

THE SOCIAL ENTERPRISE INVESTMENT FUND (SEIF) EVALUATION

**Phase one: scoping, review and methodology
development**

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Executive summary

Introduction

The £100m Social Enterprise Investment Fund (SEIF) aims to stimulate and increase the numbers of Social Enterprises (SEs) that are involved in the delivery of health and social care services via grants, loans and equity investments. The SEIF seeks to generate sufficient returns on its investments to become self-sustaining over the initial fund period (2007-2011).

The evaluation of the SEIF aims to:

- assess the effectiveness of the Fund in supporting SEs;
- identify the impact of the SEIF including some evidence of the types of social benefits produced through the activities of SEs; and
- identify lessons and make recommendations for the future improvement of the SEIF and the role of SEs in the delivery of health and social care services.

The objectives of this component of the research have been to:

- explore stakeholder expectations for SEIF and establish a common view of how the success of SEIF should be measured, and the mechanisms through which the SEIF is expected to achieve its outcomes;
- refine the study design in the light of the programme theories which have surfaced.

Objectives of Social Enterprise Investment Fund

Through a review of documents and interviews with a wide range of stakeholders, we have specified the range of outcomes that are expected and examined the assumptions underpinning these. SEIF is shown to be a response to the policy agenda encouraging a plurality of providers and also a perceived gap in the provision of appropriate financial products. SEIF is now delivered by Social Investment Business (formerly known as Future Builders) who took over from Community Health Partnerships, an independent company wholly owned by the Department of Health. This has resulted in the fund now being run in parallel with other funds (such as Communitybuilders or Futurebuilders England) and with a more streamlined process of considering and approving loans.

The intended beneficiaries are social enterprises, with an emphasis on those with a legal form that does not allow profit to be distributed to individuals. These include existing organisations, start up organisations and those wanting to spin out from the NHS through the 'Right to request' policy. Applicants are also expected to have approached other sources first and been rejected.

The evaluation aims to provide evidence about the extent to which investments made by SEIF met its stated objectives. For the purposes of the evaluation, a programme theory was developed that clarified and divided the objectives into the shorter and longer term ambitions. The short term outcomes expected to be visible during the period of the evaluation include:

- social enterprises start up and grow;
- greater sustainability amongst social enterprises;

- additional social returns are generated by supported organisations;
- repayments made to SEIF.

The medium and longer term outcomes include:

- high quality services delivered;
- benefits for patients and service users;
- better commissioning;
- perceptions about SE change (as evidence of their health and social return is demonstrated);
- changes to the investment market;
- SEIF becomes self sustaining.

For each of these outcomes, a set of indicators have been identified and means of measuring them developed.

Methodology

A range of indicators are set out that relate to the outputs and outcomes set out above. The evaluation will draw on Social Return on Investment (SROI) assessments that are being used by some of the recipients. This approach provides proxy financial values on some of the social outcomes. This will provide a valuable source of data although SROI presents challenges for 'meta-analyses' that aim to examine a range of measurement studies that may have used slightly different methods. The SROI approach allows discretion and tailoring of the method for each organisation or activity being assessed in terms of the impacts measured, the indicators chosen, the quantitative values used and the presentation of this data. There are also challenges for attributing causality of SEIF as there are a range of other programmes in operation and the SEs operate in complex environments. Counterfactuals will be developed that include unsuccessful applicants, case studies in particular localities, and perceptions of key stakeholders.

The aims of the next phase of the evaluation are to:

- develop a typology of successful and unsuccessful applicants and utilise this to conduct an implementation evaluation against the programme theories outlined in phase 1 to see how far investments made fit with this logic;
- set a baseline against which SROI, health impacts and organisational impacts might be measured;
- assess the effectiveness of application and investment decision-making processes;
- review wider SE support and investment infrastructure and SEIF's place within this context;
- produce learning from the initial two waves of the SEIF for future funding rounds.

The main tasks and activities during this phase include:

- compiling a database of all applicants to SEIF;
- conducting a structured survey with sample of SEIF applicants collecting data on their position before SEIF involvement;
- analysing survey results and comparing with programme theories;

- carrying out documentary analysis of the social investment market.

The objectives of the final phase of the research are:

- to explore the extent to which SEIF as a whole is successful against the measures agreed in Phase 1;
- to explore outcomes and impact of SEIF in depth within four health and social care localities chosen;
- to identify learning and recommendations in relation to SEIF and to SE in the delivery of health and social care more generally.

The key tasks in this phase include:

- further iteration of the structured survey from Phase 2 of the research;
- twelve in-depth case studies (three in each of four locality areas) providing a detailed analysis of the processes and outcomes at play within these health and social care communities.

Next steps

The next steps of the evaluation will cover the following:

- finalisation of methods responding to feedback;
- careful engagement with SIB to ensure any data collection is not considered overly burdensome;
- continued assessment of ongoing research that can test some of the assumptions about the role of social enterprises in providing health services;
- involvement of the evaluation team in the development of SROI activities of recipients to ensure best use can be made of the information being collected already.

1. Introduction

Investing £100m over four years, the Social Enterprise Investment Fund (SEIF) is one of the largest funds aimed at Social Enterprises (SEs) and represents one of the main ways through which government aims to build the capacity of SEs to deliver social care and health services. This report sets out the scope and methods for the evaluation. The evaluation of the SEIF aims to:

- assess the effectiveness of the Fund in supporting SEs;
- identify the impact of the SEIF including some evidence of the types of social benefits produced through the activities of SEs; and
- identify lessons and make recommendations for the future improvement of the SEIF and the role of SEs in the delivery of health and social care services.

The past decade or so has seen a fundamental shift in the vision for, and modes through which health and social care services are delivered. Recent reform in the delivery of health and social care services has sought to create plurality of provision, giving patients greater choice over where, when and from whom they receive services; provide opportunities for patients to have a greater influence over the design and delivery of their care, including offering them opportunities to 'commission' services themselves through personal budgets; reduce health inequalities and improve the health of disadvantaged groups; and create opportunities for the delivery of innovative health and social care services to thrive outside the control of the state (DH 2004; 2005 a,b,c; 2006; SSfH, 2006).

SEs are seen to have a key role to play in delivering on this reform agenda given their potential to involve the public, communities, patients and a range of different staff groups in the design and delivery of health and social care services. Furthermore, SEs are also seen as having the potential to contribute to wider social outcomes in a way that traditional service delivery organisations (public but also private) are unable to do so. The influential Treasury and Cabinet Office cross-cutting review (Treasury/OTS 2004) articulated the particular benefits that government believed the third sector could bring to service delivery:

- a strong focus on the needs of service users;
- knowledge and expertise to meet complex personal needs and tackle difficult social issues;
- an ability to be flexible and offer joined up service delivery;
- the capacity to build users' trust;
- the experience and independence to innovate;
- wider benefits from involving local people to build community ownership; building the skills and experience of volunteers; and increasing trust within and across communities, thereby building social capital.

SEIF therefore responds to a range of interlinked policy priorities within the Department of Health and in other government departments. Further, as there is limited evidence to date on the extent to which the third sector more generally, and SEs in particular, can live up to the expectations set out for them, SEIF offers an important opportunity to test out some of these theories in practice.

Led by the Third Sector Research Centre (TSRC), the evaluation team were commissioned by the Department of Health (DH) in August 2009 to evaluate the SEIF over a two year period. This report presents the findings of Phase 1 of the evaluation, which ran from September to December 2009. As set out in the TSRC proposal, the objectives of this phase were to:

- build a detailed understanding of SEIF's operation and progress to date; explore stakeholder expectations for SEIF; and attempt to start to establish a common view of how the success of SEIF should be measured, and the mechanisms through which the SEIF is expected to achieve its outcomes;
- refine the study design in the light of the programme theories which underpin the design and delivery of the SEIF;
- generate detailed feedback, findings and learning that will feed into the more general analysis of the contributions that SEIF, and SEs, are making to the key aims of recent government reform in health and social care (as set out in *Our health, our care, our say*, Secretary of State for Health 2006; and Lord Darzi's Next Stage Review, Secretary of State 2008).

The first phase of the evaluation has focused on refining the study design and surfacing programme theories.

The evaluation commenced with a review of all relevant documentation relating to SEIF's development and progress, including:

- SEIF Investment Plan and other documents relating to the development of SEIF in its current form, such as the tender specification for the external fund manager;
- round 1 review and Pathfinder evaluation, and evaluations of other related programmes;
- successful SEIF applications from May 2009;
- policy documents from Departments of Health, Business, Innovation and Skills and Office of the Third Sector, Cabinet Office;
- literature relating to SE research which may have relevance in health and social care; relevant literature in terms of the social investment market; and other evaluations where comparable methodologies have been used.

Alongside the documentary analysis, semi-structured interviews were conducted with stakeholders (n= 37) in order to explore aspirations for SEIF and the links between SEIF and other organisations. These included representatives from Social Investment Business, national DH offices; Office of the Third Sector; SEIF recipients, Partnership UK, Social Enterprise Coalition and other SE finance and support funds. These interviews have been analysed in order to establish the underpinning programme theories (or theories of change) that describe and explain both what it is that the SEIF is intended to achieve (and why and how) and also what it is that SEs are supposed to achieve (and why and how). Where information has been quoted, it has been made anonymous.

Following this processes and the documentary review, a half-day workshop was held with a range of key stakeholders where emerging programme theories were presented to the group and discussed in detail. This session was used to map out the intended outputs, outcomes and impact of SEIF and assist in determining indicators to be used in the evaluation. These are presented later.

2. The Social Enterprise Investment Fund

The Social Enterprise Investment Fund (SEIF) was established by the Department of Health (DH) with a pool of £100 million (£73 million capital and £27 million revenue) over a four-year period from 2007/08 to 2010/11. The revenue funding includes provision for fund management charges and other costs.

More than 150 social enterprises have been supported. Originally managed by Community Health Partnerships (CHP), the SEIF is now managed externally by Social Investment Bank (SIB). The fund has developed considerably since it was originally set up, and its current form differs from that managed by CHP.

This section examines the objectives of SEIF from a review of documents and interviews with key stakeholders.

2.1 Drivers and objectives

Drivers for SEIF

The SEIF was developed in the context of a range of policy developments, set out in more depth in Annex 1. Stakeholders interviewed for this phase of the evaluation indicated that the vision set out *Our Health, Our Care, Our Say* (Secretary of State, 2006) of more personalised and responsive services, built on in Lord Darzi's Next Stage Review (Secretary of State, 2008), were the key policies driving the DH to try to stimulate growth of social enterprise within the health and social care sector. These documents recognised a need to improve health and social care services - particularly community services - in order to reduce health inequalities, and argued that to do this, there needed to be plurality within the provider marketplace. Social enterprises were seen as being able to bring particular added value to service delivery but support was deemed necessary to encourage social enterprises to enter the market and prevent the market place being dominated by the private sector. Social enterprises are also perceived to be more innovative, although this assumption was questioned by one interviewee as the innovations supported were less radical but rather a different form of ownership and governance. A particular challenge for this evaluation are the range of untested assumptions concerning the role of social enterprise and the wider third sector in the delivery of health and care services in comparison to other forms of delivery.

Stakeholders interviewed saw SEIF as an opportunity to explore the potential of social enterprise models for delivering health and social care services, recognising the potential benefits that SEs could bring, but acknowledging that to date, little evidence existed to demonstrate the additional value that SE could deliver over other types of provider. SEIF was seen as an opportunity to drive plurality in the marketplace, which stakeholders believed would not occur without intervention. One stakeholder involved in supporting the social enterprise sector stated:

'There is a strong commitment in Department of Health to get Social Enterprise to work and make markets plural and working. The SEIF is there to test models of SE and to see if the managed market can work.'

Further, in the context of separating commissioner and provider roles and externalising services, it was thought that SEs might be more attractive to NHS staff than a move into the private sector, as

values underpinning SE and public sector approaches to delivery were likely to be similar. However, recent policy statements on the NHS as a preferred provider have raised concerns among many social enterprises or those considering starting one.

The policy context, then, supported greater involvement of social enterprise within the health and social care marketplace, but there was thought to be several barriers that were preventing this from happening. Primary among these was the failure of commercial investors to provide financial products suitable for and accessible to social enterprises. This perceived 'market failure' was recognised by stakeholders from within DH, as well as those managing the fund, as a key justification for SEIF. While funding was available through sources such as Futurebuilders (which has in fact supported considerable numbers of third sector organisations to deliver health and social care services), those involved in the fund perceived that there was a shortage of appropriate loan finance and more flexible financial products such as quasi-equity.

At the same time, it was recognised that greater demand might need to be generated and that many third sector organisations might still have a "*grant mentality*" limiting their shift to social enterprise activity. This was questioned by other interviewees who felt that there was not 'unmet demand' as they saw SEIF actively marketing itself and enticing clients. There are also concerns that SEIF will crowd out other social investment and therefore have a longer term negative effect. One interviewee referred to the possibility of using SEIF to 'crowd in' social investment as the fund will encourage demand and create innovative products that will be taken up by other investors in the long term. These issues will be addressed in the evaluation.

Objectives

The SEIF's stated objectives, as set out in DH's Tender for the Management of the Social Enterprise Investment Fund (2008a:73) are predominantly around stimulating the development of SEs in the delivery of health and social care services, through provision of start-up funding and long term investment. They include:

- stimulating the start-up of new social enterprises of health and social care;
- enabling growth in the delivery by social enterprises of health and social care services and products;
- developing and offer a range of innovative financial products for start-up funding and longer term investment that are tailored to the needs of emerging and existing social enterprises in the health and social care sectors and which support their financial sustainability;
- encouraging social returns;
- leveraging investment from external investors.

A further, longer term objective is:

- to become financially sustainable through returns on non-grant investments and through leverage of funds from external investors.

Therefore, in addition to providing evidence on the degree to which the SEIF has supported new and existing SEs into the health and social care provision arena, this evaluation will also seek to test the extent to which the assumption set out above also has credence. That is, the evaluation will also

seek evidence on the degree to which SE as a model of delivery is in practice aiding health and social care services to drive improvement within their locality and thereby increase the well-being of local communities. It is also necessary to look at the impact on other providers of health services and the impact on other providers of finance.

A priority in the evaluation of the SEIF is determining the role and outcomes which are envisaged as flowing from SEs and then ensuring that the mechanisms it has in place are able to deliver those outcomes. Much of the academic literature (e.g. Peattie and Morley, 2008) notes the tendency to view SE as the answer to many public service problems, whilst also highlighting that evaluation has failed yet to demonstrate the evidence required to shape investment in the growth of the sector moving forward. This presents particular challenges for the SEIF programme theory as it has to rely on some untested assumptions about the role of social enterprises compared to other forms of delivery of health and care services.

2.2 SEIF management by Community Health Partnerships

Although the SEIF was launched in 2007, it has only been running in its current guise for a relatively short period of time. The history and development of the SEIF provides important context for the evaluation, so is set out briefly here.

SEIF was originally managed by Community Health Partnerships (CHP), an independent company wholly owned by the Department of Health (DH – SEIF Tender, 2008a). CHP's role in managing SEIF was to:

- develop and publish a clear application process together with investment criteria for the SEIF;
- design a range of finance products to offer social enterprises in health and social care;
- develop and implement due diligence and diagnostic processes backed up with business support and a rescue strategy;
- set up strong governance arrangements, including an investment committee;
- work with the social investment sector and other potential investors to develop the SEIF.

The first round of SEIF funding was initiated in 2007. Investment Panel meetings took place between January and March 2008 to allocate funding and, of the 189 applications, 23 investments were made (DH 2009a).

In total, 552 applications were made to the first and second rounds of SEIF and around 150 were supported, meaning that approximately one in 3.7 applications was successful. Although Round 2 was more focused towards loan investment, the majority of investments made across both rounds were grants. Further information on the scope of the investment so far will be carried out when monitoring data is made available.

2.3 SEIF management by the Social Investment Business

The administrative functions of the SEIF were managed by CHP until June 2009, when Futurebuilders (now renamed Social Investment Bank) working with Partnerships UK, took over the programme, following a competitive tender process and competitive dialogue.

The 'theories of change' underpinning Social Investment Business (SIB) management of the SEIF centred on providing awareness, support and business development to existing and potential Social

Enterprises. Compared to previous Community Health Partnerships (CHP) arrangements, SIB provided a more commercial outfit for the SEIF with greater emphasis on business models and customised approaches. The interviewees contrasted this approach with CHP's 'discrete' marketing approach and their longer decision making process. Due to these previous arrangements, there was a feeling amongst some SIB staff that they were 'starting from scratch' in setting up systems.

The strength of SIB as a fund manager was its ability to manage SEIF alongside other funds. It provided a more integrated model to help SEs access funds. The rebranding of Futurebuilders to 'Social Investment Business' further supported this aim to make stakeholders aware of a number of funds and products. Because of its existing relations with the third sector, SIB supported SEIFs theory of change in reaching out to third sector organisations. As one SIB stated, they were able to implement the 'spirit' of the Fund.

The role of marketing was seen by SEIF management as crucial it's to success, yet this remained a challenge. Raising awareness and marketing SEIF so that it resonated with SE and potential SE audiences were gaining momentum but it will take time to communicate and develop sustainable loan based approaches to funding. SIB interviewees reported how they provided the SEIF with an umbrella brand but it will take time to 'get off the ground'. More emphasis on communication and marketing was needed in reaching out to health and social care audiences. A number of conferences and workshops were planned and it was hoped that these efforts would impact in the months to come.

As one of the largest funds in the sector, some believed SEIF was slightly too big for the sector. The fund aspires to larger organisations but to date the majority of investees have been grant-based small and medium organisations. The potential for co-funding in the future is an important issue that will be examined in detail in the evaluation. There is evidence of other investors being wary of SIB as it dominates the provision of risk capital in social investment and SEIF is starting from a position of having a poor reputation with other funders.

SIB supported the KPIs set for the SEIF although, questions were raised about possible unintended outcomes from having a focus on targets as an end in itself rather than money and resources focused on business support and development. Further unintended problems could occur in managing similar SIB funds that potentially could be in competition with each other.

2.4 Products and services

There are seven different funds available as part of the Social Enterprise Investment Fund which are shown in the box below.

Growth Fund
The Growth Fund provides loans-based investments of £50,000 - £10,000,000 and may also include capital, revenue or business development grants, equity and professional support. This product is to fund the growth of existing organisations and may be used to acquire or redevelop capital assets. The fund is open but not limited to organisations who support the Department of Health's Personalisation of Care agenda.

Innovation Fund

The Innovation Fund provides loans-based investments of £50,000 - £10,000,000 and may also include equity, revenue grants and professional support. This product is primarily designed for early stage organisations with new ideas for innovation in health and social care products and services. The fund is open but not limited to organisations who support the Department of Health's Personalisation of Care agenda. The standard fixed interest rate is 6% over a term of 6 months - 25 years.

Collaboration Fund

The Collaboration Fund provides loans-based investments of £50,000 - £1,000,000 and may also include revenue grants and professional support. This product is designed for organisations that are looking to substantially improve their service delivery through the exploration of mergers, collaborations and strategic partnerships with other organisations. The standard fixed interest rate is 6% over a term of 6 months - 10 years.

Tender Fund

The Tender Fund provides interest-free loans-based investments of £3,000 - £50,000 at an interest rate of 0% over a term of 6 months - 3 years. Grants will be offered only to organisations with a turnover of less than £250,000. This product is designed specifically to help organisations tender successfully for public sector contracts.

Outreach Fund

The Outreach Funds provide Business Development Grants of £1,000 - £30,000. The Outreach Fund is for organisations that are socially or geographically excluded and need to develop their services.

Emerging Enterprise Fund

The Emerging Enterprise Funds provide Business Development Grants of £1,000 - £30,000. The Emerging Enterprise Fund is for organisations that have been operating for less than a year to use for business planning, capacity building and/or feasibility studies. Investees must have been operating for less than a year and have posted less than £20,000 income in their accounts.

Right to Request Fund

The Right to Request Fund provides loans-based investments of £50,000 - £10,000,000 to support investees that are proposing 'spin out' or alternate provision of NHS services into a social enterprise. Investees will work with Partnerships UK (PUK), through milestones set by the local PCT, and investment will be staged according to three milestones: Expressions of Interest – investees will be provided with business support; Development and business planning – investees will receive grants between £100,000 and £250,000; Project execution – full investment packages, which could consist of loan, grant and/or equity will be provided with a value of £50,000 - £10,000,000.

Adapted from <http://www.socialinvestmentbusiness.org/our-funds/social-enterprise-investment-fund/>

2.5 Intended beneficiaries

SEIF is intended to reach a wide range of different types of social enterprise. Applicants have to be a social enterprise according to the Government definition - 'a business with primarily social objectives whose surpluses are principally invested for that purpose in the business or in the community, rather

than being driven by the need to maximise profit for shareholders and owners' (DTI 2002). While there is no prescription on the type of legal format, all social enterprises who apply are expected to have a not for personal profit status, whereby surpluses are reinvested in the pursuit of their social aims. Interviewees were not aware of any cases of private limited companies receiving support although there were some questions about Community Interest Companies (CICs) when they are limited by shares rather than guarantee, or cooperatives which allow members to receive profits. The existing definition is vague and has the potential to lead to confusion as private enterprises with more than half of their profit going to social aims are considered social enterprises in other public sector related activity.

Applicants can include:

- groups of professionals, such as nurses or therapists, seeking to form a social enterprise to deliver their services using the Right to Request;
- multi-agency partnerships, particularly voluntary and community groups wishing to use their expertise to provide services across health and social care;
- existing social enterprises looking to expand into health and social care;
- voluntary sector organisations looking to set up income generating activities;
- individuals looking to start up social enterprise activity.

Other criteria include that:

- the proposed services have to deliver health and/or social care outcomes;
- the ultimate beneficiaries of the proposal must be based in England;
- applicants have to be unable to secure funding from a commercial bank (unbankable);
- they must be able to repay the investment and be able to show how they plan to do so.

Interviewees were very clear that SEIF was *not* intended *only* to support spin-outs from NHS provider arms and the way the fund is set up reflects this, with only one strand of activity focusing on Right to Request. The extent of the spin-outs from the NHS is unclear at present and with only a few related to the Right to Request policy. However, one interviewee within DH saw a potential benefit of SEIF in supporting a broader range of Right to Request applications, for example from smaller groups of clinicians. "Freeing up clinicians" in this way was seen as being "more in the spirit of Lord Darzi's reforms" than the larger scale spin-outs from the NHS that had taken place to date. The challenge for such spin-outs is developing a business model that can repay a loan. Much demand has come from organisations wanting grants. This suggests that there are key constraints such as developing business cases, pensions, data transfer and the perceptions of commissioners. The SEIF will not be able to address these but they are crucial to its success.

The issue of 'bankability' was referred to in a number of interviews with stakeholders. SEIF requires that the applicant will need to demonstrate that attempts to obtain finance elsewhere have failed while at the same time having a viable business plan to repay. However, social enterprise interviewees stated that many banks would provide letters of rejection on request and so questioned the definitions of unbankability that are currently used. The issue of bankability was reported to be as much about the individual track records or personal relationships as the business plan. Therefore SEIF can help those

who do not have relationships with banks, such as those involved in Right to Request spin-outs, to build these relationships. The extent to which these social enterprises will be bankable depends on the types of contracts they are able to have for their initial years, and the extent to which they are able to transfer assets as part of the spin out.

A set of guidelines has been developed to help to assess whether a potential applicant should be able to raise the funds needed through a commercial route and these are published (DH SEIF Policy and Plan 2009-2012 – Internal document 2009). There is the potential to use a ‘Funders Forum’ (panel of potential funders) to encourage co-investment: this can be the best solution for all parties. Applicants will be asked to give general consent to sharing information with other funders but there is always an opt-out clause.

2.6 Processes for taking investment decisions

For investments up to £200,000 decisions are made by SIB. There is an independent investment panel (involving SIB, DH and other external expertise) for applications over £200,000, to support and assess applications to the Fund. In the past the use of external panels has varied, particularly for investment decisions made in the transition to SIB. Partnerships UK will use its particular expertise in working with public bodies, to assist NHS staff who, through the Department of Health’s ‘Right to Request’ process, wish to create new social enterprises.

The SEIF investment panel makes recommendations to the Department of Health Ministers to make a final decision. The Department is responsible for oversight of the SEIF and for its strategic development. This degree of control has continued under the contract with SIB. The SEIF differs in this regard to the Futurebuilders England fund, where SIB are responsible for all loans, and OTS play an observing role. The evaluation will examine how the organisation of investment decisions and the degree of control held by Department of Health affects investment decisions compared to other social investors. There is also an innovation panel to ensure the impacts in terms of innovation are maximised, although its exact remit is not clear at present.

There are six key performance indicators (KPIs) for the fund as determined by DH which also shape the investment decision making process. These are:

- start ups (target 120 start ups over 4 years);
- growth (experienced by 200 SEs);
- innovative products (6 financial products will be developed considered innovative by SEU and used for the first time by fund managers);
- innovative services (15% of all deals each year demonstrate services that are innovative as deemed by the External Innovation Committee);
- customer Satisfaction (55-60% of investees satisfied with their interaction with SEIF, as defined by rating their interaction above 7 out of 10 on a Likert scale);
- financial sustainability (total annual losses as a percentage of average non grant investment should not be above 15%).

These concentrate on the outputs of the investment programme rather than the outcomes. This evaluation will examine these output measures as well as the outcomes, which are discussed in the next section.

2.7 Programme theories

This section so far has set out the drivers underpinning SEIF and stakeholders' views on the reasons for setting up the fund; stated objectives; its development from the CHP model to that delivered by SIB; its design and its intended outputs (KPIs).

The first phase of the evaluation also explored stakeholders' views on 'programme theories', i.e. the logic behind SEIF's design, the range of outcomes they expect to be delivered as a result, and the mechanisms through which they expect these outcomes to be achieved. These findings have been summarised in a 'theory of change' diagram below

Establishing a programme theory is crucial to the evaluation for a number of reasons. As the evaluation takes place over two years, it will only be able to measure short term change. Nevertheless, it will be important to show whether intended longer term outcomes are likely to happen, and the theory of change, by linking long and short term outcomes, will help us do this. Testing the theory itself, meanwhile, is a fundamental objective of the evaluation as this will enable us to draw out learning that can inform future programme design and delivery.

SEIF outputs

Stakeholders perceived that the immediate outputs that SEIF would engender would include social enterprise start up and growth, including development of social enterprise from other voluntary and community organisations. Start-up and growth were seen as key outputs, and are measured through KPIs.

As some stakeholders commented, SEIF is based on an assumption that stimulating growth amongst some social enterprises does not disadvantage others, for example by pushing existing social enterprises out of the market (displacement). These outputs were also seen to depend to some extent on continuing policy support for development of SE within the health and social care sector. Stakeholders perceived that if there was a change in government, this would not pose a risk to SEIF. Nevertheless, some recent developments (for example, the NHS Chief Executive's letter to PCTs describing the NHS as the "preferred provider" 13 October 2009) could be interpreted as a move away from a commitment to plurality of provision. There was also an assumption that the Right to Request would continue to be supported.

Early outcomes

Intended short-term outcomes of SEIF centred on generating greater sustainability amongst social enterprises, and generating additional social returns. SEIF would generate sustainability through a number of mechanisms. It was assumed that SEs would be able to secure contracts for public service delivery. For Right to Request applications, this would be guaranteed, while other SEs would have to demonstrate in their application to SEIF that there was a market for the services they wanted to develop. This would diversify SEs' income sources and make them less grant dependent (where relevant). In addition, as a result of the business support provided by SIB, and the process of having to manage a loan that required repayment, SEs would develop stronger financial management and business management skills. Having to interact with commissioners would raise SEs' awareness of their commercial and investment potential.

Programme theory: Social Enterprise Investment Fund

CONTEXT AND DRIVERS

Need to innovate within primary and community care – services ‘stagnating’, not meeting demand, ongoing inequalities
 Changes to commissioning environment e.g. personalisation agenda, individuals as commissioners
 DH policy (e.g. Our Health Our Care Our Say, Next Stage Review) supports SE development and encourage plurality of provision
 Cross-government commitment to create thriving third sector
 SE demand for loan investment but lack of availability of commercial investment to support SE start-up and growth = market failure

SOCIAL ENTERPRISE INVESTMENT FUND

Investment in ‘unbankable’ SEs

- £100m over 4 years: £73m capital, £27m revenue
- Grants, loans and quasi-equity
- Flexibility – ability to put together ‘bespoke’ / ‘innovative’ packages (KPI)
- Business support
- Returns reinvested to make fund ‘self sustaining’
- 15% of fund for high risk, high impact innovative investment (KPI)
- Co-investment

External management by SIB and partners

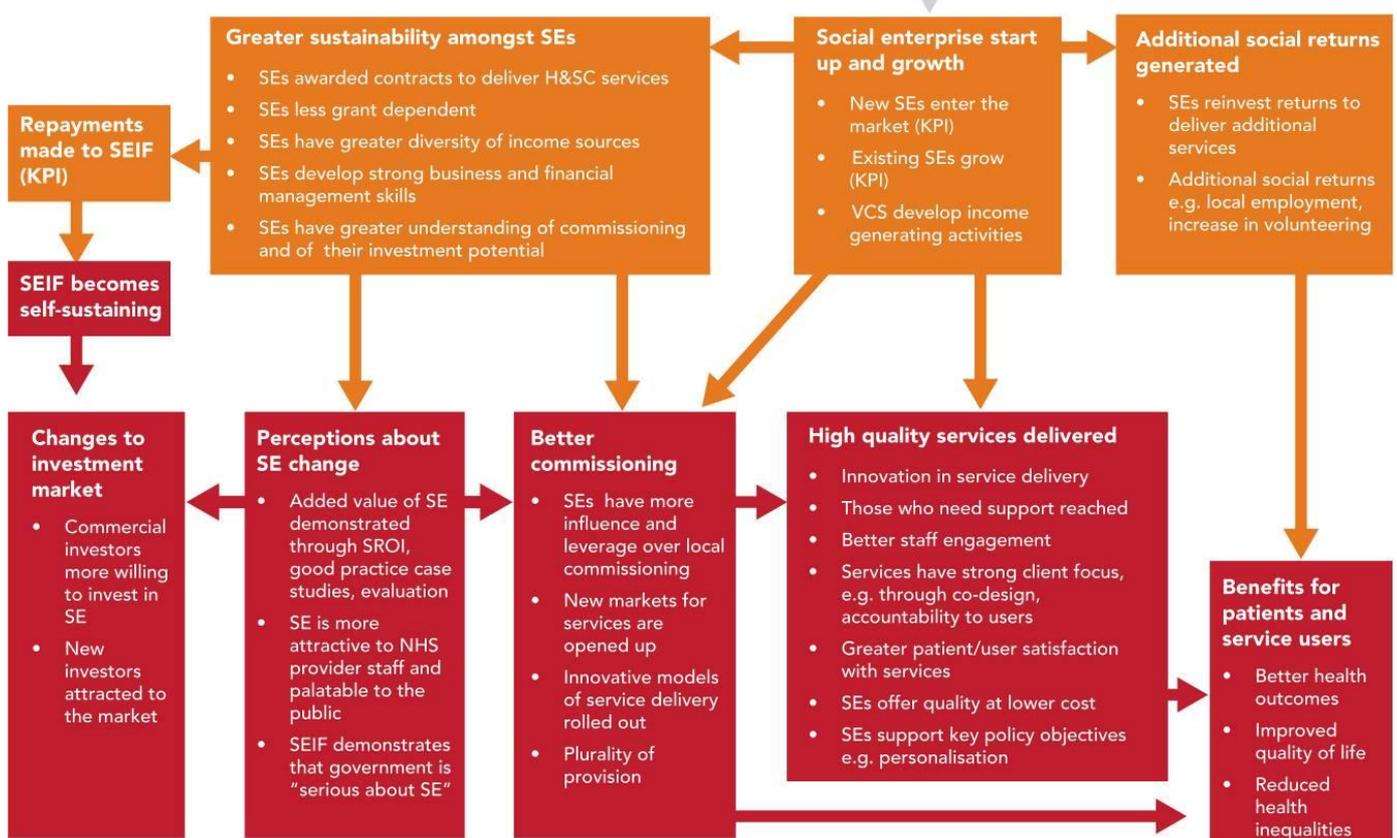
- Recognised ‘brand’
- Knowledge of the sector
- Expertise in specific aspects e.g. innovation, partnerships
- SEIF managed alongside other funds, integrated model, capacity for cross-funding

Supporting processes

- Marketing to SEs
- Awareness raising with stakeholders
- Monitoring and evaluation, including collection of SROI data

Complementary initiatives

- World Class Commissioning
- OTS’ Third Sector Commissioning Programme
- Right to Request



- Key
- Medium to longer term outcomes
 - Early outcomes
 - Outputs and context

Stakeholders recognised that an assumption underpinning this theory was that commissioners would be both willing and able to award contracts to social enterprises, but this was in fact seen as a key risk to the fund. As one commented, “I’m not sure, given that SEs are reliant on commissioning, that sustainability can be achieved ... regardless of whether they’re funded through grants or contracts, they’re still caught up in the public sector policy making scene.” In addition, one stakeholder pointed out that as public sector budgets were being squeezed, there would be increased competition from the private sector.

Additional social returns would be generated primarily as a result of SEs reinvesting their returns in services that were driven by and met community needs. It was also expected that social returns would be generated as a result of SEs’ social mission, for example that they might purposely employ local people or those suffering disadvantage in the labour market, and that they might create additional volunteering opportunities. It is assumed that SEs would maintain their social mission for some time after receiving SEIF investment. One stakeholder pointed out that this was not guaranteed and that statements of social mission in SEIF applications could be quite vague.

Medium to long term outcomes

Key medium to long term outcomes desired included delivering higher quality services; improving commissioning; changing perceptions about SEs; changing the investment market; and generating better outcomes for patients and users.

A key reason for investing in SEs was the belief that they could innovate in service delivery, engage users in co-production and governance and as a result, deliver higher quality services that met needs better, which patients and users were more satisfied with, and which could be delivered efficiently (at the same or at a lower cost than other providers’ services). SEs’ ability to deliver innovative services effectively was perceived to be high, although some stakeholders recognised that this assumption was relatively untested. Similarly, this aspiration was based on the assumption that improving quality of services reduces costs.

In addition, it was thought that SEs would engage staff more effectively than other types of provider, which in turn would help to drive up quality of services. This is based on the assumption that SEs provide a positive working environment for staff and an attractive alternative to working within the public sector. However, this was recognised as a potential risk to the programme, given that SEs as employers may in fact offer relative job insecurity compared with the NHS, and may need to deliver services on limited resources, putting staff under pressure, thus putting quality at risk.

By delivering demonstrably higher quality services efficiently, by being able to demonstrate social returns, and by actively engaging with commissioners e.g. through advocacy and partnerships, stakeholders anticipated that SEs would start to influence commissioners to commission more effectively. This would include rolling out models of service delivery piloted through SEIF investment, but would also include generating a more positive attitude amongst commissioners towards SE as service providers, thereby encouraging greater plurality of provision.

Similarly, SEIF would demonstrate to commercial investors that investing in SE could generate returns, thereby encouraging them to enter the social investment market. This would be achieved through communicating SEIF’s successes, including its success in generating returns on investment. One interview considered this crowding in rather than crowding out of investment. If this was achieved, SEIF itself could step out of the market. Stakeholders recognised that this would be a long term aim.

However, as the current funding pot will be disbursed by 2011, and returns generated by that point are likely to be small (one stakeholder estimated 10%), SEIF may become a small player, while commercial investors may not yet have entered the market. This could provide a gap in finance for SEs. In addition, to generate returns, a fundamental assumption is that social enterprises will be willing to take on loan finance, and to repay it; this in turn relies on 'good' investment decisions being made - and could conflict with the fund's ambition to support high-risk, innovative services. Stakeholders also recognised that 'high profile failures' could damage SEIF's reputation, both with commissioners and commercial investors, and saw this as a key risk for the fund.

In the long term, stakeholders perceived that by delivering higher quality services themselves, and by encouraging change in commissioning practices, SEIF would contribute towards improving outcomes for patients and service users, and reducing health inequalities.

3. Methodology

3.1 Overview of study design

The evaluation of SEIF aims to explore the effectiveness of programme design and the processes used to deliver SEIF, and the extent to which these processes have led to the outputs and outcomes desired for the fund.

The evaluation framework is based on the theory of change for SEIF, developed as part of the first phase of the evaluation [see section 2]. The theory of change has been used to inform the design of the evaluation by:

- setting out the outputs, outcomes and impact that stakeholders hope SEIF will achieve;
- giving an indication of the timescale in which these outcomes are expected to be achieved;
- showing how activities, outputs and outcomes link together and reinforce one another;
- surfacing the key assumptions on which the theory is based.

The evaluation will both capture whether these outcomes are achieved, and test the assumptions underpinning the Fund. The evaluation of SEIF is both summative (retrospective) and formative (prospective), in that it aims both to assess the achievements and outcomes of SEIF investment, and to draw out learning that can inform the ongoing implementation and development of the Fund.

The research focuses on two levels - programme level and in-depth studies – and draws on a mix of documentary, quantitative and qualitative data. Methods include qualitative stakeholder interviews; analysis of monitoring data and information about applicants held by SIB; structured longitudinal survey of successful and unsuccessful applicants; in-depth case studies in twelve localities; and documentary analysis.

The evaluation comprises three phases of research over two years, from August 2009 to June 2011. These include:

- Phase 1: Scoping and evaluation design (August 2009 – December 2009)
- Phase 2: Retrospective and prospective review of SEIF and its activities (January 2010 – March 2010)
- Phase 3: Outcome and impact assessment (April 2010 – July 2011)

The first phase of research has been completed, with this report forming its main output. Detailed methodology for Phases 2 and 3 is given below.

3.2 Indicators

The table below sets out the key questions and assumptions that the evaluation of SEIF will explore in relation to each aspect of the theory of change. These build on, and further develop, the evaluation questions set out in the evaluation specification and our tender. We then identify output and outcome indicators against each of these aspects and show which evaluation activities will help to verify these.

Inputs: investment in SE				
SEIF feature	Key evaluation questions	Indicators to be measured in evaluation	Means of verification	Assumptions to be tested
£100m invested over 4 years in new start-ups, spin-outs from public sector provision, and growing SEs	What types of SE benefit from SEIF investment?	SE characteristics (stage of development, type of organisation, organisational history, size, services provided, target groups, location)	Secondary analysis of SIB monitoring data Longitudinal survey of applicants	SEIF is attractive to the range of different types of SE
£73m capital and £27m revenue will be invested through grants, loans and quasi-equity Co-investment will be encouraged SIB will have flexibility to put together bespoke/innovative packages of investment 15% of Fund earmarked for high-risk, high impact investment	What types of SEIF investment are made? How well are SEIF funds matched and how do co-funding arrangements work? What are the benefits, limitations, and barriers associated with each type of financial product provided by SEIF?	Types of investment: grants, loans, quasi-equity, capital, revenue Size of investment Leverage of other funding KPI on innovation	Secondary analysis of SIB monitoring data, funding applications and related documentation Longitudinal survey of applicants	There is SE demand for loans and quasi-equity as well as grant funding Annuality rules, State Aid and other restrictions associated with government funding will not stop SEIF from making appropriate investments
Investment will only be made in 'unbankable' SEs (that could not attract investment elsewhere) Some investments will be repaid so that the Fund can become self-sustaining	How effective is the investment decision making process?	Rationale for investment decisions is clear and consistent 'Bankability' tested before investment decisions made	Secondary analysis of SIB monitoring data, funding applications and related documentation Stakeholder interviews	There will be sufficient numbers of high quality applications that are 'unbankable' but also solid enough to warrant investment
Fund administered by SIB and its partners	What do SEs (successful and unsuccessful) think of the processes for applying, taking investment decisions and marketing SEIF?	Applicant satisfaction with application and investment decision making processes (KPI)	Secondary analysis of SIB satisfaction surveys Longitudinal survey of applicants	SEs are aware of the Fund and have confidence in the application and decision making processes
Business support provided alongside investment	Is business support fit for purpose? What value does it add?	SE satisfaction with business support New skills developed within SEs as a result of business support	Secondary analysis of SIB satisfaction surveys Longitudinal survey of applicants	

Outputs				
SEIF outputs	Key evaluation questions	Indicators to be measured in evaluation	Means of verification	Assumptions to be tested
Social enterprise start up and growth	Does the SEIF support SEs to enter and/or grow within the health and social care marketplace? How many are supported in this way? Would SEs have been willing and/or able to enter the market if it was not for SEIF?	New SE start-ups as a result of SEIF investment SE growth following SEIF investment (turnover; staff)	Secondary analysis of SIB monitoring data and KPIs (start ups; growth and losses) Longitudinal survey of applicants Case studies	SEIF stimulates additional start-ups and growth that would not have happened without investment Opposition from unions does not reduce right to request
Greater sustainability amongst SEs	To what extent does SEIF support SEs to become more sustainable and less dependent on grant funding? How effective is the additional business support provided alongside SEIF in helping social enterprises to manage and benefit from the investment?	Contracts for service delivery awarded to SEIF investees following investment (number, size, duration) Financial returns generated by SEIF investees Diversity and sustainability of SEIF investees' income sources SEs' self-reported understanding of investment potential Investment secured from commercial providers since receiving SEIF funding New skills developed within SEs as a result of investment/business support received	Secondary analysis of SIB monitoring data Longitudinal survey of applicants Case studies	SEs are not undercut by other providers Commissioners are willing to contract with SEs for service delivery SEIF recipients will be able to secure contracts despite cuts in public spending
Returns are generated for SEIF	To what extent are SEs able to repay SEIF investment?	Repayments made to SEIF	Repayment data collected by SIB	
Added value of SE demonstrated to commissioners, investors and other stakeholders through e.g. SROI, good practice case studies, evaluation	How effectively are SEIF's successes and learning from the programme disseminated? How successful are SEs at calculating SROI?	Commercial investors know about SEIF Commissioners know about SEIF	Review of social investment market Stakeholder interviews including commissioners, case studies	Data on SROI trusted

Short-medium term outcomes				
SEIF outcomes	Key evaluation questions	Indicators to be measured in evaluation	Means of verification	Assumptions to be tested
SEIF supports innovation in service delivery	Is there evidence that the SEIF has stimulated innovation in service provision?	Services considered innovative by commissioners and other stakeholders	Case studies (commissioners' views) Stakeholder interviews	SEs do not simply deliver the same services under a different organisational structure
SEs deliver high quality services (at same, or lower, cost)	How far are SEs providing high quality services for patients/users? To what extent do SEs provide value for money?	Indicators to be tailored to case studies – for example, relevant patient-reported outcome measures (PROMS)	Case studies	Improving quality of services can reduce cost
SEs reach those most in need of support	How far have SEs filled gaps in provision? How far are SEs improving access to services?	SE services meet needs identified in commissioning plans and other relevant local documents e.g. JSNA, local area agreement SEs' services are used by people from groups experiencing health inequalities e.g. people living in deprived areas, BME groups, people with disabilities	Case studies (commissioners' views, review of local documentation, monitoring data collected by SE)	SEs are better at reaching 'hard to reach' service users than public or private sector providers
SEs engage users and are accountable to them	In what ways are SEs involving users and accountable to users? How does this change/influence the way services are designed and delivered, returns invested, etc?	SEs involve users in co-designing services and evaluating them SEs involve users through governance structures SEs carry out research with users that influences service design SEs can show how user feedback has shaped services	Case studies (interviews with SEs, review of SE documentation, research with patients/services users, interviews with commissioners and other (non-SE) providers) Longitudinal survey of applicants	SEs are better at engaging service users than public or private sector providers
SEs generate returns that are reinvested in activities that generate social value	Are SEs successful in generating additional financial returns and if so, how are these invested?	Reinvestment Surpluses are reinvested in activities that meet local needs	Longitudinal survey of applicants Case studies	SEs able to make a surplus to reinvest

Medium to long term outcomes/impacts				
SEIF outcomes/impacts	Key evaluation questions	Indicators to be measured in evaluation	Means of verification	Assumptions to be tested
<p>Greater satisfaction with services (may be beyond lifetime of evaluation in some cases)</p> <ul style="list-style-type: none"> • Improved quality of life • Additional social returns e.g. local employment, increase in volunteering • Reduced health inequalities • Changing perceptions about SE • Benefits for patients and users 	<p>Are patients/users benefiting from SEs' services more satisfied than previously/than those using other providers' services?</p>	<p>Patient/user self-reported satisfaction with services</p>	<p>Case studies and data made available by PCTs over a period since the investment</p>	<p>Services offered by SE meet needs more effectively than those offered by public or private sector providers</p> <p>Patients/users prefer to receive services from SEs than providers from other sectors</p>
<p>SEs generate additional social returns, e.g. local employment, increase in volunteering (may be beyond lifetime of evaluation in some cases)</p>	<p>What additional social value is generated by SEIF investees?</p>	<p>SROI indicators specific to each case study/investee</p>	<p>Case studies and (if feasible) meta-analysis of SROI data collected across the programme</p>	<p>SEIF recipients maintain their social objectives once they have received investment</p>
<p>SEs/SEIF stimulate positive changes in commissioning (may be beyond lifetime of evaluation in some cases)</p>	<p>What impact has SEIF had on the commissioning and provider landscape in areas where SEs have been supported?</p> <p>Is there evidence of a positive or negative impact on other (non-SEIF recipient) SEs in the area?</p> <p>Is there increased diversity of provision in local health and social care communities?</p> <p>Have successful bids to SEIF aided local health care communities in meeting DH objectives (e.g. personalisation / right to request/ improve health inequalities etc)?</p> <p>To what extent do commissioners support the development of SE in their</p>	<p>SEs influence local commissioning through advocacy, campaigning and/or partnership working</p> <p>Models of service delivery supported through SEIF are rolled out more widely (market creation)</p> <p>Greater provider diversity in areas where investees operate</p> <p>WCC assurance 'scores' improve, particularly around competency eight ('stimulating the market')</p> <p>Commissioning and procurement practices change so that SEs find it easier to participate</p> <p>Displacement of other providers</p> <p>Staff satisfaction</p>	<p>Case studies</p> <p>Document and data review (phase 3)</p>	<p>High profile failures will not deter commissioners</p> <p>SEs take on advocacy role to change commissioners</p> <p>Commissioners willing to take risks and innovate</p> <p>Working within SEs is attractive to staff from a public sector background</p>

	<p>areas?</p> <p>Have commissioner attitudes changed at all as a result of SEIF? If so, how and why?</p> <p>What impact have SEs had on staff, particularly in spin-outs from PCT providers? How satisfied are staff with working conditions?</p>			
SEs/SEIF stimulate changes in the investment market	<p>How has the investment market changed as SEIF has been running?</p> <p>In what ways has SEIF influenced these developments? What other factors have been important?</p> <p>What kinds of social value are they generating?</p>	<p>Commercial investors more willing to invest in SE and not crowded out</p> <p>More products on the market aimed at SEs, replicating investments made by SEIF</p>	Review of the social investment market	Economy recovers and lending increases
SEIF becomes self-sustaining (beyond lifetime of evaluation)	How does the value of the fund change over the course of the evaluation? How far does it move towards becoming sustainable?	<p>Repayments made to SEIF</p> <p>Value of fund</p>	SIB data	
Better health outcomes for patients and service users (beyond lifetime of evaluation)	To what extent does the evaluation suggest that SEIF investments will lead to better outcomes for patients and service users?	<i>Identify proxy indicators tailored and appropriate to case studies – e.g. changes in health behaviours; improved control of long-term conditions; changes to biometric measures e.g. BMI</i>	Case studies	
Reduced health inequalities (beyond lifetime of evaluation)	To what extent does the evaluation suggest that SEIF will contribute to reducing health inequalities?	Proxy indicators: access to services; whether services are meeting identified local needs; whether services provided are of high quality	Case studies	Commissioning services from SEs can help to tackle health inequalities through the range of mechanisms set out in the SEIF theory of change

3.3 Social Audits, SROI and measuring non-financial outputs of SEIF

The impact of SEIF cannot be measured in purely financial terms but also requires a range of innovative approaches to assess the social impacts and the social returns. The approach of Social Return on Investment (SROI) offers a range of approaches and proxy indicators that will be useful in developing this further. Our method has stressed the importance of identifying the social impacts and therefore much can be learnt from the ongoing work on social return on investment.

It should be noted that SROI approaches have been developed in order to support organisations in increasing their social impact. In this way, it could be said to be a 'bottom up' or developmental tool that is not necessarily used for comparative purposes. However, aspects of it can be adapted for more of an evaluative approach beyond the individual organisation.

Our method aims to combine the bottom up approach with the need for a 'meta analysis' in the following ways:

- recipients and other applicants encouraged to carry out SROI for themselves and share the results with the evaluators;
- key indicators of social impact identified by evaluators which are then collected systematically through surveys where not already collected through a social enterprises' SROI;
- social enterprises advised on how they can develop information systems to record a wide range of information for both their own use and for use by the evaluation;
- all information provided back to social enterprises to assist them with their development, growth and future strategies.

We recognise that SROI requires the active involvement of stakeholders and our approach stresses the importance of sharing learning with social enterprises throughout the process of the evaluation. At the time of writing 30 SROI reports were in preparation but none were ready to be shared. Ideally, the large number of SROI studies within SEIF will provide the first opportunity for a larger scale meta-analysis.

Identification of outcomes and indicators

Much attention will be given to mapping the outcomes through clarifying the theories of change for each of the case studies to be examined in detail in Phase 3. We will use the SROI databases of outcome indicators, combining qualitative and quantitative data, particularly those related to improving health and wellbeing (especially for disadvantaged groups). Other indicators may need to be developed relating to innovation, addressing gaps in service delivery.

There will be other key indicators to be explored that make a contribution to social inclusion, improving wellbeing and reducing public sector spending. These may include indicators related to:

- employment
- local spending
- education
- sustainable development
- local communities

In terms of assigning monetary values, we draw on the good practice outlined by the SROI Network. These include

- non market traded benefits (values of hypothetical changes/money spent as a result of changes);
- direct cost saving and increased income (e.g. cost savings to different parts of the state);
- indirect cost savings.

It is also necessary to identify input indicators that are not normally monetised such as volunteers and contributions of goods and services in kind. This would draw on the values of volunteers found in Volunteering England (www.volunteering.org.uk).

Challenges of using SROI in the evaluation

The use of SROI in an evaluation is innovative and presents a number of challenges. To a large degree, this relates to the variety of approaches being used and the discretion given to those measuring the social return. The SROI network has stressed the need for the methodology to be used for the development of the organisation and forecasting impacts, but not for comparative purposes. The use of SROI methods as a way of allocating scarce resources is therefore unclear within SEIF and requires further clarification. The key challenges are summarised below.

Boundary setting: There is discretion regarding the range of impacts that can be measured and depends on the intended outcomes of each project (or their own theory of change). There can be diverse views on this within an organisation, with different stakeholders emphasising the importance of different activities or different groups of beneficiaries. While there are assumptions made on the future continued benefit from a positive impact, there is also a degree of discretion concerning periods over which this benefit is measured. We would therefore expect the results of each SROI report to be highly specific as the process has emphasised the need for social enterprises to identify their own indicators and measures. It is therefore unclear whether a meta analysis of many different SROIs will be possible. Such a meta analysis may be possible where there are clusters of investments in similar activities.

Positive and negative externalities: While SROIs examine the positive impacts of their work, there may be less attention paid to the externalities, or additional impacts on local economies and communities. In particular, it may be difficult for organisations to report on their negative impacts.

Attribution: Few SROIs have the resources to assess the causality of any impacts, and the extent to which the impacts may have happened without the supported activity. This requires a counterfactual or a study of those not receiving the benefit. Such studies are expensive and present their own challenges as shown in the next section. In this evaluation, some evidence of attribution will be collected for the case studies but the quality of the data from organisations own SROI studies is not known.

Quantifying value: There are challenges involved in attributing monetised values to specific impacts. However, many within the social enterprise sector are uncomfortable with summing a range of social values into a single financial value. Such quantification has to distil the impact and can do little to recognise the other softer outcomes. Other similar questions are raised over the costs of

valuing volunteering where SROI puts a market value on this input, giving a labour market value to the work to be done by the volunteer. Finally, there are well established debates about the value of environmental benefits.

Reporting: Finally there is discretion made at the point of interpretation, reporting and presentation of results. Once the results are accepted, there is still the opportunity for some elements to be overstated and the details of the methodology, assumptions made and caveats to be left out. This is particularly tempting with the SROI methodology which can produce ‘the magic number’ in terms of a ratio of resources put into an activity and the social value attributed to this.

3.4 Exploring attribution, additionality and the counterfactual position

The evaluation of SEIF is primarily concerned with understanding how and why SEIF achieves its intended outcomes, and to what extent the theories on which it is based hold true in practice. Establishing a theory of change for SEIF at the start, and agreeing indicators that can help measure the outcomes described in the theory, forms the basis of our evaluation design. In essence it is a theory-based impact evaluation, which aims to explain change, rather than quantify it. Due to the complexity of the support environment and market within which SEIF operates, a quasi-experimental methods with a clear control group is not viable.

Nevertheless, we have built into our design elements that will allow us to carry out some counterfactual analyses - exploring what would have happened in the absence of SEIF - as well as analysing the contribution of SEIF to the changes that are observed. These elements include:

- Comparison of successful and unsuccessful SEIF applicants who had got through the preliminary stages of the investment process. This will be used to explore the comparative benefits of SEIF and other investment sources/no investment in building the sustainability of social enterprises. This will not be a ‘true control’ as those not receiving support through SEIF are likely to be in a different position from recipients: either with ‘bankable’ proposals (and therefore presumably with greater financial/organisational capacity), or at a stage where SEIF investment was also judged too risky (and therefore presumably with weaker financial/organisational capacity). Nevertheless, by comparing the progress of successful and unsuccessful applicants, we will be able to estimate the additional benefit brought by SEIF investment, taking into account factors such as a SEs’ financial/organisational strength and stage of development on applying for SEIF.
- Through the case studies, exploring the impact of SEIF on the provider market. Within the geographical areas that the case studies are focused on, we will explore displacement (for example, the extent to which SEIF recipients are delivering services that would otherwise have been delivered by other SEs or public/private sector providers), deadweight (the extent that SEIF recipients would have delivered the same services without investment), and multipliers (for example, the extent to which SEIF has ‘created a market’ for services that has benefited other SEs). This will allow us to estimate what additional benefit has been brought about by SEIF, and therefore to estimate what would have happened anyway without it. If feasible, we will also explore the additional benefits for patients and users brought about by SEIF investment within the case studies. This may be possible if services have previously been delivered by another

provider (for example, in the case of 'spin-outs' from PCT provider arms) and there is data available on patient outcomes/satisfaction that can be compared with provision delivered by SEIF recipients. The case studies will be selected purposefully to represent areas with intense and less intense SEIF activity. This will allow the evaluation to examine a diversity of experience.

- Qualitative analysis of SEIF's contribution to the policy and commissioning environment and commercial investment market using data from stakeholder interviews, in which the theory of change is explored. While this will be perception based, we will be able to explore the extent to which stakeholders perceive change has been brought about by SEIF, and the other factors that they think may have also contributed to change.

It is feasible to use a control group drawn from databases of organisations that have not received support. This requires a large sample which would be available with the Guidestar database currently being used by the Third Sector Research Centre. However, there are problems from the time lag between impacts on organisations and the recording of financial growth shown in their accounts. Evidence would not be available within the time frame of this evaluation, although it would be possible to do this retrospectively in the future, in further assessments of SEIF.

We have considered other methods of exploring the counterfactual in relation to some of our other evaluation questions. For example, to explore the proposition in the theory of change that SEs provider higher quality services than other providers, it might be possible to compare patient outcomes from providers that remain part of the NHS with those that take up Right to Request. However, this would be complex and require considerable additional research, while at the same time only providing data to answer a small number of our research questions. We therefore believe this to be outside the scope of the current evaluation, in terms of resources and timescale.

It is frequently difficult to separate the impact of a policy intervention (additionality) from other influences and the extent to which recipients of support would have performed or behaved in similar fashion, even if they had no support (deadweight). Moreover, the problem is intensified when policies are poorly specified. Measuring deadweight is difficult and studies often rely on people answering a hypothetical question, such as: 'How likely is it that the respondent would have taken this course of action (e.g. starting-up) in the absence of support?'

In this regard, we can differentiate between three forms of additionality: –'absolute additionality', where the start-up would not have occurred without the policy intervention; –'scale additionality' where the impact of a single start-up is greater (such as more employed or surviving longer) because of a policy intervention; –'time additionality' where the policy brings forward the timing of start-up or growth. There is also a need to examine any complementary support that was used by beneficiaries and consider the combined cost of all support when assessing the value for money of a policy.

The potential means of assessing additionality of impact therefore rely on the perception of interviewed firms. There are difficulties in using hypothetical questions and relying on their answers, when there may be an incentive for them to exaggerate the impact of SEIF particularly if they are deadweight. Furthermore, interviewees may not be able to remember details after several years or be able to work out what caused what.

3.5 Detailed methodology for Phase 2 Retrospective and prospective review of SEIF and its activities

The aims of Phase 2 of the evaluation are to:

- develop a typology of successful and unsuccessful applicants and utilise this to conduct an implementation evaluation against the programme theories outlined in component 1 to see how far investments made fit with this logic;
- set a baseline against which SROI, health impacts and organisational impacts might be measured;
- assess the effectiveness of application and investment decision-making processes;
- review wider SE support and investment infrastructure and SEIF's place within this context;
- produce learning from the initial two waves of the SEIF for future funding rounds.

The main tasks and activities during this phase include:

- compiling a database of all applicants to SEIF;
- conducting a structured survey with sample of SEIF applicants collecting data on their position before SEIF involvement;
- analysing survey results and compare with programme theories;
- carrying out analysis of the social investment market.

Database of applicants

A database will be compiled that will include details of applications made to SEIF in Rounds 1 and 2 as administered by Community Health Partnerships, and all applications made since to the SIB-administered Fund.

This will include data about the organisations applying for funding, including contact details; the nature and content of their application; and the investment decision taken. The database will be compiled using information provided by SIB, electronically or in documentary form. This database should allow the production of simple descriptive statistics at various points throughout the lifetime of the research in a straightforward manner. Where data is available from other sources this can be added in.

Longitudinal survey of applicants: first wave

A structured survey will then be constructed which primarily aims to explore the application and investment decision making processes and to establish a baseline against which to measure impacts in Phase 3. Care will be taken to liaise with SIB so organisations are not over-surveyed.

Survey design

The survey will add to the data already held by SIB about successful and unsuccessful applicants. It will comprise quantitative questions, exploring the characteristic and services of organisations and local health and social care communities, and also more qualitative data such as reasons for applying to the Fund and views on the SEIF process. Data will also be collected on scale of activity undertaken estimated by turnover and staff numbers. Where SROI studies have been completed, these will be recorded and collated.

For successful applicants, the survey will collect data on the position of the organisation before receiving finance and support, explore progress made using SEIF investment and early outcomes for SEs, testing the theory of change developed in Phase 1. We would expect those organisations funded in the last two years under the CHP-administered SEIF to have made more progress towards outcomes at this stage than those funded more recently by SIB. With unsuccessful applicants, we will explore the extent to which they have been able to achieve any of the outcomes in the theory of change without SEIF funding – for example, whether they have been able to draw in investment from other sources. Interviews with unsuccessful applicants will examine the other sources of funding they have used and the change in the extent of their activities since applying to SEIF.

The survey will be piloted with five organisations that have bid to the fund (as administered both by CHP and SIB). These will be selected at random and asked to take part in this process of the research.

Sampling

We will contact all organisations that have applied to SEIF since it has been administered by SIB, and a sample of successful and unsuccessful applicants to Rounds 1 and 2, administered by CHP. The sampling frame will include 250 organisations, from which we would expect to complete around 200 interviews. We will construct a stratified random sample, using the database as a starting point, which will take into account: funding round (1 or 2); success of application; and broad type of SE (e.g. new start-up; growing SE; spin-out from public sector); sector/activity; and geographic region.

Following the application of this sampling, data will be collected through both telephone interviews using the structured questionnaire and electronic surveys. Those that are not included in this initial sample will receive the structured questionnaire electronically.

Survey analysis

Data from the survey and database will be used to:

- construct a typology around the sorts of organisations who have received investment from SEIF in its different incarnations, and the types of investments made (e.g. stage of development, services, location, level of risk, previously an in-house provider, origin in community sector, origin in private sector, cooperative, CIC);
- chart and compare the progress of successful and unsuccessful applicants to the fund;
- explore the effectiveness of communication and marketing; handling of applications; business support; and investment decision making, from applicants' perspectives;
- assess recipients perceptions of additionality.

This data will be compared to the programme theories that were elicited through Phase 1 of the research to explore how far the theory of change reflects the actions and outcomes of the SEIF in practice, and to pull out any differences that emerge between the CHP model and the SIB model of programme delivery.

The survey analysis will also draw out any practical recommendations for SIB and the Department in relation to the administration of SEIF, if the findings suggest that there are ways in which this could be improved to better support SEIF in achieving its intended outcomes.

Analysis of social investment market

Given that SEIF has the potential to impact on the wider social investment market, the evaluation will build on the documentary analysis of Phase 1 and review research, practice and products to define the existing social investment market and to position the SEIF within two specific analytic dimensions:

- as it relates to macro-level structures of supply-intermediation-demand, paying attention to other state-funded social investment initiatives (e.g. Adventure Capital Fund; Futurebuilders);
- as it relates to a range of financial instruments and micro-markets: grants; debt (soft and hard); quasi-equity; equity.

We will then employ the supply-intermediation-demand model to suggest where key points of leverage for SEIF may lie in terms of:

- project/sector level impacts;
- contributions to building the wider social investment market.

This will provide us with a range of detail relating to the position and relative advantage of the SEIF in relation to the wider social investment market.

In order to assess the impact of the SEIF on the wider social investment market, a series of twenty-two key informant interviews will be carried out at the start and end of the evaluation. Interviewees will be important actors already engaged in social investment across the range of financial instruments from grants to full market return equity finance. The interviews will have a longitudinal dimension occurring at least twice over the project's duration.

Furthermore, interviews will also be held with the fund managers of the SEIF (the Social Investment Business) and Department of Health policy makers to understand their ambitions for the role and effects of the fund within the social investment landscape and how these will be approached strategically. One of the key questions will be how deliberative these impacts actually are. Specific issues to be explored in terms of macro-impacts may include: innovation in new financial instruments; new risk-return frameworks (including output/outcome calculations); models for developing deal-flow and investment readiness; wider policy leadership; the creation of hybridity and sector blurring organisational forms particularly in the intermediary space; new governance structures; start-up and mezzanine investment models.

Outputs from Phase 2

The report from this phase of the evaluation will pull together initial findings on the processes, outputs and early outcomes of the SEIF, including an assessment of additionality and deadweight.

Given the relatively short time-frames involved with this part of the research it is not envisaged that a workshop will be arranged, however, drafts of the report from this phase and its findings will be circulated to a group of key stakeholders before it is published more widely.

3.6 Phase 3: outcome and impact assessment

The objectives of this final phase of the research are:

- to explore the extent to which SEIF as a whole is successful against the measures agreed in Phase 1;

- to explore outcomes and impact of SEIF in depth within four health and social care localities;
- to identify learning and recommendations in relation to SEIF and to SE in the delivery of health and social care more generally.

The key tasks in this phase include:

- further iteration of the structured survey from Phase 2 of the research
- twelve in-depth case studies (three in each of four locality areas) providing a detailed analysis of the processes and outcomes at play within these health and social care communities.

Longitudinal survey of SEIF applicants: second wave

This phase will commence by a further iteration of the structured survey undertaken in Phase 2 of the research. This will include re-contacting a sample of respondents from the first wave to explore progress since that survey was undertaken. It will also include a top-up sample of successful and unsuccessful applications to SEIF made since the first wave survey. For the top-up sample, a similar questionnaire as that for the first wave will be used, while for the longitudinal sample, the questionnaire will be tailored in order to avoid repetition with the first wave and enable further exploration of outcomes and progress.

The precise number of responses sought via telephone will depend on the numbers of applications made to SEIF between the two surveys, but it is anticipated that around 200 responses at a minimum will likely be required. We would suggest if feasible that this is comprised of equal numbers of SEs applying to Rounds 1 and 2 of the CHP-administered Fund, and of SEs applying to the Fund since it had been delivered by SIB. We will use a stratified random sample both for the longitudinal and top-up sample based on SIB databases. Once more, those who have not been invited to take part in the research by telephone will receive an electronic version of the survey.

Case studies in health and social care communities

We will conduct 12 in-depth case studies of successful SEIF applicants. These will focus on four to six geographical or locality areas, and will explore progress and outcomes for three SEs within each of these areas. Organisations have the option to be anonymised although would risk losing much contextual detail. The case study methodology will allow us to establish the impact of the SEs themselves and the wider impact of SEIF within an area. Important factors to include within this are issues of deadweight (what would have happened anyway), displacement (of other services, organisations or of a particular problem) and drop off (where outcomes reduce over time).

The use of the SROI approach within the case studies will also allow for a more sophisticated approach to calculating the value for money in terms of the return on initial investment. In each of the case studies, we will be able to look at discounting, net present value and pay back period. Stakeholder interviewees reported that there is concern that some organisations feel like SROI was being done 'to' rather than 'with' them, and was therefore less useful. The initial analysis of SROI material is not available at present but initial views of those involved suggest that this is likely to be highly variable as organisations have been encouraged to identify their own indicators and doing a 'meta analysis' of these may present challenges.

Case studies will be selected to reflect the diversity of SEIF activity in terms of a range of factors, such as types of organisations, types of support received, scales, scope and types services provided.

The case study process will comprise three stages:

The first stage will set a baseline against which change will be measured, and establish a theory of change and set of success measures for each case study. Drawing on data from Phase 2, local documentation and stakeholder interviews, we will describe the context in each of these localities, for example, health status and local health challenges/issues; local social investment and support infrastructure; history and development of social enterprise locally. We will also examine the programme theories underpinning the SEs' work within these localities. We expect that during this phase of case study research, we will carry out semi-structured interviews with SE staff and board members, a selection of users, and a range of stakeholders who are important within the locality area (e.g. PCT and Local Authority commissioners, other third sector organisations including any SEs that are unsuccessful or non-SEIF applicants, service user and carer representatives (e.g. LINKs, community leaders etc).

Building on the theories of change for each case study, we will identify success measures (including SROI indicators) for each, and a plan for capturing data. We will undertake this process in a participative manner and encourage SEs, their users and members of their boards to choose their indicators, building on those in their application for SEIF investment, in order to build ownership. We recognise that capacity to capture data may vary between SEs, and will tailor approaches so that collecting evaluation data does not become a burden.

In an interim period we would support the case studies and the locality areas to collect outcome data in line with these plans. It will be important to make clear the demarcation between us as evaluators, and SEIF programme management in doing this, and we will work with SIB to ensure that we are not making duplicate demands for the same information.

In the final stage of the case study research we will revisit early findings via follow-up interviews, desk based research and analysis of output and outcome data. We will analyse SEIF recipients' progress against the framework of their programme theory and the success measures identified, using qualitative and quantitative indicators. We expect that in most cases, this will include an assessment of SROI (including the financial value of social impacts); health impacts (using proxy/lead indicators in most cases); degree of innovation; extent to which choice, personalisation and access had improved; degree of integration with other health and social care providers and sustainability of the investment. We will provide an assessment of value for money from each case study. We will also explore the wider impacts of SEIF recipients' work and of the Fund itself in each locality, e.g. on commissioners' attitudes, commissioning processes, scores against competencies set out in the World Class Commissioning framework, unsuccessful applicants/non-recipients of SEIF and the wider local health economy, looking for multipliers and displacement. In addition to looking at the impact of the SEs on the local areas we will also investigate the impacts on commissioning practices within these localities, and on local social investment markets.

Rather than producing a report for each case study site, we will produce a report for each locality area, which should save on repeating similar data relating to relationship with the commissioner, market management and stimulation of diversity within service provision.

Stakeholder interviews

This phase also sees a further found of interviews with key stakeholders (n=25), similar to those carried out in Phase 1, to re-verify adherence to programme theory and the validity of these programme theories within the present context. This will also be an important source of information on perceptions of additionality.

3.7 Analysis and reporting

Following on from these final interviews the last stage of analysis and reporting will take place. In this stage we will analyse and synthesise all of the data collected within the process of this research programme in order to address the questions set out at the start of this programme. We will draft a final key findings report and the implications of this will be discussed and presented in order to agree final key messages from the programme and the wider implications of this for policy and practice. It is important to note at this point, that where possible we will try to make definitive points in relation to the processes, outputs and outcomes of the SEIF and SEs within the locality sites, given the timescales involved in the process, although the ability to make clear and unequivocal links between factors and outcomes may be difficult. The research team will endeavour to establish a series of outcome indicators with local sites so that they might be able to continue to collect and monitor this data themselves in the future.

Although the brief for this evaluation is interested in assessing the long-term impacts of the SEIF, it is important to note that making definitive statements about the links between the SEIF and longer term outcomes such as health inequalities is not possible so soon after investments have been made. However, from Wave 1, we should be able to make some initial assessment of improvements to quality of services, accessibility and choice, although at this stage it is not clear to what extent this evaluation can infer what this might mean for longer term population health and wellbeing. Beyond this, any final conclusions will to some extent depend on what types of SEs are involved in the evaluation, the length of time these have been in operation and the types of services they are delivering. For example, where SEs are working with quite distinct user groups we might be able to look at health and wellbeing outcomes for service users, whereas if SEs are working across less distinct populations this may prove more challenging. We will discuss our sampling strategy in detail with the commissioning body so that the most appropriate study sites are selected.

Annex 1: Other Department of Health Social enterprise related programmes and policies

Recent reform in the delivery of health and social care services has sought to transform the way that these are delivered in order to:

- give patients greater choice over where, when and from whom they receive services;
- provide opportunities for patients to have a greater influence over the design and delivery of their care;
- reduce health inequalities and improve the health of disadvantaged groups; and
- create opportunities for the delivery of innovative health and social care services to thrive outside the control of the state.

Social Enterprises (SEs) are organisations which operate under a business model that has a primary social purpose. SEs have social aims and reinvest any surpluses made from trading activity in a way that provides benefits for the wider community, rather than being driven by the need to maximise profit for shareholders or owners. In other sectors outside of health and social care, SEs have helped to transform the delivery of services. In health and social care they have been identified by policy makers as a potential means of delivering improvements because:

- they offer potential to directly involve patients in the design and delivery of the service;
- they are recognised for their potential to engage with disadvantaged groups and address inequalities in health;
- they hold the potential to facilitate service providers to innovate and to develop new products and services which can generate increased income that might be re-invested in ways that deliver social and community benefits.

Social enterprise is a hybrid form of private and third sector agency; an umbrella term for a range of business models that promote the use of profits or 'surplus' for community benefit, and many different legal forms may be identified (Freeman & Peck, 2007; Smith, Freeman, Parker & Parker, 2006). SEs are "... business [es] with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit" (Department of Trade and Industry, 2002:13). They differ from voluntary non-profit agencies as there is no necessary requirement of voluntarism, defined as voluntary initiation and self-governance (Bourdillon, 1945; Salamon & Arnheier, 1998).

However, SE is by no means a definitive model of service delivery and there is a need to segment the different types of SEs in health and social care. Previous work has identified a typology of SE that can be used in the development of the evaluation framework (Lyon, 2007):

- large scale transfers from the NHS and other parts of the public sector;
- smaller start up community groups providing local services;
- mutuals and cooperatives of health workers;
- voluntary sector organisations becoming more reliant on trading income as they move from grant to contracts.

SE appears within recent policy documentation as one of the means through which health and social care services might be transformed so that they deliver more timely, accessible and high quality services. Indeed, the role of SE in delivering the transformation of services is a feature of the 2006 White Paper and the Next Stage review which created the SEIF and the staff “right to request” to establish a SE to deliver services.

With the formal separation of PCT commissioner and provider functions, commissioners are increasingly being encouraged to secure services from SEs and to actively ‘shape the structure of supply’ in their local area. It is proposed by the Department of Health that key drivers of change in the form of Personalisation, Transforming Community Services and World Class Commissioning are all, in part, dependent upon the growth and success of SE to deliver their outcomes.

Arguably the most significant policy developments in recent NHS documents concern encouragement of a mixed economy of autonomous care providers. On this characterisation, the NHS is in a state of transition from public monopoly insurer and provider, to insurer with devolved commissioners buying services from a mixed market of providers (Lewis & Dixon 2005), with economic regulation to remedy market failure and to ensure quality. The reforms are intended to improve access and increase efficiency through rival providers (competition), or the fear of market entry by alternative providers (contestability), and signal a renewed emphasis on pluralism, diversity and contestability through a mixed economy of welfare.

Yet, Supporting people with long term conditions: Improving care, improving lives (DH, 2005d), Independence, well-being and choice (DH, 2005c), Our Health, Our care, Our Say (Secretary of State for Health, 2006) and the Next Stage Review (Secretary of State for Health, 2008) contain countervailing messages of collaboration and integration between providers and sectors. It is clear that, as currently constituted, the rhetoric of patient choice contains shades of both entrepreneurial governance (competition) and communitarian endeavour (partnership) in tension. Within this context, the appeal of SE is that it offers the potential for increased innovation, without the need for competition (Freeman & Peck 2007). Recognising this potential and actively shaping the local market to include SE provision, where appropriate, is an explicit competency PCT commissioners have to demonstrate as part of the World Class Commissioning framework. Commissioners are expected to have a clear understanding and knowledge of their third sector community and tasked in building local social capital through increased SE provision providing incentives where necessary for market entry.

Against this frenetic policy background, a key challenge is whether practice in health and social care is keeping pace with the enthusiasm for the sector expressed in policy contexts. Evidence of the impact of SE is still limited and the programme of research set out here will build on the on-going research comparing provision of public, private and SE models.

Dickinson & Smith (2005) consider the relative strengths of public, private and third-sector provision (of which social enterprise is a variant). Public providers produce public goods, may be held directly accountable to government, and are unlikely to exploit information asymmetries; yet, they experience difficulty in catering for diversity, responding quickly to fluctuations in service demand, or experimenting with new policy options. In contrast, private providers are likely to respond well to increases in demand and be innovative in response to effective demand; yet prone to exploit

information asymmetries, ignore diversity unless profitable and do not produce public goods. Third sector providers are able to provide services, are innovative and capable of catering to diversity; yet less able to respond to fluctuations in demand and are less directly accountable to government than public sector providers.

While hybridity may yield internal contradictions (Alcock and Scott, 2007), Billis & Glennerster (1998) consider the comparative advantage of voluntary sector agencies to lie in areas where their hybridity addresses problems of principal-agent gap, voter reluctance and lack of market interest. Yet the degree to which social enterprises may achieve such benefits, in the absence of a formal commitment to voluntarism is as yet under-researched.

On the demand side, users may prefer third sector to for-profit providers in conditions where they are unable to accurately evaluate the quality of service and fear being taken advantage of by for-profit providers (contract failure theory) or where third sector organisations provide 'collective goods' both for their own benefit and that of non-controlling stakeholders, so that users identify with the coalition of demanders-suppliers, recognising the latter's self-interest in ensuring high quality provision (stakeholder theory).

Marks and Hunter (2007) highlight the different outcomes expected of SEs in delivering health and social care services ranging from increased flexibility and innovation through to facilitating greater patient involvement in service design and delivery. The report notes the growth of SEs in health and social care resulting from ownership and governance definitions and from a range of policies some indirectly leading to the growth of SEs. Lyon (2008) identifies the innovative and pioneering nature of SEs with contracts for the delivery of health services providing the opportunity to scale up their impact. However, evidence of the extent of their innovation and ability to scale up is lacking.

The policy environment for social enterprise in health and social care is highly dynamic and abounds in policy initiatives aimed at supporting social enterprise start-up and development. Policy initiatives and developments in the NHS context include:

- World Class Commissioning
- NHS Reform Programme
- NHS Next Stage Review: Our vision for primary and community care
- DH Social Enterprise Investment Fund (SEIF)
- DH Operating Framework 2008/2009 – 2009/2010
- Standard NHS contracts
- Innovation for Life Change Fund
- Right to request

Some of these are analysed below.

Social Enterprise Pathfinder Programme

The DH Social Enterprise Pathfinder Programme was established in order to support the establishment of social enterprise models for delivery of health and social care services. Pathfinders constitute one of the first policy initiatives for the development of social enterprise which had top level support from the DH.

Initially, Pathfinders were eligible to apply for financial support from the Social Enterprise Unit to help with set-up costs and wider support such as legal, business advice and training. Following the establishment of the Social Enterprise Investment Fund (SEIF) in April 2007, the pathfinder programme was funded by SEIF.

In 2008 the DH Social Enterprise Unit announced 25 successful pathfinder projects across health and social care services, which are eligible for both financial support from the £1 million available to help with start-up costs as well as business advice and training. The Pathfinder Programme was established during a period of considerable volatility in the health and social care sector which had considerable impact on the progress that most pathfinders made during the earlier stages of the programme.

'Right to request'

As part of the ongoing process of modernisation and reform of the health sector the Government is committed to support an increase in the role of social enterprise in delivering primary and community care services. The guidance *'Social Enterprise – Making a Difference: A guide to the 'right to request''* which was published by the Department of Health in November 2008, represents a new phase for the NHS's commitment to social enterprise as a provider of public services in the health and social care sector. And it is part of a bigger vision for the future of the NHS as set out in *'High Quality Care For All: NHS Next Stage Review Final Report'* – published in June 2008.

As established in the document, the guide 'aims to support NHS staff who are thinking of taking up the 'right to request' and setting up a social enterprise to deliver healthcare services to NHS patients (2008: 5). It tries to answer some questions that NHS staff may have about setting up a social enterprise, setting out some of the benefits, risks and challenges involved and helping individuals and groups to decide whether social enterprise ventures are the right decision for them.

A key assumption that underpins 'the right to request' agenda is that NHS staff have a better understanding of patients needs and how to meet them and that the creation of social enterprises will give frontline NHS staff the opportunity to innovate and redesign services that are responsive to the needs of the communities and individuals they serve.

This Government commitment to social enterprise within the NHS is underpinned by a number of 'right to request' related support mechanisms including:

- the ability for NHS staff who are transferred to social enterprises to retain their membership of the NHS Pension Scheme while they work on NHS funded services;
- the commitment to give professional advice and guidance;
- the offer of an uncontested contract for up to three years, after which they would be tendered openly, and longer five year overall contracts with a phased approach to tendering specific services.

The SEIF Right to Request Fund is to support people that want to deliver 'spin-out' or alternative provision of NHS services through a social enterprise. The NHS is committed to supporting the great ideas that current employees have and have a process in place to take these plans forward. Investees will work with Partnerships UK (PUK) (the Social Investment Business partner), through the

milestones set by the local Primary Care Trust (PCT) and loan grant and support investment will be staged according to the three milestones - (1) Expression of interest – investees will be provided with business support; (2) Development and planning - Investees will receive grants of between £100,000 - £250,000. (3) Project execution - Full investment packages, which could consist of loan, grant and/or equity, will be provided with a value of £50,000 - £10,000,000.

Personalisation Fund

The personalisation agenda was a key objective of the New Labour Government's health and social care reforms in general and the NHS Next Stage Review in particular. The Next Stage Review states that 'personal health budgets' could be given to people with predictable long-term conditions – along similar lines to 'individual budgets and direct payments in social care'. The publication of 'Personal Health Budgets: First Steps' in January 2009 placed personalisation at the heart of the reforms proposed by announcing that personal budgets would be piloted in PCTs and that powers were being sought in the Health Bill to allow piloting of direct payments in health care. The budgets would be voluntary and the intention is to give patients greater control over services they receive and over who provides those services. However, the extent to which people with PHB will choose SEs is not known.

Social Enterprise: Innovation For Life Challenge Fund

Announced in 2008 by the Care Services Minister, The Innovation For Life Challenge Fund is a discrete funding stream from within the Department of Health Social Enterprise Investment Fund. In parallel with the opening of the SEIF's second round, up to £100,000 will be available in 2008/2009 to support 'innovative and collaborative commissioners who are ready to take forward social enterprise solutions to meet local health and well-being challenges'.

The Innovation For Life Challenge Fund aims to encourage commissioners to find collaborative solutions through social enterprise. It is an opportunity for commissioners and system managers to develop and support their World Class Commissioning strategies through entrepreneurial thinking and collaborative working involving social enterprise.

The fund was developed in collaboration with the Social Enterprise Coalition and the Department of Health Social Enterprise Unit. Successful bids will have to demonstrate:

- partnership working across commissioning e.g. Local Authority or Practice Based Commissioners (PBC) involvement;
- strategic support and alignment with other partnerships e.g. Government Office, Regional Development Agencies;
- local partnerships engagement e.g. NHS trusts and wider third sector;
- entrepreneurial leadership, innovation and creativity;
- social return on investment;
- community ownership and sustainability.

World class commissioning & social enterprise

Improving commissioning has been at the heart of successive reform policies in the NHS that have aimed to achieve 'better health and well-being for all, better care for all, and better value for all' (DH 2007a: 1). The policy 'vision' of world class commissioning builds on *Commissioning a patient-led*

NHS (DH 2005) calling for a shift of emphasis from spending on services to investing in health and well-being outcomes. *World class commissioning* provided a 'statement of intent' that was designed to raise the ambitions of commissioning to meet the new challenges of changing populations and advances in healthcare (DH 2007: 1). It called on all PCTs to develop knowledge, skills and behaviours to build their organisations around the following 11 organisational competencies (DH 2007):

1. locally lead the NHS
2. work with community partners
3. engage with public and patients
4. collaborate with clinicians
5. manage knowledge and assess needs
6. prioritise investment
7. stimulate the market
8. promote improvement and innovation
9. secure procurement skills
10. manage the local health system
11. make sound financial investments

The role of social and enterprise and the third sector in general is of particular relevance to competencies that look to 'stimulate the market' and 'promote improvement and innovation'. Underpinning both of these is the view that commissioners need a choice of responsive providers in place that will need to work effectively with partners that includes third sector organisations. In order to effectively *stimulate the market* to meet demand and secure clinical, health and well-being outcomes, PCTs 'will use their investment power to influence improvement, choice and service design through new or existing providers to secure desired outcomes. This will include building on social capital and encouraging provision via third sector organisations' (DH 2007). In the promotion of *improvement and innovation*, understanding the potential of local community and third sector providers to deliver services will increase innovation and social capital (DH 2007).

There appears to be limited research on the impact of world class commissioning on social enterprise in health and social care. Historically, the role of commissioning has been a challenge for third sector organisations however the current policy agenda appears to be creating levers and incentives favourable to the social enterprise model.

The recent evaluation of the social enterprise pathfinder programme (DH 2010) found that the social enterprise model has emerged as a future organisational form for NHS community services as reflected in *High Care Quality for All* (Secretary of State for Health 2008) and *Transforming Community Services* (DH 2009b). An enthusiasm for the social enterprise model was found across stakeholder groups with a notable condition for social enterprise pathfinder success being PCT and Local Authority leadership and support. Despite this apparent success associated with the social enterprise model, the evaluation also draws attention to a number of challenges that face social enterprise. The evaluation identified challenges to the social enterprise model in the fact there was

little evidence, albeit at an early stage, that social enterprise characteristics and benefits were clear to staff, the public or service users (DH 2010).

It appears to be an exciting time for social enterprises in the current policy context. Despite this, a note of caution appears to emerge in that the implementation of the social enterprise model is still very much 'work in progress'. Greater awareness, resources and leadership will be required for it to take hold. Moreover, external factors also need to be taken into consideration of a health reform programme struggling to shift the balance of power from acute, secondary providers towards primary and community based models of provision (see Audit Commission 2008; 2009).

Annex 2: Other third sector related support programmes

The government has an objective to work with the third sector to strengthen communities, transform public services, encourage social enterprise and support the conditions for the sector to thrive. Two frontline programmes were introduced in 2004 by the Home Office in order to address the findings of a 2002 Treasury review according to which the third sector's ability to contribute to the delivery of public services was constrained by a lack of capacity. These programmes are ChangeUp and Futurebuilders which were designed to build the capacity of the third sector.

Responsibility for both ChangeUp and Futurebuilders transferred in March 2006 to the recently created Office of Third Sector (OTS), which was established as part of the Cabinet Office to lead the government's third sector strategy.

ChangeUp

ChangeUp is a £231 million programme designed to improve support services for front line third sector organisations. Since April 2006 the programme has been managed by Capacity Builders, a non-departmental public body established to administrate the programme.

One of the features of the programme is that it does not fund frontline third sector organisations directly. Instead, local and regional support providers are given funding to come together in partnership or 'consortia' so they can work in a strategic and coordinated way and provide new or improved and financially sustainable services in a more efficient fashion.

At the national level, ChangeUp has worked towards the creation of partnerships of national support providers to bring their expertise to bear by providing guidance and advice in key policy areas including governance, performance management and volunteering (NAO, 2009).

Future builders

Futurebuilders is a £215 million fund managed under contract by Social Investment Business (formerly Futurebuilders England), a company limited by guarantee. In 2006, responsibility for the fund was transferred from the Home Office to the Cabinet Office. The contract was re-tendered and a new fund manager, Adventure Capital Fund Management Limited (which took over Futurebuilders England), was appointed in April 2008.

According to NAO (2009) Futurebuilders is experimental in that it tests the idea that investing directly in third sector organisations that are financially viable, but unable to access commercial sources of finance, enables them to build their capacity to compete for and win public service delivery contracts. The fund also provides help to organisations that have specific development needs to address before they are considered fit for purpose to take on an investment.

Business Link

Social enterprises are able to source support through Business Link. As the access brand, the core role of Business Link relates to the provision of an 'Information, Diagnostic and Brokerage' (IDB) service. The new IDB service is free to all businesses and, subsequent to the diagnosis, provides referral to external providers of business support, provided by public, private or voluntary sectors. Some of this support may be subsidised but there is an expectation that business, including social

enterprises, will pay an appropriate market value for this support. Business Link also provides a start up service, which offers support to individuals considering starting a business, including a social enterprise. This is often delivered through a series of free seminars. Criticisms of the programme relate to the lack of sensitivity to social enterprise specific issues.

Findings on the current business support system also need to be seen in the context of the Business Support Simplification Programme (BSSP) being led by the Department of Business Enterprise and Regulatory Reform. The programme aims to streamline the provision of support from the plethora of support schemes that currently exist to fewer than 100 products. In tandem with the simplification of provision, the delivery mechanism in the form of Business Link is also positioned as the access brand for publicly funded business support.

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HSMC has been one of the leading UK centres for research, personal and organisational development in health care for nearly 40 years. Commissioning of healthcare and provision of healthcare outside hospitals have become specific areas of expertise in recent years, underpinned by a continuing commitment to issues of quality improvement and public and patient engagement. This reputation has also started to extend to adult social care services. HSMC has also developed a national reputation for both organisational and leadership development across all health settings. For further information visit www.hsmc.bham.ac.uk

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The third sector provides support and services to millions of people. Whether providing front-line services, making policy or campaigning for change, good quality research is vital for organisations to achieve the best possible impact. The third sector research centre exists to develop the evidence base on, for and with the third sector in the UK. Working closely with practitioners, policy-makers and other academics, TSRC is undertaking and reviewing research, and making this research widely available. The Centre works in collaboration with the third sector, ensuring its research reflects the realities of those working within it, and helping to build the sector's capacity to use and conduct research. For further information visit www.tsrc.ac.uk.

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