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NHS CONFEDERATION

an uneasy consensus: patients, citizens and the NHS

May 2012 Paper 4

Paper 4

Working locally: micro-enterprises and building community assets

Key points

- Thinking micro as well as macro will be an important part of integrating health and social care to achieve public health outcomes and improve the self-management of long-term conditions.
- The gains of personalisation through micro-enterprise are not only realised at the individual level but support individuals to form groups and draw on community contributions.
- Micro-enterprise approaches provide innovative and cost-effective solutions to delivering health and care services.
- Micro-enterprises require specific support and commissioning practices to thrive and benefit communities.

Micro-enterprises – sole traders or small groups set up to build services around the needs of a specific group of people – and other small scale approaches to planning, purchasing and delivering health and care outcomes are becoming well established within social care. They have been proved to produce highly tailored, 'personalised' responses to people's individual needs and build on individuals' potential skills and contributions to adopting healthier, more fulfilling lives. By building on and extending people's close relationships, they provide the potential to form bridges between the goal of individually tailored services and a desire to encourage communities to contribute more to the local health and care economy by becoming more supportive and inclusive.

By their nature, micro-scale approaches unlock contributions which can only be realised at the micro level, such as the mixture of paid and unpaid support, but there are also established routes to 'scaling out' micro-enterprise and related approaches. This can create the conditions in which many more micro-enterprises can survive and thrive, rather than seeking to scale-up initiatives and risk losing the added value provided by people's close personal relationships and tailored interventions.

Micro-scale approaches are not yet widely considered within health commissioning, despite the fact that many GP practices already fit the definition of a 'micro-enterprise'. This paper examines the lessons NHS decision makers could learn from micro-scale approaches in social care, and the place of micro-enterprise development within an integrated health, care and support system.

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An uneasy consensus series

These papers are intended to stimulate debate with members and others, culminating in a panel discussion with the authors during the NHS Confederation's annual conference and exhibition in June 2012. To find out more, go to **www.nhsconfed.org/2012**

Intended to stimulate discussion, this paper is the fourth in our series looking at interactions between the NHS, individuals and communities, published in the run up to the 2012 NHS Confederation annual conference and exhibition. Previous papers have explored personal experiences and changing relationships in the NHS, shared decision-making and collective involvement, and information that benefits all. A final paper will look at building social value within the system and society, and will be published during the event itself.

Introduction: the elusive community

For the NHS to focus more on health and well-being as well as treating illness, the way we understand the term 'service', and the relationship of services and professionals to the people they serve, will have to change. A highly trained expert using the latest equipment and medicines may be best placed to treat illness, but not to help an individual with a long-term condition to manage their well-being, nor to help whole populations to adopt healthier lifestyles.

Micro-enterprises are rarely commissioned by health professionals (unless we count GP practices, of which more below) and personal health budgets, which allow individuals to purchase their own healthcare, are still in pilot stage. However, micro-enterprises have shown themselves to have huge potential within the field of social care. They have helped to move the personal choice agenda from the goal of individually tailored services purchased by informed consumers to the goals of shared decision-making (co-production) and of sharing responsibility for achieving well-being.

These ideas are embedded in an 'assets' approach to working with people (see the box on page 2). Assets approaches can be located at the more radical end of the spectrum of professional/patient relationships, beyond compassion, and even the promotion of dignity. They are about recognising that patients are citizens and that there are areas of expertise about a person's motivations, capabilities and potential, which only the individual and those close to them can achieve.

Personal budget approaches, in which people are given control of public money allocated to their support, sometimes via a cash direct payment, are based on the belief that individuals and their families will be best placed to construct complex and well-tailored care packages. Some of the approaches outlined in this paper take a step further, and suggest that well-supported groups of citizens can also play an important part in shaping commissioning of health and care services.

What are micro-enterprises?

Micro-enterprises have five or fewer workers and volunteers and contribute to the support or inclusion of people who use health and social care services. They are often thought of as involving setting up co-operatives or similarly complex organisational structures, but some ex-frontline workers have set up as sole traders or in very small groups in order to build social care services around the needs of a small group of disabled or older people. Micro-enterprises often aim to remain small and personal and some are mutually owned by those who use them. A few have been set up and run by, for instance, disabled adults including adults with learning disabilities who have not previously been seen as able to become entrepreneurs. Few are formally constituted as charities, but at the micro-scale, sector boundaries become less obvious: any very small scale business needs to have a very close relationship with those it aims to serve. Micro-enterprises can offer unpaid and community resource contributions which a larger organisation, of whatever sector, would find difficult to realise.

While many elements of healthcare are not likely to be amenable to commissioning at a micro-scale, it is worth noting that the NHS has its own long-established micro-enterprise model in the GP practice: a small scale private sector partnership deeply embedded in - and valued by - the local community.

Well-tailored services = good life for patients?

One of the shortcomings of the personalisation reforms in social care[3] has been the difficulty to translate a well-tailored service into a good life for patients. In particular, even well-tailored services cannot tackle a person's isolation. With loneliness now believed to have an impact upon health comparable to that of obesity and smoking,[4] this is relevant to the health economy.

The Centre for Social Justice recently argued[5] that the community care reforms in mental health had re-located services from institutions to community settings, but had lacked the community development work needed to ensure that the community was fully engaged with supporting and including people with mental health problems. The long-term impacts of isolation and exclusion upon mental health therefore remained untouched and the expected increase in cost benefit of community-located services not always realised.

Initiatives at the micro-scale attempt to address this challenge through identifying people's close relationships and attempting to help people to strengthen and broaden them. They aim to help people become connected with a greater range of informal sources of support and finding ways to take on responsibility for others, as a route towards better health and well-being. Support and recognition of unpaid family carers, what the RCGP[6] calls, 'partners in care', is an obvious example of valuing the input and expertise of informal caring, and recognising that carers need support, training and access to information to contribute, while remaining healthy themselves. Many micro-enterprises involve family carers, but also make connections with the wider community.

Micro-scale approaches, then, can form the building blocks of what the coalition Government refers to as Big Society, a sense of community and shared responsibility which can otherwise appear elusive or impractical.

And when care and support is provided within the context of close personal relationships, people's contributions can often be greater than they might have been within the context of a traditional professional/client transaction.

Innovating at the micro-level

There have already been many positive impacts of innovation at the micro-scale. Micro-enterprises set up by disabled and older

Asset-based approaches

The term, 'asset-based', refers to approaches which look for people's gifts, skills and resources first, rather than their needs and vulnerability. Aligned with the social model of disability, an assets approach rejects labelling people according to their health condition or patient group and refuses assumptions about people's potential to contribute or to develop expertise in their own lives. Asset-based thinking tends to see people's connectedness to their family and community as a crucial part of their ability to make and sustain changes in their lives. Whereas thinking about community has a tendency to see 'the community' as being out there somewhere if only we could find it and capture it, asset-based community development tends to look for the building blocks of community in people's close relationships. There is a strong fit between 'asset-based' approaches and public health and self-management approaches which encourage people to feel more responsible for their own health and treatment.

Asset-mapping approaches at area level have been developed as a strand of commissioning. *A Glass Half Full*[1] (**www.idea.gov.uk**) set out approaches to strategic mapping of an area's community resources as well as of its 'needs', as implied by the Joint Strategic Needs Assessment approach. Micro-enterprise Skills for Care has outlined a community skills approach to strategic planning[2] (**www.skillsforcare.org.uk**) which recognises that unpaid family carers, volunteers and the whole community can have a role to play in the health and care economy and that workforce planning is incomplete without considering how to unlock and support those current and potential contributions. For example, in one area a group of people with learning disabilities were identified as having no access to financial services. Rather than train their social workers in helping people to access financial services, Notts Independent living consultancy offered the local bank branch staff training in communicating with people with learning disabilities to support access to financial services. For more information see **www.nilc.co.uk**

Case study: Notts Independent Living Consultancy

Becky Daykin and her business partner run a new micro-enterprise, Notts Independent Living Consultancy, which combines their 13 years of experience to assist people in setting up and managing personal budget direct payments. They offer support and advice on being an employer, recruitment and setting up payroll and employment contracts. They also offer training for personal assistants, organisations and corporate businesses about disability, equality and deaf awareness.

All their staff members are disabled and receive either direct payments, a personal budget or disabled students allowance. Becky Daykin, one of the founders, is herself deaf. While others often see this as a barrier, it is not the barrier she is most concerned about when she speaks of her experience of running her business. The real struggle, she says, is persuading commissioners to make better use of micro-enterprises in delivering small local services.

For more information visit **www.nilc.co.uk** or contact **becky@nilc.co.uk**

people have challenged people's perceptions about disability and later life. Micro-enterprises which provide outcome-focused solutions to people's needs, sometimes at a lower cost than less tailored solutions, have provided positive alternatives to traditional forms of care, raising service users' expectations and promoting the uptake of personal budgets.

Some examples are set out below.

Macintyre charity

Some large providers have embraced the values of small-scale work. The charity Macintyre (www.macintyrecharity.org), which runs 120 services, wanted to harness the ideas and talents of some of their employees to develop new, tailored, entrepreneurial approaches. It worked with micro-enterprise specialists, Community Catalysts (www.communitycatalysts.co.uk) to look at the changing requirements of people who use Macintyre's services. Staff members generated and tested ideas which were refined into viable new offers, with the aim of establishing them as enterprises within the organisation.

Leeds City Council

At the early intervention and wider population level, Leeds City Council has seconded social workers into three of its 39 Neighbourhood Networks, led by older people. It is experimenting with bringing personal budget holders and these grassroots community groups together to plan more cost-effective services which can operate more effectively through being embedded in genuinely inclusive communities. For more information see www.leeds.gov.uk/Health_and_social_care/Services_for_older_people/Neighbourhood_Network_Schemes.aspx.

Derby City Council

Derby City Council is introducing Local Area Coordination, in which local area coordinators have an open door, access to small amounts of money and remit to help people to find non-service ways of living a good life, with links into other agencies when services are the only option. www.inclusiveneighbourhoods.co.uk.

Barriers to micro-scale and community-led solutions

There are many barriers to growing a diverse care and support provider market place that includes small and micro-enterprises. Some of them lie in restrictive legislation and regulation which was not drawn up with micro-enterprises in mind. For example, micro-enterprises set up to provide older people with the help available within their community, as well as help in the home, found that Private Hire Vehicle regulations were a barrier to using their own cars. This and some other regulatory issues have now been addressed in *A Map for Micro-enterprise*,[10] produced with the support of the Department of Health and the Department for Business, Innovation and Skills. But there is an ongoing need for regulators to keep abreast of emerging innovations in order that overly risk-averse interpretations of regulation do not stifle market development.

Shared Lives (see the box on page 5) uses a 'hub and spoke' model of commissioning, with local or sub-regional schemes coordinating, supporting and monitoring the self-employed carers who provide the service, micro-approaches have suffered from the tension between commissioners' desire for more provider diversity and commissioners' challenge of

managing multiple small contracts. Attempts to manoeuvre micro-enterprises into commissioning approaches designed for large organisations have generally failed. Micro-enterprises can often offer lower cost services, particularly when a highly tailored solution is desired, because they have few management and overhead costs. But their lack of back office functions can make forming partnerships and consortia with larger organisations very difficult and attempts to do so can sometimes undermine the value of working at a small scale.

Healthcare markets in which micro-enterprise approaches are likely to be appropriate will be characterised by these features:

- It is possible to devolve purchasing or funding decisions to a hyper-local or individual level.
- Effective interventions are likely to involve social care, housing or other non-medical elements such as well-being.
- The effectiveness of interventions is likely to hinge on individuals' and families' own contributions, not only the contributions of professionals and services.
- Interventions would benefit from unpaid and community contributions.
- The features of effective interventions are difficult to entirely standardise and define at national level, but will often require individual tailoring for maximum cost-effectiveness.

'Solutions to commissioning challenges lie in creating marketplaces which bring microproviders together with microprocurers. '

Improving outcomes and 'scaling out'

Solutions to commissioning challenges lie in creating marketplaces which bring micro-providers together with micro-procurers. The most obvious of the latter are personal (health) budget holders, who may have taken a personal budget with the specific aim of purchasing non-traditional care; otherwise, why introduce personal control over budget allocations? But where frontline care managers, GPs or community groups are given control over small budgets, they may also wish to purchase from micro as well as traditional providers.

In some cases, individuals and community groups can co-design

Case study: Shared Lives Plus and KeyRing networks

Much social care is provided by care home and home care staff who are paid by the hour (or sometimes per 15 minutes, in the case of home care), but Shared Lives is an established form of care and support which involves matching regulated Shared Lives carers with adults who need support. An older person might visit their Shared Lives carer instead of visiting a day centre and an adult with learning disabilities or long-term mental health problems might move in with a Shared Lives carer rather than live in a care home. This approach is already being used by around 15,000 people in the UK and has the potential to be developed in the NHS as a hospital discharge and rehabilitation service, particularly for older people who expect to be in and out of hospital frequently and would prefer their intermediate care to take place in a consistent family setting rather than a succession of care homes. While 23 per cent of London's live-in Shared Lives arrangements are used by people with mental health problems, this use is yet to be developed in most other regions, suggesting the potential for significant development.[7] Shared Lives combines the national infrastructure of a regulated service, regulated by the Care Quality Commission, the Scottish Care Inspectorate and the Care and Social Services Inspectorate Wales, with the space and flexibility for participants to create their own version of the 'ordinary' family and community life, which is Shared Lives' goal. Shared Lives creates significant savings, sometimes of as much as £50,000 per individual per year,[8] while achieving better quality.[9]

KeyRing networks bring a similar ethos to supporting and including people with learning disabilities and others who wish to live in their own tenancies, but would benefit from a wider network of supporters and friends in their community. KeyRing's volunteer community connectors help individuals to network with each other and their wider communities to help turn an independent living care package into settled and resilient community life. For more information see **www.sharedlivesplus.org.uk** and **www.communitycatalysts.co.uk**

their own micro-provider. The task of commissioners, then, becomes one of helping to create a market place in which start-ups can thrive and in which micro-commissioning is well-informed and provides good quality information for local decision makers.

The numerous e-marketplace solutions that have sprung up in social care are examples of attempts to achieve better-informed purchasing, but there is as yet little evidence of commissioning decision makers strategically to manage that new marketplace. There has been a tendency to run a personal budget-based system and a traditional procurement regime in parallel, rather than to realise the efficiencies of enabling a wider range of staff and service users to manage small contracting decisions.

Creating the conditions in which micro-enterprise can thrive could be called 'scaling-out', as opposed to a traditional 'scaling up' solution which relies on equipping and replicating small-scale initiatives or encouraging individual small-scale enterprises to grow into large organisations. Scaling up can lose the essence of what made the micro-enterprise distinct and valuable along the way.

Through its work to support micro-enterprise start-ups and helping areas to become micro-friendly,[11] Community Catalysts found that:

- Market-places and quality assurance schemes should be accessible to new entrants.
- Specialist advisers must be knowledgeable about both enterprise and the relevant sector.
- Start-up funding can be helpful, but does not guarantee success itself.
- Paying small contractors quickly and taking a pragmatic approach to the application of regulation is essential.
- Micro-enterprises require access to affordable, appropriate insurance.
- Micro-entrepreneurs' needs should be considered during workforce development planning.
- A whole-area approach allows innovators to cross health, social care and other sector boundaries.

Aligning the NHS and social care visions

One challenge inherent in integrating health and social care is that the two sectors have two different operating models. The NHS model is for expert clinicians in the lead at every level, including commissioning services, with patients as informed consumers.

The social care model is more radical and aims to place citizens in the lead, with the opportunity to exercise control over the money allocated to supporting them and to influence or take charge of commissioning. While neither of these models are fully realised, evidence from social care suggests that an asset-based approach to working with people who use services and their communities could be particularly relevant to health goals which can only be achieved by people taking responsibility for making changes, not by professionals acting on their behalf. The Public Health agenda, the [self-] management of long-term conditions and improving mental health for isolated older people could all fit this category.

It may be difficult to change behaviour within the NHS and for professionals to see patients as people first and put citizens in charge. But the gains from 'scaling out' micro-scale, family-based and community-led innovations have the potential to make a huge impact on establishing a sustainable healthcare infrastructure which genuinely focuses on health and well-being and not just treating illness.

If you have any queries or comments on this paper, please contact Nicola Stevenson at nicola.stevenson@nhsconfed.org

What does this mean for your organisation?

- How are the issues raised in this paper relevant to you?
- How can patients contribute to local commissioning decisions?
- How could your local health economy support the development of more micro-scale and personal budget approaches?
- Which health outcomes could be achieved through better-supported informal and community contributions?

References and web links

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Come and meet Alex and the other authors of the *An uneasy consensus* series at the **2012 NHS Confederation annual conference and exhibition**.

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