

# Social Enterprise Coalition Response to *Liberating the NHS:* *Transparency in outcomes – a framework for the NHS*

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**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: Transparency in outcomes – a framework for the NHS***

### **Background**

1. The Social Enterprise Coalition (SEC) welcomes the opportunity to respond to *Liberating the NHS: Transparency in outcomes – a framework for the NHS*.
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.
  - 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.

### **Specific comments**

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

#### **Do you agree with the principles that underpin the NHS outcomes framework?**

9. We broadly agree with the principles that underpin the NHS outcomes framework. We would also welcome an NHS Outcomes Framework that ensured equity of access, appropriately focusing on different socio-economic groups and recognising diversity within the population.
10. We believe that service-related outcomes should in many cases be much broader than just health, otherwise the potential full value (in both human and financial terms) will not be realised.

#### **How can we ensure that the NHS outcomes framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?**

11. In order to ensure an NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities, it is essential the focus is given to those who are disproportionately affected by poor health and that the wider determinants of health are considered.
12. This will require both data and extensive consultation with organisations that have true expertise in these areas and knowledge of working with these groups. It will also be required to look beyond

clinical outcomes to broader well-being. Cross-agency working will be essential for this to be achieved.

13. It is also important to note there is increasing evidence that inequalities generally result in poorer health outcomes. Consequently, how GP commissioning consortia link to non clinical services such as economic development teams and those responsible for addressing the wider determinants of health will also be essential.
14. 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 professionals is absolutely right when a clinical solution is required. However, often when people are presenting to the NHS it is a non clinical solution that is required.
15. It is estimated that as many as 33% of people presenting to General Practice require a non-clinical response. 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 interventions.
16. 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. It is through such approaches that inequalities can be addressed.
17. Finally, outcomes should include not only the direct outcomes from the service being delivered but also the social value generated by the organisation being commissioned. There has been much work done commissioning for social value for example most recently by NHS North West - this should underpin commissioning going forward.

**How can we ensure that where outcomes require integrated care across the NHS public health and or social care this happens?**

18. Integrated care will only occur if it is actively encouraged, supported and part of a performance framework. The entrenched public silo working will not be broken down across the country without considerable effort. It requires the active participation of representatives of all elements of the system and from outside the system from the outset so the process is designed and then introduced in an inclusive way.

**Do you agree with the five outcome domains that are proposed?**

19. We agree with the five outcome domains that are proposed. However, we believe that what constitutes quality of life will require considerable exploration and is often very personal to the individual extending well beyond clinical outcomes.

**Is there any way in which the proposed approach to the NHS outcomes framework might impact upon sustainable development?**

20. The current well-being powers local authorities are guided by also take into consideration economic and environmental factors. These also have impact on overall health and well-being and how these are considered together is key.

**How can the NHS outcomes framework best support the NHS to deliver best value for money?**

21. There is a danger that the challenge of bringing about the structural changes proposed along with the systems and process required will prevent value for money being achieved. But we should not overlook what will be required to make this work in the long term.

22. Looking beyond only clinical outcomes to wider social and economic outcomes is essential if value for money is to be delivered.