Royal College of Nursing

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Social enterprise and mutual organisations in the delivery of NHS-funded healthcare

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Introduction

In recent times there has been increasing debate about social enterprise in the health sector. This debate builds on the previous Government's existing policy framework to encourage and support social enterprise, and the established tradition of worker co-operatives in the UK. The NHS White Paper, *Liberating the NHS: equity and excellence*[1] called for a 'vibrant' social enterprise sector within the health economy in England, and despite the expected revisions to the Health and Social Care bill following the Government's listening pause, it is clear that social enterprises are still intended to have a significant role within the health sector.

This paper provides an overview of the current policy context around the role of social enterprise, including mutuals or employee-led organisations, in delivering NHS-funded healthcare.

The political context: a brief overview

- In 2008 the final report of Lord Darzi's NHS next stage review, *High Quality Care For All*, introduced the 'right to request' to set up a social enterprise to primary and community care staff.[2] This was part of the wave of policies intended to empower front line staff with a greater role in improving the quality of NHS care. Under the proposals, the social enterprises set up were guaranteed an uncontested contract for up to five years and staff were offered access to the NHS pension scheme whilst they continued to deliver NHS care.

- In the same year the Transforming Community Services programme required Primary Care Trusts (PCTs) to separate their commissioning and provider functions. Forming a social enterprise was one of the options available. Data published at the end of 2010 showed that whilst a similar portion of PCTs had selected integration with a Mental Health Trust (28%), integration with an Acute Trust (27%) and becoming a Community Foundation Trust (26%), fewer had opted to develop social enterprises (10%).[3]

- In November 2010, 61 NHS social enterprises had been set up through the 'right to request'.[4] 25,000 staff delivering NHS services now work in the social enterprise sector (accounting for around £900 million of services). Services delivered include primary care for the vulnerable and homeless, sexual health services and support for bereaved children and families. Nurses are leading or playing key leadership roles in a number of the in-development or recently launched social enterprises.[5]

[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
[2] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085828.pdf
[3] http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_122189
[4] http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_121692
[5] http://www.nursingtimes.net/whats-new-in-nursing/management/nearly-half-of-enterprises-nurse-led/5017850.article

Social enterprise and Any Qualified Provider (formerly Any Willing Provider)

The Any Willing Provider policy, through which a range of providers can seek accreditation to offer health care services, was established in 2006. It was intended to provide patients with greater choice of treatment providers, encouraging ever greater competition within the healthcare market. *Liberating the NHS* and the subsequent legislation currently before Parliament[6] also utilises Any Willing Provider as a vehicle for widening patient choice, stating *"our aim is to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market"*.

In March 2011, the government re-branded the policy as Any Qualified Provider. In July, government issued plans to extend patient choice of provider. To date, choice only includes non-urgent hospital care but from September 2012 will be extended to 8 areas of community and mental health services, including services for back and neck pain, adult hearing services, diagnostic tests and leg ulcer and would healing. [7]

Social enterprise organisations, including mutuals, will make up an element of this competitive market, and the Government has been clear that it considers this type of organisation to have a vital role in delivering a variety of public services as part of a 'Big Society'. In late 2010 Francis Maude, Minister for the Cabinet Office announced the roll out of 'rights to provide' across public services and a package of support for new mutuals.[8] Extra support to stimulate the development of these organisations includes a new information line and web service,[9] a £10 million fund, and a group of employee-ownership experts to suggest ways to improve relevant regulation.

What is a social enterprise? Definitions and types

The definition of social enterprise adopted by the UK government when establishing the Social Enterprise Unit in 2002 is: *a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners.*[10]

Mutual, co-operative or employee-owned organisations are owned by their members and are one type of social enterprise. Historically there has been a tradition in the UK for co-operatives, such as building societies, which are run for the benefit of owners (i.e. financial benefit for building societies). In recent years, mutuals have been established on the basis of 'community ownership'. *Mutuo*, an organisation which promotes mutuals, describes this as individuals effectively becoming 'stewards for their defined community' and focusing on serving customers, with no personal benefit such as profit distribution. Instead, profits are re-invested for the benefit of the community.[11]

[6] http://services.parliament.uk/bills/2010-11/healthandsocialcare.html
[7] http://healthandcare.dh.gov.uk/any-qualified-provider/
[8] http://www.cabinetoffice.gov.uk/news/big-society-plans-better-public-services
[9] http://www.cabinetoffice.gov.uk/sites/default/files/resources/MCO-Mutuals-Speech-171110.pdf
[10] http://www.businesslink.gov.uk/bdotg/action/layer?topicId=1077475650
[11] http://www.mutuo.co.uk/about/

Whilst many different types of organisation could be called employee-owned in broad terms employee ownership refers to "any form of employee financial participation", which could range from a 1p nominal share held in trust to a full partnership model. Some mutual organisations may have profit related pay or profit sharing in the form of a bonus. The Employee Ownership Association provides the following definitions on possible forms of mutual:[12]

- Employee ownership: employees own a controlling stake (more than 51%), either owning shares directly or indirectly through a trust.
- Co-ownership: a wider definition with employees owning a minority stake.
- Employer share ownership: a narrower definition, in which employees may only own a small proportion of total shares.

To be successful, a mutual must still have an outcomes focused 'business' ethos, and like any business needs a professional executive structure. Ultimately, unlike private businesses, a mutual is accountable to its members, normally through a link into the Board structure (e.g. electing a number of members of the Board). Throughout the mutual sector there is a wide range of member involvement, from almost entirely passive to very active.

Concern has been raised that social enterprises/mutual organisations may be at risk of being bought out and 'de-mutualised' by commercial companies. The head of the Social Enterprise Coalition has called for mutuals to be 'asset locked' to make sure that they cannot be taken over in this way.[13]

Community Interest Companies (CICs)[14], another type of social enterprise, were designed to provide a framework and brand identity for social enterprises wanting to adopt the limited company form. Although there are similarities with charity status, the regulation and requirements placed on CICs are less onerous, and there is more flexibility – for example allowing the payment of salary to directors so that the founders' of an organisation can maintain strategic control. They do, however, have additional obligations to normal companies:

- they must satisfy a 'community interest test' to show the company's activities benefit the community it was established to serve;
- and there is an asset lock meaning that assets must be devoted to the community rather than owners or investors. This means that a CIC cannot be bought out and its assets used to fund profit for private owners or shareholders.

Foundation trusts (FTs). FTs are not social enterprises. They are distinct legal entities known as 'public benefit corporations'. They have greater freedoms than NHS trusts, including the ability to opt out of Agenda for Change, the national pay and conditions framework. FTs are accountable to their membership, which include separate constituencies for both staff and the public.

[12] http://www.employeeownership.co.uk/
[13] http://www.socialenterpriselive.com/section/news/public-services/20101117/public-mutuals-must-not-end-private-takeover
[14] For more information see http://www.cicregulator.gov.uk/

When FTs were first established, it was envisioned that they would be fertile ground for the promotion of effective staff engagement, building on the membership model. However, a 2010 survey of RCN members working in FTs suggests that in many trusts there continue to be problems with effective membership (staff) engagement and transparency in decision making and communication.[15] Nearly half (47%) of the RCN members who responded did not feel that being a member of their FT made a difference to how it was run; only a quarter (26%) had voted in their trust's most recent governor elections; and nearly half (49%) reported that all or most board meetings were held in private.

Models of mutual organisation in healthcare delivery

There are a number of social enterprise and/or mutual models which already exist within the health economy. For example:

- Partnership structures are prevalent in general practice and new primary care contracts have encouraged multi-professional partnerships (e.g. GPs, nurses and managers responsible for the running and delivery of services).
- A variety of community based social enterprises delivering primary care and social care services, often led and owned by the relevant clinical staff.
- Medical chambers, whereby a group of consultants or GPs come together to offer medical or surgical services. They can benefit by sharing premises and management, sharing the cost and the risk of private practice.

Employment terms and conditions

Social enterprise and mutual organisations are free to establish their own pay frameworks. The NHS Staff Passport developed by the NHS Social Partnership Forum sets out the employment standards and rights, which employees undertaking NHS-funded work have the right to expect when their employment is transferred to a new employer.[16]

Evaluating social enterprises in health care delivery

<u>The social enterprise pathfinder evaluation</u>

The Social Enterprise Pathfinder Programme launched in 2006 to support the early development of 26 social enterprises and evaluate their success.[17] Key points following evaluation include:[18]

- The benefits of the social enterprise model can include enhanced care provision, a better fit with needs of particular client/patient groups, greater innovation and entrepreneurship, value for money and wider social dividend.
- Risks include a lack of secure contracts or revenue, which had a "severe impact on the ability of the pathfinders to establish themselves and develop"; and social

[15] Royal College of Nursing (2010) New foundations: the future of NHS trust providers, see http://www.rcn.org.uk/__data/assets/pdf_file/0006/314619/05.10_New_Foundations_the_future_of_NHS_Trust_Providers_Report.pdf
[16] http://www.socialpartnershipforum.org/StaffPassport/Pages/StaffPassport.aspx
[17] http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_4139501
[18] http://www.tribalgroup.com/Documents/Health/Tribal_DH_SEPP_Evaluation_final_report.pdf

enterprises' vulnerability to competition due to the "relatively low engagement in marketing activities and competitive analysis".

- Pensions were the most common issue of concern, with transferring NHS staff wishing to maintain access to the NHS pension scheme.
- NHS brand loyalty was very strong amongst staff and highlighted as an issue which could be a stumbling block. The Community FT option was felt to be attractive to staff as it retains NHS brand.
- Timescale is often underestimated – it can be between 3-5 years before a social enterprise is established and begins to trade, after allowing for time to develop, plan, secure funding and contracts and negotiate legalities.

The evaluation also identified elements which are important to the success of social enterprise organisations. These include;

- strong leadership and management;
- a clearly articulated social mission with strong community engagement;
- the support of GPs, clinicians, PCTs and local authorities;
- a clear focus on target service users;
- the ability to cope with uncertainty, risks and challenges;
- sufficient revenue for 2-3 years and capital funding.

Other research on the 'benefits' of mutuals

Although there is not a substantial amount of evidence to demonstrate the hard benefits of mutuals in relation to healthcare, evidence from outside the sector demonstrates a number of benefits of employee ownership including a boost in productivity; higher levels of consumer loyalty and trust because of the lack of shareholders; and the greater willingness of staff to confront a non-performing colleague due to a heightened sense of collective responsibility.[19]

Ownership of an organisation matters because it helps to determine culture, goals, processes and values. The benefits of the mutual model for the nursing workforce could include a more empowered staff who are involved in decisions that matter to them, for example, around working patterns or where any surplus should be invested and the ability to help shape the services offered to patients.

Employee-owned and social enterprise organisations might also be seen as a more acceptable alternative provider of NHS funded services than commercial providers, as they are perceived to be more closely aligned to NHS values. The RCN's survey of members working for foundation trusts in 2007 demonstrated some support for this view, finding evidence of strong concern that too much emphasis on a 'big business ethos' would squeeze out patient, public and professional engagement.[20]

Staff engagement and involvement and health care delivery

There is a wealth of evidence on the benefits of staff engagement and involvement within a healthcare environment. Following the 2009 NHS staff survey, the Care Quality

[19] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/NHS_Mutual%20July%202009.pdf
[20] www.rcn.org.uk/__data/assets/pdf_file/0009/287739/NHS_Foundation_Trusts_Survey_2008.pdf

Commission concluded that "research shows that engaging staff is the single most important action a leader can take to positively influence patient care"[21]. The benefits associated with staff involvement and engagement include lower sickness absence; lower patient mortality; lower patient complaints; higher levels of innovation; and improved better job satisfaction.[22]

The Institute for Employment Studies (IES) defines staff engagement as: "A positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context, and works with colleagues to improve performance within the job for the benefit of the organisation."[23]

A number of elements have been highlighted as essential for successful engagement – sharing information about the performance of the organisation; rewards based on the performance of the organisation; knowledge that enables employees to understand and contribute to organisational performance; power to make decisions that influence organisational performance and direction.

Effective staff engagement and empowering staff in their roles and workplaces contributes to their sense of well-being and the Boorman report demonstrated the clear link between staff health and well-being and the three dimensions of service quality – patient safety, patient experience and the effectiveness of patient care.[24]

Social enterprise in practice: some case studies

Below are some examples of organisations that demonstrate potential structures and benefits of mutuals in healthcare delivery, and the importance of staff engagement.

John Lewis

John Lewis is an example of a commercially successful mutual business model, in which staff are rewarded for success with a bonus share of company profits. The elements the company considers key to success include:[25]

- Recruiting on attitude - do people want to be part of the business and take personal responsibility for its success?
- Commitment to making staff as happy as possible, as a successful relationship between organisation and staff will secure long-term sustainability.
- Allowing time to build the right culture within the organisation.
- Clarity on desired outcomes - defining what 'success' is.
- The Chief Executive and senior management team need autonomy to make decisions.
- Clear structures of accountability, including through elected board members and a weekly staff magazine with anonymous staff questions which senior management must answer.

[21] http://www.cqc.org.uk/_db/_documents/16032010_NHSstaffsurvey_Nationalbriefing.doc
[22] See Nuffield Trust (2009) *NHS Mutual: engaging staff and aligning incentives to achieve higher levels of performance*
[23] http://www.employment-studies.co.uk/pubs/summary.php?id=408
[24] http://www.nhshealthandwellbeing.org/FinalReport.html
[25] Kings Fund seminar, 5 July 2010

Sandwell and West Birmingham NHS Trust

Sandwell and West Birmingham NHS Trust has implemented a successful staff engagement process, using the Listening into Action (LiA) programme, which turns feedback from staff into tangible, positive action. Early implementation of LiA involved a series of staff conversations, hosted by the Chief Executive, followed by a programme of action including identifying quick wins such as long service awards and regular walkabouts.

Since LiA was implemented staff turnover has reduced by 2% and sickness absence has also reduced.[26]

The trust is currently "exploring how permanent engagement structures and processes can be created, and the ways in which incentivisation could be used to create a model somewhat similar to the John Lewis Partnership. In parallel, the use of the LiA approach continues to spread across the organisation, and evidence suggests that it is becoming successfully embedded".[27]

Central Surrey Health

Central Surrey Health (CSH) provides community nursing and therapy services to the population in central Surrey and is co-owned by 750 employees. CSH believes that the mutual model is better for patients because the organisation has the freedom to be more innovative e.g. in service developments; that it is better for commissioners because CSH is more responsive; and that it is better for employee co-owners who are more engaged.

Each CSH employee has a 1p share. Accountability to the membership is aided by one member of the Board being elected by a group of 9 elected council members who deal with strategy for the organisation. Surplus from the organisation is reinvested into the business to benefit everyone. For example, in the first year of operation the surplus was used to address two issues identified by employees – improving the IT system and increasing the staff training and development budget.

Key lessons from the CSH management team include:[28]

- The need for a clear idea of the different roles for unions versus employees.
- Management is transparent and open with all information - even around difficult issues – to help staff to understand and accept when difficult decisions are made.
- Co-owning does not mean everyone takes part in everything – that is where democratic institutions come into play.

CSH was established with a commitment to Agenda for Change, however in an open seminar in early 2010 a representative indicated that a more 'individualised' approach to staff reward might now be more appropriate. It should be noted that CSH had substantial support during the set-up phase and benefitted from arrangements that would not be available to future organisations.

[26] Kings Fund seminar, 5 July 2010
[27] http://www.listeningintoaction.co.uk/LiAinfo/docs/0.0.0%20LiA%20Case%20Story.doc
[28] Kings Fund seminar, 5 July 2010

Circle

Circle is Europe's largest partnership of healthcare professionals and runs a number of hospitals and treatment centres in the UK, treating both NHS and private patients. Circle is co-owned and run by clinicians and describes itself in the following way: "The management team reports to the clinicians, working side by side in Clinical Units and not in a rigid pyramid. Circle is structured as a partnership of clinicians and other professionals. Being a partner means you share in the ownership of Circle, with shareholder voting rights to help direct the company."[29]

49.9% is owned by Circle Partnership Ltd, which is owned by everyone who works in clinical services, directly or indirectly, at every level. 50.1% is owned by Circle International plc, the investment vehicle for investors to provide the capital for Circle. They ensure that any refinancing is achieved without diluting partners' 49.9% ownership. In addition, every year from 2003-2015, up to ten million shares will be available for allocation to partners until 100 million shares have been issued.

In June 2011 Circle was floated on the AIM stock exchange market.[30] The investment needed to buy land and build hospitals, clinics and invest in infrastructure is raised by Health Properties Ltd, a separate business.

RCN's position and matters for discussion

The RCN has developed a set of principles – based around quality, accountability, equality and partnership – which form the bedrock of our response to policy and service change[31].

The RCN is fundamentally opposed to any competition amongst providers based on price, which risks a 'race to the bottom' and places patients at risk. We believe that there may be a role for competition as a lever to improve quality but safeguards must be in place. For example, effective regulation from Monitor and the Care Quality Commission must ensure the various parts of the health system work together effectively and to assure minimum standards of quality and patient care.

Every service providing care to NHS patients must offer care which meets quality standards encompassing safety, effectiveness, efficiency sustainability and dignity. High quality patient-centred care must be the aim for every service.

The long term sustainability of service providers is also of critical importance, as the failure of Secure Healthcare (a staff-owned social enterprise delivering NHS services to prisoners in Wandsworth[32]) demonstrates. The organisation was reported to have failed due to lack of capital and the banks' unwillingness to provide a loan. The NHS under the local PCT were obliged to step in and protect the jobs of the employees working for Secure Healthcare and to ensure the prisoners continued to receive care.

[29] http://www.circlepartnership.co.uk/

[30] http://www.healthinvestor.co.uk/(X(1)A(BkiGDiphzAEkAAAAZmYzOTIzZGItZTllNS00NjdkLTgyZGItNGY5ZWU0ODY2YWZhtxzOADWnBF0LvuhrQanPP8NLiZg1)S(g2qndy450jo3d1z5ob2gxnuj))/ShowArticleNews.aspx?ID=1721

[31] http://www.rcn.org.uk/__data/assets/pdf_file/0009/78696/003034.pdf

[32] http://www.guardian.co.uk/society/2009/nov/18/prison-healthcare-nhs-social-enterprise

In view of the evidenced link between positive patient outcomes and staff engagement and employment conditions, it is essential that all staff delivering NHS services have guaranteed access to the NHS pension scheme and that the national pay framework developed under Agenda for Change is protected.

Tell us what you think...

The Policy and International Department is keen to incorporate your views into this debate and the thinking it develops around this policy area and would like therefore to receive comments and feedback from as many members as possible on this important issue. Please contact us at **policycontacts@rcn.org.uk**

Questions to consider:

- Do nurses want to work for social enterprises/mutuals?
- What are the experiences of nurses already working in social enterprise or mutual organisations?
- Are social enterprises/mutuals a more acceptable vehicle for delivering NHS-funded services than commercial providers?
- Are nurses confident that social enterprise/mutual models will be sustainable in the long term and that they will have the business acumen and resources needed to survive in a competitive market?
- Within an employee-led organisation what safeguards are needed to protect the patient and public involvement?
- What safeguards for staff engagement and involvement should be in place?

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