

# Social Enterprise Coalition Response to *Liberating the NHS:* *Regulating healthcare providers*

October 2010

**Contact:** Ceri Jones

**Telephone:** 020 7793 2320

**Email:** [ceri.jones@socialenterprise.org.uk](mailto:ceri.jones@socialenterprise.org.uk)

## **The Social Enterprise Coalition's Response to *Liberating the NHS: Regulating healthcare providers***

### **Introduction**

1. The Social Enterprise Coalition (SEC) welcomes the opportunity to respond to *Liberating the NHS: Regulating healthcare providers*.
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 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.

### **General comments**

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 enterprises 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.
- Providing a bolder ambition for patient and service user involvement that goes beyond choice to co-designing, co-delivering services.

### **Foundation Trusts as Social Enterprises**

9. 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 driven by the desire to bring about social and environmental change, they are accountable to their staff, service users and communities and are autonomous in their governance.

10. The majority of social enterprises have grown from the bottom up, led by people committed to social change.

11. There are times when a central policy has supported the creation of social enterprises from the public sector. These have been created through a rights approach, where employees who are committed to the values of social enterprise and who feel this is a model that can transform their services have been given the right to establish a social enterprise. Such policies include the Right to Request in health and some of the Rights to be introduced in the Localism Bill.

12. With proposed new powers Foundation Trusts may technically qualify as social enterprises although they will be subject to protections that social enterprises are not, primarily with regard to their ability to fail. But more importantly – social enterprise is not a blanket term that can be applied en masse. It will be for each Foundation Trust to decide on a case by case basis whether they want to be part of the social enterprise movement and therefore sign up to the broader set of values that we as a movement stand for.

### **The Role of Monitor**

13. The Social Enterprise Coalition is concerned by the role of Monitor as the regulator of all healthcare providers. Monitor has no experience of regulating smaller organisations and we are concerned that this will result both in creating insurmountable barriers to entry and in also being disproportionate to the scale of some organisations causing a disproportionate administration burden.

14. Our experience with the Right to Request has been that the assurance process for Foundation Trusts is incompatible for social enterprises delivering community services.

## **Specific Comments**

### **Do you think that Foundation Trusts should be able to change their constitution without the consent of monitor?**

15. The Social Enterprise Coalition does not have a position on whether Foundation Trusts should be able to change their constitution without the consent of Monitor. What is essential, however, is that any changes to their constitution are made to create a positive impact for patients, service users and staff.

### **Do you agree with the proposals set out in this document for Monitor's licensing role?**

16. The Social Enterprise Coalition is concerned that the joint licensing role of the Care Quality Commission and Monitor will lead to unnecessary bureaucracy and cost that will be disproportionately felt by smaller organisations. We believe further information is required on how the joint licensing regime would work, how bureaucracy and cost would be reduced and how this has been considered with regard to the size of an organisation.

### **Under what circumstances should providers have the right to appeal against proposed licence modifications?**

17. The Social Enterprise Coalition believes that providers should have the right to appeal against proposed licence modifications. We believe that groups of providers should have the right to appeal to the Competition Commission if a significant proportion oppose proposed changes to general licence conditions and that individual providers should have the right to appeal proposed changes to special licence conditions.

### **Do you agree that Monitor should fund its regulatory activities through fees? What if any constraints should be imposed on Monitor's ability to charge fees?**

18. We believe that Monitor's regulatory activities should remain funded by grant-in-aid from central government. We believe that Monitor would be unable to raise fees in a proportionate non-bureaucratic way that would not have a disproportionate effect on smaller organisations, which many social enterprises are, and also create an additional barrier to entry for new organisations moving into health services.

**How should Monitor have regard to overall affordability constraints in regulating prices for NHS services?**

19. We believe that, when setting prices for NHS-funded services, deciding which services should be subject to national tariffs and determining appropriate currencies, Monitor should consult commissioners, providers and the public.
20. We also believe it is essential that tariffs and prices are not designed in a way that prevents innovation and service redesign.

**Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor's pricing methodology?**

21. Providers should have the right to appeal against Monitor's pricing methodology in most if not all cases. Clarity is required on who they would appeal to.

**Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?**

22. The Social Enterprise Coalition does not support Monitor's role as promoter of competition in healthcare and believes its focus should be on ensuring quality. We would urge caution over the use of powers to prevent anti-competitive behaviour.

**What more should be done to support a level playing field for providers?**

23. The Social Enterprise Coalition believes that the introduction of competition alone is not sufficient to create a well functioning market.
24. We support the principles of competition as social enterprises are fundamentally businesses. However, we also recognise that open competition in its purest sense can only occur where there is a fully functioning market. Healthcare markets in England are in their infancy. Further, they will always, to some extent, be imperfect markets as the consumer/user and the purchaser are not the same; consequently providers compete on the whole 'for the market' rather than 'in the market'. Where both demand and supply side are underdeveloped, we believe that open competition can result in high barriers to entry, limited choice and compromised quality and outcomes.
25. In such situations SEC believes that interventions to shape the market architecture are required. As it is recognised that a plurality of providers is beneficial to achieving health outcomes, we believe that supporting the creation of these providers and developing the supply side is a means by which to achieve a well functioning market structure. How this supply side is to be supported is a complete omission from the White Paper. New social enterprises are emerging under the right to request without clarity on contract length or value and with inconsistent rules regarding pensions, VAT, Corporation Tax and assets ownership. They are not being offered the support they require to make the transition.
26. This will fundamentally place them at a disadvantage in the marketplace.

**How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anti-competitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?**

27. We are unsure that legislation can prevent against anti-competitive behaviour. We believe that it would be more appropriate for a code of practice to be developed by the regulator for commissioners and managers to guide them in their decisions and have very clear mechanisms where challenges can be made if it is felt that anti-competitive behaviour is occurring.

### **Further comments**

Do you have any further comments or proposals on freeing Foundation Trusts and introducing a system of economic regulation?

28. If a plurality of providers is to be achieved then efforts must be made to not only that there is no unfair competition but to ensure that these organisations are starting from a level footing. At present there are considerably different rules relating to the different organisations that will form part of this new NHS family comprised of GPs, Foundation Trusts and spin out social enterprises. We believe these rules considerably disadvantage social enterprises.

### **Asset ownership**

29. Asset ownership is an area where newly established social enterprises are at a disadvantage from the outset. Asset ownership has widely been recognised as being an essential success factor for social enterprises. From organisations such as development trusts to flagship social enterprises such as Sandwell Community Caring Trust and Blackburne House the ownership and management of assets and ability to leverage capital against these assets has been a critical success factor.

30. The recommendation within the Right to Request that newly emerging social enterprises should be 'asset light' automatically puts these organisations at a disadvantage, particularly when trying to leverage capital in these austere times. There is now considerable experience of how assets can be transferred to social enterprises with protections in place such that public bodies are given a first refusal if the asset were ever to be sold.

31. Social enterprises emerging under the right to request are limited to adopt 'asset locked' legal forms where any assets are protected for public or community benefit. As such we would strongly recommend that a review of the position of Department of Health with regard to the transfer of assets to social enterprise ownership under the right to request. This is particularly opportune since the restructuring from Primary Care Trust to GP commissioning is going to result in public assets being available and we believe the transfer of these to asset locked social enterprise could dramatically increase the chances of the social enterprises thriving and fulfilling their potential.

### **Pensions**

32. Another area where social enterprises will be at a disadvantage to Foundation Trusts and GPs is through the eligibility to remain within the NHS pension scheme for new staff as well as existing staff.

33. This has large implications on integration of health and social care given that the ruling at present is only for staff who work on “*wholly on NHS funded activity*”. It limits the ability of social enterprises to recruit new staff as they are automatically at a disadvantage with regard to the terms they can offer compared to other providers. Further it considerably increases the challenge of encouraging staff to make such a transition if their terms and conditions cannot be guaranteed. Like the BMA we believe that, where social enterprises are created, all social enterprise staff should have access to the NHS pension scheme.
34. We recognise that the Hutton review is currently underway reviewing public sector pensions and we would urge that the eligibility of social enterprises to retain membership of the NHS pension scheme for existing and new staff be a key consideration as part of this review.

### **Contracts**

35. If the social enterprises moving out of the NHS are to be viable and successful greater clarity is required on the length and value of the contract they receive. The move from the community contract with a PCT to any willing provider (AWP) model with GP consortia means that these new social enterprises will have no certainty of their future income.
36. The proposed timeline for changes means that, by the time the majority of these social enterprises emerge from the NHS, there will be a maximum of 18 months left in their community contract with the PCT – before they are moved onto AWP contracts where neither the value nor length is secured. As these organisation’s income will, on the whole be based on this one contract this places them in an immensely vulnerable position.
37. Our experience in the social enterprise sector dictates that 18 months is insufficient time for these social enterprises to bring about the enormous cultural change and reorganisation required to make them viable. Further, without greater security on their income it will be almost impossible for these new social enterprises to plan, invest in service development, and leverage investment or working capital. This will place them at a great disadvantage in the market and leave them immensely vulnerable. We strongly recommend that greater consideration is give to the transition of contracts for social enterprises that are emerging from PCTs to GP commissioning consortia.