Kirklees Solidarity Economy Network

Cooperate with Care

Developing Community Social Care Cooperatives in Kirklees

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Introduction: crisis and cooperation

It is hardly worth asking whether the adult social care system is in crisis. A better question would be 'Why might cooperation offer a better way?' The answer to that lies in the main features of the current crisis:

- An ageing population and fuller recognition of the rights of vulnerable people to decent care have exponentially driven demand.
- Inadequate public funding, especially since 2010 and the shift to austerity. The Dilnot Report (2011) recognised that the sector was in crisis and a more stable system of funding was needed.
- At the same time changes in benefit and social care funding systems with the Care Act (2014) aimed to put care recipients and carers in control of buying services. However, the amount of support available for those who could not contribute themselves has not matched that paid in by individuals who can, with about a 25% (and growing) gap. Put bluntly, there is increasing inequality between those who have enough money and those who don't.
- Meanwhile private sector market share rose from 5% in 1993 to 87% by 2012, driven by price as Local Authorities sought ever cheaper care creating a 'race to the bottom' effect. This has led to the insolvency of some private social care companies such Southern Cross. The number of insolvencies is growing as the financial situation of councils becomes more desperate.
- To maintain profitability private providers have inevitably sought to cut labour costs. This in turn has led to exploitation, very high staff turnover, low pay, lack of loyalty, limited training and career progression opportunities and low morale.
- Predictably in such a person-centred sector, declining staff pay and conditions have led to issues with the quality of the service as measured by the Quality Care Commission (QCC). In some cases, such as at Winterbourne View in Bristol (2011) criminal cases of abuse have surfaced.

It's tempting to say that more money will fix the problem - and it is certainly needed! But this is unlikely to be forthcoming in the near future and would not address all the issues in any case. As important is the ***way*** care is delivered and ***by whom***.

The purpose of this brief ideas paper is to argue that a shift of policy by Kirklees Council towards Social Care Cooperative provision would make a real difference. At the core of the argument lies some simple and well-tested principles concerning the value of cooperation and the nature of cooperative organisations. In particular, it argues for the roll out of the Multi-Stakeholder Cooperative model, as developed in countries like Italy, Japan, Canada and France. However, it is likely to require some adaptation to fit with current UK realities. In the context of the social care sector the key stakeholders are:

- Service users and their families
- Staff
- Volunteers from the wider community

- Kirklees council and other commissioning/grant giving bodies

It follows that if a cooperative approach has any validity it must meet the needs of these stakeholders better than the existing, privately dominated one.

There are solid grounds for optimism. In Italy the social care cooperative sector now has over 14,000 individual social care coops delivering a wide range of services, a workforce of over 400,000, a turnover of 9 billion euros and is serving over 5 million people. The outstanding feature of the coops is that they are small, with most employing less than 30 workers and having 100 stakeholder members. They link together within consortia to pool back office functions, share costs, engage in joint-tendering to bulk purchase goods and services. Each new co-op is committed to upholding the 'strawberry patch principle' and send out at least one 'runner' to create a new coop in its vicinity, ensuring growth and vibrancy in the sector. So 'small' is not only beautiful, but also mighty.

Finally, the paper looks only at *adult* social care in the knowledge that Children's Services require deliverers to operate in a completely different and rightly more demanding legal and regulatory framework. It has also been written particularly with elderly citizens in mind – 2/3rds of adults receiving social care are aged 65 or over. Although academic style referencing is avoided for ease of reading some useful sources are included at the end.

Cooperating to meet the needs of multiple stakeholders

There are many forms of cooperative enterprise, including consumer, worker and community coops. But at the heart of each are the basic principles of cooperation established by the pioneers of the movement in the 19th century. These assume that cooperative enterprises will have voluntary and open membership, democratic member control, members economic participation, organisational autonomy and independence, promote education, training and information, cooperate with other cooperatives and be motivated by concern for the community.

All these admirable and necessary qualities are embodied within the multi-stakeholder cooperative model. However, it's important to recognise that while the various parties will have shared needs and interests – otherwise cooperation would be impossible – there will also be differences and even potential conflicts. So its worth briefly stating what these *needs* and *interests* might be and how cooperation could help.

Service users and their families

Vulnerable adult social care service users have a wider variety of individual needs based on their age, family resources, health, chronic conditions, economic resources, housing situation and so on. The modern social care system and legislative framework rightly recognises the importance of *personalisation* - that individual service users, carers and families have unique circumstances and are usually better placed to make key decisions about their care.

A range of needs could be identified including:

- Direct care and support delivered by dedicated carers in their home
- Cleaning
- Gardening and maintenance
- Access to transport
- Advocacy and welfare advice and support
- Meals on wheels and help with online shopping
- Meeting/interacting with other people and socialising to promote wellbeing and end isolation

Multi-stakeholder cooperatives would be well placed to meet these needs because of their ethos, size, location, governance and accountability.

This model would promote social care coops that are relatively small-scale and deliver services to particular geographical areas or social groups, allowing them to take root and build up relationships within specific neighbourhoods and with local voluntary organisations like churches, community groups and schools. Moreover, they seek to mobilise volunteers and establish systems and opportunities for regular interactions between service users, their carers, families and the wider community. Digital technology, as outlined below, can

also play a significant role in networking individuals. So social care coops offer the chance to combine individual empowerment and a sense of wider community within a Solidarity Economy. They are therefore more likely to challenge social isolation and loneliness than conventional models.

As pay, terms and conditions of staff will tend to be better than under private models there is also the benefit of lower staff turnover, higher morale, better training and thus higher quality provision. All this will improve the experience of service users.

An important positive feature of this model relates to governance. Small scale care coops with management boards that involve service users and their families as key stakeholders will be more responsive and likely to deliver personalised care. Size will matter as more authentic human relationships will be fostered, but still within an overall professional context which emphasises accountability.

Staff

Successful social care provision is ultimately about people interacting in a kindly, friendly and consistently helpful way. But at the same time paid staff must be positively motivated, operate efficiently, act professionally and follow rules and procedures within a legal and regulatory framework. Continuity is particularly important in the sector and anything that limits the unacceptably high levels of turn-over within an increasingly casualised workforce will be helpful.

Stated bluntly: if you treat staff badly they are less likely to do their job well and leave.

So, staff needs must be recognised and met:

- Decent pay, terms and conditions with secure employment status once the probationary period has been completed
- Regular training and career progression
- Trade union rights and representation
- A genuine say in how the enterprise is managed
- The chance to work close to where you live

The multi-stakeholder model offers paid worker members the chance to shape decision making and safeguard their legitimate rights. A greater share of any profit can go towards boosting the pay and improving the conditions of worker members - good for them and the service users. If a genuine spirit of cooperation and mutual respect operates within each enterprise and the sector as a whole, higher levels of motivation and commitment can be expected. After all, ultimately coop worker members are part-owners of the business and have every reason to work for its success. At the same time, the fact that worker members share governance with service users and representatives from the community will help promote a culture of accountability and balance power within the coop's structures.

In the UK context, the creation of multi-stakeholder coops offers a golden opportunity for trade unions to be fully engaged with their creation, maintenance and even the recruitment

of potential staff. This would not only advantage trade union members but also help further root and connect coops with wider society.

Volunteers and community involvement

It has become commonplace in government to call for more civic engagement and voluntary/community involvement in public service delivery. But the potential for *organised* voluntary support, as opposed to the ongoing *informal* support offered by millions of dedicated carers and families has yet to be fully realised. Cooperative enterprises have a track record of acting as intermediary organisations between the state and the public.

The Japanese model of cooperative social care may offer some features that could be applied here. The cooperative movement in Japan operates largescale health coops across all aspects of the sector covering 3 million household members through 120 coops with 1300 branches. Interestingly, it also mobilises volunteers in over 26,000 Han Groups. Each Han group has 10-20 members and promotes mutual aid, self help and healthy lifestyles. These often highlights issues like food and exercise. Thus care users are part of and supported by networks within the wider community.

While the idealist within us would hope this admirable form of mutual aid could simply be replicated here the realist might say 'hang on a minute!' The Han Group model doesn't sit easily with dominant British cultural norms and expectations which tend to be more individualistic. People are encouraged to think any form of 'legitimate' work has to validated by money payment and there is often less sense of community than in Asia.

So if we are to cut with the grain of British culture it may be necessary to incentivise community participation by meeting volunteer needs:

- There are 6.3 million unpaid carers in the UK, many of whom are isolated. Many of the families and carers of service user members would welcome the opportunity offered by the coop to share worries and help each other out in a safe, organised setting. In effect, the coop would be *formally* recognising the value of the *informal* care they already do.
- Feeling valued - respect and recognition for any contribution. The potential to gain satisfaction by working cooperatively with others, make friends and quite simply have a laugh!
- Some form of compensation would be welcome given the poverty of many Kirklees residents, but the current benefit system offers little potential for cash payments without it being treated as income and therefore reducing benefit payments. But cash payment for travel expenses and childcare paid for directly, alongside vouchers/payment in kind for meals and clothing if required would be feasible.
- Similarly, social 'virtual' currencies with volunteers/carers earning and exchanging time credits for their mutual benefit could operate. For example, volunteers with caring responsibilities could bank hours and cash them in to 'buy' some respite care delivered by other volunteers.

- Training and the possibility of moving from volunteering into paid employment – especially valuable for women whose careers have been interrupted by caring or family commitments

Not only can volunteer members be represented on the managing boards of coops, but they can also be important agents within the community, identifying problems early on and tackling loneliness and isolation in more authentic ways.

Summary of key features of social care coops' community volunteer and family carer engagement strategy

a) Formally recognise the importance of community volunteers and family carers as an essential part of the cooperative structure

b) Community volunteer and family carer democratic representation on the Board of management

c) Specific part of staff remit to involve, educate and nurture voluntary community activity. Coop to provide full induction and training, with appropriate background checks and induction

d) Volunteers and family carers to be respected as ancillary support for teams of paid staff, who will retain full authority and responsibility for service delivery and decision making within the terms agreed with service user coop members

e) Seek to incentivise volunteers and carers by using digital social currencies, such as Time Banks to reward and compensate their efforts

f) Principle that no volunteer or carer will be directly out of pocket due to activities with the coop will apply, so all valid expenses, bearing in mind the rules of the current benefit system, will be met including uniforms, meals, costs of childcare, travel etc.

g) Develop systems and partnerships so that volunteers can move into paid employment

Kirklees council and other commissioning/grant giving bodies

Given that Kirklees Council would be the primary commissioning body any system of social care coops will have to meet its needs. Much here depends on the council's strategic and operational policies and priorities, but obvious boxes that would need to be ticked might include:

- Retain money spent within Kirklees – promote the 'Kirklees Pound'

- Be effective at encouraging service users to stay in their homes and avoid more expensive care further down the line
- Be able to ensure that the council meets its Statutory Obligations
- Be based on sound research with proven successful examples to draw upon
- Be cost effective and if possible reduce the amount of expensive back office oversight and contracting functions undertaken by the council
- Be accountable and provide measurable levels of care and resources as defined by the Quality Care Commission
- Be able to offer health prevention and educational outcomes. Involving community volunteers as far as possible will encourage early prevention and action to manage care
- Be able to encourage communities to be more resilient and sustainable

It is easier to see how social care coops could indeed meet these needs when some of the practicalities are considered below.

Summary: what is going to be different in terms of *ethos*, *practice* and *outcomes* in concrete terms?

The following table seeks to clarify the key features by contrasting them with those of private providers who currently dominate the sector

	Private provider	MSH Coop
Ethos and motivation	Private ownership Bottom line = profit Care as a **costed commodity**, priced by the hour and measured in commercial terms within the context of the current benefit and public procurement system	Member owned Not-for-profit Care as a **personalised service** measured in humanistic as well as commercial terms within the context of the current benefit and public procurement system
Power, management structure and staffing	Board of directors or individual owners make policy and agree strategy CEO and managers within a hierarchical structure – based on top-down instruction Staff accountable to managers representing interests of owners Stand-alone commercial operations, often of large size to achieve economies of scale and facilitate contracting functions	Member elected Management Board representing multiple stakeholder interests – staff, service users and community Day-to day decision making within more horizontal and democratic structures. More egalitarian teams which aim to release professional and personal skills and potential. Staff accountable to service users/community through elected Management Board on which they also have representation Individual, relatively small sized locally based coops working cooperatively with *consortia* to share back office functions, achieve economies of scale and facilitate contracting functions
Outcomes	**Success** measured by: • market share • meeting CQC standards • targets and cost p/h of care contracted with Council • profitability	**Success** measured by: • market share • meeting CQC standards • meeting personalised targets for service user members defined within **Independent Service Fund** agreements negotiated by all relevant coop members and the Council • Staff skills, satisfaction, motivation and retention • Extent of genuine volunteer engagement through the coop by community members and/family

Practical Cooperation: How might it work?

As an ideas paper this is not intended to be a detailed operating manual for any future local cooperative social care sector. Nevertheless, building on previous examples of care coops in the UK and abroad a plausible model of organisation can provisionally be identified that would have the following basic features:

Expanded ethos, aims and remit

Modern companies and public bodies love drawing up high-faluting mission statements. But for ethical commitment the principles of cooperation set out on page 4 are hard to beat! At their heart lie a deeply optimistic view of the potential of human beings to interact and assist each other. Given the dire state of the current social care system and the ultimate profit-based bottom line practices operated by many providers this sort of ethos can only be a good thing.

But more specifically, multi-stakeholder social care coops, motivated and run along cooperative principles, are much more likely to develop a more humanistic and holistic approach to delivering the service. So while direct care provision to vulnerable adults lies at its heart, other more expanded aims could be simultaneously be pursued. These would include:

- Involving members of the community to promote the sorts of befriending and health prevention strategies employed by Japanese Han groups but in a less formal way
- Networking individuals to tackle loneliness and isolation using both traditional means and new digital technology
- Promote local economic growth and resilience

Small is mighty

A striking feature of the Italian system of social care cooperatives is their highly local and small-scale nature. This helps *humanise* the system so that people, especially older people, are less likely to be shunted along a quasi-industrial style system of social care according to priorities decided in a top-down manner. Instead, the democratic, pluralistic model of multi-stakeholder management boards encourages service user interests to lie at the heart of decision making.

Smaller organisations mean that more responsive personalised relationships can develop. A local, community-based approach would be important if the coops are to a develop serious and effective volunteer networks. The ideal here would be for people who live near service users to pop in and when emergencies happen respond flexibly and promptly. Similarly, loneliness and isolation have serious health effects, so there is a clear preventative function.

Consortia

While small-scale, locally rooted coops are envisaged that operate autonomously day-to-day, every coop would be expected to assist in setting up at least one other. In Italy this has

worked well and should be a must here to develop the overall strength of the sector. But growth is also essential for survival. Unless individual coops cooperate with each other within consortia they will be unable to:

- Share risks and costs, such as recruitment, IT, training, advertising, research and development, procurement etc
- Seek and secure external funding as efficiently
- Talk with a single voice when negotiating and interacting with the local authority and other external agencies
- Facilitate advice sharing and foster horizontal, democratic culture of knowledge sharing

Governance, quality standards and accountability

Of the four main stakeholder member groups that would be involved in the delivery of social care, realistically only service users and their families, staff and community volunteers are likely to be represented on individual coop management boards. However, it may well be desirable for representatives from Kirklees council or other outside relevant bodies to have some formal input into consortia. The exact proportion of representation from different stakeholders would presumably vary from coop to coop and arise organically, but it's worth noting that there are several models that could be considered from existing examples from the UK and other countries.

Any system of governance has to have accountability and care quality at its heart, with all stakeholders fully understanding, collectively agreeing and implementing quality control systems. Regular communication between management and members to ensure a healthy, democratic accountability culture within the coop must apply. So – concretely - from the outset it is important to assess what is going to be different in people's lives after the implementation of social care coops compared with the current system? For instance, will they be involved in more social and community activities, will they have more independence or less dependence, and if so in which activities? Tools that encourage the service users' perception of goals for themselves, such as the "Canadian Occupational Performance Measure" could work for cognitively intact people who can set their own care targets.

But there are also potential governance challenges as multi-stakeholder coops have different interests represented at Board level. There are no simple solutions to prevent clashes of interests – perhaps on one level it would be unnatural as well as unrealistic to expect them not to occur. Clearly, a well-developed cooperative ethos that permeates all levels of the organisation will help. So too will getting the balance of representation right on the Board, so that professionally skilled members work alongside service user/community member representatives without either wholly dominating. For example, in Italy Type A coops can have no more than 50% of board volunteer members, while in Canada it is a third. Italian Type B coops discriminate positively to employ workers from disadvantaged groups (minimum of 30% of total workforce), such as the disabled. Over 60% of all social care coops in Italy involve volunteers in decision making.

The importance of digital

Digital technology offers the opportunity to develop cheaper, more innovative ways of working.

- Better communications between all stakeholders to aid democratic governance, including online voting systems
- Social media options to help tackle isolation in online forums
- Better communication between staff and service users to identify issues and help meet needs. This could include alarms in cases of crisis
- Individuals can use digital resources to co-design with staff their care plan, empowering all concerned
- Online monitoring and quality control systems
- Linking staff and volunteers for mutual aid, advice and support. For example, the Dutch **Buurtzorg Neighbourhood Care System** uses an internal social network to link up with a colleague with specific expertise. Nurses can post questions on a Facebook-like platform and share knowledge in a bottom up decentralised way and it is well-used by staff.
- Develop social digital currencies and time banks to incentivise and reward volunteers and member carers that could be repaid by help from others – a sort of solidarity swap-shop!

To fully develop the potential and share costs of digital technology it would be clearly important for individual coops to work closely with others within consortia.

Income and non-financial support from existing agencies

It is highly likely that social care coops would be well placed to attract start-up funding from sympathetic 'social solidarity' types of capital providers, such as cooperative banks, and possibly state grants. Similarly, there are sources of free business advice and support services from within the Cooperative movement and other government agencies. But ultimately, while social care cooperatives will function as non-profit making enterprises, they must balance the books and set aside reserves for future investment like any other business.

Adult social care is means-tested and two thirds of those receiving it are over 65. Only c. 20% of older people get public financial help via local authorities, the main public commissioning agency. Another c. 12% pay for it themselves and the rest either receive no help (c. 30%) or are cared for by family and friends (c. 37%). Public funding as a proportion of social care has been declining in real terms since 2011/12, but did increase marginally in 2016/17. However, local authorities' statutory duty and a genuine desire to help vulnerable adults in need means that they have tended to protect this sector with the percentage of spending attributed to social care remaining relatively constant since 2010/11.

In many ways the crisis in the social care system can be characterised as one of local authority finance. Councils have introduced a series of 'efficiencies' to try to cut costs, including reducing back office functions, limiting eligibility for assistance, early prevention and care strategies and above all employing private sector providers who offer services at lower prices. The average price p/h paid for care was £14.58 in 2016 compared to the minimum price demanded by the providers' trade body of £16.70 p/h. In other words, councils have been forced to cut their own provision, which employed workers at higher rates with good terms and conditions, and contracted to private for-profit providers who pay lower wages and have worst terms and conditions. Even so, margins are so tight that bankruptcies and market failure is increasingly a problem.

One important development that could erode the incentive for councils to contract out to for-profit providers are changes to the National Minimum Wage (NMW) and National Living Wage (NLW). The government's target is for the NLW to be 60% of median earnings by 2020, estimated as around £9 p/h. All this is relevant as Multi-Stakeholder Social Care Coops will aim to provide the best possible pay and conditions for staff and thus be relatively better placed to compete on price if private providers are forced to pay higher wages too.

If a widespread network of coops is established, negotiating and contracting through consortia, there may also be scope for councils to reduce the amount spent on contracting and oversight. A key argument here is that care coops working flexibly in partnership with local councils to deliver more personalised care in line with their statutory duty under the 2014 Care Act can offer efficiency savings for the council who would not have to spend so much on expensive contracting and regulatory back office functions and picking up the bill when things go wrong.

Personalisation of budgets is likely to be a key factor and opportunity for nascent social care coops. In 2013-4 c.234,000 adults, older people and carers received direct payments, with 29% of these employing their own staff and carers. It is envisaged that the number of direct payment recipients will continue to grow by roughly 10% p.a. Given the potential of coops to provide higher quality, more personalised care with more motivated staff there is every chance that they can compete successfully for this section of the market.

However, the relationship with Kirklees Council as the key public commissioning body will be crucial for viability. From a local authority perspective there are clear advantages to encouraging the growth of locally rooted social care coops including local sourcing policies through the Kirklees' pound, a commitment to community-based solutions and sustainable voluntarism, their potential for meaningful health prevention outcomes and potential to tackle social isolation. Hopefully, the ethical value of cooperation will also weigh heavily in favour of the project.

FURTHER READING

www.uk.coop/**Owningourcare**report

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