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Social enterprises and public health improvement in England: a qualitative case study

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Abstract

Objectives: To explore the contribution of social enterprises to publicly-commissioned public health improvement, and assess the risks and benefits of their role.

Study design: Qualitative case study of four south London boroughs.

Methods: Documentary research; in-depth interviews with 19 key informants.

Results: This study identified 24 social enterprises that were currently commissioned to contribute to public health improvement. These organisations ranged in size, longevity, and structure. They were widely reported as flexible and able to rapidly develop services responsive to local community needs. Their work often addressed upstream health determinants. However, to capitalise on securing contracts, they had to bureaucratise and establish provider alliances, which risked losing the very characteristics that make them unique. Social enterprises bore the financial risk of innovative service developments. Emerging mixed economies of public health were fragmented, limiting commissioners' abilities to plan strategically and evaluate impact.

Conclusions. Social enterprises have an increasing role in providing potential solutions to intractable health improvement challenges, contributing to a broader vision around upstream action for health. However, the fragmentation and growing outsourcing of public health has risks for coherent and equitable service planning.

Key words: commissioning; England; health improvement; qualitative; social enterprises; third sector.

Social enterprises and public health improvement in England: a qualitative case study

Introduction

The 2012 Health & Social Care Act led to the emergence of a complex commissioning landscape for public health in England, with responsibilities spread across a number of bodies. This reorganisation was implemented in various ways ¹, but in all areas Directors of Public Health (DsPH) were moved to local authorities, which had primary responsibility for commissioning for health improvement, including programmes to improve health equity. One year after the reorganisation, a survey of DsPH ² found that most reported increased ability to influence policy for health improvement, with reports of new service commissioning, reconfigured services, and decommissioned services within the ring-fenced public health budgets. This paper addresses an under-explored implication of these commissioning decisions following reorganisations: the growing role for third sector providers, particularly social enterprises. There are no formal criteria for describing organisations as social enterprises, but in general these are mission-driven ventures (non-profit or for profit) that pursue innovative solutions to social problems. An often used definition of social enterprises in the UK is “a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners” ³. Social enterprise is not new, but there have been renewed incentives for working with third sector providers. These include financial constraints on local authority budgets, and The Public Services (Social Value) Act 2012, which required contracts to “have regard to economic, social and environmental well-being in connection with public services”. Social enterprises have emerged as important providers of such services. They have been viewed by

government as offering a unique combination of public orientated high quality services and the flexibility and innovation of having a business focus⁴. A systematic review by Roy et al⁵ noted their potential for contributing to public health, but also identified limited empirical evidence to date on their effectiveness. The challenges of evaluating the impact of social enterprises are well documented, including: different outcomes prioritised by different actors in partnerships; limited comparable data on outcomes; and the fact that some benefits of coming into contact with a social enterprise may be longer term, and flow from the nature of engagement, rather than specific services themselves^{6,7}. A key issue is that involving novel organisations in the hybrid partnerships⁸ that deliver health promotion programmes may well change “what a public health intervention could or should look like”⁵: that is, that involvement in social enterprise may itself be a health intervention, rather than simply a means of providing services.

In this rapidly changing field of public health in England, we aimed to explore the opportunities and risks of commissioning services intending to contribute to health improvement from social enterprises, taking south east London as a case study. This area covers four inner London boroughs (Lambeth, Southwark, Lewisham and Greenwich) with generally young, highly diverse populations, including substantial areas of deprivation. Local priorities include teenage pregnancy, sexually transmitted infections, substance abuse, diabetes prevention, multiple conditions and long-term care. In common with other areas in England, these boroughs have experienced major reductions in funding for services over the past few years.

Methods

Participants and sampling

It was not straightforward to identify which organisations were being commissioned to improve public health across the four boroughs, or to identify which of these were social enterprises. There was no accessible directory of organisations, and social enterprises include a number of organisational forms (such as co-operatives, Community Interest Companies, and charities). We first mapped the existing social enterprises involved in providing public health services across the boroughs by reviewing web sites and following leads from contacts within local authorities. This provided a sampling frame of social enterprises involved in partnerships with local boroughs, from which we purposively sampled 19 participants to invite for interview. These were purposively selected to generate a maximum variation sample in terms of role in partnership, and characteristics of the social enterprise including longevity, reach, and size. Our sample included public health consultants and commissioners, and social enterprise providers and managers from the 24 identified as operating locally. Participants' current or most recent roles are summarised in Table 1, but it should be noted that these roles were fluid, with some having both worked as Public Health consultants and in social enterprises, for instance, and considerable overlap in roles of 'managers' and 'practitioners' in social enterprises. During interviews, details of other social enterprises and relevant commissioners were often provided. These leads helped recruitment for interviews and with building-up the documentary map of social enterprises in south London.

[table 1 about here]

Data collection and analysis

Face to face (n=14) or telephone (n=5) in-depth interviews were audio-recorded and transcribed for analysis, supplemented by observations and informal interviews in several

social enterprises. A topic guide included: emergence, structure and organisation of any partnerships between commissioners and providers; motivations for involvement; and mechanisms for recording and evaluating outcomes. Transcripts were analysed using a primarily deductive thematic content analysis, with a coding framework informed by literature on the third sector, along with a more inductive analysis of initial data. Analysis and coding was undertaken primarily by the first author, with discussion across the team to refine the codes and attributions. Key themes included: motivations for commissioning social enterprises; barriers and facilitators for social enterprises entering the market; sustainability; and implications for commissioning.

All participants provided written informed consent. To protect confidentiality, data extracts do not include specific places and personal names, and are tagged with an interview number, and a summary description of the interviewee's role. These descriptions are: 'Commissioner' (including current or past DsPH and public health consultants, members of Clinical Commissioning Groups); 'SE Practitioner' (including all those working within social enterprises directly with clients); and 'SE Manager' (including development workers, chief executives of social enterprises).

Results

Taking a working definition of organisations which are independent, mission-driven ventures that generate income through trading to pursue new innovative solutions to existing social problems, we identified 24 social enterprises which were commissioned within the four boroughs to provide public health improvement. Their characteristics are summarised in Table 2.

[Table 2 about here] **Table 2 Summary characteristics of social enterprises commissioned to provide public health improvement in south London**

These ranged from organisations of 6000 employees providing leisure centres within and beyond a borough, to small start-up groups that had a largely campaigning function but with small contracts to provide services. The majority were ‘micro’ enterprises of fewer than 10 employees and annual turnover well below £2 million. Some were well-established organisations which had emerged from 1980s co-operatives, others more recently established. Services provided by social enterprises ranged widely, including innovative sexual health testing services, peer support to help homeless clients access health services, therapeutic performance arts, employment training services for mental health service users, fruit and vegetable voucher provision, patient-centred health technologies and business advice on running a social enterprise in health-related settings.

Why social enterprises were commissioned: flexibility and responsiveness

The key reported advantage of commissioning services from social enterprises was their capacity to innovate and respond quickly to changing demands. Characteristics such as nimbleness, adaptability and flexibility were cited by both social enterprises themselves, and public health partners, as typical of social enterprises:

You know, we can turn things round you know, overnight, pretty much. You’re very able to be incredibly flexible about the way you work (4 SE Manager)

Small scale organisations could, at a local level, respond to public health needs in innovative ways that addressed upstream health improvement goals. Some commented that new commissioning arrangements had enabled them to leverage a broader view of ‘public health’ to develop more upstream programmes:

I think public health in [borough] have been extraordinary, you know, for me to say to them, “I think we should do food growing, because I think that’s really good if we really want to talk about food security and stuff and it’s also good for physical activity and mental health.” And they said, “Yes we get it.” ... then they found money to invest (6 SE Manager)

A view that social enterprises were more likely to be embedded in their local communities, and more likely to be proactive in developing innovative solutions responsive to those community needs, made them an attractive option for ‘hard to reach’ sections of the community, and for new areas of service provision, where it might be difficult to tightly specify contracts:

The drivers were that we were aware that certain communities had, certain populations had very high smoking rates, but we weren’t necessarily reaching those through general practice or through the [hospital] stop smoking service. So, we were very keen to reach people we weren’t already reaching. And to reduce health inequalities [which required] an innovative approach. (13 Commissioner).

You can bring people together to solve the problem – [it] isn’t like a commissioner-provider split, where you describe what you want and the market [...] responds to that. I think that doesn’t always work when you’re not absolutely clear what it is that you want to commission. Or if you want to commission something that’s new, or you want it to emerge. (7 Commissioner)

Social enterprises stressed their comparative creativity and ‘niche’ responsiveness. One clinician cited time and resource limitations in the NHS, where she was previously employed, as constraints which would have prohibited the development of an innovative performing arts service for patients that she was now involved in, which was commissioned directly by the

local Clinical Commissioning Group (CCG). This, she said, “felt very clinically creative. Very clinically effective, very targeted” (10 SE Practitioner). For public health challenges, social enterprises could implement new services within short time scales. An example was testing for sexually transmitted diseases in a context of high prevalence and perceived barriers to clinic access: a social enterprise developed, tested and rolled out an innovative online provision in ways that NHS providers were reportedly unable to do.

That’s roughly where a social enterprise comes from, isn’t it - that the existing offers that you’ve got to contract with an individual or an alliance contracting model or doesn’t quite fit or doesn’t quite feel right. And often when you really want someone that’s local and specialist, you’ve just got more control, I think, if you’re looking at social enterprise (7 Commissioner)

These advantages for more innovative approaches to health improvement were widely contrasted with NHS provider organisations (and to a lesser extent local authorities), which were cited as inflexible, slow, “bureaucratic and time consuming” (6 SE Manager). Reported barriers to this kind of innovation within the NHS included the perceived inflexibility and slowness of human resources and IT processes. Participants reported, for instance, being unable to advertise on requested salary bands, or being told that preferred IT solutions could not be supported by NHS Trusts. There were also issues with the scale of organisations such as NHS Trusts, which added layers of accountability, as multiple agreements might be needed from different parts of the organisation.

Facilitators and challenges for social enterprises entering the market

The relatively large number of social enterprises active in the area was reported to be a result of organisations dedicated to ‘championing’ their role, and trying to “change how we procure things locally” (18 Commissioner), as well as long-established networks across organisations:

Happily, there were a lot of us who felt like that to make it happen, but, it was interesting that it’s not just about organisations and people going back to their organisational aims. There’s something about personalities as well. (3 Commissioner)

The importance of these embodied relationships was marked in the ways interviewees sometimes discussed their contracts and partnerships in terms of individuals, rather than organisations:

We have that informal relationship with [clinical lead] and his team [...] At least two projects for [named individual], and we finished a project for [named individual] and yes, we work with quite a lot, few professors at [named institute]. (6 SE Manager)

That many commissioned programmes were clearly the outcomes of long-established local networks meant that there could be steep barriers to market entry for organisations not already embedded in these partnerships. Opportunities for winning service provision contracts were curtailed by: criteria which were challenging for small organisations to meet; lack of skills in tendering; and sometimes anxieties about accountabilities written into contracts. One CEO of a social enterprise (12 SE Manager) that provides employment support for mental health service users expressed considerable frustration at losing past bids to competitor (larger) organisations who had not delivered, but were never de-commissioned, and which did not necessarily meet the ethical standards they would adhere to. Others spoke of being ‘undercut’ by private providers. There were also concerns about the ways contracts could, from their perspective, shift lines of responsibility such that they had less discretion

over how they managed their organisation: in this case, an organisation in which there was less distinction between ‘client’ and ‘provider’ than assumed in tenders:

We’ve got board members with mental health problems [...] and one contract was basically saying “Under no circumstances can you send a user,” that’s their language, service user, “you cannot send a user in with a consultation with a CCG”. (12 SE Manager)

These constraints on social enterprises were also recognised by commissioners. As commissioners were becoming more strategic, and reducing their contracting costs by bundling services provisions together, smaller enterprises were less and less likely to have the skills or range of services needed to successfully tender in competition:

Often, you’ll find that they run the most wonderful services but [...] the reporting, the systems, the structures, you know, they haven’t [got them], and I think that over time that can grow itself out, and they realise that to function in this world, bureaucracy, contract management and all the rest of it, they have to get good at it. (7 Commissioner)

One strategy for integrating services across evolving markets of providers was encouraging collaboration between social enterprises within and across boroughs. These could develop critical mass, in terms of both client reach and business skills:

We have formed an alliance within the four providers in [borough] who provide employment services for people with mental health problems. Three of them are in the voluntary sector, so it’s us, and [hospital] (2 SE Manager)

However, provider alliances could be problematic, given that social enterprises, as trading organisations, are competitive. Other scholars, such as Eikenberry & Kluver, have analysed

the potential risks of social enterprise organisations adopting a business model, a tension that our informants also articulated ⁹:

I think, across the voluntary sector, including social enterprises, there was always a bit of a tension about how do organisations collaborate and work together when they often perceive that they're also in competition with each other for the same funding.
(13 Commissioner)

Collaborating, or sub-contracting to maintain niche service provision, also generated multiple lines of accountability that could be difficult to manage. One social enterprise director (2 SE Manager) talked about meetings to form a commissioning alliance which would have a major impact on their contracts, including accountability to: two CCGs which award some of their funding; individual customers in smaller hospitals and other public sector providers, various umbrella voluntary organisations which co-ordinate their work; an alliance of providers; and trustees of the social enterprise. The constantly changing commissioning landscape also created new barriers to keeping informed about changing local health markets: "I didn't realise actually, until about this week that in [borough] they're talking about a similar alliance thing" (2 SE Manager), and in constantly changing procedures: "there comes a reshuffle of funding and every area has a different application process for putting in new projects and new treatments" (9 SE Practitioner).

From grants to contracts: developing sustainability

The longer established social enterprises reported sustainable income streams which, as one described, had largely moved from 'grants to contracts'. Many described benefitting from the move of public health to the local authority:

So, we've set up hundreds of projects in fifteen years [...] And we sustain it a lot through our own work, so not grant funded [...] With public health going into the local authority, they had to put it out to contract. And we won it. So, we now deliver that and there's a real strong partnership with public health. [...] we used our knowledge developed around food to fund us to continue to do work in public health. So things like our food poverty work, we fund that all ourselves. Last financial year we were only 2% grant funded, 49% self-funded ... And 49% public sector contracts, which we win in a commercial, you know, European way. (6 SE Manager)

Social enterprises have considerable freedom in terms of operating structures, and most reported a mix of income streams, which might include crowd funding or donations, as well as trading, grants and contracts. As grant income had declined, they had diversified funding streams and their core work, particularly if they were providing for local community needs:

for a kind of niche organisation, like ourselves, it becomes much more difficult to access those kind of avenues for funding. And so, you have to be more versatile in order to kind of stay alive as an organisation (9 SE Practitioner)

There were risks in diversification and expansion. In terms of service provision, extending to new client groups or geographical areas risked stretching beyond core credibility, if the organisation was rooted in its community or particular groups of clients. Social enterprises noted the limitations in expanding their trading roles, in that successfully competing for large contracts was unlikely: one, whose income from trading was still largely reliant on other third sector customers, with long standing relationships, noted:

[Getting a public sector contract] is like pushing concrete, because they've got these big suppliers and they only want to use their big suppliers and although they'll tell

you if you go and see them, they like to encourage local, it's nonsense (2 SE Manager)

Market failure was also high. One organisation, which worked with clients with high needs to get them into employment, was described as having “folded before it started... because the service users were too unreliable” (18 Commissioner). Others had taken on the risks of innovating, but then lost out to larger organisations once services had been tendered competitively. Discussing one well-known local example, one commissioner noted:

If they'd won the contract, it would have been the happiest of all endings to the story. We would have grown it locally. [...] But at the end of the day it was a competitive process ... and they weren't appointed, and the other provider was [...] I think that's one of the downsides if you're competing against a big American provider that has a business development team that writes bids for a living. (7 Commissioner)

Sustainability is, therefore, fragile. Strategies for sustainability – strengthening governance, establishing collaborations, and diversifying – bear inherent risks of losing some of the uniqueness that arose from being small scale, locally relevant and adaptable organisations:

but obviously there is a contract [...] but no different from any other commissioning arrangements and [the fact that they are a] social enterprise makes no difference. As far as we are concerned they are just one of the providers. (17 Commissioner)

The challenges of outsourcing for strategic public health commissioning

Where social enterprises were still small, and niche, their embeddedness in, and responsiveness to, particular communities could limit their ability to demonstrate effectiveness for tendering purposes, or commissioners' ability to comparatively assess

outcomes. Social enterprises typically developed ‘unique’ ways of evaluating their services, often providing rich narrative data in interviews to evidence the far-reaching impacts they had for their communities. Where formal evaluations were done, interviewees often stressed appropriateness to their communities:

We use the Warwick-Edinburgh Wellbeing questionnaire with our clients because we think we make a big impact on their wellbeing. Nobody else uses it (2 SE Manager)

So, we would be using system dynamics as a way into an issue, the process of insider learning and capture is more important often than the product. (11 SE Manager)

One provided detailed case histories of successes, and introductions to those now working for the social enterprise who had a history of mental health issues, finishing with “We know that what we do works. We’ve got evidence” (12 SE Practitioner). These kinds of data could be difficult to align with broader evaluative or monitoring practices that are more traditionally used in the public health sphere.

Community involvement, particularly for the longer established organisations, also meant that their timescales could be misaligned with short-term NHS targets. One noted that “early intervention now [leads to] long-term improvement”, but that health benefits of services provided now might take too long to emerge or be challenging to quantify: “sometimes proving the efficacy of what we were doing, can be quite challenging” (10 SE Practitioner). A broader concern was the ability of social enterprises to either ‘undercut’ public sector provision, or to provide niche services that may not be equitable as their client groups were tightly linked to locality or organisation-defined needs. One organisation reported an innovative scheme to provide healthy food for low-income clients, which was in part funded from for-profit trading of other goods, and in part from donations. Such redistributions may meet public health goals, but have inevitable risks for equitable and needs-based provision.

Discussion

The demands on DsPH and constrained budgets have provided incentives for many to seek innovative solutions to enduring challenges such as accessing hard to reach communities and addressing acute local needs, such as obesity. Social enterprises have been creative in leveraging interest in the broader determinants of health to win contracts for innovative programmes for particular client groups (such as those with mental illness), and around food and physical activity, which are often explicitly directed ‘upstream’ at the determinants of health. Indeed, the shift from public health to local authorities was nearly always provided by the social enterprises we spoke to as a historical point of reference in narrating a social enterprise’s (strategic) development. It was impossible to identify all social enterprises, or quantify the income social enterprises were generating from public health improvement budgets, or the reach of their services. Our mapping was conservative, in that many more enterprises were providing services with important potential public health impacts (e.g. managing green spaces, or installing draught proofing) but were not necessarily funded through public health budgets. However, social enterprises had clearly emerged as important publicly-funded providers of health improvement services in these case study boroughs. Given that a 2017 census of social enterprises in the UK reported that 16% of social enterprises’ principal activity was in the health and social care sector ¹⁰, this may reflect the growing role of social enterprises in public health nationally, as well as a shift towards action on broader health determinants.

Our findings for health improvement echo those found in the health protection arena. Chantler et al ¹¹ found that the growing complexity of commissioning arrangements for immunisation had led to fragmentation which entailed risks for evaluation and monitoring,

and potentially large transaction costs in managing multiple small contracts. In our study, there were reported attempts to mitigate similar risks through alliance contracts that involve multiple providers, and offering larger block contracts, either geographically, or for a broader range of services. Although such strategies can offset the documented high barriers to third sector providers entering the market ¹², they also potentially result in a ‘patchwork monolith’ that risks simply reproducing the negative organisational features of a public sector organisation, without the benefits of clear accountabilities, better administrative infrastructure and greater sustainability. That is, such arrangements inevitably favoured larger, longstanding, more bureaucratic organisations or alliances: those that were least likely to have the local, niche credibility and creativity that were the initial rationale for commissioning from social enterprises. The broader issue raised by this creeping ‘outsourcing’ of public health improvement to the third sector mirrors those of subcontracting services to the private sector ^{13,14,15}. An overreliance on social enterprises by public health departments could place these services and clients at risk of fewer services of an inferior quality due to unclear lines of accountability and the financial fragility of these providers.

This study has two limitations. Our sample was small; and we are reliant on accounts of rationales for decisions, rather than any direct evidence of why social enterprises were or weren’t commissioned, and what the alternatives were. Claims around both the distinctiveness of services that can be provided, and the risks, are difficult to evidence. This is a finding that echoes debates about commissioning public services from the third sector more generally, which suggests that in practice, service provision may be more ‘business as usual’ than radically different. What happens in practice is a contingent outcome of local networks as much as policy drivers ^{16, 17}, and public health practitioners working within social enterprises may not be doing anything different in practice from those in other types of organisation ¹⁸. Despite its limited geographical scope, and reliance on reports of practice,

the findings of the present study document a growing role for social enterprises in public health provision, with risks and potential benefits that need further exploration at the level of population health. Further research is needed, across broader geographical regions, to identify the impacts of commissioning social enterprises on the types of public health interventions being implemented, and on effectiveness in terms of sustainability, health gain and equity.

Conclusions

This study has begun to map an important development in public health commissioning; the critical role that social enterprises are playing in fostering health improvement. In our case study area, long-established social enterprises included those providing respected and sustainable niche services; those which had bureaucratized to the extent they operated like a large company, and more recent organisations that offered innovative solutions to local health needs. They could offer innovation largely because they are unconstrained by the requirements of governance found within public sector organisations, such as robust and secure IT systems, or HR systems that are designed to protect employees and clients. Social enterprises can be ‘light footed’ largely because they are lightly governed: with attendant risks for employees, clients and (ultimately) taxpayers. Further research is needed to understand the implications for population health of a rapidly changing market in health improvement.

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Ethics

Ethics approval was provided by KCL Ethics Committee, number **MR/16/17-507**

Competing interests

The authors have no competing interests to declare.

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Tables

Table 1 Summary of roles of participants

Commissioning	
Directors of /consultants in Public Health	4
Clinical Commissioning Group members	4

Social enterprise	
Managers, development workers, CEOs	6
Practitioners	5

Total	19
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Table 2 Summary characteristics of social enterprises commissioned to provide public health improvement in south London

	Size of Enterprise*		
	Micro	Small	Medium/Large
Broad area of work			
Consultancy/services	5		1
Vulnerable clients	7	1	
Physical activity	3	1	1
Food	3		
Sexual health		1	
Therapeutic services	1		
Total	19	3	2

Note * Using EU definitions of ‘micro’ enterprises having under 10 employees and/or up to Euro 2m turnover; ‘small’ having under 50 employees and/or a turnover of up to Euro 5m.