Quarterly Research Meeting – Summary Report

Local Governance, Social Enterprise, Health and Wellbeing

26 January 2016: 9.30am-3.00pm

Lindisfarne Centre, Durham University

Introduction

This report summarises the keynote speaker's presentations, and the concluding panel discussion session at the January 2016 Quarterly Research Meeting held on the topic of social enterprise and health. This event was jointly organised by the Fuse Complex Systems research group, the Institute of Local Governance in association with the North East Social Enterprise Network (NESEP). This summary report is to be read in conjunction with the slide sets kindly provided by our speakers, also on the Fuse website.

Introductions by Professor John Mawson (ILG) and Dr Duika Burgess Watson (Fuse)

John Mawson introduced the topic by highlighting that to date 6,000 social enterprises have emerged out of the NHS. Although research in this area is sparse, the Department of Health have recently released a report on relevant research and their findings. The report highlights the importance of the community and voluntary sector for setting up social enterprises in health and the many challenges that they face. He urged for a collaborative plan between the five North East universities to help address issues and challenges.

PLENARY SPEAKERS

Professor Cam Donaldson, Yunus Chair in Social Business & Health at Glasgow Caledonian University, 'Controversies and agreements in the interface between social enterprise and health'

Cam Donaldson started with offering a definition for social enterprises: "organisations that trade for the common good (e.g. addressing social vulnerability) and where the profits of that trade are used for social and community benefit". He argued that developing social enterprises in health requires a new relationship with government, in which organisations become more than service providers and instead act on a wider basis tackling the wider determinants of health, which should also make these organisations eligible for subsidisation by the government. He highlighted challenges and gaps in evidencing the impact of social enterprises on health and wider social benefits, recommending organisations to demonstrate improved health through improvements in the wider determinants, such as more social capital and cohesion in supported communities. Available systematic reviews indicate a lack of studies on impact and illustrate the heterogeneity of their work and potential outcomes. A particular challenge is finding suitable comparators to make more rigorous claims about effectiveness. Finally, Cam Donaldson discussed social finance as a potential resource for social enterprises as this provides a monetary investment in a social policy objective.

Q: Social enterprises typically focus on one particular issue. How to support multiple issues through this model as is common in public health?

A: There is no definite answer to this and it is a conversation that needs to be had. Do we need to gather more evidence? Does it require public subsidisation?

Q: How to set up (spin off) social enterprises in health without putting jobs at risk of staff in the NHS?

A: This is possible through utilising and focusing on existing community health initiatives.

Steve Camm, North East Social Enterprise Partnership 'Challenges and opportunities for different social enterprise models in the North East'

Steve Camm highlighted that social enterprises in the UK employ nearly a million people and contribute £18.5 billion to the economy. The social enterprise sector is flourishing and growing in marked contrast to parts of the public/private sectors. Research shows that growth in jobs delivered by social enterprises is often in the most disadvantaged parts of the region where public and private sectors have failed to deliver effective and efficient services. He explained that social enterprise is a way of doing business, not just a legal form, where organisations are required to make a profit to in order to be sustainable. Steve Camm argued that social enterprises challenge the other three sectors by sitting in the middle of them: they challenge the values of the private sector; challenge the efficiency of the public sector; and challenge the third sector to generate income for sustainability. He provided two examples of this: a local mutual that incentivised staff and reduced turnover; and a spin-off can that gave the organisation more freedom to operate while opening up alternative funding routes, such as asset transfers. He told the audience that social enterprises provide a natural fit with the values of the health system but also listed a number of barriers that organisations need to overcome, including differences in organisational cultures and behaviours; the need to secure contracts in the face of stiff competition from large organisations; and difficulties in demonstrating the impact of their work.

Q: The question related to an example of a social enterprise in Newcastle. Should the social enterprise model provided tiered access or does it operate in a mixed market?

A: It depends on the sector in which they operate. Regardless of the sector they work it, social enterprise need to operate in line with their values, otherwise they will not work.

Tim Keilty, New Prospects, 'How to set up a social enterprise? Experiences from a mental health spin-off'

Tim Keilty discussed his experiences of developing a mental health spin-off, highlighting a number of barriers and opportunities and illustrating the considerable time it takes to develop a sustainable social enterprise. His organisation supports adults with learning disabilities and receives funding from Local Authorities. The enterprise has been operation for 25 years and has a £4 million turnover. One particular issue that he highlighted was lack of funding to support social enterprising in setting up. For instance, the government's transformational fund set up for this reason was mostly spent on staff salaries and less on assessing and addressing local need.

Q: Very valuable messages. How does the academic community get to grips with things like this?

A: That is a good question and it is work in progress.

Jane Hartley, Chief Executive VONNE, 'The Voluntary Community & Social Enterprise Sector's role in supporting health and wellbeing'

Jane Hartley highlighted the considerable contributions that charities in the North East make to regional health which often goes unnoticed as 57% of VCS organisations in the North East are not formally registered and operate on budget below £50,000. She raised a concern over the disappearing grant culture and therefore the need for third sector organisations to generate income in order to survive. She felt that VCS organisations were well placed to support reducing health inequalities (as highlighted in the Due North report) and the current devolution proposals for the North presented new opportunities for health and third sector organisations. However, funding through contracts allowed less resources for voice and empowerment, which is a key function for the sector. Payment by results is also prohibitive for smaller VCS organisations. Jane Hartley recommended more co-production of services between third sector organisations and commissioners, which requires mutual respect. Finally, in demonstrating the impact of their work, outcomes for volunteers should not be overlooked.

Q: Are we meekly accepting financial problems?

A: We already had it tough in the North East, so it is just about accepting that things may become tougher.

Q: How are NESEP and VONNE working together?

A: The organisations are not in competition but signpost to each other and jointly represented each other at events and meetings. They perform different functions: VONNE does not provide direct support to VCS organisations that want to set up a social enterprise; it provides more strategic support at sector level, while NESEP provides 1-to-1 support to aspiring social enterprise organisations that also include private and public sector enterprises.

Practical examples

Tim Keilty, New Prospects, 'Learning Disability Support Providers – The Unwanted Innovators'

Tim followed up his earlier presentation with more practical examples.

Ian Reeve, North East Community Health Network, 'Langbaugh Social Enterprise supporting 15 General Practices'

Ian Reeve explained the rationale behind GPs joining forces in the NECHN, outlining the current changes in the primary care landscape with 7 days a week working schedules and the ongoing challenges faced by providers from previous changes, such as the commissioner-provider split in England, which has put more responsibilities on the shoulders of providers and has led to fragmentation of services. The main benefit of a social enterprise for GPs is ownership; it unites all practices, including does that want to make profit and those that want to work not-for-profit. He discussed a number of barriers in setting up the NECHN: social enterprises models do not fit in the current NHS system; the need to create an infrastructure and maintain momentum; and challenges in tendering and competing with the big players. On balance, he argued that social enterprises are

unique positioned in primary care to provide integrated services but that trust between GPs was crucial to achieve this.

Dr Duika Burges Watson, Durham University, 'Station Masters Centre and Community Garden not for profit'

Duika Burges Watson introduced social innovation as a conceptual framework for researching the impact of social enterprises in health. She defined social innovation as a novel solution to a novel problem that is more effective and, based on this definition, argued that social enterprises in health are a novel model for novel problems; enabling unification of different services under one banner, some for profit, some not-for-profit. By combining her role as researcher with supporting the Station Masters Centre and Community Garden, she was able to add value to both and develop new research, particularly around food pleasure for cancer survivors. She highlighted pleasure as an important outcome for further research in this area that is currently undervalued.

Chris Elliott, County Durham Council, 'My Sporting Chance (CIC), tackling child obesity in schools with parents'

Chris Elliot introduced the My Sporting Changes programme and showcased a video about the programme. My Sporting Chance is a 10-week school based and family focused activity programme that tackles childhood obesity of children aged 6-12 years in County Durham. The programme has been developed by a Community Partnership lead by My Sporting Chance. The programme gives young people and their families, who are finding it difficult to maintain a healthy weight, a chance to build their self-esteem and fitness through a range of physical activities, including recreational boxing training, swimming, multi sports and basketball. Families train and learn together during this innovative programme that aims to encourage and motivate young people to develop confidence and build on their desire to engage in their own sporting development, whilst increasing fitness and normalising body weight. The programme aims to empower families through the provision of guidance and training.

Panel discussion with Prof Cam Donaldson, Ms Karen Wood, Mr Tim Keilty and Mrs Jane Hartley

Q: Why is there a lack of research on the operational delivery of social enterprises in health and how can we address this gap?

A: The panel acknowledged that funding panels are often conservative in their reviews of funding applications and hesitant in funding more risky innovative proposals.

Q: Is SROI a useful tool for measuring impact of social enterprises?

A: The panel noted some of the short comings of SROI for measuring impact of social enterprises by arguing that SROI is a subjective and quite onerous undertaking that both service providers and commissioners need to buy into it. Panel members were concerned that the research involved would add to the burden of operating a social enterprise and raised concerns about the social measures in SROI, with wider health and social outcomes often not being captured. These outcomes were perhaps less suited to numerical measurement and needed to be captured in a more natural way.

This was also felt to be an issue with commissioners: although commissioners understand the importance of well-being, they are unlikely to pay for it unless you can demonstrate that it will save them money (at least in the longer term). As commissioners of services, research on interventions was often still undertaken in a compartmented way. The example was given of the Ways to Wellness programme in Newcastle which has demonstratively reduced the revolving door experiences for patients but the commissioners of the programme are more interested in the impact on A&E visits and whether this has reduced these costs.

Another issue highlighted for impact research was the emphasis put (in line with REF) on outcomes at the end of research rather than viewing this a co-production process between commissioners, service users and academics from the start of the research. The present process and methods for capturing impact do not reward co-production.

The panel members advocated a more anthropological approach to impact research that allowed researchers to be more open minded about the outcomes of social enterprise services and to explore new outcomes along the way. Economic measures were are not always adequate for measuring outcomes. For instance, a social enterprise might cause staff turnover to go down (due to more sustainable funding) or to go up with existing staff not being comfortable or sufficiently skilled to operate within this model. In economic models increased staff turnover is often only seen as a negative outcome.

Panel members agreed that the social enterprise model provided new opportunities for health by a holistic service view that was flexible and could be built up from the ground. Positive examples and pathways for developing social enterprises already exist, such as the health and social care partnerships. However, it was acknowledged that their strategies are often not aligned with government policies, although efforts are being made to achieve this. Panel members urged government to take a more holistic view and for academics to developed both the quantitative and qualitative evidence base for the impact of social enterprises on health and wellbeing.

The panel discussion ended with a reflection on the role of third sector organisations. Some panel members expressed concerns about the sustainability of small VCS organisations, while other highlighted that change and churn have always been part of both the health and the VCS sector.

Supporting and researching delivery models of (smaller) local social enterprises was felt to be important to be able to answer the question ‘what works for whom, where (and why)?’. Not all VCS organisations would be keen to develop a business model but they could play their part in supporting the wider determinants of health and third sector infrastructure organisations could help them to do well in this regard.