industrial Strategy (BEIS), and it is responsible for ensuring that CICs comply with the legislation and thus can continue to function under the CIC brand. The CIC Regulator is also ‘committed to providing informed, impartial and fair regulatory decisions and ‘light touch regulation’ (CIC Regulator, 2007:6). The light touch regulation has been based on the UK government best practice guidelines and is defined by five principles that were set out by the Better Regulation Task Force: proportionality, accountability, consistency, transparency and targeted (BRTF, 2005)

The expansion of CICs into public sector provision does raise the question of whether the investigative powers vested in the Regulator are sufficiently robust. A staff from the office of the CIC Regulator remarked:

Such action [intervention] was rarely necessary as the effective regulation and inspection at the initial stage of registration helped to deal with issues early on. […] the model [was] subject to greater scrutiny via two-tiered level checks, e.g. from the Companies House and the Regulator. In addition, all CICs [were] required to file their accounts on public records, which in itself [was] a type of self-governance check. (ID3, Site01)

In addition, to assisting new applicants and existing CICs, the CIC Regulator issued detailed guidance regarding the formation and operation of CICs. The guide published on the official website of the CIC Regulator consists of 11 chapters and 3 appendices. A simple word search of key terms such as ‘accountability’ or ‘accountable’ generated only 5 finds. In contrast ‘accounting’, ‘accountancy’, ‘accountant’ produced 72 entries. It could be argued, therefore, that despite the new provision for the community test and stakeholder engagement the traditional conception of accountability interlinked to accounting practices (see chapter three) was still the dominant
framework through which to scrutinise and assess the role of CICs. Moreover, the studied CICs as mentioned above were subject to further regulatory practices notably via contracts and compliance with clinical governance (CQC, NHS Improvement, commissioners) suggesting continued expansion and embeddness of traditional, auditing mechanisms into the social realm of non-profit sector. At the same time, the narrative of light touch regulation, consistent with NPM anti-hierarchical, rule-based principle, created an impression that CICs were operating in a reformed regulatory terrain mediated by social and ethical considerations.

8.4 Accountability for what?

In the ‘Enterprise for Communities: Proposal for a Community Interest Company’ the government expressed the intention to create a transparent, flexible and easily recognised model that would allow organisations to ‘thrive and grow, while being accountable to local communities’ (DTI, 2003:7). Consequently, the CIC model was created by using the template of private company law and by incorporating additional features notably community purpose and constraint on profit distribution, which together ensured joint accountability for a dual purpose of its operation. For instance, as one of the studied CICs noted in its Annual Accounts (ID5, 2016:7):

<table>
<thead>
<tr>
<th>As a CIC we must remain financially sustainable and deliver year-on-year surpluses as we commit to reinvest these through the enhancement of existing services, the creation of new services, investment in partnerships or donations to charities or other organisations that are supporting our corporate objectives. To ensure we offer the greatest benefit we:</th>
</tr>
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<tbody>
<tr>
<td>Engage with staff to scope the potential for service investment and new services based on their expert knowledge of the services and the communities in which they work.</td>
</tr>
<tr>
<td>Involve the local community through established engagement groups, local partnerships and discussion with other third sector organisations.</td>
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</table>

These mechanisms constitute a trend in company law whereby the advancement of shareholder value appears to be enhanced by stakeholder benefit (Deakin, 2005). Thus, the asserted innovation of the CIC necessarily resides in its obligations to attend to economic and social concerns
simultaneously. Under this framework, accountability and legitimacy of the organisation is achieved in three main ways: the community test; constraints on profit distribution; and contractual obligation.

8.4.1 Community test and social mission

Organisations wishing to register as a CIC are required to meet the ‘community test’. The test ensures that the organisation will work to benefit a community and as long as a reasonable person considers the proposed activities to be of such value the criteria is successfully met (BEIS, 2016b). The light touch regulation of CICs means that the ‘test’ is necessarily simple with a broad range of possible interpretations of what community benefit stands for. Likewise, the term reasonable is also ambiguous and open to interpretation. In the case of the studied CICs the community benefit was relatively easy to establish as these organisations were already involved in delivering health care services and therefore promoted wider community interest before they spun out of the NHS. In this sense, the ability to meet the community test was already assumed from the previous position in the service delivery rather than requiring verification. As noted by one of the CICs:

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We have been providing high-quality, effective and safe services for many years, prior to our birth as a stand-alone Community Interest Company. (ID6, website)
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Critics argued, therefore, that the role of a new provider particularly in relation to the so-called ‘community benefit’ was unnecessarily duplicating the already existing commitment of the comprehensive national health service, which was established to improve physical and mental health of all people in England and Wales (Whitefield, 2013). Likewise, some of the staff that transferred to the CICs appeared uncertain of what the added value in respect of community benefit would look like. As one interviewee explained:

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We encourage people to put back something to the community even more so than they do through the day job, which is something that I think we also overlook. People don’t recognise that the day job already adds something to the community. They think they have
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to do something additional, amazing to have some influence in the community and actually they are already doing it. (ID6.3)

Accordingly, the CIC36 form, which CICs had to submit at the time of their formation, defined the beneficiaries of proposed services as ‘the users of health services, local population, any person wishing or needing to access health, the local community, carers and finally all citizens […] as identified and commissioned’ for by the CCGs.

Thus, both activities as well as the community came already predefined and closely linked to the specific health and social care concerns and conditions that these organisations were contracted to address albeit in an innovative way.

The delivery of services is so closely linked to the commissioning intentions of the commissioners [that] I think whatever constraints they are under will be reflected in what we deliver as a funded service. (ID4.1)

In this sense accountability was restricted to the ‘community’ which was defined by the terms of the contract and arbitrated by the local CCG rather than the newly created CIC. However, the commitment to social value as opposed to administrative targets was supported by the unique brand. This was particularly pertinent for CICs at the early stage as they needed to establish themselves as independent from the state and distinct from the private sector.

As a CIC the group prioritises quality of provision over financial return […]. (ID4, website)
We’re not chasing targets. The NHS is stuck on chasing targets. (ID3.1)

The community focus was, therefore, crucial to all the interviewed CICs and was evident in their published material such as annual accounts, quality reports and websites. Some of the examples here illustrate how CICs defined their role and purpose:

[O]ur services are rooted in the community we serve. (ID6, website)

[A]s an established, credible community provider, we will protect the breadth, responsiveness and quality of services that patients and the public rely on. (ID4, website).
[W]e are owned by our members (both staff and community) and unlike private healthcare providers, we do not make a profit. […] Any money that is saved through working more efficiently is reinvested back in to local services for local people. (ID2, Annual Report)

Similar accounts were also proposed during the interviews where staff frequently expressed the importance of accountability to patients, wider community as well as to each other.

I’d like to think and I’m sure our members, community, staff would support that we listen more to our members, they have a lot more involvement in what they’d like to do, what they’d like to see and we do try and provide. (ID2.8)

The above assertions are not unique and echo broader themes in public policy, which emphasise greater patient engagement in health care (see Chapter two and four). As High Quality Care for All: NHS Next Stage Review Report suggested the NHS needed to establish a different form of accountability by ‘set[ting] NHS staff free from central control requires a new, stronger accountability that is rooted in the people that the NHS is there to serve. It means that service should look out to patients and the community they serve not up the line’ (DH, 2008a:61).

The legal framework of CICs was therefore considered to provide a necessary vehicle to achieve community purpose and accountability. The independent statutory office-holder, the Regulator of Community Interest Companies, was created to offer an oversight and to give assurance that the commitment to good governance would be met and delivered. It can then be suggested that accountability of the CIC prima facie emanated from its distinct legal structure and therefore was granted by virtue of what the company was rather than necessarily what it did. This assumption was at times evident during the interviews with the respondents where the CIC branding acted as a proxy for improved accountability, responsiveness and efficiency. In one of the Annual Accounts, the Chief Executive stated:

As a Community Interest Company, [we] can focus on what is right for the communities we serve rather than following national policies […]. (ID4, Annual Accounts)
However, another interviewee in the same site noted that the structure of the CIC was unhelpful and therefore what mattered to him was:

> What we are is far more important than the organisational form. The CIC was just a format we came into. […] We are still struggling to see any benefit to be a CIC apart from the fact that […] we can say we are a community interest company - that sounds nice. (ID4.4)

While the CICs’ governance was considered inadequate, the name ‘serve[d] a useful “badging” purpose’ meaning it led the public, rightly or wrongly, to form a view that the organisation would perform for public good by virtue of being called a community interest company (Dunn & Riley, 2004:653). Nicholls (2010a) described this as a form of legitimating certificate. However, the general public appears largely unaware of what CICs are and so the service users themselves were not always able to tell the difference between the CIC and the NHS (see Singh, 2010). For instance, one interviewee when asked if patients knew who delivered the services, provided the following response:

> I don’t think they care. I think as long as the nurse turns up and she’s doing a good job and helping them, I don’t think it matters to them. And I think it’s so confusing. I don’t think the majority of people out there do understand how it works now. I really don’t. Even my close friends say: what do you mean you don’t work for the NHS. And I say, I don’t. And they just can’t grasp it. But I suppose it’s like me talking to someone in banking without understanding ins and outs of that. But as long as my money is being invested by my bank and is there when I need it, I’m not knowledgeable enough to really appreciate it. (ID6.2)

It is possible to suggest that the idea of ‘badging’ worked in the other direction, that is to say that legitimacy of CICs was directly linked to the NHS brand. This assertion, however, reflects what Broadbent and Guthrie (2007, also see chapter three, section 3.3) defined as a shift from public sector to public service whereby it no longer matters who delivered the service as long as the service continued to be provided. However, as section 8.2 in this chapter illustrated, it was important to staff whether the community service transferred to the private company, acute trust or a social enterprise. The affiliation with the social economy, and the social enterprise sector more specifically, mattered as the studied CICs, felt that ‘[…] for us social enterprise is far more important tag than
The interviewees remarked that as members of the third sector family they were able to maintain accountability and social ethos in the mainstream provision of health care services.

We [as an organisation] are driven by ethics. […] One or two theories that people put in my head have served me well. So, I don’t have to make decisions. Sometimes, I just know what is right. (ID2.1)

The responses shared a common understanding of accountability as a normative system of values that was effectively embedded in the unique structure of the organisation. However, the lack of knowledge is problematic as it affects whom to hold to account if things go wrong. The next section examines how CICs achieve accountability via a statutory requirement, which limits their ability to redistribute profits beyond the immediate needs of the community.

8.4.2 Social value and surplus redistribution

In dealing with the demands for accountability it is important to draw attention to the special features of the CIC - the statutory asset lock and caps on dividends (see chapter four, section 4.4). These mandatory instruments ensure that any profit or savings made will be locked in perpetuity in the organisation and used solely for the benefit of the community. The constraint on profit distribution offers a certain security and ‘fosters relationships of trust, thus, building legitimacy and public confidence’ amongst the wider community and potential investors and funders (Borzega & Galera, 2014:98). In practice, the asset lock also performs a more strategic role. It prevents organisations from being demutualised and stops profits being redistributed to directors and members; a lesson learnt from the earlier experience of public sector spinouts in the 1980s. However, as chapter three highlighted, there are a number of conditions under which the CIC can transfer assets and capitalise on profits. Likewise, some lawyers have advocated the position that removing the asset lock on dividends from CICs would support greater social venture that until now had been suppressed by the limits on how much profit can be exerted by the investors (James, 2014).
Similar to the community test, the constraint on profit is codified by law and is therefore integral to the CIC structure albeit not unique to it (see for instance cooperatives). It means that a standard of accountability is instituted via statutory mechanisms and regulated by the independent body of the CIC Regulator providing necessary checks and balances. The significance of the restriction on profit distribution appears particularly relevant to the CICs that deliver publicly funded health care. It stands the organisation apart from other commercial and for-profit companies. Most interviewees felt that the non-for-profit category mattered and was a significant factor in gaining the trust of the public as well as staff, particularly at the early stages of the spin out process. For some, the status had also a symbolic value insofar as it was seen as a way to balance the on-going commercialisation and privatisation of the NHS.

I thought on the national [policy] level we were moving towards commercialisation, privatisation, markets […] and if that's happening it would be probably a good thing if the 5-10% of the market were non-profit providers therefore I was happy to work on this agenda [Right to Request]. If I could be involved in making small percentage of markets non-profit then I was happy […] I saw it as a defensive against privatisation. (ID0, Site0)

Although the proposition is contestable as there is no evidence to suggest that the inclusion of voluntary and third sector organisations would have an adverse effect on the growth of private providers, the legitimacy of CICs has become linked to some extent with strategic and moral notions of accountability. Solutions to the challenge of legitimacy and accountability of CICs can also be found in the organisations’ emphasis on social value through charitable work and donations.

One way in which CICs seek to achieve legitimacy and accountability for social performance is through allocating a proportion of savings or income towards charitable goals i.e. social mission. Unlike the traditional NHS organisations but similar to Foundation Trusts, CICs are allowed to retain surplus and reinvest it in activities that further their social mission. As one interviewee reflected:
We keep hold of resource and choose [how to invest them] in the way we want. This year we have used 15% of our trading surpluses to sponsor charitable causes that further our social mission. NHS would claw back any surplus because of the efficiency criteria. (ID1.1)

A similar view of how to balance the demand for accountability in what is nevertheless a private, trading company was also reflected during a separate interview:

That’s why we’re different. We are the CIC so savings or when we do things more efficiently we plough those back into the community; back to the charitable organisations that are supporting people who are helping themselves. (ID6.6)

However, a different interviewee, pointed out that this may not always be possible to achieve, and it might be problematic for social value to be closely coupled with the generated surplus.

It’s alright when you have a surplus to be able to say we’ve invested here, we’ve done this and that. But when you don’t have a surplus and the money is really tight then how can you say what’s the difference? (ID5.2)

These observations sit neatly with the government’s broader definition of social enterprises *sui generis* whereby ‘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’ (DTI, 2002:7). However, such a classification is problematic. According to the recent *Social Enterprise: Trends in 2017* report, 22% of small commercial businesses in the UK considered themselves to be socially orientated and mission led with their profits and surplus reinvested back into the business instead of being redistributed amongst the shareholders or owners (BEIS & DCMS, 2017). Equally, private health care providers have long recognised the benefits of working in partnership with charitable organisations and in providing support to local causes. For example, a multinational, private company Capita has recently formed a partnership with the Alzheimer’s Society while operating a payroll-giving scheme at the same time. A similar system was also in place in one of the visited sites where staff were encouraged to make a wage sacrifice to support a number of local charities. However, during the staff meeting I observed that there was a general lack of
awareness about the scheme and staff seemed confused as to who should benefit from these donations. Some felt that the current list of beneficiaries was drawn based on historical arrangements and that it no longer represented the ethos of the organisation or indeed the current staff’s preference.

In other case the surplus of the CIC was spent on providing staff with opportunities to take courses which were not part of compulsory training and therefore considered to be adding extra value to the workforce, organisations and to other stakeholders.

> We provide free training or free support so for example [name] charity do huge amount with our […] patients so we train all their staff for nothing because we are all dealing with the same people. (ID4.4)

The financial pressure, however, meant that it was increasingly difficult for CICs to extract profit or make significant savings that could be spent on charitable activities. In most cases the amount the organisations were able to allocate to a non-contracted, community projects were relatively small, ranging between £400 and £5,000 although one site recorded a donation of over £200,000 to charities and voluntary sector organisations claiming:

> This is an enormous part of our ethos as a Community Interest Company, and we will continue to look for ways to use our surpluses in this way.’ (ID7, Annual Accounts)

The financing of social activity in the above site, however, was dependent on the provider being able to maintain a steady growth in the business despite experiencing the loss of a substantial contract. As a result, the company was looking to expand the market for its services and was in the process of setting up a separate commercial entity based on a self-pay model to facilitate this.

> What we’re doing is to create a private company, separate to [the CIC] that does private business. With that we’ll extract considerable, we hope, income which it’ll then go back, be ploughed back to X because it’ll be wholly owned company and it’ll go back to the CIC which will then go back to community. So, we’re finding other ways of supplementing the fact that local authority and NHS are cutting. (ID6.1)
A similar argument was put forward in other sites where the participants felt under pressure to re-evaluate the ways in which they generate income at the time of considerable service cuts and rising demand. For instance, in one site the reduction in the value of the contract being commissioned caused the company to reduce the number of free health care products and to direct patients to purchase the rest from other, typically private companies. However, the interviewee found that the situation presented a unique business opportunity where instead of referring patients to other providers the organisation would directly provide the service in a more responsive way.

One of the things we’ve done is to restrict the amount we can provide. But our concern is for those individuals we would send to a private company [pause] they wouldn’t know them, they may oversell, they may not be appropriate for their need and we can see that we can do better around that’. We can’t continue to cut cost so, we’ll need to generate income elsewhere. So, we would look at the private income, but it had to be driven really by the fact that we can enhance actual patients’ care. (ID4.4)

A similar experience was noted during a separate visit where the interviewee tried to rationalise the possibility of expanding the role of that CIC into the private provision of services:

If you don’t want to pay for it [CCG] other people will. We started to go down that track now […] but stick to your ethics and your values whether you pay for something or not it doesn’t make any difference. (ID3.1)

This shift represents a stance whereby CICs pursuit of profit constructs for them a hybrid role to cross subsidise their social mission, which is implicitly associated with the welfare provision with private income. Furthermore, the analysis advanced here suggests that the commitment to social and ethical value safeguards the community benefit without hampering efforts to be entrepreneurial. In this context, business becomes transformed into a social and moral terrain that allows the reconciliation of tensions between societal and economic goals and to achieve legitimacy and accountability in this way. This notion, undeniably, is not new or exclusive to social enterprises and has been promoted via initiatives such as corporate social responsibility or more recently corporations that aim to simultaneously deliver economic, social and environmental benefits.
The non-profit status as a standard feature of accountability and organisational legitimacy, therefore, must be treated with caution. The constraint on profit re-distribution, as shown earlier, is not always pertinent to smaller CICs. Increasingly, these organisations are finding it difficult to run an efficient service and not accrue any deficit let alone make a profit. Secondly, the non-profit tag may be misleading as all companies including CICs must operate for profit albeit for profit that benefits the community. Likewise, the lack of shareholders and the statutory limits on profit distribution does not guarantee a free service, as is the case with Bupa (see introduction, p.6) and, as it was illustrated above, might soon be the case with CICs.

Thus, the effectiveness of mechanisms of accountability depend on other arrangements such as these developed at the governance level e.g. Executive and Non-Executive membership Boards. The next section examines how different mechanisms of accountability developed and were implemented and understood by different CICs.

8.4.3 Constraint on profit distribution

The constraint on profit distribution offers a certain security and ‘fosters relationships of trust, thus, building legitimacy and public confidence’ amongst the wider community and potential investors and funders (Borzega and Galera, 2014:98). In practice, the asset lock also performs a more strategic role. It prevents organisations from being demutualised and stops profits being redistributed to directors and members; a lesson learnt from the earlier experience of public sector spinouts in the 1980s. However, as chapter three highlighted, there are a number of conditions under which the CIC can transfer assets and capitalise on profits. Some lawyers have advocated the position that removing the asset lock on dividends from CICs would support greater social venture that until now had been suppressed by the limits on how much profit can be exerted by the investors (James, 2014).
Similar to the community test, the constraint on profit is codified by law and is therefore integral to the CIC structure albeit not unique to it (see for instance cooperatives). It means that a standard of accountability is instituted via statutory mechanisms and regulated by the independent body of the CIC Regulator providing necessary checks and balances. The significance of the restriction on profit distribution appears particularly relevant to CICs that deliver publicly funded health care. It stands the organisation apart from other commercial and for-profit companies. Most interviewees felt that the non-for-profit category mattered and was a significant factor in gaining the trust of the public as well as staff, particularly at the early stages of the spin out process. For some the status had also a symbolic value insofar as it was seen as a way to balance the on-going commercialisation and privatisation of the NHS.

I thought on the national [policy] level we were moving towards commercialisation, privatisation, markets [...] and if that’s happening it would be probably a good thing if the 5-10% of the market were non-profit providers therefore I was happy to work on this agenda [Right to Request]. If I could be involved in making small percentage of markets non-profit then I was happy [pause] I saw it as a defence against privatisation. (ID0, Site0)

Although the proposition is contestable as there is no evidence to suggest that the inclusion of voluntary and third sector organisations would have an adverse effect on the growth of private providers, the legitimacy of CICs has become linked to some extent with strategic and moral notion of accountability.

8.5 Mechanisms of accountability

The issue of how CICs should achieve accountability and what are the best mechanisms for it, was the subject of the ‘Report on the public consultation and the government’s intentions’ (DTI, 2003). This was closely linked to the requirement for CICs to involve a wider group of stakeholders via for instance consultations. Subsequently the two proposals were formulated as follows:
Proposal 8:
CICs should submit short annual reports on the action they have taken to pursue their public or community benefit objectives, and to involve stakeholders (para 32), and

Proposal 9:
CICs will be encouraged to involve stakeholders in their enterprises. The Government invites views on whether a statutory requirement for CICs to seek the views of their stakeholders, with an exemption for small CICs, would be appropriate. (DTI, 2003a: pp.23 & 25)

Out of 84 responses, from public, private and third sector organisation, received by the government, 81% supported the proposal number eight, claiming it was an important mechanism ‘to concentrate on their community benefit objectives, and […] promote accountability to stakeholders’ (ibid, p. 23). However, some pointed out that self-evaluation would necessarily involve a bias and therefore would be a weak mechanism of accountability.

Under these proposals, [it would] be the individual CIC’s self-assessment rather than any attempt at impartial evaluation of community benefit. We believe this may be a weakness. (Action with Communities in Rural England cited in DTI, 2003)

Other respondents pointed out that the proposed measure might be an additional administrative burden that would hinder the take up of this new legal form.

[Transparency requirements] could over burden CICs to the point that no one will want to take up the new model. (Charity Law Association cited in DTI, 2003a)

Consequently, the government concluded that the proposed reporting requirement should be introduced as it added value to meeting the community interest by CICs. At the same time, a higher percentage of respondents opposed the proposal number nine. Out of 88 registered responses only 43% supported the idea with 32% strongly opposing it while 25% did not make any specific recommendations either for or against (ibid, p.25). Those who did not support the proposal shared the view that that it impractical and burdensome to expect CICs to impose engagement by de jure requirement. Some of these responses included the following statements.

[A requirement] would run contrary to the ‘light touch’ regulation that the Government intends for CICs, making them an unattractive option for social entrepreneurs. (Association of Chief Executives of Voluntary Organisations cited in DTI, 2003a:26)
Unless stakeholders are discrete and easily available just how can you obtain their views practically? (Bulwell Hall Community Garden Ltd cited in DTI, 2003a:26)
There is always the possibility of a latent tension in any community organisation that truly represents all stakeholders. (Local Investment Fund cited in DTI, 2003a:26)

There are two main ways in which CICs seek to achieve accountability. The first one concerns explicit mechanisms that have been codified in law (i.e. articles of association) and second that are demanded by administrative and contractual obligations.

8.6 Annual Reporting and disclosure regulations

One mechanism via which CICs ensure they are accountable and transparent for their commercial conduct and in meeting social obligation involve reporting and public disclosure. The practice of completing and submitting information allows CICs to demonstrate to the public and other stakeholders how they meet the mandatory requirements associated with the CIC legal structure.

8.6.1 Annual Accounts

All CICs must prepare standard annual financial accounts, which need to be approved by the board of directors and filed on public record with Companies House. The accounting requirements for CICs are exactly the same as for any other company and are subject to the same rules and regulations. The accounts are normally audited (based on turnover) and include a balance sheet, a consolidated statement of financial activities. Larger organisations may give more details about voluntary income and grants, stakeholder investments (dividends), staff costs, and directors’ remuneration. Much like any other private companies, the CIC must ensure that in meeting its additional obligation for wider community interest it remains solvent and complies with company law. The CIC Regulator asserts that for organisations to be transparent and accountable they should aspire to ‘produce accounts and directors’ reports that provide high quality information for shareholders and other stakeholders rather than simply complying with the minimum requirements’ (BEIS, 2016:3). Where the provision for accountability imposed by the corporate law, however,
differs is in placing a statutory requirement on CICs to elaborate on the nature and extent of meeting its obligation for stakeholder engagement.

### 8.6.2 Annual CIC Report

Every year CICs have to produce a community interest report which as a minimum standard prescribed by the CIC Regulations 2005 needs to include the following information: details of how the activities of the CIC benefitted the community; how and what regarding, the organisation consulted with its stakeholders, declaration on proposed payment of dividends on shares or any performance related remuneration; and finally whether or not any transfer of assets was made. The main purpose of the report is ‘to ensure transparency of operation and to improve community accountability’ (CIC Regulator, 2009). Accordingly, the specifics of CIC34 map activities of the organisation against the three key areas:

1. *General description of company activities and impact*

The information provided here contains details of how the organisation managed to meet community test with examples of any impact made. The extent to which different CICs elaborated varied and in most cases reflected the size of the organisation. For instance, a small local provider of community mental health services offered a two-paragraphs statement, citing achievements around its key organisational targets.

\[
\text{In } x \text{ year over } x \text{ people used our services and over } x \% \text{ of the people who entered treatment reported a measurable improvement […]}
\]

\[
[…] X \text{ is amongst the highest ranking performers in England in the Key domain of the Department of Health’s Improving Access to Psychological Therapies (IAPT) […] (CIC34, ID1)}
\]

While a much larger provider of nursing and health care services was able to elaborate further listing its achievement that ranged from commissioned work, partnership working and safeguarding measures it successfully implemented into the service.
Significantly, the breadth of information was consistent across the sites and in line with clinical outputs that CICs were commissioned to deliver.

2. Consultation with Stakeholders

CICs were asked to provide detailed information on how they engaged stakeholders and whether the feedback that they received resulted in any changes in the organisations. It could be argued that the following provision seeks to nudge the organisations to take active action towards the stakeholder engagement and to account for it. Again, the examples from the CIC34 forms submitted by the studied CICs showed considerable variation in regard to the amount of detail provided. While the form is not unique or the most accurate measure for stakeholder participation and engagement, it was nonetheless consistent with the findings from the individual site visits and interviews.

For example, a small therapy and rehabilitation unit reported on its performance around consultation and stakeholders’ engagement in the following way:

We ask all stakeholders to be involved in various meetings such as Board meetings, public member meetings […]. Stakeholders are included in various events such as the AGM, business planning days, strategy days, a manager’s day and various promotional events. (CIC34, ID3)

However, none of the recent and publicly available information about the organisation gave any specific details of how to get involved. While it is possible that such information existed on the ward or was directly distributed by staff working there, it was still not clear how other groups of service users could be included.

In contrast a large mental health service that had effective membership representation was able to report in greater detail of how members were involved and how their feedback led to implementing new practices.

Following the membership vote at our AGM meeting over last four years, priorities were identified as to how we should spend any surplus that was achieved.
Following a ballot regarding sickness, we have now implemented a new policy which has seen our sickness absence rates drop significantly which enabled us to award Xmas hampers to all staff. (CIC34, ID2)

However, a local Healthwatch expressed concern about how a separate CIC was seeking information and feedback. It claimed that CIC’s sole dependence on online tools for patients’ feedback was not sufficiently inclusive and was likely to introduce an element of bias into the patients and service user data that the CIC was citing in its Quality Accounts. However, the filed by the studied CICs Community Interest Report forms revealed that except for one company, the information provided was the same at least in two but in some case three consecutive years raising questions about the quality of the information provided. This further confirmed that the concerns about making community engagement part of statutory requirement, resulted in CICs duplicating the information in order to deal with additional administrative responsibility. At the same time, it is doubtful whether the members of a local community would be searching Companies House for this information suggesting the limited potential of such mechanism of accountability.

3. Directors’ remuneration

In contrast with other for-profit companies, CICs are required to disclose the full details of directors’ remuneration including any compensation paid to directors. The level of openness and transparency imposed by this provision is significant and it is particularly pertinent to the studied CICs. There has been much criticism around the role of private providers in NHS, which through commercial confidentiality clause are exempt from Freedom of Information request raising questions about the level of transparency and accountability.

8.7 Summary

This chapter explored the role of accountability from different perspectives, most notably to whom, for what and how. It illustrated how accountability of CICs is linked to their unique governance that included specific instruments to achieve organisational legitimacy. The discussion drew
attention to various practices and specifically the role of engagement and participation as a mechanism to improve accountability. In focusing on the different aspects of accountability, the chapter sought to examine the nature of formalised arrangements. In doing so it highlighted the complex relationships that exist and challenges that arise from dealing with multiple sources and demands for accountabilities. The next and final chapter offers an in-depth analysis of the key findings from this research focusing on both macro and micro impacts of CICs in the NHS.

Chapter Nine: Conclusion

9.1 Introduction

The purpose of this PhD has been to explore the role and nature of CICs as new types of provider in the delivery of health and social care services in the English NHS. The research set out with the intention to examine the role of CICs in the English NHS and the impact these new providers have on the delivery of health care particularly in relation to innovation, organisational governance and accountability (see chapter one).
The chapter reflects on the overall objectives and provides a summary of previous chapters and discussions. It is structured as follows. The first section draws together the analysis of the empirical findings from the qualitative work carried out with eight CICs across England. This is organised under three broad themes: innovation, organisational governance and accountability, which were identified as important in understanding the roll out of CICs in the English NHS (see chapter four). Section two revisits the main research dilemmas and summarises the key arguments put forward in this research. Here the utility of NPM and Governance as conceptual frameworks to make sense of the role and nature of CICs in the English NHS is discussed. Finally, the last section critically assesses to the strengths and weakness of the chosen approaches, highlights the contribution made and offers suggestions for further research.

9.2 Summary of key findings

The introduction of CICs into the English NHS was linked to the programme of reforms that sought to modernise public services by promoting greater organisational autonomy. New Labour and later the Coalition and Conservative governments honed a narrative, which suggested that the ‘right’ governance in the delivery of welfare services had the potential to increase efficiency and accountability while maintaining a high quality free at the point of delivery service. The approach assumed that staff and ‘health care managers value enhanced autonomy and view[ed] it as an incentive to improve their performance’ by innovating and experimenting with new ways of doing things (Mannion et al, 2007:402). In addition, delegating operational control and decision making to front line staff within flattened hierarchies was thought to boost staff moral and reduce absenteeism while driving improvements in overall patient care (Ham, 2014). Policy makers and politicians promoted the unique governance arrangements of CICs as conducive to generate and adopt innovation. In the public sector, innovation has reached prominence with the expectation that it would produce necessary efficiency and quality of the service. To better understand the role CICs play and the impact they have on the governance of health care delivery, the research focused
on three areas with the main findings discussed here - innovation, organisational governance and accountability.

9.3 Innovation

The emergence and development of CICs in the English NHS has been promulgated by the view that these organisations were able to stimulate innovation in health care delivery. Exploring this point, the research asked: **what type of innovation is promoted by CICs and does this innovation transform the way healthcare is delivered and managed?**

The research found that there was general consensus that innovation was a priori a good thing. The normative conceptualisation of innovation was particularly evident in responses that highlighted CIC’s propensity to generate outcomes that had a wider social and community benefits. Similarly, innovation was considered to be intrinsic to CIC’s governance arrangements allowing them to adopt new approaches and introduce novel processes. In drawing comparisons between the traditional structure of the NHS and the CIC model, the interviewees tended to define innovation by emphasising what it was not, notably bureaucratic and hierarchical, rather than what it was implying that the two concepts were mutually exclusive. A wide range of interpretations of innovation ranged from a new concept or idea, to a new service such as specific therapies and new way of working. Innovation was also seen as a process that was necessary to ensure, as one interviewee explained that CICs were able ‘to survive in health care’ (ID6.2). Some respondents emphasised the evolutionary and organic nature of innovation that resulted from the changing demands and needs of the wider population. One participant suggested that innovation was mainly about applying new solutions to old problems no matter how insignificant or mundane these were. To illustrate the point they described the task of sharpening a pencil as innovative as long as it was done in a new and different way (ID3.1). These interpretations were in line with established accounts of innovation (see chapter three), in which for instance service innovation was conceived as a process that was ‘intrinsically entangled with customisation of continually evolving product’
(Coombs and Miles, 2000:95) or where innovation was viewed as a necessary change in the delivery of public services (Brown & Osborne, 2005).

However, the problem with broad conceptualisations is that innovation becomes so elastic, everything and anything, conflating what is essentially an incremental service improvement achieved through effective management and good practice rather than via bursts of innovative ideas. Moreover, the normative nature of the phenomena tends to ignore the adverse and unintended consequences. The discourse conceives innovation as a modern panacea for structural problems shifting attention away from redistributive policies towards entrepreneurial potential of individuals. In doing so, it oversimplifies the complex process of innovation and grants an individual the status of hero capable of overcoming systemic problems in a health care economy for instance funding. This corresponds, as discussed in chapter three, with the view of a charismatic leader, an entrepreneur who is capable of generating innovative ideas.

In analysing the interview data and the wider literature (see chapter three), a number of interrelated themes emerged. The first concerned managerial types of innovation, which involved new organisational approaches and techniques in service delivery. The second tended to generate difficult to quantify, social benefits that were essential in advancing the social mission of these organisations. The next section discusses these types of innovation in greater detail.

9.3.1 Managerial Innovation

The techniques adopted by the studied CICs included changes to the management structure making it necessarily flatter and leaner, altering staff roles to ensure the service flexibility and introducing solutions based on new technology. As one interviewee (ID2.8) observed, this type of innovation meant that ‘things happen[ed] more quickly than they used to’. In some cases, the service was redesigned to address waiting times and to improve access to treatment while in others the priority
was given to innovative solutions that would ensure services were increasingly delivered in the community. Involving staff and service users was generally considered an innovation in its own right with Chief Executives playing an important role in empowering front-line staff to test new ideas in health care delivery. A number of innovations were attributed to individual members of staff who came up with an idea of how to improve the way health care was administered and delivered (see chapter six). A member of staff in one of the studied CICs came up with an idea for a new product to prevent dehydration amongst vulnerable patients. The innovation received both national and international recognition and was awarded a UK patent in 2013. Some of the innovations cited by the studied CICs involved management initiatives such as providing staff with access to wellbeing treatments and therapies, training and development as well as offering a range of benefits including car schemes and various discounts on shopping and leisure. CICs also sought to implement administrative practices that seemingly represented a departure from bureaucratic norms and process rejecting rigid system in place of flexibility. They developed a range of innovative practices around financing to address the reductions in the national contracts aimed at cross-subsidising the services provided with their own income streams. One CIC established a charity to receive donations from patients, carers and their families who wished to show their appreciation for good community health and the care that they received. This enabled the CIC to purchase equipment, provide training to health care professionals and improve overall facilities for patients.

The study found that there was a positive relationship between CIC governance arrangements and the implementation of new initiatives with a generally quick uptake of innovations. The positive attitude of Chief Executives played an important part in how quickly innovations were adopted and spread throughout the organisations. Likewise, there was a strong relationship between the Chief Executives’ professional backgrounds and interests with the type of innovations pursued by CICs.
However, innovation was also found to produce contradictions and dilemmas. Improving access and reducing waiting times inevitably freed space for increased demand with more people seeking to enter the service. At the same time, implementing cost effective solutions led in some places to shorter consultation times and substitution of grades and staff roles (see chapter six). Likewise, the emphasis on innovation privileged the notion of creativity *vis à vis* routine practice questioning the commitment and ability of some staff to be entrepreneurial. While the flexibility of CICs was useful in ensuring managers were able to quickly respond to changing priorities by moving staff around, the approach also led to increased workload in other parts of the service. The quick uptake of innovations by CICs was not necessarily followed up by financial support from CCGs (the local commissioners) reducing the potential of innovation to be scaled up across the wider health system.

Not all innovations that CICs adopted had proven benefits at the time of implementation and the evidence tended to be collated and evaluated *post ante*. This practice varied across the eight CICs with a participant in one CIC describing it as the ‘Achilles heel of his organisation’ (ID3.1). There were two notable examples where CICs were involved in research activity including randomised controlled trials alongside Universities and NHS Trusts.

The logic behind many of the managerial innovations mentioned by the respondents had both economic and contractual foundations. A proportion of the CICs’ income was conditional on meeting locally agreed targets for innovation and quality improvements known as CQUIN. These measures while locally developed were subject to approval by CCGs who held considerable power and influence in this regard. The research also found that efficiencies gained (monetary value) through CICs’ innovations were often lost to CCGs who tended to claw back the savings leading, in some cases, to the reduction of the value of the contract next time it went to tender. Likewise, *A Framework and Guidance on the Management of Intellectual Property in the NHS* (DH, 2002b) under which all independent providers operate meant that benefits arising from innovations from NHS funding had to be shared between a range of stakeholders including the NHS. For instance, the
copyrights of an innovative product that was developed and successfully applied by one of the studied CICs was fully owned by the NHS Institute for Innovation impeding the CIC’s control over its own asset. Likewise, there was no guarantee that innovations, even when they had positive outcomes for local communities would continue into the future. For example, one of the studied CICs had to close its innovative and award-winning service claiming financial uncertainty as the main factor.

Innovation was also coupled to changing contexts in the wider health economy with emerging expectations and demands. One of the CICs saw this as an opportunity to introduce technology and specifically new health-related apps to enable patients to successfully manage their own conditions. The Chief Executive believed that in future most health care would be delivered in this way and therefore it was important to start developing the right culture and workforce. However, the research found that there were mixed responses in regard to this innovation. For instance, patients were not necessarily averse to using new technology per se but they were resentful of the fact that it reduced social interactions which while not directly related to their medical condition were fundamental to their wellbeing. At the same time, some staff feared that new technology would ultimately lead to redundancy or redeployment. However, the innovation proved successful with younger people particularly in the context of diabetes and sexual health removing potential barriers and stigma associated with the latter service.

Finally, the emphasis on cost reduction and containment in organisational innovation further illustrated the endurance of new public management thinking that necessarily limited the repertoire of innovation. The approach ignored the role of investment and support needed assuming innovation would take care of itself. Likewise, it privileged a certain type of innovation that was typically cost efficient potentially overlooking other valuable ideas. The studied CICs looked to generate a broad range of innovations including social, however, the process by which proposed innovation were selected was based on the business case. At the same time, innovations that sought
to contain costs, for instance information and technology, might ultimately lead to higher charges with varying results in terms of quality and performance.

9.3.2 Social Innovation

For the studied CICs innovation was strongly associated with the legal status of their company insofar as it was set up to promote wider social benefits rather than making profit alone. The participatory nature of CICs’ governance and the relatively small size of the organisation compared to acute trust was considered conducive to establishing special types of relations with local communities and creating social value. Respondents felt that as a CIC they were able to focus on the complexities of social rather than exclusively clinical issues allowing them to deliver services according to local needs rather than nationally set targets. As one interviewee (ID2.8) explained, since becoming a CIC ‘everything [was] very much focused on local services for local people […] with people saying to us more what they’d like’. Critical to this approach was the involvement of service users and staff via different groups and fora in how the services were designed and delivered. Likewise, front line staff were encouraged to use their initiative and experience in order to implement new ways of working. This type of innovation was thought to lead to better outcomes by empowering staff and patients simultaneously. Other examples of social innovation adopted by CICs included an employment and training programme run by service-users and aimed at people with mental health problems as well as relaxation classes for staff. Social innovations were considered to be crucial to fostering staff and patient satisfaction leading to improved morale and the quality of care. This was reflected in better than national average scores from staff and patient surveys including the ‘Friends and Family Test’ (DH, 2013b) as well as lower sickness levels and absenteeism. Examples of social innovations, albeit with varying success, were also found in initiatives that sought to involve stakeholders in setting wider objectives for the organisations and deciding how to spend the surplus by allocating grants to local voluntary groups. Similarly, many respondents highlighted the unique ‘person centred’ approach adopted throughout the
organisations that sought to give patients more control in managing their needs and conditions. The impact of social innovation, while difficult to capture and quantify, was typically reported in official organisational publications including Quality Accounts and Community Interest Statement as well as in independent evaluations by CQC. Some CICs also used social accounting practice where for example every £1 invested in the organisation was claimed to yield four times more in social value.

These examples of social innovations, however, pose some bigger question for the analysis. First, the focus on local evokes tension with the NHS as a national service and more specifically with the administrative and regulatory systems arranged in the way as to privilege the latter rather than the former. The implications of this have already been discussed in the earlier part of this chapter but what is worth noting here is that in providing universal and local health care requires constant negotiation of patient, commissioner, CIC and other stakeholders’ interests. The term ‘local’ may not be appropriately inclusive and representative, with some groups more likely to fall through the safety net because of not meeting the terms of the ‘local’ definition, for instance newly arrived communities with unregulated residential status?

Social innovation remains a contested topic with less than obvious and quantifiable outcomes. It was not easy to determine the substantive and normative content of social innovation without resolving to comparisons with examples from public, private and voluntary granting some cases a less novel status of imitation if not duplication. The democratic features of CIC governance, as earlier examples showed, were not enough to secure full participation challenging a common assumption that patients and staff want to be involved and consulted at all times. The involvement of patients, carers and the wider public is no longer an innovation per se but a statutory requirement set out for by commissioning bodies, which have a duty to consult the public about the services they commission or which they intend to reform. The NHS Constitution (NHS England, 2013:9)
introduced a commitment and pledge to patient and the public stating that these have the right to ‘be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes […]', and in decisions that would affect how these services operate. On the other hand, the trend that focuses on the capacity of patients to self-manage their care is not necessarily novel but rather a manifestation of a wider trend in public policy that seeks to transform patients from passive recipients and consumers of care into more active agents bearing the risk and cost of its health together with the state. The question worth asking is whether or not this social innovation is desirable and if so to who? Put simply, who stands to gain from innovation?

Secondly, the emphasis on non-hierarchical approaches to innovation are nonetheless supported and managed by top down arrangements. While the CICs’ structure may not be as complex as is the case with the NHS decisions are still taken at the management level and what essentially becomes an agenda item and thus part of any deliberation process is necessarily decided there. Many of the claims made about the relationship between the democratic workplace and innovation have been difficult to test with some respondents claiming that recent shifts in the political landscape notably, STPs with some now slowly becoming Integrate Care Systems (ICSs) were leading for greater convergence. At the same time, the research found that social innovation provoked conflicts between the visions of CIC Chief Executives and professional cadres, most notably GPs and commissioners. Some of the interviewed Chief Executives regarded professionals as self-interested groups who were more concerned about preserving their own status than in advancing social innovation, which was thought to better serve patients’ interest. Such reasoning is consistent with NPM that aimed to de-professionalise public servants and other professional groups ultimately weakening the public sector ethos.
The studied CICs were all involved in research activity although the extent of the practice varied. Some CICs appeared to prioritise studies that looked at establishing the evidence base of various innovations these organisations implemented and to seek to disseminate the results via academic and clinical routes. Other CICs were focused on research that looked at the clinical impacts of services they were commissioned to deliver. Significantly, the level of activity did not appear to be determined by the size of the organisation with both large and a small CIC leading in this area simultaneously. However, there was again a positive relationship between the involvement of Chief Executives and the extent of research activity. Moreover, as one respondent pointed out, having a dedicated member of staff in the research role was crucial to developing and embedding the research agenda within the organisation. Consequently, the breadth and range of studies that CICs undertook varied considerably with one CIC (ID.4) in particular claiming to hold 50 distinct research portfolios across for instance public health, nursing and lung cancers.

Supporting research activity was generally considered an important aspect of CICs albeit not adequately supported and acknowledged by the wider national policy. For instance, a Chief Executive of one of the studied CICs remarked that despite actively engaging in the clinical research of primary care, an area traditionally under studied, the government was not ‘welcoming us with open arms saying you’re doing the job for us’ (ID4.4). Instead, as another respondent pointed out there was lack of clarity in respect of what grant funding and support was available to CICs. Whilst CICs sought to address these problems by collaborating with universities and other trusts as well as each other, the opportunities to increase clinical research were hampered by existing policy.

The next section focuses on the governance of CICs in the area of health care delivery in the English NHS. More specifically, how the dual mission of CICs (social impact and financial sustainability) works in practice and how it contributes to a responsive and empowered service. In this sense, the
research sought to address the second question, namely: in what way CICs governance allowed for greater autonomy, empowerment and responsiveness to staff and service users?

9.4 Governance

Based on the research, which utilised case study methods in eight different CICs, it was found that the democratic values of CICs were easily understood but harder to operationalise. The dynamic and hybrid nature of these organisations meant that in practice the governance of CICs evoked tensions and ambiguities simultaneously. In seeking answer to the next research question: what is the nature of CICs governance and how does it allow for greater autonomy and responsiveness to staff and service users?, the study identified a number of relevant findings, which I will address in turn.

9.4.1 Public sector ethos versus social mission

The eight CICs examined primarily employed former public sector staff who at the time of TCS programme (2009) transferred to the private company under the TUPE arrangement. This was significant for two reasons. Firstly, the pre-existing culture which transferred to the new organisation with the staff was founded on NHS values and a public sector ethos that allowed the studied CICs to uphold legitimacy in the service despite them being essentially a private company. Secondly, the commitment to free service at the point of delivery ensured continuity with a traditional model of service provision, while at the same time introduced a degree of change based on a delegated delivery model with a renewed focus on stakeholder satisfaction. The case studies showed that while the public service ethos remained resilient under the new arrangements, the notion of public service writ large did not. The studied CICs were keen to dissociate themselves from the widely held view of an inefficient NHS by emphasising their distinctive qualities specifically in respect of innovation. At the same time, staff argued that they were custodians of public values and in the words of one interviewee ‘more public than public sector itself’ (ID2.2). In this sense, CICs
appeared to legitimise their role in the publicly funded NHS by simultaneously upholding and rejecting the public sector background.

The studied CICs were careful not to overuse the term ‘business’ as the label was seen to have a negative connotation. In one case, the Chief Executive (ID2.1) admitted that while he did not allow his staff to speak of the CIC as a business, they recognised that essentially it was. However, the study found that CICs believed their social mission permitted commercial behaviour as long as profits were re-invested for the benefit of local communities, notably patients and carers. The prospect of introducing a fee-paying service by the studied CICs was acceptable under some circumstances, with one interviewee (ID3.1) insisting that the quality would remain the same for private as well as publicly funded patients. It was not clear, however, if access to such care would be equally uniform. The shift towards a model based on paid services would suggest that CICs in future might be increasingly focused on delivering services to the public rather than delivering free public services, which as the Parliamentary Committee (2008) pointed out was not the same thing.

**9.4.2 Balancing multiple institutional logics**

CICs represent a hybrid form of governance spanning different institutional logics (see chapter three). On one hand, CICs are premised on corporate law meaning they have to carry out business activities and generate profit. At the same time, the provision of the Companies Act 2004 (chapter three and four) augmented CICs’ corporate governance by introducing community benefit in place of shareholder value ensuring that profits are distributed for the wider public good. The development of CICs in the English NHS meant that CICs were bound by rule-orientated public governance including adhering to clinical governance. Policymakers championed this innovative form claiming it was capable of delivering publicly, socially and economically desirable outcomes for patients and wider communities. However, this research found that multiple institutional logics were not easy to reconcile and frequently produced tensions and unintended consequences. For
instance, upholding social mission and public ethos in a competitive environment presented challenges. The studied CICs appeared cautious and were less likely to tender for a contract if they considered it to be undervalued having the potential to compromise the quality of the service to be provided. By forfeiting the opportunity for income CICs were under pressure to find alternative sources of revenue. The studied CICs created separate trading arms to ensure greater financial autonomy, established partnerships with other CICs for commercial and research purposes. In all cases, collaboration with the private sector was considered a viable option with two CICs already having established relationships with the private sector. This approach initially seemed plausible and in line with a popular discourse around the entrepreneurial potential of social enterprises. In reviewing the financial data, it was found that public sector contracts remained the principal source of income. Commercial activity was either still underdeveloped or running at the margins of CICs’ operation with a number of CICs reporting no return or losses on business ventures. In most cases where CICs recorded profit for the financial year 2016-17 the amount was lower than the year before with only one CIC reporting an increase on the previous years. Two separate CICs had registered charges at Companies House in relation to mortgages taken against the assets raising a question to what extent the governance of CICs was facilitating the embeddedness of market mechanisms in the delivery of public services rather than advancing social mission. The use of the asset lock, albeit under conditions stipulated by the Regulator, as collateral against which to secure commercial loans highlighted the limitations of this tool to safeguard community interest.

In order to reconcile normative tensions arising from their governance and to deliver social goals, the studied CICs used a wide range of techniques such as salary sacrifice, donations, small grants schemes and one even set up a charity to distribute surpluses generated through efficient running of their services. The practices adopted were not dissimilar to private sector organisations, which also sought to achieve social corporate responsibility and legitimacy via similar routes.
The ambiguity of different institutional logics was further evident during interviews when participants were asked to identify which sector public, private or third sector they believed best characterised the nature of their organisation. Only three participants felt that their organisations intersected the three sectors highlighting hybridity of the CIC. The remaining participants chose public, private and third sector respectively suggesting that it was not easy to relate to all logics simultaneously and in the same way.

9.4.3 Quasi-private, quasi-public and quasi-third sector governance of CICs: implications

As noted above, attending to multiple institutional logics and the demands these generate is challenging. It is even harder when the policy context is constantly shifting and where political interference is the norm. At the time of interviews respondents identified a number of problems, which although shared by most providers in the health care economy, notably funding and recruitment, were particularly problematic for CICs due to their distinct governance arrangements.

9.4.4 CICs as Quasi-private

While CICs are essentially a type of private company they have a number of mandatory requirements and constitutional provisions that distinguish them from other corporate forms. For instance, CICs’ governance arrangements impose controls in terms of the distribution of assets, profits (dividend cap) and places restrictions on the amount of interest these organisations are liable to pay to their creditors. These features have been put in place to safeguard the social mission of CICs and to protect organisations from demutualisation and self-interest. However, the research found that unlike standard commercial companies that operate in the NHS, CICs were at considerable disadvantage precisely because of these features. At the time of spinning out the physical assets were transferred to NHS Property Services, which then granted leases to CICs. As a result, CICs found it difficult to access commercial loans and in addition were burdened with
ongoing rental charges. This issue is pertinent as the majority of registered CICs are limited by guarantee meaning they cannot issue shares and thus in order to expand business they need to be able to raise funds from loans. Likewise, the governance of CICs is based on the assumption that there are investors who are willing to forfeit the right to full compensation on the investment made. In the guidelines, *Financing Community Interest Companies*, the Regulator (BEIS, 2016c:7) suggested that CICs were intended to attract investors who were ‘seeking community, social, or environmental, benefits alongside (sometimes below-market) financial returns, accruing over long periods’ of time. In practice, however, none of the studied CICs (limited by shares) had financial support from an external investor casting doubt over the practicality of such claims. Moreover, the studied cases, even the large ones, did not have sufficient economies of scale or well-developed business acumen making competing with already established private providers much harder. Where relationships between the studied CICs and commissioners were positive and based on trust built over time, CICs were more likely to succeed in retaining or securing new contracts.

### 9.4.5 CICs as Quasi-public

CICs are fundamentally a product of the public sector. They emerged from NHS structures, are predominately staffed by former public employees transferred across and they deliver NHS funded services albeit in seemingly more efficient and innovative ways. As one interviewee observed, ‘I am not convinced that patients do appreciate the difference between an NHS organisation and a community interest organisation’ (ID7.2). However, there are some significant differences that emanate from CICs’ governance arrangements that had direct bearing on the studied CICs. First of all, despite delivering public services CICs are liable for corporation tax on profits made. In addition, unlike NHS organisations they cannot reclaim VAT on purchases of contracted-out services, which one interviewee pointed out could add another 20% to the running costs. Likewise, CICs by virtue of their legal status are unable to claim rate relief from local authorities or run a
deficit because of the personal liability to company directors as stipulated by the Insolvency Act 1986. In contrast, NHS organisations can and do run a deficit with no direct implications for directors. In one studied case, the CIC had to turn down an offer from local commissioners to extend their contract, which was crucial to the organisational sustainability, as there was a significant risk of running a deficit. This contradictory nature of governance arrangements led one interviewee (ID4.3) to conclude that the model was ‘useless’ as it had all the intrinsic problems of public, third sector and corporate governance and none of their benefits. The findings also highlighted the limitations of the claims made in respect of CICs being able to take more risks than their public sector counterparts. In practice, the studied CICs were as likely to avoid situations that presented high cost risks as any other public sector organisations delivering public services.

9.4.6 CICs as Quasi-third sector

The studied CICs were keen to identify themselves as members of the social enterprise sector emphasising their social and entrepreneurial credentials. The traditional model of a charity was considered outdated and burdensome in terms of regulation and ethos however more advantageous in terms of certain benefits. For instance, the studied CICs argued that although they were established for the benefit of a community they were unable to claim any rebates and thus had no tax advantages. Unlike charities, they could not apply for gift aid status and were subject to business rates, however, they were able to claim tax relief by deducting the value of donations made to charities from profits made. Likewise, a number of interviewed CICs were successful in obtaining grants from bodies such as Big Lottery Fund. In this sense, CICs governance arrangements were flexible allowing these organisations to assume seemingly contradictory roles. CICs acted as benefactors supporting good causes through donations and own grant programmes while at the same time they themselves were beneficiaries of similar schemes suggesting the blurring of boundaries within and across the sectors. The issue was raised by some stakeholders in the third
sector who argued that CICs were essentially public sector organisations that were created by the state to ‘allow public services to carry on as before, with little change to staffing and ethos’ effectively marginalising the traditional voluntary sector (Plummer, 2007). Likewise, the extent to which CICs in NHS can be defined as social enterprises is also contentious. According to the Social Enterprise UK (chapter four) definition, a social enterprise needs to be autonomous from the state and draw the majority of its income from trade. Even if a public sector contract is considered trade in a fully commercial sense, which is problematic in itself, the issue of autonomy is still debatable.

9.4.7 Flexibility and Organisational Autonomy

Despite the structural shortcomings noted above, respondents were mainly positive about the governance of CICs. More specifically, they regarded the model to be superior to top–down bureaucratic structures of NHS insofar as it permitted staff greater freedom and flexibility to ‘get on with the job’. The study found that staff considered the governance arrangements of CICs to play a role in connecting them to local communities and service users and thus allowing them to respond more quickly to the changing demands and needs of local populations. At the same time, CIC managers reported that autonomy presented opportunities to exercise discretion over internal matters, significantly reducing the amount of time needed to make decisions and implement change. There was evidence that CICs were able to shape their business plans and develop their own strategies as long as these were in line with the contract or funded from own resources. Despite the initial resistance of staff to leave the NHS, the participants seemed content with the working conditions and seemed reluctant to return to former structures of NHS especially that of an Acute Trust. Nevertheless, the freedom in the delivery of publicly funded health care is implicit rather than explicit.

CICs depended on local CCGs for income (via contracts for specific services), which meant their operational autonomy was considerably shaped by contractual arrangement with distinct power
relations. CIC respondents frequently complained that the amount of control and interference from various public bodies had an adverse impact on the capacity to innovate and make decisions independently even when these were to benefit local population. CICs had to conform with established rules and regulations in respect of health care delivery notably by holding a licence and by being subject to scrutiny by the Care Quality Commission, which regulates for quality and safety. They also had to produce annual Quality Accounts. Concurrently, the legal status of CICs meant they had to comply with the company law (Companies Act 2006) and their own specific legislation (Companies Act 2004) and meet a number of requirements to ensure that the company holds proper financial records and statutory records such as registers of members and directors, produces accounts and issues community interest statement. It could be argued, therefore, that the pressure to conform within the regulatory and commissioning environments had a direct bearing on the flexibility of CICs challenging and shaping their ability to act independently.

9.4.8 Staff and user engagement

The involvement of staff and users in the studied CICs varied across the eight CICs. In general, the level of engagement tended to be shaped by the structure of the organisation (employee led vs employee owned) and more significantly by its leadership. For instance, the most developed model in terms of opportunities for staff and service users was found in the CIC which was run as 100% employee owned model and where the Chief Executive had an active interest and commitment to developing the culture along these lines. The most common mechanism to involve staff was through representation on the board, with all but one studied CICs having staff representatives. Likewise, in engaging with the local community CICs pursued various mechanisms such as informal patients’ groups, member panels based on consultative forms of engagement, surveys, and service user groups. The study found that CICs relied on service user feedback to ensure legitimacy, meet contract related performance targets and as means of developing future service provision. The
engagement with the community and staff had both symbolic and performative value insofar as practice was not necessarily developed throughout the process itself but shaped by the expectations of the CICs governance arrangements.

The research also found that a larger sized organisation did not necessarily result in better outcomes in respect of staff engagement, with the medium size organisations showing best practice in this area. Small sized CICs tended to depend mainly on staff representation and patient feedback as a main mechanism for involvement. However, despite embedding the provision for engagement in the CICs’ constitution, the research found that, recruitment to the role of a staff representative presented challenges, the uptake of membership by new members of staff was slow and participation at various meetings including staff fora was considerably low. Some interviewees suggested that in their organisations there were those who wanted to participate and be engaged, and others who simply wished to do their job and ‘collect the pay check’ by the end of the working day and leave. In another CIC, the Chief Executive admitted that staff did not always seem interested in taking up opportunities for membership including enrolling into a company pension scheme despite being actively encouraged by the Chief Executive.

It is possible that time was needed for staff to develop a new culture and attitudes towards participation. On the other hand, the research found, that membership based on conditions such as a permanent contract of employment and the requirement for staff to submit an application may discouraged employees from applying to become members. For example, one CIC sought to address this by introducing an amendment to its memorandum and articles with an opt-out system in place of opt-in, assuming all staff wanted to be a member of the CIC unless otherwise stated.

In addition, the study found that there were mixed views in respect of the £1 share in the business issued by some of the studied CICs. For some, the significance of share-ownership played a
symbolic but nevertheless important role, with staff expressing a strong sense of collective and personal responsibility as a result. At the same time, other interviewees reported neither positive nor negative impact of £1 share in terms of their behaviour or attitude towards their workplace.

9.4.9 External conditions

All the studied CICs expressed concern over a rapidly changing political and policy landscape. The development of new care models such as ICSs was perceived as a potential threat to CICs unique governance and autonomy. Moreover, CICs noted the implications arising from the development of Sustainability and Transformation Plans/Partnerships (STPs) and suggested that the proposed changes were likely to transform CICs back into the bureaucratic and hierarchical bodies they once were. The reforms were also threatening the potential to innovate with one of the studied CICs abandoning a project aimed at setting up a ‘community supermarket’ claiming the idea was no longer in line with the priorities for mental health as set out by the Five Year Forward View (NHSE et al, 2014). The next section deals with empirical findings relating to the theme of accountability.

9.5 Accountability

Accountability has been an important component of public sector reform. Since the professed transformation from ‘government’ to ‘governance’, the role of conventional mechanisms of accountability has been expanded to include new forms based on participation and increased stakeholder engagement. The development of CICs in the NHS relates directly to this agenda and thus one the research sub-questions of the thesis sought to address: how CICs achieve greater accountability in the delivery of health care services? In elaborating the main findings, the section follows the order based on three dimensions of accountability, to whom, for what and how, as set out in chapter three and applied in chapter eight.
9.5.1 Accountability to whom?

The research identified that CICs were accountable to a diverse range of actors. These included members (staff with voting rights), staff (without voting rights), boards of directors, commissioners, regulators (CCQ and Monitor), patients, service users, local communities, carers and other stakeholders (see chapter eight).

In managing these complex relationships, CICs had a good understanding of the expectations (and sanctions) placed upon them specifically by commissioners, health and economic regulators (CQC, Monitor) and the internal actors (boards, staff). At the same time, accountability to local communities was aligned with the objectives of the contract suggesting a limited scope for these groups to influence these arrangements. Local communities tended to be defined in reference to the public sector contract and therefore as homogenous groups consisting of patients, service users, customers and carers. Significantly, while CICs were able to demonstrate knowledge of different stakeholders, patients found it difficult to distinguish between a CIC and a NHS provider. According to a number of participants and in line with Singh (2010) there was a limited appreciation amongst the general public as to what social enterprises, and CICs in particular, were. This confusion had potential consequences for establishing lines of accountability but also raised questions about the extent of the claimed autonomy and distinctiveness of these organisations (see chapter four). Moreover, since a number of CICs were subcontracting their services including to the private sector the accountability ‘to whom’ was further complicated in relation to what extent the members’ rights and social mission of CICs was compatible with the interests of shareholders.

The expectations that the ‘ultimate control […] and responsibility for major policy and other decisions […] [was] with the members’ of the CIC, was not evident across the studied CICs. Instead, the loci of accountability remained at the executive and board level with commissioners exerting a significant amount of power and control. Subsequently, accountability ‘to whom’ was considerably
skewed towards these actors indicating embeddness of managerial rather than grass root forms of accountability (BEIS, 2016d:4). While the interviewees at times expressed frustration with the system, they did not necessarily challenge it (except in one case) rather they sought to accommodate and adapt to the emerging new demands.

In this sense, the multi–stakeholder and multi–institutional governance of CICs remained rooted in hierarchical relationships, preserving rather than constructing an alternative paradigm. This was also characteristic of the internal structures with a Chief Executive of the CIC giving account to the Board while the staff to the Chief Executive. Despite the employee–led and owned status and the attempt to include staff voice through representation the accountability followed a familiar pattern of organisational hierarchy. The idea that members were powerful enough to vote the Chief Executive in and out was dismissed as ‘naïve’ with one Chief Executive suggesting that the rights of members needed to be balanced in order to prevent potential risk of destabilising an organisation. Therefore, while the governance of CICs was conducive to the emergence of multi-stakeholder relations this was not necessarily translated into equal rights for members. Likewise, there was mixed evidence for staff and patients taking advantage of opportunities to be more involved in the organisation.

The condition ‘to whom’ CICs were accountable was directly linked to the unique institutional context in which these organisations operated as well as organisational governance. However, there were noted discrepancies between these two areas suggesting that accountability was discharged on the basis of status and power held within the organisation. Accountability to commissioners and health care regulators was considerably high. Participants reported that much time and effort was taken up to collect data which could be fed to relevant statutory bodies. The overwhelming reliance on public sector contracts meant that the relationship between provider (CICs) and the purchaser (CCGs) was cognisant of power asymmetries compelling CICs to be first and foremost responsive
to commissioners’ expectations. Nonetheless, the prevailing assumption amongst the interviewees was that any potential conflict was mitigated by the fact that the contract was aimed to meet patients’ needs. However, under market conditions accountability ‘for what’ is difficult and may invoke trade-offs privileging the interests of purchases who need to balance the need to generate a continued efficiency and costs savings at the time of the growing demand and expectations of the public.

Accountability to commissioners and independent regulators was widely acknowledged by all CICs and followed up by practices that sought to ensure conformity and compliance with these bodies. While all participants recognised the importance of accountability to members, staff and local communities, the engagement of these groups varied across the eight CICs. The common thread running through all the studied cases was that CICs ‘served’, ‘delivered’ and ‘protected’ the interests of others suggesting enduring relationship hierarchical model with CICs acting to achieve not only accountability but what was perceived a ‘common good’.

Despite the CIC status, none of the participants expressed accountability towards the CIC Regulator indicating perhaps a limited role for this statutory body in contrast to CQC. While this is in line with the overall intention of the CIC Regulator to be a light touch mechanism, it does beg the question if this is justified in the context of health care and increasingly in other areas, e.g. local authority. As of 2015, however, the function of the CIC Regulator had been expanded by the Memorandum of Understanding with Monitor to provide a framework for collaboration and exchange of information. In this way, the Memorandum helped to create an implicit (via the CIC Regulator) and explicit (via NHS contract in the NHS) model of accountability without necessarily altering the already established ways of accounting.
9.5.2 Accountability for what

As the section above illustrated CICs were accountable to a wide range of stakeholders suggesting different areas for accountability. As social enterprises CICs were expected to meet social and financial obligations simultaneously. To that end, CICs’ social mission was coupled with the public sector ethos enabling CICs to be, as one interviewee described it, a ‘true NHS’ (ID2.1). This close association was critical for achieving accountability as well as conferring legitimacy in publicly funded health care. CICs were also expected to provide efficiency savings and by adopting innovative approaches to health care delivery. Accountability for financial prudence, therefore, had two important caveats. CICs were able to account for effective and responsible management of tax funded service. By creating surplus from an efficient provision, CICs could offer financial support to local community groups and in this way satisfy the community interest test. The research found, however, that accountability for profit redistribution was problematic not least because private and public sector organisations were already using similar practices albeit for possibly different reasons. As one participant observed, the emphasis on a surplus redistribution as qualifying criterium for CICs’ distinctiveness presented a challenge where CICs were not able to secure profit leaving a potential gap in terms of legitimacy and accountability (see section 8.4.2).

Accounting for social mission had other limitations. For instance, while all CICs provided some level of funding to local groups, it was not always clear how this support was evaluated and measured against the impact made. It seemed that what mattered most was the ability to redistribute profit with grants becoming the preferred vehicle to achieve this. However, since these donations came primarily from the public sector contract (funded by taxation) rather than private income (e.g. commercial ventures that seven out of eight CICs had set up) the source of accountability remained with the state albeit under the conflated lines of responsibility.
As chapter three illustrated, the strength of accountability can also be adjudicated on the basis of the consequences it invokes. The research found that there were no obvious ways in which CICs could be held to account for not providing funding to local community groups. Neither evidence that beneficiary groups would be willing to act against CICs if funding support was denied or reduced. In practice, the pressure to meet this objective tended to be self-reinforced and driven from within the organisations although facing outward. To this end a form of mutual interdependence followed with both parties seeking to benefit from these arrangements albeit in different way.

In addition to social value, CICs like any other provider in the NHS had to account for meeting agreed performance targets. In pursuing these objectives CICs showed an appreciation of a local context specifically in relation to commissioners with a due regard for quality, safety and clinical governance. Accountability for ensuring compliance with company law, however, was only mentioned by one CIC with none of the CICs referring to the Regulator as a body to whom accountability had to be discharged. Instead, CICs considered meeting the terms and conditions of the contract as the key objectives for which they needed to account for. In this sense, CICs were directly accountable for managerial competence which involved achieving performance targets in terms of quality as well as control of spending highlighting the entrenchment of NPM logic.

Alongside accountability for performance, CICs sought to generate accountability from engaging and involving staff and patients in the running of the organisation. The democratising potential arising from this activity was believed to have positive impact for creating a better workplace. This was particularly pertinent since CICs advocated a model of organisations giving staff a greater autonomy and responsibility for self-management would bode well for accountability. To this end, CICs reported the levels of staff and patient satisfaction to be on average higher than to those in the public sector with a number of CICs recording a significant reduction in staff absence. However,
the results varied across the sets of adopted categories, for instance ability to raise issues with management, geographies and more specifically times at which these surveys were conducted. For instance, the research found that the level of satisfaction fell when the contract was up for renewal or when there was a possible risk that it would not be continued into the future. Therefore, the financial stability rather than the status of the organisation alone played an import role in determining the level of satisfaction amongst staff. Given the participant emphasis on the role of leaders and line managers, it was possible that factors such as individual relationships played an important role in determining levels of staff satisfaction. If, however the correlation between accountability and staff satisfaction is not derived from an organisational structure but rather from a discrete ability of managers, it could be argued that accountability was one of the mechanisms of management control with which to achieve performance targets.

The research found that by focusing on accountability for compliance and financial prudence resulted in CICs’ Boards becoming increasingly concerned with strategic plans and managerial performance rather than seeking to secure new opportunities for engagement. The social value although integral to CICs mission, was understood in terms of financial viability meaning it was subject to operational success criteria. Subjecting social values to economic concerns ensured that markets became permanently entrenched and prioritised in the public realm facilitating further marketisation, albeit in ways that were nuanced and variegated.

9.5.3 Accountability how?

Sections above illustrated how the accountability to different groups had consequences for what CICs were held to account for. In seeking accountability across the different areas, this led CICs to develop a range of mechanisms and strategies to account for action. It was found that despite an emphasis on social value, the reporting was skewed towards the traditional mechanisms and measures necessarily grounded in the managerial type of accountability. Operating under the NHS
commissioning framework meant that CICs had to adopt specific tools that involved conventional audit measures and performance indicators. As with other providers in primary care, CICs also had to ensure professional accountability. This took place via the system of clinical governance, which provided a common framework for improving quality of services delivered coupling them with greater public involvement. In this sense, CICs role in ensuring improved accountability via engagement and participation was linked to external and internal mechanisms imposed by the national policy rather than governing structure per se. As one interviewee observed (ID6.2), the improvements in health care delivery were closely linked to the of the national regulator, CQC, rather than the distinct governance of CICs.

Central to CICs’ accountability was the process that established requirements for statutory disclosure of information, most notably via Quality Accounts and Annual Reports. The availability and access to these documents across all CICs was good with only 2 CICs not providing the information on their public website. Much of the content concerned the clinical achievements as well as other measures relating to the commissioned service. As expected there were no significant differences across the Reports with Annual Accounts providing a more user-friendly format for communication. In preparing these documents, CICs drew on staff and patients surveys, feedback, comments cards, Friends and Family Test as well as social media creating an evidence base to be presented to commissioners, the Board and the wider public. In addition, CICs submitted Annual Accounts alongside the additional Community Interest Company Report (CIC34) to the Companies House. In contrast to other private companies, CICs had to disclose information about director pay, creating the assumption that these organisations were more trustworthy and transparent. However, similar to other companies CICs did not need to provide information under the Freedom of Information Act although it is difficult to ascertain if they would on a voluntary basis.
Another mechanism of accountability that five of the CICs instituted was through an ownership model of a £1 share in the business. Having a stake in the organisation, it was believed would lead to improvements not only in performance but also in creating a sense of responsibility amongst the staff-owners positively contributing to greater organisational accountability. Similarly, in an employee–led model, the established mechanisms for staff engagement typically via staff councils and staff representation. One CIC had a dedicated forum for young people to come together and seek to influence decisions about how services should be delivered to them. In another CIC, four distinct sub-committees were created to provide additional oversight and scrutiny for discrete streams of work, for instance partnerships.

However, it was found that the quality and depth of the information provided by CICs varied depending on who was the recipient of the information. For instance, the Quality Accounts presented across the approximate 50 pages, offered a detailed and thorough analysis of activities including testimonials from external partners (for example, Health Watch) as well as patients and staff. CIC34 intended to help CICs account for how they met their social obligations tended to consist of replicated, if not entirely copied material, from one year to another. In making sense of this, it is possible to argue that the ‘tick box mentality’ exhibited here reflected the difficulty in attending to multiple demands equitably and therefore prioritising some mechanisms over others. Furthermore, a multi–layered system of accountability did not necessarily mean an increased accountability but rather a more fragmented and delegated structure with more challenges in terms of co-ordination.

On the other hand, the emphasis on accountability for performance and managerial competence limited the scope for alternative methods to develop. Whilst disclosure of information offered an important source for transparency, it was not conducive to creating opportunities for bottom-up accountability. Since much of the data came from surveys, comments cards and patients’ feedback,
the process was necessarily reduced to obtaining views rather than establishing open dialogue in real time. CICs held a significant influence as owners and moderators of the information. Accounting for social value was similar across the eight CICs with a selection of ‘good stories’ as an illustrative backdrop, patient feedback, and testimonials with only two CICs referring to the Social Return on Investment to indicate the generated value for every £1 of investment. One CIC (ID1), for instance, in reporting on social value, used a sector specific framework, underpinned by values of empowerment, collaboration and integration.

It is difficult to ascertain to what extent CICs differed in their approaches to accountability from other health care providers. Since, stakeholder engagement is no longer an optional extra but an essential component in the public procurement there has been much convergence around narratives as well as practices of accountability. As hybrids CICs might be disproportionately affected by the commissioning and regulatory frameworks that seems to encourage standardised responses to the demands for new accountability. At the same time, insufficient economies of scales, as one participant observed, might force CICs to become like any other providers raising questions about the effectiveness as well as motivation of the RtR programme.

The dilemmas faced by CICs can be better understood from the NPM perspective. The practices introduced by the NPM styled reforms created a sufficiently homogenised space in public service delivery with all three sectors displaying a degree of convergence. For instance, the private sector became nudged to act in a socially responsible manner while the public sector had been indoctrinated to act as more like a private business. At the same time, non-profits in order to maintain the status quo have developed strategies whereby social fairness could only be achieved by market mechanisms.
9.6 Governance and NPM – a wider perspective

This thesis sought to better understand the role of CICs in the delivery of health and social care in the English NHS. More specifically, the research explored the impact these providers had in improving staff and patient engagement, generating innovation and new forms of accountability. In studying these areas, the research first established the wider historical and policy context for analysis arguing that macro and meso dimensions mattered in understanding the trajectory of CICs. In drawing on theories and practices of NPM and Governance, the research illustrated the embedded nature of the narratives that contributed to creating a set of expectations conducive to delegated modes of co-ordination based on multi-level and multi-stakeholder arrangements. These two paradigms revealed the complex co-existence of past and present, continuity and change, that preserve as well as change the existing public policy.

Contextualising the emergence and development of CICs also illuminated the role of NPM in facilitating the growth of independent providers in the NHS. The conceptual basis for this transformation rested in new public management logics that emphasise unbundling, outsourcing and contracting out of public services as an important lever for innovation and productivity as well as increased accountability (Politt & Bouckaert, 2011). Traditional values of equity and universalism juxtaposed to individualism, enterprise and innovation created a vision of distinctness and potential for stimulating innovation, responsiveness and efficient public service delivery (du Gay, 2013). From this perspective, hierarchy is conspicuously associated with a public sector bureaucracy that is considered wasteful and neglects staff potential to be creative and innovative. Although the view does not necessarily reject the public sector ethos, it nonetheless implies a negative impact in terms of staff moral and motivation and questions state capacity to deliver responsive public service (Moon, 2000). The emergence of CICs in the English NHS has not challenged this perception but instead offered an alternative route to reconcile the apparent conflict between private, public and
non-profit with the CIC model seen to provide a normative and organisational solution to a political problem.

Like all significant political change reform has taken a variety of forms, and as the research shows has been influenced by distinct path dependencies. In a more concrete sense public management reforms entailed significant changes in the nature of health care delivery articulating the transformation as a neutral albeit necessary process of ‘technical’ readjustment to competitive pressures. The trend of outsourcing public services to private and third sector organisation and the increasing delivery of traditional policy functions at arm’s length is seen as an integral feature of contemporary governance or dispersed public governance (OECD 2002). In the NHS, privatisation and delegation of certain health services (independent GPs, dentists and pharmacies) has played an important part since the inception of the NHS in 1948. In this sense, the utility of CICs for successive neoliberalising governments ‘lies in their discursive, strategic, and organisational reformulation of liberalism’ contingent of social and community values vis-à-vis increasingly globalised and messy world (Jessop 2002: 453). From the critical realist perspective outlined in chapter 5 section 5.3.1, CICs emerge and operate in the political, social and institutional contexts bound by specific rules, norms and values which either support or inhabit these phenomena. For instance, the research found that the regulatory framework of the NHS resulted in CICs converging around innovation and governance mimicking public bureaucracy (Di Maggio and Powell, 1983). Likewise, resource dependency led these organisations to generate market like responses characteristic of the private sector. However, another way of looking at this is that CICs were activated in the NHS to deal with the consequences of austerity in the way that had a potential for obtaining legitimacy and public support by shifting attention from privatisation to ‘social entreprisation’. This issue has particular salience with the critics of these novel forms of organisation regarding them as a ‘stealth privatisation’ of NHS. Perhaps an important point worth making here is that CICs emerge and develop through the process that is both deliberate and political rather
than ‘natural’ and ‘evolutionary’. When viewed this way, CICs in the NHS are more significant insofar as they highlight an ongoing transformation of welfare provision that is complex and hybrid-like and while it may not result in privatisation *per se* it nonetheless relies on market mechanisms such as CICs that further embed markets into the public realm.

9.7 Limitations

This research investigated an area that is subject to constant changes and political interventions. For instance, the recent development of Sustainability and Transformation Plans/Partnerships (STPs) and new ways of working introduced by the Five Year Forward View (NHSE, 2014) were beginning to have an impact on CICs, but it was too early to determine in what way and to what extent.

Secondly, and on reflection the research might have benefited from a comparative analysis carried out over a longer period of time and involving organisations that represented the three distinct sectors, notably private, public and third sector. Such a study would offer a rich data set and would provide an understanding of CICs in relation to other sectors rather than just to each other. At the same time, local authorities are increasingly looking for new models of service delivery to help them deal with budget cuts under the austerity measures and integrated ways of working across sectors are still high on the policy agenda. For instance, Kingston and Richmond councils created an independent community interest company to deliver children’s services.

There are also methodological limitations involved in this research. While I addressed them in more detail in chapter five, it is worth reiterating the point that as with any qualitative study there is a danger that personal assumptions, perceptions and beliefs will find their way to the research influencing the findings and conclusion. While, efforts had been made to ensure that the impact from this is minimised through the triangulation of data sources, acting as a lone PhD researcher
means limited time, resources and capacity to explore new themes as these develop in the research. This last point takes me to the final section of this concluding chapter, which explores some of the possible routes for future research.

### 9.8 Suggestions for future research

Since the beginning of this PhD much has changed in the health care economy as well as in British politics more generally. The vote to leave the EU by the end of March 2019 started a difficult process of negotiation with the EU with a topic colonising the domestic policy arena. The publication of the 10-year plan for the NHS in England, following new NHS funding settlement, have recently been postponed until January raising concerns about future priorities for the NHS. In the meantime, the reconfiguration of services under the FYFV (2014) continue to move forward although not at the pace policy makers hoped for or as effectively as the collaborative working would have it (see for instance the challenge to Mid and South Essex STPs reconfiguration plans as reported by HSJ, 2018). The NHS Improvement (NHSI, 2018) has recently published the data for the second quarter of 2018/19 reporting a £1,23mln deficit in the provider sector with financial and performance targets not met. Issues around commissioning, accountability and governance under the emerging regime of ICSs continue to be unresolved posing challenges for the providers of services. There have been no changes to the legislative s to facilitate the implementation of new ways of working based on a system wide approach rather than single organisation. As a result, the regulatory and commissioning structure remains underpinned by the provision of Health and Social Care Act (2012) frustrating efforts to move the agenda forward. It is against this backdrop that next section seeks to explore the potential areas for future research.

The new emphasis on system wide working shifts attention away from a single organisation towards a model that is based on providing services as part of a unified and integrated system. In this sense, it is no longer important if CICs can demonstrate their capacity to be different and unique rather whether or not they are able to be alike other providers. This means adopting common working
practices and cultures, delivering to the same key performance indicators (KPIs) and supporting not only service users (patients) but other organisations in meeting the overall outcomes and objectives. For CICs that prided themselves on the efficient running of the service as well as creativity in extracting savings, the sharing of risks might be problematic particularly with the NHS organisations that run significant deficits.

There is also another issue worth noting here that relates to the ability of CICs to safeguard and enhance their mission statement maintaining its unique character as a social enterprise. This is already proving challenging as the findings in this chapter suggest but might become more complicated under the new system. For instance, board membership might need to be reviewed to allow for community and service user representation from different organisations that work together under a one system arrangement. The changes might nudge more entrepreneurial CICs to pursue alternative income from commercial ventures outside health care although this seems less likely given the time implications involved in adapting to the new way of working as well as other factors identified in the sections above. Either way, the ICS will play a considerable role in how CICs operate in the English NHS.

The emphasis on integrating health and social care might renew interest in spinning out these services to the established outside of local authorities’ bodies. As mentioned earlier there is already an indication of new CICs are set up to deliver children’s’ services. These functions might become integrated into existing providers under new contractual arrangement although there seems to be some resistance with one CIC (ID4) claiming that the last thing they wanted to take on was a local authority culture. This aspect in itself presents an interesting research route to explore and tease out the difference and/or similarities between the CICs that emerged from a local authority and the NHS. Significantly, there is a lack of a comprehensive data source for CICs and while the information is ‘out there’ it cannot be easily retrieved as it is not consolidated and classified under
any meaningful term of reference. Lastly, touching on earlier problematisations of CICs there might be a need to review how these organisations are defined and whether or not the existing social enterprise status hinders our understanding as well as their development in publicly funded health care.

Bibliography

Abel-Smith, B. & Titmuss, R., (1956), The Cost of the National Health Service in England and Wales, Cambridge University Press


Ashoka Innovators for the Public, (2000), Selecting leading social entrepreneurs, Washington, DC.


Betz, F., (2003), Managing technological innovation: competitive advantage from change, New York: John Wiley & Sons

Bevan, A., (1945), ‘Memorandum by the Minister of Health: National Health Service. The Future of the Hospital Services’, Cabinet, C.P., (45) 205


Blond P., (2009), The Ownership State: Restoring excellence, innovation and ethos to the public services, London: ResPublica/NESTA


BRTF, (2005), *Regulation – less is more*, Cabinet Office, London


Chair, R.; Ryan, W. & Taylor B., (2005), *Governance as leadership: Reframing the Work of Nonprofit Boards*, New York: John Wiley


CIC Regulator, (2007), Report to the Secretary of State for Trade and Industry: Year to 31 March 2007, Regulator of Community Interest Companies, Cardiff


Companies (Audit, Investigations and Community Enterprise) Act 2004, Ch.27, London: HMSO
Companies Act 2006, Ch.46, London: HMSO


Davies, S., (2005), Hospital Contract Cleaning and Infection Control, UNISON, London, available https://pdfs.semanticscholar.org/cde2/93ab760261a8c10d69a203e00184661218d2.pdf, accessed on 01/09/18


DH, (1989b), *Caring For People — Community Care In The Next Decade And Beyond*, London: HMSO


DH, (2001b), *Shifting the balance of power within the NHS: securing delivery*, London: Department of Health

DH, (2002a), *Delivering the NHS plan: next steps on investment next steps on reform*, London: HMSO


DH, (2005a), *Creating a Patient-led NHS. Delivering the NHS Improvement Plan*, London: TSO


DH, (2008a), *High Quality Care for All —NHS Next Stage Review*, London: TSO


DHSS, (1983a), *Competitive tendering in the provision of domestic, catering and laundry services*, Health Circular, (83)18, London: HMSO


DHSS, (1986), *Primary Health Care: An Agenda for Discussion*, London: HMSO


Edmonds, T., (2014), Briefing Note: Community Interest Companies, Standard Note (SN/BT/3426), London: House of Common’s Library, p.4


Health and Social Care (Community Health and Standards) Act, (2003), Ch.43, London: TSO
Health and Social Care Act, (2012), Ch.7, London: HMSO
Health Services Act, (1980), Ch.53, London: HMSO
HM Treasury, (2005), Exploring the role of the third sector in public service delivery and


Lipsky M (1983), *Street-Level Bureaucracy: Dilemmas of the individual in public services*, New York: Russell Sage


Maude, F., (2010), *Speech by the Minister for the Cabinet Office Francis Maude, unveiling new support for public service ‘spin-outs’*, available on https://www.gov.uk/government/speeches/francis-maude-speech-unveiling-new-support-for-mutuals, accessed 01/12/18


National Audit Office, (NAO), Benefits that third sector organisations can give commissioners, available https://www.nao.org.uk/successful-commissioning/introduction/what-are-civil-society-organisations-and-their-benefits-for-commissioners/#notes, accessed on 29/12/18

National Health Service Act (Scotland), (1947), 10 & 11 Geo. 6., Ch.27, London: HMSO

National Health Service Act (Scotland), (1978), Ch. 29, London: HMSO

National Health Service Act, (1946), Ch.81, 9 & 10 Geo, London: HMSO

National Health Service Management Executive, (1992), Local Voices: The Views of Local People in Commissioning for Health, London: HMSO

National Health Service Reorganisation Act (1973), Ch. 32, HMSO, London

Nayak, P. R., & Ketteringham, J. M., (1986), Breakthroughs!, New York: Rawson Associates


NHS and Community Care Act 1990, (1990), London: HMSO


Nicholls, A., (2009), ‘We do good things, don’t we?: ‘Blended Value Accounting’ in social entrepreneurship’, Accounting, Organizations and Society, 34(6–7):755-769


Niskanen, W., (1971), Bureaucracy and representative government, Chicago: Aldine-Atherton


Osborne, D. & Gaebler, T., (1993), Reinventing government: how the entrepreneurial spirit is transforming the public sector, New York: Penguin


OTS (2009), Enterprising Services, London: Cabinet Office of the Third Sector


Parsons, T., (1951), The Social System, London: Routledge & Kegan Paul

Parsons, T., (1960), Structure and process in modern societies, Glencoe, IL: Free Press


Public Services (Social Value) Act, (2012), London: HMSO


Rivett, G., (1998), From Cradle to Grave: Fifty Years of the NHS, London: King’s Fund Publishing


Social Enterprise Coalition, (2011), ‘The right to run: A practical guide for public sector staff thinking about setting up a mutual or social enterprise’, London: Social Enterprise Coalition

The King’s Fund, (2017), Sustainability and transformation plans (STPs) explained, available https://www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained, accessed 28/12/18


Thomas, J., (2012), Citizen, customer, partner: Engaging the public in public management, New York: M. E. Sharpe


Timmins, N., (2013), The Four UK Health Systems: Learning from each other, London: The King’s Fund


Tussell-Social Enterprise UK Index, (2018), ‘Community Interest Companies (CICs) in Public Procurement: Q1 2018’, available www.socialenterprise.org.uk/Handlers/Download.ashx?IDMF=ac1d9272-a438-4d4e-be73-601b3f2a54e, accessed on 17/12/18


Webb, K., (2002), From County Hospitals to NHS Trust. The history and archives of NHS hospitals, services and management in York, York: University of York


Whitefield, D., (2013), ‘Should we turn the NHS into co-ops and mutuals?’, Open Democracy, available www.opendemocracy.net/ournhs/dexter-whitfield/should-we-turn-nhs-into-co-ops-and-mutuals, accessed on 20/12/18


Wolfenden Committee, (1978), The future of voluntary organisations, London: Croom Helm


APPENDICES

Appendix 1 Interview Schedule

Interview Questions:

Innovation:
1. Can you tell me what do you understand by innovation?
2. Why do you think innovation matters?
3. Can you think an example of innovation that your organisation is responsible for?
4. What impact do you think innovation has had on your patients and staff?
5. How do you measure innovation? Do you promote it and how?
6. How many new (NHS and non-NHS) contracts or services have you secured since you have become a CIC?

Governance:
1. Do you think patients notice any difference since you became a CIC?
2. Does a CIC structure offers anything additional to staff?
3. Since becoming a CIC have any changes been introduced in terms of day-to-day practice?
4. How significant is £1 share in the business to you and your staff?
5. What does your organisation do to achieve the social mission?
6. How did you draw up your mission statement?
7. What plans do you have for future, e.g. new projects, capital growth?

Accountability and Transparency:
1. How do your Board and management communicate with the range of stakeholders (local communities who are not recipients of your service, patients, staff)?
2. How do you maintain members’ involvement and commitment and how do you ensure that broader interests and views are represented in your organisation?
3. Is there a broad consensus on future development of your organisation?
4. How do you measure the impact on social investment?
5. Are your patients aware that the service is delivered by a CIC? Do they understand what a CIC is and is this important to them?
6. As a social enterprise how do you balance the needs and interests of your users, members and staff with the demands of funders and investors?

Appendix 1 Interview Schedule

Interview Questions:

**Innovation:**
7. Can you tell me what do you understand by innovation?
8. Why do you think innovation matters?
9. Can you think an example of innovation that your organisation is responsible for?
10. What impact do you think innovation has had on your patients and staff?
11. How do you measure innovation? Do you promote it and how?
12. How many new (NHS and non-NHS) contracts or services have you secured since you have become a CIC?

**Governance:**
8. Do you think patients notice any difference since you became a CIC?
9. Does a CIC structure offers anything additional to staff?
10. Since becoming a CIC have any changes been introduced in terms of day-to-day practice?
11. How significant is £1 share in the business to you and your staff?
12. What does your organisation do to achieve the social mission?
13. How did you draw up your mission statement?
14. What plans do you have for future, e.g. new projects, capital growth?

**Accountability and Transparency:**
7. How do your Board and management communicate with the range of stakeholders (local communities who are not recipients of your service, patients, staff)?
8. How do you maintain members’ involvement and commitment and how do you ensure that broader interests and views are represented in your organisation?
9. Is there a broad consensus on future development of your organisation?
10. How do you measure the impact on social investment?
11. Are your patients aware that the service is delivered by a CIC? Do they understand what a CIC is and is this important to them?

12. As a social enterprise how do you balance the needs and interests of your users, members and staff with the demands of funders and investors?
Appendix 2  Standard Letter

Dear,

As advised during the phone call conversation, I’m attaching a brief outline of my query. I do hope that you will be able to direct it to the relevant person. If you need any further clarification please don’t hesitate to contact me. I’m very grateful for considering my request.

I’m a second year PhD Researcher at the University of Manchester. I have been awarded two prestigious awards from the Economic and Social Research Council (ESRC) and the University of Manchester President’s Doctoral Scholarship (PDS) to conduct a study into the role of Community Interest Companies (CIC) in the NHS. The purpose of the project is to examine the character of these organisations and their role in transforming the provision of primary health in the UK.

The research asks if CICs are able to successfully blend their social mission with their financial purpose and lead the way towards a more balanced and responsible health care provision. Or is the shift part of marketisation albeit by means that appear more socially acceptable and sustainable?

The main aim of my research is to better understand the CIC and to examine its relative advantages compared with traditional public, private and voluntary sector provision. I am particularly interested to see whether or not CICs are capable of producing more innovation, social value and engagement relative to other providers. My research attempts to explore the opportunities and potential shortcomings of this model in relation to health care delivery. The research hopes to identify examples of the variety of contributions made by social enterprises, the challenges they face and the wider policy context for the emergence of CICs in the NHS in England.

The number of case studies planned for this research will help to explore different experiences of CICs operating in health care. There is currently a big gap in research around this type of provider and new data would help to add knowledge and hopefully inform future policy in this area.

To help me address these dilemmas, I am seeking the views of different stakeholders, policy makers, staff working in CICs, commissioners etc. who are involved in the delivery as well as redesign of primary health care in England either directly or indirectly.

I very much hope that my request for interviews can be considered positively. I would like to reassure you that my research seeks to contribute to the academic debate and as a PhD student I adhere to strict research rules and guidelines of my institution. I have received an approval from the University of Manchester research ethics committee, which I attach here for your information.

If you have any further questions relating to my research please do not hesitate to contact me. All the information and the consent form will be presented to you prior to interviews taking place.

I look forward to hearing from you,

Kind regards,
28th July 2015

Ms Jolanta Shields
Politics Discipline
The University of Manchester

Dear Jolanta,

Re: ETHICAL PRACTICE IN CONDUCTING RESEARCH

Title of research: What is the role of the Community Interest Company in the English NHS: innovation or commercialisation?

Thank you for submitting your Ethical Declaration form in line with the Graduate School’s guidelines. Your declaration has now been considered and approved by the School of Social Sciences’ Ethics Panel.

Yours sincerely

Ann Cronley
Postgraduate Administrator
SoSS Postgraduate Office
Appendix 4  Participant Information Sheet

Participant Information Sheet (Interview)

This is an invitation to participate in a study conducted by a PhD researcher at the University of Manchester. Before you decide whether or not you wish to take part it is important that you understand the purpose of the research and what is involved. Please take time to read the following information carefully and do not hesitate to ask if there is anything that is not clear or if you would like more information.

Thank you for reading this.

Who will conduct the research?
Jolanta Shields, PhD researcher, The University of Manchester, School of Social Sciences, Oxford Rd, Manchester, Greater Manchester M13 9PL, e-mail: Jolanta.shields@postgrad.manchester.ac.uk

Title of the Research
What is the role of the Community Interest Company in the English NHS: innovation or commercialisation?

What is the aim of the research?
The main aim of the research is to better understand the role of a new provider of primary care, the Community Interest Company (CIC). The study is concerned with the relative advantages / disadvantages of this new model of service delivery compared with traditional public, private and voluntary sector provision. Specifically, the research will try to establish to what extent CICs are capable of producing more innovation, social value and engagement relative to other providers. The research attempts to explore the opportunities and potential shortcomings of this model in relation to health care delivery. The research will aim to identify examples of the variety of contributions made by social enterprises, the challenges they face and the wider policy context for the emergence of CICs in the NHS in England.

Why have I been chosen?
You are invited to take part in this research as your professional background, knowledge and expertise have been identified as relevant and important to the study.

What would I be asked to do if I took part?
If you decide to take part in the interview, you will be asked a series of questions, both general and more specific, in relation to CICs. This will involve giving your opinions, statements and referring to other potential sources of information in relation to CICs.

What happens to the data collected?
All information collected during the course of the research will be kept strictly confidential. You will be asked (consent form) for your opinions/statements to be used as quotations and you will be able to decide whether or not you wish for your opinions to be quoted anonymously or directly attributed to you.

Confidentiality/Anonymity
Under no circumstances will identifiable responses be provided to any other third party. Information emanating from the evaluation will only be made public in a completely non-attributable format or at the aggregate level in order to ensure that no participant will be
identified, unless you give permission for its usage in this way.

**What happens if I do not want to take part or if I change my mind?**
It is up to you to decide whether or not to take part. If you do decide to take part you will be given information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without detriment to yourself or your organisation.

**Will I be paid for participating in the research?**
There will be no compensation for your time. However, should you wish for your name to be disclosed, your contribution to the research will be acknowledged in the PhD thesis. It is also hoped that the feedback from the research may generate new knowledge and subsequently benefit your organisation and the wider development of CICs.

**What is the duration of the research?**
The interview will be audiotaped (with your permission) and should take no longer than 1 hour. It is possible that a follow up interview might be required to clarify or obtain additional information, however, this will be subject to your agreement.

**Where will the research be conducted?**
If possible the most convenient location for the participants will be selected for example, a workplace. However, at times it may not be possible for the participants to take part in face to face interviews in which case I will arrange for telephone interview, video conferencing or e-mail exchange whichever is most convenient.

**Will the outcomes of the research be published?**
The interviews form an integral part of the PhD thesis and will be submitted to the University of Manchester. It is hoped to publish academic papers on completion and thus may be publicly available.

**What if there is a problem?**
If you have any concerns about any aspect of this study, you should speak to the researcher undertaking the interview who will do her best to answer your questions (see contact details at the top of the first page). However, if you remain unhappy and wish to complain formally, you can do this through the University of Manchester Complaints Procedure. See the next section.

**Research Misconduct**
The University of Manchester is committed to the highest standards of research integrity and takes very seriously any concerns raised about the conduct of research undertaken by any of its staff or students. If you have any concerns about the conduct of research, or complaints about potential research misconduct, please contact:

Mrs April Lockyer  
Research Governance and Integrity Manager  
University of Manchester  
Oxford Road  
Manchester  
M13 9PL  
Email: April.Lockyer@Manchester.ac.uk  
Tel: 0161 275 8093  
Fax: 0161 275 2445

**Contact for further information**
If there are any further issues regarding this research please contact the PhD Supervisors:

- Francesca Gains, Professor in Politics, Arthur Lewis Building, School of Social Sciences, The University of Manchester, Manchester, M13 9PL; e-mail: Francesca.Gains@manchester.ac.uk or
- Anna Coleman, Research Fellow, Health Policy, Politics & Organisation Research Group, Centre for Primary Care, Institute of Population Health, University of Manchester, Suite 1, 6th Flr Williamson Building, Oxford Road, Manchester M13 9PL; e-mail: anna.j.coleman@manchester.ac.uk
Appendix 5  Consent Form

University of Manchester
School of Social Sciences
What is the role of the Community Interest Company in the English NHS: innovation or commercialisation?

CONSENT FORM

If you are happy to participate please read the consent form and initial where you agree:

I confirm that I have read the information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason.

I understand that the interviews will be audio/video-recorded.

I am happy for the researcher to take notes during the interview/observations.

I agree to the use of quotations that are anonymous/attribution (delete as appropriate).

<table>
<thead>
<tr>
<th>I agree to take part in the above project</th>
</tr>
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<tbody>
<tr>
<td>Name of participant</td>
</tr>
<tr>
<td>Name of person taking consent</td>
</tr>
</tbody>
</table>

Please Initial Box
## Appendix 6  Governance Structure by site

### APPENDIX 6  Governance Structure by site

<table>
<thead>
<tr>
<th>SITE 1</th>
<th>SITE 2</th>
<th>SITE 3</th>
<th>SITE 4</th>
<th>SITE 5</th>
<th>SITE 6</th>
<th>SITE 7</th>
<th>SITE 8</th>
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</thead>
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<td>&gt; 30mln</td>
<td>&gt; 50mln</td>
</tr>
</tbody>
</table>

### Ownership model:
- £1 share
- Employee-owned

### Board: 6 and 1 service user on the Board
- Board 8 (includes: 1 Staff Rep, 1 Community Reps + a number of local organisations have non-voting places on the Board)
- Board 5 Directors
- Board 7 + 4 committees with a nominated executive director responsible to the chair for delivering the key goals: Exec performance, partnership, sustainability and workforce
- Board 7 (including Exec and non-Exec): 1 Staff – elected member
- Board 10 (incl. Chief Exec, 2 Non-Exec & Chair of the Council of Governors)
- Board 4 (Exec members)
- Board of Directors: 8
- 4 Executives including Chief Exec and 4 Non-Exec
- Board of Trustees: 4

### Staff rep: 1
- Community Reps: 4 (no shares but same voting rights)
- Staff Reps: 4

### Staff engagement council ("Our Voice")
- 1 Staff – elected member

### Council of Governors works with the Board to develop organisational strategy
- Community Interest Forum (held in public and open to public) represented by elected Members

### Staff Council & Staff owners who:
- • vote on which charities receive donations.
- • elect governors
Appendix 7  CIC 36 Sample

Please ensure this form is placed at the top of your application when posted to Companies House and the company name is consistent throughout all documents.

Declarations on Formation of a Community Interest Company

Please complete in typescript, or in bold black capitals.

<table>
<thead>
<tr>
<th>Company Name in full</th>
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<tr>
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<tr>
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<tr>
<td>Community Interest Company</td>
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</tbody>
</table>

SECTION A: COMMUNITY INTEREST STATEMENT – beneficiaries
We/I, the undersigned, declare that the company will carry on its activities for the benefit of the community, or a section of the community. [Insert a short description of the community, or section of the community, which it is intended that the company will benefit below ]

The company’s activities will provide benefit to ...
SECTON B: Community Interest Statement – Activities & Related Benefit

Please indicate how it is proposed that the company’s activities will benefit the community, or a section of the community. Please provide as much detail as possible to enable the CIC Regulator to make an informed decision about whether your proposed company is eligible to become a community interest company. It would be useful if you were to explain how you think your company will be different from a commercial company providing similar services or products for individual or personal gain.

<table>
<thead>
<tr>
<th>Activities (Tell us here what the company is being set up to do)</th>
<th>How will the activity benefit the community? (The community will benefit by…)</th>
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If the company makes any surplus it will be used for…

(Please continue on separate sheet if necessary.)
COMPANY NAME

SECTION C:
We/I, the undersigned, declare that the company in respect of which this application is made will not be:

(a) a political party;
(b) a political campaigning organisation; or
(c) a subsidiary of a political party or of a political campaigning organisation.

SECTION D:
Each person who will be a first director of the company must sign the declarations.

<table>
<thead>
<tr>
<th>Signed</th>
<th>Date</th>
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CHECKLIST

Have the first directors signed the CIC36?

Is the company name consistent throughout all documents being sent?

This form must be accompanied by the following documents:

Memorandum of Association
Articles of Association, which comply with requirements imposed by section 32 of the Act and Part 3 of the Regulations or which are otherwise appropriate in connection with becoming a community interest company
Form IN01- you need to indicate that the proposed company is adopting bespoke articles.
Any completed continuation sheets
A cheque or postal order for £35 made payable to Companies House

You do not have to give any contact information in the box opposite but if you do, it will help the Registrar of Companies to contact you if there is a query on the form. The contact information that you give will be visible to searchers of the public record.

<table>
<thead>
<tr>
<th>DX Number</th>
<th>DX Exchange</th>
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</tbody>
</table>

When you have completed and signed this form, please ensure it is placed at the top of your application and send it to the Registrar of Companies at:

For companies registered in England and Wales: New Companies Section, Companies House, Crown Way, Cardiff, CF14 3UZ
DX 33050 Cardiff

For companies registered in Scotland: Companies House, 4th Floor, Edinburgh Quay 2, 139 Fountainbridge, EH3 9FF DX 235 Edinburgh

For companies registered in Northern Ireland: Companies House, 2nd Floor, The Linenhall, 32-38 Linenhall Street, Belfast, BT2 8BG

NOTES

1 This form will be placed on the public record. Any information relevant to the application that you do not wish to appear on the public record, should be described in a separate letter.
The community interest test is referred to in section 35 of the Companies (Audit, Investigations and Community Enterprise) Act 2004 and is expanded upon in regulations 3, 4 & 5 of the Regulations.

E.g. "the residents of Oldtown" or "those suffering from XYZ disease".

A company is not eligible to be formed as a community interest company if it will be an “excluded company”. If you are not sure whether the company which you wish to form falls into any of these categories, you should refer to the definitions of the terms “political party”, “political campaigning organisation” and “subsidiary” (and of the related terms “election”, “governmental authority”, “public authority” and “referendum”) in Regulation 2 of the Regulations before completing this form.
PART 1 - GENERAL DESCRIPTION OF THE COMPANY’S ACTIVITIES AND IMPACT
In the space provided below, please insert a general account of the company’s activities in the financial year to which the report relates, including a description of how they have benefited the community.

(If applicable, please just state “A social audit report covering these points is attached”).

(Please continue on separate continuation sheet if necessary.)
PART 2 – CONSULTATION WITH STAKEHOLDERS – Please indicate who the company’s stakeholders are; how the stakeholders have been consulted and what action, if any, has the company taken in response to feedback from its consultations? If there has been no consultation, this should be made clear.

(If applicable, please just state “A social audit report covering these points is attached”).

PART 3 – DIRECTORS’ REMUNERATION – if you have provided full details in your accounts you need not reproduce it here. Please clearly identify the information within the accounts and confirm that, “There were no other transactions or arrangements in connection with the remuneration of directors, or compensation for director’s loss of office, which require to be disclosed” (See example with full notes). If no remuneration was received you must state that “no remuneration was received” below.

PART 4 – TRANSFERS OF ASSETS OTHER THAN FOR FULL CONSIDERATION – Please insert full details of any transfers of assets other than for full consideration e.g. Donations to outside bodies. If this does not apply you must state that “no transfer of assets other than for full consideration has been made” below.

(Please continue on separate continuation sheet if necessary.)

PART 5 – SIGNATORY
The original report must be signed by a director or secretary of the company
You do not have to give any contact information in the box opposite but if you do, it will help the Registrar of Companies to contact you if there is a query on the form. The contact information that you give will be visible to searchers of the public record.

When you have completed and signed the form, please attach it to the accounts and send both forms by post to the Registrar of Companies at:

For companies registered in England and Wales: Companies House, Crown Way, Cardiff, CF14 3UZ
DX 33050 Cardiff

For companies registered in Scotland: Companies House, 4th Floor, Edinburgh Quay 2, 139 Fountainbridge, Edinburgh, EH3 9FF DX 235 Edinburgh or LP – 4 Edinburgh 2

For companies registered in Northern Ireland: Companies House, 2nd Floor, The Linenhall, 32-38 Linenhall Street, Belfast, BT2 8BG

The accounts and CIC34 cannot be filed online

(N.B. Please enclose a cheque for £15 payable to Companies House)