

REFGOV

Reflexive Governance in the Public Interest

Services of General Interest

**Patient and Public Involvement in Healthcare Governance
Summary and Institutional Recommendations
England**

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1. Summary and conclusions

1.1. The case study on patient and public involvement (PPI) in England shows how reflexive governance in healthcare may be analyzed in terms of the progressive broadening of conditions of social learning (economic institutionalist, collaborative/relational, and pragmatic) in collective actions to resolve problems in the general interest. We show how the attainment of fully reflexive governance is dependent on a combination of institutional conditions and capacities that are cumulative rather than mutually exclusive. Hence the effective engagement of patients and the public in decision making processes is essential to establishing the collaborative and relational foundations on which advanced social learning operations – involving cognitive reframing and identity transformation on the part of key actors in healthcare networks – are based. We consider in detail how the recently reformed PPI framework in England may impede or facilitate the development of such conditions of social learning within particular organizations (for example, regulators, purchasers and providers, NGOs), in the relationships between these bodies, and in healthcare networks as a whole. We conclude that the Care Quality Commission (CQC) has a crucial role to play in helping secure these conditions. The nature of the institutional and organizational environment, and the way in which relationships between key actors are structured by legal powers and duties, are summarized in Figure 1 and the accompanying notes (below).

1.2. We conclude that the English PPI reforms reflect a significant shift in dominant political discourse from an earlier concern with patient *and* public involvement towards a focus on consumer choice and economic regulation, with collective voice and citizen participation playing a subordinate part in the government's NHS modernization agenda. Hence the new 'section 11' duty (s 242 of the amended Health and Social Care Act 2006) deliberately limits the scope of patient and public involvement to matters of user experience and choice, thereby precluding public engagement and debate on the issue of how (and by whom) services are provided. This displacement of 'voice' by 'choice' has been accompanied by a reduction in the potential for independent review of decision making on politically controversial issues, both by the courts and the Independent Reconfiguration Panel. Furthermore, against the recommendations of various committees that the role of patients and the public in debates on healthcare policy at national level should be increased, the government has avoided establishing such representation on a statutory basis. Instead an independent sector organization, National Voices, will represent mainly the interests of users and carers rather than the views of citizens or members of the public on health policy more generally. As competition between NHS and independent sector providers intensifies and the form of organization of healthcare approximates increasingly to the regulatory model found in the public utilities, the neo-institutional economic approach to governance is increasing in importance.

1.3. Yet at the same time, other aspects of the reformed PPI system have in some ways strengthened the collaborative and relational foundations of reflexive governance, and embody at least the potential for increased reflexivity in the more developed pragmatist and even genetic senses. In English healthcare, therefore, we find not a

single dominant approach to governance, but at least two approaches in uneasy tension. The duty on the part of health bodies to involve users ('whether by being consulted or provided with information') remains at least in some form. Other potential stimuli to social learning in the regulatory framework include the duty on commissioners of services to report on past or proposed consultations and their influence, requirements on the part of decision makers to respond to requests for information or to reports and recommendations made by Local Involvement Networks (LINks), and the power of the CQC to require explanations on matters connected with the exercise of its regulatory functions. Also on the plus side, both the merging of previously separate regulators in the CQC and the replacement of Forums by LINks appear progressive developments given the changing organisational landscape of health and social care provision. Again, the scope for public involvement in the development of healthcare policy at national level may well be greater than the government envisages, not only due to the formal independence of National Voices but also because this body will be making recommendations on behalf of whole groups of users.

1.4. One implication of the finding that some aspects of the new PPI framework tend to undermine the collaborative and relational foundations of social learning is that further legislative reform may be necessary to reverse this trend, for example by restoring the breadth and scope of the original consultation duty. However, legal duties of whatever kind can have only limited effect in changing the behaviour of key actors in public service environments in the absence of other institutional and organizational conditions. Leaving aside questions of legal institutional reform, the following recommendations focus on the potential for reflexive governance within the parameters set by the current system.

2. Implications and recommendations

2.1. Social learning as a key policy objective. Policy makers should pay specific attention to the *social learning* dimension of governance in public service sectors such as healthcare, as distinct from more familiar issues of efficiency, legitimacy and accountability. Such recognition might lead to a better understanding of the relationship between economic and democratic strategies for modernisation, and of the paramount importance of patient and public involvement for service improvement. The disappointing results of PPI to date may be explained by the failure, both in official discourse and in the wider policy literature, to consider the linkages between democratic engagement, social learning and service improvement. Social learning should be seen as a quality not only of individual organizations but also of healthcare networks. Regulators, government bodies, health authorities, commissioners, patients and citizens, and public and independent sector providers are members of such networks by virtue of their performance of healthcare functions or their consumption of, or interest in, healthcare services. Social learning may occur, or fail to occur, at a number of levels: within particular organizations, in the relationships between these bodies, and in healthcare networks more broadly. A paradigm shift in government thinking is needed in order to promote social learning within and across these domains.

2.2. Social learning as a goal of regulation in a system of multi-level governance. The role of the state in promoting social learning should then be conceptualized as a problem of meta-regulation involving 'indirect steering' within a system of multi-level governance. While European and North American scholars have accorded much

attention recently to the phenomenon of ‘new governance’ in EU policy fields such as employment, health and education, the national and sub-national levels have remained relatively unexplored. The new institutional and organizational landscape of PPI in England may be analyzed as a regulatory space comprising a range of actors and stakeholders engaging in processes of standard setting, monitoring and enforcement, exercising powers and subject to duties of various kinds, in complex and interlocking relationships of control and accountability within an economic system driven by choice and competition (see Figure 1 and accompanying notes). The novel twist given this analysis in the present context is its extension beyond the familiar problematic of regulatory effectiveness and legitimacy to include consideration of meta-governance of the specific conditions that favour or inhibit social learning among key actors in health and social care networks. There already exists in England a system of semi-independent regulation that might help secure increased reflexivity in the governance of healthcare. Local authority Oversight and Scrutiny Committees, the independent regulator of Foundation Trusts (Monitor), LINKs, and the new CQC which came into existence on 1st April 2009 might all have a part to play. These bodies might include in their conception of the regulatory function the need to overcome obstacles to social learning in the collaborative/relational, experimentalist and pragmatist senses. Of course this implies a significant challenge to the currently dominant conception of regulation. Indeed, the regulators themselves may be viewed as collective actors engaged in social learning, addressing the problem of how to interpret their new roles and approach the tasks of monitoring, evaluation and enforcement in the new healthcare environment.

2.3. Building capacities for involvement. LINKs have a vital role in building capacities for public involvement in the commissioning, scrutiny, and provision of local care services. Compared with earlier representative structures (Community Health Councils, Forums based in NHS Trusts) LINKs enjoy wider terms of reference in considering and reporting on matters covering both health and social care, and have greater potential for developing novel forms of engagement with a broader range of stakeholders. There is scope for innovation in particular in how they organize the role of participants, for example in relation to the making of reports and recommendations, and decision making more generally. Given the flexibility and lack of government prescription as to the form of LINKs, experimentation and the sharing of different experiences should enable the selection of governance structures appropriate to local circumstances. The choice is between a steering group model in which the detailed discussion of issues will primarily fall to a limited number of people, or a network model enabling the direct involvement of a greater number of participants but at the cost of increased complexity and problems of inclusivity.

2.4. Dialogue and deliberation in healthcare networks. A further pre-requisite for effective social learning is that patient and public involvement provoke genuine reflection on the part of decision makers who are receptive to external inputs. The regulatory goal here is the inculcation of a form of democratic engagement entailing dialogue and deliberation, drawing on people’s ideas and questions to test and challenge decision making on existing or proposed policy. In this ideal iterative process, citizens and service users should be entitled to expect a reasoned response to relevant matters raised, which may lead to further queries or questions, to which further responses should in turn be provided. Where no relevant response can be given, the decision should be reconsidered to the point where this is achieved, or where plans or practices are altered and developed to enable such a response. As well as leading to more

legitimate decision making, such dialogue is essential in order to create the space within which social learning can occur. In addition to building capacities, LINKs have a key role to play in providing fora or methods of debate which maximize dialogue based on the input of relevant ideas, questions and challenges within the deliberative process, drawing upon the widest possible range of experience, knowledge and understanding.

2.5. Incentives to cognitive reframing – duties to respond, explain and give reasons. Even assuming adequate representation and capacitation of patients and the public, and receptiveness to external inputs on the part of healthcare bodies coupled with genuine deliberation, the potential for social learning in the most intractable cases will not be realized absent other institutional conditions. While legal institutions are insufficient in themselves to promote ‘double-loop’ learning and frame-reflective processes enabling decision makers to avoid repetitive and defensive patterns of thinking, certain elements in the regulatory framework (depending on their interpretation and implementation) may help bring about fundamental changes in the way in which key actors in healthcare networks approach their tasks. Possible stimuli to cognitive reframing in this sense include: (i) the duty on commissioners of services to report on past or proposed consultations and their influence; (ii) the requirement on the part of a wide range of other actors in healthcare networks to respond to requests for information or to reports and recommendations made by Local Involvement Networks (LINKs), explaining the action to be taken in respect of the report or recommendation or explaining the intention not to take such action; and (iii) the power of the CQC to require explanations to be provided by prescribed persons on matters connected with the exercise of regulatory functions including registration, review and investigation, and inspection and enforcement.

2.6. Standard setting and assessment. The report of the Expert Panel set up to review PPI in 2006, later accepted by government, recommended that ‘core standards’ and assessment criteria be established to enable regulators to assess the quality of local arrangements for involving service users and the public. The realization of the potential of the regulatory framework to foster social learning depends at least in part on the way in which the CQC interprets and exercises its powers to devise indicators and develop criteria for assessing PCTs, NHS providers and Local Authorities across all aspects of their performance. In devising such indicators and criteria, the CQC should have particular regard to the importance of patient and public involvement. Patients, the public and other stakeholders must be enabled effectively to participate in and contribute ideas and challenges to decision making, as a necessary precondition of effective social learning.

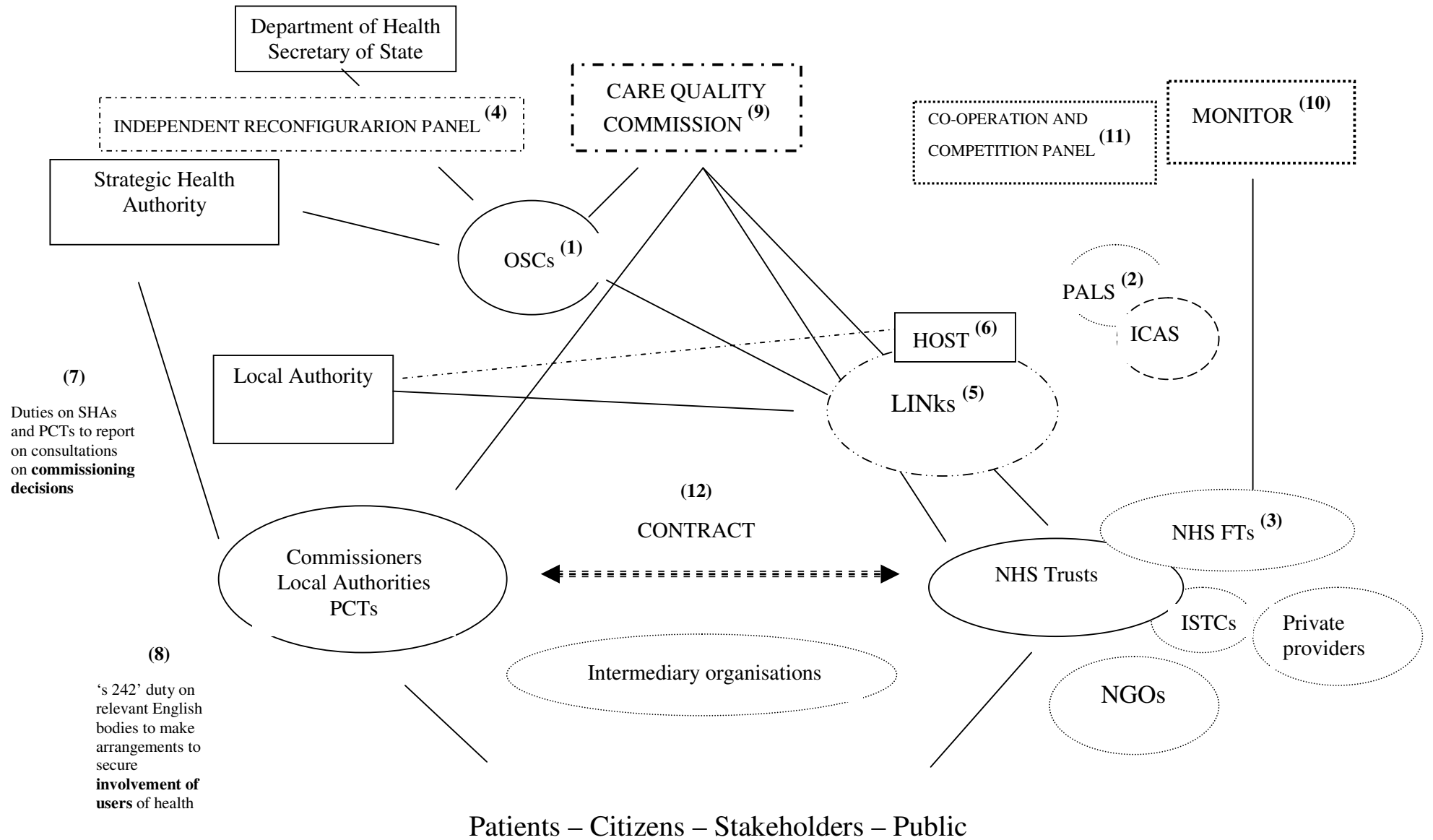
2.7. Monitoring and oversight. The CQC should exercise its powers of review, investigation and inspection with particular attention to need to encourage receptiveness on the part of decision makers to inputs from patients and citizens. This function should be performed in close liaison with LINKs, which also exercise regulatory powers (for example, to enter onto NHS and other premises in order to observe and make reports on health and social care services, and to monitor contract performance and service provision in relation to user involvement). The CQC might have a further regulatory role in encouraging and monitoring experimentalist practices, for example through support for the grass roots development of benchmarking schemes within and between different sectors and functions. Democratic experimentalism implies a collaborative relationship between those responsible for policy and implementation involving a high

degree of trust. This relational quality might be easier create and maintain between regulated bodies and the semi-independent CQC than with central government directly.

2.8. The transformative role of NGOs in social learning. The third sector is playing an increasingly important part in the organization and provision of public services in modern Britain. Throughout the UK, governments are working in partnership with voluntary sector bodies to harness their energies and expand their role in shaping, commissioning and delivering public services. The current policy environment has created significant opportunities for NGOs to move from the periphery to the centre of health and social care networks, by both influencing policy making and bidding for and winning social care and health service contracts. The contribution of NGOs to reforming services, linked with their distinctive social values and public service missions, is widely recognized. While the conceptualization of the role of the third sector in public services in terms of ‘learning’ is not new, a specific focus on the social learning potential of NGOs from the REFGOV perspective could yield further recommendations for institutional design. Our case study on the changing role of NGOs in health and social care networks in England suggests that these organizations are promising sites for the study of reflexive governance as social learning. In order to be successful in achieving their public service goals, such bodies are compelled to respond to challenges and opportunities in their environments through the exercise of cognitive capacities involving the reframing of problems and representations, and the adjustment and transformation of their collective identities. Further research is necessary in order to understand the relationship between social learning occurring within NGOs, and their contribution to social learning in health and social networks more widely. Our ongoing research is exploring the ‘transformative’ role of selected charities in England and Wales in twin senses referring to both their capacities for internal adaptation, and their potential external impact in helping secure transformations in the networks in which they operate. We expect that this research will identify obstacles to the effective contribution of NGOs to social learning, and lead to recommendations as to how their role in health and social care networks might be enhanced through regulatory reform.

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Figure 1, *Health and Social Care Network (England)*



(1) Oversight and Scrutiny Committees were established by local councils under s 21 of the Local Government Act 2000, amended by s 7 of the Health and Social Care Act 2001 (now s 244 of the NHS Act 2006). The 2001 Act gave OSCs an extended role in reviewing health and social care services. OSCs have powers:

- to request information and summon people before them to explain actions;
- to examine the efficacy of efforts to involve patients and public;
- to request action to be taken;
- to scrutinise any subsequent report; and
- to recommend an independent inspection of premises.

OSCs must be consulted by NHS organizations in the event of proposed major changes to health services. They may investigate matters referred by LINKs, and may refer matters upwards to the Secretary of State for review in certain circumstances (see ⁽⁵⁾ below).

(2) The Patient Advice and Liaison Services and the Independent Complaints Advisory Services were set up to take over the advisory and redress functions previously performed by Community Health Councils (CHCs). Based in each NHS Trust, PALS provide a range of information, advice, and support to patients, families and carers. Local formal complaints are now dealt with by ICAS, an independent charity commissioned by the Department of Health to provide support for patients with complaints regarding their NHS treatment.

(3) The first Foundation Trusts (FTs) created under the Health and Social Care (Community Health and Standards) Act 2003 came into existence in 2004. By September 2009 there were 122 FTs. The legislation places FTs under a duty to engage with their local community, and to encourage local people to become members of the organisation. Accordingly FTs are required to establish a Board of Governors (also called 'Members Council'), nominated and elected by the local community. The majority of places on the Board must be taken by representatives elected from the public and patient membership of the Trust. At least three governors must be elected from staff membership, with a further one from the Local Authority, one from the local PCT, and one from a local university if there is one. The legislation provides for the appointment and removal of the Chair and non-executive directors of the Board; the approval and appointment of a Chief Executive; the appointment of auditors; and consideration of the Trust's annual forward plan.

(4) The Independent Reconfiguration Panel was established as an advisory non-departmental public body in 2003 to provide independent expert advice to the Secretary of State for Health on contested proposals for health service change in England, in cases where local agreement on service changes cannot be achieved. The Panel also offers ongoing support and advice to the NHS and other interested bodies on successful service changes, with the aim of sharing good practice and avoiding formal referrals at a later date. In providing expert advice, the Panel is required by its terms of reference to take account of:

- patient safety, clinical and service quality;
- accessibility, service capacity and waiting times;
- other national policies, for example, national service frameworks;
- the rigour of consultation processes;
- the wider configuration of the NHS and other services locally, including likely future plans; and
- any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular.

Once the referral of a contested proposal has been accepted, the Panel consults with interested parties and may make site visits, hold meetings, conduct interviews, and request written evidence. While the focus throughout is on the quality of patient care, a principal concern is with the rigour of local involvement and consultation processes. On completion of the review, a final report containing recommendations is published and submitted to the Secretary of State, who makes the final decision on any disputed proposal.

- (5) Local Involvement Networks will be engaged in:
- ‘promoting, and supporting, the involvement of people in the commissioning, provision, and scrutiny of local care services’ (Local Government and Public Involvement in Health Act 2007, s221(2)(a));
 - the ‘obtaining of views of people about their needs for, and their experiences of, local care services’ (s221(2)(c));
 - making such views known, and making reports and recommendations about how local care services could or ought to be improved, ‘to persons responsible for commissioning, providing, managing or scrutinising local care services’ (s221(2)(d));
 - monitoring contract performance and service provision, and encouraging commissioners and providers ‘to talk to local people, to seek their views and insights, and to involve them in how to plan, prioritise and decide their activities’ (GovResp, para 2.9).

LINKs have powers:

- to enter NHS premises and observe and assess the nature and quality of health and social care services (2007 Act s225).
- to enter premises of independent providers for similar purposes, but only in respect of health and care services that are funded by taxpayers (i.e. not those provided solely to people paying in full for their own care), through terms in their contracts with service commissioners, in accordance with directions of the Secretary of State. Independent providers are similarly required to provide information about their services to LINKs when requested. An ‘independent provider’ is ‘a provider with which a local authority with social services responsibilities, NHS Trust, SHA or PCT contracts ... usually a private or voluntary sector organisation’ (ibid, p5).
- to require ‘services providers’ to respond to requests for information or to reports or recommendations made by the LINK (2007 Act, s224(1)). Regulations specify that the response must ‘provide an explanation to the referrer of any action it intends to take in respect of the report or recommendation or an explanation of why it does not intend to take any action in respect of that report or recommendation.’ ‘Services-provider’ is defined in regulation 1(3) of Statutory Instrument 2008, No. 528, *The Local Involvement Networks Regulations 2008* as meaning: ‘(a) a National Health Service Trust; (b) an NHS foundation trust; (c) a PCT; and (d) a local authority. Included within this definition therefore are bodies which in the terminology of the ‘purchaser-provider’ split have traditionally been described as *purchasers/commissioners*, as opposed to *service providers*.
- to refer matters regarding services to local authority Oversight and Scrutiny Committees (OSCs), who in turn may conduct reviews and make their own recommendations to the services-providers (Statutory Instrument 2002, No. 3048; 2007 Act, s226; DoH 2007b, p. 17). The influence of LINKs in this sense is dependent on the OSC’s decision to take on a case that has been referred to it. While OSCs are made up of elected councillors, it has been suggested that they may not reflect the political diversity within the local authority (HCHC 2007, paras 50-54). Even where they do take on an issue, their recommendations are not binding. Further, LINKs have not regained the power that CHCs had ‘to veto proposals involving service re-design, such as ward closures, and to refer matters directly to the Secretary of State’ (ibid, p. 18).

- (6) Each Local Authority with social service responsibilities is required to make contractual arrangements with someone other than the authority (the ‘Host’) for the establishing of a LINK in its area, roughly corresponding with the new geographical map of PCTs (2007 Act s221(1)). The contracts tendered and awarded by Local Authorities must conform to a specification developed by the Department of Health, which takes into account the views of respondents to the White Paper consultation. The Department of Health has published guidance, *Getting Ready for LINKs: Contracting a host organisation for your Local Involvement Network* (August 2007).

LINKs are required:

- to develop and publish procedures for making decisions (2007 Act s223; Statutory Instrument 2008, Number 528, ss 2,3,4);
- to produce an annual report to the Secretary of State, to ‘demonstrate how they have performed to the local communities, to the host, to the local authority and, through this local approach, to the government’ (Planning Your Local Involvement Network, para. 9.11)

(7) Duties on the part of Strategic Health Authorities and Primary Care Trusts (s 17A and s 24A NHS Act 2006):

- to report on consultations that they have carried out or propose to carry out before making commissioning decisions, and
- on the influence that the results of consultation have on commissioning decisions.

The first 'reporting period' is 1st April 2009 – 31st March 2010, the report due to be published between April and September 2010. Subsequent reports must be published annually for each financial year (DH, 'Real Involvement: Working with People to Improve Health Services', October 2008).

(8) Duty on the part of 'relevant bodies' to involve users of health services in planning and decision making. Under the NHS Act 2006 (as amended):

- 'Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services' (s 242(1B)).
- 'Subsection (1B)(b) applies to a proposal only if implementation of the proposal would have an impact on (a) the manner in which the services are delivered to users of those services, or (b) the range of health services available to those users' (s 242(1C)).
- 'Subsection (1B)(c) applies to a decision only if implementation of the decision (if made) would have an impact on (a) the manner in which the services are delivered to users of those services, or (b) the range of health services available to those users (s242(1D)).

(9) The main objective of the Care Quality Commission under the Health and Social Care Act 2008 is 'to protect and promote the health, safety and welfare of people who use health and social care services' (s3(1)). The Commission must perform its functions 'for the general purpose of encouraging – (a) the improvement of health and social care services, (b) the provision of health and social care services in a way that focuses on the needs *and experiences* of people who use those services, and (c) the efficient and effective use of resources in the provision of health and social care services' (s 3(2)).

The CQC has duties and powers under in respect of:

- Registration (Ch 2) – persons carrying out 'regulated activities' in health or social care in England are required to register with the Commission as service providers (s 10). The registration regime includes NHS service providers for the first time.
- Review and investigation (Ch 3) – for each PCT and English NHS provider and local authority, the Commission must conduct periodic reviews of the provision of health/adult social services, and publish a report on its assessment (s 46).
- Inspection and enforcement (Ch 6) – powers of entry onto, and inspection of, regulated premises are granted the Commission for the purpose of carrying out its regulatory functions (ss 60-63).
- Requiring explanations. The Commission has powers to require prescribed persons 'to provide an explanation of any relevant matter to the Commission ... in circumstances where the Commission considers the explanation necessary or expedient for the purposes of any of its regulatory functions' (s65(1)).

The Commission must have regard to: (a) views expressed by or on behalf of members of the public about health and social care services; (b) experiences of people who use health and social care services and their families and friends; (c) views expressed by local involvement networks about the provision of health and social care services in their areas; (d) the need to protect and promote the rights of people who use health and social care services (including, in particular, the rights of children, of persons detained under the Mental Health Act 1983, of persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005 (c.9), and of other vulnerable adults); (e) the need to ensure that action taken by the Commission in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed; (f) any developments in approaches to regulatory action; and (g) best practice among

persons performing function comparable to those of the Commission (including the principles under which regulatory action should be transparent, accountable and consistent)’ (s 4(1)).

The Commission must:

- Publish a ‘statement on user involvement’, describing ‘how it proposes to – (a) promote awareness among service users and carers of its functions, (b) promote and engage in discussion with service users and carers about the provision of health and social care services and about the way in which the Commission exercises its functions, (c) ensure that proper regard is had to the views expressed by service users and carers, and (d) arrange of any of its functions to be exercised by, or with the assistance of, service users and carers’ (s 5).
- Prepare a statement describing the method that it proposes to use in assessing and evaluating a body’s performance ... and submit the statement to the Secretary of State for approval’ (s 46 6). ‘The regulators will seek to develop assessment criteria to measure performance against national standards ... Current core standards for the NHS include the need to seek out and take account of the views of patients, carers and others in designing, planning, delivering, and improving healthcare services. LINKs and OSCs will help commissioners be more accountable to local people. There is a formal line of accountability from PCTs to SHAs, and LINKs and OSCs will be able to make formal representation to an SHA if they have concerns (*A Stronger Local Voice*, 20).

(10)

The Office of the Independent Regulator of Foundation Trusts (Monitor) was created under Part I of the Health and Social Care (Community Health and Standards) Act 2003. While FTs are not subject to central direction by the Secretary of State, the regulator is required to exercise regulatory functions in a manner consistent with the performance by the Secretary of State of duties under the National Health Service Act 1977 (s 3). The regulator is required to make a code for determining borrowing limits of any FT (s 12). The regulator is charged with administering the process of ‘authorisation’ of FTs to provide goods and services for purposes related to the provision of health care.

(11)

The Co-operation and Competition Panel (CCP) began work on 30th January 2009, charged with helping to ensure value for money for taxpayers and high quality care for patients for NHS funded services. Its regulatory remit, set out in terms of reference agreed by the Department of Health and Monitor, includes:

- monitoring compliance with the Principles and Rules of Co-operation and Competition (PRCC);
- investigating potential breaches of the Rules, conducting inquiries, and making of recommendations to SHAs, the DH, and Monitor (in relation to Foundation Trusts) on how such breaches should be resolved;
- reviewing proposed mergers, and providing advice on the wider development of co-operation, patient choice and competition within the NHS;
- hearing procurement dispute appeals in accordance with the Rules of Procedure and Procurement Dispute Appeal Guidelines;
- hearing appeals in cases involving complaints concerning advertising or misleading information, where commissioners and/or providers are alleged to have failed to provide accurate and reliable information to enable patients to exercise choice and control over their healthcare.

‘The CCP’s approach is grounded in the established principles of economic and competition analysis. However, in applying these principles, the CCP ensures that it takes account of the special features of the healthcare sector, such as it being free at the point of service for patients, the not for profit nature of many organisations providing healthcare services and the help many patients need to make informed choices between service providers’ - <http://www.ccpanel.org.uk/about-the-ccp/index.html>

(12)

Service commissioners (Local Authorities, Primary Care Trusts, some Strategic Health Authorities) enter legally enforceable contracts for the provision of health and social care services with corporatized NHS Foundation Trusts, private sector and third sector organisations (such as NGOs). They enter into service level agreements that are not legally enforceable with ordinary ‘non-corporatized’ NHS Trusts. The purchaser-provider contract also serves as the mechanism whereby LINKs acquire powers to enter premises of independent providers, and to observe and assess the nature and quality of their health and social care services. In the negotiation and conduct of contracts,

commissioners and providers are expected to have regard to the Principles and Rules for Cooperation and Competition (PRCC)(DH Guidance, 13 December 2007) and other guidance on World Class Commissioning. The ten principles state:

1. Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population
2. Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability
3. Commissioning and procurement should be transparent and non-discriminatory
4. Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare
5. Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS
6. Providers must not discriminate against patients and must promote equality
7. Payment regimes must be transparent and fair
8. Financial intervention in the system must be transparent and fair
9. Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money
10. Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money