

Social Enterprise Coalition Response to *Liberating the NHS:* *Commissioning for Patients*

October 2010

Contact: Ceri Jones

Telephone: 020 7793 2320

Email: ceri.jones@socialenterprise.org.uk

The Social Enterprise Coalition's Response to *Liberating the NHS: Commissioning for Patients*

Background

1. The Social Enterprise Coalition (SEC) welcomes the opportunity to respond to *Liberating the NHS: Commissioning for Patients*.
2. The Social Enterprise Coalition was established in 2002 as the national body for social enterprise in the UK. We represent a wide range of social enterprises with a combined membership reaching over 7,000 social enterprises. These include social enterprises that take a range of organisational forms including co-operatives and mutuals, housing associations, leisure trusts and charitable structures.
3. Social enterprises are businesses driven by social or environmental objectives whose surpluses are reinvested for that purpose in the business or in the community. They operate across an incredibly wide range of industries and sectors from health and social care, to renewable energy, recycling and fair trade and at all scales, from small businesses to large international companies. They take a range of organisational forms, from co-operatives and mutuals to employee owned structures and charitable models. What they share, however, is a commitment to bring about social or environmental change using a business model.
4. Social enterprises have been increasingly important players in the health and social care landscape for many years now. Well-known examples of social enterprises include Central Surrey Health, Sandwell Community Caring Trust and the Big Life Group. Government figures estimate there to be 62,000 social enterprises in the UK contributing £24 billion to the UK economy per year. There is no definitive data on the proportion of these operating in health and social care. However 'A Survey of Social Enterprises Across the UK' prepared for the The Small Business Service (SBS) by IFF Research Ltd in 2005 estimates that 33% of social enterprises in the UK operate in health and social care. SEC's State of Social Enterprise Survey 2009 estimates that 9% of social enterprises operate in health and social care. Both surveys therefore demonstrate a significant contribution.

Introduction

5. This White Paper and accompanying consultation documents present the opportunity to rethink the fundamentals underlying how health and social care is delivered. Their overarching aims are to put patients at the heart of everything; focus on improving those things that really matter; and empowering and liberating staff. These are very much aligned with the values of the social enterprise movement. Achieving this vision requires a greater role for organisations that support this ambition. Social enterprises are such organisations.
6. Social enterprise is a movement. It is a group of organisations that are united by a set of values and principles and are committed to a certain way of operating. They are based on the principles of mutualism, co-production and participation. They offer a model where people, be it staff, service users or community members are given a direct voice in running their organisation; where public assets can be locked into community ownership; and where people are empowered to transform their lives and the lives of those around them. As such they are well placed to play a key role in the future of health and social care.

7. The Social Enterprise Coalition is consequently supportive of the overarching ambition of the White Paper. We believe achieving this vision requires a complete transformation in the way in which public services are designed, commissioned and delivered. We as a sector are concerned that the White Paper has not considered the commitment and support required to bringing about such a cultural change that goes far beyond any proposed structural reforms. This is a fundamental omission from the consultation regarding how the White Paper is to be implemented. Yet this will be critical for new and existing social enterprises to fulfill their potential to transform health and social care.
8. This includes:
 - Ensuring a level playing field for the different players in this new broader NHS family.
 - Creating the mechanisms to support staff to create viable new social enterprise organisations and bring about the required culture change drawing on the extensive expertise in the sector.
 - Ensuring that the market architecture is created in such a way that doesn't disadvantage any one form of organisation and supports new entrants and social entrepreneurs.
 - Redefining outcomes to focus on quality of life.
 - Providing a bolder ambition for patient and service user involvement that goes beyond choice to co-designing, co-delivering services.
 - Providing a clearer plan for the integration of health and social care, particularly for those with long-term conditions.

General Comments

9. A fundamental rethink of commissioning is essential if we are to make the shifts required to achieve the ambition of the White Paper. This requires a far greater focus on commissioning for outcomes that improve people's quality of life rather than commissioning for services and outputs. It also requires the ability to recognise when a medical approach is required and when an alternative intervention would be more effective at delivering the desired outcome. The emphasis of laying control with clinical professional is absolutely right when a clinical solution is required. However, often when presenting to the NHS it is a non clinical solution that is required and should be commissioned accordingly.
10. It is estimated that as many as 33% of people presenting to General Practice require a non-clinical intervention. Providing channels where organisations that specialise in such interventions can be part of the commissioning process is essential. This would reduce the demand on GP and other health interventions giving more time to better respond to those requiring clinical interventions. Social enterprises are well placed to deliver such support.
11. We believe that the basis of the approach to commissioning should be about the strengths and assets of people, rather than the traditional needs-based (deficit) model, which simply invites professionals not only to see only problems, but to look for more and more of them, rather than the strengths and solutions that lay people may already have.

Specific Points

12. We have only responded to questions with particular relevance to social enterprises.

In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?

13. We welcome the proposed plans for the Commissioning Board to commission maternity services. A strong, well informed, national commissioning body should be able to commission for a standard high quality service no matter where the woman lives. The needs of a pregnant woman and her family are very similar regardless of where she lives or which socio economic group she falls into. All women need their own flexible midwife with access to all the full range of maternity services should her individual needs dictate.
14. Consideration should be given to making the role of the maternity network one of being a regional co-ordinator of services with the capability to ensure women and their midwives are able to access seamlessly any of the services they need.
15. There are a number of public health areas where national campaigns will be more effective. Things like 'no smoking day' have had considerable success in achieving public health outcomes and how these are connected with local decision making and GP consortia will need to be considered.

What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

16. Transparency and fairness in commissioning decision is essential if the shift to GP commissioning consortia is to achieve the desired impact of ensuring the ambition of the White Paper is delivered and a plural economy of health and social care is achieved.
17. There is a large risk that GPs' role as gatekeepers of information and in making referrals could have the unintended consequence of limiting choice to a small number of well recognised providers. We have repeatedly seen this in many other public service markets, where the supply-side shrinks rather than grows due to control being held by a small number of people with little knowledge of the market and the role they play as market shapers. Public transport and waste would be good examples of such markets. Measures must be taken to mitigate against this.
18. To prevent against this it is firstly essential that that all decisions are transparent both with regard to the organisations commissioned and who their directors and governors are. Clinicians involved in the commissioning process should declare any conflicts of interest and remove themselves from the process where this occurs.
19. Secondly, it is essential that there is be a proper audit process of the commissioning decisions that are made and that this is fully transparent and freely available. Obtaining this information should not require a freedom of information request which would cause delays and unnecessary administration.

20. Thirdly, GP commissioning consortia must be assessed on their skills at market shapers and stimulators to ensure there are not unnecessary barriers to entry and that GP commissioning markets support market entry rather than limit it. This is essential to ensure that new entrants with innovative solutions are able to enter the market.

What features should be considered essential for the governance of GP consortia?

21. The social enterprise community has extensive experience of accountable governance structures. Our members include employee owned organisations, cooperatives and charitable structures all of which place strong emphasis on governance as a mechanism to ensure accountability.
22. Firstly, we believe that form must follow function in the case of governance; consequently it is difficult to assess at this stage until the full role of GP consortia is agreed. However, we also believe that whatever structure is selected it should include representatives from a broad range of disciplines both clinical and non clinical as well as representatives from the community. It is through this that these commissioning consortia can be truly representative. It is essential that their involvement not be tokenistic as community involvement often is. These representatives should have decision making powers rather than have consultative roles.
23. We believe that these consortia should adhere to the principles of social enterprise. They should be driven by social change, be participatory and inclusive in their governance, be accountable to their communities, staff, patients and service users, and be transparent in their decision making. They should also reinvest their surpluses and profits in the organisation.

Underpinned by clinical insight and knowledge of local needs what about other skills?

24. While clinical insight is important and has been missing from commissioning decisions in England. GPs alone will not have sufficient understanding of local needs, breadth of clinical and not clinical services or have extensive skill in community engagement. On the whole GPs' knowledge of local needs comes from those who present to them rather than working in a proactive way with the community to truly understand their needs.
25. There needs to be recognition that there are many people in communities with complex health needs that do not present to GPs and as such GPs will have little understanding of their needs. Recent research in Grimsby alone found more than 1000 people who were not registered with a GP; similar situations can be found in towns and cities across England. Meeting the needs of these vulnerable people requires a very different set of skills.
26. Similarly, GPs consortia will need to have understanding of a far broader range of skills and disciplines both clinical and non clinical. This is essential if the ambition of better integration of health and social care is to be achieved and if we are going to transform public health.

How can GP consortia best be supported in developing their own capacity and capability in commissioning?

27. There has been extensive work done in recent years to build commissioning capability under the World Class Commissioning Programme. This has, however, not achieved the desired results. A simple assessment of why this programme did not achieve its potential impact should be carried out.
28. Considerable efforts must be made to ensure full transparency of decision-making and that these consortia have the required skills to commission effectively. The experience of social enterprises is that immature commissioning capabilities often result in very risk averse commissioning behaviour and an over-reliance on the procurement process to protect against risk, rather than intelligent commissioning. There is a danger that the enormous shift in capacity and capability required for GPs to take on this role will result in what is perceived as 'safe commissioning' rather than commissioning for outcomes that can truly transform people's lives. This could be further compounded by the role of monitor as a licensing organisation with little knowledge or understanding of smaller organisations.
29. The shift needs to consider the following:
 - Understanding the needs of users and other communities by ensuring engagement with social enterprises and third sector organisations, as advocates, to access their specialist knowledge;
 - Including patient and carer feedback and involvement in the commissioning process;
 - Being sufficiently flexible within service specifications to allow for innovation;
 - Developing mechanisms to share risk rather than rely on heavy procurement;
 - Recognising their role as market shapers to work with potential providers and supporting new entrants rather than relying only on large established providers who often alone cannot bring about the innovation required to truly transform services;
 - Commissioning on the basis of outcomes rather than outputs and services;
 - Assessing broader social value of commissioning decisions such as the economic and environmental impact as these too have implications on health and wellbeing.

What support will GP led consortia need to access and evaluate external providers of commissioning support?

30. Consortia will require support from those who already have direct experience of doing this from both the supply and demand side. On the supply side this should include the full breadth of suppliers including social enterprises and the broader third sector. We strongly recommend that they be engaged at the earliest stages of the commissioning process to solicit their extensive expertise.
31. We also recommend that GP consortia will require skills in risk management and proportionality. Without these there is a danger that they will be over-reliant on financial track record or processes to allow new and innovative providers enter the market.

32. GPs will also require skill in comparing providers that may in fact look very different and in assessing their various skills. Social enterprises for example may be smaller, some will be newly established organisations that may have huge expertise to offer and extensive local knowledge. How bids are compared between these organisations and large corporate or public sector bodies requires considerable skill to be able to judge them on their different merits.

What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

33. In order to safeguard choice and competition we recommend the following actions:

- Details of commissioning decisions should be published alongside details of organisations tendering for a service and the winning bidder. This could include information such as the named directors of provider organisations.
- Fair commissioning will also be demonstrated by the outcomes achieved and evaluation of the commissioned service. Publicly reporting spend against budgets and health outcomes is also essential.
- Publication of annual quality accounts (once these have been piloted and evaluated for primary and secondary care), identifying commissioning successes and areas for improvement.

What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

34. We believe that outcomes frameworks must consider exactly that – outcomes rather than financially driven targets. Often outcomes are misunderstood in the commissioning process as outputs which limit the possibilities of organisations innovating to develop new solutions.

35. These outcomes should be developed in a transparent way in consultation with the providers, as they will be the experts in determining what an outcome framework should be. It is essential that this includes the broadest range of providers including social enterprises and other third sector organisations.

36. Commissioning for broader social value will be essential in achieving the ambition of the transformation.

Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

37. No, we do not believe that this should be the case.

What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

38. The joint strategic needs assessment will be essential here. This must be developed in an inclusive way with a range of organisations input.
39. It is also essential that consortia leadership is properly representative of the local health economy, to ensure that the needs and views of all sections of the population and healthcare and other providers are included in the decision-making process. We would urge that this needs to be explicit in consortia governance arrangements.
40. Finally we believe that the basis of the approach to commissioning should be about the strengths and assets of people, rather than the traditional needs-based (deficit) model, which simply invites professionals not only to see only problems, but to look for more and more of them, rather than the strengths and solutions that lay people may already have.

How can GP consortia and the NHS commissioning board best involve patients in making commissioning decisions that are built on patient insight?

41. There are a number of ways in which patients can be involved in commissioning decisions:
 - Involving patients and other service users in the needs assessment stage can play an important role in ensuring that specifications truly represent their needs.
 - Engaging with organisations that have extensive experience working with specific groups or are user or patient led social enterprises can support this process.
 - IT solutions can also play an important part here. Patient Opinion is a social enterprise that makes the insights of patients available to the NHS. Using such IT solutions will allow far greater volumes of insight to be generated than expert patients.

How can GP consortia best work alongside community partners to ensure commissioning decision are equitable and reflect public voice and local priorities?

42. It will be necessary for a formal process to be developed to enable consortia to consider the views of all relevant stakeholders and the public in relation to significant commissioning decisions. Partnership with local authorities will be vital to enabling this process in some areas as well as other public bodies such as probation trusts/boards.
43. This, however, should be extended beyond simply including statutory bodies to other representative organisations including social enterprises.

How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

44. Forging stronger links with local authorities requires commitment from both parties. To date, cross public sector agency working in England has not been successful because there has been little in the way of drivers and incentives to do this.
45. Consequently we believe that cross partnership working should be a key performance indicator for GP consortia. Without this, the successful integration of health and social care will not be achieved.

How can multi-professional involvement in commissioning most effectively be promoted and sustained?

46. Collaboration rather than competition should be the focus if effective multi-professional involvement in commissioning is truly the goal. Collaboration favours the development of integrated services across service boundaries that are designed around the requirements of service users.
47. Achieving this requires GP consortia to be open and transparent. It also requires multi-professional involvement to be a key performance indicator for GP consortia with outcomes achieved by cross-agency working being reported.