Community Health Services: Made Mutual

mutuo

By Cliff Mills and Chris Brophy

Capsticks

About Mutuo

Since 2001, Mutuo has worked to promote new mutuals. This has led to renewed growth in the mutual sector, with public sector mutuals established in health, housing and education and new community based businesses ranging from football to childcare.

- Mutuo operates as a not-for-profit Society, committed to:
- Campaigning for a better understanding of the benefits of mutual businesses
- Conducting and publishing policy research on issues of importance to the mutual sector
- Developing innovative new mutual businesses for the delivery of public services

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1 Executive summary

NHS community services are undergoing a sea-change.

These fundamental services which rarely attract the headlines – including health visiting, midwives, rehabilitation, community and specialist nursing, therapies such as speech and language, physiotherapy and podiatry – account for about 10% of NHS expenditure.

As part of the Coalition Government's plans to create the "largest social enterprise sector in the world", a significant number of community health service providers are being separated out from Primary Care Trusts and established as independent social enterprises.

Four of these new providers, which are featured in this publication, have been set up as member-based organisations, with democratic governance, and a professional board of executive and non-executive directors. As independent trading organisations, they need to operate in a business-efficient way and to make a profit (income exceeding expenditure) in order to survive; but they exist to provide services for the public benefit, not to trade for private benefit.

Although they are no longer state-owned and controlled, they are constitutionally and culturally committed to providing services for the public benefit, according to traditional NHS values and principles. They are led by people who are convinced that this is the way to secure the long-term future of NHS services.

These new organisations are not yet well-known or understood; but they are examples of the future of public ownership.

... part of the Coalition Government's plans to create the "largest social enterprise sector in the world"

“Within the NHS, a dramatic new course was set by the last government by the creation of a new form of ownership – NHS Foundation Trusts.”

2 Introduction

This publication concerns the future of public ownership.

Ever since the reforms of 1948, the concept of public ownership has been synonymous with state or municipal ownership. But since the early 1980s, this form of public ownership has been in decline, driven by a combination of political, managerial, fiscal and other reasons.

Within the NHS, a dramatic new course was set by the last government by the creation of a new form of ownership – NHS Foundation Trusts. These member-based, locally-owned providers of healthcare are no longer directly owned and controlled by the state, and have their own form of democratic governance.

In its White Paper, Equity and excellence: Liberating the NHS, the Coalition Government announced that it was their aim "to create the largest social enterprise sector in the world". This was to be achieved by increasing the freedoms of NHS Foundation Trusts, and by giving NHS staff the opportunity to have a greater say in the future of their organisations, including as employee-led social enterprises.

This is a vision for the future of NHS provision which ranges from organisations established under the relatively restrictive statutory arrangements applying to Foundation Trusts, to something much less-well defined but including "employee-led social enterprises". Whatever else it implies, it clearly heralds a future where direct state ownership and control of NHS provision will be substantially reduced. It leaves open the question of what sort of public-service organisations will replace traditional state-owned providers. What is the future of public ownership?

The extent to which Foundation Trusts are in practice no longer controlled by the state is clearly debatable. The concept as established by the previous government introduced a basic separation and independence from the state, and a move towards local community ownership, but with a strong role for the Independent Regulator (Monitor), and substantial continuing state control through commissioning. The Health and Social Care bill looks likely to increase the freedoms, and to change the role of Monitor.

But what about those services which do not have a future within a Foundation Trust, but wish to continue as public service providers within the existing ethos? What are those services, and what sort of organisations will they be or become? What does it mean – for staff, patients and tax-payers – for them to be classified as part of "the largest social enterprise sector in the world"?

Community services

NHS Community Services are at the centre of this debate. They include an everyday range of fundamental services which do not tend to have the profile of general practice or acute (hospital) services, but which are vitally important: district

“Whereas legislation in 2003 provided a framework to transform acute (hospital) trusts into NHS Foundation Trusts (followed rapidly by mental health trusts and then care trusts), no such process was established for community services. ”

nursing, health visiting, midwives, physiotherapy, rehabilitation, speech and language therapy and many other services which can be delivered in a community setting. Community services represent 10% of the NHS annual spend, a total yearly investment of more than £10 billion based on the current NHS budget,[1] and over 200,000 staff are involved in delivering these services.

In recent years, community services have been under the ownership and control of Primary Care Trusts. The main function of PCTs was to be commissioners of health services, and the ownership of substantial service-provision did not sit comfortably alongside this commissioning role. Since at least 2008[2], health policy has been for the provision of community services to be internally separated within PCTs, and for future alternative ownership options to be explored.

Whereas legislation in 2003 provided a framework to transform acute (hospital) trusts into NHS Foundation Trusts (followed rapidly by mental health trusts and then care trusts), no such process was established for community services. The policy was to leave this to local determination, with no ideal form being prescribed. The suggested options included Community Foundation Trusts, social enterprises, and integration with other NHS organisations. Currently, there are fourteen aspirant Community Foundation Trusts – the first due to go live in 2012.[3] However in the majority of cases, the choice has been to transfer into existing NHS Trusts or Foundation Trusts, or to set up as a new and independent social enterprise.

Social enterprise

The debate about what is meant by “social enterprise” can be a dry and tedious one, descending into comparisons of different legal forms, and how the phrase relates to other particular words and phrases such as mutual, co-operative, and employee-ownership. The essence of the matter is (1) whether an organisation is intended to exist for a private purpose or a public/social purpose, and (2) what sort of ownership and governance arrangements are in place, and how appropriately they underpin and protect that private or public purpose. Both of these issues will be explored further below.

To date, 47 projects involving community services providers within 41 PCTs have chosen to go down the social enterprise route.[4] These have all proceeded using the Right to Request process, a staff-led procedure introduced by the NHS in 2008, which was open until 30th September 2010, with some projects still to be completed. Some 25,000 NHS staff will have been involved in this process, amounting to approximately 10% of those in community services, with a projected annual turn-over of £900 million, about 11% of total spend on community services.[5]

1 NHS Information Centre

2 See NHS Operating Framework 2008/09; also see Transforming Community Services: Enabling new patterns of provision DH January 2009

3 Health Service Journal (HSJ) April 13th 2011

4 DH website

5 Mark Thaxter, Social Enterprise Unit, 15th September 2011

From March 2011, a new Right to Provide[6] process was introduced, giving staff of NHS trusts[7] the right to take the initiative to become independent social enterprises.

Outside the immediate NHS context, the nature and scale of change to community services is not widely understood. Nor is it widely recognised that a substantial part of the transformation of the NHS which is taking place is to bring these important services within a new form of ownership, which is no longer state-owned and controlled, but where those engaged in delivering and managing the delivery of those services remain fully and permanently committed to traditional values and principles of public service delivery.

But what is this form of ownership? How can it be said to be "public service" or even a form of public ownership, and how are those involved committed to serving public, rather than private interests? Are they in reality stalking horses for privatisation, just one step away from ownership by a PLC?

This publication sets out to tell the story of four of these organisations, involving over 3600 staff, providing services to nearly a million people. These four organisations have all adopted a form of member-based ownership and governance, drawing on traditional mutual concepts and principles. They are all based on direct engagement with staff and service-users, local accountability and control, and a conviction that this model of ownership is the best way to deliver these services for the benefit of service-users, to optimise the use of available financial resources, and to provide a working environment in which staff will be most fulfilled and effective in carrying out their roles.

These organisations are Anglian Community Enterprise (ACE) Community Interest Company which commenced trading on 1st January 2011[8], Medway Community Healthcare CIC which commenced trading on 1st April 2011[9], Your Healthcare Community Interest Company which commenced trading on 1st August[10] 2010, and Care Plus Group (North East Lincolnshire) Limited which commenced trading on 1st July 2011. This publication is based on interviews with their managing directors/chief executives, Lynne Woodcock, Martin Riley, Siobhan Clarke and Lance Gardner.

This publication, which will also give a thumbnail sketch of the four organisations, will proceed by exploring the following subject areas:

- Why these providers chose to go down this route – what motivated them and what they hoped to achieve?
- What sort of organisation they are – their overall ownership and governance arrangements, the relationship between structure and culture?
- How they aim to succeed as social enterprises, and the new public sector.

[6] Making Quality Your Business: A guide to the right to provide DH 30th March 2011

[7] Staff of Foundation Trusts, Arms Length Bodies and Special Health Authorities do not have the same "right", but they are encouraged to follow a similar process.

[8] http://www.acecic.co.uk/

[9] http://www.medwaycommunityhealthcare.nhs.uk/

[10] http://www.yourhealthcare.org/

3 Motivation: why did you change?

Choosing to become social enterprises was certainly not the easy option. In an environment used to strong central control, setting off on an ill-defined path, with no statutory framework (as for Foundation Trusts) and no clear precedents (as with transfer to other NHS trusts) was clearly challenging for all four organisations. They all required strong, independently-minded leadership, to take staff with them and to overcome hurdles. Why did they choose to do this?

Service commitment

That leadership displays a strong degree of commitment – a genuine recognition of the need to transform community services, to become more efficient and change in order to survive, driven by a commitment to meeting the needs of the different local communities. In all four cases, the journey involved personal risks for their leadership, but which they were willing to take because of their belief that the outcome would be better for patients and service-users. There is a clear personal commitment to care.

Although these organisations have, as some would characterise it, opted out of the system, and chosen to become independent self-standing organisations, there is a strong sense in each case of a fundamental commitment to NHS values and ethos. They have chosen to go down this route because they actually believe that this is the most likely way to improve and maintain core NHS community services: it will enable them to become better providers. Their current arrangements within the PCT were restrictive, holding them back from transforming their services in the ways they planned. Transfer to another NHS trust would have been the "least change" option, and not the enabling, transformative change that was needed. In one case where there was previous experience of being part of an acute trust, there was experience of how this had made the service more vulnerable as resources were sucked out of the community to meet other priorities.

So the starting point for pursuing the social enterprise option was a specific focus on service-provision, and practical experience that a different approach was needed in order to meet the high standards which patients and service-users deserved (and tax-payers were paying for). Becoming part of another trust was not seen as likely to deliver this; and none of the organisations ultimately saw the Community Foundation Trust as a viable option – they were probably too small, and saw this option as likely to continue to constrict them in development, given the prescriptive membership and governance arrangements.

NHS public service commitment

Although they have therefore become independent, self-standing organisations, they have become social enterprises as they believe that that is the way in which the permanent future commitment to an NHS public service ethos can be maintained (in one case where a fully integrated health and social care model has been in place for 4 years, those who were previously local authority staff were happy to sign up

> "There is a fundamental belief that the business should exist to deliver care, not to maximise profitability."

to NHS values and principles as well). We will consider below what that means in terms of the design of the organisation and its legal/constitutional commitments, but suffice to say at this point that choosing the social enterprise option was strongly driven by a commitment to a social purpose, to reinvesting any surplus in the interests of the local community, and specifically setting up arrangements to distinguish themselves from privately owned providers. They exist in order to provide services for the public or community benefit, not for private benefit.

There is a fundamental belief that the business should exist to deliver care, not to maximise profitability. But there is also a belief that to achieve the best value out of tax-payers' funds (especially where money is tight), the delivery of care should be achieved in a business-like way, responsibly and commercially managed. Being a business means that making a profit (income exceeding expenditure) is necessary in order to survive and grow. Being entrepreneurial and imaginative is an important part of this. But the organisation exists to fulfil a public need, not to make profits for private benefit. The basis on which the organisations trade – their core values – are very important to them and underpin their method of operation.

In this sense, whilst the social enterprise option sets out to challenge privately owned providers by operating for the public rather than private interest, by becoming an independent business and vulnerable to failure it is also a significant departure from being within the protective environment of an NHS Trust. There is a high requirement for self-belief.

Flexibility

In discussing the motivation for becoming a social enterprise, flexibility is mentioned frequently. These organisations are serving diverse communities, with their own particular characteristics in terms of socio-economic diversity, ethnicity, age, and geography. They are also providing services within a specific health economy, with competing and collaborative relationships with a range of other service providers including statutory, community-based, charitable and privately-owned. By their very nature (compared with the services of an acute hospital), community health services are more mobile, subject to change and threats, and need to be able to develop rapidly to meet changing needs.

Flexibility in this context includes a range of aspects: flexibility in service-provision to meet the different and changing needs of a diverse population; flexibility to partner with a wider range of organisations, in radically different ways; flexibility in management and decision-making, so that change is not inhibited by structures and the need for permission or authority from elsewhere, or bogged down by repetitive bureaucratic processes; flexibility to allow staff to innovate, and contribute their ideas and thoughts both to improve services and reduce costs.

The latter point (staff involvement) will be explored further below in the context of culture, but at this point the relevant issue is providing an environment in which frontline staff can drive change when redesigning services, rather than service directors with a white-board behind closed doors. Breaking

"Becoming a member and owner of the organisation is a major change. It immediately denotes a different role and relationship, even if it will take some time for the implications to become understood and fully effective."

down silos between service-lines is also needed to succeed in this way, and becoming an independent business helps to develop a culture in which staff work proactively across services to find better solutions.

Part of having improved flexibility depends on greater freedom and less bureaucracy. Whilst there is some immediate evidence of this (such as freedom from central purchasing and the ability to buy locally, and no longer having to spend so much management time providing almost the same assurance to PCT, SHA and the Department of Health), one of the draw-backs for the social enterprises is that commissioners do not necessarily know and understand them. This is one of the challenges for the future discussed below.

Also seen to be very important is the flexibility associated with being in control of their own activities and destiny, and having the ability to choose which partners to work with. One of the social enterprises has successfully tendered for Out of Hours work in partnership with an independent provider, another has successfully competed with an acute trust in a tender for a stroke service, and they all are considering ambitious plans for the future in terms of development of their business.

Staff involvement

This was a powerful driver for all four organisations to become social enterprises. Enabling staff to have a say in the running of the organisation and to influence its development were clearly seen as important both in terms of improving services, and being a successful business. There is a strong sense in which staff had become disenfranchised; they were not engaged and so they did not expect to do more than carry out their functional role. Empowering staff was fundamental to enabling the organisation to fulfil its potential, and to capturing their knowledge and ideas. There was also recognition that if staff were going to buy in to the level of change and future risk, and share in the search for solutions to problems, then they needed to have some form of ownership of the organisation, and could not merely be spectators.

Becoming a member and owner of the organisation is a major change. It immediately denotes a different role and relationship, even if it will take some time for the implications to become understood and fully effective. However already all four social enterprises have been involving staff in the development of their organisations – in developing their governance arrangements, designing their image to the outside world, influencing new management structures, developing ideas about incentives to provide a basis for increased pay, taking responsibility for internal communications, and of course working with patients and community to influence services and service-delivery. How far staff influence will develop remains to be seen, but at least one of the organisations sees staff influencing the managing director's personal objectives and remuneration.

All healthcare services depend upon staff for their success and continuing viability. However, compared with the acute sector, community

services rely on limited physical assets, and staff form the main component of their establishment. Those staff carry out a significant part of their work in people's homes, or in locations close to where they live in the community. Being out in the community, working alongside other organisations, carers and health professionals, staff have insight and opportunities which can be of great value to their organisation, and ultimately to their patients. But the value of this insight and these opportunities is unlikely to be captured if staff do not feel that they are part of their organisation, able to influence the future and to contribute to its success.

The relationship between staff and the organisation is therefore fundamental. They are not just employees; they need to be seen, and to see themselves, as key participants and contributors to the business – owners, with a sense of responsibility for whether it succeeds or fails, and whether it is providing their patients and service-users with the care they need. Clearly this is understood within the leadership of these four organisations, and they have started a process designed to create new relationships, and effectively to break down the historic employer/employee divide, which can disempower the individual to the detriment of the service.

Ownership

The term "ownership" is being used to describe the role of members – but what exactly does it mean here?

The members are the owners in the sense that nobody else owns the organisation – neither the state, nor investors, nor any other organisation. Only the members can agree to any changes to the constitution, and ultimately (as will be explained further below) the directors are accountable to the members for the running of the organisation.

However, it is not a form of ownership that can be sold. In today's world, we are only really familiar with a form of ownership in which the subject matter can be sold for money, or generates money. But that is not the case with these organisations – they are owned by their members on behalf of the wider community. The members derive no financial benefit from being a member. This is not "John Lewis public services", where the annual profits are shared out amongst the staff at the end of the year. It is a form of ownership in which the members are custodians for the time being of this organisation – making sure it delivers what it is supposed to do.

In at least one of the case-studies, there is already a noticeable difference in the way that the organisation is being treated and regarded within its community. Being independently owned, but committed to a public purpose, it is regarded as neutral – an "honest broker" – and not regarded as threatening by commissioners, local authority or others.

"The constitutional arrangements created by these different types of legal structure ensure that the registered organisations are legally and constitutionally committed to carrying on their business for the benefit of the communities which they are serving, and not for private benefit."

Early days

These are all still young organisations, which have only been in existence as independent businesses for a short time. The reasons why they went down the social enterprise route are clear, but some of the perceived benefits of this format will take some time to develop to their full potential.

What is clear, even at this stage, is the basis on which these four organisations see themselves as having been established.

- They exist to provide care services, according to the traditional NHS ethos.
- They operate as independent businesses that need to be profitable to survive.
- Their method of trading is underpinned by values which are fundamental.
- They are set up as member-based organisations to give their staff a real say in the running and ownership of the organisation.

4 What are these new organisations?

Legal structure

Community interest company

Anglian Community Enterprise, Medway Community Healthcare, and Your Healthcare are all incorporated as community interest companies. This is a relatively new legal structure created by legislation in 2004, which provides some legal assurance that the business is being carried on in the interest of the community, rather than for private benefit. What is this assurance?

First, before a community interest company can be registered, the Regulator must be satisfied on the basis of the Community Interest Test that their activities are being carried on for the benefit of the community. This must be confirmed annually by the directors by means of a community interest report. The Regulator has a range of enforcement powers in the event, for example, of failure to continue to satisfy the community interest test.

Once registered, there are restrictions in the constitution prohibiting the distribution of assets (ordinary limited companies are not so restricted, and can therefore operate for private interest). Subject to certain exceptions, the so-called "asset lock" prohibits any distribution of assets including on a solvent winding-up, and puts a limit on any dividend payable to shareholders. Whilst in practice this allows distribution of profits, the four organisations the subject of this publication all contain express commitments in their constitution to retain profits for the benefit of the community. Furthermore, no member or shareholder can hold more than one share, making it impossible for any one shareholder to control the organisation.

Community benefit society

Care Plus Group is incorporated as a community benefit society. This is one of two types of industrial and provident societies (the other being the co-operative). A community benefit society can only be established if the registrar is satisfied that the business is to be conducted for the benefit of the community.

In order to be registered, the constitution must prohibit any benefit going to members, either by way of dividend out of trading surplus, or by way of capital distribution on a solvent winding-up. As with the community interest company, there is an asset lock to protect accumulated reserves, ensuring that all surplus is retained and applied for the benefit of the community, and not for the private benefit of members.

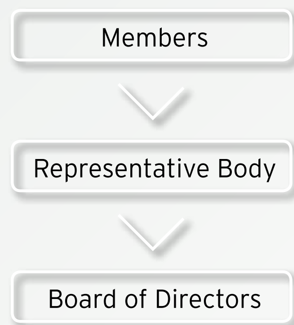
The constitutional arrangements created by these different types of legal structure ensure that the registered organisations are legally and constitutionally committed to carrying on their business for the benefit of the communities which they are serving, and not for private benefit.

Ownership and governance – the model

The choice of legal structure provides a base-line for understanding the nature of the organisation (i.e. community interest company, community benefit society), but it is the ownership and governance arrangements which establish the day-to-day basis on which it is run. How are our four case-studies set up?

“What is the role of the representative body? Its key role is to influence the direction and strategy of the organisation as a whole, bringing into the formal governance arrangements the viewpoint of key constituencies of interest.”

All of them have a similar basic framework, namely members, who elect the majority if not all those who serve on a representative body; and a separate board of directors comprising a majority of non-executives, and a minority of executive directors.



This basic model follows the pattern of Foundation Trusts, and other new mutual organisations. It represents a significant development from more traditional member-based models, where it was common for the board of directors to include representatives of stakeholders. Stakeholder boards can be problematic with conflict of interest issues, and an inability for the stakeholders properly to promote the viewpoint of those they represent, given their duties as directors.

The more modern approach keeps the representative function outside the boardroom, specifically enabling the interests of those represented to be expressed and to carry influence via the representative body. The board of directors is then comprised solely of those who fulfil criteria for skills and experience, either as appointed (employed) executives, or as independent non-executives.

What is the role of the representative body? Its key role is to influence the direction and strategy of the organisation as a whole, bringing into the formal governance arrangements the viewpoint of key constituencies of interest. In this way, it links those carrying ultimate responsibility for running the business and delivering the services, to those actually delivering the services on the ground and those receiving the services.

The specific roles of the representative body therefore include: working with the board of directors in developing strategy and future plans, overseeing membership strategy, appointing and removing non-executive directors, and working in other ways to support the board of directors. The representative body receives regular reports on the progress of the business, and with the wider membership it provides the mechanism by which the board of directors is held to account.

Ownership and governance - specific arrangements

Each of the four social enterprises has slightly different arrangements.

ACE

Membership is open to permanent staff. Staff elect 12 of their number to sit on the representative body, called the Staff Council. In addition, there is a Community Forum, the outcomes of which must be taken into account by the company (see case-study). The board

comprises not less than half non-executives one of whom is chair, and executives including a managing director, director of resources, clinical director and director of operations.

Medway Community Healthcare

Membership is open to permanent staff as defined in the Elected Members Strategy. Staff elect at least 12 of their number to the representative body, called the Elected Members Forum. There is a Community Forum, the outcomes of which must be taken into account by the company (see case-study). The board comprises not less than half non-executives (minimum of four) one of whom is chair, and executives (minimum of four) including managing director, finance director, and clinical lead or medical director.

Your Healthcare

Membership is open to all employees (Staff Members), and to service-users, carers and volunteers (Community Members). The representative body, called the Council of Governors, comprises 9 Community Governors, 4 Staff Governors, and not more than 4 Appointed Governors, appointed by organisations approved by the Governors and Directors. The Board's chair must be a non-executive director, and executive directors must include a chief executive, a finance director, and a healthcare professional.

Care Plus Group

All those employed by or carrying out functions for the organisation (but not including volunteers or independent professional carers) are members, unless they choose not to be. The representative body, called the Council of Governors, comprises 8 Staff Governors, two Local Authority Governors, two GP Governors, and three Community Governors. More than half of the board of directors (minimum of 4) are non-executives, one of whom is chair, and one of the executive directors is the chief executive.

The basic governance model which underpins all four of these organisations is still comparatively young (first implemented in 2004), and the roles and responsibilities of the representative body are still evolving. It is evolving because this model is designed to accompany a change in culture, away from a top-down hierarchical approach, towards a more collaborative and engaging approach. It seeks to bring the key constituencies of interest of that community inside the organisation and its governance, enabling them to work together to optimise the resources and opportunities available, in the pursuit of the organisation's ultimate aims.

This culture change is still in progress. The vision to create the "largest social enterprise sector in the world" builds on the introduction of Foundation Trusts in 2003, the development of new member-based models for out of hours GP services from 2004/5, and the promotion of social enterprises in community services from 2009. This represents very significant reform of NHS provision, and the scale and extent of change brought about must not be under-estimated. There is a very significant culture change underway,

involving the opening up of NHS provision to influence by staff, patients, service-users and carers, and it should come as no surprise to learn that the model needed to underpin this new culture needs to be allowed to evolve.

Structure and culture

There can be a tendency to focus on change of structure as an end in itself. Certainly, on transferring out of ownership by a Primary Care Trust, establishing a new structure is an essential component. But it is always important to recognise that legal and constitutional arrangements are a means to an end, not an end in themselves. They exist to provide a framework for the holding and operation of a business or service, and need to be designed to enable that business or service to succeed in its vision, strategic and business plan.

This type of structure is designed to underpin and support a social enterprise approach, a collaborative and participative way of working, committed to NHS and public service values and the other factors identified above. But becoming a social enterprise, and adopting the mindset of an independent business, locally and directly accountable, with staff playing a real role in everyday matters affecting the business – this is a very big step from the institutional NHS background.

You can provide the opportunity for people to become members, to be elected onto a representative body, and to have the chance to hold directors to account, but that of itself does not make those things happen. Where people have little or no previous experience of those activities, or that way of working, it will take them some time before they understand what it possible, what is expected, and what they might want to do from their own perspective. Getting the culture to change is a major and long-term exercise, which can ultimately only be achieved through peer-pressure, though clearly the lead has to be taken by management.

All four organisations have experienced the extent to which, from the point at which they started on the pathway towards becoming an independent social enterprise, their organisation and the relationships within it started to change as people started to realise what it meant. Starting to get people interested, involved in a dialogue – at first about things of immediate relevance to them, but over time of wider significance. They need to see things happening and changing, and realise that they have influenced those changes. The four organisations have all followed their own instincts and ideas in how to build engagement, with a range of plans in the pipeline including road-shows to staff groups, use of the annual members meeting to highlight exemplary teams, choosing how to spend funds earmarked for community initiatives.

The culture change is not just in terms of engagement as members and via the representative body. It also involves becoming aware that there is not simply an entitlement to an annual pay increase for continuing to do the same job: if the business is to prosper,

"The changes needed are at all levels of the organisation. It is not only those involved as health professionals delivering services to patients."

pay increases need to be based on an element of performance, cost and efficiency savings. There are already clear indications of progress in this, providing a basis for the message to travel through the work-force by peer-pressure, rather than from management.

The changes needed are at all levels of the organisation. It is not only those involved as health professionals delivering services to patients. It involves a very significant change for those in management, for whom this way of working is unfamiliar and at first challenging.

The changes which are underpinned by these new ownership and governance arrangements have the effect of breaking down hierarchy and professional (or service-line) barriers, giving staff the confidence to have ideas and to share them, and enabling a collaborative working environment to evolve which can shape the future business, helping to optimise the level of care and finding the commercial opportunities which will enable the business to prosper for the benefit of those whom it is serving. It invariably leads to a more open, transparent and accountable working environment.

Public and community involvement

All four organisations are clear about the importance of the role of patients and service-users in influencing the service, and for the organisation to exist for the benefit of them, not staff. How to introduce the voice of service-users is not straightforward. Two of the social enterprises have provided in their constitutions for community forums, one provides for community representation on the representative body, whilst one provides for community membership (see case-studies).

Foundation trusts adopted the route of public membership, with an option for a separate constituency for patients and carers. There are mixed views about the success of the public membership model of Foundation Trusts, perhaps partly to do with the somewhat unclear nature of the role of membership, but also the rather prescriptive nature of the membership arrangements permitted by the legislation for Foundation Trusts.

Clearly there need to be some constitutional links to the community, enabling key voices to be heard, to influence and to play a role in accountability. These voices obviously include patients and service-users, carers in the community, and voluntary, charitable and third sector organisations supporting particular groups. It is too early at this stage to gauge the success or otherwise of the current arrangements for these four social enterprises as they are still effectively in their start-up phase.

5 Succeeding as Social Enterprises: becoming the new public sector

As pointed out in section 2 above, the leadership of all four of these organisations chose to become social enterprises because they believed that it was the most likely way of securing the future of core NHS community services, and not because it was the least difficult route to pursue (it certainly was not that).

That belief can only be realised if these new social enterprises can do two things: turning their new found status into a unique selling point, and then convincing others of their ability to deliver.

Unique selling point

It may be unfamiliar to think of ownership and governance arrangements as being a USP, but where they constitute the framework which underlines a new type of organisation and way of working, then clearly they can be. Where an organisation can demonstrate that it is quicker at responding to the changing needs of patients and service-users, more flexible and quicker in decision-making, a flatter organisation with less hierarchy, and overall a more responsive and versatile service-provider, then it is starting to make itself more attractive to commissioners as well as users of the service.

The change of culture, underpinned by the constitutional arrangements then become a distinguishing feature, enabling practical comparison with other organisations which cannot claim these features. Where it can also show that its core NHS values are central to its operation and delivery, that all surplus remains within the local economy for the benefit of the local community, and that its ongoing accountability and governance arrangements provide a credible basis for sustaining those commitments, it clearly has advantages over other competitors.

But these benefits have to be developed. Unless they can be demonstrated with practical illustrations, third parties are unlikely to be convinced. In other words, the cultural and organisational changes need to be driven forwards, not just as an end in themselves, but because they are an essential part of the business plan and selling strategy.

But even then, that may not be enough. It has to be recognised that social enterprises remain the exception rather than the rule, and commissioners in particular will be unfamiliar with the implications of the change, and in particular of becoming independent. Commissioners may be used to being able to get an in-house provider to "help out" where the provider has a surplus from a previous year, and the commissioner has a deficit problem. This sort of arrangement will no longer be applicable for an independent social enterprise, with existing commitments as to how to treat any trading surplus. Commissioners need to understand both the implications of independent existence, and also of the nature of the social enterprise as committed to public service.

Other external relationships have to develop and understand the nature of the change. Relationships with the unions have been a feature of a number of these transfers. Whilst there may be initial hostility

"...the most important message to the health sector and beyond is that these organisations represent the new public service providers of the future."

both locally and regionally, and concerns about maintaining terms and conditions (particularly pensions), in the longer term positive relationships are growing, with a much more collaborative attitude than before, and a recognition of the benefits of the new way of working.

It will also take time for the new organisations to win the respect of neighbouring NHS bodies and their management. There can be a tendency to see the social enterprise model as somehow inferior or less reliable than a trust (e.g. not having been through Monitor's assessment process for Foundation Trust status). It is only by proving the continuing quality of the services delivered, and the sustainability of the business itself that colleagues elsewhere in the NHS will start to see social enterprises as significant and reliable providers and partners.

There are already signs of successful tendering for new contracts, including in public health, a stroke service (winning this from an acute trust), and partnering an established provider to win out of hours services.

The ultimate success for these new organisations will be by becoming champions of innovation, developing new dynamic ways of working based on their more open and collaborative approach. This will not be an easy path to follow, for the reasons already mentioned, as well as all of the uncertainties created by the level of change taking place at present.

The new public sector

But the most important message to the health sector and beyond is that these organisations represent the new public service providers of the future. Public service delivery has now moved beyond state and municipal ownership. Through entities established to serve the interests of the community, and legally committed to a public, and not a private purpose, with direct local accountability, these organisations provide credible evidence of a new form of ownership and governance capable of delivering high quality, cost-efficient services, in an accountable and sustainable way.

It is clear from talking to the leaders of these four organisations that their increasingly inclusive, collaborative way of working, underpinned by governance arrangements designed to support such an approach, are focussed on human relationships. For too long, the organisational and cultural landscape has been dominated by a series of binary relationships, which at times have polarised the parties to the wider detriment – employer/employee, patient/clinician, manager/operative, statutory/voluntary, and many others. These new organisations – and others in the wider emerging new public sector – seek not to be hide-bound by these relationships, but to work much more openly and co-operatively, across previous barriers, in the public interest.

This collaborative, member-based approach is a paradigm for the future of public ownership.

CASE STUDY

Anglian Community Enterprise (ACE) Community Interest Company

Overview

ACE was created as an independent organisation from NHS North East Essex under the Department of Health's "Right to Request" framework, launching on 1st January 2011. It was one of the Department of Health's First Wave Right to Request projects and is a Cabinet Office Mutuals Pathfinder.

Based in Clacton-on-Sea, ACE is a provider of NHS Community Services and also Learning Disabilities Therapy and some Specialist Nursing. Currently the services are provided across North East Essex to a population of approximately 318,000, with some Learning Disabilities Services across North Essex.

ACE currently provides over 40 community based services, including specialist services and children's services, with their main commissioner being NHS North East Essex Primary Care Trust.

Its communities include a district that is the most deprived in Essex, with pockets of deprivation overshadowed by overall affluence in parts of North East Essex, above average numbers of elderly people, above average numbers of children in care, a military garrison, a university, and a seaside town which has a high influx of holidaymakers in summer.

The organisation employs over 1,000 staff, and has an income of approximately £40 million.

ACE is registered as a community interest company, limited by shares.

Ownership and governance

ACE has an ownership and governance structure based on members, a representative body (Staff Council) and a Board of Directors.

Membership of the company is open to those employed on permanent or fixed term basis. Members have to choose to join, and currently there are 400 members. Every member holds a £1 share, and nobody may hold more than one share.

The Staff Council comprises up to 12 Staff Council Representatives, elected by the members. During the start-up period, a pilot Staff Council was established, with its representatives selected and appointed. The pilot staff council has developed the election process, with the outcome of the election due at the end of the year.

The Staff Council, amongst other things, appoints and removes the chair and other non-executive directors and decides their remuneration and allowances, approves the appointment of the managing director by the non-executive directors, and works with the Board of Directors in preparing and approving the mission, strategy and forward plans.

The Board of Directors comprises non-executive directors, who must be not less than half of the Board, and executive directors who include a Managing Director (appointed by the non-executive directors), and a Director of Resources, Clinical and Corporate Governance Director, and Director of Operations (appointed by the Managing Director and the non-

"ACE currently provides over 40 community based services, including specialist services and children's services, with their main commissioner being NHS North East Essex Primary Care Trust."

executive directors). The Board is responsible for managing the affairs of the company.

Commitment to public purpose

Being registered as a Community Interest Company, the constitution contains an asset lock which prevents its assets and accumulated profits being distributed to its members. The constitution also contains an express commitment that the company will retain its profits and apply them in the community interest.

Every year, the company must hold at least one Community Forum, open to service-users, carers, volunteers and relevant interested persons from the local health community. The purpose of the Forum is to assist the Company in understanding the perspective and feedback of the community. The Staff Council in consultation with the Board of Directors must ensure that the outcomes of the Community Forums are taken into account by the company.

Ultimately, the Directors are in charge of the Company, but they are accountable to the Staff Council and the members. The Staff Council itself has a responsibility to strive to ensure that the relevant interest of the community including service-users, carers and staff are appropriately represented, and the Community Forum assists in this.

Comment by Lynne Woodcock, Managing Director

"We're immensely proud of this achievement. Our desire was to become a social enterprise in order that we could further improve how we support the health and wellbeing of local people. Our on-going vision is to transform services, providing these in the community, and closer to people's homes."

Vision

As a Social Enterprise our vision is:

"To be the leader in the communities that we serve, providing innovation, quality and value for money, as we deliver healthcare services that are accessible to all".

We believe strongly that social enterprise is the way that we can:

- Develop staff, service user and community involvement.
- Keep NHS values by being an organisation who's guiding purpose is health and well-being.
- Increase the impact we have in communities.
- Have the flexibility as an independent organisation to access funding from a range of sources.
- Provide services which are locally based and informed by the needs of local communities.

CASE STUDY

Care Plus Group (North East Lincolnshire) Limited

Overview

Care Plus Group is a fully integrated health and social care provider, which was created as an independent social enterprise under the Department of Health's "Right to Request" framework, launching on 1st July 2011. It was created on the transfer of community services out of North East Lincolnshire Care Trust Plus, and of the adult social care services which had previously been delegated to Care Trust Plus by North East Lincolnshire Council.

The services include intermediate care, community nursing, home care, specialist nursing, employability, meals on wheels, day services and chlamydia screening alongside many other health and social care services. The organisation employs over 700 staff, and has an income of approximately £23 million.

Care Plus Group serves a population of approximately 158,000 in a very densely populated but geographically isolated part of the country at the mouth of the Humber estuary. The community has never recovered from the loss of the fishing industry since the late 1970s and aspiration amongst large elements of the community is poor. Very few people have the academic or economic means to leave the area but those who do rarely return. It is 30 miles in any direction to the next acute trust. 88% of the population live within a 5 mile radius of the main district hospital.

Care Plus Group has a single NHS Standard Contract with a single commissioner, the Care Trust Plus, who have delegated powers to commission social care on behalf of North East Lincolnshire Council. The Care Trust Plus is part of the wider Humber Cluster of 4 PCTs. The GPs have been accredited with Pathfinder status as a GP Commissioning Consortium and will become the primary commissioner from 2012/13.

Ownership and governance

Care Plus Group has an ownership and governance structure based on members, a representative body (Council of Governors) and a Board of Directors.

Everybody who is employed by or carries out functions for the organisation (not including volunteers or independent professional carers) is a member, unless they choose not to be. Every member holds a £1 share, and nobody may hold more than one share.

The Council of Governors comprises 8 Staff Governors to be elected by the Members, 2 Local Authority Governors appointed by North East Lincolnshire Council, two GP Governors appointed by GPs, and 3 Community Governors.

The Council of Governors represents Members and the wider community within the organisation, and is a link between the Members and the Board of Directors. Amongst other things, it appoints and removes the chair and other non-executive directors and decides their remuneration and allowances, approves the appointment of the managing director by the non-executive directors, and works with the Board of

"Care Plus Group serves a population of approximately 158,000 in a very densely populated but geographically isolated part of the country at the mouth of the Humber estuary. "

Directors in preparing and approving the mission, strategy and forward plans.

The Board of Directors comprises a minimum of 4 non-executive directors (one of whom is chair), who must be not less than half of the Board, and executive directors one of whom is to be the Chief Executive. The Board is responsible for managing the affairs of the company.

Commitment to public purpose

Being registered as a community benefit society, the constitution contains an express commitment to retain its profits and apply them for the benefit of the community. There is an express prohibition on distributing any profits or surpluses to the members, either directly or indirectly. On a solvent winding-up, surplus assets must be passed to an organisation with similar provisions about protection of assets. The constitution also contains an asset lock which prevents its assets and accumulated profits from being distributed to its members.

Ultimately, the Directors are in charge of the organisation, but they are accountable to the Council of Governors and the members, and must present an annual report and accounts to each annual members meeting.

Comment by Lance Gardner, Chief Executive:

"The values in our charter were borrowed verbatim from the 1946 National Health Service Act. Whilst we now have greater flexibility to introduce better ways of working, delivering health care free at the point of need is still our underlying mission, but this is challenging because of the fact that we deliver some social care services which may be means tested and charged in appropriate circumstances. Becoming a social enterprise simply means we can work more closely with the local community to reshape adult care and deliver a totally patient-focused service. The savings we make from doing things more efficiently will be ploughed back into developing and delivering new services."

"As part of our commitment to the regeneration of the local community, Care Plus Group is the largest user of Employability and Modern Apprenticeships in the NHS in England."

Care Plus Values

- We provide high quality services and offer value for money
- We put people at the heart of what we do
- We strive to support our staff and make them feel valued
- We work together to improve peoples lives
- We support people to have the best life possible
- We aim to be green

CASE STUDY

Medway Community Healthcare CIC

Overview

On 1 April 2011 Medway Community Healthcare became a social enterprise, providing community NHS services to the people of Medway. The organisation was formed on the transfer of services previously provided by NHS Medway, and the service has a strong history of partnership working with local GPs, Medway NHS Foundation Trust, Medway Council (a unitary authority) and other local stakeholders.

Medway Community Healthcare is a £46 million business with 1195 staff providing a wide range of both planned and unscheduled care in local settings including healthy living centres, inpatient units and people's homes.

It is part of the new enterprise culture and one of the first phase of social enterprises delivering high quality community health care to local people; from community nurses and health visitors to speech and language therapists and out of hours urgent care.

As a social enterprise, Medway Community Healthcare is owned and run by its staff members on behalf of the community and trades as a business for social purposes.

Uniquely, Medway Community Healthcare is co-terminous with its unitary local authority – Medway Council. Medway Community Healthcare serves a population of over 350,000 people across Medway, Swale and West Kent living in both rural and urban communities. The majority of the services provided are for the people of Medway.

Medway is a generally less affluent area compared to the surrounding Kent area and has areas/pockets of significant health inequalities, which lead to a greater demand on its services. It is a national priority area for regeneration and growth and currently is bidding for City status in 2012. Population trends indicate that Medway Community Healthcare will have increased demand for the majority of our services and in particular, services for children, older people and people with long-term conditions, unscheduled care and primary care.

Medway has a higher than average population of young children and a predominantly white population with only 7% of the population from ethnic minorities but this is increasing. There are four universities and two further education colleges bringing 15,000 students to Medway each year.

Ownership and governance

Medway Community Healthcare has an ownership and governance structure based on members, a representative body (Elected Members' Forum) and a Board of Directors.

Membership of the company is open to all those employed by the company. Members have to choose to join, and currently around 25% of staff (over 300 members) have chosen to become members. Every member holds a £1 share, and nobody may hold more than one share.

The Elected Members' Forum comprises of 12 Elected Members, elected by and from the Members.

The Elected Members' Forum represents Members and is a link between the staff and the Board of Directors. Amongst other things, it appoints and removes the chair and other non-executive directors and decides their remuneration and allowances, approves the appointment of the managing director by the non-executive directors, works with the Board of Directors in preparing and approving the mission, strategy and forward plans

"Medway Community Healthcare is a £46 million business with 1195 staff providing a wide range of both planned and unscheduled care in local settings including healthy living centres, inpatient units and people's homes."

and is responsible for engaging with staff across the organisation. Each member has a constituency of around 100 staff.

The Board of Directors comprises not less than 4 non-executive directors (one of whom is to be chair), who must be not less than half of the Board, and not less than 4 executive directors who are to fulfil the role, duties and obligations generally attributed to the managing director, finance director, and a clinical lead, medical director or operations director. The Board is responsible for managing the affairs of the company.

Commitment to public purpose

Being registered as a Community Interest Company, the constitution contains an asset lock which prevents its assets and accumulated profits being distributed to its members. The constitution also contains an express commitment that the company will retain its profits and apply them in the community interest.

Every year, the company must hold at least one Community Forum, open to service-users, carers, volunteers, local people, representatives from health and social care agencies, GPs, local community groups, the local involvement network, the local council, voluntary sector organisations and local businesses, as determined by the Board of Directors with the Elected Members' Forum. The purpose of the Forum is to assist the Company in understanding the perspective and feedback of the community. The Elected Members' Forum in consultation with the Board of Directors must ensure that the outcomes of the Community Forum are taken into account by the company.

Ultimately, the Directors are in charge of the Company, but they are accountable to the Elected Members' Forum and the members. The Elected Members' Forum itself has a responsibility to strive to ensure that the relevant interest of the community including service-users, carers, staff, local people, voluntary sector organisations and local authorities are appropriately represented; the Community Forum assists in this.

Comment by Martin Riley, Managing Director:
"We are proud to be part of a new enterprise culture that will enable us to work closely with our local community and deliver the health care they need.
"We will continue to provide an extensive range of services locally at inpatient units at St Bartholomew's Hospital, Darland House and the Wisdom Hospice as well as in people's homes, healthy living centres and some services based within Medway Hospital. These services range from community nurses, health visitors and physiotherapists to wound therapy and specialist services such as stroke and cardiology care to MedOCC (Medway ON Call Care), which provides urgent GP and nursing care 24 hours a day."

We will continue to provide an extensive range of services for local people. Looking forward we seek to both develop its existing services and grow the range of specialist services to meet the needs of the community we serve."

Commitment

Medway Community Healthcare has made a commitment to ensure that we are 'leading the way in excellent healthcare'.
Our organisational values, developed by our staff, are key to our success in delivering this commitment:

- we are caring and compassionate
- we deliver quality and value
- we work in partnership

CASE STUDY

Your Healthcare Community Interest Company

Overview

Your Healthcare began trading on 1 August 2010 as a not-for-profit social enterprise organisation in Kingston upon Thames after separating from NHS Kingston as part of the first wave of the Department of Health's 'Right to Request' projects. It was the first in London and only the second in the country to do so. It has 607 staff with considerable and exclusive experience of delivering high quality community healthcare services to local populations.

It provides 23 distinct services – from school health and health visiting, to rehabilitation, community and specialist nursing, therapies such as speech and language, physiotherapy and podiatry, and learning disability services to a Kingston-registered GP population of about 187,000 people and people in Richmond with learning disabilities.

It also provides a range of business and infrastructure services, such as IT services, HR and Facilities Management to a range of customers including partners such as NHS Kingston and local GPs.

Your Healthcare has an annual income of £24.7million, £20.6 million of which is awarded by NHS Kingston. Any financial surpluses are re-invested back into frontline services and the local community. In its first year of operation it made considerable savings and was able to re-invest resources back into services including facilitating a new five-day-a-week primary care service in one of the borough's most deprived communities, and an extended Rapid Response service to help prevent unnecessary hospital admissions.

The organisation has also partnered with Kingston's out-of-hours GP provider, and is a partner in the Surbiton Education and Health Trust which has been awarded the right to provide a brand new school in the borough.

Your Healthcare, and their partner organisation Age Concern, is also partnering the Local Authority and others to consider the best approach to residential and day care services.

Your Healthcare is registered as a community interest company.

Ownership and governance

Your Healthcare has an ownership and governance structure based on members, a representative body (Council of Governors) and a Board of Directors.

Membership of the company is open to staff, service-users, carers and registered volunteers (Community Members), and those employed on permanent or fixed term basis (Staff Members).

The Council of Governors comprises 9 Community Governors elected by Community Members, 4 Staff Governors elected by the Staff Members, and up to 4 Appointed Governors appointed by Appointing organisations. Your Healthcare is operating with an interim Governors' arrangement at present.

The Council of Governors, amongst other things, appoints and removes the chair and other non-executive directors and decides their remuneration and allowances, approves the appointment of the

"Your Healthcare has an annual income of £24.7million, £20.6 million of which is awarded by NHS Kingston. Any financial surpluses are re-invested back into frontline services and the local community."

managing director by the non-executive directors, and works with the Board of Directors in preparing and approving the mission, strategy and forward plans.

The Board of Directors comprises non-executive directors (one of whom is the chair), and executive directors, one of whom is the Managing Director, one the Director of Finance, and one a healthcare professional. The Board is responsible for managing the affairs of the company. Your Healthcare, in day to day practice, does not use the traditional 'director/executive' terminology preferring to refer to the executives as Board Leads (e.g. Board Lead for Finance).

Commitment to public purpose

Being registered as a Community Interest Company, the constitution contains an asset lock which prevents its assets and accumulated profits being distributed to its members. The constitution also contains an express commitment that the company will retain its profits and apply them in the community interest.

Ultimately, the Directors are in charge of the Company, but they are accountable to the Council of Governors, and the Members, who include both Community Members and Staff Members. The Council of Governors contains a majority of Community Governors, and has an ongoing responsibility to seek to ensure that the interests of the community served by the Company are appropriately represented. Quotation from Managing Director. Siobhan Clarke said: "There were never any doubts that we would be successful in this endeavour, and a year on, the evidence speaks for itself. We are now free from unnecessary bureaucracy. We can re-shape services according to need and re-invest any financial surpluses back into the system to enhance frontline services. Our aim is to put as much tax payers' resource into frontline services as is possible to do. We have encouraged our staff to come up with creative solutions and ideas, which have already made a difference.

Comment by Siobhan Clarke, Managing Director: "Like everybody else, we have been subject to financial constraints in the current economic climate, but the good news is that we have not had to make any redundancies. We also have an excellent record on staff retention – currently we have a near nil turnover – which is fabulous as one of our other goals is to be an employer of choice, successfully recruiting and retaining talented staff, who are without a doubt our greatest asset and without whom this seamless transition to social enterprise would not have been possible."

Your Healthcare values:

Your Healthcare has retained its commitment to promoting and embedding its core values based on the founding principles of the NHS by:

- Providing and investing in a wide range of community healthcare services for local people when and where needed
- Working in partnership with service users, their carers, the local community, our commissioners, third sector and other health and social care providers to deliver co-ordinated healthcare, at the best value, to the highest standard.

About the authors

Cliff Mills

Cliff Mills is a practitioner in the law and governance of co-operative, mutual and membership-based organisations. He has written the constitutions of a number of the UK's leading co-operative retail societies including the Co-operative Group, established the constitution and governance of a substantial number of NHS Foundation Trusts, and played a significant part in the development of mutual society legislation in the UK.

He has worked extensively with Mutuo over the last decade in the development and application of mutual and co-operative models of ownership for public services. These have included healthcare, social housing, leisure services, education and children's services. He has also worked in the voluntary and charitable sector. The aim has been to create robust models for organisations which are trading for a public or community purpose, with an ownership and governance structure based on user, staff and local community membership.

Recent and current projects include the mutualisation of Post Office Limited, Co-operative Councils, library services and community health services.

Cliff is a consultant with Capsticks Solicitors LLP and Principal Associate with Mutuo.

Chris Brophy

Chris Brophy is a partner with Capsticks, specialising in commercial and contractual work for healthcare bodies, social enterprises, mutuals and charities.

He advises on major constitutional and governance changes, such as the implications of the new ways of working in primary, community and social care, including the development of new social enterprises from public sector organisations such as NHS bodies and Local Authorities through programmes such as ‘Transforming Community Services’ and the Government’s new ‘Right to Provide’.

Chris was involved in the original establishment of Central Surrey Health one of the first social enterprises to develop out of the NHS and led the creation of Your Healthcare Community Interest Company in August 2010. Your Healthcare was originally part of Kingston PCT and the first social enterprise to develop out of the NHS in London. Chris’s team was also involved in the establishment of Anglian Community Enterprise CIC on 1 January 2011 and other social enterprises such as Bromley Healthcare, Medway Community Healthcare and Central Essex Community Services.

Chris is currently leading the Capsticks team advising on over 17 social enterprise projects involving transferring thousands of staff from the NHS into new businesses and also the development of such businesses from local authorities in relation to people involved in social care.

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