The King's Fund

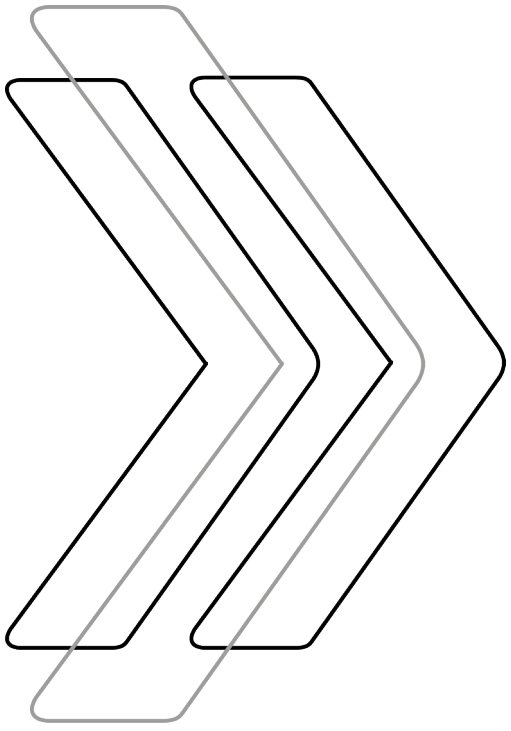
Ideas that change health and care

Social enterprises in health and care

Author

Ben Collins

August 2020



This independent report was commissioned by Social Enterprise UK. The views in the report are those of the author and all conclusions are the author's own.

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

www.kingsfund.org.uk **@thekingsfund**

Contents

1 Introduction

In 2008, the Labour government introduced the right for groups of NHS staff to request to create a social enterprise (a business with a social mission) to deliver NHS services. At the same time, primary care trusts, the commissioners of the day, were instructed to focus on purchasing rather than delivering health care and to divest their community health services, either by transferring them to an existing NHS service provider or creating a new standalone provider organisation. Over the next 5 years, around 20 new social enterprises were created to deliver community health services. With interest and political backing for the social enterprise model, new social enterprises were also created and expanded outside the 'right to request programme' in primary care and social care.

If you speak to the leaders and staff who 'span out', they tell a common story: a particularly strong sense of commitment to their patients and communities; an eagerness to test innovative management practices and approaches to service delivery; and the desire to be the masters of their own destiny, escaping some of the scrutiny and bureaucracy that restricts in innovation in the public sector. In some cases, staff within the primary care trust had been able to extract a small, failing 'Cinderella service' from a large NHS provider and turn it around. The last thing they wanted was to see it transferred back to a large trust or moved to a private sector chain where they might struggle to maintain their philosophy and approach. But the price of relative freedom would be high. New recruits to social enterprises do not receive NHS terms and conditions. Social enterprises have tougher tax obligations than trusts. The government has always ensured that NHS Trusts can pay their staff and creditors. Social enterprises enjoy no such protections. They can and do go bankrupt.

It has now been a decade since creation of the group of social enterprises under the right to request programme – long enough for these new organisations to develop their own management practices, cultures and approaches to providing care. This discussion paper makes a rapid assessment of the particular contribution of social enterprises to the delivery of publicly funded health and care, based on visits to five well-reputed social enterprises and interviews with staff and service users (*see* 'Case examples' box below).

While the paper is based on five organisations, there are similarities with other social enterprises that The King's Fund has studied. Social enterprises in health and care have formed a tight-knit community. Leaders and staff know each other well, support each other and exchange ideas. When you join a social enterprise, you join a group whose intellectual influences and interests are quite different to most policy-makers and managers in the NHS and, perhaps to a slightly lesser degree, local government. There are subtle shifts in language: staff in social enterprises often talk about their 'members' or even just 'people' rather than 'patients' or 'service users'. They are more likely to talk about 'shifting the balance of power' than 'patient engagement'. You also join a sector with specific governance requirements, for example to engage staff and communities in decision-making, which tilt organisations towards particular practices and cultures and away from others (Ham 2014).

This paper focuses on the contribution of these five organisations as 'engines of innovation' within health and care. The following sections highlight these organisations' creativity in building relationships with people who use services, harnessing the talents of their workforce, and developing new approaches to seemly intractable social challenges, such as ensuring that children in run down neighbourhoods get a good start in life or helping people with profound mental health problems or disabilities to live happily and independently. They also illustrate how providers of publicly funded health and care services can work with partners to build more resilient communities.

These skills were evident in how social enterprises responded to the Covid-19 pandemic from spring 2020. One of the social enterprises studied here, Social Adventures, opened their headquarters as a Covid-19 triage centre, used their garden centre as a community food hub, and took a community caterer out of furlough to provide meals for NHS staff. Another, Thurrock Lifestyle Solutions, redeployed staff to support older people in care homes, while creating seven-day rotas for staff to live with people with learning difficulties and disabilities, so that they could support them safely without exposing them to infection. The primary care provider, Here, set up a 'Covid-19 hot hub' where people with Covid-19 can receive care without visiting other primary care facilities. In what follows, we provide a brief overview of the five organisations before discussing their approaches to partnership working with service users, creating humane working environments, innovation in care delivery, supporting people with the greatest needs and building more resilient communities. If social enterprises, along with other not-for-profit and public sector organisations, are 'engines' for particular forms of innovation, producing important and distinctive innovations that other organisations in the public or private sectors struggle to generate, there is surely a case for more careful thought about how we can preserve them. And if NHS

organisations are increasingly committed to becoming 'anchor institutions', organisations that protect the economic resilience of a local area, there is surely also a case for closer partnerships and careful learning from the social enterprises and other organisations already playing this role in their communities.

Case examples

Bevan Healthcare

In 2011, a group of twelve staff left Bradford Primary Care Trust to set up Bevan Healthcare, a social enterprise delivering primary care and support to people who are homeless and asylum seekers. Their aim was to provide much more flexible and responsive services for deprived groups, and to move away from reactive health care to holistic services to support recovery and wellbeing. Over the past nine years, it has established new primary care centres for deprived groups in Bradford and Leeds, established a mobile primary care clinic that visits homeless shelters, set up late-night primary care clinics for street sex workers, and used lottery funding to develop a new wellbeing centre for people who are homeless and asylum seekers in Bradford. Its primary care clinics for these groups are considered amongst the best in England (Bevan Healthcare 2018).

Here

In 2008, a small group of primary care doctors and NHS managers established Brighton and Hove Integrated Care Service, with the ambition of harnessing data and applying systems thinking to redesign pathways and deliver effective integrated care. By the mid-2010s, they were delivering a range of specialist primary and community services including eye services, dermatology and community mental health services in Brighton and Hove and integrated musculoskeletal services in Brighton, Hove and Sussex. At this point, leaders and staff had an epiphany. Exhausted after winning two large contracts, they began to reconsider their purpose and whether they could deliver transformative change in healthcare relying only on their existing management tools. Staff investigated 70 case studies of people's journeys through health services and how the system affected their lives. In 2014, they renamed the organisation 'Here,' signalling their attention the present, to what really matters to people and creating new possibilities for staff and people receiving care. Over the past six years, Here has embedded the concept of mindfulness in its working practices. It has also made far-reaching changes to put service users in control of their health journeys and design services that meet their needs.

Thurrock Lifestyle Solutions

In 2007, a group of staff at Thurrock Council committed a minor act of sedition: they started to meet with people with disabilities out of hours at a local Scout hut to discuss the nature of local services. They wanted to know if it was possible to offer more than just compassionate day care for people with disabilities, to give people much more choice and control over their care and to allow them to lead the lives they wanted for themselves. In 2013, Thurrock Lifestyle Solutions took over the majority of the council's services for disabled people including its independent living and day centre services. Since 2013, it has closed a large council day centre on an isolated trading estate and replaced it with five new centres close to people's homes and communities, established an innovative therapeutic community for people with severe autism, bought and renovated houses to allow people with disabilities to live independently with support, and created new services to help people to transition from school to adult life. Thurrock Lifestyle Solutions bought a campervan to help people with disabilities to travel and spend time where they want. It trains people to be DJs and runs a nightclub event once a month.

NAViGO

In 2002, Kevin Bond, a mental health nurse by training, became the care director for mental health services in north east Lincolnshire, a typical set of 'Cinderella services' – understaffed, underfunded, discretely hidden in a large hospital Trust. By 2005, Kevin had persuaded his local Primary Care Trust to take the services in house so that it could provide leadership and investment. In 2010, he persuaded the workforce to become a social enterprise, so they could take control of their destiny and develop services in partnership with their community. NAViGO's aim is to deliver services that staff would be happy for their families to use. Over the last ten years, it has eradicated practices that inflict harm on service users such as rapid tranquilisation, prone restraint and prolonged seclusion. It has built new, humane in-patient facilities, created new services for people with complex conditions, established leading dementia and eating disorder services and built new residential facilities to help people transition to independent living. By 2018 it had virtually removed all out of area placements by bringing patients back to local services. It provides training and jobs for service users in its facilities, catering and events services, cafes and garden centre.

Social Adventures

In 2008, Scott Darragh, a manager of public health services, persuaded Salford Primary Care Trust to create a new social enterprise to deliver public health services for people in Salford. Social Adventures runs a healthy living

centre, the Angel Centre, which runs fitness groups, counselling, health coaching, arts and crafts and family activities. It has also established Garden Needs, a community garden, which aims to connect people with nature so they can live healthier and happier lives. It has also set up affordable childcare services, forest schools to connect children to nature, a community gym and a community café.

2 Innovation within social enterprises

Partnerships with service users

Since 2013, Thurrock Lifestyle Solutions, the provider of services for people with disabilities in Thurrock, has pursued an almost unique innovation in leadership and governance: it has appointed people with significant physical disabilities and learning disabilities as the chair and non-executive directors of an organisation that delivers publicly funded care. With support from an independent advisory group, these leaders take on the fiduciary responsibilities of the organisation members including setting direction, ensuring that the organisation uses its resources appropriately, holding the management team to account for performance and protecting the interests of shareholders.

On our visit to Thurrock, we spent a large amount of the day talking to the Chair, Anne White, who has learning disabilities and severe physical disabilities, and some non-executive directors, including Sunny Saini who has Down's Syndrome. Anne described her ambitions for the organisation, her determination to address injustice for people with disabilities and her impatience for faster progress. Sunny gave a presentation on the philosophy and evolution of the organisation, founded on the theory that disability is a social construct and that people's prejudices, the distribution of power and resources and the design of physical infrastructure are what constrain the lives of people with disabilities. The discussions we had followed a slightly different rhythm to other business conversations. The chief executive, Neil Woodbridge, occasionally interrupted to remind Anne and Sunny of an issue or bring them back to a particular topic. They in turn interrupted Neil to correct him or ensure their points were heard.

Outsiders might question whether people with significant learning disabilities are really in a position to hold an executive team of professional managers to account. On our visit, the chair and non-executives were incredibly clear in explaining what mattered to them, including through the stories they told to illustrate positive and damaging experiences of care. They highlighted the importance of being treated with dignity, being listened to sincerely, deciding their own priorities for care, and being much more ambitious about the potential of disabled people to live useful and fulfilling lives. These priorities can be seen in how Thurrock Lifestyle Solutions delivers services, for example its focus on giving people choice and control over their care. It's not unusual to hear that a

support worker and a person with disabilities are on the other side of the country or have crossed the channel for a weekend break: people with autism also want to see the Eiffel tower.

It was also clear that specific things were needed to make these governance arrangements work effectively, such as weekly board meetings, support from an advisory committee and techniques for managing safe and productive discussions. When the chair and non-executive directors of Thurrock Lifestyle Solutions attended meetings with the NHS and council services, they found that the pace of meetings, the inability to provide clear, easy-to-read documents and the way staff engaged with them made it much harder to participate in discussions and make their voices heard. Executive directors such as John Paddick, the finance director, whose son is severely disabled, are clearly deeply committed to empowering and defending the interests of people with disabilities so that they can contribute effectively.

There is a body of theory and evidence showing that differences in social position, power and access to resources between staff and service users are a root cause of unfairness in how public services are delivered, contributing to failures to direct resources to those in most need, to develop services that respond to the priorities of service users rather than professionals and to deliver humane and compassionate care (Wattis *et al* 2017). There is also a growing group of researchers and activists who argue that health and care services cannot redress the balance through small scale changes such as listening to patient stories, establishing citizens' panels or engagement processes. Instead, if we really want to change the relationship between staff and service users, we need to make substantive and binding changes in the distribution of power and authority between groups (Cottam 2018; Beresford 2002).

These five social enterprises have pursued an astonishing range of innovations to change the relationship between professionals and service users and establish genuine partnerships. Like Thurrock, the mental health provider NAViGO gives people who use services formal powers as members with voting rights to set strategic direction and decide how resources are used. The primary care provider, Here, was the first organisation in the NHS to recruit a 'patient director' as an executive member on its board. The patient director brings insight from personal experience of using services to support the leadership of the organisation and its strategic decision-making. Here has appointed 9 remunerated Patient and Carer Partners with experience of life-changing illness whose role is to bring patients' perspectives and lay expertise to its day to day work. They are not there merely to feedback on their experiences or represent others but as team-members who

work alongside other staff, bringing practical experience and insight to improvement projects.

Many of these organisations also routinely put service users on recruitment panels for hiring new staff, an innovation that has not yet been adopted systematically in any NHS trusts or foundation trusts. Interviewees described how this helped to set the tone within an organisation, making clear to new recruits how they were expected to engage with service users. They also described the immediate impact on the sort of people who join the organisation. The non-executives at Thurrock and members at NAViGO do not hire people who ignore them, patronise them, talk over them or whom they suspect might inflict pain in a moment of crisis.

Humane working environments

At Here, the provider of health services in Sussex, we spent the first few minutes of the senior management team meeting in silent meditation. Afterwards, and in subsequent meetings, we started each meeting with a 'check-in' where people shared how they were feeling right now, what was troubling them and what was exciting them in their work and personal lives. The staff leading the monthly open house meeting in the afternoon started by celebrating the contributions of different people in the previous month, from completing major projects to small acts of kindness to colleagues and service users. At a large meeting, one senior doctor shared his personal grief after treating a boy, the same age as his son, who was struggling with mental illness and had harmed himself.

Isabel EP Menzies' ground-breaking study of nursing in a London teaching hospital of 1960 made the case that the modes of functioning, organisation structures and professional cultures in health services created inhumane environments for staff and undermined their ability to deliver compassionate care (Menzies 1960).Over the following sixty years, organisational psychologists have provided further evidence of the links between how work is organised, staff wellbeing and the ability of staff to deliver their roles effectively. Strands of research have highlighted the impact of senior leadership behaviours, line management styles, hierarchical structures, levels of staff autonomy and care delivery structures on staff wellbeing. There is extensive literature on the impact on staff burnout, the ability of staff to be creative in delivering their roles and the ability of staff to show empathy and compassion when providing care (Ham 2014; Sorenson *et al* 2016). Nevertheless, reviews of failures in care in the NHS have focused more on oversight and reporting than innovation in these areas.

The social enterprises we visited were developing innovative arrangements to give staff greater control over the organisation and their own work, practices which tend to create better conditions for wellbeing, creativity and compassion. Each organisation has developed arrangements to give staff a meaningful rather than tokenistic role in strategic decision-making, including through staff representatives on boards and staff forums to decide on how to use the organisation's surpluses.

Each organisation has introduced approaches that give frontline staff greater autonomy in delivering services. Leaders at NAViGO encourage staff to innovate in patients' interests, reminding them only that they shouldn't spend money their team doesn't have, they shouldn't put staff or patients at risk and they shouldn't do things that might damage the NAViGO brand. Scott Darragh, chief executive of Social Adventures, describes reviewing the organisation's strict rules on staff expenditure: a maximum of 39p for a cup of tea, £2 for a sandwich. (It turns out they were copied from the Church of England's website.) Rather than limits and approval processes, staff were encouraged to make their own decisions on expenditure, simply remembering to spend money as if it were their own and in the interests of the organisation and its service users. After the change, the amounts spent went down.

Like Buurtzog in the Netherlands and Resources for Human Development in the United States, some of these organisations have introduced more formal principles of self-organisation. At Here, groups of staff supporting particular patient groups work as self-contained teams, decide their own staffing levels and approaches to care delivery, manage their own finances and make their own investment decisions without requiring approval from people above them in the hierarchy. Both Here and NAViGO have kept head office teams as small as possible as one way of ensuring that resources and autonomy continue to be held by staff delivering services.

These organisations are also developing innovative management practices to protect staff wellbeing, encourage creativity and provide the conditions for compassionate care. Leaders and staff at Here had gone furthest in codifying their philosophy and distinctive working practices. Their focus is on building mindfulness into work, creating the conditions for people to be authentic and bring their whole selves to work and building human relationships. The aims include slowing down the pace of work so that people can act with purpose, creating a safe environment where people can bring all dimensions of themselves and all of their creative potential to their work, softening the working environment and protecting people's emotional resilience. At Thurrock and Social Adventures, the presence of children, animals and musical instruments in

professional spaces appeared subtly to change the environment, making it less formal and more humane.

Like any early stage innovation, the impact of these innovations in working practices and organisation structures is unclear. Even within Here, some staff groups are more enthusiastic about mindfulness and checking in than others. Some people are eager to 'bring their whole selves to work' while others may be rather less enthusiastic. There are tensions between the organisation's aspirations and the challenges of delivering support in cash strapped health and care services. There is a ping pong table in the main open plan area, a symbol of an organisation that aspires to offer space for work and play. On the morning of our visit, we didn't see anybody using it. Nevertheless, social enterprises have consistently had some of the highest staff engagement scores in the NHS, as well as lower levels of sickness absence and staff turnover ('NHS Staff Surveys' 2003 - 2019).

Innovation in providing care

In the mid-2000s, NAViGO took responsibility for the 'out of area' budget for North East Lincolnshire, the budget for people with mental health problems in residential units outside the area. It reviewed the cases of people who had spent years in locked 'rehabilitation' units – without much evidence of rehabilitation – and started to bring them home. While other providers were closing therapeutic communities, it established a new two-year therapeutic community for people with severe mental health and social challenges. Rather than diagnosis and a treatment pathway, service users work together with staff to make sense of what has happened to them, recognise the cycles of their illness, build relationships and envisage what a better life might look like. One person told us: 'I have seen members change so much you had to be there to believe it. I have personally changed beyond belief. I can now eat and drink with others. I can talk to almost anyone. I can trust people. I'm starting to help people. Best of all, I have reconnected with my family.'

Despite their differences, there is a particular focus in these organisations on developing meaningful relationships between staff and service users. At Bevan, GPs and social workers develop close friendships with people who are homeless as they help them rebuild their lives. Staff at NAViGO also build close relationships with people with severe mental health problems, in some cases working together for many years and staying in touch after support programmes finish. Staff at Thurrock build close relationships with both people with severe autism and their carers, so that they can gradually persuade families to try new approaches such as trialling independent living. Many people have argued that state services discourage the development of meaningful relationships between

staff and service users, possibly for fear of creating dependency, compassion fatigue in staff or safeguarding risks (Cottam 2018). In contrast, leaders and staff in these social enterprises see meaningful relationships between staff and service users as a necessary foundation for effective care.

These organisations have all developed approaches to care that are more focused on and tailored to individuals than many traditional health and care services. Perola Sestini, the manager of Thurrock's therapeutic community for people with severe autism, described how the community differed from traditional therapeutic groups. Rather than institutional routines – drawing club at 10.00am, lunch at 12.00pm – staff provide person-centred support that is entirely different from one person to another. Staff observe and document people's moods and behaviour with precision to identify the specific factors that trigger behavioural problems in a person and what interventions help. People with disabilities desperately want freedom. For at least some of the time, they want to be able to choose where to go and what to do like the rest of society. Staff bought a campervan so that, once or twice a year, services users can point on a map and say 'let's go there'.

One common feature of these examples is a rebalancing of attention and resources from medical issues to social support that may sometimes make more of a difference to people's lives. When they reviewed their memory assessment service, staff at Here found that service users were much less interested than professionals in completing rapid diagnostic processes and being put on the appropriate treatment pathway as quickly as possible. Instead, they were much more concerned about fitting diagnosis and treatment in with other aspects of their lives, say attending their lunch club or spending time with grandchildren, and much more interested in getting practical help. They redesigned the service to allow people to choose when they wanted appointments and to start getting the social support they needed before the diagnostic process was completed.

These organisations have all developed asset-based approaches to supporting people and communities, using people's strengths to build health and resilience. At the same time, they actively create opportunities for their service users, for example playing leadership roles in the organisation, volunteering and working in the organisation, or joining spinoff enterprises.

Supporting people with the greatest needs

At Bevan Healthcare, which supports asylum seekers and people experiencing homelessness, we were shown around by the handyman, Steve Manley, who had been a service user before becoming an employee. Steve described sitting at home without work or friends and family. Struggling with depression, he stopped

signing on for benefits and paying the rent, leading to an eviction letter from his landlord. One day, he left home and started walking, from Bradford to Leeds to Manchester to Halifax, where he lived on the streets, returning trolleys to supermarkets for the £1 deposits. After a collapse, he spent a day in hospital in Halifax before being discharged back onto the streets. Health care staff 'signposted' him to a local authority housing service, but they refused to help as he wasn't from the local area.

A few months later, Steve was back in Bradford and collapsed again on the street. This time he spent a day unconscious at Bradford Royal Infirmary. When he woke up, the first person he saw was Helen Phelan, the lead nurse at Bevan's 'pathway service', a team of staff based at the hospital who support people who are homeless on the wards and in accident and emergency. Helen found Steve a room at Bradford Respite Intermediate Care Support Service (BRICSS), a partnership between Bevan and Horton Housing Association, which provides accommodation and support for people for up to a year when they leave hospital.

At BRICSS, Steve built a lasting friendship with one of the GPs at Bevan, who was visiting regularly to check on his health. With another resident, he also started making plant boxes and furniture out of pallets. He is one of those rare people who can turn their hand to pretty much any practical task. The GP suggested that Bevan needed somebody like Steve, something which led to him helping with tasks at the centre, providing support for other people at drop-in sessions, and then to a permanent job. Steve explained that staff at Bevan had clubbed together to buy him curtains and a bed when he moved back into a flat of his own.

If we want to improve access to care for the most deprived, one lesson from these five social enterprises is on the need for radical changes to these groups' access routes into services. There is a strong case for bespoke services, designed specifically to make it as easy as possible to access care. At Bevan, staff converted a second-hand campervan into a mobile unit, with cervical screening, HIV testing and wound care, so that GPs and nurses could care for the hardest to reach people at homeless shelters and on the streets. They created a late-night clinic, staffed only by women, offering primary care services to vulnerable sex workers in one of Bradford's districts, since these women were unlikely to attend other primary care services in the day. They ran it for a year from their surpluses, while the clinical commissioning group and the council negotiated on who should provide ongoing funding for the service. Thurrock paid for its own health checks for disabled people, having failed to persuade local GP

practices to do them systematically and properly, revealing significant, undiagnosed and untreated medical conditions.

These five social enterprises also emphasise the importance of filling gaps and smoothing the transitions of care for vulnerable groups. Bevan's pathway team ensures that people experiencing homelessness are moved directly into short-term accommodation with health and social support after a hospital stay rather than simply signposted to other services. Thurrock's 'transition team' helps children with learning disabilities to transition from school to adult life with programmes to support independent living, work experience and volunteering. At Bevan's centre in Bradford and Social Adventures' Angel Centre in Salford, people can access a wide range of health and support services, with staff introducing them to the people running other services rather than signposting or referral letters.

Our examples highlight the value of small practical innovations to address the problems preventing deprived people getting support. These are often simple but neglected things like providing transport for people to get to services or providing childcare so that parents with small children can attend an appointment or group. In Salford, one of the biggest challenges faced by poor families is paying for childcare so they can get back in work. Social Adventures has established affordable and high-quality childcare within its centres. It gives families a month of free childcare so that they can start work and get their first pay cheque. NAViGO puts down deposits and provides guarantees so that people with mental health problems can rent a home. The King's Fund's recent report on delivering health and care for people who sleep rough also highlights the need for active steps to find and engage people, going beyond the limitations of existing services and tailored approaches to join up services and meet the needs of vulnerable groups (Cream *et al* 2020).

Joining the dots

Neil Woodbridge, the chief executive of Thurrock Lifestyle Solutions is one of those outgoing people who seem to know absolutely everyone, from the Secretary of State for Health and Social Care and the chair of the health and social care select committee to the local barber and the conductor of the church choir. For students of social networks, he is a 'boundary spanner', one of those people who ensure that we are on average only six degrees of separation, probably less, from anyone else on the planet. A chemist might compare him with oxygen or hydrogen, the molecules at the heart of almost any chemical reaction.

In 2015, Neil and his colleagues closed down the day centre for disabled people that they had inherited from the local authority: a large centre on a trading estate in the middle of nowhere, what critics might call a warehouse, where people with disabilities would be bussed in to spend their days. In its place, they created small centres in high streets close to other human activity and people's homes

Over the past five years, staff and service users have gradually built links with the local shops, businesses and voluntary organisations. If the local choir is looking for somewhere to practice, they can use one of the Thurrock centres for free. When a group of local people wanted to renovate a derelict park, Gray's Beach, Thurrock Lifestyle Solutions offered advice and financial resources. The group built play areas, sports facilities, a wooden play ship and a café. Staff only ask for one thing in exchange, that people with physical and learning disabilities can participate in activities.

Many of the organisations in this study appear to play a particularly important role as connectors within local communities, spotting opportunities for organisations to work together and opportunities to make better use of the community's combined resources. Bevan partnered with a local housing association to prevent homeless people in hospital falling back onto the streets. It asked students from a local grammar school to run homework clubs for children seeking asylum. The children are able to catch up at school and get a sense of the futures they might aspire to The students have an achievement to put on their university applications and, perhaps more importantly, an opportunity for personal development that academic study is unlikely to provide. It's a perfect example of connecting groups and harnessing community resources where everybody benefits and grows.

Another theme is just how much can be achieved with limited amounts of money through leveraging the existing resources within communities better. When Scott Darragh and colleagues met the owner of a small garden centre in Salford, they saw a new opportunity to support people with anxiety and depression. For running costs of £70,000 per year, dozens of people with mental health problems spend time as volunteers at the centre, designing plots, planting, harvesting and cooking together. They develop friendships, connect with nature, develop their cooking skills and improve their physical health, with many going on to sustainable employment. Everybody in the local community is invited to join in activities at the centre. Social Adventures has now created a woodland school on the site where children learn about nature, build dens and cook on open fires.

Research so far on anchor institutions in health care has focused on how large organisations with significant budgets can use their financial resources strengthen the local economy, for example through procurement from local businesses, capital investment in local enterprises and hiring local people (Reed *et al* 2019). These social enterprises also appear to be playing a slightly different anchoring role, one that depends more on small but strategic actions to link up a local system: bridging social divisions, combining resources, building partnerships and enabling new social entrepreneurship.

3 Preserving social innovation

This paper has argued that social enterprises, along with other organisations, appear to play a particularly valuable role in innovation within health and care services. The five social enterprises studied here provide a long list of innovations, both in organisation design and management practices and in approaches to delivering care to patients and service users. Public sector bureaucracies have a well-documented set of disadvantages when it comes to innovation, even if some succeed in overcoming them. Attempts to harness the innovation capability of the private sector in addressing complex social problems have also proved harder than policy makers from the 1990s imagined, not least because of the challenges in devising appropriate incentives. At their best, social entrepreneurs can bring creativity and agility to complex social problems, with their motivation coming from primarily from their mission rather than the hope of financial gain (Murray; Murray *et al* 2010).

Yet extensive research highlights the challenges faced by innovators who challenge established ways of doing things in an industry. Even in private markets, the capitalist parable of the plucky entrant who fells the corporate giant only plays out a small amount of the time. More often, the individuals and small organisations that question the status quo are discretely sidelined. Sometimes the antibodies of the system kick in to neutralise a threat. Other times, those in positions of authority simply ignore valuable innovation that does not fit with their world view. We look past the things that don't conform with our understanding of the world (Henderson and Clark 1990; Senge 2006; Hamel 1996).

The leaders and staff we spoke to in these social enterprises were acutely aware of the risks. Right now, there are few visible political champions of social enterprise in government, the likes of Francis Maude, Norman Lamb or Hazel Blears. Some social enterprises are struggling to make their voices heard and retain a seat at the table, as decision-making moves upwards to new regional bodies. Some described a health system that was 'circling the wagons', protecting the financial position of public sector organisations at the expense of anyone on the periphery of the system. Despite their successes, some of the social enterprises we visited were withdrawing from delivering services because of the costs and difficulties of contracting and unsustainable funding.

There is a huge amount that government and health and care commissioners could do to better protect innovators on the margins. Top of the list might be providing a much greater degree of financial security for social enterprises that play essential roles with partners in local communities and unravelling complexities in contracting and performance management that restrict innovation and increase providers' costs. What social enterprises really want, along with voluntary sector and community-based organisations, is public sector partners who recognise the unique contribution they can make, are alert to the broader social value of their work and are open minded about radically different approaches to care.

As well as preserving social innovation, there is also a pressing case for NHS organisations to learn more actively from social enterprises and other similar organisations on their approaches to serving particular social groups and supporting local communities. In response to the Covid-19 pandemic, many NHS organisations are currently considering how they can play the role of 'anchor institutions'; organisations that play an active role in protecting the economic resilience of their communities. The starting point must surely be to build closer partnerships with the social enterprises and other local organisations already playing an anchor role and to learn from their methods for supporting their communities.

4 References

Anon (2003). *NHS Staff Surveys* Available at: https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2019/ (accessed on 20 April 2020).

Beresford P (2002). Thinking about 'mental health': Towards a social model. *Journal of Mental Health*, vol 11, no 6, pp 581–4.

Bevan Healthcare (2018). Bradford doctor surgery 'best of its kind' in the UK - according to top health inspector. Bevan Healthcare Available at: https://bevanhealthcare.co.uk/bradford-doctor-surgery-best-of-its-kind-in-the-uk-according-to-top-health-inspector-2/ (accessed on 20 April 2020).

Cottam H (2018). *Radical help: how we can remake the relationships between us and revolutionise the welfare state*. London: Virago.

Cream J, Fenney D, Williams E, Baylis A, Dahir S, Wyatt H (2020). *Delivering health and care for people who sleep rough*. Available at: www.kingsfund.org.uk/publications/delivering-health-care-people-sleep-rough (accessed on 20 April 2020).

Ham C (2014). *Improving NHS care by engaging staff and devolving decision-making*. Available at: www.kingsfund.org.uk/publications/articles/improving-nhs-care-engaging-staff-and-devolving-decision-making (accessed on 20 April 2020).

Hamel G (1996). 'Strategy as revolution'. *Harvard Business Review*, July–August 1996. Available at: https://hbr.org/1996/07/strategy-as-revolution (accessed on 20 April 2020).

Henderson R and Clark K (1990). 'Architectural innovation: the reconfiguration of existing product technologies and the failure of established firms. *Administrative science quarterly*, vol 35, issue 1, p 9. Available at: http://dimetic.dime-eu.org/dimetic_files/HendersonClarkASQ1990.pdf (accessed on 29 July 2020).

Matrix Evidence (2010). 'The employee ownership effect: a review of the evidence'. Employee Ownership Association website. Available at: https://employeeownership.co.uk/resources/reports (accessed on 29 July 2020).

Menzies IEP (1960). 'A case-study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital'. *Human Relations*, 13, 2, pp 95-121 Available at: https://journals.sagepub.com/doi/10.1177/001872676001300201 (accessed on 20 April 2020).

Murray R, Mulgan G, Caulier-Grice J (2010). 'The open book of social innovation'. The Young Foundation website. Available at: https://youngfoundation.org/publications/the-open-book-of-social-innovation (accessed on 29 July 2020).

Murray R (2009). *Danger and opportunity: crisis and the new social economy*. London: NESTA. Available at: www.nesta.org.uk/report/danger-and-opportunity-crisis-and-the-new-social-economy (accessed on 29 July 2020).

Reed S, Gopfert A, Wood S, Allwood D, Warburton W (2019). *Building healthier communities: the role of the NHS as an anchor institution*. London: Health Foundation. Available at: www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution (accessed on 20 April 2020).

Senge PM (2006). *The fifth discipline: the art and practice of the learning organization*. London: Random House Business Books.

Social Adventures (2020). 'Community and impact report'. Social Adventures website. Available at: http://socialadventures.org.uk/wp-content/uploads/2019/12/SA_Community-and-Impact-Report-web-version.pdf (accessed on 29 July 2020).

Sorenson C, Bolick B, Wright K, Hamilton R (2016). 'Understanding compassion fatigue in healthcare providers: a review of current literature'. *Journal of Nursing Scholarship*, vol 48, no 5, pp 456–65. Available at: https://journals.sagepub.com/doi/abs/10.1177/0969733019889400 (accessed on 29 July 2020).

Wattis J, Curran S, Rogers M (2017). *Spiritually Competent Practice in Health Care*. London: CRC Press.