Third Sector Organisations: unique or simply other qualified providers?

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Abstract

Purpose

The Third Sector has been promoted by progressive English governments as a provider of health and social care services for people with mental health difficulties. This article considers the assumptions that lie behind these polices and reviews the evidence that Third Sector Organisations can be said to have a ‘unique’ role and approach. The challenges and opportunities of the current market based reforms on the Third Sector are discussed.

Design/methodology/approach

The article is based on literature reviews of the Third Sector’s role in mental health care and commissioning of Third Sector Organisations.

Findings

The Third Sector delivers a range of mental health services in England, in particular those related to accommodation, advice, advocacy and employment. Its activity extends into other roles such as campaigning and development of new approaches to care and support. Evidence of the distinctiveness of the sector as a whole is limited, but there are examples of such organisations providing innovative and user-led services. Market based reforms are seen as posing a threat to smaller organisations in particular but personalised approaches (including allocation of individual budgets), outcome based payments and the need for large scale service redesign are seen as offering considerable opportunity for expansion.

Practical implications

For the new market to include a strong Third Sector will require leadership within organisations, a collaborative approach within the sector, and commissioners that understand and engage positively with the sector in all its diversity.

Originality/value

This article draws together the research literature on the Third Sector’s engagement in mental health and the impact of market based reforms and in doing so provides original value in the fields of mental health and third sector studies.
Introduction

Third sector organisations (TSOs) were involved in English health and social care before the current publically funded and organised systems were founded, and continue to this day to have a significant role (see Mohan & Gorsky 2001, Harris 2010, Dickinson et al 2012). Whilst arguments continue about the most apt term to describe a sector that contains charities, voluntary organisations, community groups and social enterprises and indeed if it can be described as a sector at all, the number, range and roles of such organisations continue to grow (Alcock 2010, Carmel & Harlock 2008). It is estimated that about a quarter (39,340) of England’s 171,000 TSOs work in the area of adult health and/or social care, and a significant proportion of these work with people with mental health difficulties (Clarke et al 2010). In recent years there has been considerable debate regarding the future of the third sector, particularly in relation to the interest of successive English governments in these organisations becoming the deliverers of publicly funded services. These debates have arguably been played out most explicitly in health and social care, in which a series of reforms have sought to introduce market-based approaches to both the planning and delivery of services. In healthcare, the roles of ‘purchaser’ and ‘provider’ have been created through the development of separate commissioning bodies, and patient choice over many elective procedures has been expanded to any ‘qualified providers’ that meet quality and cost standards, including TSOs. Initiatives have sought to increase the diversity of providers through new opportunities to bid for clinical services and encouraging NHS staff to ‘spin-out’ services into social enterprises (Miller et al 2012). Underpinning the NHS system is a new payments process (Payments by Results) which has progressively replaced contracts based on block annual payments with those linked to activity and outcomes. A market approach was adopted in social care in 1990’s and as a consequence there is greater diversity of provision, with state-run facilities comprising 7.4%, private 68.7% and third sector 22.3% of registered care homes (Care Quality Commission 2010). In recent years the focus in social care has been on ‘personalisation’, including user-held budgets that can be used to employ staff directly or purchasing from private or third sector providers.

Health and social care services for adults with mental health difficulties (‘mental health services’) in England have been described as receiving less attention from central government than services connected to older people and / or physical health. The Centre for Economic Performance (2012) asserts that whilst ‘mental illness accounts for 23% of the total burden of disease….it receives only 13% of NHS health expenditure’ (p2’), a disparity which it views as the ‘most glaring case of health inequality in our country’ (p2). Whilst arguably it may not be sufficient to address the growing demand, the investment in mental health services has grown by 59% in real terms from 2001/2 (Mental Health Strategies 2012a). Alongside this investment there has also been considerable policy interest in this area, with Hardy (2011) estimating that there were three White Papers, six Acts of Parliament, 140 consultations, guides and good practice publications and 53 sets of mental health related guidance from the National Institute for Health and Clinical Excellence between November 2006 and April 2010. It is true though that aside from the adoption of FT status the market reforms have been implemented more slowly within mental health. This seems set to change however, with
a shadow Payment by Results system being introduced, psychological therapies being promoted as a good contender for local patient choice initiatives, and patient-held budgets being piloted within mental health (Mental Health Strategies 2012b).

The rationale behind the introduction of a market approach, its impact on user experience, financial efficiency and health inequalities, and what it will mean long-term for our understanding of a national health service (social care provision having become so diversified that there is no sense of a publically delivered service) continue to be divisive issues. The Third Sector role in delivery has also been contested, being seen by some as a more acceptable form of diversification than private sector and as having advantages over the public sector, but by others as a Trojan horse through which public ownership is lost and so enabling private business to take control of these services at a later point. Linked to these debates is the alleged distinctiveness of TSOs and the danger that this could be lost if their focus becomes competing with public and private sector within the new mental health market place. Based on a review of literature this article seeks to explore these discussions through considering three key questions - do third sector organisations have a unique role?, do they deliver services in a unique way?, and are they uniquely challenged by the introduction of a market approach?. The article concludes by considering the current reforms and the opportunities for this sector.

The Third Sector: a unique role?

The dispersed, dynamic and evolving nature of the third sector makes it difficult to provide an exact picture of its scale and involvement in mental health services. The Department of Health sponsored mapping of TSOs in England (DH 2007a) estimated that there were 35,000 organisations delivering £12 billion of health and social care related services. The organisation diversity was highlighted through the largest two per cent of TSOs accounting for over a quarter of the sector’s income whilst nearly half had an annual income of less than £50,000. The common services provided were advice, counselling and education, with between 25 and 30% of TSO’s working with people with mental health difficulties. NHS providers receive the majority (68%) of health and social care public sector investment in mental health services and are the major players in a number of key service areas such as crisis support, clinical care and community teams (Mental Health Strategies 2012). Approximately a quarter (26%) of the services purchased in 2011/12 were provided by non-statutory (i.e. private and third sector) organisations (ibid). This proportion has risen from less than 10% in 2005/6 (Mental Health Strategies 2006) highlighting an overall shift from public to non-statutory provision, and this is in relation to a considerably increased funding pot.

Non-statutory organisations are the majority providers in relation to three areas of service - community based support (such as day care, employment schemes, respite and home-based support), support services (such as advocacy and information), and accommodation services (including residential and nursing care). Non-statutory providers receive approximately a quarter of the current NHS investment in the new Improving Access to Psychological Therapies services and in one English region are the principle provider (Mental Health Strategies 2012b). The annual investment survey does not breakdown ‘non-statutory’ into private and third sectors however there are other sources that provide an indication of their respective involvement - 80% of independent sector treatment and care home placements are in the private sector (Hatfield et al 2007) whilst...
TSOs are more dominant players in relation to employment and advocacy (Schneider 2005, Newbigging et al 2012). In addition to direct service delivery TSOs have played a range of other roles in mental health including campaigning, developing new approaches to care and support, and facilitating people with mental health difficulties to be involved in service development and commissioning (Curry et al 2011, DH 2012a).

The Third Sector: a unique approach?

Clarifying what, if anything is ‘unique’ about the outcomes achieved by the third sector is an issue that has vexed researchers, policy makers and practitioners alike. Whilst there are numerous examples of innovative mental health services being developed, delivered and promoted by individual or alliances of TSOs, there are also examples of TSOs providing more traditional and less flexible services. Buckingham (2009) summarises the distinctive qualities commonly attributed to third sector organisations— ‘innovative, personalised, trusted or responsive to local needs... strengthen active citizenship and democracy... nurture ‘social environments’ in which individuals and communities can develop and interact.. and to embody values such as compassion and commitment’ (p238). Appearing at the House of Commons Public Administration Committee (PAC) in 2008, the CEO of the National Council of Voluntary Organisations summarised the uniqueness in relation to both the way it is organised and how it is perceived – ‘Historically, the voluntary sector has done things in a different way. It tends to involve users more in describing and developing the type of service that it runs. It tends to be slightly more risk-taking in terms of the sorts of services that it provides. It is often more trusted in terms of provision by excluded groups than the state or, indeed, the market’ (p33). The Department of Health describes a ‘huge untapped potential for third sector organisations to make a significant contribution to driving quality, innovation, productivity and prevention across health and social care: as advocates and influencers; and as providers of innovative responsive services’ (DH 2007, p2).

Evidencing a common uniqueness across such a diverse collection of organisations and then attributing this to the range of legal forms and governance arrangements that apply in the third sector is a methodologically difficult, if not impossible task. McMillan (2011) highlights the lack of systematic comparative evidence regarding the distinctiveness of the third sector as whole and echoes the findings of the Select Committee – ‘The evidence is simply not there to judge conclusively whether there are shared characteristics across all third sector organisations, arising from their commonality of origins or ethos, which might make them particularly suited to the provision of public services. Indeed, there is widespread consensus that this evidence base does not yet exist’ (PAC 2008, p34). Hopkins (2007) found that user reported better experiences from third sector organisations providing employment services but not those providing domiciliary care in which private sector organisations were better at responding to users’ wishes. Allen et al (2011) raise the lack of quantitative studies comparing third sector delivery to that of the NHS, suggesting that this may be due to the two sectors historically delivering different types of service and limited research of community health in comparison to acute services. Heins et al (2010) agree with the limited depth of evidence regarding an English context, identifying many more studies based on the US experience and questioning its transferability to such a different health care system. Dickinson et al (2012) do
not find significantly more in relation to social care services, although do highlight the findings of Kendall (2000) that dependant on the service in question differences could be observed in relation to policies, services offered, and costs. Knapp et al (2012) review the evidence on differences in delivery by the private, statutory and third sectors in relation to community care for people with mental health difficulties within three European countries and again find limited research and at times conflicting findings, and warn against the dangers of generalising from a particular region or indeed country. Furthermore they suggest that a range of impacts need to be considered when comparing sectors – one study which found lower costs in the private sector related these to fewer opportunities for recipients and more restricted environments as well as unsustainable financial deficits for the providers (Knapp 1999). In contrast, Forder (2000) studied the pricing behaviours of the ‘private’ and ‘not-for profit’ sectors and concluded that whilst the ‘not-for-profit’ had greater potential to ‘mark-up’ costs above what was actually required to deliver the service they were less likely to do so than the private sector.

The Third Sector: uniquely challenged?

Public sector funding connected to service delivery has enabled a considerable expansion of the third sector over recent years. Whilst advocates for TSOs may welcome increased investment, there are also concerns regarding the contractual (rather than grant) basis in which much of it is being provided. This is on the basis that responding to service specifications dictated by commissioning will determine what TSOs do and the way that they operate, and will therefore diminish the sought after ‘distinctiveness’ outlined above (see Table 1 for a overview of these concerns).

Table 1: Negative Impacts of public sector procurement on TSOs (after McMillan 2011)

<table>
<thead>
<tr>
<th>Independence</th>
<th>Increase dependence on statutory funders may lead to TSO’s feeling unable to challenge and lobby</th>
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<tbody>
<tr>
<td>Mission</td>
<td>In ‘chasing’ funding opportunities from the public sector TSOs may shift from their original purpose</td>
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<tr>
<td>Innovation</td>
<td>Tight specification of how and what should be delivered will reduce the ability of TSOs to be creative and responsive</td>
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<td>Employment</td>
<td>The need to tightly control costs combined with insecurity regarding continuation of funding will lead to poorer terms and conditions for staff and to employ disadvantaged groups</td>
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<tr>
<td>Partnerships</td>
<td>Competitive funding processes will lead to TSOs being unwilling to work with other TSOs that they see as potential competitors</td>
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<tr>
<td>Solidarity</td>
<td>There will be a polarisation between those TSOs who are willing and able to win contracts and those who are either unwilling and / or do not have the skills and infrastructure</td>
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McMillan (2011) summarises the evidence for and against these claims, and whilst there is not a consistent picture across service areas, regions and different TSO organisational forms the claims are supported to some extent. A second concern is that whilst many and in particular the larger TSOs have benefited, a significant proportion will struggle to participate effectively in procurement processes due to a lack of capacity, skills and experience. Hatfield et al (2007) reported that market conditions in treatment and accommodation services were more conducive to private rather than third organisations, and Lester et al (2008) highlighted small organisational size being a barrier for TSOs to respond to opportunities for more holistic delivery in relation to people newly diagnosed with psychotic conditions. Munoz (2009) discovered that procurement professionals had experience of TSOs not being able to complete the documentation to the necessary standard – ‘The problem is that social enterprises don’t know how to fill in tender applications properly, they make school boy errors, they don’t do it in a professional manner’ (p74). Buckingham (2010) categorises the response and ability of TSOs working within the homelessness field to the move to Supporting People contracts as lying within four broad categories – Comfortable Contractors; Compliant Contractors; Cautious Contractors; and Community Non-Contractors. The factors that led to the TSOs’ relationship with contractual income included their size, business models (e.g. previous reliance on voluntary donations over earned income), mission and history. There is also evidence that public sector commissioners have reservations in regards to TSOs being suitable organisation to undertake many aspects of service delivery. These include the perception that TSO’s are unwilling to move with the times in relation to purchaser-provider relationships, insufficiently business-like and not able to justify the value that they claim to deliver (Baines et al 2010). Munoz (2008) adds a lack of understanding of what is meant by different organisational forms within the third sector (such as social enterprise) and a failure to incorporate recognition of the added value that TSOs may bring within tendering processes. In mental health services the dominance of NHS providers is another obstacle to greater entry by TSOs into the market (Mental Health Strategies 2012b).

The potential barriers to TSOs in competing for new delivery contracted were reviewed by a Department of Health Third Sector Commissioning Task Force. This identified ‘culture and behavioural change’ as the greatest obstacles, and highlighted that ‘commissioners and providers must step out of their respective ‘comfort zones’ and collaborate to develop genuine diversity of provision and support new providers entering the market’ (DH 2006. p9). It recommended a number of areas that needed to be addressed to achieve the desired change in relationships, and produced guidance to illustrate these in more detail (See Box 1).
A Third Sector Delivery Board was subsequently set up to ensure that a commitment to engaging and developing the third sector was reflected in policy initiatives, and a Voluntary Sector Strategic Partner Programme (SPP) developed to improve communication and dialogue. The SPP includes a Mental Health Providers Forum (see www.mhpf.org.uk). Alongside ‘horizontal’ funds and business development available to any Third Sector Organisations there have been significant ‘vertical’ funds available to support and develop those working in health and social care. These include the £100 million Social Enterprise Investment Fund (which aimed to stimulate the social enterprise sector through providing start-up funding and long term investments); an Innovation, Excellence and Strategic Development Fund (which sought to enable third sector organisations to ‘test and develop innovative approaches to improve health and well-being’ and in 2012/13 allocated £6.8 million to 74 organisations; and a Third Sector Hardship Fund in 2010/11 for those facing financial difficulties.

The commissioning of Independent Mental Health Advocacy (IMHA) Services in England provides a recent case study within a service in which the third sector has traditionally had the dominant role. Newbigging et al (2012) highlight that difficulties in the commissioner-provider relationship remain, despite the guidance and support outlined above. Concerns raised by TSOs include - commissioners prioritising IMHA over other forms of advocacy so that these were lost to the system altogether and/or opportunities for the different types to be provided in tandem were not explored; tendering
favouring larger organisations due to the demands of the process and short-term nature of awards which could put smaller organisations at too great a financial risk; a lack of insight by commissioners regarding the considerable work involved to take on the new responsibilities; and insufficient capacity being commissioned due to plans being based on previous service patterns and not an accurate mapping of future need. A number of these concerns can be seen to have arisen from the relative short-timescales within which PCT commissioners had to act to meet the deadlines imposed by the Department of Health, but there was also evidence that commissioners saw the process as an opportunity to pool together disparate pots of funding to enable the procurement of an efficient service without duplication or gaps.

**The current reforms: a unique opportunity?**

As set out in the introduction to the health and social care system as a whole in England are undergoing considerable reforms, and linked to this there is a broader governmental agenda linked to promoting localism, volunteering and community control over public sector assets and services. These are taking place against a backdrop of financial challenge both now and in the future due to demographics, rising public expectations, and new technology and treatments. In mental health, despite the considerable progress made under the National Service Framework in relation to the development of new models of delivery, many people still experience social inclusion and inequalities regarding patient experience remain, particularly in relation to those from minority ethnic groups (Appleby 2009). These, along with an improvement in the mental well-being of the general population, are reflected in the new mental health strategy and its recognition that these can only be delivered if there is commitment not only from health and social care agencies but within the public sector as a whole (DH 2011). These changes suggest that TSOs along with other mental health agencies are in the midst of considerable policy upheaval – whilst the changes in structures and restrictions in funding will undoubtedly lead to considerable challenge, there are also a number of aspects which could lead to this being a time of unique opportunity for TSOs working in mental health.

**The scale of change**

The scale of the financial challenge that is faced by both the NHS and Local Authorities in relation to health and social care is well-documented. There is clearly a danger that this will adversely affect TSOs if it is responded to by short term cost cutting measures, and such reductions in public sector funding may be amplified by the general public having less disposable income to donate to TSOs. There is evidence that such financial impacts are being experienced, and these are at a time when mental wellbeing of the population may suffer due to actual or concerns over loss of employment and insufficient income (Centre for Mental health et al 2012). There is also the potential however that such desperate financial times will lead to more radical solutions to the organisation and delivery of mental health services being considered, and in relation to cost reductions these are likely to centre on supporting people in the community rather than in acute or long-term residential care, facilitating people with long term conditions to have a greater ability to self-manage their condition and providing holistic support that responds to the person’s combined needs and
circumstances (Naylor & Bell 2010). Alongside these issues are those that were seen as priority areas before the financial crisis (i.e. addressing social exclusion; achieving equality in patient experience; increasing the availability of cognitive behavioural therapies; and improving general mental well-being of the population) (Appleby 2009) which collectively are areas of service in which the third sector is traditionally seen to have expertise and experience.

Greater focus on outcomes and social value

Despite the complex and diverse nature of the third sector working in mental health services, a common link between TSOs is an underpinning mission to improve the quality of life and opportunities available to their beneficiaries. This suggests that TSOs should primarily judge their success not in terms of organisational growth or financial rewards for employees but rather in the nature and extent of the outcomes achieved by the people with mental health difficulties. The move to ‘outcome’ based payments should in principle then be a positive change as TSOs would be paid for achieving improvements in vulnerable people’s lives and this should be in line with their overall purposes. Furthermore less specification about the process about how the outcomes are achieved could give more opportunity for creativity in the manner in which these are achieved, addressing some of the concerns regarding contractual funding streams (DH 2012b). There are potential downsides though in the form of the possible complexity of the new payments systems and connected internal information systems that may be needed, the financial difficulties for smaller TSOs of being paid in arrears, and (going on evidence of Payment by Results in other service areas) the opportunity for large NHS providers to absorb the funding available due to their greater activity levels. Furthermore the initial development focused on NHS rather than independent providers of mental health services (NHS Confederation 2011). Linked to this emphasis on outcomes is the Public Services (Social Value) Act, in which public sector authorities are required to ‘have regard to economic, social and environmental well-being in connection with public services contracts’. Again, this can be seen as potentially favourable to TSOs for whom achieving wider benefits for people who access their services, their families and/or the wider communities is likely to be a central aim. There are though complications in connection with social value, most notably in the lack of agreed definition as to what ‘social value’ means and the difficulties connected with measuring the social value that has been achieved by an organisation and / or activity (Mulgan 2010; Wood & Leighton 2010). Social Return on Investment (SROI) is one approach that has been heavily promoted by the English government and the Department of Health in particular (DH 2010), but this has been criticised on the basis of its complexity, cost and attempt to translate all value into a monetary based measurement (Millar & Hall 2012). Realising the potential of ‘social value’ will arguably require a clear and co-ordinated response from the third sector during this initial development period to ensure that commissioners understand and apply its principles its practice.

A more personalised approach

There is not agreement regarding what is meant by ‘personalisation’, how best to achieve it, if it is actually something new and what the underlying motivations behind its promotion in health and social care policy (Needham 2011; Means 2012). The current consultation to the new Care and
Support Bill describes it in terms of what the person receiving services would experience – ‘real choice and control over the care and support they need to achieve their goals, to live a fulfilling life, and to be connected with society’ (DH 2012c, p18) and this mirrors the expectations set out by a mental health expert by experience quoted in the Mental health Development Unit Guide – ‘Personalisation? I know this is happening when I am treated with warmth, respect and honesty – when people listen to me, treat me as an equal, and support me – and when I don’t have to fight all the time to get what I want to help me recover and live my life the way I choose to’ (p7). In line with ‘outcomes’ and ‘social value’, there should in theory be a connection between the values generally espoused by TSO’s such as ‘empowerment’ and ‘respect’ and the principles that are often seen to underpin personalisation. A more divisive aspect may be the introduction of user-held or managed budgets. These were initially limited to social care but pilots are underway in relation to health or combined health and social care budgets. Considerable variation has been noted in the response of TSOs, from those that have adapted internally and were in a good position to those who were at considerable risk (Dayson 2010). Difficulties relate to the further move to individualised funding streams and a fundamental change in relationship with recipients, who will now become consumers to whom TSOs have to market their service and invoice appropriately (Dickinson & Glasby 2010; Harlock 2010). For those who are able to respond positively, individual budgets arguably provide greater financial security than commissioner-led contracts. Service recipients who agree with the values of the TSO, trust them as an organisation and who are satisfied with the support purchased are more likely to continue to with the same provider than a cash-strapped commissioner who has to prioritise cost and / or who believes in market diversity on principle. Furthermore TSOs that have service recipients meaningfully involved in their governance and leadership structures should be well-placed to understand what is required and valued by these individual purchasers, and to shape their services to meet this demand.

**Conclusion & Recommendations**

It is clear then the Third Sector is a significant part within the current mental health system in England, that there are roles and services that it is more likely to play and provide, and that in some of these service areas it has a dominant position over the statutory and private sectors. There is not at present evidence to support claims that TSOs have a distinctiveness that leads to a better delivery than public or private sector organisations. The combination of market based policy reform in health and social care and unprecedented financial pressures presents great opportunity but also great risk for TSOs working in mental health, with concerns regarding not only their survival but the extent to which any distinctiveness may be lost.

To a large extent responsibility for ensuring that the next decade is a time of growth and increased impact lies with individual TSOs, and the willingness and capability of their Boards and Executive to use these opportunities to further their overall mission. This will require strong and principled leadership that involves people who access services in determining their future roles and priorities, and which can convince staff that any changes necessary to practice and working patterns are in the best interests of people who they are there to support as well as the long-term survival of the organisation. There will need to be a collective responsibility across the sector in which larger TSOs are willing to support smaller organisations that are struggling due to lack of capacity or access to
financial investment and to do so in a manner which does not lead to a loss of sector diversity and organisational autonomy. Responsibility will also lie with the new local GP-led commissioning bodies, the national Commissioning Board that will set their outcomes and the Health & Wellbeing Boards that will bring together health and social care strategies. It remains to be seen if these new commissioners will build on pilot projects that have demonstrated how purchasers can pro-actively engage with the Third Sector (LGID 2010). There is considerable potential for benefits to both commissioners and third sector providers from a close and collaborative relationship but it remains to be seen if the emphasis on competition and dominance of NHS providers will enable this to happen. Ultimately of course it is the extent to which the changes lead to improved quality of life of people with mental health difficulties and the mental wellbeing of the population as whole that will determine if these policy changes and indeed the work of TSOs have been successful.

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