

**Response by the Social Enterprise Coalition to the Department of  
Health's Commissioning Framework for Health and Well-being  
Consultation**

## **Introduction**

1. The Social Enterprise Coalition (SEC) welcomes the opportunity to respond to the Department of Health's commissioning framework for health and well-being consultation. We have responded to the main headings of the consultation.
2. The Social Enterprise Coalition was established in 2002 as the national voice of social enterprise. The Coalition represents a wide range of social enterprises, umbrella bodies and networks, with a combined membership reaching of over 10,500 social enterprises. This response was informed by consultation with members of the Coalition practicing in health and/or social care. The Coalition has now established a Health and Care forum for existing and aspiring health and care enterprises. The Forum would welcome an ongoing dialogue on the development of Commissioning and its members look forward to meeting the new Department of Health Director as soon as he has taken up post.
3. The Coalition is broadly supportive of the commissioning framework for health and well-being, particularly the emphasis placed on community participation and the involvement of the social enterprises and the third sector. We believe that real and sustained improvements in the commissioning of health and social care services will only be achieved by engaging in intelligent commissioning from a sufficiently active and diverse supplier base. Social enterprises form an essential part of this supplier base, applying innovative and efficient approaches to addressing the complex and diverse health and social care needs of the nation.
4. To date, however, social enterprises have often been forced to compete on an uneven playing field by the failure of the market to take account of the benefits they provide and the perception that scale and size equates to true efficiency and quality. While this framework addresses many of these issues at a high level, our concern lies in their implementation. Such changes will require significant improvements in the quality of commissioning and affecting cultural change in the public sector both to reduce risk-aversion and improve understanding of and, receptivity to social enterprises in service delivery. Additionally the reduced funding facing the NHS from 2008 raises concerns that commissioners will place greater importance upon unit cost rather than outcomes and quality.

## **Key recommendations**

5. The Coalition recommends a comprehensive programme to bring about the required cultural change to implement the recommendations identified in this framework and fully engage social enterprises in service delivery. This should include:
  - increasing commissioners understanding of social enterprises and the role they can play in delivering health and social care services;
  - re-defining value-for-money, ensuring commissioners are aware of the wider social, environmental and economic impacts of their decisions;
  - empowering commissioners to be increasingly innovative and enable them to take advantage of the role social enterprises can play in delivering health and social care services.

## **Putting people at the centre of commissioning**

6. The Coalition welcomes the emphasis on empowering individuals to take greater control of their health and well-being. The Coalition believes that this is an area where social enterprises could play an integral role given that a key characteristic of social enterprise is often a close understanding of and commitment to their client groups often including the

involvement of these clients in the organisational structure. Many social enterprises have specific skills in reaching underserved and hard-to-reach groups.

7. The Coalition however feels that in addition to shaping the delivery of services, individuals should also be involved in shaping their own health outcomes. What an individual desires from a health intervention is often considerably different from the clinical outcome which has traditionally been focussed on counting services rather than well-being focussed outcomes.
8. Further clarity is required, however, on how putting people at the centre of commissioning will translate in practice. While the framework identifies the need to access hard-to-reach groups it provides little guidance on how this will occur and has not taken into account the full spectrum of mechanisms available to do this, particularly with regard to Web 2.0 technologies.
9. Additionally reaching the most marginalised groups of society requires relationship building that traditionally has not occurred in any scale within the NHS. The Coalition would like to know what measures will be put in place to ensure that the decisions made by commissioners **fully** represent the needs of the communities they represent and to ensure they have the capacity to reach these individuals.
10. The Coalition would like to see further emphasis placed upon Direct Payments and the introduction of Individual Budgets. The extension of Direct Payments from social care to health and the introduction of Individual Budgets could play a key part in ensuring that individuals have more power to take control of their health, allowing a greater degree of flexibility of services tailored to each individual's specific needs. However, the introduction of Direct Payments alone without the option of Individual Budgets could prevent individuals who are unwilling to take on the responsibility of a Direct Budget to access the same degree of individualised care.

### **Understanding and planning for the needs of individuals and of the local population**

11. The Coalition is supportive of the emphasis placed on Joint Strategic Needs Assessment (JSNA) and the role this can potentially play in ensuring that services are tailored to meet diverse health needs. In order for the objectives set out in this framework to be realised, commissioners will require considerably increased capacity in data collection, data analysis and in interpreting the data to develop local priorities. Paragraph 3.19 also raises concerns that the JSNA set out in this framework represents only a guide to which minimal adherence will be required.

### **Sharing and using information more effectively**

12. The Coalition is supportive of the sharing of information in order to prevent a duplication of effort and apply a more efficient use of resources. This will, however, be difficult to implement on the emergent competitive market, as there will be a tension between the traditional functioning of inter-actor dynamics and the objectives outlined here. Given that social enterprises are primarily motivated by social purposes rather than share holder value, they may be better placed to engage in the collaborative approach envisaged by this framework.

### **Assuring high quality providers for all services**

13. The Coalition welcomes the emphasis in this section on the role that the third sector and user-led organisations can play in providing responsive personalised services and the move away from counting services to measuring outcomes. However, commissioning is about more than just procurement, and a greater standardisation and clarity on the use of the term is required.

14. If the government wants to achieve the degree of collaboration with the third sector it promotes this must be accompanied by sufficient time and resources for genuine partnerships to emerge. Adequate resources are required for the various roles that social enterprises can play in identifying need, designing solutions and delivering services if health and social care services are to be genuinely transformed for the benefit of patients and other users.
15. The Coalition is supportive of model contracts if they are able to reduce the administrative burden and associated costs facing smaller organisations and if they facilitate increased focus on the actual services rather than the legal framework within which they are delivered. Their standardisation could also serve as a monitoring tool to make comparisons between service providers and their impact.
16. The contract could also play a role in protecting social enterprises from the threat of decommissioning by PCTs. Frequent changes in the organisational structures supporting the commissioning of health and social care often makes it difficult for social enterprises to develop mature relationships with commissioners and negotiate the robust contracts required to provide services to marginalised or socially excluded groups. The recent rationalisation in the number of PCTs has led to several cases of new management teams questioning the value for money delivered by specialist teams working with the socially excluded. In an effort to reduce the short term risk to these services, the Coalition would like to see lengthier termination periods within contracts to provide social enterprises time to demonstrate their added worth to new commissioners or alternatively to ensure an adequate transition period to new service providers for vulnerable individuals.
17. Many social enterprises with niche expertise in reaching highly underserved communities have argued that contracts be disaggregated, to allow specialist organisations to provide different components of a service package ensuring services are tailored to best meet the needs of all the population. The model contract should take account of these flexibilities.
18. Additionally contract length should reflect patient need, particularly for those with prolonged conditions for example mental health. Such cases require longer-term, consistent support. Shorter contracts resulting in repeatedly changing providers could hinder well-being outcomes in these cases.
19. The Charity Commission report "Stand and Deliver: The Future of Charities Delivering Public Services", highlighted that only 12% of charities delivering services reported that they received full cost recovery in all cases. Our members inform us that a similar situation exists for many social enterprises hindering their ability to be truly innovative. We believe that social enterprises should receive the same treatment as the private sector with commissioners finding ways to encourage innovation at both the onset and during the contract.

### **Recognising the interdependence between work, health and well-being**

20. The Coalition would also like to see the development of more unified commissioning and programme budgets including social care, housing, healthcare and benefits. The aims of the White Paper cannot be achieved until effective commissioning by health and social care becomes the norm. The Government should examine the costs and benefits of investment in coordination and integration mechanisms to make the fullest use of all available health, social care and employment resources.
21. The Coalition feels that commissioners should be incentivised for meeting multiple objectives and joining up different types of service for efficiency gains. Work carried out by the New Economics Foundation on local multipliers has demonstrated that by spending locally,

procurement spending can play a role in stimulating local economies<sup>1</sup>. Commissioners consequently need to reassess what constitutes value for money to take into consideration wider social, environmental and economic gains. The Coalition would like to see the commissioning framework being utilised locally to enable a plurality of commissioners to tender for a shared contract to deliver a wide range of social and benefits.

### **Making it happen – capability and leadership**

22. Our consultation has highlighted a disparate understanding among commissioners of what constitutes a social enterprise, their potential role in delivering health and care services and the added social benefits they bring. To address this we recommend a comprehensive capacity building programme to bring about the required cultural change including increase commissioners understanding of social enterprises, ensuring they are aware of the wider social, environmental and economic impacts of their decisions and are empowered to take advantage of the innovation that social enterprises can offer. This should also include GP commissioners.
23. Commissioners are often reluctant to contract to social enterprises given the perceived risk involved and that often they are not on the 'approved provider list'. This combined with the scale of competing demands facing commissioners as set out in this framework may result in increased commissioning to larger providers, perceived by commissioners to be lower risk, at the likely disadvantage of social enterprises, particularly those that are smaller scale or with specialist areas of expertise. The Coalition believes measures need to be in place to support and incentivise commissioners to shift investment into new models of service as the objectives set out in this document will require innovation and risk-taking.
24. The Coalition welcomes the emphasis placed throughout this framework on the involvement of the social enterprises and the third sector. However, if commissioners are to be empowered to engage in intelligent commissioning from a sufficiently active and diverse supplier base they also need adequate financial flexibility. For example many start-up social enterprises are ideally positioned to address the needs identified in this framework, however, require interim resources and support to establish their organisational structure prior to their beginning service delivery which commissioners are often unable to provide. While the Department of Health Pathfinder process goes some way to address this, such funding flexibility needs to be mainstreamed across commissioners.



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<sup>1</sup> [http://www.neweconomics.org/gen/newways\\_socialreturn.aspx](http://www.neweconomics.org/gen/newways_socialreturn.aspx)