



**The Social, Cooperative
and Community Economy**
All-Party Parliamentary Group



Accelerating NHS reform

Levelling the playing field to unlock
social enterprises

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AUTHORS

- Patrick Hurley MP, Chair of the Social, Co-operative & Community Economy All Party Parliamentary Group
- Social Enterprise UK
- Baxendale
- Locala Community Partnerships CIC

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KEY MESSAGES

1 The NHS is already a mixed provider system and policy should reflect this

Social enterprises deliver over £1bn of NHS care annually. Yet national policy continues to treat NHS trusts as the default provider, distorting how resources, funding and governance reflect the system as it actually operates.

2 Social enterprises are already delivering the Government’s priorities

This report demonstrates that social enterprises are already delivering what the 10 Year Health Plan sets out to achieve, including prevention, hospital to community, and delivering neighbourhood health.

3 Structural inequity is working against the Government’s own ambitions

From National Insurance to workforce funding, digital investment to capital access, social enterprises delivering equivalent NHS services are systematically excluded from resources - diverting resources away from prevention and community care.

4 Outcome-based reform requires form-neutral commissioning

Activity-based commissioning protects acute providers and disadvantages those whose value lies in prevention and continuity. Shifting incentives toward outcomes would unlock the contribution of mission-led providers.

5 Government must actively shape markets

Reward reinvestment and intervene when providers are failing. Mission-led providers deliver better outcomes and should be supported to scale, moving away from extractive models of care.

6 Without reform, excellence will remain isolated

Without action on capital, commissioning and funding eligibility, innovative social enterprise models will remain pockets of excellence rather than the foundation of a rebalanced system.

7 Addressing barriers requires the effective use of existing powers

This report calls for commissioners and system leaders to make fuller use of existing flexibilities and powers, including in the Procurement Act 2023 and Provider Selection Regime, to remove structural barriers, embed best practice in VCSE commissioning, and create the market conditions for social enterprise to scale.

INTRODUCTION

This report addresses the structural barriers facing social enterprises delivering health and care services, sets out the interventions needed to embed provider pluralism, and makes the case for social enterprise as a central delivery partner in NHS reform.

Social enterprises already deliver over £1bn of NHS care annually and operate at scale across community, urgent, mental health and end-of-life services. They demonstrate lean cost structures, high staff engagement, and strong quality performance. However, structural barriers limit their ability to scale - and in many cases threaten their ability to operate at all.

This report builds on Social Enterprise UK's 2025 publication, *Ahead of the Curve on Healthcare*, which drew on independent data analysis by Baxendale and demonstrated that social enterprises are already delivering the shifts set out in the Government's 10 Year Plan

- better outcomes, leaner operations and more community-centred care. Where that report showed that social enterprise models work, this report examines how the system is failing to support them - preventing them from scaling and, in many cases, actively undermining their ability to continue to operate successfully.

This report sets out targeted, non-legislative interventions to remove those barriers and unlock the contribution of social enterprises to the Government's priorities - from sickness to prevention, hospital to community, and long-term fiscal sustainability.

EXECUTIVE SUMMARY

The NHS was established as a universal public service, funded through taxation and free at the point of use. It remains one of the UK's most important public institutions. Over time, however, the system has evolved in ways that favour particular organisational forms in funding access, governance arrangements and policy design.

In practice, the NHS already operates as a mixed provider system. Social enterprises, (including cooperatives, mutuals and Community Interest Companies), charities, independent providers, partnership models (general practice) and NHS trusts all deliver publicly commissioned care and have long been integral to the UK's health and care system. Yet policy frameworks, capital flows and decision-making structures do not consistently reflect this reality. Organisational form neutrality does not currently exist and NHS providers are the primary and often sole consideration when policy decisions and subsequent guidance and resources are determined.

The result is a system that advantages two provider types above all others:

- NHS trusts - through policy and public resource
- Private providers - through access to capital markets, flexible ownership structures and tax advantages

Mission-led providers like social enterprises benefit from neither.

This report argues that the NHS would benefit from a more explicit commitment to provider pluralism and a stronger shift toward outcome based public service reform to deliver on policy ambitions for neighbourhood health and the government's 10 Year Health Plan for the NHS. A more balanced system would enable different mission aligned providers to contribute on fair terms, embed plural representation in governance, and align incentives around long-term health outcomes, rather than organisational status.

This is not an argument for privatisation or fragmentation. It is an argument for ensuring that the system uses all its assets effectively, and that decisions are driven by outcomes, public value and long-term sustainability. It advocates for a model of investments in communities and services and proposes positive steps to move away from structural incentives that can lead to extraction of value and wealth from places and local public service budgets.



A doctor consults with a patient at the Jean Bishop Centre, Hull

1 WHY PROVIDER PLURALISM MATTERS

The NHS is often described as a single provider system. In reality it is not. A substantial proportion of community health services, mental health provision, primary care and specialist services are delivered by organisations that are not NHS trusts. Many of these organisations operate on a not-for-profit basis and reinvest surpluses into services and communities.

Despite this diversity, national policy frequently assumes that NHS trusts are the default provider model. Funding streams are designed with trusts in mind. Workforce settlements are negotiated centrally, but not always funded consistently across provider types. When pay is renegotiated nationally, uplift funding flows to NHS trusts but not consistently to independent providers - including social enterprises operating on Agenda for Change terms following Transfer of Undertakings, Protection of Employment (TUPE) transfer from the NHS. Providers that the system itself created are left to absorb centrally-negotiated cost increases without equivalent financial support.

Access to capital, digital transformation programmes, workforce development and continuing professional development can vary. Asset and infrastructure ownership e.g. in the case of NHS property services, is only accessible to NHS Trusts - despite the common use of 'asset

locked' social enterprise vehicles. Representation within system leadership structures is inconsistent and sometimes actively punitive. See Annex A for documented examples of structural exclusion across funding, workforce and governance.

This creates structural imbalance. Providers delivering identical NHS commissioned services may face different levels of support depending on their legal form. The issue is not simply fairness between organisations. It is whether the NHS is making full use of the diversity within its own delivery system.

Provider pluralism means recognising that different organisational forms can contribute to public service delivery, and that these forms should be treated equitably where they are delivering NHS services. It means focusing on function and outcomes rather than institutional status.

2 THE CASE FOR OUTCOME BASED REFORM

The NHS has made significant progress in improving quality and access, but it continues to face pressures from rising demand, workforce shortages and financial constraint. Much of the commissioning framework remains activity driven, with incentives linked to throughput rather than long term health outcomes.

This has predictable consequences. Acute activity is protected because performance frameworks and funding models reward hospital activity, elective throughput, and waiting list metrics - and as such, these are what leaders prioritise. Prevention and community-based models struggle to scale because savings are often realised in different parts of the system from where investment is required.

Outcome based reform would shift attention toward population health improvement, reduced avoidable admissions, workforce stability, reinvestment in local communities and long-term financial

sustainability. It would encourage providers to design services around impact rather than volume.

A plural provider landscape can support this shift. Mission-led organisations such as social enterprises and charities are often structurally aligned with long-term outcomes. They reinvest surpluses, tend to have strong community relationships and may be more able to take a longer-term view where incentives support it. NHS Trusts bring scale, clinical integration and infrastructure. A system designed around outcomes should draw on these complementary strengths.

3 EMBEDDING PLURALISM IN GOVERNANCE

Integrated Care Systems were established to promote collaboration, reduce fragmentation and improve population health. However, representation within Integrated Care Boards and related structures varies significantly across the country.

Where non-trust providers are delivering substantial volumes of NHS commissioned care, it is reasonable that they should have a voice in system level planning and transformation. This is not about institutional lobbying. It is about ensuring that decision making reflects the full provider landscape and that system reform is informed by operational realities across different organisational forms.

Clearer national guidance would help. The Department of Health and Social Care (DHSC)

should confirm that organisational form alone should not exclude a provider from governance roles where it delivers significant NHS services. Integrated Care Boards should be encouraged to ensure that their advisory and provider engagement structures reflect the diversity of local delivery.

Embedding pluralism in governance would strengthen accountability and improve the quality of system-wide decision making.

4 CAPITAL AND FINANCIAL FRAMEWORKS

Access to capital is a critical determinant of organisational sustainability and innovation. NHS Trusts can access public capital budgets, although these are constrained. Investor-owned providers can access private capital markets. Mission led providers that are not statutory bodies often have limited access to either.

This capital gap can constrain the ability of not-for-profit providers to invest in estates, digital infrastructure or service redesign. If the government and the NHS are serious about shifting care into the community and investing in prevention to successfully deliver neighbourhood health, it will need mechanisms that allow a wider range of providers to access transformation funding.

Potential approaches could include blended finance models, national transformation funds accessible on a form neutral basis, and outcome-based repayment mechanisms where savings are demonstrable. The principle should be that access to transformation capital is linked to delivery of NHS commissioned services and measurable outcomes, not to legal status.

The development of neighbourhood health infrastructure - including neighbourhood health centres - presents a significant opportunity. However, they should avoid repeating the structural weaknesses of Private Finance Initiative (PFI) and earlier public-private partnership models, which often embedded long-term cost rigidity, limited public control, and extracted value from essential services.

Instead, new delivery models should be founded on Public Social Partnerships (PSPs) and social enterprise vehicles. These models should prioritise retained public value, transparent reinvestment, and mission-aligned governance.

This approach should:

- embed community benefit and reinvestment of surplus into service design from the outset
- ensure long-term public control and accountability over assets and service direction
- explore the use blended finance and social investment only where it supports patient, place-based capital rather than financialised return extraction
- favour mission-locked and community-governed providers as anchor delivery partners
- build on the demonstrated strengths of social enterprises in delivering integrated, locally accountable and preventative services

Crucially, existing social investments could be used to hold these assets and potentially invest in them on behalf of neighbourhoods and place-based developments, ensuring assets and investment are retained locally.



A soup making session in Vibrant Village Birkenhead in August 2025
One Wirral CIC - Community Hearts Programme



Staff and patients at the Jean Bishop Centre in Hull.

5 MARKET SHAPING AND LONG-TERM VALUE

In several areas of health and social care, market dynamics have combined with structural barriers to produce persistent and well-evidenced market failure. These markets become increasingly dominated by highly leveraged, private-equity-owned providers, characterised by poor outcomes and rising costs. Despite this, these models have been allowed to persist and expand.

This is not the result of effective competition, but of commissioning under acute pressure. Local authorities and NHS bodies operate in thin markets where supply is constrained, and statutory duties must be met regardless of cost or quality. In this context, commissioners often have little practical choice but to purchase available capacity, even where outcomes are poor and value for money is weak. Highly leveraged providers can scale rapidly by accessing private capital, acquiring assets and absorbing short term risk, while passing long term financial and service risk back to the public sector.

Mission-led providers, including social enterprises and other reinvesting models, consistently demonstrate locally rooted, outcomes-focused

approaches that reinvest surplus into workforce stability, quality improvement and expanded capacity. However, these models face significant barriers to scale. Access to capital is limited and commissioning frameworks prioritise short-term price and transactional contracts. Procurement processes are also often poorly aligned to providers whose value lies in prevention, continuity and long-term system benefit rather than short-term throughput.

The result is a structurally imbalanced market in which extractive models are rewarded for financial engineering, while providers aligned with public purpose struggle to grow, despite delivering better outcomes and greater system resilience.

Not all independent provision is extractive; however, the structural incentives often favour scale and leverage over reinvestment. Too often, this leads to public money being taken out of local economies and redistributed to private individuals and investors through shareholder dividends

and other extractive mechanisms. In some areas of health and social care, these dynamics have produced fragile and highly leveraged ownership models and introduced risk into essential public services.

Children's residential care is increasingly dominated by private equity-owned providers, characterised by very high and rising placement costs, inconsistent outcomes, and children being placed far from their communities and support networks. These dynamics persist despite long standing policy commitments to stability, local provision and relational care, and are compounded by opaque ownership structures that extract value rather than reinvest in capacity or quality.

Specialist mental health and neurodevelopmental services, including ADHD and autism diagnosis and residential care for people with learning disabilities, show similar signs of market failure. Long NHS waiting lists and constrained local capacity have enabled rapid growth by large corporate providers, driving inflationary costs, variable quality, weak integration with local pathways, and continued reliance on out of area placements.

Social enterprise and community led models demonstrate a viable alternative: integrated, person-centred services that link diagnosis, treatment and ongoing support, reinvesting surplus into workforce development, quality improvement and pathway sustainability. Yet these providers face structural barriers to growth, including transactional commissioning, capital constraints and procurement frameworks that undervalue integration, continuity and social value.

Government has a legitimate and necessary role in actively shaping markets to ensure stability, quality and value for money, not simply overseeing them. Commissioning frameworks can and should be designed to promote stability, quality and value for money by rewarding long-term reinvestment, workforce continuity and place-based delivery. Where markets are demonstrably failing to deliver good outcomes, affordability or resilience, there is a strong case for targeted intervention - including stronger incentives, risk sharing mechanisms and capital support - to enable models aligned with public purpose to enter, scale and rebalance the market.

Social enterprise models of public service provision ensure public funds generate economic and social value which is retained in areas where services are commissioned and reinvested in service improvements.



This is not about excluding particular organisational types. It is about ensuring that incentives favour sustainability and public value.

6 WHAT A REBALANCED SYSTEM WOULD LOOK LIKE

A more form neutral NHS would demonstrate consistent access to national policy initiatives for all providers delivering NHS commissioned services. Governance structures would reflect the diversity of delivery in each area. Capital frameworks would support transformation across organisational forms. Commissioning would place greater weight on outcomes and long-term value. Assets and infrastructure developed to support neighbourhood health would be designed from the outset for community benefit. Such a system would be better positioned to shift resources upstream, strengthen community services and deliver improved value for taxpayers.

Some may argue that stronger provider pluralism risks fragmentation. In practice, fragmentation arises from poor coordination and unclear accountability rather than from organisational diversity itself. If outcomes are defined at system level, data flows are interoperable, and governance structures include all significant contributors, pluralism can coexist with integration. The key is clarity of accountability and shared outcome frameworks.

Social enterprises are already demonstrating what this looks like in practice. The following case studies show how mission-driven providers are delivering on the government's ambitions for neighbourhood health, reducing acute demand, and improving outcomes for some of the NHS's most complex patients.

Taken together, these examples demonstrate the innovation and outcomes social enterprises can deliver. Without reform to capital frameworks, commissioning practice, and form-neutral access to national policy initiatives, models like these will remain isolated pockets of excellence rather than the foundation of a rebalanced system.

For further examples of social enterprises delivering innovative health and social care, including models already delivering on the neighbourhood health agenda, visit Social Enterprise UK's case study library: <https://www.socialenterprise.org.uk/health-and-social-care-case-studies/>



Consultant Community Geriatrician Daniel Harman of the CHCP's Jean Bishop Centre



Here - Community Appointment Days

Here is a not-for-profit healthcare social enterprise, rated Outstanding by the CQC, delivering innovative community care across Sussex. Since 2024, it has supported a population of over one million people as part of the Sussex MSK Partnership - a practical demonstration of how social enterprise can deliver the neighbourhood health agenda at scale.

A neighbourhood solution to system pressure

In 2023, in response to post-pandemic waiting times, workforce pressures, and fragmented care, Here launched Community Appointment Days (CADs) for musculoskeletal conditions (MSK). Held in well-known community assets, including local leisure centres and faith settings, CADs bring together clinicians, rehabilitation services, and VCSE (voluntary, community and social enterprise) organisations - including Citizens Advice, carer support, and Department for Work and Pensions (DWP) - in a single, accessible community setting. Every patient encounter begins with one question: 'What matters to you?'

What the evidence shows

(Data from 2023)

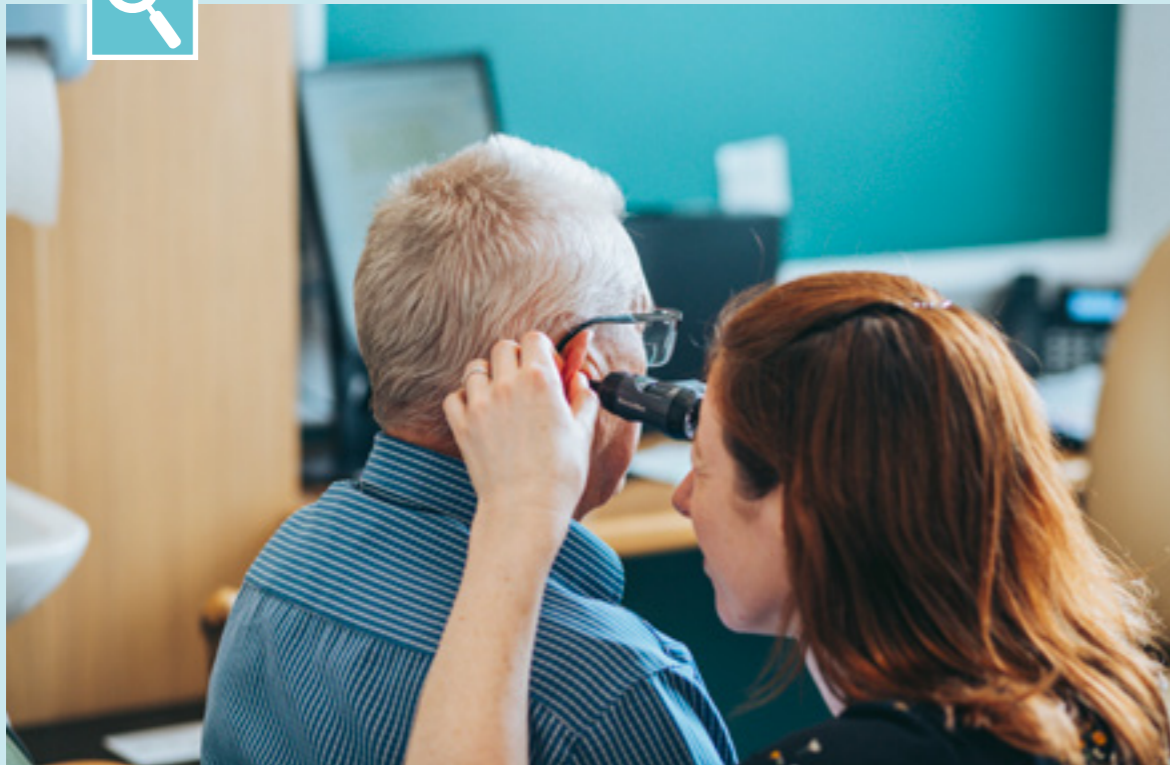
- **52%** of attendees received everything they needed in a single day and were able to effectively self-manage their conditions
- Over **90%** of care providers agreed CADs enabled people to take an active part in their own care
- Sussex MSK Partnership has outperformed national trends in reducing waiting times for patients waiting over 18 weeks

Why the social enterprise model matters

Here's staff identify the social enterprise model as a critical enabler. Financial autonomy supports innovation; nimble governance fosters a culture of testing and learning. These are structural features of the model - not incidental to Here's success, but foundational to it.

CADs are what the neighbourhood health agenda is designed to achieve: care delivered in communities, coordinated around the whole person, drawing on VCSE and community assets, and focused on prevention over acute intervention.

To find out more about Here's work, visit their website <https://hereweare.org.uk/>



City Health Care Partnership (CHCP) – Jean Bishop Centre

City Health Care Partnership (CHCP) is a co-owned social enterprise whose profits are reinvested into services, staff, and community. Its Jean Bishop Centre in Hull demonstrates how mission-driven social enterprise can tackle frailty through a neighbourhood-based, person-centred model.

A neighbourhood solution to frailty

Opened in 2018 to address health inequalities among older people with frailty, the centre takes a proactive rather than reactive approach - engaging individuals in shaping their own care before frailty generates acute demand. Within two years, it had worked with 90% of Hull's 3,000 people living with severe frailty.

The evidence

Independent evaluation found significant reductions in acute demand:

- 50% reduction in emergency admissions for the most frequent attenders
- 10–25% reduction in GP visits across the wider group
- 13.6% reduction in A&E admissions for people over 80; 18% for care home residents
- £100 per person per year reduction in medicine costs
- 63% of ambulance referrals to the Centre avoided hospital transfer

Wellbeing outcomes were equally striking: those receiving intervention showed measurable improvement at both 2–4 and 10–14 weeks post-intervention, while a matched control group declined over the same period.

Why the social enterprise model matters

CHCP's financial autonomy and mission-driven governance provided the conditions to design, test, and embed this model at scale - free from the short-term pressures and profit incentives that constrain innovation in other provider types. The Jean Bishop Centre is a clear proof point for what the neighbourhood health agenda can achieve when social enterprises are resourced and empowered.

To find out more about CHCP's work, visit their website <https://www.chcpcic.org.uk/>



One Wirral CIC - Community Hearts Programme

One Wirral CIC is a social enterprise with a mission to remove barriers to health and wellbeing and reduce health inequalities in the Wirral, targeting support where it is most needed. One Wirral also runs its own GP practice, delivering frontline NHS primary care. Its Community Hearts Programme demonstrates how a community-rooted social enterprise can tackle the social and cultural determinants of cardiovascular disease where health inequalities are greatest.

A neighbourhood solution to cardiovascular disease

Launched in 2025 with support from the Step-Up Fund - a UK government initiative backing VCSE organisations delivering health and wellbeing work in Wirral - the Community Hearts Programme weaves cardiovascular disease (CVD) prevention into everyday community life. Working through social supermarkets, food banks, allotments, and household fund providers, the programme addresses the social and cultural determinants of poor heart health: knowledge, time poverty, and access to quality care. People in the most deprived communities are 30% more likely to experience high blood pressure. The programme targets these communities directly, promoting health knowledge, heart-healthy diets, and access to medical support.

The evidence

In its first year, the programme:

- Engaged over 460 community members
- Delivered over 40 one-to-one sessions and workshops on healthy cooking, salt reduction, and cardiovascular health
- Completed 55+ health checks and health MOTs, and over 150 blood pressure checks

The programme was recognised by the Health Creation Alliance as 'Health Creating Community Connector of the Year' in 2025.

Why the social enterprise model matters

The Community Hearts Programme is built on trust, relationships, familiar spaces, and working with people in their communities and local organisations. One Wirral's model demonstrates that the most effective CVD prevention does not always begin in a clinic; it begins where people already are, delivered by organisations they already trust.

To find out more about One Wirral CIC's work, visit their website <https://www.onewirral.co.uk/>



A community conversation in a social supermarket in Birkenhead in February 2025.

CONCLUSION & RECOMMENDATIONS

The evidence set out in this report points to a clear conclusion: social enterprises are capable of delivering the Government's ambitions for NHS reform, yet structural barriers prevent them from scaling.

Addressing these barriers requires no new legislation or structural reorganisation. It requires targeted use of existing policy levers and powers to reduce avoidable acute demand, mitigate long-term expenditure growth, and shift structural incentives toward reinvestment and delivering sustained community benefit.

Embedding provider pluralism in policy design, funding and governance would enable the transformation needed in health and care.

The following actions would deliver meaningful change:

Parity in access to funding, capital and resources

- 1 Issue DHSC/NHS England formal guidance confirming social enterprise eligibility for capital, estates, digital and workforce funding on parity with NHS Trusts. This is particularly important in the disbandment of NHS property services where the transfer of some estates to NHS Trusts further increases the uneven playing field.
- 2 Require that future national funding initiatives and system communications explicitly state inclusion of social enterprise providers.

Structural accountability within government

- 3 Establish clear ownership and accountability for social enterprise within the new DHSC organisational structure, including considering establishing a dedicated 'unit' to embed these models in the reform of NHS and care delivery.

Embed best practice in commissioning and procurement

- 4 Strengthen and embed the use of the flexibilities and powers available within the Procurement Act 2023 and the Provider Selection Regime (PSR). Promote best practice in VCSE commissioning through clearer operational guidance and more consistent application across systems, to incentivise the delivery of public value, sustainability and long-term stewardship, including:
 - a. Update procurement and social value guidance to support commissioners to recognise reinvestment, mission-led governance and protections against extractive profit distribution as material differentiators in delivering sustainable public services.
 - b. Ensure neighbourhood delivery vehicles (those organisations likely to hold the neighbourhood provider contracts) are expected to demonstrate transparency around subcontracting, reinvestment and profit distribution arrangements.
 - c. Ensure contracting mechanisms are applied

- d. Promote and support alternative delivery models, including Public Social Partnerships and mission-led collaborative approaches.
 - e. Commit to upskilling procurement and commissioning teams on how to engage successfully with VCSE and social enterprise providers and how to apply the flexibilities within the Procurement Act and Provider Selection Regime (PSR) effectively.
- in ways that positively enable social enterprise and VCSE participation, including through proportionate contracting, partnership models and outcome-based commissioning.

Social enterprise market development

- 5 Develop a time limited social enterprise market development programme to address areas of market failure and structural inequity.

Recognition and governance

- 6 Issue guidance confirming that organisational form alone should not exclude a provider from governance roles where it delivers significant NHS services.

Adopt Public Social Partnership and social enterprise model

- 7 Adopt a Public Social Partnership and social enterprise model for neighbourhood health infrastructure and care, including Neighbourhood Health Centres, prioritising long-term public value, transparent reinvestment and mission-aligned governance.

The NHS is a universal public service, but it is delivered through a range of organisational forms. Recognising this reality in policy, funding and governance would strengthen the system rather than weaken it.

Provider pluralism is not an end in itself. It is a means of improving outcomes, enhancing resilience and ensuring that reform is driven by public value rather than institutional preference.

If the NHS is to meet the challenges of the coming decade, it will need to draw on the full range of its delivery partners. Taking forward the recommendations outlined in this report would be a significant step towards that goal.

ANNEX A – BACKGROUND

What is a social enterprise?

Social enterprises are businesses which trade for a social or environmental purpose. Like any other business, they seek to make a profit and succeed commercially. However, they prioritise benefit to people and planet and use the majority of any profit to further their mission.

They operate as independent, non-profit distributing organisations with a legal duty to reinvest surpluses into services and communities. In doing so, they combine strong public service values with entrepreneurial capability, workforce empowerment, and deep local accountability.

The history of social enterprise in the UK's health and care system

Social enterprises, charities, co-operatives and mutuals have long been integral to the UK's health and care system. Many were deliberately established by the last Labour government as part of successive waves of reform to modernise public services, improve outcomes, and increase responsiveness to local need.

A significant proportion of today's largest health and care social enterprises emerged from NHS community services. They were created to:

- Decentralise decision-making and empower frontline staff.
- Enable innovation and service redesign outside rigid statutory structures.
- Retain public service ethos while increasing flexibility, productivity and accountability.
- Strengthen community connection and integration with wider local services.

Size and scale of social enterprise delivering NHS services

Social enterprises already deliver billions of pounds worth of vital NHS care across the country, employ tens of thousands of staff, and play a central role in community health, mental health and social care.

There are over 1,200 social enterprises in the NHS's supply chain. Collectively, social enterprises deliver a substantial share of community health, mental health, urgent care, end-of-life care, and social care services.

NHS Confederation reports that one third of community services are delivered by social enterprises. (NHS Confederation, Social Enterprises: Part of the NHS Family, 2019).

Contracts, workforce and standards

Social enterprise organisations continue to deliver the majority of their activity under NHS and local authority contracts, often employing staff on NHS Agenda for Change terms and conditions and operating to the same regulatory standards as statutory providers.

Data and evidence

The 60 largest healthcare social enterprises deliver £2.4 billion worth of services annually, with the biggest 15 employing nearly 12,000 staff.

Research undertaken by Baxendale and The King's Fund demonstrated how health and care social enterprises:

- Have higher staff engagement levels, lower sickness rates – at a time where public sector culture has been identified as being a key inhibitor to public sector transformation.
- Have significantly higher performance in terms of quality with 23% fewer organisations being rated as 'Requires Improvement'.
- Have leaner more efficient operating models when compared to equivalent organisations.
- Operate with lower overhead costs relative to total spend indicating, lean management, devolved accountability, and a prioritisation on front line care.

(Social Enterprise UK, Baxendale and The King's Fund, 2025)

Evidence of exclusion and barriers to social enterprise

There have been many examples over recent years in which social enterprises have faced exclusion and barriers. Some of these examples are outlined below:

National Insurance	The 2024 Autumn Budget increased employers' National Insurance contributions to 15% and lowered the payment threshold. Public sector providers were protected; charities and social enterprises were not. This created an uneven playing field across providers delivering equivalent NHS services, with cost pressures falling on the community and voluntary providers best placed to deliver prevention and neighbourhood health, diverting resources away from prevention and community services towards acute care and private providers, contrary to the Government's own ambitions.
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Agenda for Change (AfC) pay uplift	When negotiating pay for staff on AfC terms, the government makes no assessment or provision for social enterprises delivering NHS services. For the vast majority of social enterprises delivering health and care, nearly all staff are employed on AfC terms and conditions. As a result, these organisations face an unfunded liability that threatens the financial viability of contracts and, ultimately, continuity of care for the people they serve.
The NHS pay deal	Staff on Agenda for Change terms of conditions were told explicitly they would receive the 'backlog bonus' by the Conservative Secretary of State, but their employers were not funded accordingly until SEUK launched a Judicial Review.
Digital funding	Exclusion from national digital transformation funding, such as the Frontline Digitisation Fund, estimated to be worth around £2bn.
NHS workforce plan	Social enterprise was largely forgotten in the NHS workforce plan published in 2023, worth over £2 billion.
Nurse recruitment resources	Social enterprises were left out of resources to support international nurse recruitment, including NHS England's 2022/23 funding of £7,000 per overseas nurse recruited, available exclusively to NHS Trusts, leaving social enterprise community providers without equivalent support.
CPD funding	Social enterprises are excluded from Continuing Professional Development (CPD) funding.
E-rostering investment	National e-rostering investment was directed exclusively at NHS Trusts, leaving social enterprise providers without equivalent support for workforce digitisation.
Exclusion from capital funding	Social enterprises have not been eligible to apply for various capital budgets over the years, worth many billions of pounds.
NHS Property Services	Social enterprises are excluded from the transfer of NHS Property Services (NHSPS) assets to NHS trusts, despite being asset-locked organisations delivering NHS services from many of those same properties, and despite NHSPS originally being established to hold property for use by social enterprises among others.
Governance	Some social enterprise organisations are told they cannot sit on ICBs and related structures as "they are not NHS" despite being the principal community services provider in an area, while others are only allowed "observer status" and others again are being allowed, demonstrating the lack of understanding in the system. The guidance says they should be.
NHS pension access	Social enterprise staff continue to report issues accessing NHS pensions, despite being previously agreed.
Restrictions in medicine service referrals	Issues in referrals to a medicines service, as many are told they "can only be from an NHS Trust and so community services provided by a SE cannot refer" with a direct impact on services and patients.
EU exit planning	Social enterprise providers were forgotten in planning for the potential EU Exit supplies disruption to the NHS, despite concerns being repeatedly raised by social enterprises to NHSE. This includes issues in getting on the PPE supply chains and late delivery of lateral flow test kits and staff vaccines, much later than NHS Trusts, putting patients and staff at risk.
Corporation tax and VAT	In addition to the inequities outlined above, social enterprises are also subject to corporation tax and VAT, which can create further structural disadvantage relative to other delivery models operating in the public service landscape. While it is recognised that changes to tax treatment for any one provider type within a specific sector may not be feasible, it is important to note that, when combined with other commissioning and funding constraints, the cumulative effect can act as a brake on the growth and scalability of this important sector.

References

1. NHS Confederation (2019) Social Enterprises: Part of the NHS Family. London: NHS Confederation.
2. Social Enterprise UK, Baxendale and The King's Fund (2025) Ahead of the Curve.

ANNEX B



About Social Enterprise UK

As the national voice for social enterprises, we lead the world's largest network of businesses with a social purpose, working together to create a fairer economy and a more sustainable future for everyone.

Social enterprises are businesses which trade for a social or environmental purpose. There are around 100,000 social enterprises in the UK, with a collective turnover of £60 billion and employing around 2.3 million people.

Social enterprises demonstrate a better way to do business, one that prioritises benefit to people and planet. They use the majority of any profit to further their mission. Social enterprises contribute to reducing economic inequality, embedding social justice and improving environmental sustainability.

We exist to advocate for social enterprise, demonstrating the difference that our sector makes, and influencing decision-makers to create an environment where our way of working can thrive.



About Locala

Locala Health & Wellbeing is proud to be a leading provider of health and care services in communities across West Yorkshire and Greater Manchester.

As an independent not-for-profit social enterprise, we have the flexibility to tailor our services to meet the needs of our communities – and any financial surplus is re-invested straight back into supporting patient care and our communities through Social Value initiatives.

We're here for people at all stages of their life. Our services range from health visiting to district nursing, sexual health, school nursing, physiotherapy, dental care, podiatry and end of life care. Our colleagues always aim to provide high-quality, value for money care and support people closer to home.

Feedback shows 97% of our patients rate our services as very good or good.

We work with GPs and other key partners, including social care, local NHS organisations, local authorities, community pharmacies, social prescribers, patient groups and VCSE organisations to ensure a coordinated approach to health and social care services.

BAXENDALE About Baxendale

Baxendale is an employee-owned healthcare transformation consultancy focused on out-of-hospital care. We combine specialist expertise with commercial insight, helping leaders navigate complexity across primary care, community and mental health. Our approach connects strategy to delivery, providing practical, end-to-end solutions that improve outcomes, strengthen organisations and create long-term social and economic value.





Locala
Health & Wellbeing

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