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Regulatory hybrids: Partnerships, budgeting and modernising government

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ABSTRACT

This paper examines the 'modernising government' initiative in the UK, and the 'flexibilities' – lead commissioning, integrated provision, and pooled budgets – introduced in the Health Act 1999. This policy reform, and the associated tools to operationalise it, placed ideas of cooperation and partnership at the heart of inter-organizational relations in the domain of public administration, and gave prominence to the roles of management control practices in facilitating cooperation. We consider how the ideals of cooperation and partnership were discursively articulated, how professional and administrative boundaries were given visibility in particular legal cases, and what happened when local practitioners sought to make these ideals operable. We demonstrate how cooperation initially emerged as a 'local' phenomenon, both prior to and subsequent to the Health Act 1999. We then examine how those delivering services sought to mediate pragmatically between legal and policy injunctions to engage in formal cooperation, and the imperative to provide services across organizational and professional boundaries. Finally, we consider the limits of cooperation across organizational boundaries in settings with strongly developed professional enclosures. The paper draws on both archival material and fieldwork to examine what are termed 'regulatory hybrids' – those inter-organizational processes, practices and expertises that are formed from two or more elements that previously existed separately, and that emerge in part out of regulatory or judicial interventions rather than simply the imperatives of voluntary coordination. The paper seeks to build on suggestions for developing the links between the accounting and public administration literatures, and it draws on 'governmentality' studies to analyse the phenomenon. This argues for the importance of considering three distinct and interrelated layers or levels of analysis: the programmatic or discursive, the practices and processes to which such discourses are intrinsically linked, and the professional 'enclosures' that can emerge in some domains. While drawing on governmentality studies, we also suggest extending them by paying greater attention than is customary in such writings to localised processes and practices. In particular, we propose the concept of 'mediating instruments' to explain how management control practices link the larger political culture with the 'everyday doings of practitioners'.

1. Introduction

More than two decades of research by scholars of organizations have demonstrated the importance of inter-organizational relationships, and the existence of hybrid or intermediate organizational forms (Eccles, 1981; Granovetter, 1985; Nohria and Eccles, 1992; Powell, 1985, 1987, 1990; Teece, 1996; Williamson, 1979, 1985, 2002).

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During the last decade, accounting scholars have begun to explore the roles of accounting in inter-organizational relations, and within networks of organizations (Baxter and Chua, 2003; Busco et al., 2006; Cooper and Slagmulder, 2004; Dekker, 2003, 2004, 2008; Håkansson and Lind, 2004; Hopwood, 1996; Ittner et al., 1999; Meer-Kooistra and Vosselman, 2000, 2006; Miller and O'Leary, 2005, 2007; Mouritsen, 1999; Mouritsen et al., 2001; Seal et al., 2004; Tomkins, 2001). However, the bulk of this work to date within accounting has focused on the private sector, with little attention paid to inter-organizational relations within the public sector (Brignall and Modell, 2000; Clarke and Lapsley, 2004; Kurunmäki, 1999, 2004; Kurunmäki and Miller, 2006; Lapsley and Wright, 2004; Lehtonen, 2007; Llewellyn, 1991, 1994; Miller et al., 2008; Modell et al., 2007; Northcott and Llewellyn, 2003; Meer-Kooistra and Scapens, 2008). This paper seeks to help remedy this deficit, by considering the roles of management control systems in the context of inter-organizational relations in the domain of public administration. The example we focus on is the 'modernising government' policy that emerged in the UK in the late 1990s. This promoted 'partnership working' and the use of 'flexibilities', including novel budgeting practices, through the 1999 Health Act. We suggest that analysing these reforms illustrates something distinctive about inter-organizational relations and management control in the domain of public administration: the existence of what we term 'regulatory hybrids', those inter-organizational processes, practices and expertises that are formed from two or more elements that previously existed separately, and that emerge in part out of regulatory or judicial interventions, rather than simply from the imperatives of voluntary coordination (Kurunmäki, 2004; Miller et al., 2008).

The importance of noting the distinctiveness of such inter-organizational relations is attested by the public administration literature, which for many years has demonstrated that matrix organizations, inter-agency coordination, and complex networks are not only relatively common in the delivery of public services, but likely to increase still further in number and importance (Agranoff, 1986; Bardach, 2001; Berry et al., 2004; Bevir and Rhodes, 2003; Mandell, 1988; O'Toole, 1997; Page, 2004; Provan and Milward, 2001; Rhodes, 2000). Also, whereas networks have been a focus of public policy scholars since at least the 1960s, attention in the past decade has focused increasingly on complex networks and multiple interactions including information sharing across agency and programme lines (Provan and Kenis, 2008; Provan and Milward, 2001). It is important to obtain an empirically accurate picture of such networks, in order to understand the contexts in which the network's actors are embedded (Berry et al., 2004). As Modell et al. (2007) have argued recently, there is much to be gained by attending to the potential links between accounting and public administration research. While the latter draws attention to a range of public policy issues, including for instance the fragmentation of public service delivery and calls for a new performance management ethos, the former offers the opportunity to build on a substantial body of empirical work on the potential consequences of management control systems and their varying logics.

This paper seeks to build on these suggestions for developing the links between the accounting and public administration literatures. Specifically, we aim to demonstrate how inter-organizational and hybrid organizational relations have recently been discursively articulated as a public policy objective, how a particular policy initiative has sought to operationalise them through specific management control practices, and what happens when these aspirations come into contact with strongly defined professional groupings and boundaries. The research has been conducted through a mixture of archival study and fieldwork, in an attempt to understand the interrelations between large-scale policy changes and the localised operation of these through particular management control practices. We do not seek to explain the efficacy of the new arrangements, or to identify those characteristics of networks that lead to successful performance outcomes (e.g. Berry et al., 2004). We do, however, point to some possible obstacles to the development of partnership working, most notably the way in which professional 'enclosures' can, in strongly professionalised contexts, limit the possibilities for the creation of inter-organizational or hybrid forms.

We employ concepts drawn from the 'governmentality' literature to analyse this phenomenon (Foucault, 1991; Miller and Rose, 2008; Rose and Miller, 1992). This rather awkward term governmentality can give rise to confusion, particularly in relation to more contemporary or current notions such as 'governance', government and 'the' government. It is used here in the sense defined initially by Foucault (1991, p. 102), as "the ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power" that arose since the sixteenth century. Defined somewhat more broadly, it refers to those forms of indirect means of governing or acting on the behaviours or actions of individuals and groups of individuals, together with the varied ways in which the exercise of such modes of governing are reflected on and articulated discursively. Governmentality studies alert us to the importance of considering three more or less distinct layers or levels of analysis, and their interrelations: the programmatic or discursive; the practices, processes and instruments to which they are intrinsically linked; and the professional or 'expert' knowledges through which they are made operable, and which can give rise to 'enclosures' in some domains (Rose and Miller, 1992). This approach has been used successfully in accounting research and in many other domains, and we suggest that it can be usefully employed to analyse the emergence of particular types of inter-organizational relations in the context of the modernising government reforms.[1] But, while it has proved fruitful in analysing large-scale shifts in 'modes of governing' – for instance in relation to factories, prisons or social

[1] For a review of the scope of governmentality studies, and their application to a wide range of topics, see Dean (1999), Miller and Rose (2008).

life more generally[2] – to date it has been little used to examine the interrelations between large-scale policy reforms and the more localised re-design of management control practices and organizational arrangements for service delivery. In seeking to extend the governmentality literature in this respect, this article is necessarily exploratory and tentative, but we suggest it demonstrates the potential for further extensions of governmentality studies.

In accordance with the governmentality approach, we consider first the *programmatic* or discursive dimension of appeals to engage in inter-organizational cooperation through partnership working and use of the Health Act 'flexibilities' (Ezzamel et al., 2007; Miller and Rose, 1990, 2008; Rose and Miller, 1992; Morrison and Morgan, 1999; Wise, 1988). We examine how partnership working emerged in relation to abstract ideals articulated through various proposals that sought to re-design the delivery of services in ways considered 'modern'. Government reports, committees of inquiry, White Papers, the advice of consultants and academics, all helped articulate general political ideals concerning the 'modern' ends to which government should be addressed, and in the broadest terms how these should be delivered. These were more than wishes or intentions. They were ways of representing a domain such that it could be treated as an object of conscious political calculation and intervention. Governmentality research highlights the importance of attending to these often highly abstract values and goals, the generalised aspirations and ideals that are mobilised and articulated by a wide range of regulatory agencies and policy designers as they seek to re-design organizations and their interrelations.

Second, and equally importantly, governmentality scholars emphasise the various *practices and processes* through which administrative re-design – in this instance the creation of novel inter-organizational interrelations and management control mechanisms – is sought. In this respect, we seek to extend governmentality research by paying greater attention than is customary in such studies to the localised processes and practices through which programmes of government are made operational (Mennicken, 2008). Drawing on science studies, we propose the concept of 'mediating instruments' as a way of addressing this issue. Most generally, this means considering the ways in which a set of practices or instruments comes to embed distinct and possibly competing ideas into an operating ensemble. The instrument may be a machine, as Wise (1988) demonstrated with respect to the steam engine and the electric telegraph. It may be a model, as Morrison and Morgan (1999) demonstrated with respect to the Leontief input–output model. Or it may be a 'law', as Miller and O'Leary (2007) demonstrated with respect to "Moore's Law". Mediating instruments can link domains such as science and the economy, politics and medicine, or medical and social care. Mediating instruments operate as both means of representation and means of intervention, connecting with, yet remaining distinct from the object of intervention.

Our particular concern in this paper is with how such processes of mediation work out at the local level, and how the larger political culture interacts with the "everyday doings of practitioners" (Wise, 1988, p. 78). We address this in the particular context of the Modernising Government reforms and the 'flexibilities' introduced in the 1999 Health Act. We suggest it is important to attempt to understand how the emergence of new forms of inter-organizational cooperation and management control practices – new ways of structuring, assessing and monitoring work, and new ways of allocating and controlling resources through novel budgeting practices – are understood and framed in terms of both larger political ideals and localised concerns for service delivery. We suggest that focusing on such processes allows us to understand how these administrative reforms entail mediation between larger political transformations and the local concerns and preoccupations of practitioners of varied types. As actor-network theory has emphasised, this is not a uni-directional process, but entails assembling and linking together disparate and possibly competing sets of actors, activities and aspirations.[3] We suggest that scholars concerned with management control in the context of public administration should pay more attention to these discursive and instrumental processes of mediation, so as to better understand the conditions that give rise to, or hinder, the creation of novel inter-organizational practices and relations.

Third, and once again in accordance with the governmentality literature, we consider the professional *enclosures* that can arise in certain domains. By enclosures, we mean relatively bounded domains or modes of judgement and evaluation within which and through which the authority of a particular group of experts or professionals comes to be associated and concentrated. Enclosures may form around esoteric knowledge, technical skill, established position, or the control of resources (Kurunmäki, 1999, 2004; Rose and Miller, 1992). While such enclosures are not fixed and are subject to contestation, they can none the less play an important role in hindering inter-organizational cooperation. We suggest that this is more likely in highly professionalised contexts, such as health and social care, with their attendant clearly demarcated organizational boundaries. For inter-organizational cooperation, and the management control practices designed to facilitate it, can be hampered if one professional group or another seeks to translate the aspirations of policy reformers into their own interests, reinforcing existing modes of working rather than re-designing them in line with policy initiatives. We suggest that a focus on the varying strength of professional enclosures and boundaries – both across different service domains and different national contexts – can help us analyse the conditions under which inter-organizational cooperation and associated management control practices can emerge.

These three levels of analysis suggested by governmentality studies are, we propose, complementary to some

[2] See for instance Dean (1999), Miller and Rose (2008) and Rose (1990).

[3] We owe much of our thinking here to ideas derived from the works of Callon (1998) and Latour (1987), even if we do not frame our enquiry here explicitly in terms of actor-network theory.

existing concerns in the public administration literature, as well as with recent calls to widen the analysis of management accounting research by examining the interplay between management control and the broader political and institutional environment (Dillard et al., 2004; Modell et al., 2007). The focus on changing patterns of governance, defined as the aggregates of "the patterns of thought that inform a political practice" (Bevir and Rhodes, 2003, p. 42), is similar to our focus here on the programmatic or discursive aspect of modes of governing. Bevir and Rhodes (2003) trace the patterns of thought informing British governance, and document the shifts from hierarchies to markets, and then to networks. While endorsing their emphasis on the beliefs or concepts that inform differing modes of governance, we seek to go beyond their analysis of aggregates of concepts by unpacking the ideas and beliefs behind particular policies, and by considering also the practices and processes through which their enactment is sought, and the ways in which professional enclosures can limit the development of inter-organizational relations. As O'Toole (1997) argues, the limits that liberal political theory imposes on government intervention can encourage the further development of inter-organizational and network forms for service delivery, paradoxically extending the reach of government programmes while loosening their immediate managerial grasp. While much has been accomplished by researchers in the intervening decade, there still remains much to be done, particularly for those topics that reside at the intersection of more than one discipline. This is the case for our concern here with the 'modernising government' and 'partnership working' policies. To understand these initiatives adequately, we suggest, requires consideration of the dynamics that arise at the intersection of practices or processes for enacting management control, the programmatic or discursive ideals that animate them and help define their roles, and the professional enclosures they may come into contact with.

It is to a consideration of these interactions that we now turn. The next section describes these policies in greater detail, and also the methodology followed in this study. The following sections consider, in turn: the emergence of the cooperative ideal in both policy and judicial contexts; the ways in which these ideals intersected with local formulations of joint and partnership working; and the encounters between management control practices, cooperative ideals, and particular professional enclosures.

2. Policy context and methodology

This paper focuses on the 'Modernising Government' initiative, and the associated 'partnership working' policies promoted in the UK in the late 1990s. More specifically, we examine formalised partnership working as specified in Section 31 of the Health Act 1999,[4] distinguishing it from the informal cooperation among service providers that has long existed despite administrative and professional boundaries. New powers called 'flexibilities', introduced under Section 31 of the Act, meant that money could now be pooled between health bodies and health-related local authority services, functions could be delegated, and resources and management structures integrated. Our interest in these policies and legal reforms was triggered by the central role they gave to management control practices, and budgeting in particular. To study this phenomenon, and following a preliminary phase of defining the research questions, we conducted fieldwork in five sites, undertook archival analysis of published and unpublished documents, including confidential internal material, and organised a seminar that included representatives from all field sites to test our findings.

The archival analysis focused initially on a wide range of policy documents, including the White Paper titled *Modern Public Services for Britain: Investing in Reform* (CM 4011, 1998), and the subsequent and more detailed *Modernising Government* White Paper (CM 4310, 1999). The aim here was to begin with the overall programmatic and discursive level of analysis, within which the specific reforms and the proposed changes in management control practices took place. These documents placed inter-organizational relations at the heart of government policy, making partnership working and formal cooperation central to the attempted transformation of political discourse in Britain at the end of the twentieth century. The *Modernising Government* White Paper set out this agenda very clearly:

> "We want to encourage initiatives to establish partnerships in delivering services, by all parts of government in ways that fit local circumstances; and to establish common targets, financial frameworks, IT links, management control and accountability mechanisms that support such arrangements." (CM 4310, p. 12)

An encouragement to cooperate formally, which for service providers rapidly became a *de facto* requirement, supplanted the harsh language of markets and competition that had characterised politics and public policy in the 1980s and 1990s. Instead of hierarchical control by the state, or the untrammelled workings of the market, agencies were called upon to cooperate formally and explicitly:

> "The aims and timetables for these initiatives differ. But they all share some common principles. They depend on partnership between different agencies in the public, private and voluntary sectors, and often involve users and staff too. They encourage experimentation and innovation. They make access to services easier for citizens and for businesses. By working together with other services, each organisation can make more effective use of its resources. And they encourage the spread of good practice. Above all, they are designed to make a difference on the ground. They have measurable outcomes, such as improving healthcare and giving better value for money. The Government will make sure they do." (CM 4310, p. 30)

The term partnership came to dominate political discourse. Whereas in 1989 the term was only used in Parliament 38 times, in 1999 it was mentioned 6,197 times

[4] In England, Section 31 of the Health Act 1999 has now been replaced by Section 75 of the National Health Service Act 2006, which has consolidated NHS legislation. The new provision is in exactly the same terms, and existing Section 31 arrangements will continue unchanged.

(Jupp, 2000, p. 13). Even in one single document – the 'Modernising Government' White Paper – it was used 35 times.

We reviewed these White Papers in terms of the promise they held out that public services would be improved through lateral 'joined-up' working among agencies that provide complementary services to citizens. Service providers were called upon to build services 'around the needs of those who use them' (Department of Health, 1998, p. 5), and this was to be sought particularly through partnership working:

> "[. . .] we will deliver public services to meet the needs of citizens, not the convenience of service providers. We will deliver a big push on obstacles to joined-up working, through local partnerships, one-stop shops, and other means." (CM 4310, p. 7)

Progress was to be measured and monitored, and action was to be taken, where improvements were not seen to be taking place:

> "[. . .] we will deliver efficient, high quality public services and will not tolerate mediocrity. We will review all central and local government department services and activities over the next five years to identify the best supplier in each case. We will set new targets for all public bodies, focusing on real improvements in the quality and effectiveness of public services. We will monitor performance closely so that we strike the right balance between intervening where services are failing and giving successful organisations the freedom to manage." (CM 4310, p. 7)

We also examined the White Papers titled *New NHS: Modern, Dependable* (CM 3807, 1997), and *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards* (CM 4169, 1998). These exhibited a similar incitation to break down the boundaries between service providers. New opportunities and obligations for co-operative working were to be created, and existing barriers for innovative, cross-sectoral working removed by legislative means, and by a range of tools including Health Improvement Programmes (HImPs), Joint Investment Plans (JIPs), Health Action Zones (HAZs), and partnership grants. Consistent with the arguments of Bevir and Rhodes (2003) and Rhodes (2000), we suggest that these documents, taken together, represented a new programme or a new discourse for the design of public services, one that placed networks and inter-organizational cooperation at its core.

Our archival analysis focused also on the Health Act 1999. Our interest here was with the way in which this Act gave such a central place to management accounting and management control, and linked this to a specific inter-organizational encounter—that of health care and social services. The Health Act 1999 was one of the clearest examples of a regulatory requirement to create lateral inter-organizational relations, to blur organizational boundaries and weaken the power of existing managerial and professional enclosures, and to do so in significant part through novel management control practices. The Health Act recognized the informal co-operative work that already existed in many places, but called on this to be extended substantially to create more widespread, formal and *regulatory* partnerships. Sections 26–32 of the 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 created by the Act, together with an extended duty of co-operation between NHS bodies and local authorities. A new statutory mechanism for strategic planning was introduced, 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 'flexibilities' introduced in Section 31 of this Act were threefold, and each of these had implications for management control practices: pooled budgets, lead commissioning and integrated service provision. *Pooled budgets* allowed health and social services to bring together resources in a discrete fund for a given client group, with organizations agreeing at the outset the full range of services to be purchased and provided from the fund. *Lead commissioning* allowed one authority – either health care or social services – to take responsibility for commissioning a range of services for a client group on behalf of the other. Finally, *integrated provision* allowed local authorities, Primary Care Trusts and NHS Trusts to provide services under a single management structure, thus offering integrated services from one provider rather than many. Providers of healthcare and social care were encouraged to make use of these 'flexibilities', which required a formal 'notification' to be made to the Department of Health.

The signatories to the 'notification' of a proposed partnership arrangement were asked to satisfy themselves that there existed robust arrangements for all aspects of the partnership. This included: governance; reviews of the partnership arrangements; terms, conditions and policies for human resources; information sharing practices; identification of functions included in the partnership arrangement; eligibility criteria and assessment processes; complaints procedures; financial issues (such as charging); dispute resolving mechanisms; and plans for exit strategies. Accountability was to be demonstrated through agreed targets. All those who planned to introduce new partnership arrangements were required to monitor their effectiveness, and to develop and use explicit performance metrics (Department of Health, 2000a,b). While the choice of which particular 'flexibility' to adopt was a matter for local agreement and initiative, the implication was clear: some evidence was required on the part of all healthcare and social care providers of a willingness to engage in formal partnership working. It was equally clear that 'pooled budgeting' was the most ambitious and demanding of all the flexibilities, in terms of both governance arrangements and willingness to devise mechanisms for spanning or attenuating professional and organizational boundaries. To this extent, management control practices were placed at the heart of the new public policy emphasis on lateral inter-organizational relations and formalised cooperation.

In addition to this initial archival research, and prior to commencing the fieldwork in the five study sites, we conducted two preliminary interviews with individuals

who had designated responsibility for the reforms in the Department of Health and the Treasury, held two additional exploratory meetings with individuals who were very familiar with the reforms (one of whom had previously held a very senior policy role, and one of whom was currently in a senior policy role in a 'think tank' concerned with healthcare policy), and attended one half-day seminar for policy makers and academics on partnership working. These interviews and meetings, apart from the seminar, lasted for approximately one hour each in all cases.

This preliminary stage of the research is comparable to that described by Eisenhardt (1989) as 'getting started' and 'selecting cases'. It is also similar to the three initial and interrelated stages described by Yin (1994) as defining the study's questions, propositions, and unit(s) of analysis. Put differently, it was a matter of being clearer about what the 'case' in question was, and how we were to go about investigating it (Yin, 1994, p. 21). We used these preliminary interviews and meetings to assist us in refining our research topic, selecting study sites, and designing the specific questions to be addressed in the semi-structured interviews that were planned. This allowed us to be clear about the research question at the outset, while recognising that it should only be tentative at this stage of enquiry (Eisenhardt, 1989).

Having focused our study of management control practices and inter-organizational relations on the encounter between health and social care, and with a particular interest in pooled budgets as one of the 'flexibilities', we then faced the issue of selecting study sites. We wanted to balance depth and breadth, and opted to study five sites. It was considered that this would avoid the findings being unduly idiosyncratic, although it was recognized that it was still a small sample. A greater number of sites would, however, have limited the ability of the research team to negotiate access, carry out preliminary research, conduct the interviews and attend meetings across the whole of the south of England. All sites were at an early stage of the reform process, but all, except one, had issued formal 'notifications'. The research commenced in summer 2000, and most of the fieldwork was conducted during the following eighteen months. The selection of the research sites was based primarily on the following three criteria: first, to cover a range of client groups (e.g. the elderly, children's services, and physical and learning disabilities); second, to provide a reasonable geographical spread (i.e. to include a mix of metropolitan boroughs and shire counties); and third, to include a mix of large and small budgets. The actual service innovations that we studied, and that were based on the use of the Health Act 'flexibilities', were: the provision of care for those with learning disabilities; the creation of support for multi-agency cooperation in the care of children with behavioural problems; and attempts to develop and speed up processes of care home placements for the elderly. In addition to observing instances where experiments with the flexibilities were already underway, we were able to observe, in one site, how plans were developed to experiment with the Health Act flexibilities in the care of people with mental health problems. And, in another site, where the formal procedures of the Health Act flexibilities were not yet being used, we were able to study how various actors were developing plans for partnership working in a number of service areas. Research sites visited were: primary and secondary health care provider organizations, strategic health authorities, and local authority social service departments. Our initial focus was always on those groups or individuals that were leading the reform process locally, as this allowed us greatest insight into how local innovators were seeking to link service delivery in their particular field with changes to management control practices, and consistent with the overall reform process and discourse.

Research data was collected through semi-structured interviews with a variety of stakeholders involved in the financing and delivery of services, as well as through observation of a total of five 'Section 31' meetings in two research sites. These meetings typically lasted half a day, and involved six or eight individuals (such as social workers, doctors, psychiatrists, and physiotherapists). Detailed notes were taken by both researchers during the meetings. In addition to these meetings, sixteen individuals were interviewed in total, including at least three in each site experimenting with formal partnership arrangements. All interviews lasted a minimum of one hour, with several lasting two hours. Those selected for interview included a mixture of managers responsible for overall organizational strategy and commitment (e.g. Health Authority Chief Executives), and those responsible managerially for developing and designing partnership arrangements and governance mechanisms (e.g. Service and Purchasing Managers). A relatively standardized set of questions was developed at an early stage, and these were used as the basis for conducting the interviews and their analysis. All interviews were attended by both researchers, and were tape recorded and transcribed to facilitate their analysis. These transcripts were subsequently coded according to research themes that emerged out of the interview and other research material. The themes were identified independently by the researchers on the basis of a review of a selection of the material, and the agreed themes then coded manually.

In addition to the initial archival research, and once the fieldwork was underway, we also collected confidential internal material from the research sites as well as other key documents pertaining to partnership working both generally and specific to the research sites, including Annual Reports and any 'local' policy documents and guidelines that were publicly available. Further, in addition to the observations and interviews as well as collection of documentary materials – and subsequent to them – the research team organised a one-day workshop for participants from the organizations being studied. The purpose of the workshop was to provide a setting in which further information concerning partnership working could be obtained, experiences shared, and our preliminary findings tested. Each site was asked to nominate a spokesperson to provide a 5–10 minute introduction, which would cover the following three questions: how and when did joint working begin; what are the principal achievements to date; and what obstacles have been faced and still remain. The remaining time in each session was intended for discussion, and time was also allocated at the end of the day to allow for common issues to be addressed.

3. The emerging cooperative ideal

The political imperative to innovate and cooperate across organizational, administrative and professional boundaries surfaced in a number of distinct arenas. Some of these were relatively abstract and distant from the concerns of service providers, while others were more immediately concerned with issues of service delivery and coordination. In this section, we consider two separate yet overlapping arenas where issues of cooperation across organizational, administrative and professional boundaries took centre stage. First, we examine the ways in which policy makers, academics, and advisors of various types came to problematise existing modes of working and organising, and to advocate co-operative or partnership arrangements for political and economic life. Second, we consider the ways in which a particular legal case brought the issue of institutional and professional boundaries, with their different funding principles, into sharp and very public relief. In these two relatively discrete arenas, 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 separate issues.

3.1. Policy makers articulate the co-operative ideal

If the 1980s were dominated by notions of markets and contracting-out, the 1990s came to be dominated by ideas of partnership and cooperation. Diagnoses varied, as did the arenas in which these concepts surfaced, but a common theme emerged from policy-makers, political commentators, academics and those that spanned these distinct yet overlapping arenas: new and cooperative modes of working based on inter-organizational relations were needed for public services.

Proponents of what came to be called the 'Third Way' argued that markets and hierarchies should not be viewed as the only ways of organizing political and social life (Giddens, 1998). Instead, it was suggested, they should be viewed as just two possible modalities of governance that could be readily combined with other arrangements. Earlier calls for 'reinventing government' had meant that government should mimic the marketplace (Osborne and Gaebler, 1992). For 'third way' theorists, reinventing government meant reasserting the effectiveness of government in the face of markets (Giddens, 1998, p. 75). Welfare institutions should be modernised, administrative efficiency improved, and governments should learn from business best practice. But this did not mean that one could hand everything over to market-based mechanisms. Rather, states should act in *partnership* with the bodies representing civil society and business. The basis of such partnership should be a mixed economy whose effectiveness would be assured by the existence of modernised welfare institutions. Market practices and principles should be brought together with non-market mechanisms, thereby embedding the market system in a social network of coordinative and regulatory institutions. Bodies such as Demos argued, for instance:

> In almost every major area of policy, a strong consensus is now emerging among policy-makers and professionals that *partnership* is the key. *Collaboration* between public agencies, businesses, community and voluntary groups, is seen as essential to progress. (Jupp, 2000, p. 12, emphases added)

Those concerned with central government policy making also came to view partnerships as intrinsically desirable. Policy documents crafted in countries such as Australia, Canada, New-Zealand and the United Kingdom exhibited a remarkable consistency, despite the somewhat different labelling of the phenomena. Solutions were sought variously under labels such as 'joined-up government', 'connected government', 'networked government', and 'whole-of-government'. These referred to a set of distinct yet related problems to do with increasingly demanding citizens, budgetary pressures, globalisation, fragmentation, as well as public servants' conservatism, risk avoidance and lack of innovation. From the late 1990s, policy documents propagated a political vocabulary that promoted 'horizontal management' as well as 'inter-agency', 'inter-sectoral', 'inter-departmental' and 'multi-organizational' cooperation (Miller et al., 2008).[5]

In the UK, the ideals of modernisation and cooperation were presented by policy makers as antidotes to a culture of conservatism that had for too long been buttressed by rigid departmental and administrative boundaries. The traditional separation of central government into different departments and units for administrative purposes was increasingly criticized as dysfunctional. 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.. . .

The establishment of the Social Exclusion Unit in 1997 by the then Prime Minister is one example of the attempts to produce at the heart of central government 'joined-up solutions to joined-up problems'. Staffed by a mixture of civil servants from a number of government departments, together with external secondees from organizations with experience of tackling social exclusion, the unit sought 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 – which brought 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 exam-

[5] See e.g. Advisory Group (2001), The Review of the Centre, State Services Commission, Wellington, New Zealand; Treasury Board (2002) Results for Canadians: A Management Framework for the Government of Canada, Treasury Board of Canada Secretariat, Ottawa, Canada; and Management Advisory Committee (2004) Connecting Government: Whole of Government Responses to Australia's Priority Challenges, Commonwealth of Australia.

ple of central government endeavours to use organizational re-design as a way of tackling issues that cut across departmental boundaries.

Changes were held to be needed also in more localised settings of service provision, where rigid institutional boundaries were considered to result in uncoordinated service delivery, inefficiency, complication and confusion (CM 4310, 1999, Chapter 3, p. 1). In national level policy debates, health and social services in particular were criticised for the poor co-ordination of their services.[6] 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 (Department of Health, 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.. . .

Promoting modernisation and coordination at the level of central government, or among local service providers, was not, however, considered to be a matter of simple 'implementation' of these ideals. Public servants were berated for being insufficiently entrepreneurial and excessively risk-averse (CM 4310, 1999; Hood and Rothstein, 2000; Power, 2003). A longstanding critique of parliament, ministers and the civil service represented them as inhabiting a culture in which rewards for success are limited, while penalties for failure can be severe. A high profile focus on policy and delivery failures by the Public Accounts Committee, 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 and 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). Partnership working, as set out in the Health Act 1999, was promoted in large part as a solution to this supposed conservatism and segmentation.

3.2. Legal experts adjudicate on inter-professional boundaries and responsibilities

Much of the debate about partnership working and cooperation took place at a relatively abstract level, and concerned general principles or ideas about how public policy should be organised. Our concern in this paper, however, is with how such aspirations work out in a specific inter-professional encounter, and their implications for inter-organizational relations and management control practices. In the judicial arena, the prominent and highly influential 'Coughlan case' in the late 1990s brought longstanding issues of the institutional and professional boundaries between healthcare and social care, together with the sensitive issues of responsibility for provision and funding, into sharp relief. The case centred on a person who was severely injured in a road traffic accident in the early 1970s. The accident had 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 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 unambiguous 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 follows[8]:

> 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.

[6] See e.g. Audit Commission Reports, 1997, 1999, 2000, 2002 regarding co-ordination of services for the elderly.

[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] R v North and East Devon Health Authority, *ex parte* Pamela Coughlan, Case No. QBCOF 99/ 0110/ CM54, 16 July 1999, paragraph 1.

The Appeal judges commented[9]:

> 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 dismissed.[10] 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 care.[11]

> 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 most importantly responsibility for paying for it, could not be decided according to the location in which the care was provided. Nursing services could, according to the judgment, be provided as social care and in a social care setting, rather than as a health service, and as such would be subject to the same regime for payment as other social services (i.e. means-tested). But the fact that some nursing services could be regarded as part of social services' care, to be provided by the local authority, would not mean that all nursing services provided in social care settings should be treated in that way. There could, the Appeal judges stated[12]:

> . . . 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.

The judgment continued[13]:

> 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 case highlighted and gave publicity to problems that were by no means new (Luxton, 2004). These problems originated from two parallel systems of care established by the 1946 NHS Act and the 1948 National Assistance Act: the universal system of health care, provided by the NHS, and a subsidiary system for those in need of other 'care and attention', provided by local authorities. Changes in the manner of continuing care provision over the past few decades – including the significant reduction of hospital beds specifically designed for older people between the mid-1970s and mid-1990s – had transferred more and more heavily dependent people from hospital care to care homes, where charges can be levied, increasing the significance of the elusive distinction between free 'health care' and means-tested 'personal care' (Pollock, 2004, p. 168). A discharge of a brain-damaged 55-year-old man into local authority care by a Leeds hospital, often referred to as the 'Leeds case' (HC 157, 1994), had led to a dispute similar to the Coughlan case in the early part of the 1990s. A complaint addressed to the Ombudsman regarding the ability of the NHS to refuse to accept responsibility for care, and to meet the cost of the care, led in that instance to the Department of Health issuing guidance regarding NHS responsibilities for continuing care needs in 1995 (Department of Health, 1995, HSG (95)8), and revised guidance in 1996 (Department of Health, 1996, EL (96)8).

The Coughlan judgment gave rise to a plethora of further 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 (Department of Health, HSC, 1999/180), and revised guidance in June 2001 (Department of Health, HSC 2001/015; LAC 2001/018). This listed the issues that health authorities had to consider when establishing eligibility criteria for continuing NHS care, i.e. care arranged and funded solely by the NHS. A circular and practice guide on 'free' nursing care was issued by the Department of Health in August 2001. A circular and guidance (Department of Health, HSC 2002/001; LAC 2002/1) on the implementation of a single assessment process for older people was issued by the Department of Health in January 2002. 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

[9] R v North and East Devon Health Authority, *ex parte* Pamela Coughlan, Case No. QBCOF 99/ 0110/ CM54, 16 July 1999, paragraph 19.

[10] The decision to close Mardon House, funded by the Health Authority, was decided on appeal to be unlawful on three grounds: first, misinterpretation by the Health Authority of its statutory responsibilities; second, unlawful eligibility criteria; third, unjustified breach of promise by the Health Authority that Mardon House would be a home for life (R v North and East Devon Health Authority, *ex parte* Pamela Coughlan, Case No. QBCOF 99/ 0110/ CM54, 16 July 1999, paragraph 118).

[11] R v North and East Devon Health Authority, *ex parte* Pamela Coughlan, Case No. QBCOF 99/ 0110/ CM54, 16 July 1999, paragraph 31.

[12] R v North and East Devon Health Authority, *ex parte* Pamela Coughlan, Case No. QBCOF 99/ 0110/ CM54, 16 July 1999, paragraph 30 (d).

[13] R v North and East Devon Health Authority, *ex parte* Pamela Coughlan, Case No. QBCOF 99/ 0110/ CM54, 16 July 1999, paragraph 30 (e).

Health in June 2001 (Department of Health, HSC 2001/015; LAC 2001/018).[14]

Together with other similar cases that preceded it, the Coughlan case made the boundaries between healthcare and social care highly visible. This affected those at all levels within the healthcare and social care domains. For Chief Executives, it posed a serious managerial and financial challenge, as well as an issue of management control and information – existing systems did not allow one to differentiate sufficiently precisely between healthcare and social care, when delivered in a social care setting, and adequately cost and report the former. For those delivering services, it posed the challenge of how to accurately identify and record the balance or mix of healthcare and social care when provided to a particular individual, and to do so in a sufficiently robust manner as to satisfy both healthcare and social care officials. This made the boundaries between these two administrative and professional domains highly contestable and politically sensitive, not least because of the potentially substantial financial implications, and posed challenges for management control systems. Also, ironically, this took place within a context in which the language of partnership and cooperation had become the dominant discourse for public policy. The following section explores how those managing and delivering services in localised settings combined the imperatives of service delivery with the twin injunction to rethink their work practices in line with the discourse of partnership, while being increasingly attentive to the boundaries between healthcare and social care.

4. Mediating the ideal of cooperation with the imperatives of service delivery

The issue of professional and administrative boundaries, and the need to cooperate across them, surfaced not only in the arenas populated by policy makers, politicians, academics, lawyers and the like. Organizational boundaries were problematised, and the issue of cooperation surfaced almost daily among those responsible for delivering and managing services. Prior to the Modernising Government agenda, and the Health Act 1999 with its formal definitions and requirements for 'partnership' working, the matter of cooperation had assumed a much more immediate and mundane form. Co-operative work had surfaced as a partial 'solution' around issues to do with delayed hospital discharges of elderly patients, shortage of resources to deal with increasing demand of services, and parallel policy changes such as de-institutionalisation of the mentally ill or those with learning disabilities. When Section 31 of the Health Act came into force, it was in these localised arenas that the larger political culture came to be mediated in the 'everyday doings of practitioners' (Wise, 1988, p. 78). This mediation took the form of decisions about whether to experiment formally with Health Act flexibilities, and if so, the choice of client groups, types of partner, and forms of partnership. Attached to these choices were possibilities and requirements for specific managerial accounting and control tools, including new 'pooled' budgeting arrangements and other forms of inter-organizational cooperation and information exchange.

It is to these issues that we now turn, and we address them in three stages as follows. First, we examine how cooperation emerged as a 'local' phenomenon, both prior to and subsequent to the Health Act 1999. In such settings, we consider how partnership working as set out in the Health Act was enthusiastically embraced, and what it meant to the local actors. Second, we consider how those delivering services sought to 'mediate' between the legal and policy injunction to engage in formal cooperation, and the pragmatic imperative to continue to provide services across organizational and professional boundaries. Third, we consider the limits of cooperation across organizational boundaries, in settings with strongly developed professional 'enclosures'.

4.1. Cooperating as a local phenomenon

For those delivering services such as continuing care for the elderly, and care for those with learning difficulties, cooperation across organizational boundaries was a matter of the 'everyday doings' of practitioners, rather than an abstract policy ideal or an injunction to comply. Service providers had long endured the adverse implications of rigid organizational and professional boundaries, and had sought ways of cooperating to deliver services and improve their quality, as well as to alleviate the effects of limited resources. In one of our research sites, the Health Act flexibilities were considered to offer new possibilities for enhancing the co-operative working that had been developing in the area of continuing care provision for some years already. Services for the elderly in this site were considered to have deteriorated over the years as a result of the strict administrative separation of health and social care. Imprecise boundaries between the actual services to be delivered, combined with distinct budgetary entities and tight fiscal 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 caused serious budgetary problems in this site. They had also generated significant dissatisfaction with single agency working on the part of service-providers, and cooperative arrangements had been devised to try to address the concerns. This involved joint planning and monitoring of targets for a maximum num-

[14] 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 to estimate the number of people who may have been wrongly assessed.

ber of delayed discharges, as well as budget transfers from health care to social services.[15] As a social services representative commented:

> It probably was the crisis point for us... around winter '97. At that point Social Services were running into inter-budget problems and the number of people sitting in hospital beds that winter waiting for Social Services funds for discharge into institutional care rocketed and we got the dubious pleasure of being the out-lier of the country, our number of blocked beds and so on. At the same time of course we were placing too many people into nursing homes and our balance was completely out. You can see the opportunity costs immediately... that you're going to run into significant budget problems.

This same person elaborated:

> ...we were looking for more joint working across the grass roots staff in terms how they did their assessments. Because it was much too easy to assume that everyone needed a nurse and needed a nursing home and we actually have to get back to that level of joint working on our various training programmes to get the assessors from professional staff to think more carefully about how they came to decisions.

A multi-agency team – comprising 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 – was formed to conduct joint assessments for nursing home care. Prompted by the Health Act 1999 flexibilities, an experiment with lead commissioning of continuing care placements by a social services purchasing manager began. 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 for those assisted through these services. 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 [...]

For those concerned managerially and administratively with service provision, the idea of cooperation also appealed. It is important to note, however, that 'partnership' here was understood initially in its more everyday sense, as distinct from the way in which it was defined formally in the Health Act 1999 flexibilities. As one social services representative put it:

> ...one of my hobby horses would be around the way in which people interpret the word partnership anyway, and I have a suspicion that in X we probably use partnership to be the broader fraternity association rather than thinking that partnership is actually something that's structured and needs to have clear purpose, clear investment from both sides for mutual benefit. I don't think that definition is... certainly from Social Services... and that might not be the case across all of my Health colleagues... from Social Services that's definitely the way people approach it. They would rather focus on the values and the principles than thinking about the details and the structure and the discipline.

If partnership was celebrated or at least aspired to by local practitioners, it was in these informal yet no less benign terms. But it also had a pragmatic meaning in these local settings, which provided fertile ground for the more formal aspects of partnership working as set out in the Health Act 1999. It was viewed as a possible way of addressing a set of problems to do with meeting budgetary targets and reducing costs. This was not a matter of arbitrary cost reduction, however. The cooperative assessment of care needs allowed a better use of the limited nursing and residential placements available. As a social services representative commented:

> ... 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 [...]

Substantial savings had already been achieved, and further savings were expected, as a result of the planned review by the joint assessment team 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 – with the commissioning of all continuing care placements carried out by the social services commissioner regardless of whether the funding came from health care or social services – was seen to offer solutions to other issues that gave rise to financial pressures. As one health authority representative commented:

> Its opportunistic as far as I was concerned... how best can we actually utilise the flexibilities to actually reach a better arrangement than existed at the present time... from our perspective we're just saying its pragmatic, its something which isn't revolutionary which actually feels right, appropriate and everything else.

For example, joint commissioning of 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:

[15] Section 28A of the NHS Act 1977 had made it possible for Health Trusts to contribute funds to a package of community care managed by social services.

> . . . 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.

In accordance with the modernising government agenda and the associated ideals of the 'third way', 'markets' and 'partnerships' thus co-existed readily as complementary modes of organising service provision. The combined purchasing power and expertise of health care and social services was considered to offer such a significant potential that 'you really need to capitalise on the opportunity', as expressed by one social services representative.

Savings, as well as improved consistency of the quality of care, were also expected from joint monitoring of contract compliance. In the most extreme cases, joint monitoring processes could help with 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 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. [. . .] 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. [. . .]

Care for the elderly was thus an area where the 'modernisation' of services through increasing cooperation between service providers was seen to offer multiple benefits. Care for people with learning disabilities was another area where cooperative working was considered to provide 'solutions', and where the new formal partnership tools were viewed positively, in terms of building on existing cooperative work.

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. Prior to the reforms, and placed within institutions, the mentally ill were wholly in the medical domain. Placed in the community, however, 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 organizations (Provan and 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 organizational and financial solution needed to be found to this 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 of our research sites 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 local community. With the explicit aim of facilitating the process of de-institutionalisation, and to support effective information sharing and more efficient co-operative working between statutory and independent organizations, 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 gave welcome support to the de-institutionalisation programme already underway. The head of learning disability services was confident that the project had produced significant improvements in services, and in the overall quality of life for the client group involved. He 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.

A move away from institutional-based care for those with learning disabilities was not only celebrated by those responsible for the immediate delivery of services. As with the case of care for the elderly, this programme also found favour in managerial circles, partly 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[. . .]

The programmatic ambitions of the Modernising Government agenda, and partnership working in particular, seemed to offer solutions to some longstanding problems experienced by local service providers. In the service areas discussed above, the Health Act flexibilities offered opportunities to develop further work that was already underway. Interviews in the study sites demonstrated, however, that experiments with the Health Act flexibilities not only happened as a result of benign wishes on the part of service providers to enhance the quality or efficiency of provision. Experimentation with the new flex-

ibilities was also motivated by the perceived need of service providers to demonstrate to those funding and regulating their domains a willingness to embrace the modernisation agenda explicitly and visibly. An awareness of the need to make the wishes of policy reformers operational, and a concomitant concern to avoid failure, had a significant influence on the ways in which service providers sought to align their everyday work with the cooperative ideal of the modernising government agenda and the Health Act 1999. It is to this that we now turn in the next section.

4.2. Mediating local service delivery and the cooperative ideal

Following the Health Act 1999, local innovation and informal cooperation were no longer sufficient. Service providers interviewed were intensely aware of the importance of being seen to cooperate, and of demonstrating that they were entering into *formal* partnerships. Senior managers felt that they needed to be able to show that they were aligning local service delivery with the cooperative ideal. They realised that they now inhabited a world in which single agency working had been openly called into question, and in which formal cooperation and innovation with respect to joint working was more or less obligatory. Even though Section 31 of the Health Act did not make formal partnership working in respect of using 'flexibilities' an absolute requirement, it was none the less perceived by actors in both health and social service agencies that some visible steps in this direction were essential. Yet they still had a choice as to which type of 'flexibility' to adopt, whether to opt for the more cautious approach of lead commissioning, or whether to take a further and substantial step in the direction of pooled budgets and integrated provision. The initial steps that we observed were of the more cautious type.

In many instances, formal partnership working was cited by those interviewed as strongly driven by attempts on the part of service providers to improve their reputation among a variety of regulatory, monitoring and funding bodies. It mattered to these actors how the external funding and inspectorate bodies viewed them. '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 [...]

Pressure to show a willingness to experiment with the Health Act flexibilities was felt most strongly in sites with recognised problems with service delivery. None the less, 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...

Another interviewee remarked:

> I suppose it was just pragmatics.

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

> ... 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.

Against the risk of not taking risks – by rejecting the modernisation agenda – there was awareness of the risks related to experimenting with new forms of formal partnership working. The potential risks of not being able to deliver were regarded as high by those interviewed, due to the eagerness of government departments to demonstrate success in delivering the modernisation programme. The sharpened focus on 'failing services' by the new inspectorate and regulatory regimes, such as 'star ratings' for health care and social service organizations, as well as comprehensive performance assessment regimes in local government, had induced a greater sense of vulnerability among senior staff (Martin, 2000; Newman et al., 2001). One way of managing this risk was to start by experimenting 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 front-runner. 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.

Experimenting was seen as hazardous for a variety of reasons. There were uncertainties with the possible partners, and their ability to deliver, as well as concerns about respective accountabilities if things did not go accord-

ing to plan. There was nervousness about appropriate governance mechanisms and required performance measurement frameworks. And there were issues to do with trust and the distribution of power between those organizations entering formal partnerships.[16]

The Health Act 1999 encouraged formal partnership working across a wide range of client groups, and with a range of partners. It also allowed sites to experiment with one or more of the three forms of flexibilities set out – pooled budgets, lead commissioning, and integrated provision. The possibility of embracing the publicly declared ideals of co-operation, while adapting the experiments to multiple existing and localised agendas, allowed the actors involved to align their experiments with the cooperative ideal while taking into account conceivable risks. Interviews and documents from the five study sites demonstrated how the perceived risks of formal partnership working influenced the choice of client groups, the selection of partners, and the particular forms of partnership working adopted.

When asked about the reasons for selecting a particular client group for formal partnership working, 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 centred mostly on client groups and partner organizations with which there was at least some experience in joint working. 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. [. . .] 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 also saw experience of prior cooperative 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.

Risks were also considered when choosing the particular form of partnership working. Possible loss of control over financial resources was a concern for many of those interviewed. Pooling resources – via pooled budgets – was seen as risky, in comparison with lead commissioning, because of the 'loss of identity' with regard to sources once the money had been pooled. As one interviewee remarked:

> We went to a lead commissioning arrangement, not a pooled budget. So that the only money that's changed hands. . . is Health paying for one post to manage the system.

A similar sentiment was voiced by 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 concern on the part of local participants about the control of resources was expressed also in documents gathered from the research sites. A consultation document from one of the research sites – seeking endorsement from the local Family and Community Care Sub Committee for experimentation with lead commissioning of continuing care placements – discussed the risks of partnership working for the local authority social services department. Under the heading 'risk management', the document set out 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 pooled budgets – as opposed to employing other forms of partnership working that were 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

[16] There is a large literature on the issue of 'trust' in inter-organizational relationships (see for instance Vélez et al., 2008; Sako, 1992), but a consideration of this is beyond the scope of the current paper.

> 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 [. . .]

The 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, was 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 [. . .]

Mediating local service delivery with the cooperative ideal was, however, more than a facade, and it had implications for management control practices. Inter-organizational cooperation, even in its more modest formal versions, required a set of devices and arrangements for bringing together different professional groups as well as recording and monitoring their respective inputs. New management control practices had to be devised, such as reporting the respective inputs of healthcare and social care, in accordance with the Coughlan judgement. This required forms to be produced so as to allow charging between entities, and subsequent auditing. One social service representative commented as follows on these issues, and the documentation and controls they required:

> It's a county agreed form. As you probably know there are lots of models around and that counties have decided to use different forms at different times but we felt what we wanted was something that identified nursing needs and residential needs so the form asks for the extent to which a nurse is required to carry out a particular task which gave us the audit trail a couple of years ago to start distinguishing those cases that really shouldn't go to nursing because, for instance, I remember one example we looked at was one of the forms we turned back was. . . no you don't need a nurse to help someone brush their hair. It might be part of holistic care, but you don't need a nurse. We take the assessment forms, they're logged and checked off and sent to the County-wide Assessment Team. And then the County-wide Assessment Team, which if you remember was the geriatrician and the nurse and the professionals, make the decision about whether someone is eligible for continuing care and what sort of care is appropriate for them.

New organizational structures were devised also, as indicated by this interviewee. A healthcare representative commented on the multi-professional assessment team put in place in one site:

> The other structure which is round that is the County-wide Assessment Team. . . that actually is a team who will look at each of the applications for the Health Authority in terms of does it fit the eligibility criteria or not, and makes a judgement back to the Health Authority about whether this person actually meets eligibility criteria. And in terms of when they looked at the criteria what individuals actually had requested and what they subsequently recommended they saved a significant amount of money. . .

A representative from social services commented as follows on how the reporting mechanisms of this team helped to identify and calculate the savings:

> Yes, and part of it was calculated on the number of cases they looked at where people would otherwise have gone into nursing homes and subsequently were placed in residential homes. So it was all part of the bigger picture. . .

Inter-organizational cooperation thus emerged not only out of local innovation and attempts at improved coordination. It emerged also out of attempts on the part of local actors to 'mediate' between their 'everyday doings' and the policy imperative to cooperate formally and visibly, in ways consistent with the Health Act 1999. This is what we have referred to in this paper as the forming of 'regulatory hybrids', modes of inter-organizational cooperation and control that arise out of regulatory and legal injunctions, rather than the immediate imperatives of service delivery to individuals. To achieve this inter-organizational cooperation, contracts were redesigned, working practices altered, and formal 'notifications' made for the use of the Health Act 'flexibilities'. But larger steps, such as the pooling of budgets or the creation of new 'integrated' entities, remained future possibilities rather than actual accomplishments at the time of our study. In the next section, we consider how the existence of professional and organizational enclosures acted as a more or less fundamental obstacle to the implementation of these more ambitious aspects of partnership working.

4.3. The limits of cooperating across organizational and professional boundaries

It was difficult, if not impossible, for service providers to openly challenge the language of modernisation and cooperation. In any event, many of them subscribed to it implicitly and embedded its principles in their everyday doings, even if they had not previously articulated their activities in such abstract and grandiose terms. But making it fully operable meant going beyond the realm of abstract ideals. In particular, it meant confronting and giving visibil-

ity to a specific inter-professional and inter-organizational encounter – that between health care and social services – as well as addressing more localised encounters within the field of health care itself. Despite the general policy commitment to cooperate, and notwithstanding the expressed commitment by key actors in the sites studied to cross-sectoral working, this encounter brought into sharp relief the tensions inherent in the cooperative 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.

There was tension, for example, when devising management control practices for reporting the outcomes of cooperative arrangements, which was required as part of the formal reporting process associated with the Health Act flexibilities (Department of Health, 2000a,b). The Lead Commissioner of Learning Disability Services in one of the research sites spoke of the difficulties in explaining to health care colleagues some of the expenditure incurred by social services as part of the joint commissioning experiment. For this commissioner, 'some people if they just survive living in a house and being able to look after themselves is a significant improvement'. Yet, according to him, 'there is a feeling at times that health will say what is the outcome of this because they don't get better'. Different expectations, stemming from different professional backgrounds, with respect to desired or achievable outcomes, were considered problematic from a performance measurement standpoint. The Commissioner stated, 'we're not growing a percentage of hip operations, we're not reducing the number of heart attacks, we're not going to reduce the number of people with a learning disability' (cited in Kurunmäki and Miller, 2006).

Differences in professional cultures were regarded 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 Commissioning 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.

The views of the Head of Commissioning and Performance Management in another site resonated with the views of this Team Manager. The problems caused by different professional cultures, languages, values, and attitudes could not, according to this interviewee, be resolved by mere organizational changes:

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

In addition to the different professional cultures and values, the different governance arrangements of health and social services were viewed as important limiting factors by those in both arenas, 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 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 ser-

vices) 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 increasingly come into contact with different professional cultures, which had exacerbated the problems. The new government policy of integrated service provision – to be achieved through the new organizational form of Care Trusts introduced in the NHS Plan by the Department of Health in summer 2000 (Department of Health, 2000a,b) – 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 Commissioning 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'.

The Health Act flexibilities gave increased visibility to long-standing issues of professional boundaries and enclosures. They also offered some possibilities for mediating between formally separate organizational units, for creating new entities, or creating new modes of managing the tensions between different professional domains. A range of ways of seeking to address these issues was suggested by those interviewed. A change in the management team was cited by one health authority Chief Executive 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 organizational 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 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 organizations (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 hybridising, a combining of the skills and knowledge base of two or more formally separate 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 now 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, an optimistic scenario could be envisaged in which many of the inherent tensions would be alleviated by managerial changes, organizational redesign, and professional hybridisation. A substantial change in thinking, however, was still 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 change in attitude. Rather than focusing on problems, actors should see the opportunities. He underlined that those who were

concerned to protect an organization, 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', 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.

It would be easy to conclude from the above that the long-standing turf battles between health care and social services are so deeply entrenched that nothing can dislodge them. Our view is different, and more empirical. We have sought to explore how, and to what extent, the hybridising of processes, practices and expertises takes place in such situations, and how service providers and management control practices mediate between the ideals of reformers and the imperatives of service delivery. We have also sought to investigate how, and to what degree, professional enclosures can inhibit the process of mediation and the forming of regulatory hybrids.

5. Conclusions

This paper has examined the 'modernising government' reform programme, and more specifically the 'flexibilities' (lead commissioning, integrated provision and pooled budgets) introduced in the Health Act 1999. Through a mixture of archival research and fieldwork, we have explored the early experiences of those experimenting with these new possibilities for inter-organizational cooperation. These 'flexibilities' placed management control practices at the centre of inter-organizational and inter-professional cooperative arrangements in public administration. We have examined how the ideals of cooperation and partnership were discursively articulated, how professional and administrative boundaries were given visibility in particular legal cases, and what happened when local practitioners sought to make these ideals operable across strongly defined professional and organizational boundaries or enclosures. We have argued for attention to 'regulatory hybrids', suggesting that the hybrid organizational practices and processes that emerge out of regulatory interventions are a distinctive feature of inter-organizational relations and management control in the domain of public administration.

To analyse these issues, we suggested that much can be gained by linking the public administration literature, which has long been concerned with inter-organizational and network forms, with the literature on accounting and inter-organizational relations. We drew on the governmentality literature to analyse these issues, focusing on three dimensions: the programmatic or discursive articulation of ideals of cooperation and partnership working; the practices and processes through which administrative re-design was sought; and the professional enclosures that can arise in certain domains. We focused in particular on the interactions between healthcare and social care (Miller and Rose, 2008). Consistent with Modell et al. (2007), this approach meant emphasising the multi-level nature of the analysis, with particular attention being given to the interrelations between the different levels or layers. While the public administration literature (e.g. Bevir and Rhodes, 2003) has examined the changing patterns of thought informing governance models, and the attendant shift from hierarchies to markets, and then to networks, we argue for exploring the links between changing discursive frameworks and the practices and processes that operationalise them and at times constrain them. The discursive articulation of policies regarding partnership working comes into contact repeatedly, and in different settings, with management control practices such as budgeting, resource allocation and accountability mechanisms, and with the organizational and professional enclosures that characterise public services such as healthcare and social care. Reciprocally, those delivering services not only have to maintain the delivery of services, but they also have to articulate that delivery and their daily work in terms that may be discrepant with, or at least not wholly aligned with their organizational and professional boundaries and logics. Management control practices reside, as it were, at the intersection of a variety of discursive and professional expectations, which are accorded particular significance in the case of reform processes such as those considered here which seek to promote regulatory hybrids.

While drawing on the governmentality literature, we argued that it needs to be extended beyond existing concerns with large-scale discursive and regulatory shifts, to consider what happens when such reforms come into contact with the localised aspirations and activities of service providers. Here, we drew upon the notion of 'mediating instruments' that has been successfully used in the science studies literature, and more recently in accounting. We considered how this notion helps us to understand the 'everyday doings' of local practitioners. The aim was to preserve the focus on the programmatic or discursive aspect of regulatory and administrative reform, while understanding how it interacts with more localised ideals and practices, which can range from attempts to operationalise de-institutionalisation policies (for people with learning disabilities), to the specifics of designing forms to report and cost the different inputs of various professional groups, or designing new organizational processes within which multiple professional groups can interact. The notion of mediating instruments suggests focusing less

on the entities that populate a domain, and paying greater attention to the linkages between them, and particularly the instruments that act as intermediaries by connecting actors, agencies and aspirations. For it is through these, and particularly through the management control practices deployed, that a working ensemble can be formed out of all the components and practices that make up the increasingly complex sphere of public service provision. Rather than viewing management control practices as simply the 'implementation' of policy, they are viewed as *interdefined* with the political, professional and organizational categories that animate them.

We suggest that this focus indicates the need to broaden the study of inter-organizational relations and management control to include not only organizational forms, but the *practices* and *processes* through which they are made operable (Miller et al., 2008). These may be formalised, as in the 'notifications' required for all partnership proposals submitted as part of the Health Act 1999, including governance arrangements, specification of functions to be included, complaints procedures and dispute resolution mechanisms. But they may also be relatively localised, such as the County Wide Assessment Team devised in one site, or the forms produced for the recording of costs and inputs. We suggest that greater attention to these 'mediating instruments' can help us to understand better how local practitioners combine the imperatives of continued and even enhanced service delivery with the injunction to adhere to new regulatory reforms or legal categories. For it is in such settings that management control practices in the public sector are increasingly having to operate: at the intersection of highly abstract reform processes couched in the language of cooperation, professional boundaries that can be very strongly defined, and management control practices that have to enable information exchanges and modes of reporting that respect administrative boundaries while seeking to attenuate them.

Our fieldwork reported in Section 4 demonstrated how cooperation can exist and even flourish at a local level, albeit within certain parameters, how it can develop more pragmatically as a way of 'mediating' between the expectations of reformers and the immediate needs of service delivery, and how it can encounter rather more fundamental limits as a result of strongly defined professional enclosures. This suggests that future research should pay more attention to the ways in which management control practices in the field of public administration encounter inter-professional boundaries and enclosures, and the implications this has for developing still further inter-organizational cooperation and control practices.

Our fieldwork suggests also that greater attention should be paid to the rather more modest 'mediating instruments' that emerge and are formed within such processes, for it is through these that the discursive aspirations of policy makers are brought into contact with the organizational and professional boundaries that characterise domains such as healthcare and social care. Inter-organizational management controls act, as it were, as an intermediary in the interplay between public administration and professional enclosures. This is consistent with what has been noted in the very different setting of the microprocessor industry with respect to 'roadmapping practices' (Miller and O'Leary, 2007), which have been viewed similarly as instruments of mediation. There, a dense network of information exchanges across organizational boundaries has developed over a period of several decades, resulting in a large amount of information sharing that one would not normally expect in competitive situations. Accounting researchers, together with organization scholars, sociologists and economists, have to date paid relatively little attention to such information exchanges, focussing instead more on the entities that populate the socio-economic world, rather than the instruments and processes that link them. The analogy with the microprocessor industry is that cooperation can be enhanced through the creation of settings in which information can be exchanged, formally separate administrative or professional groups can meet, and instruments can be devised that provide visibility to the norms and expectations of different parties. This allows the assessment of instruments, policies and time-lines, together with negotiation over their alignment. While we did not observe in our research major steps being taken towards the formal pooling of budgets, or the creation of new integrated entities, we did observe novel working and management control practices that spanned organizational and professional boundaries. We suggest that greater attention should be paid to these apparently more modest steps, and the practices or instruments that facilitate them, for these can help us understand better what may be required to extend cooperation and partnership working even in situations where organizational and professional boundaries are highly developed. For instance, localised management control practices that demonstrate the relative inputs of distinct professional groups, or forums that bring together these groups into decision-making entities, can provide assurance with respect to financial flows and potential dialogue across professional boundaries. Put differently, by emphasising the multi-level nature of the phenomenon we are investigating, and the importance of attending to intermediaries rather than entities, we may better understand the roles played by inter-organizational management controls in the context of public administration.

Finally, by conducting research in a variety of sites dealing with diverse client groups (the elderly, children, and people with learning disabilities), we were able to document the complex regulatory and policy world in which inter-organizational relations and management control in public administration exists. This was not simply a matter of appreciating the difficulties of 'implementation' of the Health Act 1999 'flexibilities'. Rather, it was a matter of examining the ways in which this particular reform process comes into contact with many other reform and regulatory processes, such as the de-institutionalisation of people with learning disabilities, the 'star ratings' for hospitals, and the new focus on 'failing services'. By examining the ways in which 'regulatory hybrids' emerge out of the everyday doings of practitioners, and in relation to large-scale reform processes such as the modernising government agenda, we were able to chart the multiple roles that management control practices play in local settings in public administration.

Future research could usefully examine developments subsequent to these early experiences of experimenting with the flexibilities introduced in the Health Act 1999. This could, for instance, include analysing the conditions under which formal partnerships prosper or perish. It could, perhaps, focus on particular services such as learning disability or mental health, where formal partnership arrangements seem to have developed to a greater extent than in areas such as services for older people (Goldman, 2010, p. 6). It should, in any event, take into account the curious paradox of the continuing strong policy commitment to formal partnership working, combined with the persistent relatively low take-up overall of joint financing at the national level.[17]

One thing that is clear, however, is that formal partnership working has remained at the forefront of public policy across the whole of the decade that has elapsed since the Health Act 1999. For instance, Section 75 of the NHS Act 2006 restated in identical terms the provisions of Section 31 of the Health Act 1999 regarding 'flexibilities'. Published in the same year, the White Paper *Our Health, Our Care, Our Say* (CM 6737, 2006) affirmed the importance of joint commissioning of services, while *High Quality Care for All* (CM 7432, 2008) – the final report of Lord Darzi's 'Next Stage Review' – also stressed the central role played by joint arrangements in care provision.

It remains to be seen what will happen under the new coalition government, although initial indications are that formal partnerships are here to stay. The White Paper *Equity and Excellence: Liberating the NHS* (CM 7881, 2010), published only two months after the creation of the new government, not only reaffirmed the importance of partnership working but broadened its focus still further. The proposal to create consortia of GP practices placed partnership working once again at the heart of health and social policy, while the appeal to the need for partnerships between patients and clinicians extended the rhetorical remit of the notion of partnership. Inter-agency cooperation as a policy objective, and the multiple modes of partnership working that may make it operable, seem set to stay for the foreseeable future, while there is no reason to assume that the longstanding obstacles to such cooperation created by professional and organizational enclosures are in any way attenuated.

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[17] Goldman (2010, p. 5) reports that formal joint financing represented only 3.4% of total health and social care spend in 2007/8, although expresses some caution as to the reliability of the overall figures, due to a mixture of (inadvertent) mislabelling, and definitional issues regarding what counts as partnership working.

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