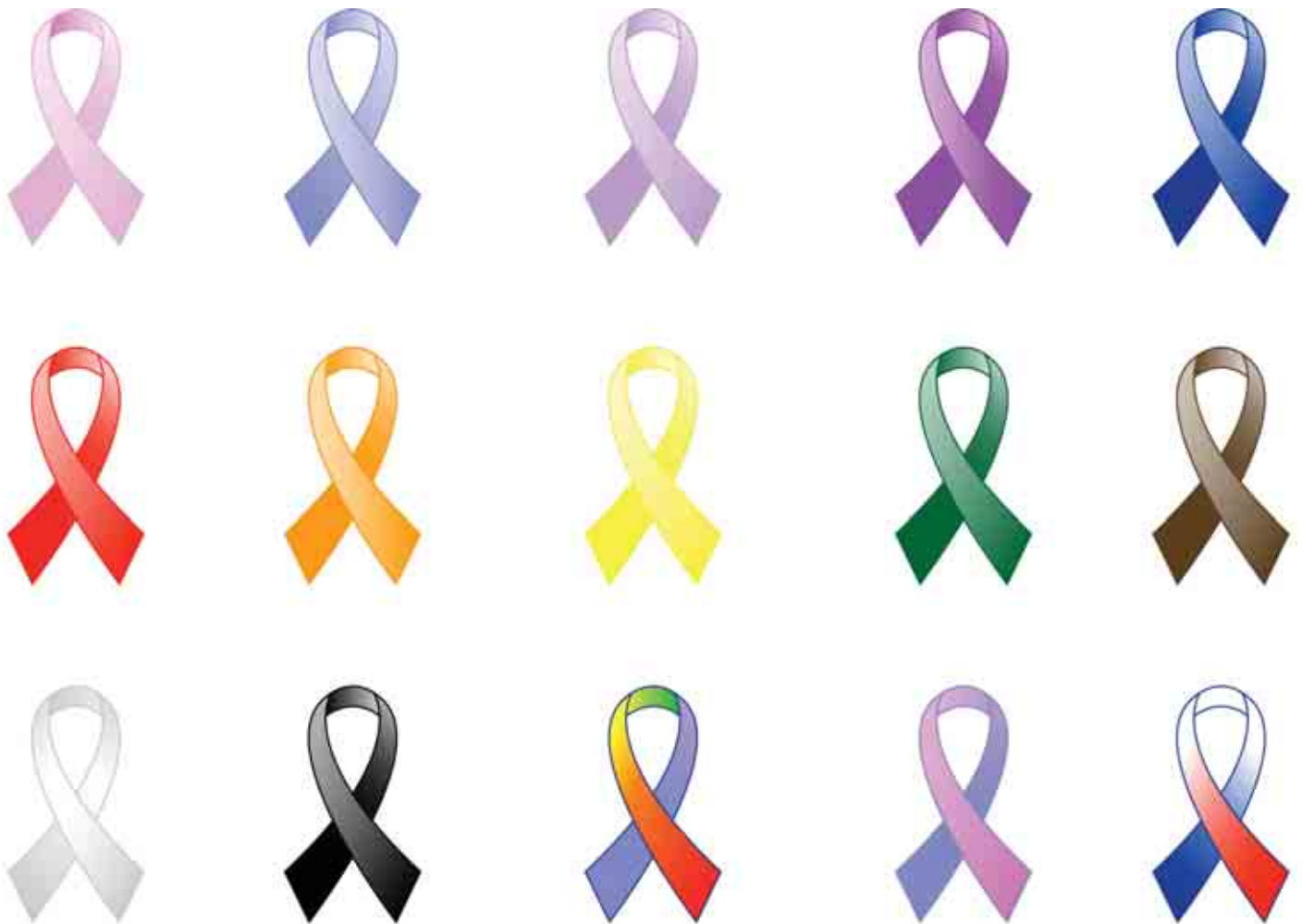


NEWSTATESMAN



HEALTHCARE AND THE THIRD SECTOR



Getting new ideas and new value from social enterprise

16 JULY 2007

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On 28 June, the Pfizer UK Foundation held its inaugural symposium event to celebrate the success of the 110 community-based health inequality projects it has supported. Over 130 delegates attended, representing a broad range of charities, community groups and patient organisations, to hear inspiring stories of how these projects have provided much-needed support to the UK's most deprived communities.

Delegates at the symposium were also given the opportunity to listen and contribute to the *New Statesman* and Pfizer Policy Forum round table debate on the role of the voluntary sector in healthcare, an edited transcript of which is in this report, following a personal view from Cliff Prior, chief executive of UnLtd, the Foundation for Social Entrepreneurs.

The Pfizer UK Foundation was established in 2005 to address health inequalities across the UK, arising from social, economic, cultural and demographic factors. It supports community-based projects that tackle health inequalities in England, Northern Ireland, Scotland and Wales that fall outside core NHS statutory funding. Grants are allocated to projects that provide tailored, innovative, modest and local solutions to needs defined by local healthcare and social care experts, community groups and charities.

Since 2005, the Pfizer UK Foundation has donated over £2.6m in grants to 110 community projects addressing health inequalities, experienced by approximately 240,000 people across the UK. For more information, please visit www.pfizer.co.uk under the community section or call 01737 330713.

This and the other reports in the long-running series from the *New Statesman* and Pfizer Policy Forum are available from the website: www.policyforum.co.uk. Your comments are welcome.

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There may be answers, but what's the question?

What is the Department of Health hoping to get out of the third sector and social entrepreneurs?
By Cliff Prior

They say there is nothing new under the sun. Certainly, there is nothing new about charity or social enterprise providing health services. Before 1948 they formed the mainstream in the UK. Nationalisation was introduced to deal with the problems of the time: inequity of access and fragmentation, and there are salutary lessons there. But even before the government's strategy to extend the role of the third sector in health services has had time to bite, over 10 per cent of mental healthcare and most care for people with learning disabilities is delivered in this way. In case anyone thinks that the third-sector role is limited to the lower tech and non-medical services, remember Macmillan in cancer care, St Andrews Hospital in children's mental health, the hospice movement, and Wellcome on research.

The Department of Health (DoH) now has a Social Enterprise Unit, and a delivery board on third sector and social enterprise provision. A pathfinder fund of £1m last year has been followed by a new programme of over £70m. Serious work is going into expansion of the sector.

But it is not easy to get a clear answer to the question: why? Is the DoH looking for better managers of existing provision, or choice for patients and service users? Or perhaps the goals are innovation, or reaching the hard to reach, building community capacity, or user- and carer-led services to help engage people in their own health. All of these are worthy goals, but different ones, and amenable to different solutions. The DoH may well want to achieve several of them, which would be fine, but would still require distinct programmes. Some people cynically believe it is all about money, the hunt for cheaper providers less generous

on pay and conditions.

A blanket view that the third sector and social enterprise are

simply better will not be adequate. Apart from the serious questions about whether it is true, posed recently by the National Consumer Council, it will be challenged by other interests. Once healthcare is opened out to competition, EU rules may apply and favourable treatment for any specific sector needs to be justified.

Passion to improve lives

On the ground, these high level considerations are not the issue. Most social entrepreneurs in health are motivated in the same way as their peers in other sectors – often by personal or community experience that has given them a passion to improve the lives of people living with specific health problems. They may be patients, users, carers, professionals or none of these, but they have seen inadequacies and are driven to end them.



They have new ways of working, which they know will help, but they struggle to find a productive way to engage with the NHS commissioning machine.

Their models do not fit the predetermined lists of primary care trusts or payment by results. Their operations are often small, cash strapped, lacking the financial solvency required to do well in a public tender. They are on the outside track, not part of the NHS club and often unaware of how decisions are really made. Sadly, many of the start-up social entrepreneurs supported by UnLtd simply give up on the NHS and look to other contracts instead.

Even social enterprises offering support services find it difficult. To take one example, Affirmative Business is a catering service in which staff include people with disabilities; it seeks contracts to run cafes in healthcare premises. It has faced bureaucratic and heavy-handed negotiations, public tendering even for tiny contracts, draft agreements that never get signed, or lengthy bespoke contracts that need expensive legal advice. Despite this it has four cafes running

Commissioners tend only to consider agencies for services they already provide in their area, rather than looking at what they could do

successfully. Should it be such a struggle?

It is good that the DoH's action-plan targets training and awareness for commissioners as a top priority. Larger charities may fare better, having more staff to engage with commissioners and more experience. However, even here, there are serious problems. Commissioners tend only to consider agencies for services they already provide in their area, rather than looking at what they could do. Larger organisations, looking for larger contracts, start to hit some major logistics problems. The NHS pensions scheme is exceptionally generous, heavily subsidised, very expensive to match, and yet matching may be required by TUPE regulations: as a result, third-sector bids look artificially expensive compared to the in-house proposition. In the future, full access to the new NHS IT system for patient records will

be essential for clinical services, but is not planned as part of the roll-out. Continuing professional development may be difficult to provide outside the NHS, and qualified staff will regard this as key to career choices.

Developing an organisation to the point where it can cope with these challenges may even be more difficult now than in the past. As Nick Partridge, chief executive of the Terrence Higgins Trust (THT) says, "I doubt THT could develop the way it did between 1983 and 1987 if we were in that position now. It's also why 23 HIV charities have merged to create the current THT. If we hadn't pooled our resources, we just wouldn't be able to bid for new contracts."

Is it worth the effort?

There are plenty of problems to tackle, so is it worth the effort? A few examples show why it is. The best social enterprises can motivate staff to deliver exceptional service: Sunderland Home Care Associates, one of the 2006 Enterprising Solutions winners, shows how. The best health charities can transform care: Macmillan cancer nurses, carer support in mental health and others too numerous to list. The best patient and user groups can help people to manage their own conditions: the development of self-management programmes by the Long-Term Conditions Alliance (LTCA) member charities was groundbreaking.

Patient groups pioneered health-information services, writing materials from the perspective of the end user, with agencies like Patient Opinion now taking this into the new arena of web 2.0. The best community health agencies will reach populations missed by mainstream services, ranging from people with complex needs to minority groups, sometimes becoming the gold-star service in their field, as is the Medical Foundation for the Care of Victims of Torture.

All of which brings us back to square one. These are specific solutions designed for specific problems. They are examples of where the NHS could buy in to success that has been created and delivered by charities and social enterprises. Not so much asking the third sector to come in and run failing parts of an existing machine, but recognising new ideas and new value. Not so much "third sector best" but the best of the third sector.

Before we seek the answer, let's get the question clear. Then let's go for the best.

Cliff Prior is chief executive of UnLtd, the Foundation for Social Entrepreneurs

Round table: Competing and complementing

David Brindle This is a formidable panel, as I am sure you agree. Let us start with an acknowledgement that the role of the voluntary sector in healthcare is not really anything new. I think the earliest evidence offered is back in the 12th century where a hospital in Winchester was pioneering welfare services for elderly people.

More recently, when the NHS was set up in 1948, it swept up a thousand hospitals that were being run by voluntary organisations, twice as many as came into the NHS from local government. The voluntary sector was then providing the majority of TB sanatoria services across the country. That said, it is plainly the case that politicians of all the main parties clearly want to see the third sector play a much bigger role in public services, particularly in health and well-being.

A social enterprise unit has been established in the Department of Health (DoH) and the sector is being actively encouraged to bid for contracts. Just this week in the voluntary-sector press, there is a tender invitation to the voluntary sector from a group of six primary care trusts (PCTs) in the Manchester area.

So, what are the implications of all of this? Can the third sector help turn the NHS from something that administers to people into something that works with them? Or is the real agenda more one of cutting costs by exploiting voluntary groups and their funds? Does the third sector really have the capacity, the experience and the resilience to take on this major role?

I think that Mark is an appropriate person to kick us off. His organisation carried out a mapping exercise for the DoH on the third sector's role in healthcare

Mark Speed We surveyed 1,500 third-sector organisations, looking at both health and social-care provision. In total, we found £4.7bn in the health sector, an average of £350,000 per organisation. The main aim of the survey was to look at ways to improve best practice, to look at some of the barriers and to provide a lot of data.

Many of the third-sector organisations we spoke to felt they could provide more. Almost three out of five felt that they were adding value in terms of expertise and experience, relative to other providers. Two out of five of the organisations we surveyed felt they

understand the needs of their client groups better, having established community links, particularly at a local level. A key positive for around 26 organisations was that they felt that they could provide a more flexible service but, sometimes, due to contracts, commissioning and everything else, the flexible service advantage was eroded a little by some inflexibility on the part of the commissioners.

Overall, nine out of ten felt they could provide more services. Seven out of ten felt that they would like to expand more and they intended to seek new partners. They wanted to work with others as well, again if contracting commissioning would allow.

Lack of flexibility in contracts was certainly felt to be a barrier and length of contracts were an issue. If they were too short term, it was not worthwhile for them to tender in the first place. Contracts often run for more than ten years in the health sector. If contracts were only for two or three years, many organisations said that it caused problems.

One big issue was not knowing the full size of the funding available and that was not proportional to the amount of effort required. Often a lot of effort may be required for the sake of £500 or so. So, people felt, at times, that a lot of work was put in for rather minimal comeback.

Overall findings from the research were positive but it was clear that many dedicated people doing a very good job are feeling a little frustrated at the moment that they cannot develop the services a little bit more because of some of the reasons I have already talked about.

Dave Brindle Ivan, you started off in the voluntary sector and now you are sitting in Whitehall. How does it seem to you?

Ivan Lewis First of all, we need to be clear what we want to achieve and what the big picture is and then look at how to deliver change or make the existing system better. There is a long tradition in social care of commissioning from both the voluntary and private sector. There was a massive expansion of that when the new community care legislation was introduced in the early 1990s. However, there is not the same

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At a local level, there is still the NHS functions in one part of the system, local government in another and the voluntary sector somewhere else
Ivan Lewis



culture in the NHS to see the third sector as a major part of the potential solution to the challenges that society and government set. So, that is an important context to be aware of.

At a local level the NHS functions in one part of the system, local government in another and the voluntary sector somewhere else. To secure the health and well-being of every local community we need to move from a woolly notion of partnership to one of true integration, particularly if we are serious about spending more resources on early intervention and prevention. We have made progress with local area agreements to some extent and some joint appointments, but what we need is an integrated approach.

We must focus the debate around achieving and securing outcomes. It cannot be about the third sector claiming a guaranteed share of the cake. Those organisations that are best placed to secure the quality responsive outcomes that we need are those organisations that should be providing as many of those services as is possible.

We also have to examine the distinct contribution that the third sector brings to the table, which has the power to transform people's lives. The history of the third sector is innovating, testing out new ideas and thinking outside the box, pioneering new ways of working. However, increasingly, the deal is that, if you want to be commissioned to provide a service by the statutory sector, you have to be delivering to its priorities. Historically, the third sector is better at reaching the hardest to reach. That is why we have this whole debate about social mobility. In terms of getting to those at the very bottom, the state's interventions, cumulatively, have not achieved what they needed to. In terms of health inequality, as well as more general social exclusion, the state still looks to "state-ist" solutions when it actually needs to look for original and innovative solutions that can be found in the third sector.

The voluntary sector has something to offer on culturally sensitive and religiously sensitive services. We want to see more and more services led by users, and certainly influenced by users, as we look to

reshape and re-engineer services. The third sector has a crucial role here.

In terms of the control agenda, the individual budget agenda, the choice agenda in the NHS, individual budgets and social care, there is the question of advocacy. We need to build in a very strong advocacy system where people can be supported to exercise control, power and choice. The third sector is well placed to provide that new enabling and empowering advocacy support that is so essential if we are to make a reality of the new agenda.

Then there is the question of the contribution of volunteers. One of my responsibilities is older people and putting dignity and respect at the heart of the care services for older people. One of the great challenges in terms of the older population is isolation and loneliness. I do not believe it is the state's job to provide befrienders, for example, to people. It is actually the responsibility of families, communities and individuals to help tackle loneliness and isolation. Loneliness and isolation frequently lead to mental health issues and deterioration, ending up with people needing far more acute medical interventions. So, the third sector has another important role to play in the great tradition of deploying volunteers who want to make a difference and a contribution.

In relation to social care there has been almost an over-professionalisation of some of the services. If an older person wants to sit with somebody for a reasonable quality period of time, to have a quality relationship, somehow that is less important than having a 15-minute visit in the morning from a carer and a 15-minute visit in the evening as well. We have to think about the distinct contribution that volunteers can make.

Who is responsible in any community for building the capacity of the third sector where it does not have the kind of capacity you would want? Strong communities and a strong society need a flourishing and vibrant third sector. We need that to be a reality in every community and yet, at the moment, it is unclear which agency or structure is responsible for stimulating the capacity of the third sector in every community. In the health service, what are the implications of practice-based commissioning for the relationship between the NHS and the third sector going forward? We have to change the culture around their relationship and the perception of the contribution the third sector can make.

Dave Brindle Julie, as someone who has managed in the NHS, why has it not been possible for the state to demonstrate cultural sensitivity and reach those hard-to-reach groups as well as being innovative? Could those values be inculcated into NHS staff, perhaps by third-sector advice and training?

Julie Dent I think the NHS does have those values and certainly the frontline staff I have met in my career have always exhibited those values. Innovation and creativity are at the heart of being a doctor or a nurse – it is what they do on a daily basis. However, when I

visited organisations, doctors and nurses often talked about the organisation as “other”. There was not a sense that they were in control of directing it. Some of the things, like foundation trusts, are actually putting back that ownership and that sense of control.

I think we have paid some lip service to community engagement, but I had quite a sobering experience in discovering social enterprise. I visited India to work with some social enterprises and I understood for the first time what community engagement was really about. Sitting with the Nilgiri indigenous tribes, the honey-gatherers in the forests, in their village and listening to their story actually puts you in another place. That is why I became interested in social enterprise – because it enables you to get right down into the grassroots of a community, empowering the people who want control of their own lives, and empowering organisations to develop so that they enable people to deliver services for themselves, with support from professionals.

In the NHS, we tend to think that everything is top down, and social enterprise is being seen as a ministerial initiative, whereas social enterprise is a world movement. It is thriving in Africa, India, Europe and North America. It is also thriving in this country in many other sectors. The Social Enterprise Coalition has 10,000 members, all providing social enterprise. I have never met anyone in the NHS who does not want to do a good job. So, for me, it is about enabling. If social enterprise or the third sector can actually release some of that potential, then let us do it.

Geoff Walker In this room, we all share the same values and principles. The private sector cannot compete with us on price because it is looking for shareholder value. Local authorities and health cannot compete because of their bureaucracy and all the other things that tend to go with that. So, if we really get our act together, we have a great responsibility to the public of this country to take a greater chunk of public health and social care services into our control and help communities take control of their lives.

Our social enterprise has really enabled our

The first thing we did when we entered into this culture change was to get rid of HR, because they had only ever told us what we could not do
Geoff Walker



workforce. We transferred 62 workers from the council; they were completely demoralised, deflated and it was the end of their world. Now the organisation has come second in the *Sunday Times* Top 100 competition. It came first for work-life balance; managers who listen; managers who motivate and work in a supportive team. These are exactly the same people, but they are now self-managing and self-motivating, and we have to give them the opportunity to flourish and take control of things. Large bureaucracies have squeezed that out of people. People often say, “If we set a social enterprise up to take on some of the health service, we would not have the people to manage it.” That is not true. The people are there in the NHS. We just have to give them a different view of the world – confidence and some different guidance. The first thing we did when we entered into this culture change was to get rid of HR, because they had only ever told us what we could not do. I worked for 20 years in local government and people say, “Why couldn’t you do that in local government?” If I had the answer to that, I would be a millionaire.

We realised very early on that how people felt about themselves as service users was reliant on the people who cared for them. If we wanted people to be treated with dignity, respect and to be motivated and feel good about themselves, we had to do that for the workforce. As a side-effect from focusing on that, we had tremendous quality outcomes but also real value-for-money responses. In one of our local authorities, each worker working with older people had 37 days off sick – nearly eight weeks. In our organisation, doing exactly the same job, with the same pay and conditions that they would have had in the local authority, our people had 0.6 of a day off – less than one day. We estimate that, for every elderly person in a home, that saves £300, which means £300,000 for doing nothing except engaging with people.

Mark Speed This is very much what is coming out of a lot of reports. People are desperate to do more work. It is that autonomy and flexibility that people crave. There have to be guidelines and boundaries.

Julie Dent The strategic health authority (SHA) that I led until last year also went into the *Sunday Times* competition and we came 50th. The turning point was actually treating staff like adults, teaching a way of working where we had an organisation that had no rules. We had no notices anywhere that told you how to use the loo or how to wash your coffee cup. It seems to me that it is about empowering people and you can do that in the public sector. It requires leadership and will. However, I think it is easier if you are in the voluntary sector and social enterprise.

Ivan Lewis The best schools, the best hospitals and the best police divisions have social entrepreneurs leading them but I always warn the voluntary sector against implying that it is motivated by values and that those who work in statutory or “state-ist” agencies are not. That is incredibly divisive, unfair and

As a service user, I do not care whether it is the public, private or voluntary sector that is providing the service
Baroness Greengross



misleading. We have to look in a more sophisticated way at the reasons why voluntary organisations and social enterprises can often do things that, frankly, statutory agencies fail to do.

Dave Brindle Turning to the end product, the service that is delivered on the ground, Sally, what is it that is special about the third-sector approach?

Baroness Greengross I think we are talking about trust because it is rather “us and them”. It is also about innovation because the third sector can start things up much more quickly and meet a need very quickly. It is bottom-up, which is important. A lot of people do find it very difficult to relate to the statutory sector.

As Geoff was saying, good management is vital. It should not matter which sector you are in to manage people effectively and motivate them. The public sector is quite bad at contracting with the private sector or the voluntary sector, nationally and locally. You sometimes see the private sector getting away with tremendously advantageous contracts. What we are talking about is professionalism. In order to get longer-term contracts and all those advantages, we in the voluntary sector have to be really professional, measure outcomes and know that we are getting to where we want to be.

As a service user, I do not care whether it is the public, private or voluntary sector that is providing the service. I want a good service where my autonomy is maintained as far as possible. If I am an old woman, I need a bed bath, I want my toenails clipped and I want help with eating, who is going to tell me whether that is health or social care? I need an integrated service that would merit, if I was a provider, a long-term contract but, if I am not professional enough to warrant it, then I should lose it just like anyone else.

The voluntary sector is much better at the preventive role if it is allowed to do it, because that is where the statutory services have to concentrate more on things that are obviously more necessary. If you are already ill you are not actually in the business of

prevention. Preventing things getting to that stage is where the voluntary sector has a huge role.

Judith Luker We have groups in this room that are treating people with health inequalities as whole people, responding to local needs, responding to very deep insights about people in their communities, and thinking really hard about what the whole person needs, not just about their treatment pathway. Apologies for those who were not here this morning because they missed some fantastic examples of disease and prevention awareness programmes. What are we missing in terms of learning the skills that the third sector is deploying at the local level? They are doing some amazing work, and they are hitting many of the buttons that the NHS wants to hit.

Marjorie Wallace To go back to what Ivan Lewis was saying, almost every call we get emphasises the loneliness, isolation and boredom of people wanting something meaningful to do. Those things are considered luxuries, in a way, by healthcare commissioning services. Yet people like us can fill that gap because we are available, we are transcending their condition, whether that person is a family member or whether they are mentally ill. We take everybody and every caller and we can transcend inequalities.

For instance, we know that the period of time that a person is most likely to commit suicide is in the first 48 hours after leaving a hospital or leaving any treatment. Care teams often do not get to where they are needed [until] seven days later. That is their target time. The outpatient’s appointment is three months later. We could easily ring those people several times a day during that 48 hours. Even people who do not answer the phone say, “We knew it was you. We listened to your message and that got us through the day.”

Volunteers and families are a greatly underused resource, provided they get national training, which is what we give them. Some of them become real experts. For instance, some of them have done a thousand hours of listening to somebody with mental illness or mental health problems. They are a highly underused resource. I think we ought to look at their training.

We did an event last week called Medical Innovations, looking across the whole board, not just mental health. There is a wealth of ideas and information that never gets off the drawing board, both from professionals and from the voluntary sector. The idea of this event was to put them together with venture capitalists, hedge-fund managers and so on, so that they become activities that people take on. Some of the ideas were really very simple. To get ideas and imagination, the voluntary sector has to be treated well. If you are like us, on a million pounds a year, roughly, there is tension because you have people who want pump-priming money but nobody to provide the core funding. That tension is always in the background in the way that the voluntary sector finds it so hard to manage and provide the consistency that Sally is talking about.

Stuart Etherington I would like to pick up on Ivan's point about looking at what the sector does well and what it does not do very well before we proceed on the assumption that pretty much everything it does, it does well. I think your numbers are broadly right. Our analysis of the sector overall is that it is worth about £30bn, so £4.7bn in health and social care would be about right. I think your experience as to what people are saying is broadly correct.

The sector is very good at delivering services in particular ways but, in addition, it shapes public policy. It has a role in delivery and it also has a particular role in shaping the commissioning process because the users of the service should be informing it.

There is probably a distinction to be made between organisations that are being taken out of the public sector and "enterprised up" and organisations that have always sat outside the sector. Then we have the question of users' experience of the service. Voluntary organisations tend to build social capital; be innovative; take more risks and be more likely to engage in co-production, which is key. That is useful in some areas of health and social care but not in others. The sector does not do equity. It does flexibility, risk taking and innovation, but not equity.

If I live in Caithness I want to think that the probability of me being operated on for heart disease is roughly the same as if I lived in Dorset. There is a sense in which the third sector does not do this type of equity. If I want certain medical interventions, I want the professionals to learn from experience. I do not want people really innovating that much in relation to certain types of acute surgery. So I think there is an issue about tolerance and equity.

A recent National Consumer Council study looked at users' experience of three different services across different sectors: housing, domiciliary care and employment services. The third sector scored highest in terms of user experiences and employment services. In relation to housing, it scored just as badly as the public sector, which suggests that social housing is not better provided by the third sector. Interestingly, in domiciliary care, the private sector outsourced

everybody else in terms of the user experience.

So the sector is not always right or always wrong. There are a lot of technological barriers in contracting that need to be teased out. Government is a notoriously bad shopper. The nature of the contracting process often drives out the characteristics that you want to preserve or encourage. For example, public fund procurement officers tend to be pretty risk averse. The latest evidence we have about the sector is 2005 data, which shows that the sector continues to grow, large organisations tend to dominate more and more and that is being driven by two things. They are more effective fundraisers and public procurement tends to drive to scale. Organisations that can get to scale start to win more contracts.

However, the ecology of the sector is changing. The proportion of public money in the sector is not going up as fast as you would predict, given the level of rhetoric around this particular public policy issue. It is changing from grants to earned income. So, from grants to contracts, what is going on is very marked. That starts to bring into play concerns about whether third-sector organisations can take risks, can build social capital and can be involved in innovation, if the contracting process is tending to prevent that. There are real opportunities for third-sector engagement in relation to this.

The sector is still at the margin of delivery – 39 per cent of the sector's income comes from the public sector but it is less than 2 per cent of public spending. I am not surprised that organisations say they could expand but the dangers relate to the technologies of contracting and, I think, if we are on a particular trajectory, it will drive more organisations to scale, so you will lose the sense of locality and smallness. They will also drive out risk and innovation because of the nature of the process. We need a real cultural change in the way services are specified and contracted.

Dave Brindle Ivan, on the equity point. The NHS needs to guarantee equity; equity is not what the voluntary sector does.

Ivan Lewis It is at the heart of the debate about "national" and "devolved". It is going to be a growing problem. We have to understand that the word "patchy" being applied to public services is almost mainstream and that it can be within the same locality and it can be within different localities. There have to be universal, uniform, national and non-negotiable minimum standards and expectations. Beyond that, if you truly want to encourage innovation, imagination, original thinking, the testing out of new ideas and looking at the needs of communities – which can be massively different depending on the history of the community, the socioeconomic profile and the demography within that community – there has to be a significant element of encouraging and enabling local solutions to tackle local realities. Any state that does not face up to that reality is not going to be able to achieve its overall objective – a society where

The sector has a role in delivery and it also has a particular role in shaping the commissioning process
Stuart Etherington



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Dave Brindle



everybody has the opportunity to fulfil their potential, where we eradicate as much social exclusion as we can and where we make social mobility a reality.

If we seek to do all of that in a top-down, “state-ist” led way, we are destined to fail. There has to be a partnership between the state, the family, civic society and individual citizens. In that context, the third sector has a massive potential role to play. Whether it is campaigning, arguing and fighting collectively to change a global or national public policy, or whether it is changing the experience for an individual in the way that services treat that individual, or that group of individuals, if you think of mental health and other services, that role should not be underestimated or marginalised.

There are some people in the third sector who present a definition of success as being entirely about “Do we have a greater share of the cake in terms of provision?” That is one test, but if you look at the contribution and the role that the third sector has to play, it must not be the only test.

We are talking about the third sector as though it were homogenous. Large national charities and very local grassroots tenants’ and residents’ associations have very different infrastructures, missions, values and origins.

One of our great challenges is commissioning. If we are going to place an increased reliance on commissioning to re-engineer the system so that it is more personalised and focused on the needs of those who use services as patients, as users and as carers, then the commissioning decisions are going to be absolutely crucial. Do we have world-class commissioning in this country? Do we heck!

We focus, quite rightly, in public service terms, on leadership and management but, alongside that, we have to put the importance of excellent commissioning. We need commissioners who understand that their job is not to be contract managers in a traditional sense, that part of being a good commissioner is to decommission services that are simply not delivering. Until we get to that

situation where we understand that those roles are absolutely crucial, then, in a sense, we are always going to have some of the barriers and obstacles that have been described.

There are still too many people in statutory agencies who do not take the third sector seriously, who do not regard it as, potentially, an equal partner, who do not look outside of their organisational structure for some of the solutions to achieve the outcomes that they want to achieve. I have said that, in this area, there is a rhetoric and reality gap. We are all signed up to the Compact and Compact-Plus principles for equal partnership, but do commissioners implement or apply the Compact principles in making decisions? I do not believe that they do.

I hear increasing stories of an argument that you cannot work as a partner with organisations that you are commissioning services from. This is actually retrograde public policy. We did actually reach a stage where we all understood, “Yes, of course you can have a commissioning/commercial relationship while having a collaborative relationship in terms of identifying the needs of your population and seeking to meet those needs.”

We are hoping to create a new Skills Academy for social care and the focus of that will be leadership and management, but it will also be trying to spread excellence in terms of commissioning in social care.

As a minister, you become aware that the levers you have to pull are reducing from the centre in that there is a significant amount of devolution, of commitment to localism – local PCTs, local authorities and other public sector agencies at a local level. If that is the case, commissioning is crucial.

Dave Brindle Talking of the Compact, though, how many people who have got contracts or agreements with state agencies have agreements for only one year? How many people have three years? [*Show of hands*] So it is mostly one year of the small number showing. How many people are thinking that they are getting their full costs recovered under the contracts? [*Show of hands*] How many do not? [*Show of hands*] That is an overwhelming number of “nots”.

Spencer Neal You said that we are terrible at commissioning, so where should we be looking to find a model that we can mimic? If the answer is that nowhere is doing this, is there not a danger that, once again, the UK is forging the way but actually spending more money than we can afford in trialling different ways of doing things to then not do very well?

Ivan Lewis I cannot identify such a country at this stage, but I think we can always learn from international evidence and international practice. I suspect that there are some examples of excellent practice in our own country.

My point is that it is not mainstream and, over a relatively short period of time, we have put a tremendous amount of power in the hands of commissioners at a local level. Had we, at the same

time as we did that, recognised that the quality of commissioners will determine whether we are able to secure health and social care outcomes in every community we desire, we would have reflected that in the training, status and basis on which we appoint people to commissioning roles. I suspect that that is not the case at the moment.

Stuart Etherington We are pretty advanced at national level, I think. The Compact is there. There is a Compact Commissioner. The fact that things are not always working is fine. You can work away at something. We have new legislation that is good for social enterprise and good for charities. We have a good tax regime, generally. The architecture that has been worked on for the past ten years is reasonable.

In terms of service delivery, if you look at the Dutch engagement with education, for example, it is a very interesting outcomes-based delivery.

Interestingly, when you ask people which country has the biggest non-profit sector in the world, people normally reply that it is America or the UK, whereas actually it is Holland. Holland provides all of its education via a broadly contracted-out system. It has done that for a range of reasons, not the least of which is the religious divide in Holland and it has a non-profit solution to that.

Ivan is absolutely correct that we need to work away at the purchaser relationship. I was pleased to see the Office of the Third Sector put £2m into training up commissioners through the Improvement and Development Agency (IDEA). The real problem is that you have also distorted priorities. I heard an example yesterday, at a conference I was chairing, where a guy running an Aids prevention charity in the southwest had borrowed £100,000 from futurebuilders, the social investment fund, to create working capital to gear up on the assumption of contracts from local PCTs. The PCTs got themselves into financial trouble and diverted a lot of specialist money to keep themselves going. So this guy ended up with a debt of £100,000 and no contracts for cost of capital to fund it.

It seems to me that, at the beginning of negotiations, we are all going to share the risk and, by the end, we are trying to move it from one side to the other
Julie Dent



Ivan Lewis We face some of the most intractable challenges in relation to health inequality and social exclusion. Time and time again we spend vast amounts of money on traditional “state-ist” solutions. If we thought outside the box and used social enterprise in the voluntary sector in a more significant way, we may have a better chance of tackling some of those deep-rooted problems. Ultimately that is a more cost-effective way of spending public resources.

Dave Brindle Most of the panellists want to come in, but I do want to take two points from the floor. Then I will come back to the panel.

Annie Stevenson I work for Help the Aged. I am a senior policy adviser. I have worked in the public sector and in the voluntary sector. I am listening very carefully to what you say. I was a contracts manager in my last job in the public sector with social care contracts. I am a social worker by background. It is the inspiration and the extraordinary people in the voluntary sector that makes it for me. I got burned out in the public sector and I did not feel I could flourish. Being a contracts manager at the time, that was the end for me. I do agree with you about commissioning being important and I can see what was wrong. I felt so constrained and frustrated.

People like Dame Cicely Saunders [founder of the modern hospice movement] are what gives the voluntary sector spirit, energy and vision. That is what excites me about working for Help the Aged, it is about understanding all the difficult issues. We look at the difficult issues in our society. We tackle prejudice. We can be a critical friend to the system.

As a consumer and user, as the parent of a child who has been bullied in school and who went through the Kidscape system, organisations with helplines are invaluable. You are treated as a human being and you are empowered. Advocacy has such an important role to play.

The coalition that has come together on long-term care, Caring Choices, is a good example of voluntary organisations, such as the King’s Fund, Joseph Rowntree Foundation, Help the Aged and Age Concern, bringing together a hugely important issue of the funding of long-term care and asking about our vision for our old age and how we are going to fund it.

Christine Keiffer I am from the North Lambeth Healthy Living Project. I asked the panel before lunch how one gets NHS commissioners to think outside the box. A number of people came up to me during lunch to sympathise, so I think this is a fairly relevant topic for discussion. The experiences we have had would actually be quite a useful case study for people to comment on. We are a user organisation. We have sprung from the user group of a fantastic Healthy Living Centre, a Lottery-funded project, in Stockwell, which closed at the end of its five years because nobody had thought about sustainable funding. That project was amazing. It targeted so many hard-to-reach groups. It targeted the local Muslim population

The campaigning role and the independence from the statutory sector is often compromised if you have to rely on contracts
Marjorie Wallace



and it did incredibly well with black African Muslim women, as well as with African men and with the local Chinese community. It also recognised that, in the population of Lambeth as a whole, a huge number of people do shift work. If you do shift work, exercise on prescription, which is run on a sessional basis, is no good for you because you are not going to be free every Tuesday evening.

The problem we are having is that the local PCT commissioners only tender to the people they are already tendering to. The local council started off with the same sort of attitude of, "This is what we have always done and this is what we are going to do." The council is now giving us free accommodation and they are going to fund somebody to provide some of the services we need. If you are a grassroots organisation, run completely by volunteers, even getting started is very difficult. People will not fund capital or revenue costs.

I am going to disagree with Geoff Walker saying that the third sector can compete because the private sector needs a profit margin and the statutory sector has bureaucracy. The amount of time the third sector has to spend trying to raise funding makes it impracticable to compete on a level playing field.

Marjorie Wallace We have great difficulties and we are national. I think there is a problem. However, another problem that nobody has really mentioned is the other role of the third sector, the campaigning role and the independence from the statutory sector. This is often compromised if you have to rely on contracts. Anybody here who has had to rely on contracts or their conditions and the audits and all that goes with it, will understand what I am saying. It is a difficult situation.

Julie Dent Having been a commissioner in a previous life, I now find myself supporting social enterprises to win contracts. My observation is that there are three ingredients. One is a partnership approach, about forming a long-term relationship for the commissioner and the provider. The second is about

risk taking and where the risk sits. It seems to me that, at the beginning of negotiations, we are all going to share the risk and, by the end, we are trying to move it from one side to the other. The third is moving to outcome-based contracting. Certainly I used to cry to PCTs, "Why don't you just say you want a sexual-health strategy that says there is a 10 per cent reduction in chlamydia. Do not try to design the colour of the wallpaper and where the light switches go." That is the provider risk; what you are working together towards is the outcome.

If you go to the United States and look at the way that they commission, it is done because billing drives the information, but their information and metrics are very good, compared with the ones that we have.

Finally, I think there is something in trying to sell something that someone wants to buy. A number of people have been to see me at the Social Enterprise Coalition to say, "The PCT does not want us to provide this any more so we are going to set up a business to do it." I say, "That is very interesting, but what makes you think they are going to buy it now if they are not willing to provide it now?"

Geoff Walker In defence of commissioners, over the ten years that we have been contracting with health and social care, I have really seen an improvement in how commissioners operate. They are far cuter now about what it is they want to buy and what the outcomes are, and that is part of the problem for the sector. They now look in greater detail at what we are providing and how much that genuinely costs. We are working with a small organisation at present where 40 per cent of what they get in contracts and grants does not actually provide anything. It goes on buildings, photocopiers, and so on. We are trying to work with them to get some of that 40 per cent actually delivering something at the front end. I agree with Baroness Greengross that we should not get this work just because we are nice people. We have to compete on price. All the things that we do well after that are what we call the "added value". Let's not change why we do things and our values, but we have to do them slightly differently to become competitive.

In relation to chasing money all the time, it is about developing that partnership, as Julie says, so that you are not constantly going back and re-establishing that relationship for long-term contracts. We have never had more than a three-year contract, but the contracts have been renewed each time because the people we care for are getting the services they want.

You do not set out to set up a social enterprise. You set up a profitable, sustainable business. It is what you do with that profit that makes you a social enterprise.

Mark Speed We hear from so many people saying "We are only a one-man band with two volunteers" but the partnerships are not quite getting together yet, so that is probably the next step.

Baroness Greengross Ivan said that we could drive standards. I think it was a bit of an understatement. In

the end, the minister and the government, at a national or local level, are accountable to the public and they have a duty not just to contract or commission on the grounds of price but also on standards and also have a redistributive role. So, you can have a responsibility to some extent for getting equality around the country because you can gear your standards and your distribution of services where they are most needed.

I said at the beginning that, as a consumer, I do not care as long as the standards are there, and that means they must be very high. They must build in my choices, my representation and my ability to do things, but we cannot let you get away with the fact that there is an inequality because we do not live in a raw capitalist economy or a raw voluntary-sector economy. You can control and you have a duty to do that.

Ivan Lewis I agree entirely with that. Look at the levers, the variables, that the government has control over: policy, legislation, targets, the regulatory system, clearly defining expected outcomes, making absolutely clear what we expect the direction of policy travel to be. I made a bit of a thing about individual budgets, personalisation in social care, and I believe that that has made a difference. The social care world now accepts that this is not just an experiment but it is going to be a mainstream part of the social care system.

I know that too often there is a gap between the rhetoric and the reality, and that gap is for those at the sharp end of wanting to provide services, whether they be in the public sector or the third sector, and also for the people who use our services. I am very conscious that what people want is a system that is on their side. They do not want a system where they feel they are fighting every day of the week to get a basic level of service.

Stuart was positive about the architecture and the policy framework that government has put in place in terms of the interaction between the state and the third sector. I think we should be very proud of that in any international comparison, but there is still a long,

long way to go, because people are judged by their everyday experiences. I always say that all that matters in my job is the interaction between the person providing the service and the person receiving the service and their family members. Everything else is architecture and wiring. The problem is that if you get any element of that architecture and wiring wrong, or there is some dysfunctionality, that has a direct impact on the quality of that ultimate interaction.

One of the primary jobs of any minister in any government is to close the rhetoric and reality gap.

Dave Brindle I will take one more contribution from the floor. Meanwhile, I would just like the panel to reflect on one thing that could be changed to make life easier for the people out there in terms of getting a bigger role in healthcare provision and advocacy. That will be by way of conclusion.

Dr Judith Wardle I am from the Continenence Foundation, one of the many very small national organisations. Nobody has mentioned the vast number of organisations that provide condition-specific national information. That information is provided to the equivalent of NHS standards. Indeed, we employ people who, when they are not working for us, work for the NHS, and we pay them at NHS rates. However, there is no provision within what you are talking about for us to go to anybody and ask, "Can we have a contract? Will somebody pay us to do what we are doing now?" We cannot go to the National Lottery or to the Department of Health. There is nothing in the most recent Section 64 criteria for grants for next year. I am not just speaking for us but I am speaking, say, for the Migraine Trust and all those organisations that are providing something we regard as being like a public service but we are doing it on the basis of getting funding from people like Pfizer. Otherwise, we are trying to do it on the basis of public donations, which does not work.

Stuart Etherington The boundaries of what is a public service are permeable. Organisations often move between sectors. The issue about funding ratios is a hardy perennial in the sector. I worry that this area will still be invested in but invested growth rates are not going to be as high. I wonder what that will do to this sort of ecology? If people's experience of the service does not equate with the increasingly flexible services that they can buy from other places, their commitment to publicly funded and provided services will fall away.

Ivan Lewis At the moment, we are reviewing the way that we invest in Section 64 funding. There is a tendency now to say, "All funding decisions are made at a local level," which means that you are asking some organisations that are highly specialist and may have a national focus to negotiate with 152 separate PCTs, possibly nine strategic health authorities and 150 local authorities. What has happened is that we have gone from a highly centralist system to an incredibly

We should end target-driven contracts based on process rather than outcomes
Mark Speed



The message from the floor is that sustainable funding is an ongoing disaster zone
Judith Luker



devolved system. I think there needs to be a little bit of nuancing and finessing in terms of horses for courses, so I accept that we need to have a look at that.

Dave Brindle Will you offer us your one thought on what the new government could do to improve the prospects for colleagues here today?

Ivan Lewis I think it is about whether we believe that the public service is about empowering and enabling citizens and allowing them to have maximum power and control over their own lives. Also do we believe that the solutions to most of society's problems are not "state-ist" alone? The state has an incredibly important role in leadership and in setting the tone and the policy, but it cannot actually solve many of society's deepest problems without a genuine partnership between state, family and civic society – and right at the heart of civic society is the third sector.

Geoff Walker Government has created an environment where the third sector is at its best in combining public service with efficiency and effectiveness. We should be able to flourish in the health and social care services. It is about going back to our organisations and looking at where we need to change and skill up. Contract negotiation is a skill that can be learned. It is a challenge to us to try to respond to the environment that is being created.

Mark Speed I have two thoughts. First, a more creative and, ideally, shared-risk procurement process would be good and, second, from what we have been talking about earlier, we should end target-driven contracts based on process rather than outcomes.

Judith Luker The message from the floor is that sustainable funding is an ongoing disaster zone. One way to be more sustainable is to try very hard to get a greater range of funding so that you are less reliant on one source of funding, balanced over years in a more manageable way. One of those sources of funding can be the private sector and business, which requires

complete transparency and very open partnerships. Then there is no reason why that should not be a very successful formula.

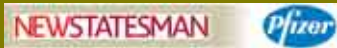
Julie Dent I have two comments. One is that the time has never been better to seize the moment for the third sector, social enterprise and the voluntary sector. The second thing is that the process for getting start-up funds is very difficult for anyone trying to get off the ground. It would be very nice if the social funders came together in some sort of concordat that set out clearly for the sector who was going to fund what and that there was one business-plan process.

Stuart Etherington I will make two points, if I may. Clearly, intelligent procurement is at the heart of the debate. The second point is not to lose sight of public policies that preserve civil society for its own sake. The sector is not just an instrument of the state. It is not just a delivery mechanism. The danger is that, if there is too much emphasis on this, the other roles – wider civil society, citizen engagement, and citizens shaping their lives and the services that they receive – may be damaged. You need to think very carefully about the ecology of civil society in these debates.

Marjorie Wallace Picking up the point made by the lady from the floor, what we would like to see is some form of national funding, core funding, for small national organisations because it is practically impossible at the moment – you have either local commissioning or the fat organisations getting the contracts. We would like to see these people transcend the boundaries, networking in local groups, whether that is statutory or voluntary. It is very important to have alternative help for people as well as that provided by health and social care. Charities are there to help the people – the people say what they need and what they want. That might be something that people think is trivial but it may be what they need, and we need to keep that vision.

Baroness Greengross There is a big difference between the organisation that is getting per capita funding to look after severely disabled people day and night (and that is a contract) and the little charities that have so much difficulty. For them, we need a simple model, a simple formula, for getting the money to do the essential work that they want to do. Things need to change so that life is made possible for the small charities and the campaigning groups, but with a proper commercial-type contract for the ones carrying out the per capita contractual service provision.

Dave Brindle Thank you all. I think it has been a very rich discussion. The third sector brings no one special factor but a mix of qualities that seems to present some magic dust. Evidently, there is a real appetite in the health voluntary sector to provide more and a sense of frustration that there are obstacles in its way. Clearly this has to be on the agenda for the incoming government.



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