



‘The third sector and social enterprise in health: the way forward?’

House of Commons, 13 May 2008

The ‘NHS Next Stage Review’ being conducted by Lord Darzi has been billed as a ‘once in a generation’ opportunity to reinvigorate the health service.

Consonant with the review, Civitas is hosting a number of high-profile debates to explore the potential for consensus on some of the key themes. The aim is to bring together the grassroots of the medical profession, along with key stakeholders in the NHS, private sector and politics, in healthy, open and unassuming discussion, independent of government.

This is the second in the series, looking at the dynamic potential offered by social enterprise and the third sector. Engaging an audience of around one hundred interested delegates were **Harry Cayton** (p.2), **Mo Girach** (p.4), **Sir Muir Gray** (p.5), **Mike Parish** (p.6) and **Lord Mawson** (p.8).

Comments (p.10) were also heard from: Charles Fraser, Daniel Green, Jenny Edwards, Dr Angela Jones, Dr Shirine Boardman, Nick Seddon, Major Ian Harris and Peter Mason.

Introduction: Professor Aidan Halligan

Healthcare has never been more challenging:

- Connectivity is going from the verbal, to the visual, to the virtual;
- The complexity of diseases is quite extraordinary and growing;
- The economics of health care is fast becoming a black hole;
- Innovation is widespread across the health service, yet so difficult to propagate;
- Medical science – stem-cell research, genomics, tissue engineering and regenerative medicine – are taking us to new levels, to things not known to practicing doctors currently;
- And our population are more aware of that knowledge than ever before.

Yet, in the middle of all this we talk about patient-centred care, which makes people wonder what we’ve been doing for all these years!

Users just aren't comfortable with the quality of service they get, because they don't feel it's personalised or joined-up. And at the same time providers are getting fed up with central targets and professionals are feeling over-worked, underpaid and definitely under-loved.

The current attempts at reforming the NHS are reaching their limit, that's becoming very clear. There are a wide number of issues that cannot be dealt with by traditional services. Here is where the third sector may well come into its own.

Harry Cayton

Co-Chair, National Voices for Health and Social Care

The potential for social enterprise and not-for-profit organisations – including the voluntary sector and the whole new range of community-interest companies and faith groups – to contribute to health and well-being remains almost completely unrealised.

Here are some of the barriers to making real progress; to bringing social enterprise into health care provision:

Within the voluntary sector:

- Risk aversion. We like to be seen as innovators, yet we are, by and large, unprepared to take risks. This applies particularly to large charities; the larger you get the more your financial directors and trustees seem to get anxious.

Futurebuilders is an example; a brilliant idea but has not succeeded because the voluntary sector has not come forward to borrow money.

- Dependency culture. The view that somehow because you are doing something good, other people ought to pay you for it; they ought to give a grant and it ought to be the government or the lottery or a trust. But the idea you might actually sell something and make a profit on it is a hard idea for the voluntary sector to take on.

For example, the transfer of the Expert Patient's Programme from the DH to a Community Interest Company: the people who were running the courses found it very difficult to realise that they now had to offer a product that people really valued. Particularly, they need the right business data, the right patient records and the right information governance.

Within the NHS:

- Procurement. The NHS' main problem is that it doesn't know how to buy anything from anyone, particularly from small suppliers and on longer-term contracts. We need the leverage of price, but we haven't developed systems of purchasing for the long-term; too much spot-purchasing still goes on.

- Over-regulation of small scale health and care services. In effect we are regulating out of political anxiety, not out of any serious risk assessment or reality. We think of safety as a feature of the state, not of individual behaviour and we over-regulate as a result.

Nearly everyone in this room is defined by parliament as a vulnerable adult; if you take a pill you're a vulnerable adult, if you're Aidan's age you're a vulnerable adult. We're creating a world where everyone is assumed to be vulnerable, whereas many of those with the most significant disabilities are feisty, successful, dynamic people who do not need to be looked after.

- Financial disincentives to change.
 - Short-term contracts (see above).
 - Pensions. We're in a divided country now in which a small group of us will be the recipients of state-funded, index-linked, generous pensions, which will be paid for by a whole group of others on self-funded, money-purchase schemes which will deliver far less.

This severely limits the mobility of workers. It is very difficult to persuade people to give up an NHS pension to go and work for a social enterprise, when those contracting – and I remember Bromley LC taking this line with myself at the Alzheimers Society – refuse to make provisions for pensions. This is a restriction on the quality of people and a huge inflation of cost in small organisations.

- Quality and Outcomes Framework. There is a rumour that GPs do what they are paid to do. The QOF is really a public health driven framework; it is in no way a patient-centred framework and it doesn't relate to patient-centred outcomes, with scarcely a nod towards patient satisfaction. It won't pay for things like the Expert Patient Programme or self-management courses, because it is not universally available to all patients in the NHS.
- Lack of radical behaviour. We're still playing in the margins of what it might be like to have patient-led, user-driven service. Many of us find sweetness out of taking risk – either for profit, or for change and a feeling of making a difference – yet it seems at the moment we are dumping it between sectors.

At a political level, politicians are still seeing this as something that sounds nice, that looks like a bit of contestability, but in reality things that are truly radical like Communities of Health in Newham – where provision is basically run by people in their own communities with help of health professionals rather than the other way round – are such a struggle because it challenges the power of the status quo.

My final point is on evidence of quality care; if the government, PCT or provider defines the terms of play, it's very hard for others to produce evidence to convince. We need patient-defined outcomes, with the consumer defining success, and much greater freedom of movement for them. I've sympathy with the argument of freeing up health professionals to do their jobs, but we won't get

patient-centred care if don't set patients free – which includes making it a lot easier to change GP and use services offered by social enterprise.

Mo Girach
Interim Chief Executive, St Alban's & Harpenden PbC Group

A social enterprise, by the government's definition, is 'a business with primarily social objectives that reinvests surpluses rather than distributing them to shareholders or maximising profit'.

The roots of it can be traced to the 19th century co-operative movement. Nowadays, the sector is much larger than most would realise; there are around 55,000 social entrepreneurs in this country, who generate about 5 per cent of GDP. The largest health cooperative is in Manchester, but we should also remember that Foundation Trusts have a mutual, cooperative, structure.

Still, this is much less than in many other countries. In Spain, for example, 60 per cent of health care is provided by cooperatives; and the sector is very much a growth industry in Taiwan and India in particular.

For me, a social enterprise has two elements: the 'Richard Branson' entrepreneurial drive and 'Mother Teresa' spirit.

I want to talk about two social enterprises I've been involved with to illustrate the huge benefits it can offer:

SELDOC: South East London Doctors Co-operative was set up in April 1996 as a GP Co-operative providing out of hours General Medical Services to its patients from a base leased within Dulwich Hospital. The call centre, cars and mobile Doctors all operate from the Dulwich Hospital site.

From the outset Seldoc was designed to be operationally self-sufficient, providing all aspects of the service from within the organisation, under the values of being a co-operative. The GP membership is drawn from Lambeth, Southwark and Lewisham; who – with local location partners – hold a share equivalent to £1.00 and own, manage and finance the social enterprise under a constitution.

It is run as a business with a focus on cost-effectiveness and value for money, but any surplus (as much as £2 million) is reinvested back into services. This is vital. Led by GPs, staff retention is high, there is shared ownership and massively reduced grant dependency.

St Alban's and Harpenden Practice-based Commissioning Group; under PbC we converted this into a co-operative to give ownership to the group of doctors and focus services on the patient. Patients are on the advisory board, health inequalities are on the agenda and we are moving fast to true commissioning rather than simply demand management.

As a social enterprise, we are able to meet unmet needs, have an awareness of untried providers and are prepared to take a few risks.

As a limited company and legal entity, the group is subject to regulation via corporate governance rules, company law and proper financial audit of its accounts. This encourages due diligence and acting in good faith, but also ensures we must drive to greater efficiency and effectiveness – if we go bankrupt we can't get bailed out as in the NHS.

Social enterprise and the third sector have massive potential; the NHS, SHAs and PCTs must be prepared to embrace them.

Sir Muir Gray
Chief Executive, Knowledge into Action

I want to start by saying I've been a public servant for 40 years; I've got the black belt, probably made every mistake possible – though hopefully only once – and seen 21 NHS reorganisations. None have made much difference. I've kept my day jobs in screening and creating a national library for health online (Chief Knowledge Officer, NHS), but I've become an entrepreneur.

I've been inspired by Japan – in particular a brilliant book, *'The Knowledge Creating Company'*. The Japanese work on sapiential authority: explicit knowledge in procedures and manuals but more often tacit knowledge, learned only by experience. Teams are passionately committed and the creativity is tremendous – they are constantly looking forward. They get on and do, to see advantages of different ways of working. Is it any accident that Lexus is better than Mercedes, BMW and Volvo?

But whether we can do this, and in health care, is an open question:

- We are becoming increasingly risk averse.
- The EU and OJEU (Official Journal of the European Union) procurement rules are nightmarish, stifling, and bad news for small companies and organisations.
- There's been a huge rise in project management and a decline in personal responsibility; we have become consumed by processes, at the cost of personal accountability.
- We are engulfed by bureaucracy that is self-serving, good only for safeguarding employment and distributing finances.

I've finished up and set up the charity Knowledge Into Action.

Here we're doing three things you can't imagine being done elsewhere:

- We're an agent for DH to organise and coordinate a national campaign for walking.

- We're campaigning for greener, sustainable healthcare, to rip out unnecessary costs.
- We're creating an internet radio station, www.soundshealthy.org, to try to create a common culture across NHS.

We're not a company trying to sell a service abroad; we're not selling TV to China, we're in England not-for-profit to make a real difference.

But there are real, important and difficult conflicts of interest with my NHS half-time working. The future of the public health service – c. 152 public health PCTs, departments and SHAs – spending vast amounts of money, is uncertain. After being appointed to my 47th committee, I decided 'time to go'.

Still, nothing will change until we stop doing business the wrong way round. Toyota doesn't say their core business is factories and showrooms, they say it is the customer; yet the NHS will say it's Foundation Trusts and PCTs. The third sector is important, but it is, after all, just another structure – I happen to think a more elegant one – whose success ultimately depends on its ability to adopt a fundamentally different approach to the individual in patient care.

Mike Parish
Chief Executive, Care UK

I don't want to be cast as something of a pantomime villain, but Care UK is a Plc, listed on London Stock Exchange. Then again, we might be deemed a social enterprise on Mo's definition! As a growth company, we are reinvesting two-to-four times the level of our annual profit, as shareholders don't want to take money out of our business.

I come at this question from a different view: of the importance of a plural, sophisticated market, with lots of organisations working together.

Personally, I'm ashamed of standards in the homecare industry, where Care UK started off. This is about poor procurement on behalf of Local Authorities. Here, where we've worked, we've successfully translated the culture from 'hours-in' to outcomes. An example: we've got Wii machines in our care homes to provide activity and stimulation, activity and inspiration.

Latterly, we've moved into healthcare, through the ISTC programme, and through running and working with GP practices. We've also partnered with acute and A&E services in Luton, where a reduction in primary type A&E admissions have thus far saved PCT £1 million. Most recently, we've signed a primary care contract with HMP Brixton – a partnership between us with the PCT and Tomorrow's People (a voluntary sector organisation).

The purpose and benefits of the third sector, from my perspective:

- Representation and lobbying. The work done by Help the Aged et al. would not exist if not for 3rd sector.
- Providing in the absence of market. The Terrence Higgins Trust – the leading and largest HIV and sexual health charity in the UK – is a classic example.
- Provision where funding need not be recognised through taxation. For example, the hospice movement, which adds massive value to the system yet is 98 per cent funded through fundraising.

In both the above, the voluntary sector can reduce costs on private or public provision – typically the workforce may be part or fully voluntary and people want to give their time and fund extra capacity.

- Motivation and inspiration. I wouldn't call John Lewis a third sector organisation, but it is a partnership; is it any accident that its staff turnover is 60 per cent less than Tesco? I've also seen from first hand with the privatisation of the National Freight Consortium that a great success can turn sour if self-interest and risk-aversion comes to dominate over serving the customer in the private sector.

Yet, though an important one, this is not the only route to quality. The point I want to make is that you can get great quality from the third sector, the private sector and the public sector, but you can equally get appalling quality from the third sector, the private sector and the public sector.

To bring this home at bit, I give the example of my wife, who is a CAB advisor. Yet she spends most her time advising people how to challenge incompetent LAs. This is Kafkaesque – if the LA solved the problem at source, through proper procurement which may well involve the third sector – it could make large savings and generate better outcomes.

It is the role of all of us, and the regulators, to address poor quality. Management is crucial; it is often said private sector organisations can pay more and get better management. But there are many motivated third sector people that make far more passionate and inspirational leaders than any I've seen in the private sector.

For me, what is important is having a competitive market, where a market can provide. The core business of the NHS is strategic planning and managing of supply. Given this, I'm a fan of freeing PCTs and SHAs from any operational role, where the default is to 'urgent for today' priorities, not building relationships and partnerships. They should be testing the not-for-profit sector in commissioning and considering:

- What it means to have a level playing field for the third sector. Some thoughts:
 - NHS organisations – particularly with an acute sector that is so dominant – clearly have an unfair 'competitive' advantage. Public sector pensions only add to this.
 - But then are tax breaks for the third sector equally an unfair advantage where there are other providers?

- Quality and price of provision. The third sector must demonstrate it can deliver this.
- Charitable purpose.
- The long-term. Does it offer potential for high growth?

A word of caution: social enterprise is something of the flavour of day in the NHS, with PCTs under pressure to divest their provider arms and with practice-based commissioning. There seems to be an emotional draw to the social enterprise movement, but is it objective and sustainable?

For PCTs, taking one hand off handlebars, and going to social enterprise may be more philosophically comfortable and less threatening for staff – who might keep NHS pensions – than other alternatives.

But we should be clear on the ultimate purpose; we want sustainable, not temporary, solutions. If we see a good, long-term, quality and cost rationale for third sector organisations – just as with the private sector – then great, but I just worry about business experience, and whether some are setting up to fail....

**Commentary: Lord Mawson, OBE
Founder, Bromley-by-Bow Centre**

It's clear there is a massive opportunity for the third sector to bring great benefit to health care, but we must understand the macro through the micro – and in great detail.

I've been in Bromley-By-Bow now for 25 years. I arrived in 1984, a clergyman by profession, and set up in a derelict church. The congregation was 12 people and we had £400 in the bank. As a nosy Yorkshireman, I decided to loiter with intent and try to understand what was going on in the run-down estates (which, incidentally, are now 50 yards from Olympic site).

I found the voluntary sector and churches in endless management committee meetings, arguing all day long about equal opportunities, reading *The Guardian* and drinking coffee. Nothing practical and useful was being done.

I have come to learn social enterprise is about backing individuals. The origins of the Bromley-by-Bow Centre were in a few parents running nursery for 12 kids in their living room coming to me and asking if they could use the church hall. We formed a partnership – and a business developed where people came together to do things. An architect ripped out the building, we reduced the excessive capacity of the church and integrated a nursery and art gallery, with artists sharing their skills.

Our idea was to invite an intake of both children whose parents needed help from social services *and* of those who could afford to pay the going rate. A social services expert arrived, hand in bag and with an encyclopaedia of 1,000 reasons why it couldn't happen. But I took the view that when

the rules don't work, you break them; I got the director down, who thankfully had something like an entrepreneurial mindset.

A similar story of struggle has been manifest at every step, but Bow Childcare is now a stand-alone social enterprise with nurseries in Tower Hamlets, Newham and Hackney; and bred the Bromley-by-Bow Centre – a multi-million pound focal point for the community providing health, education, creating jobs and generating wealth. Twenty-three social enterprises are now operating there; we don't just prescribe drugs, but activity, education and opportunity.

I've learnt that the way in is about staying with detail for a long time; dig and dig and learn how you can change, innovate and dance with dinosaur of government.

Here are a few lessons I'd draw from this discussion:

1. Drill into the detail of consequences. I thought I'd find religion in churches, but I found them in the NHS – it's full of talk of health inequalities, making everything equal and fair, but it's the patients that pay the price. Where's the customer? We need to buy into diversity, recognise human life is gloriously diverse and dump the 1970s view of world.
2. Create cultures that back success. Many people spring up who are very good at what they do, yet systems too often undermine their work. We need to reward them.
3. Take a long-term view. It's about listening to people to make things work and above all about learning-by-doing.
4. Grow together. The business community are not just pigs; we supped with Tesco and got great results – a £27,000 grant! Public vs. private and voluntary sector vs. private sector is an old religion.
5. Create an enterprise culture. Children need to breathe in the entrepreneurial traditions aged 6 not 16. Yet no teachers know anything about business. Our kids will probably have nine careers, yet many will drown in ideology. Social enterprise has two traditions: the cooperative historic roots and a new social business one.
6. Beware of politicians from all parties; the 'johnny-come-latelies' and the political culture based on 'come and go'. Five years is a very short time to launch yet another social exclusion action plan with 77 funding streams or whatever is coming next.
7. Be a lot more radical. We have to move this on and think about how to cut out the bureaucracy, to get hold of problems and really learn and try to apply a solution. *We need to back people before structures.*
8. Quality leadership. The possibilities are immense, but the devil is in the detail.
9. Recognise that health is not an illness service. We need to create environments where flowers can bloom; where people are healthier because they're empowered.

10. Prove that you are better. All can see what's happened with Bromley-by-Bow, but we've gone to some extremes. Measurement will have limitations in terms of getting integrated, holistic responses to human problems, but we've had McKinsey&Co in to show how money's been saved and have assessed quality outcomes wherever possible.

The government must grasp the implications of more entrepreneurial, organic ways of working; and populations have to be persuaded they can make a real difference. It's not magic; it's about hard work and building relationships, honesty and trust with all parties – customers, GPs, PCTs and LAs – not endless structural change.

Comments:

Charles Fraser, St. Mungo's: One reason why the voluntary sector is so reluctant to take risks is because we are overwhelmed with contracts – recently an LA asked us for a 71 heading breakdown with regard to one care home agreement. There is a massive transfer of risk from commissioners to providers, particularly with regard to pensions liability. Yet where is the NHS to pick up the mental health, alcohol and long-term condition problems? The truth is that many services are more about employment, relationships, psychological and skills strengthening. Good health is medical and non-medical, and social enterprise offers a massive potential as an enabling vehicle.

Daniel Green, BioCeramic Therapeutics: I think we need to take a close look at why people take risks. Clearly any risk involves an element of danger, yet we emphasis personal accountability, which tends to make risk a bad idea. Do we have to create an upside to incentivise it?

Jenny Edwards, Homeless Link: A good third sector organisation, social enterprise or private company thinks about the individual and what they want or need. But when the paying customer is someone else, there's a mismatch. As the third sector gets more and more into relationships with commissioners, we have to be very careful about marrying cash with the public sector attitude that 'you need an NVQ2' as the outcome. Instead, we need breathing space to create a service right for the individual.

Dr Angela Jones, GP: The QOF not about patient-centred outcomes. The new contract's bean-counting regulations destroyed that. I work with homeless, but can only get results if the professionals are liberated and set free.

Dr Shirine Boardman, Apnee Sehat: I'm a hospital doctor and was trapped in hospital, seeing patients with the most serious forms of disease, did a lot to put it right, but I wanted to be able to deal with it much earlier. I was dealing in drugs, drugs and drugs, but there is mind body and soul in health care.

I was one of the few who managed to break free and get into community to get to roots of problem; it was eye-opening. Hospital doctors would love to do more community work, but competition and the primary-secondary care divide seems to put a stop to this. I understand the need to raise

standards but integration would really get people to work to their strengths. We need a different approach and vision.

Nick Seddon: The third sector doesn't have a monopoly on quality or motivation, though it may well do it very well; how can it prove it is better? What are the metrics that are relevant to show this?

Secondly, how can we get through to commissioners to get them to think outside the NHS box and look at options provided by social enterprise and other sectors?

Major Ian Harris, Salvation Army: Commissioning needs to be much better developed. Historically, the strength of the third sector has been that we've been closer to client and person. Yet we can't get funding for a project visiting and supporting older people in home – which would enable costly services to be kept at bay – but we are asked to do what we're not so good at and go into costly residential services. We need to be freed up from such restrictions.

Peter Mason, Secure Healthcare: We're an industrial provident society for prisoner and offender healthcare; we're a big part of the new social entrepreneurial movement and it's critical. I believe there should be a social benefit dividend, expressed for user benefit; it is our duty as social entrepreneurs to break into markets, disrupt them and be measured by results.

With thanks to Norman Lamb, MP, for hosting this debate.

James Gubb
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