Social enterprise spin-outs from the English health service: a *Right to Request* but was anyone listening?

Robin Miller and Dr Ross Millar

Health Services Management Centre, University of Birmingham

January 2011

Hosted by:

UNIVERSITY^{OF} BIRMINGHAM   UNIVERSITY OF Southampton

Funded by:

Cabinet Office
Office for Civil Society   BARROW CADBURY   E·S·R·C
ECONOMIC
& SOCIAL
RESEARCH
COUNCIL

Contents

Social enterprise spin-outs from the English health service: a *Right to Request* but was anyone listening?

Abstract

The 'Right to Request' initiative was introduced by the Labour Government in 2008 as a process through which NHS clinicians and managers working in England could seek to develop a social enterprise to deliver Community Health Services. Building on the experiences of the Social Enterprise Pathfinder Programme it addressed key barriers that had been identified such as NHS staff transferring their current pension entitlements and security over the initial contract lengths. It also provided access to the Social Enterprise Investment Fund which could be used to support staff groups in completing their business cases and bringing in external consultancy and support. The Coalition Government continued the scheme, and it is estimated that approximately 10% of the community health services currently provided by Primary Care Trusts are in the process of completing their business cases or have already launched as social enterprises. The University of Birmingham have been supporting managers and clinicians within the West Midlands who are seeking to develop a social enterprise. In this paper we reflect on their experiences and the response of the local health systems in which they work. We identify that there have been a number of barriers to staff who were keen to pursue this option, and make recommendations for what could be done to encourage and support NHS staff to set up social enterprises in the future. The findings and recommendations are also of relevance for other parts of the public sector in which a 'right of challenge' is being introduced.

Introduction

The potential of 'social enterprises' and 'social entrepreneurs' to transform the delivery of public sector services was promoted by the previous Labour administration, with their combination of 'social goals' with 'private sector approaches' fitting neatly into the principles of the Third Way (Teasdale 2010). The Right to Request programme was introduced as a vehicle to enable staff working within the NHS to develop their own social enterprises by externalising services that had previously been delivered by the NHS. The coalition government are continuing with this policy direction, with the current Secretary of State Andrew Lansley declaring a wish to transform the NHS into 'the largest social enterprise sector in the world'. His definition of a social enterprise includes foundation trusts (FTs) which is a view that has been challenged by some sectors of the social enterprise community. This is on the basis that their perceived lack of autonomy and reliance on a single funding source (i.e. the NHS) means that they are more akin to a public sector bodies than independent businesses (Hampson 2010). There are concerns from other quarters regarding the rational of moving NHS services into the Third Sector in general in light of the absence of a convincing body of evidence that such organisations can consistently deliver the expected innovation and efficiencies in health provision (Pollock et al. 2007).

The University of Birmingham has been supporting budding NHS entrepreneurs in the West Midlands who are considering or developing Right to Request proposals. Using the West Midlands as a case study, we reflect on the current readiness of the various constituencies (i.e. clinicians, managers and commissioners) to embrace the option of social enterprise, and recommend what needs to be addressed if social enterprises developed and led by NHS staff are to become a significant part of our health care system.

A brief introduction to 'social enterprises' and 'social entrepreneurs'

Over the past 10 years, social entrepreneurship and social enterprise have increasingly struck a chord with policy and practice. Against a backdrop of social institutions becoming increasingly viewed as inefficient, ineffective and unresponsive they are viewed as models with the potential to deliver innovative approaches for dealing with complex social needs in the face of diminishing public funding (Peredo and McLean 2006). Austin et al. (2006: 2) define 'social entrepreneurship' as *'innovative, social value creating activity that occur within or across the non-profit, business or government sectors'*. This definition includes the principle that 'social entrepreneurship' requires the generation of a new product or practice as an innovative solution to a social problem and explicitly includes a range of organisational forms (including the public sector). Zahra et al. (2009) provide an overview of common definitions and descriptions that have been used in academic literature over the last decade or so. They identify that 'social entrepreneurs' are not only concerned with delivering 'economic wealth' but also 'social wealth', which can take the form of tangible outcomes (such as number of people served) and intangible outcomes (such as general well-being). They go onto describe three types of 'social entrepreneurs' - 'social bricoleurs' (who focus on discovering and addressing small-

scale local social need), 'social constructionists' (who introduce reforms and innovations to the broader social system by filling service gaps to neglected societal groups) and 'social engineers' (who seek to address systemic problems within existing social structures through introducing revolutionary change). Common to all these definitions are the 'entrepreneurial' process, which has been defined as a dynamic fit between four components – the 'people', the 'context', the 'deal' and 'the opportunity' (Sahlman 1996).

The current profile of 'social enterprise' within English policy appears to be have been instigated following the launch of Social Enterprise London, which was formed following the merger of two co-operative development agencies in 1999 (Brown 2003). Teasdale (2010) outlines the subsequent emergence of 'social enterprise' within different policy discourses – 'earned income' (money-making activity carried out by voluntary organisations), 'delivering public services' (filling in gaps left by the state becoming a commissioner rather than a provider of services), 'social businesses' (businesses which have social or environmental purpose central to their operation), 'community enterprise' (development trusts working to create social, economic and environmental wealth in communities) and 'co-operatives' (which are owned and controlled by members who are also beneficiaries of the business). The Labour government quickly developed an affinity for the social enterprise concept, and in 2001 the Department of Trade and Industry set up a Social Enterprise Unit to champion social enterprises across the economy and co-ordinate policy making in this area. This unit developed the definition most commonly used in current policy discussions - 'business[es] 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' (DTI 2002). In contrast with definitions of 'social entrepreneurship' this does not dictate that such organisations need to operate on 'entrepreneurial' principles, and where they contract to deliver existing public sector services they are likely to be working to a detailed specification which may restrict their flexibility to innovate from the purchaser's requirements. It does however encompass the various organisational forms in the UK that were staking a claim to the emerging social enterprise agenda, and which included members of the co-operative and voluntary sectors as well as for-profit businesses with a social purpose (Teasdale 2010).

The 'looseness' of the definition is reflected in the varying estimates of the number of social enterprises currently trading in the UK. Lyon et al. (2010) apply different definitions to surveys that have been undertaken and produce estimates that vary from 16,000 (using data from the National Survey of Third Sector Organisations) to 240,000 (using data from the Annual Small Business Survey). The figure most commonly used by government has been that there are 55,000 organisations in the UK that meet the DTI's definition with a combined turnover of £27 billion (Office of the Third Sector 2006).

Social enterprise and English health policy

Following their election in 1997 the Labour government sought to introduce a new approach to health services reform that would avoid the perceived failings of the 'divisive internal market system of the 1990s' that had been introduced by the Conservatives and the 'command and control policies' previously employed by Labour governments. The 'Third Way' involved the retention of the 'purchaser'-'provider' split, but replaced 'competition' with a more 'collaborative' approach led by 'commissioners' within Primary Care Groups. Concerns regarding quality and access continued to grow, and substantial additional funding was pledged. This funding was provided to the NHS on the basis of delivering reform, and targets were introduced relating to improved waiting times and staff numbers (Secretary of State 2000). Annual 'Star ratings' for NHS organisations were introduced with sanctions for poor performers such as 'naming and shaming' and the potential removal of Chief Executives. The pace and depth of change sought by the government was still not achieved through the new performance regime and they looked to market based competition to provide additional impetus. Payment by Results gave patients a choice of providers for elective care (including those from the private sector), Independent Sector Treatment Centres were contracted with to provide set operations and Foundation Trusts introduced.

'Social entrepreneurship' within health care was being promoted by 2005. Sir Nigel Crisp, former NHS Chief Executive, for example, extolled the virtues of 'entrepreneurial leaders (bringing) vision, leadership and passion…generat(ing) new and alternative solutions that extend the boundaries of health care' (Exton 2008). Initially the discourse focussed on 'intrapraneurs' working within the NHS but 'Our health, our care, our say – a new direction for community services' (DH 2006) developed and extended this theme to embrace NHS staff setting up their own businesses in the form of social enterprises. Such enterprises were portrayed as organisations that would be capable of 'unleashing public sector entrepreneurship' (DH 2006: 173). The policy pledged to address barriers that were preventing NHS staff from developing enterprises (such as pensions, capacity and business skills) and to set up a Social Enterprise Unit to oversee and co-ordinate this activity. It also introduced a new fund (the Social Enterprise Investment Fund) to support the development of new enterprises and to encourage existing social enterprises to extend into delivery of health care.

A social enterprise Pathfinder Programme was launched in 2006 and in February 2007 26 pathfinders were announced. These included existing social enterprises who wanted to extend their range of services, new enterprises being developed by health and social care staff, and multi-agency partnerships. The pathfinders were provided funding and specialist support to facilitate their development and by the end of programme evaluation approximately half of the enterprises had started trading (Tribal 2009).

'High Quality Care for all – NHS next stage review final report' (DH 2008) continued with the connected themes of social enterprise and 'health entrepreneurs'. It placed 'a new emphasis on enabling NHS staff to lead and manage the organisations in which they work' (p.13) and to deliver the key-principles of 'giving greater freedom to the frontline….creating a new accountability… empowering staff…. fostering leadership for quality' (p.61). It emphasised social enterprise should be considered

as a potential organisational form for future delivery of community health services and introduced the staff 'Right to Request' (Box 1) to set up social enterprise to deliver services. 'PCTs will be obliged to consider such requests, and if the PCT Board approves the business case, support the development of the social enterprise and award it a contract to provide services for an initial period of up to three years' (p.62). Social enterprises were also one of the organisational forms that could be considered under the Transforming Community Services programme (which requires PCTs to transfer their provider services to another organisation by 2012) (DH 2009a). This interest in the potential of large-scale externalisation of public sector services into Third Sector Organisations has similarities with the transfer of housing stock from Local Authorities into Housing Associations during the 1990's (Mullins & Pawson 2010).

Box 1: Right to Request process

Aspiring entrepreneur(s) identify that social enterprise could be a vehicle to meet local needs and service aspirations. They discuss with rest of staff in service and then submit an initial Expression of Interest to the Primary Care Trust Board that sets out vision, values and goals.

Milestone 1: Expression of interest approved by Primary Care Trust Board

Subject to endorsement by Strategic Health Authority (SHA) a 5 years Integrated Business Case and Transition Plan is developed. This process will include formal consultation with staff and engagement with wider stakeholders and patients. Grant funding is available through Social Enterprise Investment Fund.

Milestone 2: Business Case is approved by Primary Care Trust Board (and endorsed by Strategic Health Authority)

Social enterprise is run in 'shadow' form whilst enterprise prepares for trading and transfer of staff to new organisation. Loan, Grant and/or Equity funding is available through Social Enterprise Investment Fund.

Milestone 3: Social enterprise is launched and staff are TUPEd from NHS.

A number of potential challenges for staff groups wishing to develop social enterprises were identified by the Pathfinder programme. These were summarised in a subsequent Department of Health briefing as follows (DH 2010):

- The benefits of the social enterprise model are not always clear, not only to potential commissioners, but also to staff and stakeholders.
- New social enterprises may be at a competitive disadvantage in terms of not having the same legal and HR back up as commercial providers.
- Although the social enterprise model appears to fit well with staff principles, the potential loss of NHS branding and the feeling of no longer being within the "NHS family" is a concern.

- Understanding the issues around pensions. The issue most commonly mentioned by the pathfinders was pensions, where there is a need for clarity and a resolution to the differences faced by social enterprises as employers, when employing both staff TUPE'd over from the NHS and other staff not entitled to the NHS pension.
- The timescale required to establish a social enterprise is often underestimated. A social enterprise can take between 3 and 5 years to establish and trade.

The coalition government are continuing with the promotion of social enterprises in delivering services for the NHS and indeed for the public sector as a whole, and in their programme for government they pledged to extend employee-led initiatives to other parts of the public sector (Cabinet Office 2010a: 29). The Right to Request process in the Health Services has continued and perhaps most importantly the Social Enterprise Investment Fund is still providing funding for aspiring entrepreneurs. By September 2010 61 Expressions of Interests had been accepted by PCT Boards and been accepted as part of the three 'waves' of proposals being supported by the Department of Health. Whilst the Right to Request programme is now 'closed' to new bids the Coalition has launched a Pathfinder programme for employee-led mutuals that incorporates a broader range of public services, with the 12 initial pathfinders including health services as well as social care and education (Cabinet Office 2010b).

Methodology

At a national network event the Department of Health Social Enterprise Unit raised the possibility of developing regional networks to support staff aspiring to submit Right to Requests, and the Health Services Management Centre (HSMC) at the University of Birmingham offered to develop one in the West Midlands with the support of the West Midlands Strategic Health Authority. Staff groups who had submitted Expressions of Interest or had shown an interest in doing so were contacted and an initial meeting arranged to bring the different groups together. This paper is based on the experiences of the managers and clinicians who were leading on the Right to Request proposals, and these were gathered through individual interviews and group discussions at the network meeting. To supplement the views of the individual Right to Request leads we contacted all of the Primary Care Trusts (PCTs) in the West Midlands regarding their approach to the Right to Request initiative, and also spoke to Regional Leads and Consultancy firms working in the West Midlands. Finally, to capture learning and approaches being taken in other Strategic Health Authorities we contacted their Transforming Community Service leads in these regions.

Uptake of Right to Request in the West Midlands

Figure 1 provides an overview of the number of Right to Requests that had been submitted to the 18 PCTs in the West Midlands by July 2010. 12 PCTs were not aware of any Right to Requests being developed. From the other 6 PCTs 13 staff groups were known to be exploring Right to Requests - 6 of these had submitted Expressions of Interest (EOI) which had been approved by the PCT Board, 2 were at that point having their Expressions of Interest considered by the PCT Board and the other 5 were still to submit their Expression of Interest.

Figure 1. Number of Right to Requests in the West Midlands

Number of Right to Requests within the West Midlands (July 2010)
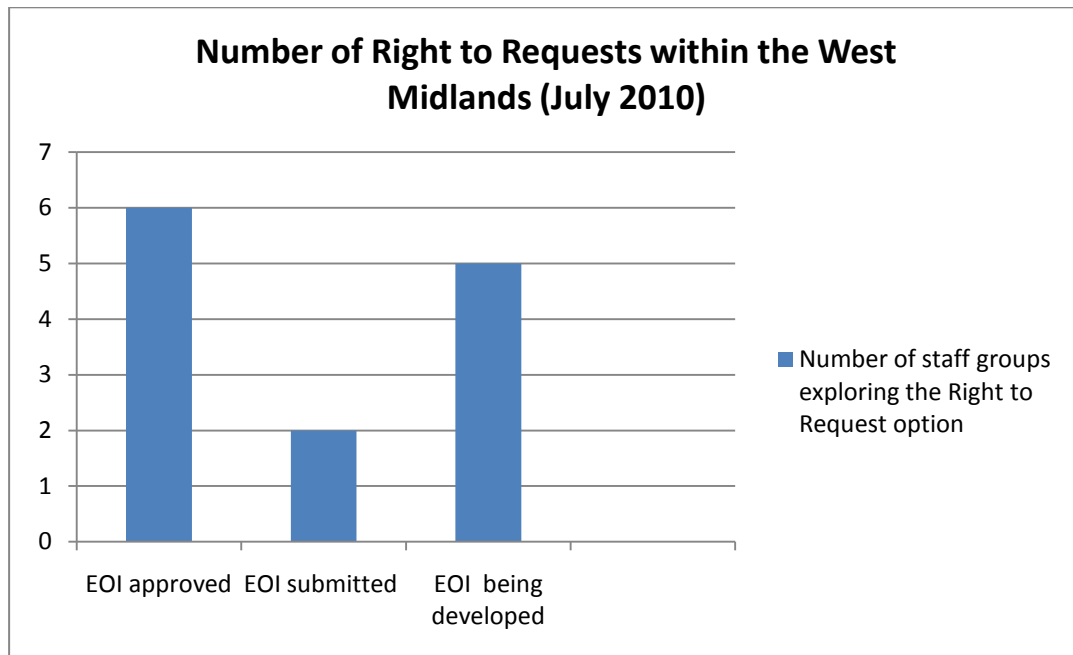
The services who were interested in social enterprise can be divided into 3 groupings' – whole provider arms (or a significant proportion of these e.g. all of adult services), service clusters (e.g. learning disability provider services), and clinical teams (e.g. podiatric service). In July the groupings had different 'success' rates in relation to turning their vision into an Expression of Interest and getting approval to develop a business case. The larger services groupings (i.e. whole provider arms and service clusters) had successfully submitted their Expressions of Interest to their Boards and were developing their Business Cases for Milestone 2. However, all but one of the clinical team groups had developed their Expression of Interest to the stage where it could be considered by their Board.

Three months later the picture was somewhat different and in October 2010 there were only 2 Right to Requests still being developed – one clinical team and one service cluster. Both of these had proceeded through Milestone 1 and were in the process of developing their business cases.

Findings

The experience of the West Midlands region is that despite the enthusiasm of policy makers, the Right to Request process and the availability of funding there remains significant barriers to the vision of social entrepreneurs and social enterprises arising from within the NHS. Nationally, if all of the current proposals for Right to Requests come to fruition (and a proportion still need to overcome the considerable hurdle of developing a Business Case that has final approval by the PCT Board) then approximately 25,000 staff would be employed in a social enterprise. According to DH figures (DH 2006) this will mean that 10% of the staff who were previously employed in PCTs will be working within a social enterprise. In contrast with the West Midlands, other SHA regions have a number of proposals moving towards the business planning phase, for instance in the South-West Region, where there are over 10 Right to Requests in development at present.

We will now consider in more depth the issues of relevance in relation to aspiring entrepreneurs, staff groups and commissioners.

Skills and confidence to become an entrepreneur

The common experience of the aspiring entrepreneurs leading the Right to Requests was that they were feeling their way into a new and very different environment.

> 'business planning skills are difficult – I need support as this is beyond my background'

There was a notable difference in levels of confidence in undertaking the role of entrepreneur between leaders of Right to Requests who were senior managers and those who were currently working as clinicians or frontline managers of smaller service areas. In general those leading larger service areas were more familiar with business planning processes and financial considerations that would underpin an enterprise surviving in a 'market place', whereas clinicians/frontline managers were finding such issues to be out of their previous experience. The leaders of the larger Right to Requests were willing to try to proceed with a majority of staff being on board (and in some cases with only a minority) whereas the clinician/frontline managers wanted consensus from their teams or at least a significant majority being supportive. As a 'venture in the unknown', staff leading the Right to Requests also expressed a feeling of 'isolation' and a sense of trying to take forward an initiative without local or peer support. The event that was organised as part of this evaluation was the first time many of them had met, and this included groups that were employed in the same PCT.

The dependency of a Right to Request's success on one or two key-leaders was emphasised by a number of PCTs -

> 'Ones that come about will be led by outstanding individuals – greatest risk is that they lose heart or leave'

This dependency highlights the fragility of Right to Requests' development, as well as the potential pressure that the entrepreneurial leaders face.

Funding and capacity to develop business case

The Social Enterprise Investment Fund is only available following the submission of Milestone 1, and the leaders of the clinical team Right to Requests were often struggling to achieve this Milestone and so could not access external funding. One Right to Request had access to charitable funding which it was using to bring in support to develop the business case. The lack of grants being awarded by the Social Enterprise Fund for the first 6 months in 2010/11 (due to general election and review of spending by new administration) meant that a number of the Right to Requests lost momentum at crucial times in their development and in some case lost the window of opportunity presented by Transforming Community Services.

All reported difficulties with capacity in trying to start or develop their business case, but leaders of larger Right to Requests seemed more able to find the time required (either through sharing existing responsibilities or working outside office hours) whereas clinicians/frontline managers teams found it difficult to find or make time outside of their clinical responsibilities.

Internal and external support

The perceived or actual views of senior managers in their Provider Arms to the potential social enterprise were also crucial to the clinicians/frontline managers. Aspiring entrepreneurs whose managers were negative about social enterprise in general and/or their service in particular were finding it difficult to proceed to the stage of submitting an Expression of Interest. This was due to their belief that it would not be worth the effort as the Expression would not proceed without support from their senior manager and/or because they perceived that their manager was actively blocking their proposal. Some of the potential entrepreneurs were also concerned that there could be repercussions for them if they continued to lead a Right to Request against the wishes of their line and/or senior managers.

> 'I'm worried that my manager could make life very difficult for me if I go ahead with the Right to Request even though she has told me that she doesn't approve'

External support from consultancy firms in relation to business case and legal advice has been positive, and where support had been sought from National Bodies such as the Social Enterprise Unit and Local Partnerships this was also seen as helpful. Despite the considerable marketing regarding the work of these organisations a number of staff leading smaller Right to Requests were not aware of them. Regional agencies who work with social enterprises more generally were also an untapped resource in the West Midlands.

Staff response

All of the Right to Request groups in the West Midlands reported staff anxiety and/or opposition to the potential of their services being transferred from the NHS to a social enterprise, and in some cases this led to the enterprise not being able to proceed.

> 'Many staff don't like change and the thought of leaving behind the NHS is very threatening'.

The main concerns being raised by staff in the West Midlands were of no great surprise – the potential loss of pension and public sector Terms and Conditions, anxiety about working in an organisational environment with which they are not familiar, and an affiliation and loyalty to the NHS brand. The emotional reaction to the thought of such a major change was also evident as portrayed in the following quote:

> 'softer factors have not been addressed and what a move out of the NHS will mean psychologically for managers and staff'

The national stance of some unions to oppose NHS services being transferred to social enterprise added to staff concerns, although there were examples of local union representatives being more flexible if they believed the local situation and the views of their members were in support.

Commissioning and Board support

In terms of 'system readiness', staff in the West Midlands leading the Right to Requests perceived that the major factors in their Expression of Interests being considered/supported were the degree to which they fitted with existing strategies of the Board and Commissioners, and the capacity of the Boards and Commissioners to consider this proposal along with the demands of the national policy initiatives.

In general Primary Care Trusts in the West Midlands either promoted at a low level (e.g. providing information to staff through e.g. road shows and written briefings and identifying points of contact for staff to discuss ideas informally) or did not take any action to promote. One local Primary Care Trust was pro-active in supporting Right to Requests through the work of a commissioner with responsibility for market development and in July 2010 this Trust had the highest number of clinical team level requests being developed. Another PCT has a 'social entrepreneur in residence' to support the development and growth of social enterprises in the local area but their work was focussed on supporting external enterprises move into healthcare delivery rather than working with staff who were developing Right to Request proposals.

The process for considering Right to Requests also varied between Primary Care Trusts. Variations included - the levels of detail required at the initial Expression of Interest; the 'pathway' prior to Board discussion (e.g. does Expression of Interest have to be considered by Provider Board first); opportunity (or not) for the Right to Request leads to attend the Board discussing their proposal. Timescales were also variable – some Right to Requests were able to negotiate the timing of the milestones to reflect the work required, whereas others had extremely tight deadlines imposed (e.g. completion of full business case in three months). These differences did make it difficult for staff to know what exactly would be required of them and by when and a common process and timescale would have been helpful.

In the West Midlands the main action that the SHA initially took to promote the Right to Request was to raise the programme at the regular meeting with Directors of Community Services, but did not actively promote the initiative direct to staff or require PCTs to report how they had done so. They have provided advice to staff that have approached them about Right to Requests and supported the setting up of the network, but tried to maintain a 'distance' in view of their assurance role regarding the decisions of the PCT Boards.

National policy

Undoubtedly national policy has had a major influence on clinicians considering the possibility of developing a social enterprise, and without the encouragement and support of the Right to Request initiative very few (if any) of the groups in the West Midlands would have been considering this option. Transforming Community Services (TCS) had a major impact on both motivating staff to submit a Right to Request (often as a way to avoid another organisational form such as being transferred to an Acute Foundation Trust). Transforming Community Services was also thought to have a strong influence on the response of the PCT Commissioners and Board. This could be positive (e.g. if there was a view from the Board that the service in question should be provided by an organisation external to the NHS) or negative (e.g. TCS deadline led to what were perceived as unachievable timescales for development of business case, and service being included in negotiations with another NHS provider in relation to vertical or horizontal integration).

Discussion

In the West Midlands there has only been a limited interest expressed by NHS staff to develop social enterprises, and the majority of the Right to Requests have not developed to or beyond Milestone 1. Nationally there has been a greater take-up of the option, but at 10% this is a still a minority of the staff who could have applied and it is still to be seen how many of the current proposals will result in a social enterprise being launched.

The reasons behind the Right to Requests in the West Midlands not going ahead can be summarised as follows:

- lack of staff support – i.e. a majority of the staff group concerned not agreeing to the proposal being developed;
- lack of leadership – i.e. the clinicians and/or managers who initially expressed an interest did not have the skills, confidence and/or capacity to take forward the proposal;
- lack of organisational support – i.e. senior managers within the provider arm of the PCT did not agree with the proposal and either choose not to support or in some cases actively blocked its development;
- lack of commissioning support – i.e. commissioners did not believe that an emerging social enterprise was the right model for delivery of the service in question.

These reflect the findings of the Pathfinder Programme regarding barriers to development of social enterprises in the programme (Tribal 2009). It is also clear that a proportion of Right to Requests were based primarily on a wish to avoid an alternative organisational form and/or the service in question being put out to tender, which is a different motivation to that envisaged by government policies. So what can be done to achieve this vision of entrepreneurial clinicians developing enterprises due to a desire to innovate? We have identified three broad areas that need to be further developed - *evidencing the potential*, *entrepreneurial readiness*, and *an enabling environment*.

Why would anyone be listening? The need to evidence the potential of social enterprise

New innovations being introduced within a system progress through a number of stages, starting with 'discovery' and then 'adoption' (Williams et al. 2009). Our work in the West Midlands identified that many parts of the NHS system - clinicians, commissioners and Boards – are still to be convinced of the potential of social enterprises within health care. The Pathfinder Programme identified that this would be an issue for the Right to Request initiative. Other studies also reflected the need to convince the key stakeholders of the worth of this organisational form in delivering health services. For instance, a study in Manchester regarding commissioners' perceptions of third sector organisations found that they viewed them as 'not business-like enough and too prone to assert they do good while reluctant to specify the value that they bring to services' (Baines et al. 2010: 54). Cook (2006) reflected on the concerns of clinical staff regarding job security and Terms and Conditions as well as a loyalty to the NHS brand and concerns about the impact of independent providers replacing public ownership.

The research evidence available regarding the performance and outcomes of health services delivered by social enterprises is limited (Lewis et al. 2006; Marks and Hunter 2007). A literature

review for the National Institute for Health Research examined the evidence regarding the performance of not-for-profit health care organisations (Pollock et al. 2007). The review noted that the majority of literature focussed on the experience of the US health care market and questions its validity in understanding the potential impact in the UK due to the different context. It raised concerns regarding the lack of comparison of not-for-profits with organisations serving similar patient groups and a tendency in the research to focus on the provider's view of performance rather evaluating the impact on the health needs of the community. The Public Administration Select Committee reviewed the case for the third sector delivering public services and came to the view that the 'evidence base does not yet exist' (p104, Public Administration Select Committee 2008). Furthermore whilst there are examples of successful enterprises delivering health care in the UK (e.g. Principia Partners in Nottingham and Salford Health Matters) there are also examples of where enterprises have not been successful (e.g. Secure Health Care).

There is also therefore a strong case for further research both into the performance of social enterprises delivering health care and also the impact of social entrepreneurship in meeting health care needs and inequalities. This research needs to also consider the market conditions that will enable social enterprises to have the opportunity and incentives to deliver added social value. Pollock et al. (2007) note that studies into not-for-profit and profit organisations have shown that the market conditions under which they operate have a strong influence on organisational behaviour and that under certain conditions there is little difference between the two sectors.

Is anyone asking? The need for Entrepreneurial Readiness

It was clear in our evaluation that many of the clinicians who had the inspiration to consider developing a social enterprise lacked the business skills to progress their vision onto the next level. This view was confirmed by national consultancies that have supported a number of Right to Requests. They reported that staff who are leading the Right to Request have difficulty in articulating clearly their vision and goals, and in gaining a basic understanding of the concepts of market analysis and financial modelling.

> They struggle in being specific about what they are going to deliver and why this will survive in a business environment … often comes across as vague and unfocussed

These difficulties have been reported by other reviews of the needs of fledgling enterprises (Lyon and Ramsden 2006) and in studies of clinicians who had moved into entrepreneurial roles (Sankelo and Akerblad 2008). Managers who were currently responsible for large service groupings had more confidence in tackling the requirements of the business case and in trying to convince stakeholders of the worth of their vision. This confidence is likely to be related in part to their current role and responsibilities, in which they are likely to have had greater autonomy over budgets, have worked strategically and developed working relationships with key-stakeholders. These have been identified previously as key elements of 'public sector entrepreneurs' (Windrum and Koch 2008). Clinicians were on the whole less confident in these skills, and were not comfortable in proceeding unless the overwhelming majority of their colleagues were in favour of the proposal. The latter may reflect clinicians' usual preference for more collegiate working relationships (Edmonstone 2009). Furthermore the relatively limited take up nationally could be evidence of a need to 'sow the seed' of the possibility of developing or moving into an enterprise earlier in clinicians' and managers' careers so that there is

an option with which they are familiar (Lyon 2007). Research into entrepreneurial nurses (including those in the commercial sector) identified that they were few in number, and were often attracted by a wish to practice a complementary therapy or to have flexible working to fit in better with domestic responsibilities (Drennan et al. 2007).

The Right to Request Programme predicted the difficulties that clinicians would experience in this area. It produced clear guidance and backed this up with professional support and the funds to access this. It is clear though that more support has to be given to clinicians if they are to have vision, confidence and skills to consider developing social enterprises, and that this needs to be introduced systematically across their careers. It could begin with pre-registration training courses including sessions on 'entrepreneurship' and 'social entrepreneurship' to introduce the concept at the start of people's careers. Short courses for existing staff would help them to understand the opportunities and better quantify the risks, and building entrepreneurship into professional training would introduce the possibility at an early stage of clinicians' careers. Individual mentoring would be beneficial to provide an opportunity to reflect on challenges and to air anxieties. Networks have proved elsewhere to be successful in implementing innovations through developing receptive contexts, facilitating learning and problem solving, and building a 'coalition for change' (Williams et al. 2009).

Social enterprise development centres/companies such as RISE in the South-West, iSE in the West Midlands and the Hope Street Centre in the North West (Box 2) also have important roles in supporting clinicians in understanding the opportunities and being prepared for the challenges of developing an enterprise.

Box 2: Social enterprise development

Hope Street Centre (www.hopestreetcentre.com)

The Hope Street Centre is a Community Interest Company which provides consultancy, training and business development support to health and social care organisations. It has a particular focus on supporting 'emergent' provider organisations, including social enterprises, from initial discussion of an idea through to business planning and launch. As part of this work it runs open events on a regular basis that provide an opportunity for social enterprises, aspiring entrepreneurs and interested commissioners to debate relevant issues and informally network.

iSE (www.i-se.co.uk)

iSE are a social enterprise support and development agency. They provide 'free' advice (funded through grants) on starting up a social enterprise, run training and development events, and will give individual consultancy support to individuals and/or their organisations. They work across the spectrum of social enterprises including those providing health and/or social care services.

RISE (www.rise-sw.co.uk)

RISE (Regional Infrastructure for Social Enterprise) was set-up in 2003 in response to the demand for specialist social enterprise support, focus and development plans in the South West. The initial formation came from a group which had lobbied the SW Regional Development Agency around social enterprise development work and the need for a regional body. RISE has worked with social enterprises developing in the health and social care sectors and led the development of a national initiative to create awareness and certification for social enterprise – www.socialenterprisemark.org.uk

Is anyone supporting? The need for an enabling environment

Pawson and Tilley (1997) believe that a change programme must be considered not only on the basis of the 'mechanisms' that it deploys, but also on the 'context' in which it operates. National and local commissioners, PCT Boards and SHAs have varied in their response to the Government's call for social enterprise entrepreneurs to come forward. Whilst some have promoted the Right to Request positively, most could be perceived as having not engaged with the programme. For the staff in the West Midlands line-managers were also key influencers and supporters. This is to be expected in organisations which over recent years have developed tight controls over finance and expectations on performance in response to central government policies (Greener 2008). Whilst national initiatives such as Transforming Community Services supported enterprises by including them as an acceptable organisational form, the requirements of the 2010/11 Operating Framework imposed tight deadlines on future organisational forms being decided that resulted in clinicians and managers having limited time to consider social enterprise and submit an Expression of Interest (DH 2009b). The extended length of time that potential enterprises need to develop was one finding from the Pathfinder Programme (Tribal) and a stable policy environment has been shown to facilitate local managers and clinicians being able to develop local innovations (Greener 2008).

Box 3: the South-West – an example of a more supportive environment?

From the number of Expressions of Interests lodged the South-West Region appears to have had a higher level of interest than other SHA regions in relation to Right to Requests. The factors that local stakeholders believe are behind this are:

Social enterprises are currently working in the local health economy – this gives commissioners experience of contracting with third sector organisations and they also act as a positive 'example' to staff that such organisations can survive.

Development Agency – RISE (see Box 2) has a strong presence in the region, was keen to provide support to Right to Request groups and was actively engaged by the Health Authority in discussions with PCTs.

Local need – the South-West has a number of integrated arrangements in place between social care, community services and primary care. Social enterprises were seen as an opportunity to strengthen these local relationships.

SHA support – The SHA (including their Chief Executive) actively discussed the opportunity of Right to Request with the Heads of Provider services. It responded quickly to any queries or issues that were raised by Right to Request groups and circulated responses widely where this information was likely to be of a broader interest. They also supported the development of a regional network where groups could share resources and learn from national speakers.

Board and Commissioner Support – Whilst the level of support did vary between PCTs there are examples of Boards and Commissioners taking a pro-active approach and actively engaging and supporting (in some cases with financial assistance) the business planning process.

For more clinicians to be able to develop enterprises the 'environment' needs to be considerably improved on all levels. Locally, employing organisations will need to more pro-actively promote and support clinicians who are considering enterprises. Excessive control by senior managers has been shown to be a major barrier to NHS staff exhibiting entrepreneurial activity, particularly when they feel threatened by this activity (Exton 2008). Commissioners will need to be willing to give enterprises time to develop, and then have a market development strategy that enables enterprises to compete to retain current services or gain new work (Jones, Dingwall and Hempseed 2008). The Public Administration Select Committee (2008) identified that for the potential benefits of third sector organisations to be realised it is vital that commissioners determine clearly the desired outcomes and wider social benefits to be delivered and then work with appropriate organisations to deliver these. If there are any regional structures in place then these need to take more of a leadership role in relation to both commissioners and providers. This should include encouraging staff and organisations to consider social enterprises and putting in place mechanisms to support their development e.g. set up local framework agreements with consultancies that staff groups interested in developing social enterprise can then access. There also needs to be a better joining up with local initiatives to support social enterprises more generally.

Finally national policy will need to continue to support Right to Request by extending it to other organisational forms than PCTs and be aware of the impact on Right to Request of other initiatives and associated timescales. Transforming Community Services and further changes being proposed in the new White Paper will lead to most community services being incorporated into Foundation Trusts or Community Foundation Trusts. The Right to Request does not currently apply within these organisations and it is debatable in any case if many would be supportive of clinicians taking potentially profitable services out into their own social enterprises. The issue of VAT also needs to be considered (NHS organisations do not pay VAT but social enterprises do) as this has been shown to be a major issue in relation to considering the financial viability of moving services out of the NHS into an enterprise.

Conclusion

The Right to Request initiative has led to a significant number of NHS staff groups declaring an interest in delivering health services through a social enterprise. In some regions these have received support from the Boards that would 'release' them and the commissioners who will purchase their service. However it remains to be seen how many of these proposals will result in enterprises being launched as many are still at the Business Planning stage. The experience of the West Midlands Region is that the NHS has still a long way to go before it has a widespread 'unleashing' of entrepreneurial clinicians who set up their own social enterprises and achieve the innovation in health care that it is hoped for. More work needs to be done on evidencing the potential benefits and so convincing commissioners and Boards that social enterprises are worth the considerable effort and time required to develop. Aspiring entrepreneurs need to be supported and nourished. But perhaps the greatest challenge is to enable clinicians to see themselves as entrepreneurs and be willing to

accept the risks and opportunities that working in business will present to them. The new role of GPs in commissioning may have positive consequences as they come from the perspective of independent contractors funded by public money, and so may be more amenable to other clinicians looking to set up their own businesses. They may also see these organisations as competitors, and the turbulence within the Health Service over the next few years may result in commissioners not having the time or energy to consider and nurture aspiring entrepreneurs. It also remains to be seen if the social enterprises that are developed will be entrepreneurial in their approach (rather than providing the existing services through a different organisational form), and if so does this entrepreneurialism have an economic or social motivation at its heart.

The experience of Right to Request Groups should also be of interest to policy makers responsible for implementing the new 'Right to Challenge' that is being introduced through the Localism Bill (Department for Communities and Local Government 2010). Whilst the details of how the Right to Challenge will operate are still to be finalised, the basic principles of the policy appear to have much in common with the Right to Request. Local Authorities are perhaps more comfortable and experienced in externalising in-house services and working with the third sector than many health bodies, but issues regarding public sector staff's confidence and competence to move into running a private business will be similar.

The implications of this policy paper highlight a number of interesting avenues for future research. Firstly, research is needed to analyse the impact of social enterprise organisations in the delivery of health and social care services, and how this compares with public sector and private businesses. This should ideally look not just at the performance of the organisations but also their impact on the health outcomes of the populations they serve. Secondly the impact of different commissioning approaches and market pressures on the ability of social enterprises to deliver efficiency and innovation needs to be explored. Finally, there could be considerable learning from the experience of Right to Request in implementing a new approach to health care delivery that requires clinicians to take on new roles and identities and to move from the public sector to being external entrepreneurs. This could be linked with previous initiatives in housing and social care that led to public sector services being transferred to the Third Sector.

In collaboration with the Health Services Management Centre the Third Sector Research Centre are already engaged in research that is studying the processes and outcomes of social enterprise organisations in the health and social care context. One example of this is the evaluation of the Social Enterprise Investment Fund. This two year project will generate important feedback to policy makers about the role of social investment in supporting the start up and growth of social enterprise in health and social care delivery.

References

Austin, J., Stevenson, H. and Wei-Skillern, J. (2006) 'Social and Commercial Entrepreneurship: Same, Different or Both?', *Entrepreneurship Theory and Practice*, Vol. 30, No. 1, pp. 1-22.

Baines, S., Bull, M. and Woolrych, R. (2010) 'A more entrepreneurial mindset? Engaging third sector suppliers to the NHS'. *Social Enterprise Journal*, Vol. 6, No. 1.

Brown, J. (2003) 'Defining social enterprise'. Paper presented at the Small Business and Entrepreneurship Development conference, Surrey University. Cited in S. Teasdale, (2010) 'What's in a name? The construction of social enterprise', TSRC Working Paper 46.

Cabinet Office (2010a) The Coalition: Our Programme for Government. Cabinet Office, London.

Cabinet Office (2010b) 'Francis Maude launches Pathfinder Mutuals'. Press Release, Cabinet Office, London.

Cook, R. (2006) 'What does social enterprise mean for community nursing?', *British Journal or Community Nursing*, 11: pp. 472 -4.

Department for Communities and Local Government (2010) Decentralisation and the Localism Bill: an essential guide. www.communities.gov.uk.

Department of Health (2006) Our health, our care, our say. Stationery Office: London.

Department of Health (2008) High Quality Care for All - NHS Next Stage Review Final report. Stationery Office: London.

Department of Health (2009a) Transforming Community Services: Enabling new patterns of provision. Stationery Office: London.

Department of Health (2009b) The Operating Framework for the NHS in England 2010/11. Stationery Office: London.

Department of Health (2010) Leading the Way Through Social Enterprise – The social enterprise pathfinder evaluation. Stationery Office: London.

Department of Trade and Industry (2002) Strategy for Social Enterprise. HM Treasury: London.

Drennan, V., Davis, K., Goodman, C., Humphrey, C., Locke, R., Mark, A., Murray, S. and Traynor, M. (2007) 'Entrepreneurial nurses and midwives in the United Kingdom: an integrative review'. *Journal Of Advanced Nursing*, 60(5), pp. 459-69.

Edmonstone, J. (2009) 'Clinical leadership: the elephant in the room', *International Journal of Health Planning and Management*, 24, pp. 290-305.

Exton, R. (2008) Creating the conditions for entrepreneurial behaviour as a strategy for effective and sustainable change in the UK National Health Services. UK Work Organisation Network.

Greener, I. (2008) 'Decision making in a Time of Significant Reform', *Administration and Society*, Vol. 40, No. 2., pp. 194-210.

Hampson, G. (2010) 'Laying the foundation of a new NHS', *Social Enterprise*, Sept p.7.

Jones, C., Dingwall, C. and Hempseed, I. (2008) *Healthy Business: A guide to social enterprise in health and social care*. Social Enterprise Coalition.

Lewis, R., Hunt, P. and Carson, D. (2006) *Social Enterprise and Community Based Care*. Kings Fund, London.

Lyon, F. (2007) 'Social enterprises in health and social care: prospects and challenges'. SERC Conference, London South Bank University.

Lyon, F. and Ramsden, R. (2006) 'Developing fledgling social enterprises? A study of the support required and means of delivering it', *Social Enterprise Journal*, Vol. 2 Issue 1, pp. 27 – 41.

Lyon, F, Teasdale, S. and Baldock, R. (2010) 'Approaches to measuring the scale of the social enterprise sector in the UK'. TSRC Working Paper 43.

Marks, L. and Hunter, D. (2007) Social Enterprises and the NHS. Unison.

Mullins, D. & Pawson, H. (2010) Housing Association: Agents of Policy or profits in disguise, *in* Billis, D.(ed) *Hybrid Organizations and the Third Sector,* Palgrave MacMillan: Basingstoke.

Office of the Third Sector (2006) Social Enterprise Action Plan: Scaling new heights. The Cabinet Office: London.

Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*, Sage Publications: London.

Peredo, A. M. and McLean, M. (2006) 'Social entrepreneurship: A critical review of the concept', *Journal of World Business*, Volume 41, Issue 1, pp. 56-65.

Pollock, A., Price, D., Miller, E., Viebrock, E,. Shaoul, J. and Mohan, J. (2007) A literature review of the structure and performance of not-for-profit health care organisations. NHS Service Delivery and Organisation R&D Programme.

Public Administration Select Committee (2008) Public Services and the Third Sector: Rhetoric and Reality. The Stationery Office, London.

Sahlman, W. A. (1996) 'Some thoughts on business plans'. In W. A. Sahlman, H. Stevenson, M. J. Roberts and A. V. Bhide, (eds) The entrepreneurial venture. Harvard Business School Press: Boston.

Sankelo, M. and Akerblad, L. (2008) 'Nurse entrepreneurs' attitudes to management, their adoption of the manager's role and managerial assertiveness', *Journal of Nursing Management*, Vol. 17, Issue 7, pp. 829-836

Secretary of State (2000) The NHS Plan: A Plan for Investment, A Plan for Reform. Stationery Office: London.

Teasdale, S. (2010) 'What's in a name? The construction of social enterprise', TSRC Working Paper 46.

Tribal (2009) Social Enterprise Pathfinder Programme Evaluation Final Report, Tribal Newchurch.

Williams, I., Ham, C. and da Silva, D. (2009) *Promoting and Embedding Innovation - Learning from Experience*. Health Services Management Centre, University of Birmingham.

Windrum, P. and Koch, P. (2008) Innovation in Public Sector Services, Edward Elgar, Cheltenham.

Zahra, S. Gedajlovic, E. Neubaum, D. and Shulman, J. (2009) 'A typology of social entrepreneurs', *Journal of Business Venturing*, 24, pp. 519-532.

About the Health Services Management Centre

The Health Services Management Centre has been one of the leading UK centres for research, personal and organisational development in health care for nearly 40 years. Commissioning of healthcare and provision of healthcare outside hospitals have become specific areas of expertise in recent years, underpinned by a continuing commitment to issues of quality improvement and public and patient engagement. This reputation has also started to extend to adult social care, with a growing track record in inter-agency commissioning and provision of health and social care services. HSMC has also developed a national reputation for both organisational and leadership development across all health settings. For further information visit: www.hsmc.bham.ac.uk

About the Third Sector Research Centre

The third sector provides support and services to millions of people. Whether providing front-line services, making policy or campaigning for change, good quality research is vital for organisations to achieve the best possible impact. The Third Sector Research Centre exists to develop the evidence base on, for and with the third sector in the UK. Working closely with practitioners, policy-makers and other academics, TSRC is undertaking and reviewing research, and making this research widely available. The Centre works in collaboration with the third sector, ensuring its research reflects the realities of those working within it, and helping to build the sector's capacity to use and conduct research.

Third Sector Research Centre, Park House, 40 Edgbaston Park Road,
University of Birmingham, Birmingham, B15 2RT

Tel: 0121 414 3086
Email: info@tsrc.ac.uk
www.tsrc.ac.uk

Social Enterprise

What role can social enterprise play within the third sector? This work stream cuts across all other research programmes, aiming to identify the particular characteristics and contribution of social enterprise. Our research includes theoretical and policy analysis which problematises the concept of social enterprise, examining the extent to which it can be identified as a distinct sub-sector. Quantitative analysis will map and measure the social enterprise sub-sector, and our qualitative case studies will contain a distinct sub-sample of social enterprises.

Contact the Author

Robin Miller   **Ross Millar**
0121 414 8018   **0121 414 8980**
r.s.miller@bham.ac.uk   **r.millar@bham.ac.uk**