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Guest editorial

Improving primary and community health services through nurse-led social enterprise

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Quality is the dominant theme in current English National Health Service (NHS) policy and Lord Darzi's review *High Quality Care for All*, published in 2008,[1] placed health professionals firmly at the forefront of leading local change to improve services. The focus of the report was on *local* innovation with health professionals being given the freedom to propose and lead on how services will be provided in new or different ways to improve the quality of care for patients. The last decade has seen rapid diversification of models of primary and community care provision[2,3] in response to New Labour imperatives of improving access, equity and choice for patients. Experimentation with various models of organising the way GPs, nurses and other primary/community healthcare workers organise their care looks set to accelerate as commissioning expands further into the independent and third sectors.[3] For example, the introduction of 'alternative provider medical service' and 'specialist provider medical service' contracts have opened the way for a range of public, private and not-for-profit organisations to tender to provide primary/community care services. Within this mixed healthcare economy, social enterprises are becoming increasingly common as providers of NHS services. Indeed, primary care trust staff can now formally request to set up a social enterprise through the 'right to request' initiative identified in *High Quality for All*.[1] This means that primary care trust boards are required to consider proposals from NHS staff on how to improve services locally through the creation of social enterprise.[4,5]

Social enterprise is being strongly promoted by policy makers as a means of providing new forms of services in primary and community care in England.[3] The expansion of the social enterprise sector as a vehicle for achieving community care reforms is also a prominent feature of *High Quality for All*[1] and nurses have been identified as a key group to lead or contribute to these changes in six key areas: health and wellbeing, children and families, people with long-term conditions, rehabilitation, providing hospital care close to home and end-of-life care.

So what is social enterprise and what does it mean for nurses working in primary and community care contexts? What do we know about the barriers and enablers to nurses' involvement in social enterprise and how has their involvement in these endeavours so far influenced the quality of the services they provide?

Social enterprises are businesses which pursue social objectives rather than financial gain. Social enterprises trade for 'social good' and receive their funding through contracts like any business would but the profits are used to create a social rather than a financial return. There is no one single social enterprise business model, nor is the phenomenon new in the UK; the Cooperative movement, which started in the eighteenth century, is a long established example of a business with a social mission. Modern day examples include the *Big Issue*, Café Direct and the Grameen Bank. In respect of nurses' involvement in social enterprise, in the nineteenth century Mary Seacole may have been one of the first nurses to establish such a scheme, using the profits from the hotels and boarding houses she established to pay for medicines and supplies to treat people who could not afford to pay for health care.[6] A modern day example of a social enterprise is the Cuckoo Lane Surgery in London, set up in 2005 and led by a nurse practitioner to deliver primary care in the areas of acute illness, long-term conditions, screening and health promotion. Central Surrey Health is another well known example of a social enterprise, providing community and therapy services, co-owned and run by the nursing and therapy teams it employs. Many social enterprise schemes have focused on providing services which other providers may not want to or are unable to deliver, often serving disadvantaged sections of the community (e.g. those with mental illness or disabilities, the homeless or the long-term unemployed).

Social enterprises are often started and led by individuals who are described as 'social entrepreneurs'. Although there is no single definition for 'social entrepreneurship', there is general agreement about

the key activities and behaviours that characterise the role. These are:

- adopting a social mission to create and sustain social value
- recognising and relentlessly pursing new opportunities to serve that mission
- engaging in a process of continuous innovation, adaptation and learning
- acting boldly without being limited by resources currently at hand and
- exhibiting a heightened sense of accountability to the constituencies served and for the outcomes created.[7]

Successful entrepreneurs also tend to have a high tolerance for risk. Although there has been little systematic research on nursing entrepreneurship per se, there is an abundance of policy, professional and opinion-based literature highlighting how UK nurses have responded to modernising the NHS in a range of innovative ways to deliver services both within and outside of the NHS. For example, service models in primary and community care now include nursing cooperatives, nurse-run practices, GP–nurse practice partnerships, multispecialty teams and nurse-led care services,[8] although these approaches in themselves do not always constitute social enterprises.

There are many reasons why nurses may be 'pushed' or 'pulled' into initiating new ways of delivering services, including: taking advantage of an opportunity; dissatisfaction with work; GP retirement/resignation or difficulties with recruitment; a desire to exercise more autonomy; better use of skills and expertise; and as a response to seeing services delivered poorly for a particular patient group. David Dawes, himself a nurse entrepreneur, suggests the main reason why nurses choose to start a social enterprise is because they have 'a clear idea what excellent care should look like and the kind of care they want to deliver'.[9]

However, while growth in social enterprise is being encouraged, there are few nurse-led social enterprise 'health' schemes. Although reliable statistics are not available, as a proportion of the total UK nursing workforce few nurses choose to pursue an entrepreneurial role or engage in social enterprise.[9] The International Council of Nurses estimated that 0.5 to 1% of registered nurses worldwide are 'nurse entrepreneurs'[10] and even in the USA, where social enterprises are a major provider of care services, only 0.18% of nurses or midwives are self-employed or own professionally related businesses.[11] Primary Medical Service (PMS) pilot schemes launched in 1998 in England attracted only two independent nurses in the first wave and seven nurses opted into nurse-provided PMS contracts in the second wave.[9]

Isolation, lack of a 'safety net', resistance and hostility from some colleagues to nurses taking on the employer role, difficulties recruiting GPs to salaried positions and bureaucratic and legislative barriers were some of the issues reported by nurses holding these forms of contracts during the early years of implementation. Reluctance to engage in social enterprise ventures is also understandable if the skills required, such as financial accounting, business planning and high level networking/collaborative partnership skills are perceived to be lacking. Nursing is a predominantly female workforce and there is evidence that in comparison to men, women may face particular barriers. For example, women perceive greater difficulty in accessing external finance, they are less likely to be members of business or employers' associations, are more likely to underrate their performance and skills and may be more reluctant to take on risk (often attributed to their family/child care roles and responsibilities).[9]

While the professional and policy literature is full of accounts of how nurses are addressing the social enterprise agenda, many may feel the balance of risk is too high in an uncertain financial climate with future spending cuts looming. In the UK, 30% of all small business start-ups will fail in the first 12 months and this rises to 55% within three years.[9] We do not know how many social enterprises in health fail, nor how many of these are nurse-led ventures. There may be professional and cultural barriers too. Most UK nurses are employed by and intensely loyal to the NHS and some perceive these new forms of not-for-profit and private provision as fragmenting rather than enhancing accessibility, choice and the quality of primary and community care services.[12] Exactly how a range of different models of service provision in primary and community care will succeed alongside each other is uncertain. Until recently, loss of NHS pension rights was undoubtedly a key deterrent to nurses' involvement in social enterprise. Now, nurses and other health workers transferring from the NHS to social enterprise schemes have their public sector pension rights protected.[1] Whether this will trigger the expansion of nurse-led social enterprise which the government is hoping for is yet to be seen. We do not know enough about the conditions that will encourage more nurses to start up social enterprises or the factors that contribute to their success and sustainability in the long term.

So what impact has nurse-led social enterprise had on primary and community care services? To what extent have these new forms of provision improved the quality of care, reduced health inequalities and led to greater efficiency? Disappointingly, the answer to both these questions is 'we don't yet know'. In contrast to the high quality evidence accumulating on the impact of nurses substituting for GPs in providing some primary care services[13,14] there is a notable absence of any rigorous evaluation of nurse-led social

enterprise schemes. A recent review of entrepreneurial activity among nurses and midwives in the UK found only three empirical studies; most of the current literature constitutes descriptive accounts.[8] There is, therefore, little evidence available on the impact of nurse-led social enterprise on improving service access, patient choice, clinical outcomes, inequalities or experiences of care. The challenge now is to go beyond the 'good news' stories and descriptions of process and demonstrate the worth and value of social enterprises in terms of the measurable health benefits and improvements to service delivery they bring to the primary and community health sector.

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PEER REVIEW

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CONFLICTS OF INTEREST

None.

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