The Party’s health policy has not been consulted on for some years, so some of the content is no longer correct because it refers to Government policy or health bodies which no longer exist. As well as the consultation, it is proposed the below areas of existing policy are updated to reflect current circumstances. The suggestions are included in the annotations below, and members are welcome to share their views either during the consultation period or at annual conference in October.

**Foundation Trusts**

The Co-operative Party believe that the values and vision behind the creation of Foundation Trust hospitals remain the right ones. In order to realize the potential of community owned health services the following reforms need to be considered. ­

* The rapid growth in the number of Foundation Trusts has seen a widening rather than a deepening of community engagement and in some areas the experience is that little commitment to the model is evident from hospital management. Whilst the aim that every hospital should be a Foundation Trust was laudable, in practice it risks allowing it to become a ‘paper exercise’ without the necessary commitment to making a real change in governance. Therefore, consideration should be given to removing the target that all hospital trusts should become Foundation Trusts and instead allow local communities (working with their local Healthwatch) to initiate the process of becoming a Foundation Trust. ­
* The Government should review the role of Monitor in regulating Foundation Trusts with amendments made to the regulatory framework to ensure Trusts are being judged on the extent to which they are, for example engaging members in decision making and the vibrancy of governor elections. This would put governance higher up management’s priority list and provide proper incentives for the best to demonstrate what is possible.
* A strengthening of the role of members within Foundation Trusts should be considered and necessary legislation brought forward. This could include measures to increase the accountability of governors to members through a power to require updates, consultation and dialogue; reviewing whether there are powers currently held by governors that could be transferred to members; increasing the duties on Trusts to publish forward plans and up-coming decisions so that governors can consult and engage members ahead of key decisions. ­
* Healthwatch England should be asked to work with the Foundation Trust Network to consider emerging models of good practise in collaborative working between local Healthwatch and Foundation Trusts. This good practise should be disseminated.

**Community based healthcare**

Whilst it is often hospital services that attract the majority of the headlines, community-based services including mid-wifery, dental care, health visiting, physiotherapy and of course GP services account for a substantial proportion of NHS activity and spending. Even in Wales and Scotland where the shift to a ‘market’ of provision has been less profound, a substantial proportion of community based provision is provided by profit making or not-for-profit but private or voluntary organisations.

NHS community services in England have undergone a huge change in the last fifteen years with the creation of Primary Care Trusts in 2000, the halving of their numbers in 2006, the division of Trusts to separate their delivery and commissioning functions in 2011 and their replacement with Clinical Commissioning Groups in 2013. In particular, the latter two reforms have opened up the potential for co-operative, mutual and other not-for-profit providers to substantially expand in community based healthcare services.

In 2006 Labour Party Health Secretary Patricia Hewitt wrote “Unleashing the potential of new providers in the third sector and social enterprises can help us meet these extraordinary challenges and safeguard the founding values of the NHS for another generation.”

In 2010, publishing the White Paper Equity and Excellence: Liberating the NHS Andrew Lansley set out the Coalition’s ambition that the NHS in England should become the ‘largest social enterprise sector in the world.”

In England in particular the legal form and organisational models which have been utilised in the process have varied from social enterprises, employee mutuals, Community Foundation Trusts and charities. As Cliff Mills and Chris Brophy have noted this resulted from a preference for local determination over central proscription – in contrast to the move to Foundation Trust Hospitals.

The creation of the ‘right to request’ the transfer of services provided by NHS staff in England into social enterprise organisations by the last Labour Government; and the ‘right to provide’ established by the Coalition Government have provided two key mechanisms. The social enterprises that have established themselves as a result have ranged from single GP practices to large scale provider ‘arms’ providing and/or managing the provision of a wide range of community-based health and social care related services to local communities. The overarching intention has been to encourage staff to take on greater responsibility for decision making, based on evidence from other sectors that this will drive up productivity and better utilise expertise. In addition, the goal has been to increase local accountability.

Given these new organisations have only been formed in the last 2-3 years the evidence of their impact is still limited. However, research by the Kings Fund has shown many running the new social enterprises in health felt that the new way of working had led to a reduction in bureaucracy, flatter decision making structures with a narrowed gap between Executives and the front-line, increased accountability for staff, and a reinvestment of surpluses back into services and staff development.

The Co-operative Party believes that government needs to take steps to maintain momentum and ensure that firstly, the potential of the mutual and wider social enterprise sector in delivering community based healthcare services can be realized; and secondly that all necessary safeguards are put in place to ensure ‘right to provide’ spin-outs are strictly limited to those organisations that are legally committed to trading for a public or community purpose. While exact structures will continue to vary depending upon the nature of the differing services provided; it is vital that staff, patients, carers and the general public own and control the new organisations.

Key to building for the future will be provision of the necessary support for the creation of new mutuals and social enterprises and then the on-going support and commissioning framework to promote long-term sustainability and success. Issues for consideration include:

* The procurement of financial, legal, technical and HR support necessary to successfully identify an appropriate model and then go through the process of ‘spinning out’ can be challenging and expensive. Collectively procured support and more mentoring by other organisations who have been through the process can help reduce these costs and burdens.
* The increasingly competitive market place in the healthcare sector offers opportunities but also risks for social enterprises competing against well funded private sector providers with longer track-records. They will need to meet patient and commissioner expectations, develop new products and services and innovate to stay ‘competitive’.
* One of the early attractions of the ‘right to request’ programme for participants was the promise of a 5 year initial contract (compared to traditionally 3 years). Such contract lengths should be considered more widely for the not-for-profit sector in recognition of the challenges posed by more regular re-commissioning including the uncertainty it poses and the lack of investment lending that is often available to the sector.