



ESRC Centre for Analysis of Risk and Regulation

Modernisation, Partnerships and the Management of Risk

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THE LONDON SCHOOL
OF ECONOMICS AND
POLITICAL SCIENCE ■

DISCUSSION PAPER NO: 31

DATE: **November 2004**

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The support of the Economic and Social Research Council (ESRC) is gratefully acknowledged. The work was part of the programme of the ESRC Centre for Analysis of Risk and Regulation.

Published by the Centre for Analysis of Risk and Regulation at the
London School of Economics and Political Science
Houghton Street
London WC2A 2AE

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ISBN 1 7530 1798 9

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Printed and bound by Printflow, November 2004

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Liisa Kurunmäki and Peter Miller

1. Introduction

The terms ‘modernisation’ and ‘partnership’ are fundamental to an ongoing transformation of the contemporary political lexicon in Britain. A new regulatory programme (Rose and Miller, 1992) is emerging in which the incitation to innovate and co-operate takes centre stage, supplanting the harsh language of markets and competition that characterised politics and public policy in the 1980s and 1990s. Inter-professional co-operation, and the possibility of creating hybrid entities (Kurunmäki, 2004), is central to this new model of regulation. Partnership working, as specified in the Health Act 1999, is one of the principal mechanisms through which this has been promoted. Instead of coercion by the state or the untrammelled workings of the market, an injunction to co-operate is placed upon professionals and experts of varying kinds. The ‘modernising government’ programme, originally outlined in the White Paper *Modern Public Services for Britain: Investing in Reform* (Cm 4011, 1998), and later presented in more detail in the *Modernising Government White Paper* (Cm 4310, 1999), exemplifies this transformation. This programme holds out the promise of improving public services by promoting innovative joined-up working between agencies and experts that provide complementary services to citizens.

If modernisation and partnership go hand in hand, then a third term - risk - completes the triptych that brings the abstract schemes of the reformers into contact with the mechanics of service delivery. The new forms of co-operation envisaged are held to bring with them risks that need to be identified, assessed and managed (HC 864, 2000). ‘Risk taking’ is encouraged, but only in so far as it is ‘well managed’ (HC 864, 2000, p. 2). As a relatively recent arrival on the public policy and financial management scene², the formalised management of risks is promoted as a way of securing the benefits of partnership working while avoiding the dangers. In the case of partnership working in the public sector, the possible risks are seen to be multiple and novel. Instead of risks understood as pertaining to an individual organisation, as is typically the case in the private sector, or a particular policy-domain, as has traditionally been the case in the public sector, risk management in the context of the modernising government programme is held to exist at multiple levels and across organisations (Hood and Rothstein, 2000). For instance, there is the risk that key actors will be unwilling to innovate, thus losing the potential benefits of the new possibilities, and thereby

¹ This study would not have been possible without the willing co-operation provided by staff in the organisations studied. The authors much appreciate their input. The support of the Economic and Social Research Council (ESRC) is gratefully acknowledged. The work was part of the programme of the ESRC Centre for Analysis of Risk and Regulation, London School of Economics and Political Science. For more information visit: www.lse.ac.uk/depts/carr. The researchers wish to acknowledge also the funding provided by the PD Leake Trust (a charity associated with the ICAEW), the King’s Fund, and the Suntory and Toyota International Centres for Economics and Related Disciplines. We are grateful to colleagues at the London School of Economics for comments on an earlier version of this paper. Particular thanks are due to Mike Power for his comments and encouragement. The authors would also like to note their thanks for the comments received at the CIMA Workshop on New Public Management at the University of Edinburgh in September 2003, and for comments received at the Quinn School of Business, University College Dublin in May 2004. The comments of an anonymous reviewer are also greatly appreciated. The authors would like to thank Iida Keto and Debbie Ranger for their research and administrative support.

² See HC 864, 2000; HM Treasury, 2001; PAC, 2001; Strategy Unit, 2002.

jeopardising the delivery of government policy. There is the risk that the service provided by one agency will be of poor quality, diminishing the likely success of a specific co-operative programme. And there is the risk that co-operation and information sharing will be insufficient, leading to gaps in service delivery with potentially serious consequences for the client group in question. Framed in this way, the category of risk is accorded a key role in operationalising the modernising government agenda (HC 864, 2000). It is called upon to act as a 'mediating machine' (Wise, 1988), linking the twin ideals of co-operation and innovation. Risks, once lacking in visibility, are now to be given prominence and made manageable at the level of policies and programmes for inter-agency public service provision.

In the realms of health care and social services, the incitation to co-operate by breaking down the boundaries between service providers, and by building services 'around the needs of those who use them' (Department of Health, 1998, p. 5), were reflected in the White Papers titled *New NHS: Modern, Dependable* (Cm 3807, 1997), and *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards* (Cm 4169, 1998). New opportunities and obligations for co-operative working have been created, and existing barriers for innovative, cross-sectoral working removed by legislative means and by a range of tools. These include Health Improvement Programmes (HIMPs), Joint Investment Plans (JIPs), Health Action Zones (HAZs), and partnership grants. The Health Act 1999 built on these programmes, and provides one of the clearest examples of this obligation to innovate and co-operate. Sections 26 to 32 of this act aimed to increase and strengthen partnership working, both within the NHS and between the NHS and local authorities, through a number of different mechanisms. A new duty of co-operation within the NHS was introduced, together with an extended duty of co-operation between NHS bodies and local authorities. A new statutory mechanism for strategic planning was introduced, with the aim of improving health care services, along with provision for NHS bodies and local authorities to make payments to one another, and to make use of new operational flexibilities (see Explanatory Notes to Health Act, HMSO, 1999).

The Health Act 1999 gave form and substance to the abstract notions of modernisation and partnership. It made visible and necessary a specific encounter, that of health care and social care, with all its attendant intra- and inter-professional rivalries, tensions and opportunities. This paper explores the links between the modernising government agenda, the proposals for formal partnership working embodied in the Health Act 1999, and the technologies for operationalising these ideals that have been developed at a local level by those experimenting with partnership working. More specifically, it focuses on section 31 of the Act. This section encouraged voluntary but formal co-operation through the use of three mechanisms: *pooled budgets*, *lead commissioning*, and *integrated provision*. *Pooled budgets* allow service providers to bring together resources into a joint budget; *lead commissioning* allows one authority – either health care or social services – to take responsibility for commissioning services on behalf of the other; and *integrated provision* allows an NHS Trust or Primary Care Trust to provide social care services, thus offering integrated services from one provider rather than many. In different ways, and to varying extents, these three forms of partnership working were proposed as a way of making operable the modernising government agenda through innovative working arrangements that would take the shape of formal inter-agency and inter-professional co-operation. (Kurunmäki, Miller & Keen, 2003).

Yet operationalising the modernising government programme has not been a matter of straightforward implementation. If the terms modernisation and partnership are highly abstract and labile, then the possibilities for making them operable were equally variable. The obligation to co-operate imposed by the Health Act 1999 left open which form of partnership should be chosen, and which client group should be targeted initially. Formal partnership agreements had to be forged at a local level by those that would work together, and in light of the perceived benefits and risks. Innovation in such localised environments is less clear-cut than it appears in the abstract images of

programmers, reformers and those who chart their contours. Existing ‘communities of practice’ (Lave & Wenger, 1991; Collins, 1992; Wenger, 1998; Power, 2003, p. 3; Bowker & Starr, 1999), particularly those concerned with the actual delivery of services, translate idealised images of co-operation, modernisation and risk into categories and practices that are recognisable and consonant with their everyday lives. Formalised systems for regulating and managing risk arrive ‘after the event’ as it were, and have to be mapped onto pre-existing routines. A complex web of interactions, some of which may be co-operative while others may be hostile, have to be re-thought as the injunction to engage in formal partnerships permeates its way through the multiplicity of organisations and actors that are called upon to engage in partnership working. Through a combination of semi-structured interviews, observation of meetings, and analysis of relevant documentation, we sought to understand the problematising of traditional modes of service delivery and the early attempts to operationalise formal partnerships at five sites across a range of client groups. We examined the ways in which the various actors sought to align the abstract imperatives of co-operation and modernisation with the less abstract imperatives of ensuring that services as diverse as supplying pressure relieving mattresses, providing hydrotherapy, assisting clients with their shopping, and organising placements in care homes continued to be delivered. Our aim in this paper is to understand how a variety of actors in highly localised environments reacted to the new and possibly conflicting demands to modernise services through formal partnerships, and how they translated their existing activities into the new political lexicon³.

The paper is organised as follows. In section two, we examine the multiple locales in which the idea of co-operative working emerged, and how it was posed by the various actors as a way of resolving a range of more or less disparate concerns. Some of these concerns are very broad, such as those relating to the alleged lack of innovation in central government. Others are highly localised, such as the difficulties faced by service providers grappling with de-institutionalisation policies and trying to control costs, while at the same time attempting to respond to the modernising government agenda. In all these different locales, and in different ways, partnership working was seen to offer a potential solution to a particular problem. In section three, we examine the ways in which the idea of partnership working came to be aligned with the immediacy of service delivery. This represents the point at which idealised images of co-operation articulated by policy-makers intersect with existing ways of working. The pragmatism and caution of many of the actors we interviewed, combined with their enthusiasm for the principle of partnership working, suggests that in the early stages of the reforms existing communities of practice were able to absorb and accommodate the generalised injunctions to co-operate formally. While appealing to partnership working as an ideal, making it operational brought into relief the intricacies of the different professional cultures of participating organisations and the complexities of aligning them. In section four, we consider some of the tensions inherent in the co-operative ideal of partnership working, particularly those arising from the inter-professional encounter between health care and social services. Finally, in section five, we offer some conclusions and outline implications for future research.

2. Modernising Through Partnerships: the emerging co-operative ideal

The ideal of co-operation through formal partnership working surfaced in a number of different locales. For purposes of exposition, we identify three distinct yet overlapping locales: that of policy makers who define the co-operative ideal and the political and ethical issues that it is called upon to resolve; that of the legal experts who, from time to time, pronounce on inter-professional boundaries and responsibilities; and that of service providers and those responsible for managing

³ The description in this paper is consistent with an Actor-Network analysis (Latour, 1987; Callon, 1998). Our main concern in this paper has been to address the empirical issues involved in operationalising the ‘modernising government’ programme, and we plan to explore such issues further in a subsequent paper.

the delivery of services such as health and social care. In these three relatively distinct locales, and in a variety of ways, traditional practices based on individual agency delivery of services were problematised, and the ideal of co-operative working envisioned. Partnership working came to be presented as a ‘solution’ to a range of disparate and formally distinct issues.

Policy Makers Articulate the Co-operative Ideal

In one locale, that of central government policy making, public servants were berated for being insufficiently entrepreneurial and excessively risk-averse (Cm 4310, 1999; Hood and Rothstein, 2000). This longstanding critique of parliament, ministers and the civil service represented them as inhabiting a culture in which rewards for success are limited, whilst penalties for failure can be severe. A high profile focus on policy and delivery failures by the Public Accounts Committee⁴, that received considerable media attention, was seen to have contributed to this culture (Strategy Unit, 2002). Ministers and public servants were depicted as unreasonably slow in taking advantage of new opportunities (Cm 4310, 1999, Chapter 1, p. 3), with implications for the quality of service delivery. The ‘modernising government’ programme was presented explicitly as a counterbalance to this culture of conservatism, caution and ‘blame avoidance’ (Hood & Rothstein, 2000). In the words of the Comptroller and Auditor General: “The Modernising Government programme seeks to encourage departments to adopt well managed risk taking where it is likely to lead to sustainable improvements in service delivery,” (HC 864, 2000, p. 2). Examples of such risks include failure to achieve stated objectives regarding service delivery, events that undermine public confidence in service organisations, or circumstances that result in failure to comply with regulations. Against such risks arising from innovation is touted the ‘risk of not taking risks’ (Suffield & Whitehouse, 2000, p.16-17). This refers to the potential risks that may arise from *not* experimenting with new initiatives, particularly those that hold out the promise of delivering better and more cost effective public services (HC 864, 2000, p.1). As stated in the Modernising Government White Paper (Cm 4310, 1999):

Auditors are rightly interested whether organizations obtain value for money. We want them to be critical of opportunities missed by sticking with the old ways, and to support innovation and risk-taking when it is well thought through...

Framed in this way, the injunction to innovate and take risks, albeit ones that are ‘well thought through’ and managed, is a way of problematising the supposedly conservative culture of central government. While this has implications for policies concerning partnership working, with its attendant and distinctive risks, the argument is much wider. Partnership working is called upon to help resolve a problem that pre-dates and exceeds the co-operative ideal embedded in and articulated through the modernising government programme.

In the locale of central government policy making, dissatisfaction was also voiced with the traditional separation of government into different departments and units for administrative purposes. This concern was expressed bluntly in a Comprehensive Spending Review White Paper on Modern Public Services in the following terms (Cm 4011, 1998, Chapter 4, p. 2):

Giving individual departments separate responsibility for tackling one part of a multi-faceted problem is a recipe for failure....

⁴ Appointed by the House of Commons to examine “The accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit,” (Standing Order No 148).

The establishment of the Social Exclusion Unit in 1997 by the Prime Minister provides one example of the attempts to produce ‘joined-up solutions to joined-up problems’ at the heart of central government. Staffed by a mixture of civil servants from a number of government departments, together with external secondees from organisations with experience of tackling social exclusion, the unit seeks to help government reduce exclusion caused by a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown. The Prime Minister’s Strategy Unit, set up in 2002 and bringing together the Performance and Innovation Unit, the Prime Minister’s Forward Strategy Unit, as well as parts of the Centre for Management and Policy Studies, provides another example of central government endeavours to tackle issues that cut across departmental boundaries by means of organisational re-design.

In more localised settings, rigid institutional boundaries were held to have resulted in unco-ordinated service delivery, inefficiency, complication and confusion (Cm. 4310, 1999, Chapter 3, p. 1). In national level policy debates, health and social services were particularly criticised for the poor co-ordination of their services⁵. The Discussion Document titled *Partnership in Action: New Opportunities for Joint Working between Health and Social Services* by the Department of Health set out this critique as follows (1998, p. 3):

All too often when people have complex needs spanning both health and social care good quality services are sacrificed for sterile arguments about boundaries. When this happens people, often the most vulnerable in our society – the frail elderly, the mentally ill – and those who care for them find themselves in the no man’s land between health and social services....

Partnership working, as set out in the Health Act 1999, was called upon to provide a solution to these distinct yet related issues. The supposed conservatism of central government, the traditional separation of government into different departments, and the criticisms of poor co-ordination among service providers such as health and social services, were just some of the problems that formal partnership working was expected to resolve.

Legal Experts Adjudicate on Inter-professional Boundaries and Responsibilities

In the locale of legal judgment, the prominent and highly influential ‘Coughlan case’ in the late 1990s brought issues of institutional and professional boundaries, and co-operation across them, into sharp relief⁶. The case centred on a person who was severely injured in a road traffic accident in the early 1970s. The accident left Miss Coughlan tetraplegic, doubly incontinent, requiring regular catheterisation, partially paralysed in the respiratory tract with consequent difficulty in breathing, and subject to attendant problems of immobility as well as recurrent headaches caused by an associated neurological condition. From the time of her accident until the events at issue in the court case, Miss Coughlan’s care, which had always included but not been confined to nursing care, was accepted as the responsibility of the NHS, acting through her local Health Authority. Between 1971 and 1993 she received NHS care in Newcourt Hospital. In 1993, along with seven comparably disabled patients, Miss Coughlan was moved, with her agreement, from Newcourt Hospital to a purpose-built facility, Mardon House, which she had been promised would be her home for life. The decision of the Health Authority, made on 7 October 1998, to close Mardon House and transfer the care of Miss Coughlan and other disabled patients to Local Authority Social Services, gave rise to litigation and subsequent appeal. The arguments concerning the closure of Mardon House raised

⁵ See, eg Audit Commission reports 1997, 1999 and 2000 regarding co-ordination of services for the elderly.

⁶ The problem was not a new one. A similar dispute, often referred to as the ‘Leeds case’ (HC 157, 1994), had led the Department of Health to issue guidance regarding NHS responsibilities for continuing care needs in 1995 (HSG (95) 8), and revised guidance in 1996 (EL (96) 8).

a number of legal points that had far reaching implications about the relative responsibilities of health and social services for nursing care, about criteria for deciding who is eligible for nursing care free of charge in the health service, and about procedures for consultation. At the hearing of Miss Coughlan's challenge to the closure of Mardon House before Mr Justice Hidden, Miss Coughlan won on all grounds. The statement by Mr Justice Hidden that: "Nursing is 'health care' and can never be 'social care,'"⁷ suggested a very clear and firm boundary between health and social care. The Health Authority appealed, and the Secretary of State as well as the Royal College of Nursing intervened on the Appeal. The Appeal was heard by Master of the Rolls, Lord Justice Mummery, and Lord Justice Sedley whose judgment began as follows⁸:

The critical issue in this appeal is whether nursing care for a chronically ill patient may lawfully be provided by a local authority as a social service (in which case the patient pays according to means) or whether it is required by law to be provided free of charge as part of the National Health Service.

The Appeal judges commented⁹:

If the judge's decision is right on this issue, his decision will have significant adverse financial consequences for the Secretary for State and the Health Authority. [...] if the judge is right, those who receive nursing care while residing in the community in a nursing or similar home provided by a local authority will be entitled to have that care provided free of charge [...]. If the judge is wrong, it means that the nursing services will have to be paid for, unless the financial resources of the person concerned have been nearly exhausted.

The Health Authority's Appeal, with respect to the specific issue as to whether the closure of Mardon House was unlawful, was dismissed¹⁰. However, in summarising the more general principles at stake, the Appeal judges made it plain that the NHS should not have sole responsibility for all nursing care¹¹.

It follows that we do not accept the judge's conclusion that all nursing care must be the sole responsibility of the NHS and has to be provided by the Health Authority. Whether it can be provided by the local authority has to be determined on an assessment of the individual concerned.

According to this ruling by the Appeal judges, the provision of nursing care, and payment for it, could not be decided according to the type of care provided or the location in which the care was provided. Nursing services could, according to the judgment, be provided as social care, rather than as a health service, and as such would be subject to the same regime for payment as other social services (ie means-tested). The fact that some nursing services could be regarded as part of social services' care, to be provided by the local authority, would not, however, mean that all nursing services should be treated in that way. There could, the Appeal judges stated¹²:

... be no precise legal line drawn between those nursing services which are and those which are not capable of being treated as included in such a package of care services.

⁷ R v North and East Devon Health Authority, *ex parte* Pamela Coughlan, Case No. QBCOF 99/ 0110/ CM54, 16 July 1999, paragraph 18.

⁸ Ibid. paragraph 1.

⁹ Ibid. paragraph 19.

¹⁰ The decision to close Mardon House, funded by the Health Authority, was decided on appeal to be unlawful on three grounds: firstly misinterpretation by the Health Authority of its statutory responsibilities; secondly unlawful eligibility criteria; thirdly unjustified breach of promise by the Health Authority that Mardon House would be a home for life (Ibid., paragraph 118).

¹¹ Ibid. paragraph 31.

¹² Ibid, paragraph 30 (d).

The judgment continued¹³:

The distinction between those services which can and cannot be so provided is one of degree which in a borderline case will depend on a careful appraisal of the facts of the individual case.

The Coughlan judgment gave rise to a plethora of documents setting out formal guidance that directly or indirectly addressed the boundaries between health and social care, and the conditions under which 'free' nursing care should be provided. The Department of Health issued guidance on action required in response to the judgment (HSC, 1999/ 180), and revised guidance in June 2001 (HSC 2001/015; LAC 2001/018)¹⁴. A circular and practice guide on 'free' nursing care was issued by the Department of Health in August 2001, noting that responsibilities for continuing NHS health care remained unchanged. And in January 2002 the Department of Health issued a circular (HSC 2002/001; LAC 2002/1) and guidance on the implementation of a single assessment process for older people. The main purpose of this assessment process was to ensure that individuals receive appropriate responses to their health and social care needs, and that agencies do not duplicate care provision. Unsurprisingly, this spilled over into other domains. The Health Service Ombudsman was called upon to investigate a number of complaints about arrangements for long term NHS care for older and disabled people. The issue of eligibility for NHS funding for care in nursing homes was central to the case brought by many of the complainants. As a result of these cases, the Ombudsman issued a report on continuing care in February 2003 (HC 399, 2003). Following this report, Strategic Health Authorities were instructed to agree with local councils a set of criteria for continuing care, consistent with the guidance issued by the Department of Health in June 2001 (HSC 2001/015; LAC 2001/018)¹⁵. In these different ways, and with a starting point in the legal domain, the issue of co-operative working across professional and administrative boundaries was given increased prominence.

Service Providers Define the Co-operative Ideal in Local Terms

Concerns regarding the adverse implications of rigid institutional boundaries were voiced also by a variety of providers of complementary services in a number of different fields. In one site, services for the elderly were considered to have suffered as a result of the separation of health and social care. Imprecise boundaries between health care and social services in the context of distinct budgetary units, together with tight budget constraints, were seen to have led to major tensions. As one interviewee commented:

... Five years ago there were extreme tensions in our relationship, between health and social services. [...] the perspective of each party was that we were not understanding each other's position and the demands. And the social services' perspective on that would have been that health was not recognising its responsibilities for financial support for people who had continuing healthcare needs [...]. There was such a major pressure we had to do something differently.

In the winter of 1997, delayed hospital discharges of elderly patients had led to serious budgetary problems in this site. Local innovations that emerged indicated dissatisfaction with single agency working. Co-operative arrangements were devised to try to address many of the concerns. New forms of co-operative working involved joint planning and monitoring of targets for a maximum

¹³ Ibid., paragraph 30 (e).

¹⁴ The guidance issued in 2001 listed the issues that health authorities had to consider when establishing eligibility criteria for continuing NHS care, ie: "A package of care arranged and funded solely by the NHS,".

¹⁵ Strategic Health Authorities were required to review their continuing care criteria in use since 1996, with a view to assessing whether they were consistent with the Coughlan judgment. Where criteria were not consistent, they were to report on when this was identified, what action was taken, and an estimate of the number of people who may have been wrongly assessed.

number of delayed discharges, as well as budget transfers from health to social services under the 'Section 28A' arrangements of the NHS Act 1997¹⁶. Further, a multi-agency team was formed to conduct joint assessments for nursing home care, made up of a consultant geriatrician, an occupational therapist, a community psychiatric nurse, a social service manager, a care manager, a community care manager and a district nurse. Also, for continuing care placements, there was an experiment with lead commissioning by a social services purchasing manager. The advantages of such co-operative arrangements seemed self-evident to the service providers in this site. Speedier access to services, a simplified structure of service provision, less uncertainty for clients, as well as a reduced possibility of gaps in service provision were appealed to as likely benefits of lead commissioning. As explained by one health care representative:

... The processes are going to be from the health funded placements a lot speedier, once you mention churning in a defined number of nursing homes that are on the approved list and also giving that structure to families also actually dovetailing into the process which having one organisation responsible for placement of the care in the community [...] and therefore individuals not having to think about is this a social services case, or is this a health funded case, who do I go to [...]

In the managerial and administrative locale of service provision, the idea of co-operation was given increased visibility by pressures to meet budgetary targets and reduce costs. This was not a simple matter of arbitrary cost reduction, but a complementary move that reinforced the principle of partnership working and co-operation. Partnership working that enabled more careful assessment of the care needs of the elderly was seen to provide an answer to some of the increasing pressures of financing care. A social services representative spoke of the savings that had been lost prior to the introduction of joint assessment of nursing home needs between health care and social services agencies:

... For every one nursing placement made, two or three residential placements could have been made, and a whole lot more people could have been supported in the community [...]

Careful assessment by the newly established joint assessment team of the eligibility of clients for nursing home care, as opposed to residential or community based care, had resulted in substantial savings. Further savings were expected as a result of the planned review of all existing placements. As stated by a social services representative:

There's a fairly significant proportion of people still being funded in nursing homes who don't need nursing.

Formalised partnership working in the shape of lead commissioning seemed to offer a solution to other issues that gave rise to financial pressures. Joint commissioning of continuing care placements in the market, in which there was a limited and decreasing number of nursing home providers, was seen to offer a better way of controlling unwarranted price inflation. As explained by the social services representative in this site:

... Having the Health Authority come along and place people in nursing homes without being able to differentiate clearly why that placement is different from our nursing home placements at a much higher price [...] pushes our prices up [...]. So we're currently trying to keep a view of what's going on in the marketplace so that we can be aware of the incoming pressures that will hit us every time we go through our price negotiations.

¹⁶ Section 28A had made money transfers between health care and social services providers possible, prior to the introduction of Health Act 1999 flexibilities.

The combined purchasing power and expertise of health care and social services were considered to offer significant potential savings in commissioning of continuing care placements, or purchasing of specialist equipment. As expressed by a social services representative:

... You really need to capitalise on the opportunity.

Joint monitoring of contract compliance was seen to offer similar financial benefits. In the more extreme cases, this could entail the detection of fraud, as described by a social services representative:

We have a very unsophisticated way of checking that a service has been delivered by sending out a form for homes to return simply to confirm that the placements we think they've got are still alive and kicking [...] and by the time we've got their signature to the fact that Mrs Bloggs is alive when she died 12 months ago gives us the evidence to call it fraud, basically.

Joint monitoring processes, involving field visits, had been put in place to avoid unnecessary costs:

... Health funded placements will go into our system of contract compliance, contract monitoring so we'll be looking at getting checks from the homes about services that have been commissioned and wanting evidence that they've actually been delivered. [...] we found that from one of our early contract monitoring visits that we'd been paying a top up of £50 a week for hydrotherapy for an individual and the service had stopped when they closed the pool six months before [...]

Another area of service provision, that of care for people with learning disabilities, highlights the multiplicity of issues around which the ideal of co-operative working developed. The shift from institutional to community based care for the mentally ill in the US in the 1960s had given visibility to the issue of inter-agency provision. Similar developments in the UK some two decades later reinforced the point. Within institutions, the mentally ill were wholly in the medical domain. Placed in the community, they inhabited a domain that was part medical care and part social care. In addition, other service providers such as housing and education were often part of the picture. Patients needed therefore to draw on the services offered by dispersed community service organisations (Provan & Milward, 1995). While de-institutionalisation for the mentally ill pre-dated the modernising government programme, the 're-provision' programme for people with learning disabilities coincided with it. The policy commitment to 'integrated living' (Cm 5086, 2001; Cm 4310, 1999) gave added impetus to the view that an organisational and financial solution needed to be found to this highly specific process. Inter-agency working was held to be required between a number of service providers, including social services departments, the NHS, Borough Council housing departments, housing associations, and care agencies.

The concept of formal partnership working was actively embraced at one site where a major re-provision programme, aimed at the closure of a specialist hospital for people with learning disabilities, was in process. The success of the de-institutionalisation programme was seen by the actors involved to depend partly on the management of services in a co-ordinated way, partly on successful arguing of the case to the community. The risk of failing to give adequate support for the client group, or the risk of failing to arrange sufficient consultation within the community, were to be minimised by cross-organisational co-operation and effective information sharing. To facilitate the process of de-institutionalisation, and to support more efficient co-operative working between statutory and independent organisations, formal partnership working, in accordance with the Health Act 1999 flexibilities, was being experimented with. The head of learning disability services had been appointed to the role of lead commissioner for learning disability services on behalf of both health care and social services in this locality. The modernising government agenda promoted 'more innovative', 'more joined up', 'more locally responsive', and 'more efficient' services, along with the need to 'transform government so that it is organised around what the public wants and needs, rather than around the needs and convenience of the institutions' (Cm 4310, 1999). These

ideals were seen as consistent with, and gave support to the de-institutionalisation programme already underway. The project was considered to have produced significant improvements in services, and in the overall quality of life for the client group targeted. As the head of learning disability services enthused:

Come and see somebody who lived in an institution a year ago, see their demeanour... and then see them a year later in their own home.

In this site, a move away from institutional-based care for those with learning disabilities was celebrated not only by those responsible for the delivery of services. This programme also found favour in managerial circles due to its perceived potential for helping to reduce expenditure on services. A senior health authority representative articulated the view that partnership working offered a potential and partial solution to long standing financial concerns as follows:

... (We have) a history of poor performance in terms of a big financial deficit which has been accumulated over the years [...]. An important part of our financial strategy is to try and reduce our investment in learning disability services and that's associated with [...] the re-provision programme [...]

In these widely varying locales, institutional and professional boundaries came to be defined as a problem by a variety of actors. Reciprocally, the ideal of co-operation through partnership working came to be defined as a way of overcoming many of the difficulties associated with single agency working and service delivery. For those critical of the conservatism of central government, partnership working offered the possibility of well managed innovation consistent with the modernising government agenda. In another locale, it held out the promise of rectifying the perceived shortcomings of decades of single-agency provision of services. Partnership working was made consistent in many respects with existing communities of practice, which were able to translate the injunction to co-operate into their own localised agendas. In the case of services for the elderly in one site, partnership working was consistent with attempts across the previous five years to overcome extreme tensions between health and social services. In the case of people with learning disabilities in another site, the generalised injunctions to co-operate were accentuated by a specific event - a major re-provision programme aimed at closing a specialist hospital for people with learning disabilities, and transferring their care to community-based provision. And in the case of the financing of services, partnership working aligned readily with localised agendas to the extent that budgetary pressures and cost savings appeared more achievable through co-operative arrangements. The ideal of co-operation thus emerged in a multiplicity of locales, and was made to fit a variety of existing agendas. In most cases, the fit was achieved with relative ease, at least in the early stages, when it was more a matter of aligning ideals and aspirations rather than transforming structures and governance arrangements. In the next section, we examine how this emergent ideal of partnership working and co-operation was made operable by those delivering actual services.

3. Aligning the Ideal of Co-operation with Service Delivery: choice of client groups, types of partner and forms of partnership

Single agency working had been called into question. Co-operation and innovation had been made to appear obligatory in a variety of locales. Partnership working appeared to offer a solution to a range of diverse concerns. This was not just a matter, however, of rethinking service provision and organisational arrangements within each locale. For the locales are linked. In particular, the emergence of the co-operative ideal at the level of individual service providers arose in part out of a perceived need to satisfy external demands. Even though Section 31 of the Health Act did not formally require partnership working, it was none the less perceived by actors in health and social service agencies that some steps in this direction were needed. Formal partnership working was, in many instances, strongly driven by the attempt on the part of service providers to improve their

reputation amongst a variety of regulatory, monitoring and funding bodies. “It’s about brownie points,” commented one interviewee. The propensity of service providers to present a positive gloss was expressed by this interviewee as follows:

I think there’s an element now of almost expediency... that Section 31’s here, the government is now saying you’ve got to deliver on it. ... (We are) a monitored authority in terms of social services [...]. There’s a will, a desire to try and persuade the SSI (Social Services Inspectorate) that we’re fully embracing the modernisation agenda [...]

While pressure to show willingness to experiment with the Health Act flexibilities was felt most strongly in sites with recognised problems with service delivery, representatives at all sites studied felt that they were under considerable pressure to deliver changes that would fit the government’s modernisation agenda. According to one interviewee:

You’ve got to remember that all these [...] modernisation agendas across health and social care, we’re all being pushed to deliver on all of it...

Government departments and their representatives were understood to have their own goals and targets, as one interviewee remarked:

... The government wants to be able to say we’ve now got 50 Section 31’s [...]

While those responsible for overall policy delivery in government departments, such as health, were keen to see experimentation taking place, service providers at the local level had to make things operational. A social services representative described the pressures her locality was under as follows:

... There was a sense that Department of Health were playing up the project and talking about this leading to pooled budgets for continuing care placements and so on and so forth. And there’s a strong feeling in the steering group that we’re learning to walk at the moment and please don’t make us sprint.

Due to these considerable external pressures to experiment with the new flexibilities, and the eagerness of government departments to demonstrate success in delivering the modernisation programme, the perceived risks of not being able to deliver were also regarded as high by those interviewed. The sharpened focus on ‘failing services’ by the new inspectorate and regulatory regimes, such as star ratings for health care and social service organisations, as well as comprehensive performance assessment regimes in local government, have induced a greater sense of vulnerability among senior staff (Martin, 2000; Newman, Raine & Skelcher, 2001). One way of managing this risk was seen to be to experiment with partnership working informally, prior to committing to formal co-operation. According to one interviewee:

What you might be finding is that in different localities they’re working stuff up but not actually going public on it until they know they can deliver...

Another possibility was to support the modernisation agenda publicly, and even to begin the process of creating formal partnerships, but to avoid being a forerunner. According to another interviewee:

There’s something about striving to be average isn’t there. You head up too far and you get shot down and you go too far down the performance ladder and you get shot as well, so if we can stay with the herd, you’re probably safest.

An ability to demonstrate a willingness for partnership working, and even to achieve some progress in making it operable, was generally considered important. It mattered to these actors how the external funding and inspectorate bodies viewed them.

Against the risks of not taking risks there were risks related to the experimentation with new forms of partnership working. Experimentation was seen as hazardous for a variety of reasons. The possibility of embracing the publicly declared ideals of co-operation, while adapting them to multiple existing and localised agendas, allowed the actors involved in delivering services to align multiple and differing requirements. While the Health Act 1999 encouraged formal partnership working across a wide range of client groups, and with a range of partners, it allowed sites to experiment with one or more of three forms of flexibilities – pooled budgets, lead commissioning, and integrated provision. In addition, it left open the choice of client groups for which partnership working might be developed. The perceived risks of co-operative working had implications for the choice of client groups, partners and the particular forms of partnership working adopted.

When those interviewed were asked about the reasons for selecting a particular client group, considerations were typically pragmatic. Reasons commonly cited included the relative ease of experimenting, and the likelihood of success. This unwillingness of key actors to take risks had an important influence on the client groups selected for formal partnership working. According to one interviewee:

We wanted schemes that were well placed for success [...] so, I guess, we've taken a fairly safe approach in looking at some easy wins...

According to another interviewee:

I'll be honest here that the reason why we went for these (client groups) is that we think they're going to be straightforward [...]. We're already there. The structure's there more or less it's just actually regularising it, for want of a better term, into a formal Section 31 arrangements [...]

Risks were also managed by careful choice of partners. Experiments with formal partnerships in the sites studied centred mostly on client groups and partner organisations with whom experience in joint working had already accumulated. As one interviewee commented:

We were absolutely clear that we weren't going to create new schemes to fit flexibilities but that we were trying to identify areas where existing partnership work in projects happened which we thought could be supported and enhanced by the use of flexibilities. So all the schemes had some notion of partnership context around previously. We looked at being clear that the schemes must need to exercise one of these flexibilities to make progress and they had some things that we thought were going along pretty well already [...]

Another interviewee saw experience of prior co-operative working as highly significant:

There was a bedrock of joint co-operation already between social services and health [...]. When you've actually got that kind of foundation and bedrock it's a lot easier to have the confidence and ability to actually jointly work together and actually have some degree of confidence that things are going to be delivered.

Similarly with the choice of a client group and partners, costs and benefits as well as potential risks were considered when choosing the particular form of partnership working. The potential risks of partnership working were often related to a concern about possible loss of control over financial resources. Pooling resources was perceived as risky, in comparison with lead commissioning, because of the 'loss of identity' with regard to sources once the money had been pooled. According to one health care representative:

The obstacle to pooled budgets is that within the whole of that business, nobody trusts each other enough just to hand over their budgets...

A related problem was accountability for the use of money. As explained by this interviewee:

However much they pool it [...] they've still got to account for the money.

A consultation document seeking endorsement from the local Family and Community Care Sub Committee for experimentation with lead commissioning of continuing care placements, in one of the research sites, discusses the risks of partnership working for the local authority social services department. Under the heading 'risk management', the document discusses the benefits of lead commissioning as opposed to pooling of resources as follows:

In financial terms, there is negligible risk for the (Social Services) Department as the budget for continuing care remain with the relevant Primary Care Group. The lead commissioning arrangement will provide authorised and coded invoices for the PCG to pay Providers of care and information relating to budget management. Any 'overheating' of budgets caused by increased demand as identified by Health professionals will remain a Health responsibility.

In many sites, the benefits of pooling resources, as opposed to employing other forms of partnerships working perceived as less demanding, were not considered to outweigh the risks. For one senior health care representative, the additional benefits of pooling resources, as distinct from engaging in joint commissioning, were not clear. He stated as follows:

One needs to be clear about what those benefits actually are, what can you achieve through joint commissioning and what extra benefits do you get from having a pooled budget [...]. So I think it's very much an experimental thing at this stage and we just need to move fairly cautiously, set up some pilots, evaluate them and in a sense see whether there are benefits achieved by a pooled budget as opposed to just the joint commissioning process [...]

One of the research sites was experimenting with pooling resources for children's services. The perceived risks associated with pooling resources had been overcome in this site by not having to commit existing resources to the 'project'. The availability of new ring-fenced 'modernisation money' had helped experimentation with a pot of money, as if it was a pooled budget, in this locality. As explained by one social services representative:

... New ring fenced money came along, modernisation money, some of it was delivered to health, and some of it was delivered to social services and we made the decision to use that as though it was a pooled budget [...]. We have made joint decisions in relation to this pot of money for the last two years as though it were a pooled budget [...]

The availability of 'new money' had influenced the form of partnership chosen. Experimentation with a pooled budget, in this particular case, was seen as less risky than lead commissioning or integrated provision, which were seen to require 'longer term commitment'. Experiences with joined-up working had been positive so far:

... We have shifted in thinking departmentally about that pot to thinking in terms of meeting children's holistic needs [...]

The real test, however, was seen as the moment when resources were to be brought into the pooled budget from the baseline budgets of various agencies. As explained by this interviewee:

... The next thing that we're going to do is try and identify what monies are in our baseline budgets in this area of service as well, and bring that into the pooled budget as well. So in a way we've done it the easy way round because we've got co-operation there, agreement in principle, new money, great. The difficult bit is agreeing what should go into that from our baseline budgets [...]. It will be an interesting and testing exercise.

In many sites, risks related to partnership working were typically seen to be managed and reduced by progressing on a piecemeal basis. The idea, in a number of sites, had been to start with joint commissioning, and to move towards pooled budgets. A health authority representative explained this as follows:

... We've now got joint commissioning in place. [...]. As we move forward into next year, we will gradually develop pooled budgets. We don't see pooled budgets as being something you can just achieve overnight [...]. We think it's better to get a commissioning framework in place and then on a piecemeal basis put resources into a pooled budget as you understand what the implications of that would be...

Another interviewee, in the same research site, supported piecemeal progress in similar terms:

I suppose there's more of a nervousness and anxiety about moving to pooled budgets quite quickly before understanding how the joint commissioning arrangements are going to work in detail and how they will pan out, there's lots of issues to be resolved [...]

The co-operative ideal of partnership working thus emerged in a variety of locales, and its meaning and significance was understood differently by different communities of practice. This new regulatory programme required alignments to be forged between these multiple locales and meanings. In particular, those delivering services translated the injunction to co-operate into modes of working that satisfied local conditions and practices as well as more general ideals. Despite the variation between sites, the general enthusiasm for partnership working was tempered by pragmatism and local conditions when deciding whether to take a large step in the form of pooling of budgets or experimenting with integrated provision, or whether to take a smaller step by experimenting with lead commissioning. At the time of our interviews, and apart from cases where new ring-fenced money was available, the general picture was one of significant nervousness regarding the use of pooled budgets. The ideal of co-operation was aligned with existing practices, allowing service providers to demonstrate their commitment to modernisation, while minimising the dangers of formal partnership working. But more was at stake than simply trying to reconcile in pragmatic fashion differences of emphasis or interpretation. At stake also were the different managerial and professional cultures in health and social services, inter-professional boundaries and the tensions between professional groups which are individually far from homogeneous, and the ways in which they impacted on the possibilities for formal partnership working. It is these issues we turn to consider in the following section.

4. Modernisation and Inter-Professional Boundaries: the tensions inherent in the co-operative ideal

If the principles of modernisation and co-operation are difficult to challenge openly, making them operable takes us beyond the realm of abstract programmes and ideals. In particular, it takes us into the realm of a specific inter-professional encounter – that between health care and social services – as well as to more localised encounters within the field of health care itself. Despite the general policy commitment to co-operate, and notwithstanding the expressed commitment to cross-sectoral working by key actors in the sites studied, this inter-professional encounter brought into sharp relief the tensions inherent in the co-operative ideal.

The head of commissioning and performance management in one of the sites put the matter bluntly:

We do not speak the same language. And we have different values and attitudes, so there's a lot of work as we go through this.

The problems caused by different organisational cultures, languages, values, and attitudes could not be resolved by mere organisational changes, according to this interviewee:

We may have arrangements organisationally in place, but we can't think that the work is going to finish then.

The different governance arrangements of health and social services were viewed as important limiting factors by those in both locales, although the reasoning in health and social services was very different. The chief executive of one health authority described the complexities he had experienced when working with social services, by stating:

You have got people sitting round the joint board who are not used to sitting around a board making decisions.

He also noted the 'very delicate negotiations about who's going to be chairing the joint board'. The chief executive of a hospital trust, located in the same research site, commented on the difference between the 'statutorily ordained governance arrangements' and the 'freedom and the power within which key individuals can flex them'. While he described himself as having 'enormous freedom to flex the government's arrangements around an NHS Trust', he described 'the scrutiny that is in the County Council' as 'horrendous'. Ironically, whereas these chief executives from the domain of health care regarded local authority-based decision-making as slow, politically motivated and bureaucratic, the lead commissioner based in social services in the same research site, saw things quite differently. He noted the problems of working with central government run health services by stating:

The culture of the Health Authority is a very control culture, right down from the Minister... We (social services) don't tend to have that... That's the reality of democracy. So we don't have this overbearing mountain from above.

These differences in governance structures were evident not only at senior management levels, but also at the operational level. As a consequence of partnership experiments, different governance regimes had come into contact increasingly with different professional cultures, which had exacerbated the problems. Differences in professional cultures were regarded by a number of our interviewees as a significant obstacle to developing joint working. The greater the number of professional groups involved, the more difficult things were seen to become. The head of children's services in one of the research sites gave children and adolescent mental health services as an example of an area that had been regarded as the 'too difficult box' because of its 'multi-agency' and 'multi-professional' nature:

Children and adolescent mental health services is traditionally an area that has caused a lot of tensions in multi-agency working [...]. You've got psychiatrists, you've got nurses, you've got therapists, you've got administrators... there are lots of professional dimensions to it.

The problems arising from different professional cultures were mentioned also by the joint commission team manager in one of the research sites. He explained how, in his view, attempts to create joint review of care needs had 'hit a brick wall' in this location because of some therapists hanging on to the professional standards of their Royal Society, and questioning any other professionals having a say about how services should be organised. This team manager stated:

Assessments on the wards are nurse and consultant led. Social workers aren't even involved in the bloody assessment, which is nonsensical when you're talking about whole systems (approach).

Conversely, he referred to 'real tension' between social workers and other mental health professionals as to 'who's taking the lead' in the area of services for the elderly mentally ill. He claimed to have witnessed, on a number of occasions, social workers questioning the idea that another professional could lead the care planning for an older person. These inter-professional

issues, according to him, needed to be resolved at a grass roots level to create a basis for joint working:

That's where the investment needs to actually take place. (The idea of a) pooled budget, in one respect, is all a bit previous, to be honest, until you sort out some of those basics.

Integrated service provision, to be achieved through the new organisational form of Care Trusts introduced in the NHS Plan by the Department of Health in summer 2000 (Cm4818-I, 2000), was viewed by many of the interviewees as particularly threatening to staff located in social services. According to the head of commissioning and performance management in one of the research sites:

People are threatened because they feel the social work profession is under threat and things are going to change.

A joint commission team manager in another site had registered similar concerns. He stated:

Many in the social care arena feel that it is part of the takeover process by health of their services.

But inter-professional rivalry was not only seen to exist between health and social services. According to the director of mental health in one of the study sites:

Those tensions exist not only between health and social care, but also within the health system.

In the view of the joint commission team manager in one of the research sites, the issue of professional boundaries within health care services had been accentuated by nurses 'taking on additional responsibilities' which doctors 'perceived encroach on their professional domain'.

In face of these difficulties, a range of ways of dealing with them was suggested by those interviewed. A change in the management team was cited by the health authority chief executive in one of the research sites as an important factor facilitating the use of formal partnership working. In another site, the corporate director of social services cited a radical reshaping of organisational units as the main facilitator. According to this interviewee:

(With the establishment of) a joint commissioning team... funded by both (health and social services) and doing the commissioning for both organisations... people began to see concrete evidence of the way they intended to work in the future.

A further possibility for addressing the tensions arising from different operational and professional cultures was the recruitment of persons who are not overly committed to existing boundaries. In one instance, a different educational background (MPhil in social anthropology), as well as prior experience in a wide range of organisations including the private sector, a community health council, and local government were seen by one corporate director of social services as having helped him in generating new forms of co-operative working with health service partners. This interviewee explained:

I don't have any particular thing about preserving local government for the sake of it. So it makes working on the boundaries much easier for me.

These multiple and sometimes highly localised inter-professional encounters were viewed by some as competitive, although hybridisation, a combining of the skills and knowledge base of two or more professions, was also increasingly valued in the new environment (Kurunmäki, 2004). A 'lot of interchange' had started to occur, and 'various competencies', some of which were 'common to a number of the professionals', were being required. This could happen via formal training: 'Social workers can go on to become psychotherapists,' just as 'a nurse can go on to become a doctor',

remarked the director of mental health in one of the research sites. The learning of new skills could also occur as a result of joint working. The community care manager in the site experimenting with the multidisciplinary assessment of care needs of the elderly explained as follows:

Experience has shown that [...] initially staff within health and social services find their role a bit threatening... that somebody (is) coming in, having a professional overview of another profession... but, in fact, once the team have got engaged in an area, they are seen as actually helpful [...]. People within the team would say that joining the countywide assessment team has given them the opportunity to learn and extend their own capacity as professionals. They've learnt from one another and got a broader overview. They've seen it as a positive thing.

For those committed to the co-operative ideal, many of the inherent tensions could be alleviated by managerial changes, organisational redesign, and professional hybridisation. A substantial change in ways of working and thinking, however, was seen as necessary before successful formal partnership working could be made a reality. A corporate director of social services was highly critical of the way in which partnership working had been discussed in the meetings of the elected members of local authorities in his area. According to him:

The members were too busy all playing their own games.

His view was that there was 'a lot of mistrust' and 'lack of understanding'. Instead of seeing partnership working as a 'big opportunity', the elected members of the local authority had seen the development as 'local government loss of power'. The head of commissioning and performance management in another site encouraged a similar change in ways of thinking. Rather than focusing on problems, actors should see the opportunities. He underlined that those who were concerned to protect an organisation, or the boundaries of a profession, should 'embrace the change and influence it' rather than 'fight it and get nothing out of it'. In a third research site, one health authority chief executive regarded it as 'better to go about working in a partnership way than being at loggerheads with colleagues in local government'.

Despite these tensions inherent in co-operative working that manifested themselves in 'pockets of professional caution', and the occasional 'sense of frustration', as expressed by one interviewee, many actors were optimistic that a way of resolving the problems could be devised, even if the time frame might turn out to be rather longer than the reformers and policy-makers would have wished. According to the head of children's services in one of the sites:

The speed at which we've been able to go is slower than we would have anticipated in spite of our enthusiasm and commitment [but] there's a definite feeling that partnership work is the way of the future. It offers solutions.

This interviewee continued:

The difficulty is it actually takes time, you can't do it quickly... you've got to put the input of energy and time before you begin to see the results.

5. Conclusions

This paper has examined how the ideals of co-operation, modernisation and partnership working emerged as a set of organising themes for government policy in the UK in the late 1990s. These ideals emerged in a range of distinct locales, and in relation to varied concerns. Co-operative, or 'joined-up' working came to be seen as a panacea for longstanding difficulties identified by central government policy makers, those responsible for managing and organising health and social care, as well as those responsible for the actual delivery of care. As is often the case, accounting practices were called upon to mediate between different entities, interests and domains. Budgeting, in the

form of pooled budgets, was the most developed form of this aspiration to co-operate. A range of other accounting practices, including performance measurement and governance mechanisms, were also seen as central. Our research in five sites experimenting with the partnership proposals in Section 31 of the Health Act 1999 showed relatively little progress towards the more ambitious forms of partnership working such as pooled budgets, although this did not diminish its status as an ideal to be striven for.

In Section 2 we charted the emergence of the co-operative ideal in a range of locales. In addition, we explored the early experiments with formal partnership working in five sites. In Section 3, we considered the choice of client groups, the types of partner, and the forms of partnership selected. A perception on the part of service providers of external pressure to make use of the new 'flexibilities' made available in the Health Act 1999 had to be aligned with local conditions and practices. Existing communities of practices translated the new regulatory programme of modernisation and partnership into terms commensurable with a wide range of ongoing policies and practices. In Section 4, we considered one particular set of tensions inherent in the co-operative ideal, those associated with inter-professional boundaries. We examined the encounter between health care professionals and social services, as well as more localised encounters within the field of health care itself. Different governance arrangements, distinct professional cultures regarding issues such as assessments, and blunt issues such as control of resources and lack of trust meant that progress towards the more ambitious types of formal partnership such as pooled budgets was very slow.

Despite the tensions inherent in the co-operative ideal, and the extent to which local communities of practice were able to align this new regulatory programme with existing ways of working, the ideals of modernisation and partnership had become established in a relatively short period of time as fundamental to public policy in the UK. Co-operative working, in the sense of formal partnerships as defined in Section 31 of the Health Act 1999, came to be viewed as an imperative. Those responsible for managing and delivering services at the local level were busy devising practices that would align the ideal of co-operation with the existing governance practices and professional cultures, and in ways that secured potential benefits while avoiding the most obvious dangers. While formalised practices for managing the risks of partnership working remained to be developed¹⁷, the imperative to co-operate was firmly established.

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