OWNERSHIP IN SOCIAL CARE

WHY IT MATTERS AND WHAT CAN BE DONE

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This short paper sets out a vision for adult social care as a Universal Basic Service, with an emphasis on the achievement of social goals. It is one of a series of working papers developing proposals for Universal Basic Services (UBS).

The New Economics Foundation supports UBS as central to its mission to develop a new social settlement. In this context, 'services' mean collectively generated activities that serve the public interest, 'basic' means essential and sufficient, enabling people to meet their needs, and 'universal' means that everyone is entitled to services that meet their needs, regardless of ability to pay. UBS is about exercising collective responsibility to meet needs that we all share. The aim is to improve the quality and reach of existing services such as healthcare and education, and to extend this approach into areas such as care, housing, transport and access to digital information. These services represent a 'social wage', providing essentials that people would otherwise have to pay for. They are part of our 'social infrastructure' and should be treated as an investment that yields social, environmental and economic benefits. This approach is closely aligned with the UN's Sustainable Development Goals and is a crucial strategy for realising them.

INTRODUCTION

Adult social care has received extensive press coverage in recent years due to failures to treat people with dignity and to meet their needs. High-profile reports like those from Panorama reveal a service far from fulfilling its mission to support people to lead the life they want, regardless of age or disability.

Much of the debate has focused on the need for more investment in social care. After a decade of cuts to local government funding, the care system is under huge pressure. It now seems that, despite a series of delays to the publication of a green paper intended to address this issue, there may be more political will to pay for care. Boris Johnson claimed in his first speech as prime minister that his government will "fix the crisis in social care once and for all". After the December 2019 election, the prime minister pledged to provide a plan for solving social care with a year and to introduce changes by 2025.

As well as improving access to social care, more public investment – if accompanied by the right set of policies – could put real momentum behind efforts that are already being made by some local authorities to address entrenched problems within social care provision. With services almost entirely outsourced, there is a long-term trend towards an increased role in the provision of domiciliary and residential care from chain companies with an ownership model that concentrates power among shareholders. A change in direction is imperative, as social care – already a major sector of the economy – is set to grow. The Personal Social Services Research Unit projects that the number of younger adults needing support in England will rise by 32% by 2030, while the number of older adults needing support will rise by 41% by the same year.[1] Just to maintain current entitlements to care will require between 450,000 and 750,000 new jobs.[2] The choice facing policymakers, both local and national, is whether to let services continue to develop in a way that is extractive, drives inequality through low-paid, insecure jobs, and puts downward pressure on the quality of care, or to intervene.

This short paper focuses on the issue of ownership in social care. Drawing on analyses by the Centre for Health in the Public Interest (CHPI) and the Centre for Research on Socio-Cultural Change (CRESC) at the University of Manchester, among others, we outline patterns of ownership in social care and set out why ownership matters. Rather than reinforcing a top-down model of private ownership, we argue that any new money for social care should be used to support new forms of democratic ownership that shift power to care workers and, above all, to people needing support, their families and communities. Short-termist, cost-driven, competitive tendering should be scrapped and

replaced by public-social partnerships, where the local state collaborates with socially-driven, not-for-profit organisations. Shaping service provision and its relationship to the state in this way has the potential to drive improvements in care quality through refocusing on a core purpose of supporting people to lead the life they want. It can also help to provide better jobs for a growing workforce, to increase the resilience of local economies, and to build more connected, resourceful and powerful communities.

OWNERSHIP AND WHY IT MATTERS

Ownership patterns

In the 1970s social care services were largely delivered by the state. Today services are almost entirely outsourced, with the private for-profit sector playing the biggest role. In residential care, for example, 83% of beds are provided by for-profit organisations, 13% by the voluntary sector and 4% by local government or the NHS.[3] Both public and private money is spent on these services. In 2016/17 the total value of care arranged by local authorities was £20.4 billion, while care purchased by those who self-fund without local authority involvement amounted to £10.9 billion.[4]

Domiciliary and residential care markets remain relatively dispersed, but there is a long-term trend for smaller providers to be bought out by large chain companies. The biggest four residential care companies, for instance, are responsible for 15% of residential care provision, and just under a third (31%) of all beds are provided by the biggest 25 companies.[5] If things do not change, it is reasonable to assume that the market share of chain companies will increase in years to come, above all in residential care where they have the major advantage of easy access to capital, which they can use to update old homes and build new ones.[6] A more generous funding settlement for social care could have the side-effect of propping up their business model and reinforcing their monopolising trend.

Why it matters

These ownership patterns stem from reforms that were introduced to develop a mixed economy of care and to offer those using social care services a choice over their service provider.[7] The post-war model of delivery, centrally controlled by Whitehall, was said to be paternalistic. Reflecting the rationale used to justify reforms across public services – from education to the NHS – giving people a choice in a quasi-market was argued to be a means of decentralising decision-making and thereby aligning services with people's wants and needs.[8]

The problem is that the marketisation and privatisation of social care has not decentralised decision-making in the way that proponents claimed it would.

Firstly, it has not given people meaningful control over social care services, neither enabling them to shape the services on offer nor the service they will eventually use. The Care Act 2014 does recommend that commissioners in local authorities treat the shaping of social care provision as a "shared endeavour" with "people with care and support

needs, carers, family members, care providers and representatives of care workers, relevant voluntary, user and other support organisations, and the public".[9] Yet there is little evidence that the Act is changing practice. The National Audit Office notes that some local authorities are struggling to manage and support their local care market, and are moving towards fewer, larger contracts to achieve economies of scale.[10] Continued pressure to reduce overall spending is a major barrier to genuine engagement with people needing support, their families and communities – who are too often treated passively as consumers, rather than active producers of their own care.

Secondly, it has not given people a meaningful choice over the type of service provider. The original vision of a mixed economy of care has been superseded by the dominance of the private, for-profit sector. Neither the voluntary sector, nor local authorities – which pay staff more and offer more secure working conditions[11] – have been able to compete.[12] Most people can only choose between private, for-profit providers.

Ultimately, top-down state services have largely been replaced by top-down private services. The provision of care increasingly resembles, in the words of the Royal Society for the encouragement of Arts, Manufactures and Commerce (RSA), a "factory production line" – which delivers a series of pre-determined tasks focused on the basics of survival, like helping people get washed, dressed and fed. A 2016 UNISON survey found that more than half (58%) of domiciliary care workers have been given just 15 minutes or less to provide personal care, sometimes for people they had never met before. The majority (74%) said that they do not have enough time to provide dignified care.[13]

The consequences are wide-ranging. Social care loses its relational quality and people have less say over what the support they receive looks like. Care workers are put under pressure while having very little autonomy in their roles, and they do not receive a decent wage or, increasingly, job security.[14] Turnover is high – close to three times higher in the private sector than in local authority-provided care[15] – which makes it even harder for people needing support to build relationships with care workers. Money is spent on frequent cycles of recruitment, rather than invested in care worker training, or improvements in pay and working conditions.

As the role of chain companies becomes greater, services are becoming more and more homogenous – defined far from the point of delivery. In residential care in particular, chain companies have become adept at extracting money out of the social care system, generally by adopting practices known to be at odds with care quality in order to save money. They are building 'Travelodge' style homes with between 60 and 70 beds, using floor plan layouts that minimise the number of care workers needed per bed.[16]

Moreover, the extractive model of chain companies, combined with their complex and risky financial structures, is increasing the instability of social care provision. Many providers rightly argue for a sustainable funding settlement that will enable local authorities to pay an adequate price for social care. But if more money is channelled towards chain companies it will shore up business models that seek to make a profit out of care without having a strong sense of social purpose or adequate mechanisms of accountability built into them.

DEMOCRATIC MODELS OF OWNERSHIP AND PRACTICE

The case for an alternative approach is clear. This need not mean a return to top-down state control of services. While the post-war welfare state did a huge amount to improve people's lives, it perpetuated a deeply flawed model of care and support, treating disabled and older people as passive recipients of services and affording them little control over those services. The disability rights movement set out to challenge the paternalism inherent in this approach.

The number one priority for reform of social care provision should be to shift power towards people needing support and carers, both paid and unpaid. This means putting the principle of co-production at the centre of social care. Co-production describes a particular way of getting things done, where the people using services and those providing them work together in equal and reciprocal partnership, pooling their diverse knowledge and skills. The strengths of people needing support are valued, rather than overlooked, and they have a genuine say in how services work.

Key to achieving this is to move away from short-termist, cost-driven competitive tendering towards public-social partnerships between the state and diverse, decentralised providers with ownership structures that enable people to have a greater stake and control over the care that is provided. These alternative ownership models must be:

- **legally bound to follow a clear social mission**.
- **accountable to people needing, and those providing, support**. This means shifting to more co-operative models in which services are owned and run by employees and/or people receiving support and their families (see Box A for an example). It also means a much more significant role for local authorities, as public bodies that are democratically accountable to their local communities. Those that develop a culture of working in co-productive ways will be well placed to provide more care.
- **organised at the smallest appropriate scale**. This does not necessarily imply that providers will be small. A proliferation of small organisations can be an important part of a local social care eco-system. Community micro-enterprises – which are social businesses, often set up by just one person to provide care and support – have been found to be particularly good at certain kinds of innovation. Compared to bigger providers, they are more likely to be run by disabled people,

to offer support to diverse groups and to be flexible in the ways in which they provide care (see Box B for more details).[17] But large providers can find ways to work at a human level too. Buurtzorg – a Dutch model of neighbourhood care – employs more than 10,000 nurses, who work in small, self-managing teams. With decision-making devolved to them, they are able to co-create support with the people they help. Their care is of a higher cost per hour than the typical alternative – but it is also of a higher quality, so much so that people only require half as many hours to be delivered (see Box C for more details).

Changing the balance of social care provision to favour these forms of ownership and practice could create multiple overlapping benefits. It could improve the quality of care and the quality of jobs by promoting relational approaches and distributing control to people needing, and those providing, support. It could build local wealth by supporting the development of diverse locally-owned and socially-minded organisations, and ensuring public, as well as private, money flows towards those organisations. Overall, it has the potential to contribute towards a more impactful, sustainable and resilient care sector, where every pound of investment works harder to achieve social value for local communities.

Box A: Cartrefi Cymru – a multi-stakeholder co-operative supporting people with learning disabilities in Wales

Cartrefi was established in 1989 by a group of parents and activists who wanted to ensure that people with learning disabilities had the opportunity to live in their local community, rather than large institutions. Much of their work is in rural Wales, providing support for tenants of housing associations. Their core purpose is to enable the people they support to enjoy a good life, with good health, a secure home, positive relationships, whilst being in control and making a contribution.

In 2016, Cartrefi became a multi-stakeholder co-operative, enabling them to build co-production into the governance of their organisation. Co-operative membership is open to people they support, employees and community supporters. They have a democratic structure to give members control over the organisation, including an elected representative body (the Council of Members) who are involved in decisions on strategy and remuneration, and appoint the management board. Now they are one of Wales' largest support providers, employing 1,200 people, supporting 650 people and working with thousands of friends, family members and supporters.[18]

Box B: Community Catalysts – a social enterprise accelerating the development of community micro-enterprise across the UK

Founded in 2009, Community Catalysts is a social enterprise that works through local partners to help people set up small local ventures providing care and support in diverse ways. By harnessing talents and imaginations, they look to catalyse creative approaches to health and social care, with the goal of ensuring that everyone can get the help they need to live the life they want.

The organisation works in an embedded way in communities, employing a single coordinator or 'Catalyst' who supports local residents to turn their business ideas for care into micro-enterprises. At the same time, they partner with the local authority and help them understand and build the cultures and systems that will create an enabling environment for creative approaches to care.

Over the past ten years, Community Catalysts has worked in more than 60 areas across the UK and supported the development of more than 5,000 micro-enterprises.[19] They use a range of business models, from unformed community groups to formally constituted community interest companies and charities. Most of those that deliver care at home are run by one person, working on their own. Examples range from providers of personal care to peer support groups, art classes and dance companies. They have been found to offer better value for money than larger providers, giving more personalised support, delivering more valued outcomes and being better at certain kinds of innovation.[20] Micro-enterprises are spread across different regions of the country. There is a particularly large presence in the south west, reflecting the rapidity with which they have developed in Somerset.[21] Concerned about gaps in domiciliary care provision in rural areas, the local council approached Community Catalysts with the aim of stimulating 50 micro-enterprises. They are now on course to have 600 micro-enterprises up and running by 2020. With the help of the local Catalyst, the micro-entrepreneurs have formed a self-organising network, comprised of various different local groups that communicate via WhatsApp and meet once a month to support each other, share good practice, and introduce each other to people looking for care and support. For the council, who are under huge pressure due to deep funding cuts, the investment in micro-enterprise is paying off: the micro-enterprises are delivering savings, while doing a better job of achieving outcomes than traditional domiciliary care agencies.[22]

Box C: Buurtzorg – a Dutch model of district nursing and domiciliary care

Buurtzorg – which translates as 'neighbourhood care' – is famous for pioneering an innovative approach to domiciliary care in the Netherlands. The social enterprise was founded in 2006 by a small group of nurses who were frustrated by reforms that undermined their ability to build relationships with the people they were supporting. They believed that people would have more control over their own care if nurses were empowered to work in a more autonomous way with them.

Since then Buurtzorg has grown fast, notably taking on more than 3,000 of the workers who lost their jobs when the Netherlands' largest private domiciliary care provider, TSN, went bankrupt in 2016.[23] Now it employs more than 10,000 district nurses, who work in small, self-managing teams and have the autonomy to genuinely co-create support with the people they help. The teams of nurses are supported by a light but effective infrastructure of 15 coaches, 45 back office staff, and an IT system for sharing knowledge, information and advice.[24]

Buurtzorg has been voted the Netherlands' best employer in four out of the past five years.[25] The care it provides is of a higher cost per hour than the typical alternative – but it is also of a higher quality, so much so that people only require half as many hours to be delivered.[26] These successes have inspired similar approaches in other countries, including in the UK where Wellbeing Teams are spreading across a number of local authorities and have recently been rated outstanding by the Care Quality Commission, England's health and social care regulator.[27] The model illustrates that large organisations can find ways to provide high-quality care at scale, if they are committed to making sure that power and control are dispersed close to the relationships between people needing, and those providing, support.

HOW TO GET THERE

The question of how to claw back the role of markets and private provision in social care is a difficult one. Writing for the CHPI, Bob Hudson argues that "the privatisation and marketisation process has gone unchecked for so long that there is now no feasible prospect of simple and total reversal".[28] Repealing these processes should be the end goal, but change will need to be gradual, beginning with curbing the role of the worst offenders – those failing to provide quality care and prone to recurrent crisis because of their financialised business models – while at the same time supporting the development of, and channelling investment into, new and existing democratic models of ownership and practice. Drawing on recommendations made by NEF in our report on doubling the size of the UK's co-operative sector[29] and by the Co-operative Party in their report on a co-operative vision for social care in England,[30] we suggest a number of ideas as a starting point.

Recommendations for national government

- **Create a 'right to own', giving employees first refusal to buyout care providers at the point of business transition**. In residential care 30% of beds are provided by small businesses with one home. CRESC note that the "buoyant nature of the UK housing market provides a strong temptation for family providers to sell up and cash in".[31] Supporting employee buy-outs could help to counteract the trend towards these homes being bought out by chain companies when they come up for sale.
- **Give local authorities new powers to buyout providers that are either failing or consistently providing poor quality care**, who can run them or support workers, residents and family members to run them as multi-stakeholder co-operatives. All of the 'big four' providers of residential care were up for sale between April to July 2018. As recently as April 2019, Four Seasons Health Care Group – one of the largest providers of residential care – went into administration and was put up for sale by its creditors.
- **Direct resources towards support for co-operative care transitions and business development.** Co-operative Development Scotland and the Welsh Co-operative Centre have proven successful in building the capacity of the co-operative movement in their countries, and above all in promoting employee takeovers of companies in transition. In NEF's 'Co-operatives Unleashed' report, we recommend establishing a new Co-operative Development Agency in

England and one in Northern Ireland.[32] These could play a pivotal role in helping people needing support, their families and care workers to set up social care co-operatives and to take ownership of care businesses in transition.

- **Improve access to investment with not expectation of quick or high return for the co-operative, mutual and social enterprise sector**, so that they are able to play a much greater role in the provision of social care and, above all, residential care.
- **Strengthen the Care Act 2014 by placing a duty on local authorities to promote diverse forms of democratic ownership across domiciliary and residential social care provision.** This duty would be part of local authorities' market shaping role, which already requires them to "stimulate a diverse range of care and support services" to ensure that "people and their carers have choice over how their needs are met and that they are able to achieve the things that are important to them".[33]

Recommendations for local government

- **Direct a growing share of social care funding each year to public sector, co-operative and community-based providers**, while setting a top-line objective within local economic strategies for an increase in the provision of care from diverse forms of democratic ownership that can act as challengers to private, for-profit providers.
- **Build capacity within local authorities and the voluntary, community and social enterprise sector to play a greater role in the provision of care**, mapping and understanding care needs, what long-term roles the statutory and the voluntary sector might play in meeting those needs, and what skills and support are necessary for those roles.
- **Develop collaborative, rather than competitive, forms of commissioning.** Local authorities should reimagine their role – with the necessary funding from central government – as a "coral reef around which symbiotic agencies thrive".[34] Through public-social partnerships, they should shift from short-termist, cost-driven competitive tendering to a trusted partner system, able to give – and of course terminate – long-term grants to socially-minded, accountable providers.
- **Commission for co-production**, opening up the commissioning process to people needing support and their families, and using commissioning to

encourage local providers to design and deliver social care services with the people intended to benefit from them.

CONCLUSION

Adult social care has undergone a dramatic transformation over the past 40 years. Today services are almost entirely outsourced, with the private for-profit sector playing the biggest role in a quasi-market where providers compete, largely on the basis of cost. Despite the promise of more choice and control, power has largely been transferred from top-down state services to top-down private services. Care is standardised with little power for those working in or using services. The rise of chain companies – which maximise their profits by adopting practices known to be at odds with care quality – is making matters worse.

This paper argues that any new money for social care should be used to shift power to people needing support, their families and communities, as well as frontline staff. By supporting diverse forms of democratic ownership and practice, policymakers can help to build a more impactful, sustainable and resilient care sector that provides high-quality care at the same time as building local wealth. Without this ambition, a new funding settlement for social care will prop up a failing system – and miss the mark altogether.

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