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Social enterprise in health care

Promoting organisational autonomy and
staff engagement



Key messages

- The coalition government has continued the previous Labour government's commitment to the development of social enterprises to deliver health and social care. There are new opportunities available to providers, and a positive policy environment to encourage them to be taken up.
- Providers are beginning to recognise the benefits of social enterprise – particularly greater organisational autonomy to innovate and more staff involvement in decision-making. A shift in the underlying way the organisation operates and the way staff communicate will be necessary in order for any structural changes to be effective.
- The new policy environment presents a number of challenges and risks for social enterprises. A more competitive provider market, alongside short-term contracts with commissioners, means that social enterprises will need to develop business models that are effective and sustainable. It is vital that these business models focus on viability of the service in the long term and on succession planning.
- If the government is to encourage the growth of the social enterprise sector, organisations need time to develop a track record and to get established. This will require a supportive commissioning environment and, in particular, the opportunity for long-term contracts. Organisations will need the necessary legal, financial and other support to develop and grow in this sector.
- The growth of social enterprises has largely arisen as a reaction to government policy to separate purchasing and provision of community services. There are questions about whether there is an appetite for their growth in health care, particularly across the acute sector.
- There are opportunities for social enterprises to play a significant role as providers of health care. The question is whether these new organisations and their leaders have the necessary competencies to manage the risks and establish themselves as viable organisations in this increasingly competitive context.

Introduction

The coalition government wants to encourage health care providers to consider employee ownership, and the development of mutuals, with the aim of creating ‘the largest and most vibrant social enterprise sector in the world’ (Department of Health 2010a, p 36). These plans are part of a broader programme of public service reform, moving away from state ownership to greater diversity in how public services are run in pursuit of the Big Society. This builds on the previous government’s interest in mutualism in the public sector, and signals a continued commitment to explore alternatives to state ownership and for-profit private provision of public services.

The previous government’s policy to separate provision and commissioning of community health services signalled the potential development of a new range of community services and primary care providers. This paper explores how NHS providers are responding to the proposals and requirements of the Transforming Community Services programme (Department of Health 2009). We explore the motivations for organisations to become social enterprises, as well as the benefits and challenges of implementing this organisational model in practice. Finally, we present recommendations as to how they should develop, and what support they require.

In November 2010, Francis Maude, the Minister for the Cabinet Office, announced that all public sector employees would have the right to form mutuals or other types of social enterprises, which would then negotiate contracts with their relevant government department or commissioning agency. As part of this announcement, the Cabinet Office pledged to support emergent social enterprises through financial investments, an information line and web service, and a ‘challenge group’ of experts that would focus on ways to improve regulation of social enterprises. In health care, the Department of Health will provide support to staff who take up this ‘Right to Provide’. Staff will have the right to present to their board a proposal for a staff-led enterprise and to seek approval to develop a full business case to test that proposal. If the business case is approved, staff will then have the opportunity to establish the enterprise (Department of Health 2011a).

In 2006, The King’s Fund published a paper that explored the potential for growth of social enterprises in the health sector (Lewis *et al* 2006). The discussion of benefits and challenges was largely theoretical, however, as there was limited practical experience to draw on. The Public Services (Social Enterprise and Social Value) Bill 2010–11 is currently going through parliament, and suggests that a national social enterprise strategy should be established to further support the development of social enterprises across the whole public sector.

This paper is intended to be a resource for policy-makers and health care providers. It explores the structural and leadership changes needed to support the development of social enterprises that are both viable and sustainable. The recommendations will be of interest to those leading and designing the reforms, and to providers, who will benefit from a deeper understanding of the benefits and challenges of becoming, and operating as, a social enterprise.

Methodology

The report draws on findings from primary research (interviews) with directors of 13 social enterprises (community providers), and chief executives of 11 acute foundation trusts and 3 mental health foundation trusts (*see* Appendix A for more details on the methodology). We interviewed social enterprise directors to explore their views and experiences (both positive and negative) on provider reform in the NHS and their motivations for becoming a social enterprise. We also asked them to consider what additional support would have been useful during the implementation and delivery

phases. We interviewed chief executives of foundation trusts to get their views on provider reform, and how models of social enterprise might have some resonance within this setting. Both types of organisation were asked to describe their main challenges and concerns in the coming months of public service reform.

Social enterprises were identified with the help of the Social Enterprise Investment Fund (SEIF) and the Employee Ownership Association (EOA). A range of provider organisations were invited to participate, chosen to represent different stages of progression and different sizes. These social enterprises employed between 5 and 700 staff, and had a geographical spread across England. They included GP practices, community nursing providers and entire NHS provider arms. Foundation trusts (acute and mental health) were identified using a snowball method of contacts, stemming from initial scoping interviews.

We start with some definitions of key terms, then provide an overview of public sector reform and the rise of social enterprises in public services. We give a brief overview of the levers that have prompted the rise of social enterprises across sectors, and what we know from existing research findings about the impact of these organisational models on staff satisfaction and productivity. We then go on to explore why social enterprises were initially considered a viable option for the NHS and public services, and then also the advantages and challenges that have been experienced in practice by those organisations becoming social enterprises.

The empirical findings first focus on the different motivations for organisations opting to become a social enterprise, followed by a discussion of the benefits and challenges actually experienced in practice – particularly around staff engagement. We then describe some of the anxieties facing social enterprise directors around the longer-term sustainability of the model, as they compete in a reformed, competitive health care environment. Although social enterprises have emerged largely in community and primary care, we also explore how some of these principles might apply to the acute setting. We then conclude with a set of recommendations to support policy-makers and providers in further developing social enterprise as a viable and sustainable model for health care delivery.

What is a social enterprise?

Terms such as ‘social enterprise’, ‘employee-owned organisation’, ‘mutual’ and ‘co-operative’ are used interchangeably but can have different meanings. Employee-owned organisations, for instance, can take many different forms – including co-operatives and mutuals – and can be structured in different ways. Similarly, many social enterprises are owned in some way by staff or the wider community; however, this is not a necessary characteristic. The term ‘social enterprise’ may be taken to include mutuals and co-operatives. However, not all social enterprises are co-operatives or mutuals, nor are all mutuals co-operatives (Girach and Day 2010).

In essence, social enterprises are businesses that are guided by social objectives, with surpluses reinvested in the organisation rather than taken as profit by investors. Some employee-owned organisations, mutuals and co-operatives fit this definition, but in others some proportion of profit is taken as dividends or bonuses. Within the range of organisational models, there can be variation in the legal framework, internal governance structures, and what (if anything) is actually ‘owned’ by staff.

For the purposes of our analysis, we consider ‘social enterprise’ as an umbrella term to describe a range of organisational forms, some of which include elements of employee ownership or mutual and co-operative design.

Table 1 overleaf gives definitions of key terms as they are used in this paper.

Table 1 Definitions and key characteristics of social enterprises

Type of organisation	Definition
Social enterprise	An organisation with an objective to fulfil a social purpose. It may use market-based mechanisms to operate, but its aim is to fulfil a social goal. Profits are reinvested in the company or used for the benefit of the wider community.
Employee ownership	Organisations in which employees own at least a 51 per cent share of the business, either through direct share ownership, or indirectly through an employee benefit trust that holds shares collectively on behalf of employees.
Mutual	A membership organisation that operates according to the principles of mutuality. The intention is that members should benefit in some way as a result of the organisation's activities.
Co-operative	An organisation whose members determine what is done with any profits. Unlike the other models described here, co-operatives conform to a set of internationally agreed principles: ■ voluntary and open membership ■ democratic member control, with each member having an equal say ■ member economic participation ■ autonomy and independence from the state ■ education, training and information for members ■ co-operation with other co-operatives ■ concern for the community. Co-operatives often share profits with their members. In turn, members may also be investors (some making nominal, while others make more substantive, contributions).
Staff engagement	A two-way relationship between employer and employee. Information about the performance of the organisation is shared so that employees are able to understand and contribute to improvements in performance. Employees have powers to make decisions affecting organisational performance, which may be linked to incentive or reward programmes.

Sources: Girach and Day 2010; Ellins and Ham 2009

There are a variety of legal structures that social enterprises can consider. The most common are as follows.

- Community interest company: the social enterprise intention is 'regulated' to ensure that it fulfils its social ambitions and its assets are protected.
- Company limited by guarantee or shares: this is the most common structure, as it is the most flexible.
- Industrial and provident society: this is the usual form taken by co-operatives.
- Group structures and charitable status: these are frequently established for tax reasons where organisations wish to retain surpluses, particularly if they cannot take on equity (see Social Enterprise Coalition website www.socialenterprise.org.uk).

There are also distinctions between direct and indirect employee ownership. In some employee-owned organisations, staff own shares (direct ownership) – they can draw profits as dividends and can buy and sell shares whenever they wish. Alternatively, shares can be held in trust for the benefit of staff (indirect ownership), in which case the trust has the authority to make decisions about shareholding rights. Indirect ownership is more common, as it allows greater ownership stability in the long term (Ellins and Ham 2009). The John Lewis Partnership, for instance, the largest employee-owned organisation in the UK, is indirectly owned by staff.

There are around 62,000 social enterprises in the UK, which contribute more than £24 billion to the economy, employing approximately 800,000 people. It is estimated that about 9 per cent of them operate in the health and social care sectors (Social Enterprise Coalition 2009; Williams and Cowling 2009).

While the government has not prescribed the kinds of social enterprise it wishes to support, it appears that it wants to promote and develop alternative organisational models in public services that retain the overarching objective of social enterprises.

Therefore, this report will not focus on the structural or legal frameworks of these alternative models, but will instead consider how social enterprises are being developed more generally by providers, and how these emergent enterprises are grappling with the structural and legal decisions.

We do not differentiate between the structural forms that the various organisations may take. Instead, we categorise them as social enterprises because of their overarching intention of operating independently from the NHS, and reinvesting profits for the benefit of patients.

Public sector reform and the Big Society

As part of the broader public sector reform programme, the government is continuing to emphasise the development of its Big Society vision across the public sector and local communities. The aim is to build a stronger civil society through greater community empowerment, open up public services to mutualise, and promote social action for change.

The principles that underpin this vision largely focus on decentralisation of responsibility to communities and citizens. One of its defining features is the promotion of social enterprises and employee involvement in decision-making for the delivery of public services. In order to realise this vision, the government has made a commitment to support the creation and expansion of mutuals, co-operatives, charities and social enterprises, to give them much greater involvement in the running of public services. It has also given public sector workers a new right to form employee-owned co-operatives that can bid to take over the services they deliver (Cabinet Office 2010, p 2). The first of these was launched in the NHS in March 2011, with other sectors to follow.

The Big Society vision is not without its critics though, who argue that it is vague and unworkable. Some see it as a 'smoke-screen to hand the provision of public services over to the market' (Rainford and Tinkler 2010, p 2), while others have suggested that it is masking cuts in public spending. Either way, there is very little understanding of what the vision means in practice (Ipsos MORI 2010). However, several activities are beginning to emerge from central government to support the development of social enterprises.

The Cabinet Office and the Department for Business, Innovation and Skills have launched a mutuals taskforce to consider the regulation and performance monitoring of social enterprises, and other charities and voluntary organisations, intending to reduce some of the red tape involved. The Cabinet Office has also announced the development of pathfinder mutuals – organisations that are in the process of establishing themselves across public services. These pathfinder mutuals will be supported through a range of initiatives, including a mentoring programme. These organisations, and other experiments with social enterprise, are increasingly evident across the public sector, and specifically within health care.

However, Lampel *et al* (2010) have warned that the regulatory environment and access to finance act as barriers to the growth of social enterprises. The Department of Health funded the Social Enterprise Investment Fund (SEIF) to address these barriers, and it has provided £8.3 million to 'Right to Request' applicants (National Audit Office 2011). The Right to Request programme ran until September 2010, and was an initiative that allowed primary care trust (PCT) providers to establish themselves as social enterprises to deliver health care to NHS patients. The support offered through the SEIF was under pressure as it was significantly over-subscribed.

The social enterprise model was seen to give organisations greater flexibility to expand to new areas, develop new products and rationalise service delivery. However, NHS community providers are now operating in a more competitive environment where they will have to compete for contracts alongside private providers, the voluntary sector and foundation trusts – all of which may have a stronger track record of securing such contracts. This may mean that social enterprises will be increasingly vulnerable. Although there will be a greater diversity of providers, the Health and Social Care Bill suggests there will be more consistency in how they are held to account. This fits with the government's market approach to care, in which providers are to be treated equally irrespective of their ownership status.

This greater level of competition, and more consistent approach to accountability, may prove to be effective in driving up quality of services, as providers need to demonstrate their worth to attract patients in this more open market. However, this will be achievable only if contracts with commissioners are robust and transparent – indicating expected outcomes, rather than just focusing on delivering care for the lowest cost.

Impact of social enterprise

Evidence from other sectors (the commercial industry, and other public services to a lesser extent) largely focuses on the employee ownership model. In the UK, there is considerable evidence based on the John Lewis Partnership, a major retailer and the UK's largest employee-owned organisation. However, much of the literature in this field is from the United States, where a significant proportion of the workforce (more than one-fifth) is financially involved in their organisation (Ellins and Ham 2009).

Literature from the private sector is predominantly supportive of employee ownership, and suggests that there is a positive link between employee ownership and productivity (Lampel *et al* 2010; Blasi *et al* 2003; Blond 2009), innovation (Blasi *et al* 2003; Blond 2009) and job satisfaction (Nguyen *et al* 2003; Witt *et al* 2000; Ellins and Ham 2009). This literature is based on the argument that, by giving employees a stake in their organisation, they will be more engaged and potentially more productive.

However, Ellins and Ham report evidence that suggests that employee ownership may slow down decision-making and generate a risk-averse culture. A review of the literature by Matrix Evidence (2010) also suggests that any productivity gains are not immediate, but become stronger over time.

The relationship between employee ownership and staff engagement is quite complex. It has been suggested that employee ownership does not automatically lead to greater staff participation, but that staff participation is necessary for the development of a successful and productive employee-owned organisation. The literature suggests that the main benefit of employee ownership is greater staff involvement in decision-making, which is associated with a stronger tendency for organisational innovation. However, the direct link between ownership and staff satisfaction is much less clear (Matrix Evidence 2010).

In commercial industries, employee-owned firms tend to have a lower risk of failure. They are able to create jobs quickly, and are at least as profitable when compared to conventionally structured businesses (Lampel *et al* 2010). Further, a survey by the Social Enterprise Coalition (2009) found that social enterprises were twice as confident of future growth compared with small- and medium-sized enterprises (SMEs) (48 per cent as opposed to 24 per cent of SMEs). Additionally, since the recession began, 56 per cent of social enterprises have increased their turnover from the previous year (compared with 28 per cent of SMEs).

The Department of Health (2010c) also highlighted the social return on investment generated by existing social enterprises in health and social care – that is, the broader

added social value that is produced by the organisation. Analysis and subsequent cost values attributed to five social enterprises identified that, for every £1 of investment, there was a social return of between £2.52 and £5.67. This return was calculated from various sources; for some it was the quality of outcomes, while for others it was associated with outcomes other than those usually linked to the service, such as getting a patient back to work sooner or children attending school more regularly. Similarly, analysis by Frontier Economics (2011) demonstrated that the social return on investment for Whizz-Kidz (a social enterprise that provides mobility equipment to children with disabilities) generates between £10 and £65 of social return for every £1 invested.

Co-operatives UK recently commissioned a report that examined international experiences with co-operative models across a range of sectors, which may be relevant for the UK public sector (Bland 2011). The report highlighted the following key success factors.

- Supportive legal and financial frameworks: these were vital in presenting clear structural alternatives to organisations and staff.
- Sensible commissioning and procurement strategies: as per the government's commitment to choice of any qualified provider, commissioning and procurement must be opened up to support social enterprise providers in this process.
- Access to capital: financial resources must be available to help social enterprises become established. There must also be solutions for taxation constraints when moving from a publicly funded organisation to a social enterprise.
- Successful business models that endure over time: these models should be permitted to develop in a variety of ways, to better meet local needs and priorities.
- Specialist business support: social enterprises and co-operatives should benefit from dedicated business support, to offer specialist learning and development (Bland 2011).

The NHS reform programme and drivers for provider transformation

The Health and Social Care Bill 2011 signals a major reform of the way NHS care is commissioned and provided. The reforms include the abolition of primary care trusts (PCTs) and strategic health authorities (SHAs), and the creation of a national NHS Commissioning Board, while clinical commissioning groups will be tasked with commissioning the bulk of NHS-funded care at a local level. The reforms aim to further extend patient choice and competition between providers. On the provider side, the aim is to give providers greater autonomy while also opening up the market to new entrants.

The government supports a model of any qualified provider (amended from any willing provider), whereby patients will have the ability to choose care from any qualified provider and commissioners will have to pay. The NHS will be made up of a broad range of providers from the private, voluntary and independent sectors. Within the health sector, it is likely that the government's reform programme will prompt further growth in the establishment of social enterprises.

Community services

The Right to Request programme, introduced in 2008, gave staff providing community health services in PCTs the right to put forward a social enterprise proposal to their PCT board. PCTs were obliged to consider these proposals and, if approved, to support the development of the social enterprise. Support included awarding a contract to the enterprise for up to five years, as well as giving access to pump-priming and development funding through the Social Enterprise Investment Fund and broader business

development support. The Right to Request scheme closed for applications in September 2010, following the requirement that PCTs separate commissioning and provision of community services by April 2011.

All community providers have been required to undergo at least some degree of organisational change in response to the Transforming Community Services commitment to separate PCT commissioning and provider arms. They have responded in different ways – establishing community foundation trusts, merging with existing acute or mental health trusts or setting up as a social enterprise.

According to Department of Health figures, 10 per cent of community services previously provided by PCTs chose to become a social enterprise as part of the commissioner/provider divestment (Department of Health 2010d). There were 20 organisations involved in the first wave of the Right to Request programme, involving almost 8,000 staff and budgets of around £323 million. The second and third wave projects will go live later in 2011.

Foundation trusts

The government's response to the Future Forum continues to expect that all NHS trusts will have become foundation trusts (or joined an existing foundation trust) by 2014, and Monitor is tasked with retaining an oversight function until 2016 (Department of Health 2011b). Foundation trusts are more autonomous providers of community, mental health and acute care, being free from central government control and performance management by SHAs. Instead, foundation trusts are accountable to their local community through a board of governors comprised of elected representatives from the community, patients and staff.

The White Paper, *Equity and Excellence: Liberating the NHS* (Department of Health 2010a) originally discussed enabling foundation trusts to have staff-only memberships. The government is convinced that employees should be given new opportunities to provide innovative services, and giving them the right to set up their own independent organisations is an alternative way to achieve this. The government initially explored how this 'right to provide' would work for staff employed in NHS foundation trusts, and whether trusts would have to consider such requests.

Very few respondents to the subsequent consultation commented on this proposal but, with some exceptions, those that did were generally unsupportive. The Care Quality Commission responded that staff-only models, without patient and public involvement, could be at odds with public accountability and should be avoided, while the British Medical Association (BMA) thought they would do nothing to improve patient care (Department of Health 2010b). The government considered these concerns and concluded that staff-only membership would not be compatible with the foundation trust model. However, aspects of the social enterprise model could still be adapted to fit the foundation trust context. The Foundation Trust Network (2009, p 3) reaffirms this view and states that 'social enterprises are not characterised by a legal or organisational form but by a social ethos'. Further, the reform programme will continue to allow 'spin-offs' from particular areas within a foundation trust – that is, a service (such as pathology) within the organisation that is sub-contracted to an outside party.

The growth of social enterprises pre-dates the election of the coalition government and the ambitions of the Health and Social Care Bill. The rise of social enterprises in community health care was set in motion under the broader ambitions of the previous Labour government. This requirement for PCTs to divest from their provider arm shows that community services have already needed to consider changing their structure and ownership arrangements under policies of the previous Labour government. From April 2011, commissioning and provision of care was formally separated under the Transforming Community Services programme (Department of Health 2009).

Social enterprises and the NHS

Health care providers – and public services more generally – are currently undergoing a period of significant organisational change. The Cabinet Office and Department of Health are promoting social enterprises as one of their preferred models for delivering publicly funded health care services. However, there continues to be much uncertainty about how these organisations will develop and function in practice.

Social enterprises that have established themselves in health care range from a single GP practice or small centre for the homeless through to entire PCT provider arms. Their internal governance structures and processes vary, as do their ownership options and levels of employee engagement. But those that are employee-owned or have explicit strategies to engage employees are likely to have stronger internal accountability mechanisms. The overriding intention of the model has been to encourage staff to take on greater responsibility for decision-making within their organisation or care setting. This also brings greater accountability at local level, with staff encouraged to take greater ownership of the problems identified and the solutions developed to address them.

If these social enterprises win contracts for NHS-funded care, or satisfy requirements such that NHS-funded patients can choose their service, the Bill suggests that they will be subject to the same accountability requirements as their NHS or independent sector counterparts. In these cases, social enterprises and other third sector providers will enter into contractual relationships with commissioners, as well as regulatory relationships with the Care Quality Commission and Monitor. They will also come under scrutiny by local authorities, supported by a requirement to publish Quality Accounts.

It is difficult to draw any substantive conclusions on the impact of social enterprises in the NHS as they are in the early stages of development. As mentioned earlier, the majority of available research evidence comes from other sectors. A recent National Audit Office (2011) review found that there is very limited hard evidence of benefits of social enterprises in health care because of their short track record.

Key opportunities and challenges

There is very little research on the opportunities, issues and challenges that provider organisations are facing in the current climate. As community providers seek to separate from PCTs, and secondary care providers consider how they will need to adapt to respond to the proposed reforms, it is vital that they receive help and guidance to understand the options available, address the likely challenges and access any further support they need to undertake such organisational change.

The remainder of this paper draws on findings from interviews with directors and chief executives of primary and community health care providers and foundation trusts, which explored the challenges and benefits of becoming a social enterprise in the NHS.

Motivations for provider transformation

Politicians and policy-makers are continuing to promote the development of social enterprises in health care. Many organisations that were previously run by the NHS – particularly those delivering community services – have recognised the potential benefits of shifting to a social enterprise model. Among the social enterprises that participated in this study, there were a number of different motivations for developing and implementing this new organisational structure. We summarise the most common ones below.

Protectionism

Some NHS community service providers reported that they felt vulnerable to the impact of the Transforming Community Services agenda. Some regarded social enterprise as an option to renegotiate a long-term block contract with commissioners, thus protecting themselves from takeover or competition. As mentioned previously, as part of the Right to Request programme, primary care trusts (PCTs) were obliged to support social enterprises by giving long-term contract assurances. A sub-group of social enterprises used this assurance as a way of protecting themselves and providing a period of stability. Some also wished to protect themselves from being taken over by neighbouring 'aggressive' foundation trusts.

Resignation

For some, the development of a social enterprise model felt like the 'least unattractive option' where the 'alternative is too grim to contemplate'. Some providers feared that merging with existing mental health or acute trusts would narrow their service to a medical model of delivery. Some of them did not employ any medical staff, so merging with a medical institution did not make sense to them. They felt that becoming a social enterprise would at least enable them to be practitioner-led and community-facing.

Innovation

Some social enterprises saw the opportunities that the model presented and put themselves forward as early adopters. They saw the 'any qualified provider' policy as an opportunity to open up the health care market to a range of providers, as well as to support patients in different and innovative ways. They anticipated that social enterprises would be a more acceptable option to commissioners and the wider health care community, some of whom had expressed concerns about the privatisation of health care.

Adaptation

Some social enterprises recognised that 'standing still was not an option'. These organisations were quick to respond to the changing policy environment, but did not necessarily see it as the positive opportunity that innovators did. Instead, they felt they were simply responding to a commissioning decision for an open market. Rather than being proactive, they feared 'being left behind'.

Freedom and autonomy

Overall, the most common motivation for wanting to become a social enterprise was the desire to become more autonomous and to speed up internal decision-making and reduce bureaucracy. In this sense, these organisations saw the model as a move away from what was described by one interviewee as the 'dead hand of the centre'. Likewise, social enterprise was seen as a mechanism for generating greater internal control over decision-making. These providers believed that other responses to the Transforming Community Services agenda (such as merger) would not afford them the desired autonomy of a standalone provider.

Summary of findings

There are a number of reasons why community services chose to become social enterprises. While some saw it as an opportunity to innovate and were proactively entrepreneurial, others were more reactive. In all cases, organisations were motivated to become social enterprises because of the benefits of the model.

Those organisations that were motivated by a desire for stability or protection through long-term contracts may now be disappointed to find these commitments disappearing

(particularly with the abolition of PCTs and introduction of any qualified provider). Only time will tell whether they have the commitment to employee engagement that is necessary for their long-term survival in a competitive market. Across all of the social enterprises we interviewed, directors were motivated by a desire to engage staff in decision-making.

Staff engagement

Directors of social enterprises involved in this research believed that a more engaged workforce would be more satisfied with their jobs, and more productive and efficient. However, as described earlier, the links between organisational structure, staff engagement and efficiency are complex. There was considerable discussion among research participants about the relationships between these factors, and whether change in organisational structure was a necessary ingredient for a more engaged workforce. Several key messages emerged.

Preserving rather than generating staff engagement

All of the organisations involved in this research were adamant that changes to organisational structures, such as the development of a social enterprise or employee-ownership model, can lead to an increase in staff engagement and job satisfaction. However, the necessary pre-conditions need to be in place for this to happen. If organisational structures to promote staff engagement are introduced into a regime that has been characterised by top-down management, there is a risk that it perpetuates a barrier of suspicion that then must be overcome.

Government support for social enterprises has arisen as a means of engaging staff in decision-making. It is uncertain whether staff can become more engaged simply by changing organisational structures and policy drivers. It is likely that, in most cases, engagement needs to be a necessary pre-condition. Social enterprises may be more successful if they are established through enthusiasm and engagement that comes from the bottom upwards, rather than top-down control mechanisms. There need to be specific mechanisms set up to promote staff engagement rather than simply making changes to organisational structures or legal ownership. Structural changes on their own will not change behaviour or make staff more engaged.

Strong, committed and consistent leadership

Respondents felt that the development of a successful social enterprise required strong leadership that was committed to engaging staff in decision-making and allowing staff to challenge decisions. This process could not be undertaken half-heartedly, otherwise it would not 'stick' and staff would not trust it enough to buy into it. Staff engagement needs to be seen as a permanent feature of the organisational culture and structure. Setting up permanent structures to engage staff would give them a greater sense of accountability. In addition, there needs to be long-term leadership stability – something that is lacking in the NHS, which has a high turnover of chief executives (The King's Fund 2011).

Some social enterprise directors spoke of instances where staff engagement processes had led to a decision being taken that was contrary to their own personal view of the best outcome. In a traditional bureaucratic hierarchy, the organisational leader could simply have implemented the decision they felt was best. However, a leader of a social enterprise that is strong and committed to the model must consistently respond to these challenges and accept that the ethos of staff engagement can potentially produce results that are at odds with their own individual preferences.

Closed-door decisions

There was consensus among our interviewees that involving staff in decision-making was particularly vital during periods of difficulty. Social enterprise directors felt that ongoing staff involvement would allow the organisation to make a collective decision about its future direction, and that staff would be more 'on board' with this direction.

One director commented that it is relatively easy to involve staff in decision-making when things are going well; however, it is particularly important (although more challenging) to involve staff when things are not going so well or when there are very difficult decisions to make. They used the example of having to introduce a pay freeze, and the challenges of communicating this to staff and getting their views on how this might operate in practice.

However, some social enterprise directors thought that it was not possible or advisable to make all decisions in this open, inclusive way. They felt that some difficult decisions should be made by the executive team, with staff being informed of the outcome.

There was considerable divergence of opinion about whether some decisions should be taken without consulting staff. Some directors felt this issue presented considerable tensions – how to involve staff sufficiently in order to be meaningful, but how to ensure this did not act as a barrier to making difficult decisions. The example given was that a social enterprise may wish to seek input from staff regarding ideas for improvement and efficiencies, but some of the possible solutions might include staff cuts or pay freezes, which staff are likely to find unacceptable. Some directors felt that unwelcome solutions such as these would be rejected through a consultative approach.

This reflects a common criticism of employee-ownership models – that there is the potential for 'staff capture', whereby decisions would be made according to the benefits and priorities of the staff involved, who could subsequently reject an outcome that would be more beneficial for the organisation as a whole or its customers (patients). It is imperative that efforts to engage staff in decision-making are not at the expense of the interests and involvement of the end users of the service – patients.

However, as mentioned previously, other directors considered that it was most valuable and important to engage staff in making the most difficult decisions. First, if staff were more aware of the pressures on their organisation and 'owned' the problem, they may be less likely to resist organisational change (as they will have a real appreciation that change is necessary). Second, where unwelcome staff cuts and pay freezes are presented as solutions to efficiency pressures, staff themselves may come up with more innovative solutions.

Summary of findings

Staff participation and engaging staff in decision-making has been considered one of the most significant benefits of the social enterprise model, both in the literature and in the findings presented here. However, evidence shows that setting up as a social enterprise does not automatically lead to greater staff involvement, engagement or job satisfaction, and therefore organisational success. While structural and governance changes may act as drivers for greater staff involvement in decision-making, specific mechanisms are needed to support and develop this process.

Are the benefits realised?

As noted earlier, some organisations were motivated to become social enterprises by the desire to reduce bureaucracy and free themselves from central control, while some providers were motivated by a desire to protect or adapt their service in response to the changing policy environment. But are they realising these benefits, and are there other unanticipated benefits of becoming a social enterprise?

Reduced bureaucracy

The social enterprises involved in this research predominantly reported faster decision-making processes. Although they were still required to interact with commissioners in the same way, significant time was saved in minimising the amount of communication with strategic health authorities (SHAs). The director of one social enterprise claimed to have freed up two days per week by limiting interaction with the local SHA.

Decisions are made and ‘owned’ by members of these organisations, and efficiencies were made by minimising bureaucracy around decision-making processes. This in turn gave them the opportunity to make changes, provide other services, collaborate with other organisations and provide services in other regions.

A more democratic decision-making structure

The social enterprise model aims to give staff a greater sense of ownership over the day-to-day and strategic direction of the organisation. As such, the hierarchical relationships were reportedly quite different under a social enterprise structure. Directors of social enterprises claimed that, whereas previously there was quite a distance between those who make the decisions at an executive level and the frontline (especially clinical) staff, the emergent structures gave them the flexibility to flatten the decision-making structure and involve all staff in the operations of the organisation.

This more inclusive and entrepreneurial approach allowed staff to be more involved in transformational changes for the organisation, rather than merely transactional decision-making. It also gave them the opportunity to change the overall objectives and values of the organisation. One former PCT provider arm reported that, since becoming a social enterprise, their main objectives are now improving customer service, performance management and staff morale.

However, directors were adamant that ownership over decision-making should also be linked to greater accountability for the outcomes. The traditional bureaucratic culture has led some staff to become disengaged from making decisions that affect the organisation, and in some cases issues were seen as ‘someone else’s problem’. Alongside the greater freedom and control that comes with a flatter decision-making structure, staff were also required to be more accountable for the decisions that were made.

Reinvestment of surplus

In fitting with the objectives of the social enterprise model, some research participants reported that they were reinvesting profits back into the development of the organisation. This was reported to be particularly effective in motivating staff, who were able to see the benefits of operating in a more efficient way.

This benefit – along with those mentioned above – was particularly important for increasing the reported level of staff satisfaction with the organisation. The benefits of increased control and involvement in decision-making were particularly felt by those groups who did not normally have a say in how the organisation was run.

Staff incentives

Some models of social enterprise and employee ownership allow staff to take a proportion of the profits as a dividend or bonus, as well as offering other financial incentives. There was generally agreement – at least at the director level – that staff in these emergent social enterprises were less concerned with financial incentives for performance. It should be noted that our research focuses on directors’ interpretations of staff preferences in this area rather than staff perceptions. The message seemed to be that staff preferred a focus on social and developmental incentives that recognise performance, at an individual, team or organisational level.

Participants mentioned other mechanisms for incentivising staff performance and encouraging greater job flexibility. Some social enterprises had established awards and rewards for performance, other forms of recognition for innovative ideas (such as additional training opportunities) and more flexible terms and conditions (such as allowing staff to buy additional annual leave with their salary).

Interviewees were unanimous in their view that the most powerful aspect of the social enterprise model had been in changing the way that decisions were made within the organisation, significantly more so than profit-sharing or other financial incentives. Further, there was some scepticism about whether profit-sharing would be acceptable to the wider public, particularly given concerns in the current climate about how NHS funds are being allocated. Similarly, many of these social enterprises, having been borne out of NHS provider organisations, may lack the commercial interest to operate in this way. Instead, staff incentives within social enterprises tended to focus more on recognition for good work and providing greater freedom and flexibility (with more influence and control over decision-making).

Summary of findings

Overall, the perceived benefits of becoming a social enterprise do seem to have been realised so far, although most such enterprises in health care are still at an early stage in their development. As well as engaging staff, the main benefits have been:

- saving time by reducing bureaucracy and limiting reporting requirements
- spreading greater accountability across all staff in the organisation, through increasing their ownership of problems and solutions
- reinvesting surpluses into frontline services and staff development.

These benefits reflect those reported in other sectors and are, in many cases, the reasons why organisations established themselves as social enterprises in the first place. The model appears to have been most successful in generating greater staff involvement in decision-making, particularly difficult decisions. Social enterprises have been reported to be more innovative than their public sector counterparts. Therefore, it is possible that engaging staff in making these difficult decisions may be a valuable mechanism for producing innovative solutions to the complex problems facing these organisations.

Key challenges in the setting-up phase

Many organisations experienced a number of practical challenges and difficulties during the establishment phase, particularly in relation to communications and uncertainties about changes to ways of working.

Staff perceptions of changing terms and conditions

Social enterprise directors experienced some challenges in managing staff perceptions of what it meant to be employed in a social enterprise. Many staff were particularly anxious about what the change meant for their terms and conditions. Maintaining NHS pension entitlements was a problematic issue and one of the biggest concerns for staff.

As these organisations have made the transformation from NHS providers to social enterprises, there has not always been a commitment to maintaining pensions or other conditions and entitlements. There were reports that NHS pension arrangements have skewed the options available to emergent social enterprises, including restrictions on their legal form, which in turn could make it more difficult to replicate successful models seen in other sectors.

Many social enterprises have successfully negotiated to maintain existing pension arrangements, at least for staff already employed by the organisation. However, it has become apparent that such exceptions will not be sustainable in the long term, and social enterprises will be expected to set up their own pension arrangements. All staff working in NHS organisations that become social enterprises through the Right to Request and Right to Provide programmes will continue to be offered membership of the NHS pensions scheme. However, staff who join after the social enterprise is set up will not have this right. Providing this certainty on pensions for existing staff was a key factor in encouraging NHS staff to consider transforming their organisation to become a social enterprise (Department of Health 2011a).

Social enterprise directors reflected on these staff anxieties and were generally not surprised by them. Some directors reported that there was a lack of awareness among staff about the need to change. Social enterprise, staff engagement and greater accountability for decision-making may challenge the professional identity of some staff who have a long history of working in particular ways in the NHS.

The NHS is traditionally quite risk averse, and many of those working in it are fearful and sceptical of change. If these providers were absorbed by their local foundation trust under the Transforming Community Services programme, staff would retain their NHS terms and conditions. As such, there was very little surprise among respondents that there was some resistance to what was seen as 'opting out' of the NHS.

Some of the social enterprise directors have had to work especially hard to convince staff that the model would give them a greater role in decision-making and deliver a stronger focus on the customer (the patient). They have also spent considerable time relaying the message that, organisationally, they will no longer be as subject to fluctuations in government cuts and savings, and that they will have greater internal control over spending.

Union opposition

Social enterprise directors reported different experiences with local unions. While some described positive communication and collaborative working to develop the best deal for staff, others had much more disruptive experiences that hindered the progress they were able to make during the implementation phase.

At a national level, some unions have expressed concerns that the growing number of social enterprises in health care represents a step towards the privatisation of the NHS (Unite 2011). It has also been suggested that union opposition to social enterprises was driven by ideology and fears about loss of membership once staff move out of the public sector.

However, social enterprise directors also wanted greater awareness among unions that PCT provider services are being required to adapt to the changing provider landscape. Their concern, as one director put it, is that unions are not 'seeing the bigger picture' – first, that provider reform is inevitable, and second, the financial climate is such that NHS terms and conditions (especially pensions) are unlikely to be maintained at current levels in the future.

However, social enterprise directors reported more variable experiences with local union representatives. While most directors reported experiencing difficulties in communications, a small number described their interaction as much more positive. One social enterprise director felt that their positive experience was a result of continually working together with local unions and developing a formal memorandum of understanding. However, they also acknowledged that their local union representatives may have been more supportive because the social enterprise had been adamant that it would retain the pay system and existing terms and conditions. Had they suggested changes to these conditions, they may have encountered more opposition.

Miscommunications and staff anxieties

The Department of Health, unions and social enterprise leaders (as well as other bodies) have all been involved in communicating with NHS staff regarding the reform agenda. In some cases, these stakeholders have presented conflicting or incomplete information (for instance, on pensions, privatisation and contracts), which has further raised anxieties among staff – some of whom are already sceptical about (or resistant to) change.

One director reported that staff in their organisation thought they would be ‘safer’ and protected from competitive tendering by becoming part of their local foundation trust. There was a lack of awareness that foundation trusts also compete as providers.

One of the directors we interviewed likened the process of overcoming these misconceptions and misinformation to ‘wading through mud’. Many of them, as leaders of their organisations, felt that overcoming these misconceptions was a fundamental part of their role, particularly during the implementation period, when there were many anxieties and unknowns about the future of the organisation.

Staff were often anxious about changes to their terms and conditions, and wanted more information or clarity on what the changes entailed. When staff were given incomplete information, directors found it very difficult to get more accurate information across to them. Even when the misconceptions were refuted, it was often difficult to make assurances and deflate the rumours.

Communicating with staff is fundamental to the ethos of the social enterprise model, which advocates greater staff engagement. Those organisations that had engaged staff in the decision to *become* a social enterprise from the outset reported a smoother process of implementation compared with those who were less communicative during the initial phases of the enterprise’s development.

Directors spoke of ongoing staff scepticism, and staff concerns about whether anything substantial was really likely to change. Many directors felt they had to invest the greatest amount of time overcoming the anxieties and scepticisms of middle management, many of whom were resistant to their authority seemingly being diluted through a flatter decision-making structure. Among the directors we interviewed, there was a consensus that the model will work only if senior executives are signed up to it, as they will then be responsible for ‘winning the hearts and minds of middle management’.

Summary of findings

One of the main challenges in the setting-up phase was addressing staff anxieties about changes to terms and conditions, particularly pensions. Regardless of the type of organisational form the enterprise adopted, it is likely that challenging economic conditions and longer-term public sector reform programmes will necessitate a review of NHS terms and conditions. Although a variety of organisations are providing ‘NHS-funded care’, what it actually means to work for the NHS is not as clear as it once was. There needs to be a review of terms and conditions across providers of NHS-funded care to account for the mobility of staff across the sector.

Conflicting information from different stakeholders and union opposition have done little to allay staff anxieties about changes to terms and conditions. Social enterprise directors have had to invest considerable time and effort in clarifying miscommunications and getting accurate information across. This has been particularly difficult as the reforms have been evolving at the same time.

Although much of the misinformation arose from sources outside of the emergent social enterprises, directors should prioritise clear and complete communication with staff early on in the process (and ideally before taking the decision to become a social enterprise) to ensure as smooth a process as possible.

Future support

The directors we interviewed highlighted the information and assistance needed to support emergent social enterprises.

Participants in the Right to Request programme had access to a range of support options, including financial and developmental assistance. However, this support was available only to those organisations committed to becoming social enterprises and already part of the Right to Request programme. There was less support or information available to organisations that wished to consider a variety of options before deciding on which structure to adopt. For instance, many may have been unaware of the availability of the social enterprise option and the associated support through the Right to Request programme.

Further, although organisations in the Right to Request programme did have access to some support, there were reportedly limitations on the availability of legal, financial and human resource support during implementation (especially regarding structural alternatives, pensions and communicating with unions). Many of these issues needed to be understood and negotiated at a local level, and the limited availability of information and support may have contributed to the confusion, inconsistency and duplication of effort. Much could be gained by emergent social enterprises working together to negotiate these issues and procure the necessary support.

Directors commented that guidance from Partnerships UK, the Social Enterprise Investment Fund and the Social Enterprise Unit at the Department of Health was useful, particularly for developing a business case and connecting with ‘mentors’ – social enterprises already operating in health care as well as in other sectors.

Some directors had felt isolated and uncertain during the phase of responding to the separation of PCT commissioning and provision. There was ignorance across the health service about what was actually possible in practice. This especially related to issues such as asset ownership and profit dividends. There was a lack of centralised information and knowledge of the options available and, more specifically, of the social enterprise model and the Right to Request programme itself.

Some of this supportive function – in particular, mentoring opportunities and support on human resource issues – was triggered through the Right to Request programme and provided through the Social Enterprise Investment Fund. The Right to Request programme’s successor, the Right to Provide (and its attention to a broader range of public services), may go some way to meeting these developmental needs.

However, with the expansion of the model and its increasing promotion across public sectors, it is likely that even more support and development will be required. Within health care, there is also growing interest from some PCT non-provider services (such as human resources, commissioners and information technology departments) in divesting from their NHS base and establishing themselves as a social enterprise in order to tender their services back to the NHS. If the government is to realise its vision of creating ‘the largest and most vibrant social enterprise sector in the world’ (Department of Health 2010a, p 36), it must provide the necessary support and guidance for the organisations and the staff concerned.

Summary of findings

Social enterprises were required to procure their own legal, financial and human resource support during their transformation, which was frequently expensive and inconsistent. Savings could have been made by emergent social enterprises coming together to buy this support. Specifically, social enterprises would value more support with how they respond to the provider challenge, as well as the specifics of social enterprise development.

Regarding the provider challenge, organisations wanted more guidance on the different models and structural alternatives available to them. They needed information on how the Right to Request (now the Right to Provide) programme works and what support it offers. Further, organisations wanted to benefit from the experiences of other social enterprises (in health care and other industries) through an established mentoring programme or forming a network of emergent social enterprises to procure additional support.

Those organisations in the process of becoming a social enterprise wanted more specific guidance and information on legal issues (ie, formal establishment of the specific business model), human resource issues (terms and conditions, pensions, dealing with staff and unions) and how to deal with estates and assets. They also wanted greater advice and guidance on longer-term business planning.

Sustainability challenges

Although emergent social enterprises are seeing a range of benefits, there are also some concerns about their sustainability. As noted earlier, some of these concerns relate to misconceptions about the nature of the reform programme. However, there are other challenges in terms of the external environment and the support available to develop the necessary competencies.

Competition and vulnerability to failure

The promotion of a competitive market for the delivery of health care could create opportunities as well as threats for social enterprises. The diversity afforded through the any qualified provider policy opens up the market to alternative organisational models – NHS providers, private companies, voluntary sector organisations and social enterprises.

Research indicates that employee-owned businesses may be less vulnerable to failure (Lampel *et al* 2010). However, for the reasons given below, social enterprises may actually be more vulnerable than other organisations. Will these emergent social enterprises be capable enough to compete in the competitive health care environment? In the first instance, many of them emerged out of a desire to protect themselves through securing long-term contracts with PCTs available through the Right to Request support package. But no such assurances will be given in future, and these providers will be potentially competing with many others when tendering for services.

Social enterprises may now need to re-tender for their entire contract in an open tendering process. If contracts are lost, staff will face a major upheaval potentially worse than the original threat of re-organisation. However, for most services (starting with a range of community services in 2012), patients will now be able to choose from any qualified provider. This indicates that such ‘cliff-edge’ tendering will become much less common, arguably significantly reducing future risk for those social enterprises providing good-quality services, which can retain the confidence of their users, communities and commissioners.

Operating in this kind of competitive market will require social enterprises to innovate and establish a business orientation, which may not have been necessary when they were ‘protected’ within the NHS system. *Becoming* a social enterprise is an important part of the process, but establishing financial sustainability and growth (and securing other sources of income) will be just as necessary through securing future contracts, developing new products and attracting more patients and referrals. There is a risk that, unless they prioritise these areas of development, social enterprises will struggle to grow and renegotiate contracts with commissioners in this more competitive environment.

Many of the directors we interviewed were also unclear about the implications of organisational failure. For the model to succeed, it is vital that organisations focus on

building capacity and succession planning so that they do not fail when existing leaders move on.

In order to ensure that smaller social enterprises are able to compete with large private providers, they must be properly equipped to operate in this competitive environment, while maintaining their interests and ethos as a social enterprise. In many instances, this will require closer integration and working across providers (formally or informally) to deliver care across a region, ensuring adaptability to local needs, and close monitoring and assurance of quality of care.

Political interference and a changing policy environment

For many social enterprises, part of the motivation for making the transformation was a desire to reduce bureaucracy and increase autonomy. However, concerns remain about whether these emergent enterprises will continue to be subject to political and bureaucratic interference. Some directors reported fears that those now responsible for co-ordinating and implementing the social enterprise agenda may not have the same 'emotional commitment' as those who initially devised the strategy.

There are, therefore, concerns that at some point the government will attempt to 'claw back' some of the autonomy and control that has been granted to these organisations. Community service providers particularly felt that they had been continually targeted for interference and re-organisation, and there was some scepticism as to whether they really will be immune from government interference in practice.

Some of those we interviewed expressed fears that the government's reform agenda was 'just another re-organisation' that will involve significant upheaval and then be subject to future re-organisations. By choosing the social enterprise option and leaving behind the top-down administrative structures of the NHS, the hope was that they would be immune from further re-organisations. Although this would appear to be the case in principle, whether it is actually the case in practice remains to be seen. These organisations will clearly continue to be subject to any commissioning reforms, budgetary constraints or regulatory changes that apply to those providing NHS-funded care. Any changes in the external policy environment will have an impact on social enterprises, and it is vital that they are prepared for any such changes and develop strategies to sustain themselves.

On the other hand, some providers voiced concerns at being 'left alone' too much. The rhetoric of the transformation, the government's Big Society agenda and attempts to reduce top-down control all appear to be desirable concepts. However, there are concerns that social enterprises still need, but do not have access to, the structure and support that accompanies being part of the larger infrastructure of NHS management.

Leadership

Our respondents raised two main leadership challenges that related more to fears about things that could become a problem rather than any issues that have presented to date.

First, some social enterprise directors mentioned that a flatter organisational structure can mean there is a lack of clarity about who is leading the organisation. This may become particularly challenging when there are complex decisions to make. In the same way that an inclusive approach to decision-making is most problematic but also most valuable during challenging times, strong leadership is also a necessary condition for effective operation in the face of difficulty.

Second, some questioned whether they were equipped with the right skills, experience and competencies to lead an organisation through these uncertain times, alongside meeting the significant productivity improvements required of the health service. The more independent model of organisation that comes with being a social enterprise means

that these leaders may not have access to the support they need to guide them through difficult decision-making, as traditional NHS providers may have.

Summary of findings

Social enterprises delivering NHS-funded care may be particularly vulnerable within the emerging competitive environment. Smaller organisations, as well as those that lack a business orientation or that emerged from a motivation to protect themselves from re-organisation, may be particularly unprepared to deal with competitive threats.

In order to survive in the long term and meet the changing needs of commissioners and the populations they serve, social enterprises will need to demonstrate the necessary business orientation and ability to innovate. The leaders of these social enterprises will require support and skills to enable this development and lead their organisation through this process.

Research suggests that the benefits of social enterprises and employee ownership are often more evident in the longer term rather than the short term. If the government is committed to the promotion of social enterprises in health and other public services, it needs to resist the urge to interfere in the short term to allow the longer-term benefits to be realised. Similarly, a commitment to a supportive commissioning environment – particularly through long-term contracts – will provide social enterprises and other new entrants to the market with the stability they need to grow and embed themselves as viable providers.

Opportunities for foundation trusts

Policy developments and political rhetoric since the formation of the coalition government in 2010 have increasingly paved the way for the expansion of social enterprises across a broader range of health care providers. As already stated, the Right to Provide programme encourages acute community and mental health trusts, social care providers, foundation trusts and PCT commissioners (and other support services) to develop staff-led enterprises (Department of Health 2011a).

Progress can be seen most clearly in the opportunities afforded to foundation trusts, which have already been identified as high-performing organisations and granted the freedom to innovate and operate more independently. As such, the innovative nature of the social enterprise model may be an attractive option to further advance their organisational capabilities.

Many of the foundation trust chief executives we interviewed spoke of their motivations for becoming a foundation trust, which were often similar to those of community providers. They included a desire for greater autonomy, as well as reducing vulnerability (to merger or takeover), protecting services, providing a more business-oriented approach, and engaging staff and the local community. With these motivations in mind, these foundation trusts were equally receptive to further innovations (such as social enterprise) that could develop and sustain their ambitions. They were already implementing activities to achieve these ambitions, particularly developing more business-oriented approaches through service line management and enabling staff to take on greater responsibilities in some service areas.

In general, foundation trusts were receptive to the social enterprise model. Chief executives were aware that it was working well in commercial industry and could see how it would translate to the health service. Many had not formally considered a change to their organisational structure, but felt it might be an option for the future in order to cement more autonomous relationships and processes.

However, some chief executives reported that successive personnel and system changes have generated some scepticism among foundation trusts as to whether there is a long-term commitment to foster the necessary competencies to operate in this more autonomous and innovative manner.

Distraction of structural reform

Foundation trust chief executives also expressed concerns that the legal processes of changing ownership and other organisational structures may be particularly complex within the acute setting. Such a move would initially require a change in legislation, as foundation trusts are currently accountable to parliament (through Monitor) and to the governors. These processes may be so complicated that they potentially distract from the model's overall aims of engaging staff in decision-making and achieving greater organisational autonomy. One chief executive said that the scale of change required 'fills me with horror'.

It was acknowledged that there is some ignorance within the service about what is actually possible in practice – particularly around the complex issues of asset ownership and profit dividends. At present, the support and advice needed to guide foundation trusts through these complex issues is lacking. Some chief executives felt that it would be a significant amount of work to change the basic structure of the organisation. Others felt that the benefits of the social enterprise model could be achieved without changing the formal ownership structure of the organisation. As one chief executive said: 'If the outcome is about culture change, frontline leadership and the relationships between staff and their line managers, how much does formal ownership matter?'

However, we should strike a note of caution here. Health care providers already have the freedom to engage staff in decision-making, regardless of policy drivers, but there have been variable efforts to do so across the sector. Changes to organisational structure and governance may, in some instances, be needed to promote greater staff engagement in decision-making.

Spin-offs

Given the government's ambitions for social enterprises and foundation trusts, and bearing in mind the views of foundation trust chief executives we interviewed, it seems likely that particular services or units within a trust will spin off and become social enterprises, rather than the entire organisation opting to make the transformation. Many hospital services are already sub-contracted and provided by outside organisations. For instance, Serco (a private sector service company) currently provides pathology services within a number of acute trusts across the UK, while the Circle Partnership has recently won a contract to manage Hinchingbrooke Health Care NHS Trust.

The chief executives we spoke to saw opportunities for clinical areas within their organisation to spin off into social enterprises and sell their services back to the NHS, managed through an NHS standard contract.

The nurse-led therapy unit at Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust was one of the first spin-offs from a foundation trust, and is one of the Cabinet Office's pathfinder mutuals. In their consultation document, the unit states that their ambition was for 'staff to be accountable and to take responsibility for the care they deliver and the resources that they manage' (Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust 2010). The service became a social enterprise during the Right to Request period (which applied only to community providers). Policies and procedures had to be developed internally and without the support that community social enterprises were given. Since starting up as a social enterprise in 2003, the unit has seen improvements in staff satisfaction and engagement, as well as reduced length of stay, increased patient satisfaction and increased activity (Foundation Trust Network 2009).

Staff engagement versus community engagement

Chief executives did consider greater staff engagement as a benefit of social enterprise. But most of those we interviewed reported that they were already undertaking activities around staff engagement. Smaller organisations in particular did not rely on formal mechanisms or processes, where staff held a strong affinity with the organisation, and the chief executive may have had a closer relationship with more staff.

Other trusts reported more formal mechanisms for engaging staff. One chief executive stated that it is important that staff 'have some skin' in the organisation they work in. All of the chief executives spoke of a desire to engage staff in decision-making and discussed the mechanisms they are using to achieve this.

One chief executive mentioned that their trust was examining models of employee ownership and staff engagement in the commercial sector, and trying to find ways of enabling staff to be more involved in identifying challenges and making suggestions for organisational improvement. Another trust had involved staff in the appointment of the new Director of Nursing; senior nurses were invited to hear the candidates' presentations, they ranked their performances, and had the opportunity to submit questions for further probing in the interview process. Staff gave positive feedback about having the opportunity to be involved in this way.

Several chief executives mentioned that the foundation trust structure itself had not had an impact on staff engagement, although they would welcome alternative structures that would achieve this. Some stated that the governance structure is quite restrictive and focuses heavily on community engagement – potentially at the expense of staff engagement. Foundation trusts are tightly monitored on their membership numbers, and staff-led approaches did not necessarily sit well within that remit. Chief executives did not feel that the current reform agenda would provide any explicit push to build greater staff engagement. Instead, trusts were largely making progress on engaging with staff outside of the formal structures and processes.

Other chief executives were anxious that the government is treating foundation trusts and social enterprises as fundamentally the same. However, through their membership models, foundation trusts are accountable to the public, whereas social enterprises tend to emphasise staff engagement and involvement. One chief executive who was a particular proponent of staff engagement strategies felt that patient and community involvement may be better situated in the commissioning framework, rather than with a single provider. Commissioning (whether through PCTs or clinical commissioning groups) is where the fundamental decisions about local population needs are going to be made, rather than by providers, which will be more 'parochial'.

One foundation trust that had made a deliberate decision to focus on staff representation on its council of governors reported that it did not want the foundation trust governance model to supersede existing mechanisms of staff engagement. Alternatively, another chief executive mentioned that they did not want the organisation to become too insular by focusing on staff engagement at the expense of the wider community. As mentioned previously, one criticism of staff-led approaches is the potential for staff capture, where decisions are made primarily in the personal interests of staff rather than those of patients or the wider community.

Although wary of potential conflicts with community engagement, chief executives believed it was vital for the organisation's ongoing performance to maintain engagement with staff.

Similar to the foundation trust model, whereby multiple stakeholders from divergent backgrounds are members and governors, education co-operatives have established a model that combines a stake for staff alongside other interested parties. In the context of

risks of staff capture (particularly in non-contestable services), this can add a potentially helpful dimension of accountability.

Summary of findings

Recent government proposals suggest significant opportunities for foundation trusts to establish more flexible and innovative organisational structures and models of governance. These proposals initially suggested that foundation trusts could more emulate the values and features of social enterprises. However, the government appears to be backing away from such specific intentions. In particular, the effort and expense involved in foundation trusts adopting different legal structures may be so complex and time consuming that it is likely to detract from the overarching ambition.

Instead, there are now opportunities for foundation trusts to embed some of the aims of the social enterprise model without making significant upheavals to organisational structures and systems of governance. They are exploring opportunities for specific clinical (or other) areas to spin off, as well as mechanisms to achieve greater staff engagement in organisational decision-making.

Many of the motivations and ambitions of foundation trusts resemble those of emergent social enterprises – greater autonomy, protection of staff and services, development of a more business-oriented approach, and greater engagement of staff and the wider community in decision-making. It is, therefore, increasingly possible that foundation trusts will continue to seek out and develop opportunities to achieve the values and aims associated with the social enterprise model.

Conclusion

There are many practical challenges facing organisations making the transformation to becoming a social enterprise, including access to NHS pensions for new staff and the vulnerability of smaller organisations to failure, particularly given the change in payment mechanisms from block contracts and grants to an ‘any qualified provider’ model. Some will fail or, at best, become subcontractors for much larger businesses. However, any qualified provider presents an opportunity for social enterprises (and other emergent providers) to enter the market. The Cabinet Office has stated that social enterprises can be a ‘force for innovation’, which need support through more intelligent commissioning (Leadbeater 2007). All providers will need to be better at demonstrating outcomes, particularly those delivering non-clinical services such as advocacy and support, where outcomes are much harder to measure and prove.

The findings presented here echo those of the recent Co-operatives UK report, *Time to Get Serious* (Bland 2011), which identified the factors that will be important in establishing mutuals and co-operatives across UK public services. These include concentrated business planning and support – during both the implementation and operational phases – and long-term commissioning and political commitment to nurturing the development of the social enterprise model.

Assuming that social enterprises are to be embedded as health care provider organisations, they need time to evolve and to emulate the levels of customer service, quality and innovation seen in organisations in the commercial sector. Social enterprise directors spoke at length about the benefits available to them; however, the extent to which they are exercising these freedoms to innovate or grow is unclear.

Transferring out of the NHS now has additional risks, because organisations will not be protected by the long-term contracts that were initially available through the Transforming Community Services programme. The social enterprise directors and foundation trust chief executives we interviewed gave a clear message that the most

significant feature of social enterprises is their focus on engaging staff in decision-making, rather than offering a package of incentives. However, some felt that staff engagement can be achieved without formally changing the ownership structure of an organisation.

Giving staff a stake in the organisation they work for needs to be combined with much deeper engagement in decision-making than has traditionally been the case in the NHS, particularly when it comes to empowering frontline teams. Changing an organisation's culture is much more difficult than altering its structure, but is essential if further improvements in performance are to be achieved. This has implications for workplace relationships, and requires leadership styles that foster collaborative and inclusive approaches to problem-solving.

There are a variety of options for NHS providers to reap the benefits of the social enterprise model – namely greater staff engagement, flexibility and autonomy, and flatter decision-making – without major organisational upheavals. For example, models such as multi-professional partnerships – extending GP partnership models to others in primary care/social and community care or in secondary care, and multi-professional chambers within foundation trusts – build on the benefits of service line management in providing autonomy and flexibility to clinical teams.

Providers, whether NHS, private sector or not-for profit, cannot wait for the commissioning intentions of clinical commissioning groups to become clear. They need to be proactive, working with others to design high-value services that no commissioner could refuse to buy. Social enterprises are well placed to do that. However, whether the government's vision of the largest social enterprise sector in the world will be realised depends on the motivation of NHS organisations, their ability to overcome barriers and realise the benefits of social enterprise, and whether social enterprise is sustainable in the long term. The opportunities are there; the question is whether staff and their leaders want to take them.

Recommendations for the future development and sustainability of social enterprises delivering NHS-funded care

- Miscommunication and misinformation has hampered the establishment and operation of social enterprises in health care. **The Department of Health must continue to take responsibility for ensuring the accurate dissemination of information about social enterprise and the Right to Provide programme, as well as broader developments in NHS terms and conditions and the support available to emergent social enterprises.** This builds on its existing programme of workshops, site visits, case studies and networks.
- **Social enterprise directors should establish and maintain an open dialogue with staff and external stakeholders in the setting-up phase and throughout operations.** The values of social enterprise and employee participation should be reflected in what the organisation does from its inception. Staff engagement is especially important during challenging periods or when making difficult decisions.
- Central government, the Department of Health and directors of health care providers should not assume that setting up new organisational structures will automatically generate greater staff engagement. **Staff engagement is a necessary pre-condition for the successful development of a social enterprise, but will not be achieved solely as a result of structural reforms.** Other providers can potentially gain this benefit without major organisational upheaval, through developing strategies for staff engagement.
- The protection afforded to social enterprises through long-term contracts at the beginning of the Transforming Community Services programme is no longer available. In these challenging economic times, and with the government committed

to provider competition, social enterprises may be more vulnerable to failure. **It is essential that social enterprises develop the necessary business orientation and flexibility to innovate that will be necessary in a more competitive environment.**

- **Social enterprise leaders should be supported to develop the necessary skills and competencies through national development programmes.** The Social Enterprise Investment Fund should continue to provide expertise, advice and support.
- **The guarantees and provisions of the earlier Right to Request programme should be continued.** Arguably, the programme has been successful because of its commitment to guarantee pensions for existing NHS staff, as well as the investment in awareness-raising and development support, the contract guarantee, and backing from the centre for individual applicants when faced with local, regional and trade union opposition.
- It is likely that the benefits of social enterprises in health care will be seen in the longer term, with potentially limited impact in the short term. To achieve this long-term impact, there needs to be greater certainty around commissioning priorities. **It is vital that the government and Department of Health commit to a long-term support programme and commissioning strategy for emergent social enterprises.**

Appendix A Research objectives and methodology

The aim of this research was to consider the intended and realised benefits of becoming a health care social enterprise, as well as the challenges that have been experienced in practice. As the model is being promoted across a wider range of public services, the paper seeks to identify recommendations for further support and advice for providers, should they consider transforming their organisation into a social enterprise.

Study design

Our research was based on interviews with the directors of 13 existing social enterprises (community providers), 11 acute foundation trust chief executives and 3 mental health foundation trust chief executives (n = 27). During the interviews, we sought to ascertain the views of these organisations on provider transformation in the NHS generally, as well as their experiences in practice and how they were responding to the government reforms.

It should be noted that the directors and chief executives were expressing their own views and experiences on provider reform in the NHS and the development of social enterprises more specifically. In some instances, they talked about the experiences of staff and the organisation as a whole, but it should be remembered that they may not offer an accurate picture of how the reforms have been experienced by all staff.

Social enterprises were identified with the support of the Social Enterprise Investment Fund and the Employee Ownership Association. A range of provider organisations were invited to participate, chosen to represent variety in their stage of progression and their size. They ranged from organisations employing between 5 and 700 staff, with a geographical spread across England. They included GP practices, community nursing providers and entire NHS provider arms. The Social Enterprise Investment Fund and Employee Ownership Association approached organisations to ascertain if they were interested in taking part, and those that were then contacted The King's Fund directly.

Foundation trusts (acute and mental health) were identified using a snowball method of contacts, stemming from initial scoping interviews. These interviews (in conjunction with use of a broader list from The King's Fund contacts database) were used to contact a range of foundation trusts, which were invited to take part.

Data collection methods

The interviews were not recorded but detailed notes were taken, including verbatim quotes where appropriate and relevant. Interviews lasted between 30 and 90 minutes. Most were conducted via telephone; however, several were conducted face-to-face where it was practical to do so.

This analysis does not attempt to provide generalisable findings that are applicable across the entire sector. Rather, the interviews were designed to be exploratory, and to elicit some of the key issues community and secondary care providers are facing at this time.

Data analysis

Data analysis was a staged approach. A thematic coding framework was established based on the research questions and objectives, and this was used to code all of the fieldwork notes. The coded data were then sorted deductively, which provided the basis for generating key findings and learning. The data have been organised into general themes, and links and contradictions between them were examined. The data were then scanned for specific examples and quotes to illustrate and provide evidence for these themes.

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