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Right to Request Social Enterprises: A Welcome Addition to Third Sector Delivery of English Health Care?

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Abstract

The English NHS introduced the Right to Request (RtR) scheme in 2008 which enabled healthcare staff working in the public sector to 'spin out' community health services into social enterprises. Staff wanting to spin out had to apply to their Primary Care Trust (PCT) Board which was required to consider their requests and if accepted to guarantee initial contracts of between 3 and 5 years. This paper reviews the RtR scheme and provides an overview of the organisations that have been launched to date. It then considers the implications of the scheme in relation to its implied objectives of improving patient care and empowering staff, as well as the impact on the health and social care system and on the Third Sector more widely.

Key Words: English NHS, social enterprise, Right to Request

Introduction

During the period of the Labour government (1997-2010), Primary Care Trusts (PCTs) in England were responsible for the commissioning of local healthcare services (with commissioning being seen to incorporate 'needs analysis', 'prioritisation', 'market development' and 'procurement and contracting'). They also directly provided a number of community health services, typically community nursing, health visiting and therapy services but also a diverse range of other services such as dentistry, prison health care and sexual health. To enable PCTs to focus on their commissioning role, the Transforming Community Services programme required them to divest themselves of all direct provision by April 2010 (DH 2009). As part of this programme, the Department of Health (DH) introduced the Right to Request (RtR) scheme which enabled and supported healthcare staff to spin their community services out of the NHS and into social

enterprises. The purpose of this article is to provide an overview of the social enterprises that have been launched to date and consider the implications of the RtR scheme in relation to its implied objectives of improving patient care and growing the Third Sector's role in healthcare.

The RtR scheme emerged from a series of policy developments since the mid-2000s in which English health policy sought to increase the role of the Third Sector in the delivery of health care services. The Third Sector has been broadly defined as occupying 'the space between the State and the private sector' and incorporating 'small local community and voluntary groups, registered charities, foundations, trusts and the growing number of social enterprises and co-operatives' (DH 2006a, p2). Whilst the English public often perceive health care to be a largely publically funded and provided service, there is in fact a sizeable involvement of the Third Sector in the delivery of health care services. A mapping completed in 2007 (IFF 2007) estimated that Third Sector Organisations provided approximately £4.7 billion worth of health services each year (the NHS budget in England is approximately £100 billion), with 70% having been in operation for over 10 years. Hospice care accounted for £1.3 billion, with equipment, advice and nursing home care being the other large areas of delivery. Furthermore, prior to the NHS, it was the voluntary sector that delivered the bulk of acute health care and the NHS took over much of this provision when it was established in 1948 – another example of the Third Sector leading, rather than following, the public sector (see Klein 2010 for an overview of the development of the NHS). It is true however that the Third Sector's role is limited in relation to what could be described as the 'core' NHS services, such as in-patient, community health or GP services.

Several initiatives have been developed to promote and support the entry of third sector providers into health (and social) care, including a Third Sector Commissioning Task Force to review the relationships between commissioners and third sector (2006a) and a programme board to ensure that opportunities to engage the third sector were co-ordinated across DH programmes (DH 2007). It is worth noting that the entry of private sector providers within the health services market was also being encouraged at this time, with notable examples including the commissioning of Independent Sector Treatment Centres to deliver a range of elective procedures and the introduction of the 'Any Willing Provider' policy in which patients could choose to receive NHS funded treatment from a variety of providers (see Allen et al. 2011 for an overview of these reforms). Thus it can be argued that the overall goal was to achieve a diverse market of provision in health care rather than the expansion of the Third Sector per se.

Social enterprises were singled out as being the part of the Third Sector that was worthy of particular attention, especially within health care. Defined by the DTI (2002) as "business(es) with primarily social objectives, whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profits for shareholders", approximately 33% of the 55,000 social enterprises identified in a DTI sponsored survey were thought to be working in health and/or social care (IFF 2005). The DH described them as bringing a 'capacity for rapid innovation, flexibility and involvement of users in designing and delivering services' (DH 2006b, p5) through combining business approaches with a commitment to delivering 'social value'. In 2006 a specific DH Social Enterprise Unit was set up and this oversaw a 'pathfinder programme' which supported 26 social enterprises either to be launched or to move into health and social care from other sectors (Tribal 2009). A £100 million fund (the Social Enterprise

Investment Fund (SEIF)) was established to encourage the growth of social enterprises and support their long-term sustainability by providing loan and equity capital (HSMC & TSRC 2010).

In 2008 the final report of the review of NHS services in England introduced arguably the most radical element of the DH's plan for social enterprise, namely the introduction of the RtR (DH 2008a). The RtR gave healthcare staff the 'right' to submit an 'Expression of Interest' to their PCT Boards to set up their services as a social enterprise (DH 2008b). The Board in turn had to consider this request and decide if there was merit in proceeding to the development of a business case. If approval was given then the aspiring enterprise could apply for funding from the SEIF to provide additional management capacity, buy in external support and undertake consultation activities. The business case was then submitted to the PCT Board for it to decide if the enterprise could go ahead. To encourage staff to consider moving out of the NHS they were given the opportunity to maintain their terms and conditions of employment (and most importantly their pensions) and the new organisations were guaranteed an initial contract of between 3 and 5 years before their services could be put out to tender. The new enterprises could choose from several organisational forms, but assets were to be maintained in public ownership, possibly to prevent the selling on of spun-out assets as occurred in transport services in the 1990s.

The following section provides brief overview of the RtR organisations that have been launched to date and considers the implications of the scheme in relation to its implied objectives of improving patient care and growing the Third Sector's role in healthcare. In doing so, we draw from our research in this area, in which we carried out qualitative interviews with organisations that went through the Right to Request scheme (Hall et al. 2012; Miller et al. 2012; Miller and Millar 2011). We also draw upon our research that attempted to map RtR activity. This combines primary and secondary data on the organisational types and characteristics of RtR enterprises that was obtained by contacting the RtR organisations directly (data was obtained from 27 out of 38 organisations) and from publically available data sources (see DH 2010a & NAO 2011). This data was then combined and presented using Geographical Information Systems (GIS) software.

Number, Location and Turnover of RtR Organisations

In November 2010 the Department of Health estimated that 60 social enterprises would be launched (DH 2010a). To date, 38 new social enterprises have been created through the Right to Request scheme, indicating that around a third did not go ahead (a further seven of these may still be established). They were launched over a two-year period, from November 2009 to November 2011, with the majority (79%) being launched from April 2011 onwards (see Fig 1.). The majority of RtR organisations (35 of the 38) took the legal form of a Community Interest Company (CIC); a new organisational form that was introduced in the UK in 2005 to support the establishment of social enterprises.

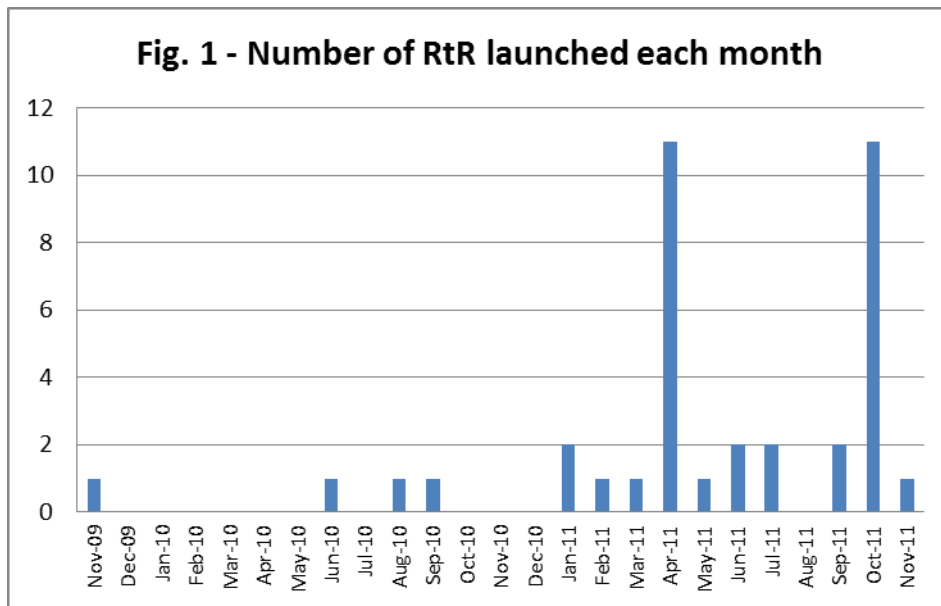
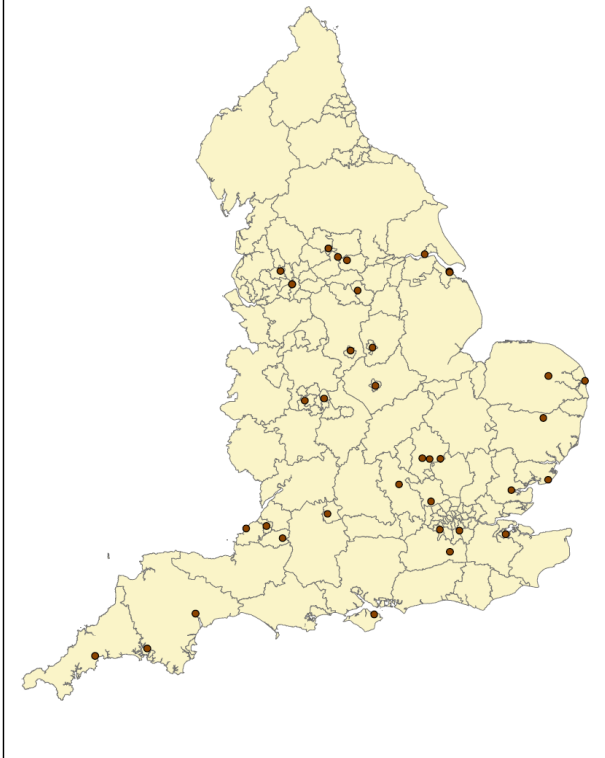


Fig. 2 indicates the geographical location of the new social enterprises, and shows that although they are somewhat dispersed across England, many are concentrated in the East of England (9 RtRs), Yorkshire/Humber (8 RtRs) and South West (7 RtRs) regions. Most notably, there are no RtRs in the North East region. A total of 17 RtRs (45%) comprise a whole provider arm of community services, including primary care and social care for adults and children. The remaining 21 organisations (55%) are mostly made up of specialist community services (e.g. physiotherapy) or general services for a focused group of users (e.g. primary care for socially excluded groups). Overall, 22 RtR services target the general population, whilst the remaining 16 are directed at vulnerable and socially disadvantaged groups, including the homeless, asylum seekers and learning disabled.

Fig. 2 - Location of RtR Organisations



The Department of Health estimated that approximately 200,000 staff, employed within £10 billion worth of NHS services, were eligible to apply for RtR (DH 2010a). Our analysis indicates that at least 22,000 staff are now employed in the new RtR organisations, ranging from 6 to 2250 employees in each social enterprise (see Table 1). Current income for the RtR organisations totals at least £362 million ranging from £220,000 to £94million each (see Table 2). Staff numbers and income are increasing for many of the new social enterprises as they grow and secure new contracts to deliver services. RtR has therefore enabled and supported the transfer of significant numbers of staff and NHS budgets into social enterprise.

Table 1

Number of Employees	Number of RtRs
1 to 10	4
11 to 50	8
51 to 100	3
101 to 1000	7
Over 1000	9
TOTAL	31

Table 2

Annual Budget	Number of RtRs
Up to £500,000	3
£500,001 to £1m	6
£1.1m to £10m	3
£10.1m to £30m	6
£30.1m to £50m	7
£50.1m to £100m	2
TOTAL	27

Discussion: Reflecting on the Right to Request Scheme

The key objectives to be achieved by the RtR scheme were never clearly articulated or quantified and the degree to which it can be deemed ‘successful’ is therefore difficult to evaluate (NAO 2011, Miller et al. 2012). However, the scheme can be seen as part of three key English healthcare policy priorities - improving patient outcomes; the engagement of clinical and other frontline staff; and the role of commissioners in developing an efficient healthcare market with a variety of providers. In the following section we consider the implications of the RtR in terms of meeting these goals. We do so by paying particular attention to the implications RtR has for the role of the Third Sector in the delivery of health care services.

Implications for Patients

In tandem with other parts of the UK, there has been a considerable focus in recent years in the English NHS to improve health and well-being for patients and communities from disadvantaged groups (DH 2010c). This is due to the strong evidence that they have poorer health outcomes than the general population in relation to both life expectancy and well-being (Marmot 2010). Our analysis reveals that several of the RtR spin outs are targeting such groups, including offenders, the homeless and asylum seekers, and they emphasise their commitment to tackling inequalities within their statements of their vision and values (see Table 3). Whilst promoting equality is an integral part of the English NHS constitution (DH 2010b), the RtR process required the enterprises to develop a fresh vision that responded to local needs and interests – the bespoke nature of this vision provides considerable potential for it to act as a ‘rallying call’ that leads to genuine changes in practice.

Table 3

Right to Request Organisation	Targeted groups	Excerpt(s) from Vision
Community Dental Services CIC www.communitydentalservices.co.uk	People with learning disabilities, complex medical conditions, mental health service users, the homeless	‘Improving oral health where people are most in need’ ‘Focus on meeting the

	or those with physical and sensory impairments.	needs of vulnerable groups'
Ripplez CIC www.ripplez.co.uk	Teenage first time vulnerable young parents	'To make a positive difference to the lives of young families'
Bevan Healthcare www.bevanhealthcare.nhs.uk	Anyone who is – Homeless, Living in emergency accommodation, Living in a hostel, temporary or unstable accommodation, Seeking asylum in the UK, A refugee, Struggling to access mainstream healthcare for other reasons	'Any profit we earn must be spent on improving services for our patients and the community that we serve. We are all passionate about our work, which we base on the key principles of our motto "Health Hope Humanity".

Research regarding Third Sector delivery of health services in comparison to the public and private sectors is limited and ambivalent in its conclusions (see for example Allen et al. 2011; Pollock et al. 2007). However, our emerging evidence suggests there is in principle at least the potential for the new enterprises to provide an organisational vehicle in which patients and service users are more empowered over both what is provided and how this is delivered (Hall et al. 2012). In doing so they may be able to address some of the long-standing criticisms that NHS organisations have faced in this regard (Ellins 2011). RtR organisations arguably have both the opportunity and incentive to diversify and adapt their services to meet patients' needs. Indeed their survival as organisations will in large part be determined by their ability to do so, as they will no longer have the safety net of public sector ownership to rely on if demand for their services does not bring in sufficient income.

Implications for Staff

A key policy driver associated with RtR was the empowerment of staff with the intention being to enable clinicians and support staff to feel more engaged with the organisation. In doing so it was hoped that they would feel more able and willing to suggest new ways of delivering care and to adapt their practice. Tables 1 and 2 show that there was a high degree of variability in staff size and income, revealing that the RtR was a possibility for all sizes of organisation. The RtR scheme also covered all service types and users from large primary and community services to small specialist services.

Whilst recognising that the staff group concerned may not unanimously agree to the development of a social enterprise, the RtR process expected that there would be considerable consultation with and involvement of staff in the decision-making process, and that there would at least be general agreement that RtR was the right way to proceed (DH 2008b). Furthermore interviews with a sample of people leading individual RtRs showed their commitment to this being a collective venture and their reluctance for the spin-out to proceed if there was not broad support within the current staff group (Hall et al. 2012). This level of staff involvement in the process does give the organisations a good 'head wind' in terms of staff motivation, but on-going leadership style and development of

meaningful staff engagement mechanisms will be vital for this momentum to be maintained (Ellins and Ham 2009).

Against this optimistic view of inclusive management could be made the fair criticism that many of the staff groups concerned will have worked within the public sector for their whole careers and that there is a danger that the organisational bureaucracy with which they are familiar will be maintained. As a result, staff support may dwindle. Furthermore innovation and the pressure of competition with private providers may require changes to their favourable terms and conditions of employment and this could lead to current and future staff not seeing the social enterprises as attractive places to work. A linked concern in relation to staff (which was raised by unions during the RtR process) is that new staff joining the enterprises are not automatically entitled to join the public sector pension scheme – if the enterprises continue to thrive this will mean a sizeable proportion of the health services workforce being denied what was seen as a ‘right’ of NHS employees.

Implications for the Health and Social Care System

From an English health policy perspective it can be argued that a major purpose of the RtR initiative was to introduce greater competition between healthcare providers in England, and that the organisational form of social enterprise was a more politically acceptable way to achieve this than putting services out for private companies to tender. This competitive pressure would not only be brought to bear on the social enterprises and the services that they deliver but they in turn would compete with remaining NHS organisations working in neighbouring areas and/or in the same area delivering different services. Indeed, there is some evidence that given the right conditions such market pressures can lead to improvement in the quality of healthcare delivered (Propper 2010). A criticism of the RtR programme in this respect is that, in 17 localities, all of the community health services have transferred to a single organisation, meaning that a monopoly enjoyed by the NHS community service provider has simply passed over to the new social enterprise.

Overseeing the local development of a competitive market in health services are NHS commissioners who have had a crucial influence whether RtR organisations become a success or not. It has been documented elsewhere that commissioners are not always clear on what social enterprises are and the additional benefits they could bring (Munoz 2011; Lyon 2007; Miller and Millar 2011). Such difficulty in the commissioning relationship mirrors the experience of many Third Sector organisations in other fields (MacMillan 2010), and the DH Third Sector Task Force (DH 2006a) saw behaviour and culture change by commissioners and providers as being the key to overcoming these difficulties. Commissioning of community health services is in the process of passing to Clinical Commissioning Consortia led by GPs (Dickinson and Miller 2011), and they will have the responsibility of holding the new organisations to account. GPs work as self-employed practitioners who are in general used to the notion of running a business and achieving a financial profit and so they may be more amenable to the ‘enterprise’ components of the new approach. In some cases they may also be in competition with them in relation to, for example, the delivery of community clinics. This could result in some conflict of interests where the dual role of GPs as commissioner and provider come into play. That said, several of the RtR organisations include primary care providers, and GPs within them will be able to participate in Clinical Commissioning Consortia. Perhaps the most important issue in relation to commissioning is the extent to which the new enterprises will be

able to focus on their 'social value' above providing their clinical services, and the interest of commissioners in this social value will be of vital importance.

Conclusion: The Implications of RtR for the Third Sector

Whilst it is possible to argue that the proportion of community health services that will be externalised through RtR is less than anticipated by the DH (2010a), it has led to at least 38 new health care social enterprise organisations being created. Furthermore, 17 of these are 'whole provider arms' delivering core NHS services and therefore in some local areas social enterprise (and thus the Third Sector) will be the main provider of community health services. The establishment of these social enterprises therefore suggests that the RtR scheme (and the policy environment in which it operated) has been able to overcome the many barriers identified by the initial Social Enterprise Pathfinder Programme – these included the long time period required for an initial idea to lead to a service being delivered, the reluctance of staff to leave the employment of the public sector, and a lack of awareness of staff (and patients) regarding the term 'social enterprise' and its perceived benefits over other organisational forms (Tribal 2009). Their guaranteed contracts will provide initial financial security, but after this period they will have to convince commissioners to renew their contracts or face an open tendering process. Whilst in some areas they effectively have a monopoly on community health services, the services that they deliver will over time be steadily opened up to competition as an increasing proportion of community health services come under the remit of Any Qualified Provider (this replaced Any Willing Provider in 2011).

RtR does potentially offer benefits for existing social enterprises and Third Sector Organisations working (or with an interest in working) in the area of healthcare through demonstrating that all types of community health services can be delivered outside of the NHS. They provide potential partners for Third Sector Organisations looking to develop new initiatives which require an element of clinical expertise, and the focus of many of the RtRs on health inequalities and meeting specific individual and community needs gives a common purpose with a Third Sector that has traditionally worked with the socially excluded. However, there are some additional risks. This includes the danger that the RtR enterprises do not lead to the innovation and efficiency that is expected from them or even worse that they fail financially (as was the case for one of the social enterprises launched following the pilot programme). This could discredit the social enterprise model in the eyes of commissioners and / or patients, and also question the amount of energy, time and funding that will have been required to support the development of the RtR organisations. The new social enterprises will also be additional competition for existing Third Sector organisations in terms of both applying for tenders and take up by patients. However, the RtR enterprises should be able to develop a strong new brand that combines the history of the NHS, the innovation of business and the principles of the Third Sector to make a persuasive sales message. They will also be able to apply for Third Sector grants that were denied to them as part of the NHS, and to appeal for charitable donations from individual benefactors and corporate sponsors. This could generate new funding sources within a local health economy but equally could result in a crowded market becoming even busier.

The coalition government elected in 2010 quickly confirmed their ongoing commitment to this policy area, with the new Health Secretary memorably calling for the NHS to become 'the largest and most vibrant social enterprise sector in the world' (DH 2010d, p36). The outcomes against which these changes should be judged are the extent to which the RtR social enterprises can lead to

improvements and innovations in patient care, and also if they do open the door to greater Third Sector involvement in delivering clinical services with added social value. It is too early to tell if these will be achieved but there is room for cautious optimism that the RtR enterprises will indeed be welcome additions to the Third Sector. Capturing the impact of transferring services from the NHS to social enterprise will be vital to evaluate the overall success of this programme, which has potential lessons not only for England but for other countries looking to undertake a similar 'spinning out' process to grow the role of Third Sector in an area of public sector delivery.

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