Innovating care services through co-operative enterprises

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Abstract

Social innovation is an approach for individual and community empowerment that seeks radical improvement in public services. The personalisation agenda has been driving huge changes in public services for adult social care and health, with profound implications for service users, commissioners, and providers. Co-operatives are run commercially but with people in mind, and there is a close match between personalisation and the co-operative values in that people share responsibilities for their services and outcomes.

This paper is about the intersection of personalisation and the cooperative tradition, with its emphasis on mutual aid and value-led enterprise. We retell the story of personalisation through a co-operative lens, considering two co-operative enterprises that were supported under a Department of Health programme in England (2006 – 2009). Drawing on empirical research, we consider the achievements, challenges and opportunities that faced the co-operatives in establishing themselves as innovative social care providers. Our other intention is to reconsider our findings in light of further advancements made in the personalisation agenda across public services in England.

Introduction

The 'personalisation' of social care and health services promises to extend choice and control to individuals, usually by allocating cash in lieu of services (Carr, 2010). It is often linked to the struggles of disabled people for control over the support they need to live independently. Social Innovation is at the heart of personalisation, which has been described as a philosophy underpinned by a shift in power, responsibility and resources from state agencies to

individuals (Glasby et al., 2009). In some versions of personalisation, service-users are treated as consumers according to market principles. In more radical (sometimes-called deep) versions, they are co-producers (Leadbetter, 2004; Needham, 2007).

Co-operatives are businesses owned and run by members, who may be customers, employees, or the local community. Their self-help business models seem closely aligned with the aspirations of personalisation for sustainable, equitable outcomes and new relationships between service providers and service users. In this paper, we examine the intersection of personalised public services and small-scale providers working within the co-operative tradition, which emphasises mutual aid and value-led enterprise.

In this paper, we are informed by Mulgan's (2007: online) 'connected difference' of social innovation that draws on three aspects:

> They are usually **new** combinations or hybrids of existing elements, rather than being wholly new in themselves.

> Putting them into practice involves **cutting across** organisational, sectoral or disciplinary boundaries.

> They leave behind **compelling new social relationships** between previously separate individuals and groups that matter greatly to the people involved, contribute to the diffusion and embedding of the innovation, and fuel a cumulative dynamic whereby each innovation opens up the possibility of further innovations.

We return to these three points in the paper.

Personalised social care

With 'choice and control' is its mantra, personalisation in social care promises to make services responsive to the citizens who use them (Duffy, 2010; Glendenning, 2008). It is enabled by mechanisms to devolve budgetary control to the individual (Glasby et al., 2009). Evaluations of personalisation programmes in England report benefits to users including increased control and independence, greater continuity of care, and fewer unmet needs (Glendenning, 2008; Hutton and Waters, 2009). Some commentary is more sceptical. Personalisation depends on neoliberal notions of consumers individually spending public money according to Burton and Kagan (2006), bringing 'enforced individualism and isolation' in the words of Roulstone and Morgan (2009: 343). From this perspective the preferences of those individuals who exercise choice can mean that the most disadvantaged will lose out, for example if services such as day centres and respite care are displaced (Manthorpe et al., 2009). The consequences of such collective provision withering away look

alarming in the light of tighter budgets and narrower eligibility criteria, with the likelihood that obligations to provide support will increasingly fall on informal family carers (Beresford, 2009).

Overall, evaluations and commentary on personalisation of social care highlight concerns and tensions around: choice and control for service users, especially the most disadvantaged; lack of accessible and affordable providers; employee working conditions; and the direction towards individual consumer models that can be seen as potentially depleting collective wellbeing. More collaborative approaches have been suggested to address these issues (Scourfield, 2007; Fergusson, 2007). However, these is little evidence for how this could work in practice

The co-operative enterprise

The first successful modern type of co-operative was set up in Rochdale in 1844 when a group of 28 artisans in that town in the north of England established the Rochdale Equitable Pioneers Society. Most co-operative movements pay tribute to this nineteenth century social innovation. Co-operatives today as in the past are trading organisations with strong values (Woodin et al., 2010). They include worker co-operatives that replace employment with 'member-ownership' as well as consumer and multi-stakeholder co-operatives. Co-operatives are distinctive because the way that they do business is driven by specific values and principles set at an international level and overseen by the International Cooperative Alliance (ICA). Co-operative identity as defined by ICA with regard to economic surplus and democratic control stand in sharp contrast to the charities, community groups and other voluntary associations that are usually said to form the third sector or civil society (International Co-operative Alliance, 1995; Ridley Duff and Bull, 2011).

Research with co-operative providers

The Department of Health funded the *Self-Managed Care – a co-operative approach* programme to support its priority to extend the uptake of personalisation. In particular, it was intended to attract new users to personalised funding mechanisms from groups who may be deterred by the perception of associated risks and burdens. The programme aimed to achieve this by enabling service users to gain personal control over their care while the

responsibilities of organisation, training, supervision and meeting quality standards would be managed through co-operatives that could also involve informal and/or paid carers. The programme was delivered by the co-operative consultancy Mutual Advantage. It ran from 2006 to 2009 during which time Mutual Advantage assisted five pilot projects to develop co-operatives involving service users, carers, or both to facilitate mutual support, and to meet aspirations to improve working conditions for paid carers. Working in close collaboration with Co-operatives UK, one of the authors of this paper followed up the experiences of two of the pilots after the end of that programme. Co-Operatives UK and the researcher identified these pilots as case studies. Case studies are widely used in social research in order to investigate contemporary phenomena within their real life context. They can encompass multiple, complementary forms of data collection (Yin, 2003). In this paper, we draw on evidence from the following:

- Site visits to the co-operatives and to key meetings (the Co-operative UK annual conference and a 'roundtable' on personalisation organised by the Association of Chief Executives of Voluntary Organisations)
- Interviews with the co-operative founders and with support workers from Mutual Advantage
- Analysis of documentary material (reports, working documents, meeting minutes, organisations' websites, and media publicity)

We used these resources to explore and assess opportunities and challenges for new small businesses set up to ensure that service recipients retain individual control over their care but share organisational burdens. This work was undertaken from March to June 2010 as a placement with Co-operatives UK, funded by ESRC under a Business Engagement Opportunities project. We refer to the case study pilots by the generic names *Workers co-operative and Stakeholder Co-operative.* (We use pseudonyms for the interviewees in this paper.)

Lessons from case studies of small co-operative care providers

Workers co-operative was established in a town in Greater Manchester in 2008 by a group of four women home care workers employed by the local authority. When we visited them for this study in 2010, they had achieved registration with the Care Quality Commission, the national regulatory body for social care providers. They had five customers and employed two personal assistants.

One of the founders, Helen, had a wealth of experience as a community activist and was very confident of the support she and her colleagues could access. The establishment of the co-operative however took a long time and suffered many setbacks. Helen said, "it has been a challenging and hard struggle throughout, everything including setting up the company has been difficult". *Workers co-operative* received a small grant from the local authority that enabled them to set up an office. They minimised costs by painting and decorating the office themselves with help from family members, negotiating cut-price rent through contacts in the community, and acquiring free materials through family and friends. The relationship with the local authority was uneasy due to mismatched working practices and values. This was dramatized in the conflict over what happens when a care worker enters a customer's home. The local authority had an e-monitoring system for all care workers, designed to provide an efficient management process. The worker had to phone a number immediately on arrival to ensure that the care job was logged on the system. They were required to do this the instant they arrived, even we were told, before saying 'good morning' to the customer! *Workers Co-operative* considered this impersonal process at odds with their values of empowering the customer.

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Stakeholder Co-operative was established by service users and carers in a London Borough. The board members are service users, unpaid carers and employees. It is registered with the regulatory body trades with customers who have direct payments, and some self-funders. The borough is much more affluent than the northern town where *Workers co-operative* is based and it is easier to attract self-funders. The founders were two women, one of whom, Maria, had MS and died in 2009. Maria received care from her husband but she had a very poor experience in a care home when she needed help after her husband was injured and temporally unable to care. This episode gave her the idea for *Stakeholder Co-operative*. She contacted her friend Vera and said she needed 'a pair of hands.' Maria was a committed socialist and political activist and the Co-operative model was in line with her personal ethos and values. Maria and Vera came into contact with Co-operatives UK through Mutual Advantage and were invited to be a pilot.

This co-operative uses a cluster-based operational model. Care is provided by personal assistants for a group of service users within a very small geographical location. The cluster idea developed because of Maria's experience of having a team of 10 people care for her. It

was an innovation that was adopted by some of the other pilots and is strongly advocated by Mutual Advantage. It provided the opportunity for new social relationships for the carers and service users (Mulgan, 2007). Each cluster has a part-time support worker and overheads are kept low with support workers being home based. Benefits of the cluster model include a reduction in travel expenses and time, which is important in a large outer London borough affected by heavy traffic congestion. The cluster facilitates development of a longer-term relationship between user and carer and flexibility to cover holidays and sickness. In principle, the co-operatives would grow by developing new clusters and they are interested in expanding into the neighbouring local authority, 'cutting across organisational boundaries' (Mulgan, 2007: online).

Stakeholder-co-operative held a high profile launch in May 2010 with banners and flyers and as a result received some very positive coverage in the national press. Vera reflected that it had been an extremely long haul to get to that point and the co-operative 'has taken over our lives' including those of her family. All Vera's work was unpaid, as is that of Maria's husband who has continued to work hard for the co-operative since her death.

Discussion and conclusions

Although there is much that is positive in evaluation and research on personalisation, there are concerns about reduced collective ethos and the status and working conditions of employees (Burton and Kagan, 2006; Roulstone and Morgan, 2009). Looking at personalisation through a co-operative lens suggests that it has three faces: customer, entrepreneur, and co-production. In a 'customer' model service users become micro-commissioners of their care, selecting and buying what they choose from options on offer. The 'entrepreneurship' face of personalisation is inflected by a discourse of individual enterprise whereby persons are required to become 'entrepreneurs of the self' in all aspects of their lives (Du Gay, 1996) and disabled people are re-imagined as neither beneficiaries nor customers but 'managers of the enterprise of their own lives' (Pavey, 2006: 227). In a 'co-production' model, in contrast, people who receive social care become partners, negotiating, constructing, producing and managing their services in equal and reciprocal relationships with professionals (Needham, 2007). Co-production has been called an idea whose time has come with the urgent need to find innovations to improve services and constrain costs (Boyle et al. 2010). In many ways, it fits with Mulgan's (2007) notion of social innovation, as it is a

'hybrid' of existing elements of providing care. It is certainly an idea that seems likely to be advanced by providers defined through the distinctive co-operative values of self-help, self-responsibility, democracy, equality, equity and solidarity.

The central tenets of personalisation - choice, empowerment and involvement - are firmly rooted in the origins of the case study co-operatives and inform their operation and values. Customers / users who are members can shape the service provided according to their needs. Employees benefit from being able to influence the organisation and there are opportunities for working in innovative ways. The 'cluster model' is an innovation in organisation that grew directly out of users and workers thinking through together how to improve their experiences as recipients and providers of care. It is adapted to the local conditions of the co-operative that created it in a London borough but in principle, according to Mutual Advantage, could be adapted in other ways in other contexts, for example by basing the clusters on types of need or medical condition rather than geographical proximity.

Personalised care and health imply revising how people and communities work together in ways that are both welcomed and feared. This form of social innovation is radical and challenging, and yet is important to those involved in the co-operatives, both as service users, providers, and carers. Lessons from co-operatives operating within the social care sector are still tentative as the phenomenon is very new. These does seem however to be potential to realise some of the optimistic claims for personalisation while avoiding the risks of depleting collective action and democratic accountability. Since undertaking our research, personalisation as an agenda is continuing to dominate social care policy (within England HM Government, 2012). The current coalition-led UK government intends to ensure that personal budgets are available to all who receive social care services. A survey in 20111 identified that 338,000 individuals are in receipt of a personal budget, a third of those who are eligible (ADASS, 2011). However, the White Paper (Caring for our future: reforming care and support) (HM Government, 2012) recognises that the provider market is still developing. There remains support for social innovation in that market, although as yet the market continues to be dominated by private sector providers. According to Needham and Tizard (2010), local authorities will move to the role of shaping the market, and individuals with budgets will become commissioners of their services. To date, the development of innovative solutions to personalisation such as a co-operative approach remains under-researched in the UK, and we continue to await more development in the area.

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