

Social Enterprise Coalition Response to the NHS White Paper *'Equity and Excellence: Liberating the NHS'*

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The Social Enterprise Coalition's Response to the NHS White Paper – 'Equity and Excellence: Liberating the NHS'

Introduction

1. The Social Enterprise Coalition (SEC) welcomes the opportunity to respond to the *NHS White Paper – Equity and Excellence: Liberating 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. The best government figures estimate there to be 62,000 social enterprises in the UK contributing £24 billion to the UK economy. 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 demonstrating a significant contribution.

General comments

5. This White Paper presents the opportunity to rethink the fundamentals underlying how health and social care is delivered. Its overarching aims to put patients at the heart of everything; focus on improving those things that really matter; and empowering and liberating staff 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 change will be critical to new and existing social enterprises fulfilling 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.
- Provide a bolder ambition for patient and service user involvement that goes beyond choice to co-designing, co-delivering services.

Ensure a level playing field from the outset

9. The Social Enterprise Coalition welcomes the recognition in the White Paper that if the new commissioning framework is to work there is a requirement to ensure a level playing field for all providers. However, we also know that creating a level playing field for social enterprises extends far beyond competition rules.
10. 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

11. 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.
12. 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.
13. 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

14. 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.
15. 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.
16. 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

17. If the social enterprises moving out of the NHS are to be viable and successful considerable 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.
18. 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.
19. 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.

Create the mechanisms to ensure newly established social enterprises are viable and staff are supported

Support

20. Detail on the mechanisms supporting staff to create new social enterprise organisations and bring about the culture shift is fundamentally missing from the White Paper. This places enormous risk for these staff and the organisations they are forming.
21. While there are a number of benefits to the social enterprise model, establishing a successful social enterprise requires a complete transformation of organisational culture. Social enterprises are fundamentally businesses requiring an additional skill set. Leading and working for a social enterprise requires a commercial as well as a socially motivated organisational culture and staff and leaders to have greater levels of personal responsibility and accountability. Consequently the leadership skills required to run a social enterprise that combine empowering staff, being accountable to service users, staff and communities with being a competitive business cannot be achieved without support.
22. Within the social enterprise movement there are many examples of organisations that have achieved this cultural change and transformed their organisations. However, there is consensus among social enterprise leaders that this change will not occur without considerable support.
23. The Social Enterprise Investment Fund (SEIF) has, to date, provided funding to support such organisations and this has been valuable. Revenue this year however, is considerably reduced while demand has increased and there has been a delay in getting funding out.
24. We believe that a clearer package of services should be funded not only to support these organisations make the transition to social enterprise but also support them develop the leadership skills to bring about the required cultural change to thrive in their new operating environment. It is essential that these draw on the expertise from across the social enterprise sector and the range of social enterprise models within it be they mutuals, employee owned models, charitable structures or co-operatives.

Ensuring that the market architecture is created in such a way that any one form of organisation.

GP commissioning consortia

25. The Social Enterprise Coalition and its members are interested in exploring the role of GP consortia. We firmly support the principle of person-centred commissioning at a local level as it is at this level that many social enterprises operate and where decisions are most appropriately made.
26. Considerable efforts will have to be made, however, 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 in the enormous shift in capacity and capability required for GPs to take on this role results in what is perceived as 'safe commissioning' rather than commissioning for outcomes that can truly transform people's lives.
27. Further, our concerns lie in the fact that while GPs may be at the front line of primary care provision they have, to date, little experience, knowledge or understanding of the social enterprise sector and the range of organisations that operate within it. This presents a risk to the social enterprise community. We believe the Department will have to play a considerably greater role in educating

GPs on the range of organisations and solutions available including social enterprise. We would welcome the opportunity to work with GPs to build this understanding - without this there could be the unintended consequence of missing the huge skill and resource these organisations offer.

A bolder vision for patient choice and participation

28. The Social Enterprise Coalition welcomes the move to increased patient choice. We do not believe this has yet been achieved despite this being a key part of the policy rhetoric for many years.
29. We believe however the White Paper could go much further. The paper discusses mechanisms for patient consultation, however we believe it should contain a bolder ambition for patient and service user involvement that goes beyond choice to co-designing, co-delivering services.
30. Social enterprises are based on the principles of mutualism, co-production and participation. They offer a model where people are given a direct voice in running their organisation and designing services. This can result, not only in services that are better tailored and more appropriate to the needs of the community, but a cultural transformation from seeing public services as services delivered to people rather than with people. This is particularly important when it comes to services for vulnerable people as there is little detail in the White Paper on how these groups will be considered within this shift to an increasingly choice based model of provision.
31. We would urge that a bolder ambition for patient and service users involvement be built into the White Paper.