

taking care

a co-operative vision for
social care in England

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the co-operative party

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Introduction

This report concerns the provision of formal adult social care in England. The analysis examines the trends influencing adult social care – legislation, public investment, personalisation, health and care integration, and the labour force – and makes policy recommendations for improving the quality of adult social care.

The analysis within finds that the shift to private provision of care has reduced the quality of care, undermined labour market conditions and reduced cost efficiency within the sector. The report argues that improving the adult social care requires the establishment and promotion of social care co-operatives.

Learning from existing social care co-operatives, it is shown that such innovation within the sector will empower service users and care workers, reduce profit leakage, and create a sector fit for the demographic and clinical challenges the country faces.

Our social care system is in urgent need of reform. Private companies profiteer, whilst older people, those who rely on social care and the staff that deliver it, pay the price. The market in social care services is broken – incentivising a race to the bottom on quality and workforce conditions, a lack of accountability, and de-personalisation of services.

Shrinking budgets and increasing demand has meant tighter eligibility criteria. Hundreds of thousands fewer people are getting help, and there is a financial imperative for local authorities to commission services at the lowest price regardless of quality. All the while the numbers providing care informally to family and friends is growing.

The social care crisis the UK faces is the result of current government policy. Since 2010, the government has created a care system this is inefficient, fragmented and faces a future of permanent crises. Whilst their rhetoric speaks of quality, choice and diversity, the reality could not be further from the truth: the sector now faces a shortfall of between £2.8bn and £3.5bn by 2020, squeezing eligibility, standards and working conditions.

This funding shortfall exacerbates the worst effects of the privatisation that has ripped through adult social care since the early 1990s. The shift towards the commissioning of services from within a competitive market of private providers should worry those who believe adult social care is a public good available to all rather than the few. Evidence shows this shift has had dire consequences for the availability of services, quality of care provided, working conditions and cost efficiency.

Care workers are exploited and underpaid. Studies suggest that around 160,000 care workers are unlawfully paid less than the National Minimum Wage¹. A HMRC investigation into eighty Care Providers found that almost half (47%) were not compliant with National Minimum Wage regulations. Carers undertake work that is difficult and critical for our society – they must receive the respect, and pay, they deserve.

At the same time, large chains of residential and nursing care homes, backed by private equity finance, persistently argue that they do not receive enough money from the state to look after older and chronically ill people. And yet their opaque models of ownership and governance allow the extraction of cash by investors and the piling up of liabilities.²

When frontline staff are squeezed by their employers, and owners seek higher returns on their investments, the quality of care falls. Domiciliary visits are shortened and high staff turnover undermines the relationship between the care workers and service users. Care workers are increasingly tired and over worked³.

1 Gardiner, L. (2015) *Resolution Foundation Briefing. The scale of minimum wage underpayment in social care*. Resolution Foundation.
2 Burns, D. et al (2016) *Where does the money go? Financialised chains and the crisis in residential care*. CRESC Public Interest Report.
3 Unison, the public service union. (2013) *Unison's ethical care charter*.

The Co-operative Party believes a new model of care is needed, one that uses the principles of co-operation to build upon the first-hand knowledge of those who rely, receive and provide care. It is care recipients, their families, and care workers who know how to create a care system that will deliver consistently high quality care. They should be allowed to lead the care sector.

A Co-operative vision for social care

The co-operative values and principles can build this new model of care. Our values are born from a history of ordinary people coming together to overcome their common problems. They are an important guide to solving the problems the UK faces today: one of which is how we provide care and support to increasing numbers of older people and those with long-term chronic conditions.

Co-operatives are based on the values of self-help, self-responsibility, democracy, equality, equity and solidarity. In the tradition of the co-operative movement's founders, co-operative members believe in the ethical values of honesty, openness, social responsibility and caring for others.

The co-operative principles are guidelines by which co-operatives put their values into practice:

1. Voluntary and Open Membership

Co-operatives are voluntary organisations, open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political or religious discrimination.

2. Democratic Member Control

Co-operatives are democratic organisations controlled by their members, who actively participate in setting their policies and making decisions. Men and women serving as elected representatives are accountable to the membership. In primary co-operatives members have equal voting rights (one member, one vote) and co-operatives at other levels are also organised in a democratic manner.

3. Member Economic Participation

Members contribute equitably to, and democratically control, the capital of their co-operative. At least part of that capital is usually the common property of the co-operative. Members usually receive limited compensation, if any, on capital subscribed as a condition of membership. Members allocate surpluses for any or all of the following purposes: developing their co-operative, possibly by setting up reserves, part of which at least would be indivisible; benefiting members in proportion to their transactions with the co-operative; and supporting other activities approved by the membership.

4. Autonomy and Independence

Co-operatives are autonomous, self-help organisations controlled by their members. If they enter into agreements with other organisations, including governments, or raise capital from external sources, they do so on terms that ensure democratic control by their members and maintain their co-operative autonomy.

5. Education, Training and Information

Co-operatives provide education and training for their members, elected representatives, managers, and employees so they can contribute effectively to the development of their co-operatives. They inform the general public - particularly young people and opinion leaders - about the nature and benefits of co-operation.

6. Co-operation among Co-operatives

Co-operatives serve their members most effectively and strengthen the co-operative movement by working together through local, national, regional and international structures.

7. Concern for Community

Co-operatives work for the sustainable development of their communities through policies approved by their members.

Most existing social care co-operatives in England are worker owned co-operatives, and some have elements of user involvement in their governance. The larger co-operatives in the social care sector tend to have either been established 20 to 30 years prior, or have emerged more recently as spin outs from local authorities. Co-ops UK report that there are 88 co-operatives delivering adult social care across the UK, with 1,706 employees and 4,607 members. According to the UK Co-operative Economy 2016 report by Co-ops UK, the total turnover of all social care co-operatives is £95.22m⁴.

The figures for England are smaller. As of April 2016 there were thirty-three Co-ops UK registered co-operatives delivering adult social care, with a reported total number of employees of 1,638 and an aggregate reported turnover of £50.98m. This represents less than 1% of the English adult social care market, which has 1.45m care workers and an estimated 17,300 organisations delivering care⁵. Such figures demonstrate that co-operatives have a long way to go before they are a significant operator in adult social care sector in England, but also that there is plenty of room for expansion in the short term.

The application of the co-operative values and principles, outlined above, to the care sector will result in co-operative growth via a number of pathways. In *The Co-operative Advantage*, Pat Conaty describes five 'strategic opportunity areas' in which social care co-operatives can be cultivated⁶ :

4 Co-operatives UK. The Co-operative Economy 2016. Available at www.uk.coop/economy2016.

5 *Skills for Care, The state of the adult social care sector and workforce report in England*, 2014, (Leeds, 2015). Available at www.skillsforcare.org.uk/stateof2014

6 Conaty, P. Social Care in Mayo, E (eds.) (2015) *The Co-operative Advantages*. Co-operatives UK Ltd. Manchester, UK.

'Strategic opportunity areas' for social care co-operatives

Pathways	Description	Challenges to overcome
Contracting	Open and competitive process led by a procurement body	<ul style="list-style-type: none"> ■ Difficult process ■ Opportunity and risk ■ High cost
Externalisation	Negotiated process to transfer staff and service to a co-operative	<ul style="list-style-type: none"> ■ Transfer of undertakings ■ Culture and management ■ Re-configuration
Partnership	Set up by a charity or voluntary body for the community as a co-operative service	<ul style="list-style-type: none"> ■ Ability to trade ■ Culture Change ■ Hard to let go
Society venture	New business set up by a co-operative society	<ul style="list-style-type: none"> ■ Poor return ■ Risk to the core brand ■ No appetite
New start	Started by stakeholder such as carers, activists and community backers	<ul style="list-style-type: none"> ■ Regulatory hurdles ■ Time and effort ■ Hard decisions

Applying co-operative values and principles, outlined above, within these pathways would necessitate the creation of a care sector very different to one we have today. It would mean the growth of not-for-profit care providers established as multi-stakeholder co-operatives, whose adherence to a high ethical standard of pay and conditions for their workers would be rewarded by a system of collaborative commission.

The characteristics of a co-operative approach

Not-for-profit

Our care services are damaged when they are privatised. Profit is not a suitable motive for delivering services to the vulnerable in our society, be they older people or those with chronic conditions. The motivation should be to help and care for those in need, rather than to exploit their situation. As such the future care sector should not include organisations paying shareholder dividends.

Multi-stakeholder model

Those who provide, receive and rely on care have the knowledge of how to deliver good quality, cost effective care. We believe in aligning the interests and knowledge of these multiple stakeholders through the mutual ownership of care services, and so envision care providers that are owned and ran by care recipients and their families, care workers and the wider community.

Worker rights

Commissioners of care services should adhere to an ethical standard, such as that within Unison's Ethical Care Charter, so that the race to bottom of workers' rights and pay, and therefore quality, does not continue. When workers' rights are neglected, everyone loses out: care recipients receive sub-standard care, their families have to step in, care workers are overburdened and underpaid (often illegally), and the NHS is hit with unnecessary admissions.

Collaborative commissioning

Commissioning of services is most effective when they utilise the knowledge of community representatives and patients. This means reform of the commissioning boards so they give equal weight to expert health and care commissioners, community and political representatives, and care recipients, patients and their families.

Examples of co-operative approaches in practice

Innovative commissioning authorities and providers are already putting into action many of these characteristics of the future care sector England needs.

Plymouth Council

Plymouth Council instigated a form of commissioning that learnt from and worked with other care providers and those receiving care. This knowledge improved the ability of commissioners to provide quality services to those in need. Responding to the co-operative values and principles, the Council defined their model of 'Co-operative Commissioning' as 'an approach that puts citizens and outcomes at the centre of commissioning and creates stronger relationships between key stakeholders. It looks beyond cost and 'value for money' to put greater emphasis on the social costs and benefits of different ways to run services'⁷

The impact of Plymouth Council's approach to commissioning was to advance the integration of health and social care services, ensuring the realisation of a 'whole person' approach locally in which public bodies responded to the unique needs of each individual.

Leading Lives

Operating in Suffolk, Leading Lives is an employee owned co-operative providing a range of services for vulnerable adults, including people with learning disabilities, with physical, multiple complex needs and autism, older people, young people in transition and family carers across Suffolk. The organisation was established by Suffolk County Council care staff who, believing their services were facing death by a thousand cuts, felt establishing a social care co-operative was a way to continue providing the services

Being a co-operative means that Leading Lives reinvests their profit back into their business, to improve services, and into the wider community. It also means the frontline staff are involved in the running of their organisation. The organisation recognises the value of the relationship between frontline staff and care recipients, and being a co-operative ensures this value is embedded within the organisation's governance.

⁷ Plymouth City Council. *Co-operative Commissioning and Market Management – A framework for delivering a brilliant Co-operative Council*. Available at www.plymouth.gov.uk/cooperative_commissioning.pdf

Southwark Council

As a commissioning authority, Southwark Council have done much work to recognise the value of frontline care staff, and to improve service quality by improving working conditions. This included signing Unison's Ethical Care Charter (app. 2), guaranteeing, amongst other conditions, that travel time between visits would be paid to domiciliary care workers and all would be paid at least the London Living Wage.

At the time of signing Unison's Ethical Care Charter in 2013, Cllr Catherine McDonald, cabinet member for adult social care, health and equalities, said 'It is utterly unfair that those who provide crucial home-caring services to our most vulnerable people are often forced to be on zero hours contracts, meaning no guarantee of work or pay. I believe that having a better paid, better skilled and well-motivated workforce in our community will help ensure high quality care, reducing unnecessary demand for hospital services and helping people stay in their own homes for longer, which is where they have told us they want to be'.

The report will now turn to specific policy recommendations required to make this vision a reality.

Policy Recommendations

Fulfilling this vision requires action by commissioning authority, central government, and the wider co-operative movement.

Recommendations for national government

Right to own

Public sector employees in health and social care currently have the 'right to request', allowing them to mutualise the service they run and turn it into an employee-owned enterprise. The Co-operative Party believes this right should be applied to those carers working for privately owned organisations as a 'Right to own'. When private organisations face financial difficulties they are often sold on to another private organisation or simply closed down. Under such circumstances a 'right to own' in the private sector would give employees first refusal on taking on part or all of their organisation, supported by patient capital investment.

Right to run

People who receive, rely on and provide care (care recipients, their families, and care workers) have the most sophisticated understanding of how to deliver good quality care. This knowledge should be respected, and given equal weight within the governance of private care providers. To hardwire the interests and knowledge of frontline staff and care recipients, a 'right to run' would require workers, care recipients and community representatives to be offered positions on corporate boards.

Regulator

The Care Quality Commission should level the playing field between co-operative and private care providers by modifying its inspection methodology to capture the ownership model of its registered providers. Currently all non-state providers are categorised as ‘independent’, undermining the ability of service users and their families, as well as commissioning authorities, to distinguish between for-profit and not-for-profit sectors. This would also allow users and commissioners to analyse the relative performance of different ownership models within care.

Asset lock

Where social care services are mutualised and moved outside the local authority they should be ‘asset locked’ to ensure that assets of all types (including any surpluses) are locked within the organisation or transferred to another asset-locked organisation on winding up. This is critical to preventing asset stripping or demutualisation as occurred with the building societies in the 1980s and 1990s.

National legislation

National policymakers should learn from Social Services and Well-being (Wales) Act 2014, which goes further than the Social Care Act 2014 by putting a duty on local authorities to promote co-operative organisations to deliver care in their area. An evaluation of the effectiveness of the Welsh legislation would provide the next steps for the legislators who wish to assist the growth of a co-operative care sector in England.

Recommendations for commissioning authorities

Co-operative Compact

Local authorities and their partner NHS bodies should develop a 'Co-operative Compact' with local co-operative and mutual organisations. Learning lessons from Islington Council's commissioning framework, this compact would set out how the statutory sector and co-operative enterprises will work together to deliver co-operative care in their area, identifying areas of need, promoting co-operative care solutions, and supporting the further development of existing co-operative care providers. The statutory sector will then have to develop an appropriate commissioning framework for delivering the agreed compact. This should include five-year initial contracts for social care co-operatives.

Co-operative Procurement

Public authorities procuring social care services should ensure that the unique benefits of co-operative and social enterprise delivery models are reflected within the evaluation of bids. This can be achieved using the Social Value Act 2012, which asks commissioning authorities to consider the wider value to community in their decisions. In retaining and reinvesting profits in their service and wider community, social care co-operatives offer a clear benefit to their community compared to private providers. Offering contracts that were suitable for co-operative providers would help to rebalance the social care market, ensuring fair competition between co-operative and for-profit providers.

Healthwatch

Local Healthwatch groups champion the rights of local people who use health and social care services. Created as social enterprises within the Health and Social Care Act 2012, they are currently governed by volunteer board members whose expertise or firsthand knowledge of health and social care is used to improve local services. Local Healthwatch groups represent the community on local authority and NHS decision-making boards.

The Co-operative Party believes Healthwatch groups can more effectively represent the interests of their local community if they are reconstituted as membership organisations, open to any person from their community, patient and care recipient, and with boards elected by that membership. Democratic reform would give Healthwatch more legitimacy, and precipitate their greater involvement within Commissioning procedures.

Recommendations for the co-operative movement

Mutual support

Co-operatives achieve the most when they support one another, acting together to serve their members. This report recommends establishing a sector wide network for social care co-operatives, enabling the sharing of best practice and advice. The network should aspire to be the foundation of collaborative working between separate social care co-operatives in the future on back office functions, such as IT or legal services. The network could be constituted as a federal, secondary co-operative.

Accreditation

The non-state, independent social care sector in England contains a number of organisational types delivering care. Many of these organisations have co-operative characteristics, but fall short of being constituted as fully co-operative or mutual enterprises. Although these efforts are welcomed, the co-operative movement should also recognise and celebrate those organisations within the care sector that are fully co-operative, as per the values and principles outlined in the introduction. This could be achieved through a sector led voluntary accreditation scheme, such as the proposed Fair Care mark⁸.

⁸ Change Agents. *Fair Care, The Three C's of Fair Care*. Available at www.changeagents.coop/Change_AGEnts/Fair_Care.html

Supporting community-led social care co-operatives

Community-led social care co-operatives should play a significant role in the future social care sector. These are co-operatives that are established by carers, community leaders and care recipients working together within their locality, rather than those co-operatives emerging as public sector spin outs or sector mutualisation in the social or private sector. Such community-led co-operatives play a significant role in the Italian care system⁹, and evidence shows micro-care providers, rooted in local relationships and with five or less employees, offer greater personalisation, innovation and value for money than larger providers.

The co-operative movement should assist the development community-led social care co-operatives. It can do this by offering technical and legal advice, financial and non-financial support, and supporting the creation of secondary co-operative organisations consisting of community-led start-ups.

The remaining sections of the report will discuss the social care crisis, how this produces an unequal market in the sector, and how the above recommendations relate to existing policy landscape influencing adult social care in England. This includes the current funding of care services, the personalisation agenda and direct payments, health and social care integration, the labour market, and finally recent legislative changes.

9 Conaty, P. (2014) *Social Co-operatives. A democratic co-production agenda for care services in the UK*. Co-operatives UK.

The social care crisis

For the purposes of this report, social care refers to those activities that aim to enhance the individual well-being of adults in England. This principle of ‘improving individual well-being’ underpins the aim of adult social care as laid out in the Social Care Act 2014, and covers a number of areas from personal dignity to protection from abuse, and from social and economic well-being to control by the individual over day-to-day life

The adult social care sector is large, with 1.3 million social care jobs in England (even when not counting those personal assistants working for direct payment recipients). In 2014 the sector employed 6% of the entire UK workforce¹⁰, and the direct economic value was estimated to be more than £20 billion per year in 2011/12.

Social care provision operates as a mixed market of public, private and voluntary organisations, and directly employed personal assistants, with funding for services coming from the public sector (local authorities and the NHS), from the recipients of direct payments, and from self-funding individuals.

Services are categorised as residential care, domiciliary care, day care or community care, and in 2014 there were 18,000 adult social care providers, 57% of which provided non-residential services and 43% provided residential services¹¹. Individual care needs addressed by the sector includes those associated with old age, physical disabilities, learning disabilities, and mental health.

It is accepted that the England faces an adult social care crisis caused by increasing demand for services at a time of reduced supply:

10 *Skills for Care. The state of the adult social care sector and workforce report in England, 2014.* (Leeds, 2015). Available at www.skillsforcare.org.uk/stateof2014

11 *Skills for Care. The size and structure of the adult social care sector and workforce in England, 2015.* (Leeds, 2015) Available at www.skillsforcare.org.uk

- The number of people expected to live to 85 or over is set to more than double over the coming decades from 1.5% in 2014 to 2% in 2024 and 3.6% in 2039¹².
- The numbers of people with chronic and complex needs living longer is growing, and the frequency of adults with learning disabilities is set to rise by almost a third over the next 20 years.
- Adult social care budgets have been declining since 2010, resulting in the tightening of eligibility criteria and the reduction in service levels (See Figure 1 on page 20)

These demographic changes created an additional cost pressure of 3% within 2016/17 alone, equating to a funding shortfall of £413m nationally, according to the Association of Directors of Adult Social Services¹³.

Since 2010 the government has responded in two ways. They have allowed local authorities to add a 2% precept onto Council Tax, ring fenced for care services, and have created the Better Care Fund, creating a local single pooled budget to advance integration of the health and social care services.

However, the Kings Fund argue that even if all Councils add the 2% optional social care levy allowed by central government every year for the next four years, there would still be funding short fall of £2.8bn to £3.5bn by 2020¹⁴. Research has also found that such financial constraints are undermining the progress of health and social integration, slowing the benefits of this initiative¹⁵.

Smaller budgets will mean a further tightening of local authority and NHS eligibility criteria. Currently 85% of adults over 65 live in local authorities that arrange services for adults with substantial or critical needs only¹⁶. Indeed, a survey of Adult Social Care Directors found that only 36% were 'fully confident' in their authority's ability to meet statutory care duties¹⁷

12 Office for National Statistics (2014) National Population Projections.

13 *The Association of Directors of Adult Social Services. ADASS Budget Survey 2016.*
Available at www.adass.org.uk/media/5379/adass-budget-survey-report-2016.pdf

14 www.theguardian.com/social-care-network/2016/jan/12/social-care-in-2016-the-financial-prospects-could-not-be-worse

15 www.communitycare.co.uk/2016/05/13/cuts-making-difficult-achieve-health-social-care-integration-warns-research/

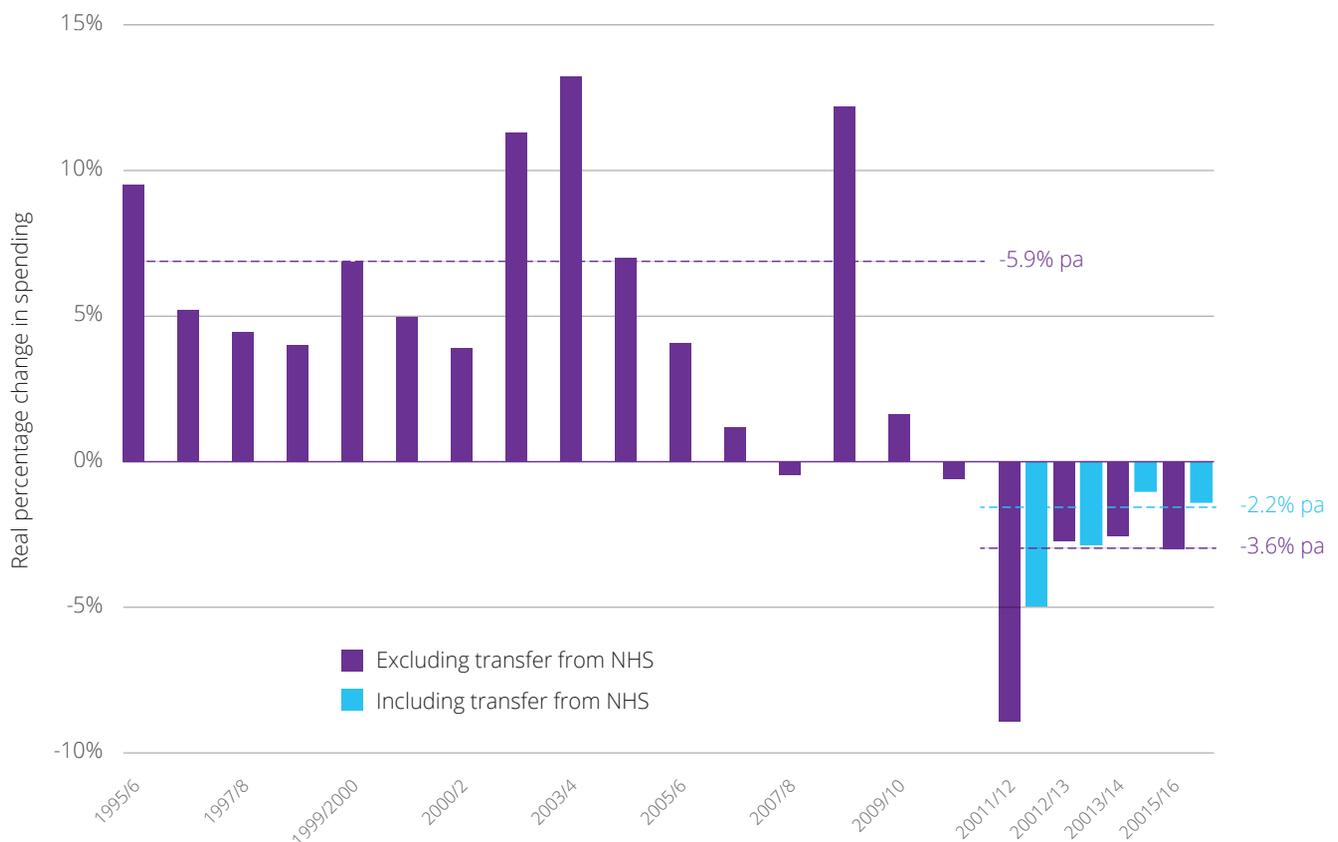
16 National Audit Office, *Adult Social Care in England*,

17 <https://www.adass.org.uk/media/5379/adass-budget-survey-report-2016.pdf>

Allowing providers to deliver shorter visits has become one way of reducing the cost of care in response to falling budgets. In 2012, almost three quarters of Domiciliary Care slots were for periods of 30 minutes or less, with one in ten for 15 minutes or less¹⁸. The result is that care workers are overworked and underpaid, and find it hard to develop meaningful relationship with their service users.

Beyond immediate concerns around the quality of care provision, the crisis is creating an unequal market in which private providers are willing and able to 'game' the scarcity by offering cheaper services delivered at scale. To understand how social care co-operative can intervene in this crisis, this report now moves to assess the broken market in adult social care.

Figure 1: Annual real change in net adult social care spending in England, with and without transfers from the NHS budget¹⁹



18 Angel, C. (2012) Care is not a commodity

19 Humphries, R. and Appleby, J. (2015) Social care: a future we don't yet know. The King's Fund Blog. Available at <http://www.kingsfund.org.uk/blog/2015/11/social-care-future>

An unequal market

The social care market is broken. It favours for-profit firms who cut costs on the back of employment conditions and service quality and punishes social care co-operatives, that are rightly unwilling to compete in a race to the bottom.

The crisis has developed in the context of a shift away from the state provision of care and the creation of a competitive market of private and voluntary care providers. Serious financial pressures have undermined the ability of local authority commissioners to construct well-functioning markets that deliver of the aims of social care.

The extent to which care services are delivered by local authorities in England has fallen dramatically in recent years. In 1993, 95 per cent of home care was provided directly by local councils, but this had fallen to less than 40 percent by 2002, and around 11 percent by 2012. Similarly, in 1979, 64 per cent of residential care and nursing home beds were provided either by local councils or the NHS, but this share had fallen to just six per cent by 2012²⁰.

The shift away from local authority delivered care was introduced for three reasons:

1. To offer those who received state funded care a choice over their care provider.
2. To create a competitive market of care providers that would keep the cost of care under control.
3. So that competition between non-local authority providers would lead to innovation and improved quality.

20 Centre for Health and Public Interest (2013) The Future of the NHS? Lessons from the market in social care in England. Centre for Health and the Public Interest (CHPI).

However, as demand for state funded services has increased at the same time as local authorities have had their care budgets reduced, contracts have often been awarded to those providers offering the lowest cost tenders. To enable delivery of services at competitively advantageous prices, providers of domiciliary care, for example, have moved towards shorter visits and billing per minute²¹.

This race to the bottom on price has driven down quality. The tenders awarded no longer cover the true cost of social care. The shortfall is picked up by the informal caring of families and friends of those in need, or is left unfulfilled and thereby leads to substandard care.

The Care Quality Commission (CQC) has also had its funding reduced, impeding its ability to ensure quality across the social care market. With an annual budget fall from £249m in the 2015-16 financial year to £217m in 2019-20, the CQC has reduced the number of inspections it undertakes of care providers²²

In this broken market, not-for-profit providers lose out. Larger private providers are more likely to have the technical ability to compete for local authority tenders, fulfill the requirements of large block contracts, and the responsive capacity to provide spot contract services.

They can also offer standardized services at scale, saving money through efficiencies, and are more willing to cut back on service quality and working conditions than those not-for profit providers with a social purpose²³.

This broken market is crowding out the potential innovation and quality that was the intention of the shift away from local authority provision. Research has found that micro-providers deliver more personalised, innovative and valued support for a similar or lower cost than larger providers. Such smaller enterprises have greater continuity of staff, greater staff autonomy and greater accessibility of managers compared to larger organisations²⁴. In the current commissioning environment such smaller providers struggle to compete.

21 <https://www.unison.org.uk/news/article/2014/12/15-minute-home-care-visits-in-england-on-the-rise/>

22 <http://www.communitycare.co.uk/2016/01/26/cqc-inspect-services-less-often-budget-falls/>

23 *Ibid.*

24 <http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/news/viewpoint/2015/06/micro-enterprise-small-enough-care.aspx>

Public investment

The Dilnot Commission

Declining levels of public investment in the care sector has created an unequal market that favours private providers. Seeking economies of scale by commissioning large private providers will only exacerbate the financial challenges, and lead to worsening quality and working conditions.

The Dilnot Commission was set up in July 2010 by the coalition Government, tasked with making recommendations for changes to the funding of care and support in England. It published its recommendations on 4 July 2011. The economist Andrew Dilnot chaired the independent Commission.

The commission's central recommendation was that the costs of care in later life should be shared between individuals and the state, with individuals paying for their own care until they reach a 'cap', after which the state pays for their care. There were four other key recommendations regarding the future financing of adult social care:

1. An individual's lifetime contributions towards their care costs should be capped at £35k, after which the individual is eligible for full state support.
2. People should still be liable for costs of accommodation and food in a care home, but this would be capped at £10,000 a year.
3. An increase in the threshold of savings and assets above which the state offers no help with care costs from £23,250 to £100,000.
4. Free care for life for all disabled children and anyone developing eligible care needs by the age of 40.

While both parties within the Coalition government supported these recommendations, when in government alone the Conservatives choose to postpone implementation of the cap from 2016 to 2020. Local authorities, citing the financial challenges of implementing the cap, welcomed this.

More recently the November 2015 Spending Review laid out an updated financial settlement for the NHS and adult social care in England that includes:

1. £8 billion real term increase in NHS funding between 2015-16 and 2020-21, of which £6 billion will be delivered by the end of 2016-17 (this is in addition to £2 billion increase in 2014-15).
2. A Council Tax 'precept' of 2% to allow councils to raise up to £2 billion a year for adult social care by 2019/20.
3. An increase in funding for social care through the Better Care Fund which, from 2017, will see an additional £1.5 billion a year provided by 2019/20.

However, as discussed above, these interventions will not be enough to ensure the supply of services meets future demand. Given this it is imperative that adult social care is delivered as efficiently as possible in the future without negating on quality. Evidence shows there are 'diseconomies of scale' within the social care sector, and that smaller micro-enterprises can deliver greater value than large providers delivering standardised services²⁵. This points to the expansion of multi-stakeholder social care co-operatives as a route to improving the cost of efficiency of the sector.

25 <http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2014/IRSPM-paper-hall-needham-allen-grassroots-panel.pdf>

Choice

The personalisation agenda

The personalisation agenda in social care shares many values with the co-operative movement, and is an opportunity for growth of social care co-operatives. However, where social care co-operatives do work with direct payment recipients, regulation is required to ensure standards.

The personalisation agenda passes control for social care budgets from commissioning authorities to those in need of care. This means that 'every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings'.

This requires the allocation of direct payments by social care departments to those deemed eligible for care. As of 2013/14 there were approximately 234,000 adults, older people and carers receiving direct payments, and that in 2014 around 70,000 (29%) of these individuals were using their direct payments to employ their own staff as carers.

The Health and Social Care Act (2001) set a duty on Councils to offer direct payments to all those eligible for care or support in their caring duties, leading to an increase in the number of direct payment recipients from 64,800 in 2008 to 234,230 in 2014. On current growth trajectories, direct payment recipients will continue to grow by roughly 10% per year.

Shifting responsibility for the purchasing of social care services to those in need is a sound principle, and as the number of direct payment recipients grows the opportunity for co-operation will increase if the NHS and local authorities provide the appropriate institutional support.

However, personalisation also carries risks, and it has the potential to undermine the rights, professionalism and standards of the social care workforce. The Co-operative Party believes that there is a need to regulate those personal assistants employed by direct payment recipients to ensure quality and standards in this service are maintained.

In the face of ever greater personalisation, multi-stakeholder co-operatives can be a means for ensuring the pay, conditions and rights of social care professionals held to an acceptable standard and that service quality is improved.

In Croydon, Caring Support is a multi-stakeholder co-operative, established by service users and carers, both paid and unpaid. It is a co-operative for the benefit of the community with exempt charity status. The organisation provides a high quality service that is underpinned by employees, families and service users having an influence on provision.

The founder of Caring Support had Multiple Sclerosis, and established the enterprise in response to her experience of care. Board members include service users, informal carers and care workers. Care is provided by personal assistants for a number of service users in a geographical location, who are in receipt of direct payments, individual budgets or private customers.

Using small geographical locations as a focus for service provision ensures that carers are local, even known, to service users and reduces travel expenses for the carers. This allows for a longer term relationship between the service user and carers and flexibility to cover staff absence and holidays.

Institutions

Health and social care integration

Co-operative principles can benefit the ongoing integration of health and social care by ensuring a whole person approach is guaranteed and making integrated commissioners responsive to the particular needs of the area in which they work.

Successive governments have sought to better integrate the funding and allocation of health and social care services. It is hoped this will break down service silos, find financial efficiencies, and create a wrap-around holistic approach that centres the wellbeing of the individual in service design.

Social care currently falls within the remit of a number of public bodies, but primarily the NHS and Local Government, and services are delivered by public, private and charitable organisations. This sector faces a large reform programme, with integration of health and social care services hoping to focus on the needs of the individual and embedding preventative measures that reduce unnecessary and costly hospital admissions.

Integration is being rolled out through two initiatives. The Sustainability and Transformation Plans (STPs) are 45 'footprint' areas covering the whole of England, each with its own plan to integrate the social care commissioning functions of NHS bodies and local authorities. These 'place-based' plans will detail how the NHS and local authorities will become financially sustainable over the next five years through integration. The shift to place-based commissioning via the creation of STPs signals the 'clear intent of national NHS bodies to move away from competition as the main driver of reform in favour of collaboration'²⁶.

26 http://www.bmj.com/bmj/section-pdf/918444?path=/bmj/352/8046/This_Week.full.pdf

The second route is through the deals struck between the combined city and county authorities, the NHS and central government. Manchester is at the forefront of this second path. In February 2015 the 37 NHS organisations and all local authorities in Greater Manchester signed an agreement with central government to take charge of health and social care spending and decisions in the city region.

This created ten locality areas across Greater Manchester, aligning the CCG and local authority commissioning functions to develop a single commissioning plan, pooled budgets, and integrated governance, decision-making and commissioning skills. Across Greater Manchester, the NHS bodies and local authorities have committed to pooling £2.7bn from a total health and care budget of £6bn.

NHS England have subsequently adopted the Manchester example as a framework to assess the viability of other potential devolution candidates within the STPs. As such, there is a possibility that other combined county and city regions will follow Manchester's lead and agree similar deals with NHS England and CCGs.

While integration progresses it is important that the voice of service users and carers has a place within governance arrangements. Only that way can integration move providers beyond seeing service users as a collection of single conditions and towards coherent services with a whole person approach.

Care demand is highly varied in quantity and type across the country. Applying co-operative principles to integrated health and care services will also make each local service more responsive to the unique characteristics and needs in that area. One means of achieving this is the democratisation of local Healthwatch groups, outlined above

Carers

The changing labour force

After a shift away from delivery of care services by local authorities over the past twenty years, most carers now work in the independent sector. Social care co-operatives can ensure worker's pay and conditions are maintained, whilst empowering carers within their workplace.

The personalisation agenda, a shift from local authority to non-state providers and an increase in the prominence of domiciliary care have led to a dramatic change in the size and character of adult social care jobs in England.

The number of adult social care jobs in England stood at 1.55 million in 2014. This number came after a 17% increase between 2009 and 2014. However, over the same period the number of adult social care jobs in local authorities declined by 27% (50,000) while jobs in the independent adult social care sector increased by 23% (225,000).

The majority of these increases are represented by increasing numbers of domiciliary care service jobs, which increased by 170,000, or 36%, between 2009 and 2014²⁷. This increase included 140,000 new jobs in the 'independent' adult social care sector and 35,000 jobs for direct payment recipients. As of 2014 the total number of domiciliary care jobs, 650,000, roughly matched the number of jobs in residential care services.

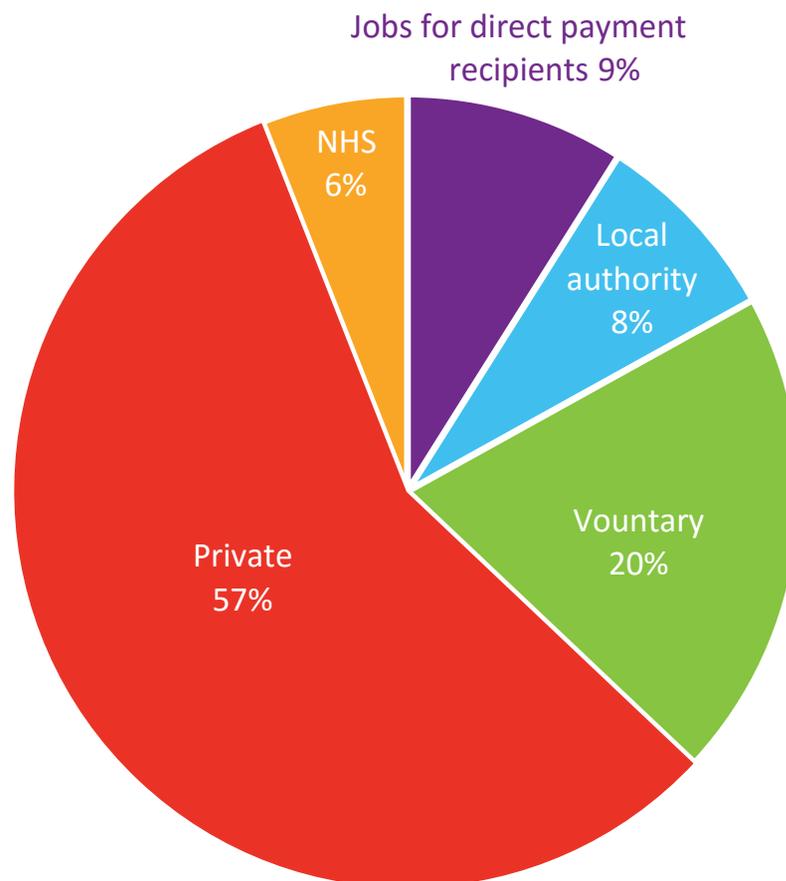
The main relevant changes in the adult social care sector since 2009 are:

1. The increasing size of the workforce (up 17% between 2009 and 2014)
2. The shift away from local authority services to 'independent' employers
3. The continued increase in the personalisation of adult social care services
4. The increase in the number and percentage of jobs in domiciliary care
5. The increase in jobs for care homes with nursing
6. The shift towards direct care providing job roles.

²⁷ Skills for Care, *The state of the adult social care sector and workforce report in England, 2014*, (Leeds, 2015)

Since 2009 the employer type distribution has changed considerably. The sector has seen a shift away from local authority jobs (14% of the workforce in 2009) towards jobs for independent employers and jobs for direct payment recipients (73% and 8% respectively in 2009).

Percentage of adult social care jobs in England by employer type, 2014²⁸



Given this, an emergent model of social care co-operation in England must be focused on transforming the independent sector and those carers employed by direct payment recipients. In England at least, debates regarding the relative merit of public and private provision do not reflect the proportion employed by each. Co-operative growth will occur for the most part within the 'independent' sector.

²⁸ Skills for Care, *The state of the adult social care sector and workforce report in England, 2014*, (Leeds, 2015) <http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/Size-and-structure/Size-and-structure-report-2015.pdf>

Legislation

Social Care Act 2014

Recent legislative changes in England require commissioners to create a diverse and sustainable markets for adult social care. This can give Commissioners scope to support the growth of social care co-operatives in their local area, and the impetus to resist the temptation to stand-by as the market consolidates around larger providers.

The Social Care Act 2014 consolidates existing social care legislation into one coherent legal and regulatory framework. The Act states that the core purpose of adult social care is improving wellbeing, which it defines as:

1. Personal dignity (including treatment of the individual with respect)
2. Physical and mental health and emotional wellbeing
3. Protection from abuse and neglect
4. Control by the individual over day-to-day life (including over care and support provided and the way it is provided)
5. Participation in work, education, training or recreation
6. Social and economic wellbeing
7. Domestic, family and personal
8. Suitability of living accommodation
9. The individual's contribution to society

The means by which a local authority can improve an individual's wellbeing is not set out in the Act. Instead a local authority should consider each case on its own merits, consider what the person wants to achieve, and how the action taken by the local authority may affect the wellbeing of the individual. This represents a shift from a requirement to deliver particular services to the concept of 'meeting needs'.

The Act also makes clear the responsibility of local authorities to take action to create a sustainable market that offers a variety of different high quality services and providers to those in need of care. The Department for Health's Guidance Notes accompanying the Act describe the range of providers that local authorities must encourage as including 'independent private providers, third sector, voluntary and community based organisations, including user-led organisations, mutual and small businesses'²⁹.

The extent to which commissioning authorities are achieving such variety of provider is unknown. Research undertaken by CRESC argues that in residential care there will be a shift to larger privately owned, purpose built care homes as the smaller 'mom and pop' firms leave the market³⁰. Such smaller firms are more likely to occupy older converted properties that are costlier to run and liable to expensive renovation works. Such market consolidation in care homes would go against the intent of the Social Care Act, and may in the future be grounds for a judicial review by the associational bodies representing co-operatives and social enterprises.

There is the further prospect of future market consolidation in the residential and community care sectors. Many of the organisational types listed in the guidance notes emerged from public sector spin-outs that successfully tendered to provide the services they previously delivered internally. The maximum length of these initial contracts was 5 years. It is possible that a number of these social enterprise spin outs could lose out to private providers when they have to competitively re-tender.

Policymakers overseeing the English care system could learn from the Social Services and Well-being (Wales) Act 2014, which goes further than the Care Act 2014 by putting a duty on local authorities to promote co-operative organisations to deliver care in their area. An evaluation of the effectiveness of the Welsh legislation would provide the next steps for the legislators who wish to assist the growth of a co-operative care sector in England.

29 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

30 www.cresc.ac.uk/medialibrary/research/WDTMG%20FINAL%2001-3-2016.pdf

Social Services and Well-being (Wales) Act 2014

Legislation passed by the Labour-led Welsh Assembly has gone further to support social care co-operatives than recent legislation in England. The 2014 Social Services and Well-being (Wales) Act includes a duty on local authorities to ‘to promote the development of new models of delivery in local authority areas through social enterprises, co-operatives, user-led and third sector services.’ As such this goes further in the encouraging development of social care co-operatives than the 2014 Social Care Act in England.

The Wales Act states that ‘In promoting social enterprises, co-operatives, user led services and the third sector (1) A local authority must promote—

- a. the development in its area of social enterprises to provide care and support and preventative services;
- b. the development in its area of co-operative organisations or arrangements to provide care and support and preventative services;
- c. the involvement of persons for whom care and support or preventative services are to be provided in the design and operation of that provision;
- d. the availability in its area of care and support and preventative services from third sector organisations (whether or not the organisations are social enterprises or cooperative organisations)’

This means that local authorities will be required to provide or arrange preventative services and promote the provision of these services through social enterprises, co-operatives, user-led services and the voluntary sector.

Gwenda Thomas, deputy minister for social services, said:

“The Act is a transformational and, I believe, a radical act. It is the most extensive and significant act to be passed by the National Assembly for Wales since devolution fifteen years ago. It will have a direct impact on the lives of many of our citizens, if not most of them.”

Conclusion

Co-operation offers a way for the adult social care sector to move beyond its current crisis, building care providers that work in the interests of those who give, receive and rely on care.

But new forms of care built on the values and principles of co-operation will only thrive when national governments and commissioning authorities take action to level the playing field between private and co-operative providers. The current model of commissioning favours those providers more willing to cut workers' rights and pay, and deliver a poor quality form of care.

Of course there is a no quick fix to the increasing demand for services associated with our aging population and the financial hole over the coming years. But, as this report has argued, a greater prevalence of social care co-operatives in the future will mean a sector that is more personalised, cost efficient, of higher quality and respectful of worker's rights. Research has shown that smaller, micro-providers, often led by small groups of people embedded within their local community, offer greater value for money than larger social care providers. Co-operation provides a model by which to grow such provision.

The wider co-operative movement has a significant role to play. By sharing knowledge of how to build and maintain co-operatives, focusing on the development of micro, community-led co-operatives, and celebrating fully co-operative providers with an accreditation system, the wider co-operative movement can play a significant role in overcoming the care crisis in England today.

Appendix

The National Audit Office lists the following as Adult Social Care services for users and carers

Advice and brokerage	Information and advice services covering care options, community support and financial benefits, and assistance in setting up packages of care or employing personal assistants.
Care homes	24-hour support in residential accommodation rather than care in an adult's own home. Includes meals and personal care, such as help with washing and dressing, permanently or short term.
Carers' services	Support to help informal carers in their role, including information, advice and training, respite care provided at home or in a care home, and direct payments to carers.
Day care	Centres open during the day providing opportunities to socialise and take part in activities, as well as providing respite for informal carers.
Direct payments	Payments either via a bank account or prepaid cards, for adults to buy their own care and support, often by employing personal assistants.
Equipment and adaptations	Modifications to the home, including wheelchair ramps, handrails, stair-lifts, walk-in showers, adapted toilet seats, and telecare (see below).

Extra-care housing	Community of self-contained properties for older adults, with on-site 24-hour support staff, care when required, maintenance and communal facilities.
Home care	Support provided at home to help with personal care tasks, or getting out of the house for shopping and leisure activities.
Meals	Hot or frozen meals delivered to adults who cannot prepare meals themselves.
Nursing care	A care home with 24-hour access to a qualified nurse.
Prevention and early intervention	Services aimed towards preventing more serious needs developing, including reablement, telecare, befriending schemes and falls prevention services.
Professional support	Active, ongoing therapy, support or professional input such as counselling from a social worker or other professional.
Reablement	Short, intensive period of support aimed at regaining skills, confidence and independence lost as a result of illness, injury or disability, normally provided in someone's own home.
Supported living	Schemes that support younger adults to live independently in their own homes. Support can include domestic and personal care, and help with tasks such as searching for jobs and claiming benefits.
Telecare	Technology used to help care users remain independent and safe. Examples include pendant alarms, bed and door sensors, and key safes.

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