An Introduction to Social Enterprise and Public Sector Restructuring
Followed by an interview with Penny Brown, Chief Executive, North Somerset Community Partnership

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Introduction

There is no single, universally agreed definition of social enterprise. Doherty *et al.* (2009: 31) suggest that current international definitions (as for example that of the OECD) identify common emphasis on the creation of an enterprise culture to achieve social aims; that is, an application of private sector methods to the achievement of primary aims normally associated with the public and voluntary sectors. They also note cross-national difference in the way the concept is delineated; Italian law emphasises the mode of governance, current UK definitions stress the business character of social enterprise.

Social enterprise is sometimes thought of as the not-for-profit sector and its various organisational forms. More typically it is narrowed to the trading sub-sector of the not-for-profit sector and/or market-focused activity serving a social goal. The last is the conceptualisation dominant in the USA. Social enterprise is sometimes described as 'the enterprising wedge of the social economy' but the idea is contentious. Those who claim authorship of the social enterprise concept in the UK, in the development of social auditing in conjunction with worker and community cooperatives from the late 1970s, distinguish 'US-style social entrepreneurship and venture philanthropy' as the polar opposite of the solidarity-rooted social enterprise movement (Ridley-Duff 2011).

New Labour governments in the UK between 1997 and 2010 promoted social enterprise in the quest, from the turn of the millennium, to mainstream the voluntary (or third) sector in public service provision. Their overall approach in public sector restructuring was shifting from the top-down performance management of public service provider organisations to the policy of competition and user-choice in the drive for efficiency and quality improvement. New Labour's 'third way' philosophy prescribed that ownership was less relevant in the provision of public services than 'what worked'. Public policy statements proposing that social enterprise was similar in value orientation to the publicly-owned public services (could match the public service ethos of public service workers), cast it as innovative, decentralised and enterprising. The public sector was deemed in need of 'modernisation' for a twenty-first century 'consumer age'. An incentive for voluntary sector organisations to be enterprising and compete for public service contracts was the reduction in grant funding (Doherty *et al.* 2009).

The definition now most commonly cited in public policy discussion of social enterprise in the UK was developed by the Social Enterprise Unit that was created in the Department of Trade and Industry in 2001.

> *... business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners (DTI 2002).*

It does not prescribe that social enterprise need to operate on entrepreneurial principles. For Miller and Millar (2011:3) social enterprise , encompassed 'the various organisational forms that in the UK were staking their claim to the emerging social enterprise agenda, which included members of the cooperative and voluntary sectors as well as for profit businesses with a social purpose'. Equally it has been sufficiently loose to generate widely varying estimates of the numbers of social enterprises currently trading in the UK, although government usually cites the Office for the Third Sector estimate for 2006 of 55,000 with a combined turnover of £27bn.

A legal form was instituted for social enterprise that in the UK had not previously had one, namely that of the community interest company (CIC): a limited liability company which carries on a social activity, must be able to generate surpluses to support its activities, maintain its assets, makes its contribution to the community and in some cases can make limited returns to the investors (Office for the Regulator, cited in Doherty et al. 2009: 38). The Office for the Third Sector from 2006 had responsibility for pushing forward the government's agenda for the sector (the DTI's 2002 social enterprise: a strategy for success). Its action plan included improved advice and support, ways of removing barriers in the access to finance and ways of developing management expertise within social enterprise requisite.

In respect to the NHS, New Labour by the mid-2000s was defining government's role as commissioner rather than provider of services. Sir Nigel Crisp, then NHS Chief Executive, proposed a need for entrepreneurial leadership. Miller and Millar (2011) record how that theme of 'intrapreneurs' was extended in the White Paper Our health, our care, our say – a new direction for community services (Department of Health 2006) to embrace staff setting up their own businesses in the form of social enterprise. Action was promised to address barriers to social enterprise formation – staff concerns about their future employment security and that of their NHS pension – and a Social Enterprise Investment Fund was introduced to support the establishment of new enterprises and encourage existing ones to extend within health care. Twenty-six Pathfinders were announced in 2007 and provided funding among other support. The 2008 Darzi Review (Department of Health 2008) also concluded in favour of social enterprise, with a new emphasis on the goal of staff engagement through empowerment, and led to the introduction a staff Right to Request to set up social enterprise. The 2009 Transforming Community Services programme obliged Primary Care Trusts to separate their provider and commissioning wings and find a new home for the former by 2012. Social enterprise was among the possible organisational forms. However, the context was not the most conducive for risk-taking. The NHS was a principal beneficiary of New Labour's investment in public services. Public expenditure retrenchment seemed the prospect in the light of the deficit accumulated in the 2007/8 banking crisis and government efforts to counter economic depression.

The Coalition government that formed after the May 2010 general election has pursued public sector reform and rapid deficit reduction through public expenditure austerity. The idea of a 'big society' alternative to state sector provision has struggled to excite support. The radical reforms of the NHS were trailed as having the aim of creating the largest social enterprise sector in the world. Yet hospitals have been obliged to convert to foundation trust status, which is at odds

with the principle that social enterprise is a voluntary, civil society creation (OECD 2006 in Doherty *et al*. 2009: 30). The proposal that competition for service contracts should be among 'any qualified provider' provoked clinicians' dissent on the grounds that quality and efficiency improvement from integrated health care would be obstructed. It remains to be seen whether social enterprise is on a level playing field to compete for service contracts with private sector multinational enterprise (Bach 2012).

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In conversation with Penny Brown, Chief Executive, North Somerset Community Partnership

Professor Stephanie Tailby, Centre for Employment Studies Research (CESR), University of the West of England, Bristol

About Penny Brown

Penny Brown joined the NHS in 1989, starting in HR in Mental Health before moving into general management in an Acute Trust and into Community Services in 2007. The Labour government's Transforming Community Services (TCS) agenda in 2010 obliged Primary Care Trusts to separate their provider and purchasing arms and providers to find another organisational form. Penny explained the options that were available and why the decision was made to enter a Right to Request to become a Social Enterprise and launch North Somerset Community Partnership.

What was the context and motive for becoming a social enterprise?

Primary Care Trusts were commissioners and providers, a bit like GPs are now. The government's agenda was to separate that and to have a clear line between them. So we needed to find another organisation, either to go into, or set up on our own.

Some community services became part of a Foundation Trust. There was a debate whether we should link in with our local secondary care provider, Weston Trust, and if we did that, would that enable them to become a Foundation Trust? But both before we became a Social Enterprise and latterly, the business case didn't stack up, whether we were in or out.

We engaged with stakeholders and looked at three options. One was to link in with Weston. The concern, particularly from people at the north of our patch which fronts with the Suspension Bridge, was that it seemed a long way away. Would the services become too Weston-centric? A second option was to link in with Bristol Community Services (who also became a Social Enterprise) and become a bigger Social Enterprise. There was a similar consideration: people in the south of the patch, by Weston hospital, didn't want to go into Bristol. Certainly from a patient perception and from the patient groups and the community in general, there was a great wish for us to be a North Somerset organisation and so the only option really was for us to set up as a Social Enterprise.

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for fewer people to be going into hospital. I thought that community services would be growing. So it stacked up as a business case model.

When did the Right to Request policy start?

It opened a lot earlier than the actual Transforming Community Services agenda. But at that point it didn't automatically guarantee your contract. As part of the encouragement to become a Social Enterprise, you'll have to be offered a 3 to 5 year contract, which is very attractive.

That was still under New Labour?

Yes. But when there was a change of government the Coalition indicated they wanted to continue and we all had to be signed off. In fact we were all supposed to be separated by April 2011, but we didn't actually separate until October.

Could you tell me a bit about North Somerset Community Partnership as it exists now? What area do you serve?

Our population is about 205,000. We have 26 GP practices and since we set up as a Social Enterprise, we've reorganised ourselves into five business units, one dealing with people with learning disabilities, which in fact is a joint service with the Council. Our biggest is Community Teams and Wards, which is the District Nurses, Physiotherapists, Occupational Therapists. And we have Clevedon Community Hospital, a range of specialist services and some children's services where the Public Health Nurses are employed.

I think we're the largest non-public sector employer in North Somerset. Our budget is £23 million. We employ 550 staff, of which 360 are shareholders. We decided to make shareholding optional and that's to test commitment to the organisation. We had to set up a Social Enterprise as part of the TCS agenda. It wasn't everybody's wish. We had to go somewhere and so I thought it would be helpful just to see, gauge the temperature by inviting people to become shareholders.

The shareholding is nominal in amount: a £1 share. But it gives staff a right to vote for things which is important. And we've now recently become a member of the Employee Owners Association and I think this is the strategy we really want to develop, really make shareholders feel as though they are shareholders and able to have their say in the way the organisation goes forward.

Social Enterprise is about having social objectives and re-investment of any surplus.

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And you're a Community Interest Company?

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Yes, it is a particular vehicle, although you can have different sorts of community interest companies. I definitely wanted to have staff engagement. That was paramount for me and so we chose to be a Community Interest Company, limited by shares so that it was like John Lewis – and you know all that? We could have been a mutual. We even looked at being a charity. But all in all, we decided that a Community Interest Company with shareholders would be the best vehicle for us to meet our strategic aims of really getting that staff engagement in the services we provide.

What about governance?

We've got a Staff Council. Ten members of it are on our Council of Governors which also includes three Community Forum representatives, so that we're actually hearing the voice of the community. We've got two provider GPs and then we have representatives from North Somerset Council and Weston Trust, as our local stakeholders.

Did you see social enterprise as an opportunity? Did you have fears?

There is opportunity. NHS funding is reducing and so I guess whereas I thought that we might gain bigger contracts, I think now what we need to do - are having to do - is use our Social Enterprise status, as a private organisation rather than part of the NHS, to capitalise on other investment routes, other ways of attracting money. That could be through grants or it could be through developing fee services or by offering training; things that normally, as an NHS organisation, we wouldn't charge for so that we can generate income that way.

What sort of risks did you think of at the time?

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The staff were looking to me to not be sailing them up a wrong river. So I had to be confident that the business case stacked up, the sustainability of the organisation, and that was quite a big commitment. You know, even since we set up as an organisation, things from a funding point of view have deteriorated, so that's always a worry. Money is always a worry. Also, it's getting staff on board with the ethos and believing it's not just because we are a new standalone organisation that things are tough, that that would be happening in any organisation providing NHS services. If things start to go wrong and there are budget constraints and you've just set up a new organisation, people automatically think 'oh, it's because it's a new organisation' rather than this would be happening because we're providing NHS services and the NHS currently is cash-strapped.

We have the one main contract. It was negotiated in April 2010 for four years. It was novated [i.e. the new contract was substituted for the old one] when we set up and then it is novated every April. That goes on until the end of March 2015. I guess my worry now - procurement under the Coalition has become far more, everything is procured. So whereas I was hoping that our contract would roll over, I realise that before the end of March 2014 we'll have to be in procurement to get our contract back again. So a lot of time is spent on writing bids. It's something that really, as NHS staff, we haven't been exposed to in the way that the Virgins and the Sercos have because that's their bread and butter. So it's a whole new skill set that we have to invest in and acquire and it takes a lot of time and resources.

A piece of King's Fund research investigated motives for social enterprise - resignation to the situation, positive aspirations for setting up. Where do you think you sat?

I personally had positive aspirations. I think that some of our staff, particularly those who haven't chosen to become a shareholder, are in the resignation camp, 'this was just something that had to happen'. There are staff who just want to come to work and provide patient care which is very, very laudable, but probably won't maximise the ability that we have now as a Social Enterprise. This is why our strategy for the year coming is to engage as much as we can with staff to get that employee ownership ethos, so that staff can take pride that we are a Social Enterprise and maximise the flexibilities that gives us.

I think there is a difference between organisations that became Social Enterprises under TCS, and those who chose to be a Social Enterprise when Right to Request was first launched. We link quite closely with two other Social Enterprises, both of which chose to be a Social Enterprise as opposed to doing it because they had to make a choice. I think in a way, they have greater staff engagement because at the time there was a genuine choice, whereas for us, there wasn't. It was a choice of three things none of which was staying as you are.

I undertook at the time not to change terms and conditions and I haven't. We are looking at benefits, we have introduced some. We haven't changed any terms and conditions. There were other things more important and I wanted to keep staff on board.

You've emphasised staff engagement and ownership. What other mechanisms are there for staff to be involved?

My intention is a bottom-up approach because I often think that in terms of efficiencies, it's the staff who are best placed to identify them

We have set up an ideas factory. We have our staff awards. We have regular away-days where people can put forward ideas for how they develop their services. In terms of the business managers, all NHS organisations have got to make efficiency savings and we very much delegated that responsibility to business managers. My intention is a bottom-up approach because I often think that in terms of efficiencies, it's the staff who are best placed to identify them.

And you said a staff council?

Yes, we've got a staff council. We set that up even before we were launched, because again I wanted to get that staff involvement. I think there was a little bit of tension at the beginning between the role of the staff council and the role of the unions, but we've got a good JUMP, which is our Joint Union and Management Partnership and we work very openly with them. I think they were pleased that we weren't part of the South West Consortium on changing terms and conditions. I don't know whether you've heard about that? We chose not to be part of that Consortium and they were pleased about that. The staff council will be fully elected. That will be in February.

Do you measure staff engagement?

That has been one of the reasons for making shareholding optional. Away-days are for shareholders only, so that they feel they have a benefit, a stake. We had a big annual general meeting, and again that was just open to shareholders, so more and more we're trying to get the shareholding ethos coming through.

Have you pursued new working practices, new working time practices?

No, but that's our next stage. We introduced the business units in April this year and needed those to consolidate a little before going on to the next stage. We're going to have integrated reports on each team within the business units, so that the team can see how they are doing in terms of some of the HR metrics and the quality metrics and the performance metrics and the financial metrics, all on one page. So I am hoping that that will give some ownership about those metrics and some correlation.

We have had to change staff numbers because we've had, as all organisations, a very challenging cash-releasing efficiency savings programme. So we have changed staff numbers. It's been accommodated through a planned skill mix.

We've got multidisciplinary teams. We are trying to set up services that streamline care delivery. So, for example, in phlebotomy – or taking bloods – that could be trained nurses or health care assistants. We now have trained nurses supervising trained practitioners. It's standardising some practice

How has the NHS environment you're working in changed?

I think the focus has been on reducing hospital bed utilisation and I think that's appropriate. I think many people were staying in hospital beds because there weren't sufficient community services. I think there's a drive to integrate health and social care and we are working very strongly on that, trying to get our partnership arrangements in place. We will be piloting a joint health and social care team. Our community teams were already working collaboratively with social care. For example, some of our nurses can commission packages of social care if it's keeping people out of hospital. Yes, and we've been actively involved with the King's Fund. We attend seminars and the King's Fund were part of the integrated care work stream.

A risk for social enterprise is thought to be the opening-up of competition for health services.

The security of our contract was reassuring. It has given us time to get our act together. I think that you're right though, in that when our contract comes up, Weston or another Acute Trust could compete for it, or Bristol as a neighbouring social enterprise. We have to be really mindful. And then there are the Sercos and Virgins. You've got competition on all sides.

Again employee engagement is vital. Front-line staff would be TUPEd over, delivering the same services. Whether they would be delivering services in the way they want to deliver them under a new commercial organisation is something different.

One of the attractions of Social Enterprise is said to be greater autonomy. Have you had that freedom?

I thought we would be free from all the bureaucracy. But we are still a provider of NHS services and there is clinical governance, the registration, statutory responsibilities and so on.

I guess what is different is our freedom to make decisions quickly. For example, an idea from one member of staff was a volunteer scheme and we've developed that. We now have volunteers helping patients in one of our services. It's great for the volunteers, it's great for the people who are working alongside the volunteers, it fulfils our social purpose and we've been able to do that without having to get the idea signed off. Feedback from staff showed one of the things they really valued was professional education and training. We decided, even though we weren't funded for it, to invest in professional education facilitators, and they've really assisted staff up-skilling. So again, we didn't have to make the business case, we could just do it.

You've mentioned integrated health care. Is there opportunity to move and grow and innovate?

We've got to make best use of all resources. So it's making sure, in terms of our work in social care, that if a nurse can see the patient needs a care package they are able to commission it, rather than having to pass it through to social care to have a person come in and do the same assessment. So we've streamlined there. I think there's still much more that can be done. The feedback from our patients is that they would much rather an intervention from one person. So we are streamlining our processes. We are making sure that we are linking closely with the ambulance service so that, for example, if there is an emergency call and the patient is known to us, we can avoid their hospital admittance. That's very positive. These are early stages but I think that we are looking at patients more holistically. We might not have the capacity through our funded nurses to improve the community service offering. But by engaging with other

organisations or other agencies, we can provide a more holistic care delivery. Again the freedom to be able to have those discussions, as opposed to having to go through a business case, has been helpful.

You mentioned the Fair Playing Field Review

As members of the Social Enterprise Unit we attend many of their events. I think Social Enterprises nationally are feeling there isn't a fair playing field. Monitor is suggesting it may need to regulate us. The costs of regulation by yet another body are quite significant. We are a small organisation, smaller than some of the smallest specialties in a Foundation Trust. Yet that same sort of regulation is required, which becomes an industry in itself.

I think in terms of pensions, that's a big issue. And property: as a Social Enterprise, we can't own assets and that makes our access to capital more difficult. All these issues are being discussed and there has been quite a lot of lobbying. I think Monitor is proposing some new guidance. I'm hoping that that will enable us to offer NHS pensions to any new staff coming in and that would make a big difference in recruitment.

There is the VAT debate. We have to make a 20 per cent saving over and above an NHS organisation tendering for the same services, because obviously they don't pay VAT.

And finally, what is your verdict on progress to date?

Progress is always a lot slower than you want. Separating from the PCT took far longer than I had hoped. Our efforts to engage staff have been slower than we would like. We will need to make a lot of progress over the coming year. But I think we're on the right track. ”