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Increasing the Role of Social Business Models in the Health and Social Care: An Evidence Review

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Increasing the Role of Social Business Models in the Health and Social Care: An Evidence Review

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Summary

- A range of Social Business Models (SBMs) operate in the delivery of health and social care. Most of the available evidence relates to three models: social enterprises, cooperatives and micro businesses.
- The evidence shows that the use of these SBMs can have positive impacts on innovation, staff retention, cost effectiveness, reducing bureaucracy, reinvestment of profit and partnership working.
- However there are still relatively few SBMs delivering health or social care and there are a number of challenges involved in trying to reverse this trend.
- The evidence suggests a number of ways in which the Welsh Government could help to promote a greater role for SBMs in delivering health and social care including:
 - Providing business and financial support to assist with the upfront capital investment which is needed to pump prime the development of SBMs;
 - Encouraging the development of SBM consortia in health and social care to enable providers to pool resources, cost-share and risk-share when looking to take bank loans;
 - Giving NHS and social care staff the right and necessary support to deliver services through SBMs;
 - Encouraging micro and small social care providers by making government regulatory processes proportional to their needs and resources;
 - Exploring financial incentives that might be offered to SBMs by the Welsh Government;
 - Addressing barriers in commissioning and tendering practices including the focus on price and an organisation's track record which can make it difficult for SBMs to secure new contracts;
 - Providing information and training to commissioners and other purchasers about SBMs and how to work effectively with them;
 - Providing clear guidance on the new EU procurement rules and the potential flexibilities that they permit and opportunities they provide; and
 - Developing a single framework to measure the added social value of SBMs and a common approach reporting on such impacts.

Introduction

The Minister for Health and Social Services asked the Public Policy Institute for Wales (PPIW) to provide independent analysis of how to increase the role of Social Business Models (SBMs) in the provision of health and social care in Wales. The PPIW worked with experts from Birmingham University's Health Services Management Centre to examine the existing evidence about factors that enable SBMs to operate successfully in health and social care settings and to consider the implications for Wales.

SBMs (such as social enterprises, cooperatives, community interest companies and mutuals) are seen as an attractive alternative to monopoly provision by the state or out-sourcing services to the private market. However, there has been limited use of SBMs in health and social care in Wales.

The Social Services and Well-being (Wales) Act 2014 is widely seen as having the potential to significantly change the provision of health and social care in Wales. It seeks to create a more mixed economy of provision through user led services and greater use of SBMs and Article 16 places a duty on local authorities and those commissioning services to promote the use of social enterprises and other delivery mechanisms.

This report identifies what can be done to encourage SBMs and a more mixed economy of provision in health and social care drawing on the evidence from and experiences of other countries (including other parts of the UK). The report:

- Highlights successful policies which have encouraged the use of SBMs;
- Examines why these interventions were successful;
- Provides practical examples of SBMs working effectively in different health and social care environments; and
- Identifies what the Welsh Government and other agencies can do to encourage the wider use of SBMs.



Methodology

This report is based on a thematic or ‘narrative’ summary of the existing literature on SBMs. We established a list of key terms and searched the published literature from 1990 to the present using a range of databases but excluding articles not written in English. In selecting papers for the review, we paid particular attention to successful examples of SBMs in health and social care as well as the practical lessons from these in terms of how successful SBMs can be achieved. A total of 79 pieces of published literature were initially identified.

Following our ‘critical appraisal’ of the literature, we used snowballing techniques to identify further literature by searching references of included papers, and electronically, via citation-tracking in google scholar. The total number of papers included in the final review was 31.

The results of our review identified three key types of SBMs working in the health and social care field: social enterprises, co-operatives, and micro enterprises. It should be noted that these terms are often used loosely, and that an organisation can contain the key elements of more than one type. In the following sections we present an overview of these SBMs with a particular reference to the key policies used to encourage them, practical examples of these SBMs working effectively, and particular ways in which these SBMs have been supported to achieve success.

Social Enterprises

Recent health and social care policies have sought to promote social enterprises as a significant form of SBM. In England, much has been made of the rise of social enterprise under New Labour along with the increased use of third sector more broadly, as part of the ‘Third Way’ approach of delivering public services through models that were ‘between the free market and state control’ (Amin et al., 2002). Often starting from the DTI (2002) definition of social enterprise, there were a number of significant policy statements in England. Of particular note, the ‘Our Health, Our Care, Our Say Policy’ White paper (DH 2006) was the first major initiative to actively encourage the development of social enterprise and the third sector (along with commercial enterprises) in the health sector in England¹. It established a range of initiatives including the Department of Health’s Social Enterprise Unit, the Social Enterprise Investment Fund and Social Enterprise Pathfinders Programme.

¹ A mixed economy was better developed in social care following the community care reforms in the 1990’s with social enterprise being promoted as a means to encourage further entrants into the adult social care market through competing for tenders and generating other income sources.

Twenty six social enterprise pathfinders were selected in 2006 to better understand the role which social enterprises can play in health and social care. They included the Dementia Care Partnership, Open Door, The Bridge and Leicester Homeless Primary Care Service. The scheme was evaluated by Tribal (2009) which concluded that there were a range of benefits including enhanced quality, choice, equality and access to health and social care services as well as greater innovation and efficiency. However, the evaluation also highlighted some challenges for social enterprises:

- “The benefits of the social enterprise model are not always clear to potential commissioners, staff and stakeholders;
- the time it takes for new social enterprises to be developed;
- the uncertainty caused by short-term contracts;
- the loss of the NHS ‘brand’; and
- the perception by staff that they would lose their favourable terms and conditions (in particular their final salary pension schemes)” (Miller et al., 2012, p. 233).

The social enterprise investment fund (SEIF) was introduced in 2007 with £100m to be disbursed over a four year period from 2007 to 2011, and was extended by a further year with an additional £19m. The SEIF was evaluated by the University of Birmingham and was found to be a successful means of providing much needed business and financial support in the form of grants to new and existing social enterprises in health and social care (Alcock et al., 2012; Hall et al., 2012b). As outlined below, the SEIF was successful in supporting the Right to Request Policy initiative which has since been evaluated and well documented (Hall et al., 2012a., 2015; Miller et al., 2012a, b; Millar et al., 2013; NAO, 2011). The SEIF was less successful in achieving its original aim of acting as a loan fund. The research highlights how the SEIF invested 86% as grants due to social enterprises, especially new start-ups, not being in a position to take on loans. This finding supports those of other reports by the Department of Health (2009) which found that grants may be the most effective way to fund third sector organisations, as they allow greater financial security and capacity building.

Another important policy introduced by the English government was the Right to Request policy. Established under the Transforming Community Services programme (Department of Health, 2008), this gave NHS employees providing community healthcare services a right to request to set up new social enterprise organisations to deliver those services. The scheme introduced a process through which staff could submit an ‘Expression of Interest’ to the commissioning board of their Primary Care Trust. To overcome some of the problems identified in the pathfinders scheme, successful staff groups were:

- Eligible to apply for funding and business support from the Social Enterprise Investment Fund (SEIF);
- Guaranteed initial contracts for between three and five years, and
- NHS staff transferred to the social enterprises were eligible to retain their pensions.

The Right to Request was successful in establishing at least 38 new social enterprises (Miller et al., 2012a) and the Coalition government continued the scheme for one year under the 'Right to Provide' (DH 2011) policy initiative, which enabled all health and social care staff to 'spin out' of their service.

The Right to Request social enterprise spin outs have also been referred to as 'public service mutuals'. Defined as "...organisations which have left the public sector i.e. spun out, but continue to deliver public services and in which employee control plays a significant role in their operation" (LeGrand and Mutuals Taskforce, 2012, p.9), mutual organisational forms were promoted under the coalition government through the £10 million 'Mutuals Support Programme' (LeGrand and Mutuals Taskforce, 2012) and its predecessor the 'Mutuals Pathfinder Programme' (Cabinet Office, 2011). This extended the right to most public sector staff to spin out their service into a mutual. According to official figures there are now 106 public service mutuals in England and a substantial proportion of these operate in health and social care (Hall and Hazenberg, 2015).

The evidence about the introduction of social enterprises in England, highlights some clear benefits of delivering health and social care through this route - for patients, communities and staff including:

- Increased innovation in service delivery;
- Greater choice for patients;
- Improved cost effectiveness;
- Greater staff ownership;
- Lower staff turnover;
- Less bureaucracy;
- Greater reinvestment of profit ;
- Diversification of income streams beyond the public sector; and
- More partnership working.

However a number of challenges have also been identified for social enterprises (e.g. Millar 2012: Miller et al., 2012). These are centred on:

- A limited interest among public sector staff to develop social enterprises due to concerns regarding job security;

- A lack of staff support, leadership, organisational support and commissioning support
- Difficulties balancing the clinical aspects of day-to-day delivery and the managerial aspects of running a business
- Commissioners may not understand and recognise social enterprises and may see them as 'not business-like enough';
- The potential loss of public sector branding; and
- The difficulties of measuring anticipated benefits and securing funding from financial institutions and commissioners in a competitive market place .

Furthermore, research by Hall et al (2012b) found that some public sector staff were pushed into establishing social enterprises when threatened with service closure or being put out to tender making the policy top down rather than bottom up and staff driven as intended.

These findings from the English NHS appear to support the wider evidence base regarding the development of social enterprises. A systematic review by Roy et al. (2014) reviewed “outcomes of social enterprise involvement in healthcare”, and “the ability of social enterprises to address health inequalities more widely through action on the social determinants of health” (Roy et al., 2014, p.182). The positive impact of social enterprises on mental health outcomes (satisfaction with life, family support, peer support and depression), in comparison to a control group was reported (Ferguson, 2012; 2013). The evaluation found that

“social enterprises enabled people with mental health problems to fulfil their desire ‘to participate in meaningful occupations’ (Williams et al., 2010: 536) and limited depressive symptoms through ‘providing the financial incentive to participate in activities that hold meaning and give direction and structure’ (Krupa et al., 2003: 363)...Social enterprises served as a ‘springboard’ (Ho and Chan, 2010: 38) or ‘stepping stone’ (Krupa et al., 2003, p. 362) to employment through providing on-the-job training. This increased the chance of further employment in the future, or assisted people to become self-employed. The overall aim was to facilitate the integration of disadvantaged groups into both the job market and the community and ‘resume their dignity’ (Ho and Chan, 2010: 40)” (Roy et al.,2014, p.190).

Three of the five studies reviewed by Roy et al. (Ferguson, 2012; Ho and Chan, 2010; Tedmanson and Guerin, 2011) found that:

“social enterprises were a mechanism for building social capital, providing an opportunity for disadvantaged and marginalized groups to expand their social networks and develop social trust, facilitating social trust and co-operation,

strengthening their existing peer support groups, and enhancing their future career prospects” (Roy et al.2014, p.190).

“The studies presented a range of evidence which demonstrates that social enterprises can enhance non-vocational outcomes such as self-confidence or self-esteem (Ferguson and Islam, 2008; Ho and Chan, 2010; Williams et al., 2010) and motivation and commitment to goals/life direction (Ferguson and Islam, 2008; Krupa et al., 2003). It was reported in three of the studies (Ferguson and Islam, 2008; Krupa et al., 2003; Williams et al., 2010) that the social enterprise work environment helped the participants to feel calm and relaxed, so that, for instance, they were better able to express their ideas (Ferguson and Islam, 2008)” (Roy et al. 2014, p.190).

The wider literature concerning social enterprises also draws attention to the experience of changing organisational characteristics (e.g. Sheaff, 2013). Documenting the experience of community health trust spin outs in New Zealand, Eyre and Gauld (2003) highlight how the “creation of an internal market system” from the 1990s “for public health care delivery” meant that “rural health services, seen as being unviable, were given the option of establishing themselves as ‘community trusts’, owning and running their own services. Community trusts have since become a feature of rural health care in New Zealand. It was expected that community trusts would facilitate community participation”. Drawing on the ‘pentagram model’ of Rifkin et al. (1988) ‘with its five dimensions of participation - needs assessment, leadership, resource mobilization, management and organisation’ - these authors identified high levels of participation. The research revealed additional dimensions that could be added to the framework, including ‘sustainability of participation’, ‘equity in participation’ and ‘the dynamic socio-political context” (Eyre and Gould, 2003, p.189).

Practical examples of social enterprise

Our review identified a number of examples of social enterprises and mutuals delivering health and social care. The review by Roy et al. provides examples of social firms/work integration style social enterprises. It identifies a particular example of US social firms which work with street living young adults and aims to strengthen their internal assets to enhance positive outcomes and protect them against high risk behaviour. The review highlights how particular studies show improved outcomes in mental health, employment, risky behaviour and for wider society (Ferguson and Islam 2008; Ferguson 2012, 2013). In addition, it shows how they supported a range of disadvantaged groups: people with disabilities, new immigrants, the elderly, unemployed youths, ex-offenders and low-income families providing specific

examples that demonstrate improvements in employability, dependency on benefits, self-respect, social capital and inclusion in the community (Ho & Chan, 2010).

Turning to the UK, the Social Enterprise Coalition (LGID/SEC, 2010) summarises a range of case studies with the aim of increasing awareness and understanding of the value of commissioning the social enterprise sector. A selection of these in-depth case studies are summarised in Figure 2.

Figure 2: Case studies of social enterprise (adapted from LGID/SEC, 2010)

Open Door
<p>This social enterprise was “established in 2007 with the stated objectives of improving health, reducing inequalities and” tackling “the determinants of health, such as homelessness, housing, unemployment”, and addictions. It takes a holistic approach to service delivery providing therapeutic sessions, counselling sessions, a psychiatrist, and a “drop-in room for agencies such as the Citizens Advice Bureau”, dentist and hygienist and the homeless team.</p>
<p>Open Door was commissioned following recognition by the Grimsby Care Trust that they could not meet the needs of some vulnerable people. “There was a strong commitment to social enterprise as the Director of Clinical Services at the Care Trust was familiar with that approach”. Following needs analysis, the commissioners “developed a business plan to demonstrate how Open Door would become viable. Pump priming was” supported by the Pathfinder programme and Neighbourhood Renewal Funding. Further “risk management mechanisms also included making the Director of Clinical Services at the Care Trust a director of Open Door and ensuring the contracts required high quality governance and clinical practice standards. Open Door was supported by an existing social enterprise – the Big Life Group”, which allowed them to benefit from “financial, HR and marketing expertise, significantly reducing the risk of failure. The commissioning of Open Door in Grimsby in North East Lincolnshire demonstrates how in certain circumstances a market solution simply doesn’t exist and commissioning the creation of a social enterprise can be a highly successful solution to complex challenges. Open Door’s” Social Return on Investment Study calculates for every £1.00 invested “there is social value in the range of £4.98 to £10.00 created” (Extracts from LGID/SEC, 2010).</p>

Unlimited Potential

This is a social enterprise Health Trainer service using “people from the local community to empower others to make and maintain healthy lifestyle choices. It involves supporting behaviour change through the provision of a ‘buddy’ or ‘health trainer’”. As a relatively small service, the commissioners (in this case PCT) were “able to justify not going to open tender”. Furthermore, “to manage the risk it was decided that the PCT would initially employ the Health Trainers” while Unlimited Potential built its capacity in this area. “Quarterly performance monitoring meetings and supervision appraisals” were undertaken “to ensure that the service remained accountable”. In doing so “the PCT chose to use the model contract featured in the Department of Health’s No Excuses document” which supports a flexible outcomes based approach where the “PCT made it a requirement to tell stories as part of the monitoring. Two stories are provided per trainer per quarter which set out the emotional support elements of the service and the range of multiple outcomes usually missed by any key performance indicators”.

“Although the principal objective of the services was to address health inequalities it was clear that Unlimited Potential created additional value by supporting some of the clients to move towards employability”. The service has been successfully evaluated with the commissioning of Unlimited Potential demonstrating how commissioners can foster innovative services, joined up commissioning and build the capacity of social enterprises in their community through strong and trusting relationships (Extracts from LGID/SEC,2010).

Sandwell Community Caring Trust (SCCT)

“In 2008 Torbay Care Trust recognised that some areas within their in-house adult social care services required considerable modernising and investment. Sandwell Community Caring Trust (SCCT) – a social enterprise - was clearly identified by the group as best meeting the objectives of the community and Care Trust with regard to vision, outcomes, staff training and empowerment, use of surplus, transparency and service innovation from the front line. The Care Trust” experienced “some resistance from the staff to being what is technically ‘outsourced’. This was addressed by involving some of the staff in engaging and challenging the potential providers”. Follow up studies reported staff being more motivated with new and improved terms and conditions. “The Trust chose this form of commissioning because they recognised that more than a new provider was required. They were looking for a culture change, for trust to be maintained with the community and for the relationships to be nurtured” (Extracts from LGID/SEC, 2010).

Care Plus Group

Care Plus Group is a mutual set up in 2011 as a Community Benefit Society through the Right to Request programme, it employs over 800 staff and in 2013/14 has an annual income of nearly £26 million (www.careplusgroup.org).

“Its services include home care, community nursing, intermediate care, meals on wheels, employability and other care services. A pathfinder GP Commissioning Consortium has awarded its contract. Care Plus Group’s multi-stakeholder ownership and governance is innovative. The mutual has a two tier board comprising a Council of Governors responsible for the strategy of the mutual and a board of directors responsible for the operations. All workers are members of the mutual and they elect eight staff governors. Two further governors are appointed by the local authority, two governors by GPs and three governors by community group members. The board of directors includes four non-executives (one of whom is the chair) and three executive directors including the chief executive of the mutual. The Council of Governor is the body that both appoints and removes the chair of the board and the other non-executive directors as well” (Conaty, 2014, p.40).

What makes social enterprise successful?

The UK government has supported the development of new and existing social enterprises in health and social care in a number of ways. This has included the loans and grant schemes discussed above (e.g. SEIF, mutuals support programme), business support, and general advice and support. The Department of Health also developed a resource pack in collaboration with the social enterprise network (DH 2007) which was designed to help social enterprises understand and maximise the opportunities in health and social care with information on establishing and financing, commissioning, staff, regulation and technology.

The Social Enterprise Coalition (LGID/SEC, 2010) concluded that it was those social enterprises able to ‘join up services’ and achieve multiple outcomes across different public



service silos that were most effective'. Social enterprises able to access alternative market opportunities' benefited from additional income streams and some social enterprises were able to demonstrate strength at connecting with service users and engaging with and empowering staff. This included involving staff in decision making processes, giving managers greater autonomy, rewarding low absentee rates and other reward systems based on outcomes. Another key to success was 'flexibility and responsiveness' in the ability to innovate and improve the range, design and delivery of services.

Co-operatives

Co-operatives are often described as 'a dynamic form of social enterprise' involving multiple stakeholders. A recent review by Conaty (2014) for Co-Operatives UK reports that co-operative SBMs in health and social care typically share a number of common characteristics including:

- The involvement of care service co-producers including workers, volunteers and service user members;
- The ability to work across the health and social care field in reaching excluded groups; and
- Operating at small scale – most have fewer than 30 staff members.

Conaty notes how the number and range of care co-operatives in the UK since 1990 has slowly expanded, with the Care and Share Associates (CASA) co-operative franchise providing a range of homecare services in a number of regions in England. Similar interest in co-operative ideas can be found in the Scottish Government's promotion of mutuality. Howieson (2013) documents how interest in mutuality in the Scottish NHS has instigated "a new ethos for health in Scotland that sees the Scottish people and the staff of the NHS as partners, or co-owners, in the NHS" (Nicola Sturgeon, Better Health Better Care, 2007, p.iv).

The Conaty (2014) review provides a number of insights into the different ways co-operatives have been utilised globally. It draws attention to how the "international evolution of multi-stakeholder care co-operatives" (Conaty, 2014, p.5) has built on Italian success with successive co-operative models being developed in Europe and beyond.

Social Co-operatives – Lessons from Italy

Conaty (2014) draws attention to Italy as the lead of good practice. ‘Social Solidarity Co-operatives’ provide a model to unite workers, service users and ‘social solidarity economy’ stakeholders. The Social Co-operative Law passed in 1991 defines two types of social co-operative:

- “Type A: the standard form involving workers and other members including service users and volunteers engaged in the provision of social services, health services and educational services. Not more than 50 per cent of members can be volunteers. Not all social co-operatives involve volunteer members in work and services provision but some do and it is an option. Many Type A social co-operatives involve only worker and service user members.
- Type B: a ‘job integration’ co-operative to maximise the economic inclusion of disadvantaged groups as employees. To be registered in this category, 30 per cent or more of co-operative workers must be from disadvantaged groups in one or more areas. These are currently accepted as including: the disabled, those with development disorders, mental illness, ex-offenders, drug and alcohol addicts and immigrant groups from outside the EU.” (Conaty, 2014, p. 16).

The field of work for Type B social co-operatives is widespread. By contrast Type A organisations work only in the social, health and education sectors. Conaty (2014) notes that co-operatives appear to be strong in Italy with “a social co-operative survival rate of 89 per cent after five years” demonstrating “the robustness of the business model”. The “typical size of a social co-operative is 23 to 30 worker members. 26.5% are small co-operatives with annual revenue of under €250,000. 15 per cent of social co-operatives are larger with an annual turnover of over €1 million” (Conaty, 2014, p.16).

While “there is a shift towards larger social co-operatives in some places, the movement overall is still strongly decentralised and human scale in most parts of Italy. It has followed four key guiding principles and methods:

- Human scale guidance: maximum recommended membership of 100 for each social co-operative to aid the building of trust and social capital;
- Locality and decentralisation: social co-operatives operate in the local economy and within defined geographical areas;
- ‘Strawberry fields’ principle: in social solidarity, each successful social co-operative commits to incubating one new social co-operative. This has been key to the rate of proliferation and replication; and

- Co-operative Consortia unite co-operatives in specific trade sectors (280 sub-regional consortia have been developed for social co-operatives); provide legal advice, training, regulatory support, back office administration services, plus tendering and negotiating power through a federated structure of service provision to their member firms.

All Italian co-operatives are expected to contribute 3 per cent of their annual net profit to mutual funds. These funds are associated with the four national co-operative federations and used for risk sharing and typically for securing medium-term bank loans. Through the development of mutual guarantees, they pool credit risk among co-operatives to enable lower cost capital to be secured from the Co-op banking sector” (Conaty, 2014, p.16-17).

In addition, “other public policy support and incentives that the legislation provides include:

- A lower rate of corporation tax for social co-operatives compared to other companies;
- A lower VAT rate for social co-operatives: 4 per cent compared to the standard 21 per cent rate 35;
- Type B social co-operatives exemptions from national insurance contributions for their disadvantaged workers;
- Tax relief available for donors to social co-operatives;
- Trading surpluses are not taxable if placed in capital reserves;
- Investment returns of up to 80 per cent of profits can be distributed to multi-stakeholder members. However the rate of profit that can be shared is capped for each share at a maximum level that is no more than 2 per cent above the current rate on bonds available from the Italian Postal Service; and
- Public investment stakes are permitted up to 7 per cent for Type A social co-operatives and up to 50 per cent for Type B” (Conaty, 2014, p. 17).

Conaty’s work also highlights lessons from co-operatives in a range of other countries – see Figure 3.

Figure 3: Co-operatives: Lessons from elsewhere (adapted from Conaty 2014)

Quebec: Solidarity Co-operatives

“Inspired by the success of the Italian Social Co-operatives, organisations in Quebec began work on a similar model in 1995 with an agreed strategic aim of developing new jobs in social care, health and many other sectors”. Worker salaries in “the Solidarity Co-operatives are generally near market rates in the Home Care sector and guided by a provincial agreement with Quebec trade union movement that was negotiated in 1998”. The “home care sector market is split between 50 co-operative providers and a similar number of non-profit care organisations” (Conaty, 2014, p.20).

France: SCIC – the ‘General interest co-operatives’:

“The French multi-stakeholder co-operative model, the Société Coopérative d’Intérêt Collectif”, includes a “broad range of health and social care sectors as well as other solidarity economy fields. This model was devised as an appropriate legal structure for all” types “of social enterprises in France. There are many similarities to Social Co-operatives in Italy” including a focus on local services at a human scale ns the encouragement of co-operative consortia and networks to foster expansion and economies of scale. The SCICs must also have “at least three categories of membership (two must be workers and service users), cannot be financed by public sector investment funds” and are subject to a five year probationary period (Conaty, 2014, p.22).

Japan: Health Co-operatives, Home Care and Han Groups: Mutual Aid and Public Health

“Health co-operatives in Japan were fostered jointly by rural agricultural co-operatives and urban consumer co-operatives. Over the past 50 years the Japanese health co-operatives have expanded and integrated their provision. They own and operate hospitals, health centres, dentistry clinics, home care nursing services, home care personal services and day-care centres for adults. The health and care co-op sector employs 28,000 full time equivalent staff with an annual turnover of more than 280 billion yen” (Conaty, 2014, p.23).

Practical Examples of Co-operatives

The review by Conaty (2014) identifies good practice in co-operatives in the UK which is of particular relevance to health and social care.

Sunderland Home Care Associates and CASA – Employee ownership model

CASA operates as a large mutual with “600 worker owners delivering over 10,000 care hours per week. The organisation is not a worker co-operative but an employee ownership firm” providing “home care for the elderly as well as adults with a range of disabilities. CASA’s approach in recent years has moved from” a “social franchise model to a larger consolidated employee owned business. They found this to be necessary because of the minimum asset requirements specified by care commissioners. In practice the locally based CASA firms will operate as semi-autonomous mutuals but legally they have become sub-divisions of a larger national scale worker ownership business. They also report low turnover of staff of only 6 per cent compared to an estimated national turnover range annually of 25 per cent to 50 per cent among private sector care providers” (Conaty, 2014, p. 37).

The Foster Care Co-operative – the potential for Externalisation through Public-Social Partnerships

“The Foster Care Co-operative (FCC) was established in 1999 as a mutually owned foster care agency. There are 50 staff who are full members plus 250 foster carers (mostly couples) who are associate members. The regulations in England and Wales do not currently allow foster carers to be full members as they are not allowed to control or manage the agency for which they foster. To seek ways to overcome this barrier, the FCC has written into its memorandum of association an explicit commitment to consult both foster carers and social workers at support meetings every six weeks.

The FCC has expanded steadily and its democratic ethos is seen as a superb fit both with the shared values of local authorities as public service providers and with trade unions. The asset lock and common ownership structure of the co-operative, together with the reinvestment of surpluses for community benefit, are all attractive aspects. High quality training and agency support for all staff and foster carers has been key to success. A free legal advice service to update members and associates is part of the support system” (Conaty 2014, p.40).



New Start: The Oxfordshire Wheel – a multi-stakeholder social and health care co-op

“The Oxfordshire Wheel is a path-finding care co-operative with a mission to develop a broad range of service provision for and with disabled people and their carers. Launched in 2010, the company is registered as a multi-stakeholder co-operative. Its board of directors is elected from three categories of membership: a) individual service users; b) user-led organisations for disabled people in Oxfordshire; and c) organisations representing people with disabilities and other service users. At the heart of the co-operative’s vision is the development of the ways and means to assist disabled people into paid work. The challenges are formidable as many of their members have learning disabilities or severe injuries and have been out of work for 15 to 20 years. To move things forward, Oxfordshire Wheel has been developing the infrastructure to provide a range of key services linked to their mission. The services include: information and advice provision to members; brokerage referrals; training and accreditation for brokers and personal assistants; support services for carers; quality assurance; advocacy; research and consultation services” (Conaty, 2014, p.46).

What makes co-operatives successful?

Conaty highlights a number of factors which influence the success of co-operatives:

- A multi-stakeholder co-operative approach with an agreed social co-operative legal definition should be used;
- The promotion of a ‘consortia’ model has the capacity to reduce operational costs as well as provide training and other shared services for social co-operatives;
- Tax reliefs and incentives from central government are effective;
- Negotiated agreements are required with the trade union movement;
- Financing systems are needed to provide access for start-ups;
- Risk funding should be developed; and
- Co-operative education is required to develop an informed membership and commissioners.

In addition, he puts forward a series of policy recommendations proposed as an action list to support and facilitate co-operatives which include:



- Briefing materials: “shorter, focused and topical documents providing targeted information about social co-operative legal structures, business models and income streams, as well as areas for cost saving through co-operative methodologies” (Conaty, 2014, p.66);
- Legal recognition and incentives: “fiscal incentives may be needed and justifiable to assist the social care co-operative sector” to secure its strategic potential. Collaborative work “should ensure that social co-operatives are included as a category of social enterprise for Social Investment Tax Relief (SITR)” (Conaty, 2014, p.66);
- “New technology: securing ‘economies of co-operation’ is crucial” (Conaty, 2014, p. 67) where the co-ordination of co-delivery of paid and unpaid care services and facilitate direct payments is needed. Digital technology is essential and innovation in this area must be a high priority;
- Consortia: Further investigation to “identify where shared cost savings lie and what functions can be pooled and developed, including back office, training, market research, technology solutions and advocacy specific to the co-operative care sector” (Conaty, 2014 p.67);
- Advocacy: “Specific areas for further research and development should include cost savings generated through social co-operative methods with evident economic benefits including job creation, employment by disadvantaged groups, reduced clinical support and medication and other identifiable impacts” (Conaty, 2014, p.67);
- “Social finance: Work needs to be undertaken to design the social financing mechanisms and framework for mobilising development capital to support a diversity of social co-operative pathways including start-ups, public sector spin-outs, non-profit conversions and co-operative partnerships” (Conaty, 2014, p.67);
- Education: “Particular attention should be focused on governance, the training needs of elected board members and ways and means to adapt legal structures, advance the cultural aspects of multi-stakeholder management and stakeholder participation, and further the economic democracy of social co-operatives” (Conaty, 2014, p.68) ;
- Open source information: “The respective roles of Co-operatives UK, local social co-operatives and Consortia organisations need to be considered strategically” (Conaty, 2014, p.68); and
- Valuing what matters: “It will be necessary to negotiate other cost-saving metrics with procurement bodies. Low-cost social accountancy systems, such as Prove it and the Balanced Scorecard, offer helpful tools” (Conaty, 2014, p.68).

Micro Enterprises

Micro-enterprises are an SBM most prominent in the social care sector (although also evident within health, housing and leisure). “Within the social care context”, they “have been defined as very small local enterprises with five or fewer workers (Community Catalysts, 2011)” that “are independent of any larger organisation”. They are typically run on an informal and flexible basis within a specific community, often by “people who are disabled or need some support” or are supporting someone who does. “They may be run from people’s own homes and often employ family members”. Micro-enterprises have no legal definition or organisational form and a recent report by Needham et al. (2015) found that they vary widely, with some employing staff (in some cases ten or more on a part-time basis) and others relying on “volunteers, whilst others are sole traders, working on their own. Some are set up as social enterprises (including Community Interest Companies) or charities”; whilst “others are limited companies”. Regardless of their organisational form, the common feature is they are not generally profit driven but instead “aim to make enough out of their venture only to pay the wages of those involved” (Needham et al., 2015, p.4).

Needham et al. (2015) found that micro-enterprises provided distinct advantages over larger care providers. Of particular note, they offer more personalised and flexible services which stems from the autonomy of front line staff, lower staff turnover (and therefore consistency in care provision) and the accessibility of managers to both staff and service users. Services delivered by micro-enterprises were also more innovative, particularly in providing flexible support tailored to the needs of an individual. Micro-enterprises are often run by and for people with learning difficulties and they offer good value for money when compared with larger care services, especially when taking into account their ‘added value’. However, the report indicated that micro-enterprises face a number of barriers and are often offered little government support.

Reddington and Fitzsimons (2013) found that micro-enterprises are treated the same as other businesses and often struggle with the cost and complexity of tax, insurance and CQC registration. Whilst they work particularly well for those with personal budgets (due to their flexibility), Needham et al. (2015) found that a low take up of personal budgets has led to micro-enterprises being reliant on self-funders. Furthermore, local authority commissioners tend to use a small number of large care organisations, excluding smaller services from the social care market. “The Care Act 2014 requires local authorities to develop a market that delivers a wide range of high quality care and support services, which combined with the personalisation agenda, should support more micro-enterprise provision” (Needham et al.,

2015, Section 4). There is some dedicated support for micro enterprises including from Community Catalysts. This is a social enterprise organisation that supports the start-up and sustainability of care and support micro enterprises, and has established a number of micro-enterprise co-ordinator roles in collaboration with local authorities across England.



Examples of micro enterprises

Community Catalysts & Pulp Friction CIC

Community Catalysts (<http://www.communitycatalysts.co.uk/case-studies/>) provide a case study of a micro-enterprise delivering a support service for people with learning disabilities called Pulp Friction Smoothie Bar CIC. Based in Nottinghamshire, it works with young adults with learning disabilities to develop their social, independent and work-readiness skills, providing opportunities and individual support for people to run pedal-powered smoothie bars at different community events. It is run by a mother and her daughter who has learning disabilities, with support from their family and friends. In 2009 they received £1800 from the Youth Opportunity Fund to buy a smoothie bike. Initially Pulp Friction operated as a youth and community group recruiting non-disabled young adults before it was set up as a social enterprise Community Interest Company in 2011.

“Micro Domiciliary Service - ‘Full Lives’² was set up by” someone who previously worked within a local authority care service. She established her own small care company as she “wanted the opportunity to provide a more flexible offer. It now has four members of staff, supporting three people. The work varies between personal care in the home, and support to access activities outside the home”. A quote by the owner states “Because we are a small company we can be more flexible, at the hours people want. We don’t have a lot of clients so we get to know the people we work with. You can build up strong relationships.” (Needham et al., 2015, Box 2)

Additional Policies to Promote SBMs: Commissioning and Procurement Practices

A recurring theme in the literature on SBMs is the role of commissioning and procurement. In part this relates to a move for funding to be paid, less through grants, and instead to be allocated on the basis of competitive tendering. Historically, for many traditional third sector organisations (TSOs) (including SBMs) this has been a challenge due to their limited experience and capacity to participate in often lengthy and detailed tendering processes. This has been thought to both prevent such organisations being able to innovate and grow, and

² Name has been changed.

denies the public sector access to organisations who could provide an alternative model. For example in their study of provider diversity in the English NHS, Allen et al. (2012) note that in principle SBMs can deliver quality improvements by using a more holistic approach and a greater degree of community involvement, however the extent of involvement of non-NHS providers in supplying services to the NHS is limited due to the commissioning process.

That said, the opportunity to compete has also been described by larger and more business orientated organisations as giving them the potential to access funds that would have historically been rolled over to 'the usual suspects' (Miller & Rees, 2014). Furthermore contracts are seen by some as more secure funding streams (particularly if they run for multiple years) than short-term grants which can be pulled due to changes in political perspectives or public sector finances. A related concern voiced by parts of the third sector is that the increasingly contractual nature of their relationship has resulted in the public sector having greater control over not only what they do but how they do it. This has been reported to result in the distinctive flavour of such organisations that the public sector values being diminished (Macmillan, 2010).

Beyond the principles of competition (which many working in this sector do not support), there are the practicalities of contracting effectively. Munford and Saunders (2001) reflected on experiences in New Zealand regarding contracting with health and social care agencies. Key issues were:

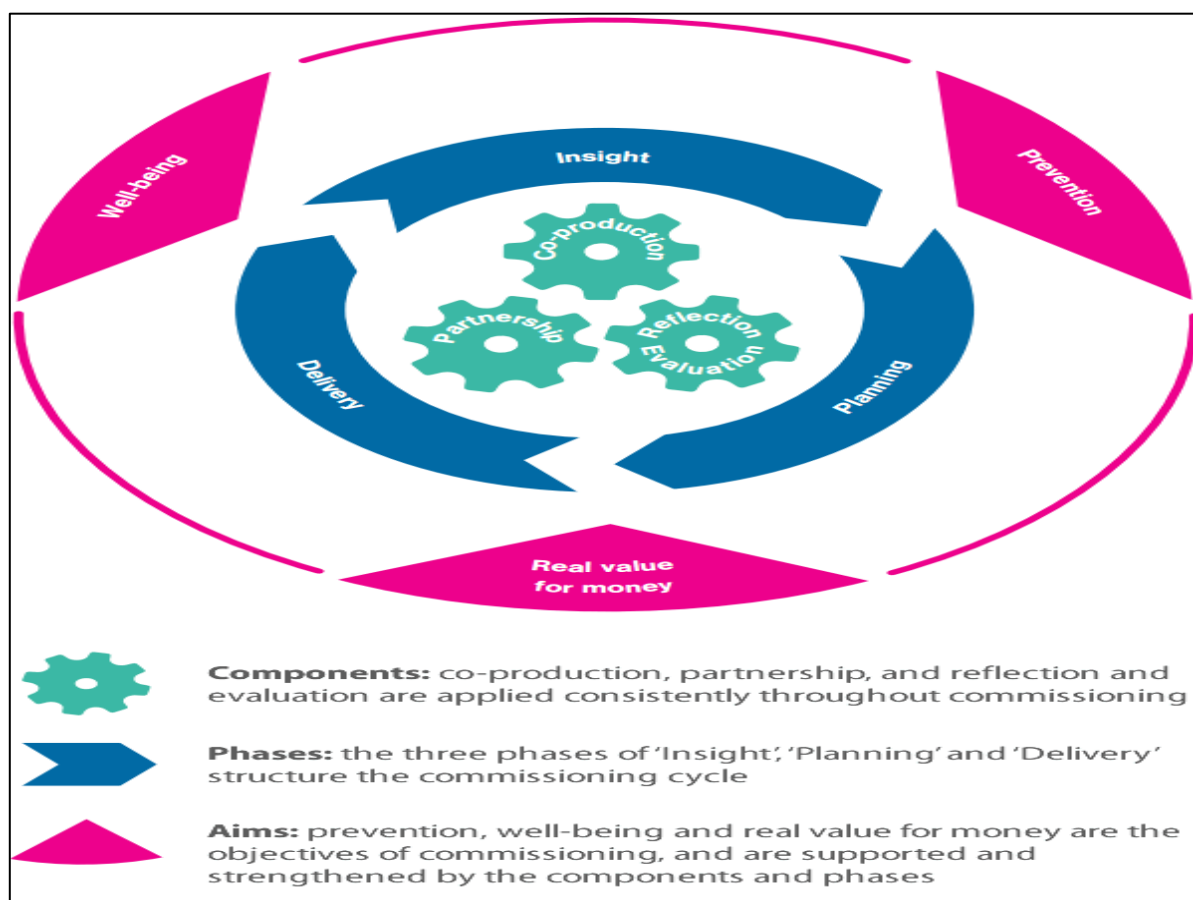
- The lack of information on behalf of the purchaser regarding future needs in relation to what their staff actually did;
- Outcome based contracts mean that provider payment is dependent on the behaviour of the service user as well as their own actions;
- High transaction costs due to multiple purchasers with their own reporting requirements;
- More focused specifications by individual purchasers can lead to fragmentation in delivery and was barrier to holistic working;
- More secure funding increased the ability of providers to generate community participation;
- Purchaser and providers need to recognise risk on both sides and are willing to share this and the value generated ; and
- Engagement of the SBMs within the commissioning cycle, particularly planning and service redesign is not consistently achieved with a number of barriers to entry remaining (Rees, 2014).

Miller et al. (2013) explored the commissioning of preventative services and found that in many cases expectations between providers and commissioners were in fact shared. Although

difficulties around outcome monitoring were expressed, the importance of trust, and the need to have the same objectives was identified as key.

To address these issues a number of good practice models have been proposed which promote the better engagement of a wide variety of providers and/or community representatives in the planning of services and a more holistic set of outcomes than is often focussed on by the public sector. The New Economics Foundation has been particularly active in this regard and in recent years has worked with various public sector bodies (notably Camden Council in relation to day services for people with mental health problems) to refine their approach in relation to commissioning for outcomes and co-production (see Figure 4). This looks to integrate the principal components of coproduction, partnership, reflection and evaluation throughout the commissioning cycle. These various dimensions of outcomes and co-production commissioning are supported through good practice examples but have not been examined through rigorous research. There have also been pilot programmes looking at more collaborative models within the framework of procurement. In Scotland, the Public Social Partnerships (Scottish Government, 2011) initiative sought to enable voluntary organisations and the public sector to co-plan and design services that responded to community need. This required the organisations to share and test out their innovative approaches with consortia of public and voluntary organisations. If the pilots were successful then the model was put out to competitive tender and the original organisation would not be guaranteed to win.

Figure 4: NEF Commissioning for outcomes and co-production (NEF 2014)



The National Programme for Third Sector Commissioning in England identified learning from five successful case studies of commissioned organisations which included SBMs (LGI / SEC, 2010). The key insights related to:

- Positive and shared management of risk between purchaser and provider;
- That commercial justification can be based on more than just the lowest costs;
- Initial investment is often needed to support cost-efficient innovation; and
- Trust with open dialogue is vital to try out new territory.

Supporting the development of SBMs requires a different approach where commissioners need to be 'risk aware rather than risk averse'. Examples might include placing a director from the commissioning body on the board of the organisation, regular face-to-face meetings to discuss progress rather than written monitoring reports to better understand the challenges faced.

In order for SBMs to compete effectively in the commissioning process the adoption of an alternative tendering process is required, to "take greater account of factors other than price

and track record". A revised process could add additional weight to factors such as "service user involvement, investment in staff development and the reinvestment of profits".

There is also a "need for initial investment capital, upfront, to pump prime the development of the organisation". In addition, such an approach would require appropriate key performance indicators as SBM "services and outcomes may not always fit neatly into standard key performance targets". These could include detailed case studies or combining hard data "with softer information on factors such as customer satisfaction" (LGID/SEG, 2010).

A more recent development in England is commissioning through consortia of organisations. This entails a lead provider or contractor acting as the 'integrator' through which the various offers of the consortia members are co-ordinated to deliver more holistic and integrated care, or a joint venture with the purchaser (Addicot, 2014). Such alliances can enable smaller organisations to pool their capacity in order to win larger contracts although evidence of their impact is still limited (Billings & De Weger, 2015). Social impact bonds are another new procurement model about which much is anticipated. These are a contractual arrangement between three parties – the commissioner, the provider and a social investor from private or third sector. The investor meets the initial costs for the provider to launch the service and the commissioner agrees to make payments if pre-determined outcomes are achieved. The emerging evidence of a pilot programme of nine 'trailblazers' projects in health and social care highlights the 'newness' and 'complexity' of introducing such arrangements (Tan et al., 2015). This does not however indicate, that with sufficient thought and time, that social impact bonds would not be an investment option worth pursuing,

Finally, procurement law and the extent to which flexibilities are allowed for different suppliers is under constant debate. New procurement directives were adopted by the EU in March 2014 and European governments have two years to introduce them. The UK's implementation regulations for the Public Sector aspect of the directions, (the Public Contracts Regulations, 2015) were laid in the UK Parliament on 5 February 2015 and take effect from 26 February 2015. These single out SBMs, with national governments given the possibility to reserve health, social and educational contracts to employee mutuals and social enterprises only, provided certain conditions are met, and an expectation that procurement should be 'SME-friendly' (NHS European Office, 2013).

Examples of Commissioning SBMs

Learning from Conwy

Dickinson and Neal (2011) summarise the work of Conwy in response to the Welsh Government's strategy to encourage better joint working between statutory and "non-statutory bodies in effective support for individuals and communities. Conwy established that intermediate care" was an area where TSOs had the potential to deliver a number of services. "Building on work already undertaken by the Conwy Maintaining Independence Project in establishing the Conwy Intermediate Care Service (CICS), this area was selected as a pilot. CICS was a multi-disciplinary statutory sector team, which includes professionals from health and social care co-located and managed as a single entity that reports to both statutory bodies on its activities.

The CIC Start Pilot aimed to link the services delivered in the community by third-sector organisations seamlessly with the CICS team. The members of the consortium each retained their own contractual relationships with their funding agencies, but developed shared processes and paperwork to support service delivery. The sharing of client information between organisations was supported by a personal information-sharing protocol as set out in the Wales Accord for the Sharing of Personal Information (WASPI) (WG, 2010). The relationship between the organisations was supported by a joint working agreement in which the distinct roles and responsibilities of each partner were made explicit, enabling the consortium to include statutory organisations as equal partners without having to resort to the cumbersome legal arrangements normally associated with traditional consortia models. It also enabled the consortium to be flexible and responsive to need, because it was expected that the number and mix of delivery organisations would develop and change over time.

Overall, the findings were very positive, particularly when considered against a background of the difficulties that are often reported in making partnerships work across organisational and sectorial boundaries and the lack of evidence on the effectiveness of partnerships for service-user outcomes. The self-reported assessments give a picture of a service that has demonstrated improvements in various dimensions of the lives of individuals with significant needs, and the routine data collected and the perspectives of all uncovered during the research suggest a very positive picture. This is despite the relatively small scale of the project, which is dealing predominantly with preventative and emotional well-being interventions for which it is notoriously difficult to demonstrate outcomes. Through an innovative combination of approaches the project has managed to demonstrate impact in the local area. Those who had accessed services were positive about the impact that it had had, and the main partners

worked together effectively across organisational, sectorial and client group boundaries. As a result of this project individuals are being signposted to a range of other services that might not be funded by health boards or local authorities and which also have a preventative effect. It is these links that the project has tried to capture, but which will ultimately be difficult to measure effectively in the short term” (Dickinson & Neal 2011, p.39).

Connected Care

Bruce et al (2011) summarise “how Connected Care, Turning Point’s model for involving the community in the design and delivery of integrated health and well-being services, aims to involve the community in the commissioning process in a way which fundamentally shifts the balance of power in favour of local people. Implementation of a new community-led social enterprise in Hartlepool began in 2007, and today its Connected Care service provides community outreach, information, and access to a range of health and social care services, advocacy, co-ordination and low- level support”.

“Key lessons, from Hartlepool and elsewhere, have centred on the value of making the case for service redesign from the ‘bottom up’ and building the capacity of the community to play a role in service delivery”. This needs to be achieved “while also promoting strong leadership within commissioning organisations to build ‘top-down’ support for the implementation of outcomes defined through intensive community engagement. The new Government’s ‘localism’ agenda creates new opportunities for community-led integration, and the Connected Care pilots provide a number of learning points about how this agenda might be successfully progressed” (The King’s Fund, 2011).

Conclusions

The evidence from our review highlights a number of ways in which SBMs can be introduced and sustained in health and social care and draws attention to the need for proactive policies and support from government as well as active engagement from SBMs in order to develop the sector(s). We have grouped the key activities that governments might usefully pay attention to under four headings: financial and business support, partnerships between SBMs, commissioning and procurement, and measurement of social impact.

Financial and business support

The development of new SBMs, expansion of existing SBMs into the health and social care sector, and scaling up of smaller successful organisations into new localities and services entails considerable challenges. Pump priming grants can provide vital capital to invest in new infrastructure, develop staffing skills and capacity, and market services to new buyers and grant making bodies. However, care is needed in the management of such a process to ensure that the grant funding is targeted towards those SBMs with a realistic chance of achieving sustainable growth through this investment. Business support is also crucial, particularly in encouraging new entrepreneurs to set up SBMs and establish development plans. The business support sector therefore presents another opportunity for the development of SBMs to provide such support.

Partnerships between SBMs

The benefits of developing and nurturing strong networks and relationships across SBMs is a key theme in the literature. On a practical note, alliances between SBMs can enable them to share backroom functions and so increase efficiency and capacity of such services, and to bid for larger scale contracts and grants. Support in understanding how to develop positive partnerships and who is to take on the role of 'lead provider' represent areas for further development. The role of strong and motivated social entrepreneurial leaders to set up and run SBMs cannot be understated. The drive and vision of such key individuals is essential to making SBMs happen, therefore the role of peer learning and support networks can be valuable in this respect. Similarly, where relevant, training for board members (which could be shared between SBMs) would facilitate engaged and informed governance which is appropriately sighted to potential risks and opportunities.

Commissioning and procurement

Commissioning and procurement practices remain a significant factor in determining the start-up and success for any SBM that is likely to rely significantly on public sector funding. Ensuring these processes are SBM friendly will entail a holistic approach, including:

- The training of public sector commissioners and procurers in the different types of SBMs and their potential benefits;

- Ensuring that tender specification and selection criteria reflect the added social impact that is sought; and
- Setting outcome and performance targets that incorporate more than activity and finance.

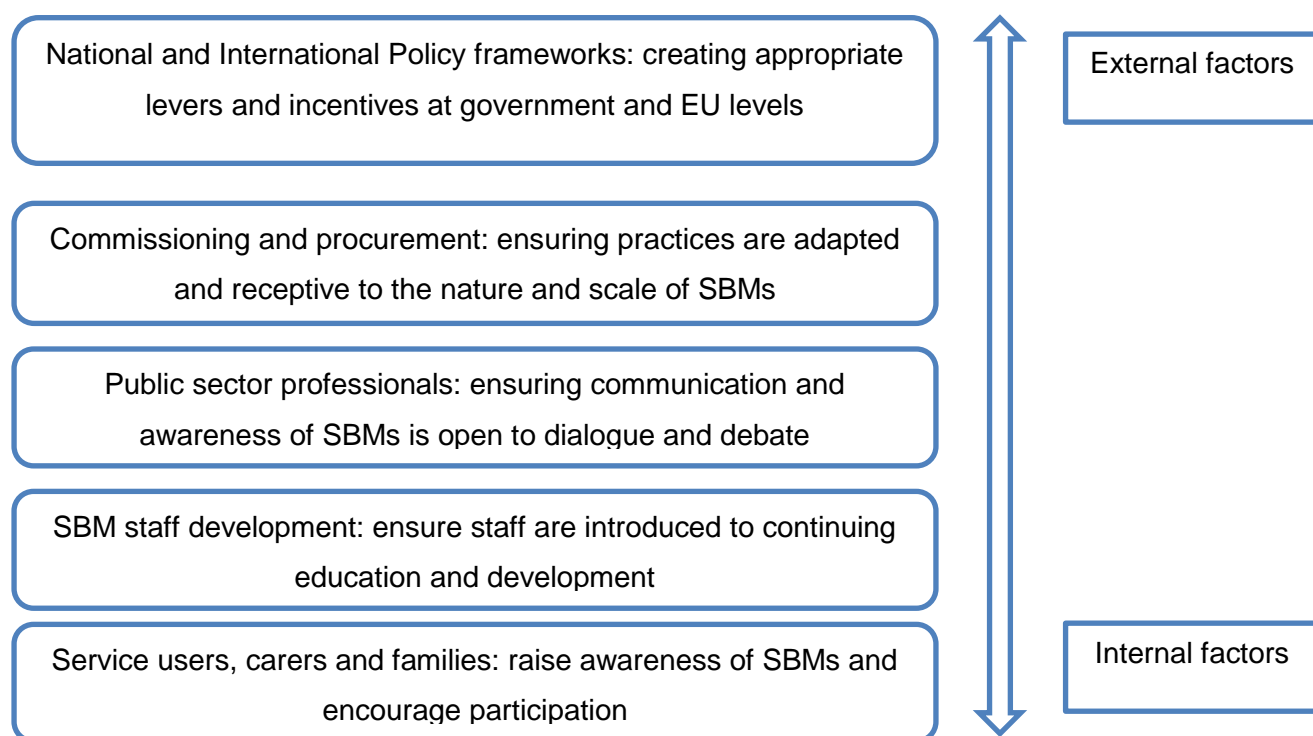
There also needs to be consideration of what public sector business opportunities will be available to SBMs, and how the associated funding will be allocated (e.g. through grants or contracts). The range of case studies presented in this report have shown the strength of SBMs and the public sector working together to explore their respective challenges of engaging in a positive commissioning and procurement process. Exploring and explaining the opportunities presented by the new EU procurement directives will help to avoid the potential inertia caused by any confusion or uncertainty.

Measuring social impact

Being able to conceptualise the added ‘social value’ or ‘community benefit’ that SBMs are expected to deliver and incorporating this within tendering and contracting processes is key to increasing their role. Despite many previous and existing initiatives across the UK to develop accessible and relevant impact and measurement frameworks, such measurement tools and techniques remains an area of uncertain practice. Learning from this experience, Wales has an opportunity to develop something meaningful and innovative in terms of taking greater account of factors other than price and track record in tendering. Instead, the weighting for service user involvement, investment in staff development and the reinvestment of profits could all be included to provide a more balanced environment for SBMs to compete.

Based on this range of activities we argue that a holistic approach is required. Figure 5 summarises the key activities presented above and looks to show how for SBMs to be successful a combination of internal (organisational, leadership) and external (government policy, commissioning practices) factors that will be needed.

Figure 5: The internal and external factors required for SBM success



Recommendations

In light of the evidence, we suggest that Ministers and others consider action in the following areas to enhance the role of SBMs in the health and social care sectors in Wales:

- The provision of business and financial support is important to enable the establishment and growth of SBMs including social enterprises. The need for initial investment capital upfront to pump prime the development of the organisation is central to the process. Financial support would normally need to be in the form of grants as new SBMs are not generally in a position to be able to repay loans. Support could also include the provision of a resource pack for aspiring social entrepreneurs, as well as the creation of mutually supportive networks of social entrepreneurs including the provision of guidance and advice from those who are running successful social enterprises and other SBMs;
- There needs to be encouragement of the development of social enterprise or co-operative consortia in health and social care allowing providers to pool resources, cost-share (for example back office and training) and risk-share when looking to take bank loans;
- NHS and social care staff could be given a right to deliver their services in a social enterprise or other SBM. Business and financial support needs to be provided to any staff

- looking to take this option. Terms and conditions of staff including pensions need to be taken into account during this process and unions need to be engaged from the outset;
- It is important to encourage micro and small social care providers by making government regulatory processes (e.g. CQC, tax, insurance) proportional to the needs and resources of smaller organisations;
 - The provision of financial incentives to social enterprises and co-operatives should be explored, including lower rates of corporation tax, lower rates of VAT, exemptions from national insurance contributions for their disadvantaged workers, tax relief for donors and non-taxable trading surpluses if placed in capital reserves;
 - The introduction alternative tendering processes that take greater account of factors other than price and track record is worth considering. These should include service user involvement, investment in staff development and the reinvestment of profits;
 - There needs to be adequate information and training for commissioners and other purchasers within the health and social care system (including care managers) to enable them to know how to work positively with SBMs;
 - Clear guidance is required on the new EU procurement rules and the potential flexibilities and opportunities they enable; and
 - A single framework for the added social value of SBMs should be developed alongside common approaches to measuring and reporting on such impacts.

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