

Social Co-operatives

a Democratic Co-production Agenda for Care Services in the UK

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Summary

Hardly a month goes by without another horror story in the press and media about a disturbing state of affairs in our health and care services. The prosecutions at Winterbourne View, the massive collapse and public sector rescue of Southern Cross are symptomatic of a national care service system in crisis. Is there a democratically accountable ownership model for health and care services that could make a difference? Quite simply, could the active membership and co-operative governance of workers, service users, volunteers and family members rebuild public trust in care services and put an end to cruelty and neglect through an ownership transformation solution by stakeholders that is socially inclusive? These fundamental questions are the focus of this study.

This report reviews best practice in the co-operative health and social care services; and through a comparative review, draws lessons from international experience of relevance to the UK. In a growing number of countries from Europe to Canada and Japan, diverse co-operative models of social care are expanding and developing creative new systems of accountability with dynamic forms of inclusive community membership and ownership.

The Development of Co-operative Care

In 1980, Alex Laidlaw, Secretary General of the International Co-operative Alliance, called for co-operative sector innovation in care and welfare services. Even prior to this the Italian co-operative movement has been at the forefront of innovation in the provision of social and health care services. During the fiscal crisis of the late 1970s, they pioneered a Social Solidarity Co-operative system that enabled workers, volunteers, service users, family members and providers of co-operative capital to become member stakeholders in the governance and ownership of care services. A rather different but also successful programme of innovation has developed in Japan, especially over the past thirty years. Setting up effective and distributed institutional structures in both Italy and Japan has been crucially important.

New Italian legislation in 1991 fostered national expansion through the introduction and active promotion of flexible and multi-stakeholder legal structures supported by an enabling fiscal and policy framework. Alongside active partnerships with a growing number of local authorities, these strategically oriented changes opened the gateway for a renamed 'social co-operative' movement to take off.

What makes social co-operatives unique is that they both celebrate and prove that 'small is beautiful' and they do so through dynamic forms of associative democracy. Most Italian social co-operatives have fewer than 30 worker-owners and less than 100 other stakeholder members. Remarkably they are able to maintain a human scale and operate efficiently by innovative systems of co-operative consortia that enable many local social co-operatives in a town or city to share back office services, pool training, transfer knowledge peer-to-peer and engage in joint tendering and bulk purchase of goods and supplies.

This collaborative economy system has enabled small to become powerful. To maintain and diffuse this system of local resilience and diversity, each new social co-operative has a mutual aid obligation to set up another. This additional 'social solidarity' enterprise mission has helped expand the network governance system. Through a practice known in Italy as the 'strawberry patch' principle, each social co-operative is obliged to put out a runner and thus plant horizontally at least one offspring.

The international evolution of multi-stakeholder care co-operatives

The success and strong growth of the model in Italy since 1991 demonstrates its potential. Today there are more than 14,000 social co-operatives in Italy delivering a wide diversity of care services. The sector has now come of age with a work force of over 400,000, an annual turnover of more than €9 billion and service provision to over five million people.

Recognition of Italian success has been spreading across Europe and similar care co-operative models have been developed, albeit with changes and adaptations, in Portugal, France and Spain and, in somewhat different ways, in Finland, Poland and Hungary as well. Greece has recently passed legislation to follow suit. Quebec in Canada was in fact the earliest adopter of the multi-stakeholder model from the mid-1990s.

The development of care co-operatives in the UK since 1990 has been slower but good practice is evident. Indeed some co-operatives in the UK are delivering home care services at scale. Care and Share Associates (CASA) has expanded into a number of regions in England through a social franchise pathway. The Childcare Co-operative and the Foster Care Co-operative are also highly successful and have spread nationally.

General Practice (GP) co-operatives expanded to provide national coverage between 1995 and 2004 but restructuring changes introduced since then has led to a drop in their market share. Notwithstanding this set back, in some cities and other regions, GP co-operatives are widening their stakeholder base and adapting to change. South East London Doctors' Co-operative (SELDOC) is a good example and provides a service for the boroughs of Lewisham, Southwark and Lambeth.

A number of local authorities are investigating co-operative care solutions or experimenting with micro-providers like Community Catalysts in Nottinghamshire. Additionally, large multi-stakeholder mutuals in community health services have emerged since 2011 in West London, Kent, Essex and Lincolnshire.

The growing UK policy interest in models of co-production is at present in need of a democratic legal structure to deliver stakeholder ownership and shared governance systems. Much can be learned from good practices developed by disability rights organisations.

Key qualities of social co-operatives

Social co-operative multi-stakeholder models across are a unique and dynamic form of democratic social enterprise. They are spreading across Europe and have their roots in the Social Solidarity Economy movement that has been strong for decades in Italy and southern Europe. Social co-operatives in Italy have a strong track record and have shown how to scale up co-production and embed this in genuine and democratic forms of mutual ownership and governance. This review has found that there are several key developmental issues and challenges where strategic guidance is vital to position a social co-operative agenda so that it is primed for success in England, Wales and other parts of the UK.

First, the involvement of multiple stakeholders in the ownership and governance of co-operatives is not straightforward. How to balance sometimes conflicting areas of interest poses major management challenges. Experiences with these models in Italy and Japan over more than 30 years and in Quebec for more than 15 years can be drawn upon for guidance.

Second, collaborative partnerships are crucial to success both with local government and other commissioning bodies but also with co-operative capital investment partners ranging from social banks to community development finance institutions.

Third, digital technology, volunteer involvement and social currencies can be used creatively to reduce organisational and management transaction costs and to mobilise the co-delivery of services. The Seikatsu Co-operatives in Japan and Elder Power in Maine, USA offer exemplary best practices.

Fourth, co-operative consortia enable co-operatives to collaborate effectively, procure jointly, secure social finance, pool risks, share research & development and replicate services more rapidly. Aligning these institutionally through distributed and interdependent co-operative structures is a sine qua non to expand nationally.

Fifth, open source information, action-learning set education and the fostering of a 'social solidarity' culture of collaboration can facilitate peer-to-peer knowledge transfer and cultivate the development of horizontal forms of economic and associative democracy.

Sixth, care quality marks need to be developed to certify, maintain and enhance standards. Involving stakeholders in the ownership and governance of social and health care services enables transparency, accountability and trust to be built. Low-cost social accounting metrics like Prove It and the Balance Scorecard can measure well-being, aid ongoing improvements of service and build credibility.

The opportunity for developing a new co-operative model for the UK

The report spells out in considerable detail a positive, practical and democratic agenda for collaborative action to develop social co-operatives for care and health services as well as other sectors, including employment for ex-offenders. Legal changes may not be necessary as existing worker co-operative, community benefit society and multi-stakeholder legal models in the UK for social co-operative should enable strategic implementation to be advanced. Some bespoke multi-stakeholder co-operative models have also been developed in recent years.

The current policy interest in co-production could become just a passing "fad" without the membership and ownership structures needed to embed and empower citizens. Social co-operatives are a proven model to learn from and if adopted can ensure that current best practice in social innovation in the UK can develop strong roots and empower communities over the long term.

It is essential to recognise that social co-operatives are a distinctly democratic form of social enterprise. The International Co-operative Alliance has agreed a set of legal principles. The report indicates how existing forms of social enterprise and voluntary services could be converted into social co-operatives. France, for example, has developed a framework to enable this to happen. There is a crucial requirement for an enabling policy agenda (including tax incentives, mutual guarantee societies and co-operative capital systems) to be co-developed by key stakeholders and backed by government. The recommendations in the report are drawn from both UK and international best practice and can help frame what is required for the implementation of a national strategy for social co-operatives to thrive and to flourish in the years ahead.

1. Introduction

Since the introduction of the NHS there has always been a strong tension between health services that are free at the point of delivery and social care services that have to be paid for - typically from local authority funds, through welfare benefits for the disabled or from other forms of individual and family financial contributions. Against a rising pattern of demand from an aging population, this split between a statutory free service and a limited local government resourced service has meant that social care has been beset over the years with a funding crisis that has become acute since 2010, as local authority cutbacks have deepened.

Many service users have to top up from (private) income and savings. Quality and continuity of care from one area to another is highly variable. Private providers have been involved in the health sector in the form of GPs and dentists since the founding of the NHS, but providers have now become dominant in the social care market. Whether or not there is any correlation with this development, the conditions of the workforce have worsened, especially in recent years with austerity pressures.¹ 15 minute in-and-out provision for home care has become the norm, while research by Age UK and Leonard Cheshire Disability has shown that such marginal provision is not adequate and cannot take the place of rigorous, sensitive and dedicated social care.²

The National Health Service and Community Care Act 1990 came into force in April 1993. While community-based care services and forms of social enterprise have existed since the 1970s (and in some forms even earlier), this legislation diversified the provision of a wide range of social care services from the public sector to the third sector and the private sector.

Since 1993 there has been some growth in care provision by the charitable sector as well as within the co-operative sector and the wider social economy. However this expansion has been far outstripped by the huge growth in market share by private sector providers. In recent years encouraging new growth trends have emerged in the provision of care by social enterprises.

Since the 1980s, other developed economies in Europe, North America and Japan have diversified their social care provision more successfully. Most notably in Italy and Japan, there has been a dramatic growth in the role of the co-operative sector as a large and innovative provider of social care.

This review of social care has considered what lessons the UK can learn from the expanding co-operative sector markets and practices in Italy and from the growing co-operative care services in Quebec, Canada and other countries. This and other UK evidence have been analysed to help inform the development of a new strategy for Co-operative Care services in the UK. The methodology adopted for completing this review is set out in Appendix 1.

1 See: <http://www.docare.co.uk/docs/business-clinic.pdf>.

2 See: <http://www.lcdisability.org/makecarefair?gclid=CNWhubq5sboCFRIptAoden0A2A> and www.ageuk.org.uk/Documents/EN-GB/Campaigns/care_in_crisis_2012_policy_report.pdf?dtrk=true

2. Background: Crisis and opportunity

Social care and other related health services have been much in the news. The conviction of 11 care staff of Winterbourne View in Bristol in 2012 for the abuse and maltreatment of vulnerable people has highlighted some of the worst problems in the system. Underlying problems appear to be endemic.

The collapse of Southern Cross and its 750 residential care homes indicated that the privatisation model for care was in trouble. Despite the rescue, a significant number of the 31,000 older people are said to be in homes with no long-term certainty about a future provider.

The sale and leaseback financing model for care homes developed by private equity investors and used by Southern Cross is common throughout the private care sector. Indeed care company insolvencies have been growing year on year from 35 in 2010 to 73 in 2012. The debt burden on residential care homes in the private sector has swelled to £4.5 billion.

Age UK's report and national campaign, Care in Crisis, highlights what they describe as a 'catastrophic' impact of a 15.4% cut in funding for social care services – a drop of £1.2 billion since 2010 against rising demand from an aging population.³ Research by The King's Fund is showing that cuts in home care are costing the NHS more, as elderly people cannot be discharged from hospitals because the right care cannot be secured for them at home.⁴

Private sector market share in the provision of home care services has expanded from 5 per cent in 1993 to 87 per cent at the end of 2011. The home care workforce in the private sector is now over 350,000, compared to 48,000 employed in the voluntary sector and 36,000 employed by local authorities.⁵ Price has driven this switchover with Council services operating at rates of £35.50 per hour for in-house home care provision compared to private sector charges at an average of £14.60.⁶

Most of care provision, in the formal and informal economies, is done by women.

The UK Home Care Association (UKHCA), the trade body for care providers, has produced data to show that, based on payment only of the minimum wage, national insurance, holiday pay and typical overheads, this works out at a minimum charge for local authorities of £15.19 per hour of care provision. The Association of Directors of Social Services recommends that Councils adhere at least to this minimum.

However, social care costs account for one-third to half of local government core budgets. The pressure to make savings is evident from the latest research. According to a BBC File on 4 investigation, a large number of local authorities are buying care for far lower than £14 an hour.⁷ The BBC found only 4 out of 100 local authorities paying the £15.19 minimum rate recommended by UKHCA. While most Councils pay more than £11, the BBC reported that the current average rate has dropped to £12.26. File on 4 researchers found rates with one London borough of £9.47 and a North West council paying £9.09. The BBC revealed that nine out of ten Councils have not been increasing their rates in line with the retail price index.

3 http://www.ageuk.org.uk/Documents/EN-GB/Campaigns/care_in_crisis_2012_policy_report.pdf?dtrk=true

4 Charlie Cooper 'NHS not ready to deal with growing number of elderly. Independent, 6 March 2014.

5 Source: UK Home Care Association.

6 Jon Ungoed-Thomas and Hannah Summers 'Home care chiefs cash in as elderly suffer', The Sunday Times, 10 February 2013.

7 Fran Abrams, BBC File on 4, 4 February 2014.

In a 2012 review (based on 13,000 inspections), the Care Quality Commission (CQC) found that one in five care homes and one in ten nursing homes failed to provide service users the food and drink they need.⁸ The CQC report found that the vast majority of care homes, nursing homes and home care providers failed to meet the minimum standards for providing their staff “proper training, supervision and development” support. Many providers failed to manage medicines properly and to keep records adequately.

Low pay is pervasive in the private care sector. In the home care sector, eight out of ten workers are estimated to be on zero-hour contracts.⁹ The non-payment of the travelling time of carers between home visits has been found to be common. This practice enables agencies to pay below the minimum wage because they only count ‘contact time’ as work time. A study by Kings College London in 2011 estimated that 150,000 to 220,000 care workers are being paid below the minimum wage in this way.¹⁰ This research has led to a crackdown by HMRC that has been issuing £20,000 fines to seek to curb this practice.

There has been a growing differential between what local authorities pay contractors through block contracts to procure care for those on the lowest income and what older people above the means test pay for care themselves. Recent comparisons show a cost of £636 per week to be the average charge made by care homes in England.¹¹ This charge is 25% above the rate paid under block contracts. The charges do vary regionally, but an approximate 25% premium charge is common. For example in the North West, the open market rate is £710 per week against a regional block contract average of £580 per week.

The Government policy move towards direct payments is a shift away from block contracts towards individual procurement through choice. But this runs the risk of higher rates for the poorest. Without a Council’s negotiating power, how would prices charged not incur the premium retail rate? While on the other hand, how can a living wage be reconciled with austerity and cuts, as a result of which Councils are driving down the pay for carers? This is clearly a double-edged sword leading to an evident and growing pattern of ‘lose-lose’ scenarios impacting upon both those needing care and the workers providing the services.

How might workers, service users and care providers secure and structure a fair trade deal? Co-operative systems and structures can provide an answer.

In July 2011 the Dilnot report called for a new funding model for care services and pointed out the danger of a race to the bottom with local authorities increasingly strapped for funds post 2008 and seeking ever lower cost provision with predictable consequences. With the support of innovators in the social enterprise sector, can the co-operative movement provide a creative solution to this crisis that might be aligned to the new more stable funding regime that Dilnot has called for?

In Italy, a democratic and multi-stakeholder model of care services has emerged in recent decades and has developed extensively on a national scale. This Social Co-operative model is unique in ways that:

- (i) Empower paid staff, volunteers, service users and family members through methods of co-production that enables them to design and shape services and improve well being;
- (ii) Make creative links to local authority purchasers and secure trade union support to improve and develop both public and community-based services;

8 Tim Ross ‘Care Quality Commission: Elderly denied dignity and respect’, *The Daily Telegraph*, 23 November 2012.

9 Vidhya Alakeson ‘Zero-hours contracts must be a two-way street’, *The Guardian*, 25 June 2013.

10 Randeep Ramesh ‘How private care firms have got away with breaking the law on pay’, *The Guardian*, 13 June 2013.

11 Robert Chamberlain ‘Is it just me.....?’ *CMM* December 2013.

- (iii) Attract low-cost, social solidarity forms of capital through mutual guarantee funds that in turn leverage investment from co-operative banks and social finance organisations.

The Italian movement has grown to over 14,000 social co-operatives that employ over 360,000 people and share an aggregate sector turnover of €9 billion annually.

The success of this innovative model has inspired action to introduce and adapt it in other countries. Social Co-operative is the generic name (internationally recognised by both the International Co-operative Alliance and the European Union) for co-operative organisations that have a multi-stakeholder membership (including paid staff, volunteers, service users, family members of service users and social solidarity citizen investors). Other names used for Social Co-operatives internationally are 'Solidarity Co-operatives' (Quebec), 'Co-operative Societies for the General Interest' (France) and 'Social Care Co-operatives'.

Today social co-operatives or their equivalent are operational in Quebec, Canada and within a growing number of EU countries including France, Spain, Portugal, Finland, Poland, Greece and Hungary. There are other key lessons from Japan that has a similar movement. This review has appraised the prospects for such a multi-stakeholder co-operative model to be developed strategically in the UK.

3. Social care co-operatives and co-production: the context of England and Wales

A global revolution is underway. New forms of horizontal provisioning are challenging the twentieth century world of large and dominant hierarchical institutions. Uffe Elbaek and Neal Lawson have described this transformation as a new 21st century landscape that will have a profound impact on welfare states in Europe.¹²

'The old vertical institutions, where knowledge was power, are corroded from within and without. No one can command because no one is in control. Power is dispersed. Complexity abounds. All that is solid melts into air. The old clunking icebergs of the state and corporation dissolve into a sea of people who can think, talk and act for themselves. But in this permanent state of fluidity, action only becomes meaningful in concert with others. The waves of change demand interconnections to flow. The vertical and the solid are giving way to the horizontal and the liquid.'

In the 1970s futurologists predicted that, in the decades ahead, there would be a move away from mass manufacturing to forms of tailored production, and that consumers would become more and more involved in collaborative relationships with producers.¹³ Today there is ample evidence of co-production and collaborative consumption.¹⁴ This is being facilitated by burgeoning social media and made feasible by dynamic interactive technology. The digital age is having an impact on all forms of work; we see this in the way blogging is radically changing journalism and the press, and the way peer-to-peer lending and crowd funding is developing a presence in banking and investment.¹⁵

A recent report from the Joseph Rowntree Foundation emphasises the central importance of supporting reciprocity for older people.¹⁶ Co-production encourages active participation, mutuality and reciprocity - seeking creative ways to involve service users and to improve wellbeing. The Social Care Institute for Excellence (SCIE) is also a strong backer of the benefits of co-production models.¹⁷ Sarah Carr of SCIE and Catherine Needham of Queen Mary University of London have described well the approach and the context for systems change.¹⁸

12 Uffe Elbaek and Neal Lawson (2014) 'The Bridge: how the politics of the future will link the vertical to the horizontal', Compass and Alternativet, www.compassonline.org.uk

13 Marshall McLuhan and Barrington Nevitt (1972) *Take Today* and Alvin Toffler *Future Shock* (1970) and in *The Third Wave* (1980). Toffler predicted a future 'prosumer' revolution where consumers would become increasingly involved with service providers in interactive ways. Producers and consumers would therefore collaborate in integrated ways of co-design.

14 Rachel Botsman and Roo Rogers (2010) *What's mine is yours: The rise of Collaborative Consumption*, Harper Collins. The implications of this developing trend could provide a conducive environment for co-operative business models to flourish in the 21st century – especially new forms of multi-stakeholder co-operatives and mutuals.

15 Jeremy Rifkin (2014) *The Zero Marginal Cost Society – The internet of things, the collaborative commons and the eclipse of capitalism*, Palgrave MacMillan

16 Widening Choices for Older People with high support needs <http://www.jrf.org.uk/publications/widening-choices-high-support-needs>. The Wales Progressive Co-operators (WPC) in their response to the Welsh Government Strategy for Older People (Phase 3) - January (2013) have argued that a social co-op operating on the basis of co-production would provide an exceptionally effective context for maximising social engagement. WPC will be consulting in early 2013 on a Social Co-op Elder Action Programme.

17 Social Care Institute for Excellence (2012) *Towards co-production: Taking participation to the next level*, Workforce Development: Report 53, 10 February 2012.

18 Catherine Needham and Sarah Carr (2009) SCIE Research Briefing 31: Co-production: an emerging evidence base for adult social care transformation, Social Care Institute for Excellence.

'The term co-production is increasingly being applied to new types of public service delivery in the UK, including new approaches to adult social care. It refers to active input by people who use service, as well as – or instead of – those who have traditionally provided them. It emphasises that the people who use services have assets, which can help to improve those services, rather than simply needs which must be met. These assets are not usually financial, but rather are the skills, expertise and mutual support that service users can contribute to public services.'

An evident weakness in such collaborative forms of service delivery is that there is currently a lack of a strategic awareness of what legal and institutional forms these co-production models and service delivery partnerships with the state should adopt to become transformative.

With clarity of foresight Paul Hirst described this need for a strategic institutional transformation as 'Associative Democracy'. In 1994 he highlighted the need for an integration of economic and social forms of governance and showed how co-operative and mutual enterprises working with the state could address the need to decentralise and democratise economic institutions in the 21st century.¹⁹

Henry Tam has argued that the roots of associative democracy spring from the communitarian practices of the nineteenth century co-operative movement.²⁰ He argues that what people fashionably call co-production today is rarely connected to the origin of this modern term in the much older, hyphenated source word, co-operation.

Tam emphasises that associative democracy in which citizens and other stakeholders (not least local government and public sector partners) participate, needs to be co-developed through inclusive communities that take and exercise collaborative power.²¹

'Inclusive communities are more effective forms of human association because they recognise the intrinsic value of enabling all their citizens/members/stakeholders to interact with each other as equals in deliberating how power is to be exercised by them, to further the good of each and all. This communitarian model builds directly on the development of co-operative thinking through the Owenites and cooperative democrats of late 19th/early 20th century.'

In a book edited by Andrea Westall for the Joseph Rowntree Foundation, the contributors revisit the theoretical and practical models for Associative Democracy advanced by Paul Hirst twenty years ago. They show that the time is ripe for such a co-operative strategy and policy framework to be developed collaboratively in order to meet the present needs of our economy, our democracy and our public services²². There is evidence of this challenge being actively taken up within the co-operative movement in England and Wales. One example from each country is illustrative of a growing practical and strategic set of discussions and experiments now underway.

19 Paul Hirst (1994) *Associative Democracy: New Forms of Economic and Social governance*, Polity Press. Hirst points to some success with this approach after World War I with the practices of the Guild Socialist movement that had strong links to the co-operative sector and also influenced profoundly the thinking and development of the NHS in the 1940s.

20 Henry Tam (1998) *Communitarianism – A new agenda for politics and citizenship*, Palgrave MacMillan.

21 Quote from a Henry Tam, University of Cambridge, commentary on this Co-operatives UK research exercise and made by email on 11 February 2014.

22 Andrea Westall (2011) *Revisiting Associative Democracy: How to get more co-operation, co-ordination and collaboration into our economy, our democracy, our public services and our lives?* Lawrence & Wishart.

In England a practical programme to develop co-operative solutions within the criminal justice system to reduce offending was piloted between 2010 and 2013 and was supported by Co-operative and Mutual Solutions (CMS). The programme's strategic objective was to expand the number of mutuals and social enterprises such as Ex-Cell in Manchester - a worker co-op for the resettlement of offenders that includes the provision of paid work for member owners.²³ Pilot projects like this were developed with the prison and the probation services to test the strategic potential of mutual solutions.²⁴

Discussions with Co-operatives UK are taking place involving senior local authority officers and politicians in England about the potential for externalising social care services into newly created co-operatives either on an "arms length" basis or through a totally autonomous approach. Exploratory discussions have also been held with a number of Co-operative Societies about developing "Co-operative Care" as a distinct aspect of their already far-reaching brand.

In Wales two successful speaking tours on the social care co-operative model were organised in 2012. Canadian co-operative experts, Jean Pierre Girard from Quebec in February 2012 and John Restakis from British Columbia, were invited as speakers in June 2012.²⁵ Evidence about the success of Quebec Solidarity Co-operatives was commissioned by Wales Progressive Co-operators and presented by Jean-Pierre Girard to the Welsh National Assembly Health and Social Services Committee at a hearing on Residential Care in February 2012.

The speaking tours galvanised action to identify effective pathways to develop Social Co-operatives. Since September 2012 growing interest in the model has been mounting from groups across Wales including the Wales Progressive Co-operators, Cartrefi Cymru, Age Connect Wales, Disability Wales, The Wales Co-op Centre, Co-operatives and Mutuals Wales and Co-operatives UK. In Wales, interest has grown in the possibility that Social Co-operatives could play an important part in delivering on both the human rights and the preventive wellbeing agendas within the framework of the Social Services and Wellbeing (Wales) Act.²⁶

Interest in social co-operatives has also been expressed by the Welsh Local Government Association, the Social Services Improvement Agency and by the Wales Association of Directors of Social Services. In January 2013, a national steering group was formed to promote and support the development of social co-operatives in Wales and evidence has been submitted on this model to the Welsh Co-operative and Mutual Commission.

23 Beth Weaver and Dave Nicholson (2012) 'Co-producing change: resettlement as a mutual enterprise'.

24 CMS and Ex-Cell had a grant agreement with the National Offender Management Service (NOMS) to promote and develop Public Service Mutuals and social co-operatives and social enterprises in partnership with prisons, probation services and the co-operative and mutual sector in the UK.

25 The tours were organised by Wales Progressive Co-operators and Cartrefi Cymru. with partner organisations Tand the programme delivered included fourteen meetings and 750 participants. The John Restakis speaking tour in June 2012 included presentations to the Public Service Management Wales Summer School, the Annual conference of the Association of Directors of Social Services in Wales, the annual conference of the Wales Alliance of Citizen Directed Support and the Wales Council for Voluntary Action's Social Care Network.

26 The Social Services and Wellbeing Wales Act (2014) has come into force

4. Lessons from Co-operative Health and Social Care models internationally

Other European countries have approached non-governmental provision using models very different from the private sector pattern now dominant in social care in the UK. Therefore it can be helpful to see the pattern of independent provision in the social care sector within a longer-term and comparative context and in particular with reference to a different pattern in other countries where the co-operative care sector is strong and a major provider.

In the late 1970s and early 1980s, an embryonic co-operative care service was developing in Italy. Alexander Laidlaw, the Canadian Secretary General of The International Co-operative Alliance called on the co-operative movement to consider ways in which it might build on this initiative and help cater for growing welfare services. Quebec responded in the 1990s by following the lead of good practice in Italy.

The emergent Italian model was a new form of multi-stakeholder co-operative that blended together the co-operative legal form with a non-profit social mission. In 1994, during the early period of the contracting out of services by the UK public sector, Roger Spear of the Co-operatives Research Unit at the Open University led a review of the state of development of the UK co-operative care sector.²⁷ The findings drew comparisons with the development in other industrialised countries.

The research led by Spear examined the rapid expansion occurring within the Italian social co-operative movement. There were then almost 1000 care co-operatives in Italy, compared to a small number in the UK. The report recommended development work on a multi-stakeholder co-operative model and said that 'the Italian Case noted earlier is the best inspirational example'.

The review also noted the similarity between the Italian model and the multi-stakeholder, Care Co-ops, in Brighton. This had been set up in 1982 with worker members and service user members holding 40 per cent of voting rights each and the remaining 20 per cent being held by other community members. Despite the recommendations made by the Open University report, the Italian social co-operative model was, however, not pursued further in the UK.

While the UK has seen some larger care sector co-operatives emerge, the rate of growth bears no comparison to the more than 14,000 social co-operatives operating today across Italy, employing over 360,000 staff. The striking fact is that the Italian care co-operative sector exceeds the employment level of 350,000 in the private home care sector in the UK.

An increasing number of European countries have been adapting and introducing the social co-operative model. In 1997, the Quebec provincial government passed specialist legislation to define multi-stakeholder co-operatives in law and to provide an enabling policy framework. Portugal passed similar legislation in 1998, Spain in 1999, France in 2001 and Greece in 2011.

²⁷ Roger Spear, Aude Leonetti, and Alan Thomas (1994) *Third Sector Care – Prospects for Co-operative and Other Small Care Providers*, published by the Co-operatives Research Unit of the Open University.

Finland passed legislation in 2003 and Poland in 2006. However the laws in these two countries for multi-stakeholder co-operatives are focused more restrictively on workforce integration of disadvantaged people and not on the wider provision of social and health care. Hungary is developing a model and beyond Europe, the Health Co-operatives in Japan have evolved remarkable practices – especially through their local Han groups, that actively mobilise members in public health promotion and with peer-to-peer support.

Social Co-operatives – Lessons from Italy

Like other western European countries in the late 1970s, Italy faced rising unemployment and a funding crisis. Public sector cutbacks and other factors led to the closure of asylums for the mentally ill. Huge needs emerged in two policy areas:

- Home care and other community care services to assist the elderly, the disabled and those with mental illness
- New work opportunities and pathways to provide something other than 'sheltered employment' for the disabled and other vulnerable groups

In response, 'Social Solidarity Co-operatives' were proposed as a new model in northern Italy to unite workers, service users and 'social solidarity economy' stakeholders. The first experimental multi-stakeholder co-operative was formed near Salo in Brescia in 1963 and the second in 1966 in the Marche region on the Adriatic coast.²⁸

The concept of 'social solidarity' is framed in the Italian constitution and calls for the support of individuals for each other and for their community. With the backing of sympathetic local authorities, church activists and other co-operative sector supporters, the Social Solidarity Co-operative movement was born in the late 1970s.²⁹

A co-operative strategy and 'collaborative partnerships' with local government developed steadily in the Lombardy, Trentino and Emilia-Romagna regions. The experiments during the early 1980s led to a new model of co-operative provision for social welfare services. What emerged had three novel and common characteristics:

4. **Multi-stakeholder co-operatives** involving care service co-producers including workers, volunteers and service user members.
5. **Co-design work and co-development** methods to build social solidarity between members including paid and unpaid workers and service users and families.
6. **Local authority partnerships** with procurement in four main operational areas: social services, health services, education and the workforce integration of excluded people.

Co-operative movement support was gradually secured during the 1980s from all four Co-operative leagues in Italy. These separate trade bodies have historical links across the political spectrum from Catholics to socialists and from liberals to conservative republicans. After ten years of advocacy and debate, the development of non-partisan support led to specific legislation and policy guidance to support the expansion of this new co-operative model.

²⁸ The information on Social Co-operatives in Italy in this section has been informed through separate interviews with Enzo Pezzini and Valerio Luterotti of Confcooperative – one of the two largest co-operative federations in Italy. Additional information and recent policy from Italian experts has been provided by Sara Depredi and Renate Goergen.

²⁹ John Restakis (2011) *Humanizing the Economy: Co-operatives in the Age of Capital*, New Society Publishers.

Social co-operatives in Italy operate to provide services where other non-profits and charities also deliver services – particularly in the field of work force integration. There is in fact a separate social enterprise form under Italian law but this has remained marginal.

The Social Co-operative Law passed in 1991: Law 381 defines a social co-operative, clarifies public policy aspects and additionally provides other guidance. The law encourages multi-stakeholder membership but does not require it. Worker co-operatives can also be social co-operatives.

The law defines two types of social co-operative:³⁰

Type A: the standard form involving workers and other members including service users and volunteers engaged in the provision of social services, health services and educational services. Not more than 50 per cent of members can be volunteers. Not all social co-operatives involve volunteer members in work and services provision but some do and it is an option. Many Type A social co-operatives involve only worker and service user members.

Type B: a 'job integration' co-operative to maximise the economic inclusion of disadvantaged groups as employees. To be registered in this category, 30 per cent or more of co-operative workers must be from disadvantaged groups in one or more areas.³¹ These are currently accepted as including: the disabled, those with development disorders, mental illness, ex-offenders, drug and alcohol addicts and immigrant groups from outside the EU.³²

The field of work for Type B social co-operatives is widespread and not confined, as are Type A organisations, to the social, health and education sectors. The law talks about Type B social co-operatives in relation to job creation in the agricultural, manufacturing and commercial sectors.

A social co-operative survival rate of 89 per cent after five years demonstrates the robustness of the business model. This achievement has built public policy confidence and encouraged private sector firms to fulfil national quotas for disabled workers by procuring services from Type B co-operatives. Across all social co-operatives, 60 per cent involve volunteer members while 8 per cent have service user and family members.³³ 69.7 per cent are structured as multi-stakeholder co-operatives.

The legislation also requires that worker members need to be the major stakeholder in any Type B social co-operative and this means that they must have a majority of member voting shares. Thus a Type B social co-operative is primarily worker owned and cannot be governed decisively by other stakeholders as a specific or a combined group of members.

In addition to worker, service user and volunteer members, the law allows for two other member categories: financing members supplying capital but without voting rights and legal entity members that can be either public, civil society or private sector incorporated bodies.

30 Confcooperative Federsolidarieta 'Building solidarity: the experience of Italian social co-operatives', paper prepared for Brussels event on 24 April 2012 and hosted by the European Economic and Social Committee during the European Co-operative week for the UN International Year of Co-operatives 2012.

31 Carlo Borzaga, (2001) Italy: The impressive development of social co-operatives, in *Tackling Social Exclusion in Europe – The contribution of the social economy*, edited by Roger Spear, Jacques DeFourney, Louis Favreau, and Jean-Louis LaVille, Ashgate Publishing.

32 Carlo Borzaga and Sara Depredi (2014) 'Cooperatives providing welfare services: the case of Italian social co-operatives' unpublished chapter in forthcoming book by Palgrave. Their data shows the three most common groups supported into paid work by Type B social co-operatives are the disabled (46.3 per cent), those overcoming drug addiction (16 per cent) and those suffering mental illness (15 per cent).

33 *ibid.*

69.7 per cent of social co-operatives involve multi-stakeholders and the remainder are forms of worker co-operative and strongly so in the case of Type B.³⁴ One in three social co-operatives includes workers, volunteers and other classes of service users on the board of directors.

Other public policy support and incentives that the legislation provides include:

1. A **lower rate of corporation tax** for social co-operatives compared to other companies
2. A **lower VAT rate** for social co-operatives: 4 per cent compared to the standard 21 per cent rate³⁵
3. Type B social co-operatives **exemptions from national insurance contributions** for their disadvantaged workers
4. **Tax relief** available for donors to social co-operatives
5. Trading surpluses are not taxable if placed in capital reserves
6. Investment returns of up to 80 per cent of profits can be distributed to multi-stakeholder members. However the rate of profit that can be shared is capped for each share at a maximum level that is no more than 2 per cent above the current rate on bonds available from the Italian Postal Service.³⁶
7. **Public investment stakes** are permitted up to 7 per cent for Type A social co-operatives and up to 50 per cent for Type B.³⁷

While the legislation allows for these forms of equity investment from members and other stakeholders, this power has been hardly used. Though they have powers to do so, social co-operatives in fact distribute few dividends to members and prefer to retain earnings to grow their indivisible reserves that benefit under the law from an asset lock. It is more common for social co-operatives to finance their expansion needs through loans from co-operative banks. These are typically short-term loans with a focus on building internal equity for the enterprises.

The social co-operative movement has successfully expanded its distributed way of working. To achieve this, it has followed four key guiding principles and methods:

- **Human scale guidance:** maximum recommended membership of 100 for each social co-operative to aid the building of trust and social capital
- **Locality and decentralisation:** social co-operatives operate in the local economy and within defined geographical areas
- **'Strawberry fields' principle:** in social solidarity, each successful social co-operative commits to incubating one new social co-operative.³⁸ This has been key to the rate of proliferation and replication.
- **Co-operative Consortia** unite co-operatives in specific trade sectors (280 sub-regional consortia have been developed for social co-operatives); provide legal advice, training, regulatory support, back office administration services, plus tendering and negotiating power through a federated structure of service provision to their member firms

³⁴ *ibid.*

³⁵ This is expected to increase to a 10 per cent VAT rate in the future but the timing and implementation of any such reduction has been postponed following the lobbying effort of the Italian co-operative movement.

³⁶ Carlo Borzaga and Alceste Santuari (1999) Italy: From traditional co-operatives to social co-operatives, chapter 9 in *The Emergence of Social Enterprise*, edited by Carlo Borzaga and Jacques Dejourney, Routledge.

³⁷ Though these investment levels are permissible under law, in practice such social investment has not developed – because of a clear conflict of interest between public sector bodies as procurers of social co-operative services. Investment beyond these thresholds would be in breach of EU State Aid rules.

³⁸ Borzaga and Santuari (1999) *op. cit.*

Work by social co-operatives is mainly secured through either partnerships negotiated with the public sector for Type A social welfare, health and education services or through partnerships agreed with the private sector for Type B work integration services. 70 per cent of work is secured through such partnerships and 30 per cent from public tenders.³⁹ Grants and donations are a small source of income for social co-operatives but only comprise 3 per cent of aggregate national revenue. In recent years, an expanding form of revenue for Type A social co-operatives lies in the growing market for services to fee-paying household-members not funded by local government.⁴⁰

Social co-operatives have very creatively adapted the co-operative consortia methods developed successfully by the Italian worker co-operative sector over many decades. This has been key to the evolution of a federated and decentralised system of service provision. This system operates at both a provincial/regional level and at national level. For example, Consorzio Gino Mattarelli is a national consortium that does research, national development work and training for provincial consortia trainers.⁴¹

The social co-operative movement has been very successful in winning allies. This was achieved first with local authorities, then with the co-operative movement as a whole and finally with the trade union movement. The last negotiated agreement took the longest to achieve but has been key to the rapid growth of the sector over the past twenty years.

Social co-operative job creation has been focused strategically on the generation of new jobs within new markets. A national Trade Union agreement was negotiated and signed in 1992 and is periodically reviewed. The key agreement provides a commitment not to threaten public sector jobs.

The provision of social finance for Type A and Type B social co-operatives has been another key factor underpinning the growth of the sector. Social investment facilities are comprised of a range of co-operative financing systems. These include:

Mutual Guarantee Societies (MGS): All Italian co-operatives are expected to contribute 3 per cent of their annual net profit to mutual funds, Fondi Mutualistici.⁴² These funds are associated with the four national co-operative federations and used for risk sharing and typically for securing medium-term bank loans. Through the development of mutual guarantees, they pool credit risk among co-operatives to enable lower cost capital to be secured from the Co-op banking sector. National consortia for social co-operatives have been set up by the different co-operative associations and have played a role in organising this mutual fund facility. Consorzio Gino Mattarelli Finance, for example, is a major provider of this service. Another mutual guarantee society and other social financing funds are managed by the CFI, a co-operative finance company that has been operating since 1986 for the promotion of worker co-operatives and social co-operatives.

Banca Popolare Etica and Co-op Banks: there are some 400 co-operative banks in Italy and several of them provide €20,000 quasi-equity loans to new social co-operatives. They also make available capital injection loans of €3000 on an individual basis to new worker members. These short-term personal loans assist worker members to capitalise their social co-operative and are repaid by payroll deductions over three years. Banca Etica Popolare is a specialist co-operative bank for the 'social solidarity economy' that was sponsored in its establishment by Fair Trade organisations, development NGOs, trade union and social co-operative networks.

39 Borzaga and Depredi (2014) op. cit.

40 ibid.

41 Enzo Pezzini (2001) The CGM Consortium – the development of a Network Business – a chapter translated from D.Cote (editor) (2001) *Les holdings coopératifs: évolution ou transformation définitive?*, De Boeck Université, Bruxelles

42 Paul Gosling (2003) *Social Co-operatives in Italy: Lessons for the UK*, Social Enterprise London.

Since the 1991 law was passed, the Italian social co-operative movement has been transformative as these figures highlight:

- 14,500 co-operatives trading in 2013 and a 57 per cent growth since 2005
- About 8000 are Type A, 5000 Type B and the remainder a mixture
- 360,000 paid workers, 40,000 who are disadvantaged workers plus an additional 34,000 volunteer members
- Service provision for almost five million people
- Annual aggregated financial turnover of €9 billion
- Median equity level of €170,000 per social co-operative

The typical size of a social co-operative is 23 to 30 worker members. 26.5% are small co-operatives with annual revenue of under €250,000.⁴³ 15 per cent of social co-operatives are larger with an annual turnover of over €1 million. There are some social co-operatives with several hundred worker-members, but the vast majority are locally based co-operatives that are socially embedded and have been set up by grass roots organisers.⁴⁴

While there is a shift towards larger social co-operatives in some places, the movement overall is still strongly decentralised and human scale in most parts of Italy. In Emilia Romagna over 50 per cent of social care is delivered by social co-operatives. In Bologna, the provincial capital, the proportion of social care services provided citywide by social co-operatives is 87 per cent.⁴⁵

43 Borzaga and Depredi (2014) op. cit.

44 Carlo Borzaga and Depredi (2014) report that 75.5 per cent in the 1990s and 66 per cent since 2000 were founded by grassroots groups of people in need. They add that 20 per cent have been founded by existing social co-operatives or by a co-operative consortium as a sponsor and only very few have been instigated by the public sector.

45 John Restakis (2011).

Solidarity Co-operatives – Lessons from Quebec

Inspired by the success of the Italian Social Co-operatives, organisations in Quebec began work on a similar model in 1995 with an agreed strategic aim of developing new jobs in social care, health and many other sectors. The multi-stakeholder structure was adapted from the Italian approach and the new organisations were called Solidarity Co-operatives.⁴⁶ The aim was to foster collaboration to grow new areas of employment within the 'social solidarity economy' by building stronger practical links aligned to this mission between the Co-operative movement, trade unions and the public sector.

The Chantier de l'économie sociale coordinates a network of cooperatives, non-profits, community economic development organisations, and social movements that focus on job creation and other benefits to the community. They played a lead role in advancing the Solidarity Co-operatives model.⁴⁷

The aim of this new social economy movement in Quebec extended well beyond the social care sector. New rules for existing provincial co-operative law were enacted in 1997.⁴⁸ They require a Solidarity Co-operative to have at least two categories of members selected from the following options: worker, consumer or supporter. The Quebec law allows for each of the stakeholder categories registered for a Solidarity Co-operative to have at least one place on the board of directors. The notable restriction is where supporter members are involved, they cannot hold more than one-third of board places. There is no guidance in the law beyond this on the set up of the board.

The strategic focus of the Quebec movement has remained job creation and Home Care is one of many areas of solidarity co-operative provision. Thus, in Quebec, with the advocacy support of the Chantier de l'économie sociale, a wide range of economic sectors has developed ranging well beyond the three service sectors in Italy for Type A social co-operatives. One main sector is rural regeneration. This work in Quebec has similarities to that of the Plunkett Foundation in the UK and includes co-operative action to save rural shops/post offices and vital services, cultural industries and strategies to revive the local economy through ecological tourism (hiking, cross country skiing, etc).

There is no consortia system in Quebec, but similar support is delivered by Regional Development Co-operatives that provide legal help, training and support.

Worker salaries in the Solidarity Co-operatives are generally near market rates in the Home Care sector and guided by a provincial agreement with Quebec trade union movement that was negotiated in 1998.

About 100 Solidarity Co-operatives have been developed in the care and health services sector in Quebec and more than 500 in other service areas including rural regeneration. Restakis reports that Solidarity Co-operatives account for 40 per cent of the home care services in the province.⁴⁹ The home care sector market is split between 50 co-operative providers and a similar number of non-profit care organisations.

46 The background and history of Solidarity Co-operatives in Canada has been informed by interviews with Jean-Pierre Girard at the University of Quebec in Montreal and John Restakis, former Executive Director of the British Columbia Co-operative Association.

47 The Chantier de l'économie sociale is an internationally recognised leader in developing financial instruments and practical supports for the social economy; they provides members with flexible loans and training, and builds partnerships with the financial sector and government on behalf of the network.

48 Jean-Pierre Girard (2006) 'Solidarity co-operatives in Quebec (Canada): overview,' in Trends and Challenges for Co-operatives and Social Enterprises.

49 John Restakis (2014) 'Institutionality for the social knowledge economy – Public Policy for a Civil Economy, unpublished paper for FLOK programme in Ecuador, May 2014.

The Solidarity Co-operatives have been begun to redefine the ownership and governance structure of the co-operative movement in Quebec and on a multi-stakeholder basis. As evidence, Jean-Pierre Girard reports that, since the law was passed in 1997, a growing proportion of new co-operatives has been set up as multi-stakeholder co-operatives and, in recent years, 60 per cent have been established as Solidarity Co-operatives.

The large Quebec credit union movement, the *Caisses Desjardins*, provides social finance for some Solidarity Co-operatives and especially for those in the care and health sector. This is linked to the support, training and back office services supplied by the twelve Regional Development Co-operatives in Quebec.

Under a system of social investment provision for social economy development in Quebec, a risk capital fund of \$10 million provides unsecured loans (up to \$50,000) to diverse social economy enterprises, including Solidarity Co-operatives. In relation to raising equity finance, Solidarity Co-operatives have the legal powers to issue preference shares with fixed interest of 2 per cent to 3 per cent over three to five years and with no maximum amount for this form of capitalisation.

Unlike in Italy, there is no lower sales tax or lower corporation tax benefits. However there is a regional network of *Centre local de développement (CLD)* funded by the Quebec government to create employment. Support is available to Solidarity Co-operatives through the CLDs and additionally with lending investment, and in some cases, start-up subsidies. The loans are normally spread over the first three trading years on a tapering basis of \$50k, \$30k and \$15k and tracked against job creation targets.⁵⁰

In recent years, there have been experiments with the Solidarity Co-operative model, which has emerged in an early stage of development in other provinces of Anglophone Canada. The model has also been developing in the USA. Margaret Lund has produced a Solidarity Co-operative manual to guide the setting up of multi-stakeholder co-operatives.⁵¹

50 According to Girard, this funding support from the Quebec government for new jobs created provides in some cases the equivalent of 100 per cent of full costs inclusive of all overheads in year one and then declining to 50 per cent in the second and 25 per cent in the third year.

51 Margaret Lund's multi-stakeholder co-operative handbook, *Solidarity as a Business Model*, can be downloaded at: <http://www.uwcc.wisc.edu/pdf/multistakeholderper cent20cooper cent20manual.pdf>

SCIC – the ‘General interest co-operatives’ in France

The French multi-stakeholder co-operative model is the Société Coopérative d’Intérêt Collectif and known as the SCIC or ‘general interest co-operative’. The legislation was passed in 2001 and drew upon lessons from Italy. There are many strong similarities to Social Co-operatives in Italy but also a number of key differences. Firstly, as in Quebec, the potential application areas are widespread within the social economy. Indeed this model was devised as an appropriate legal structure for all manner of social enterprises in France. This underlies its description in the SCIC title as a co-operative to promote and secure the general interest of citizens. Key aspects of the SCIC model are as follows:⁵²

- **Mission:** the SCIC mission as described in the law is to promote the general interest of citizens in areas of the local economy with a strong emphasis on employment creation in the social economy. As with Italian social co-operatives, the focus is on local services on a human scale that seek to replicate effective service provision through methods like the Italian ‘strawberry patch’ principle.
- **Membership:** to set up an SCIC with the Register of Companies, there needs to be at least three categories of membership and two of these must be workers and service users. Other members can include other supportive individuals as well as private and public sector corporate bodies. No member category can hold more than 50 per cent of the votes and separate categories of membership are regarded as those ranging between 10 per cent and up to 50 per cent of total membership. Membership by public sector bodies is restricted to a maximum of 20 per cent of votes.
- **Capital:** subsidies and grants are allowed along with non-voting shareholders. SCICs cannot be financed by public sector investment funds. Limited profitability is a legal principle that strictly applies to SCICs and the maximum allowable interest rate payable to investors is the average yield rate on corporate bonds determined by the Economics and Finance Ministry.
- **Regulation:** new SCICs are each subject to a five-year probationary period. The Government in each region carries out an appraisal of compliance with the social mission.
- **Profit distribution:** the law requires this to be limited to enable SCIC balance sheets to be established to support healthy co-operatives. A minimum of 57.5 per cent of any annual trading surplus must be put into the indivisible reserves of the company.
- **Conversions:** the legislation facilitates the conversion of conventional non-profits to the SCIC multi-stakeholder governance and ownership model. The allowance for subsidies and donations encourages traditional voluntary services to move to the SCIC model.
- **Consortia:** as in Italy these are encouraged to support the growth of the multi-stakeholder co-operative sector, to achieve economies of scale and to foster the expansion of SCICs through collaborative networks.

There are several social economy sectors where SCICs are developing in France. These include a broad range of health and social care sectors as well as other solidarity economy fields. SCICs operate in areas that encompass:

- (i) Local development through co-delivery of services in a town, district or sub-region
- (ii) Employment and new job creation for excluded citizens
- (iii) Citizen training and educational services that promote solidarity working and living

⁵² Information for this section has been drawn from Alix Margado, ‘A new co-operative form in France: Société Coopérative d’Intérêt Collectif (SCIC)’, Chapter 8 in Carlo Borzaga and Roger Spear (2004) *Trends and challenges in co-operatives and social enterprises in developed and transition economies*, Issan.

- (iv) Environmental protection and enhancement through social economy solutions
- (v) Know-how development and support to sustain this
- (vi) Long-term sustainability development including fair trade, organic and equal trade

Roger Spear at the Open University commented that SCICs have not had a strong rate of growth in France since 2004 – only about 600 registrations in nine years. He added that this could be due to an overly prescriptive law that is not flexible enough to encourage take-up and experimentation.

Japan - Health Co-operatives, Home Care and Han Groups: Mutual Aid and Public Health

Health co-operatives in Japan were fostered jointly by rural agricultural co-operatives and urban consumer co-operatives. Over the past 50 years the Japanese health co-operatives have expanded and integrated their provision. They own and operate 81 hospitals, 351 health centres, 55 dentistry clinics, 225 home care nursing services, 375 home care personal services and 297 day-care centres for adults.⁵³ The health and care co-op sector employs 28,000 full time equivalent staff with an annual turnover of more than 280 billion yen.

There are three million household members and 120 Japanese health co-operatives.⁵⁴ Services are delivered through 1300 branches.⁵⁵ Additionally public health promotion operates through more than 26,000 'han groups' within the co-operative network.

The han system exemplifies participative democracy and a commitment to community benefit. Each han involves typically 10 to 20 members that promote local health care at neighbourhood level and guide the development of local services. The focus is on mutual self-help, healthy lifestyles and diets. Hans address the loneliness and isolation of many retired and disabled people. They also work hand in glove with hospital discharge services and rehabilitation centres. The Japan Health Co-operatives see their unique value system in four ways: disease prevention, health promotion, social justice, solidarity and civic action.

A good example of a link between the organic food sector co-operatives in Japan, nutrition and the social care co-operatives is the Seikatsu Co-operative network. Multi-stakeholder co-operative models have been pioneered in Japan for local food and community supported agriculture (the CSA system) since 1965. Over the past ten years many Seikatsu network members have introduced the Italian social co-operative model and successfully developed this approach and earlier work on care provision and local employment. Much can be learned from Japanese Seikatsu practice.

Earlier during the 1980s they began to develop their care services based on worker collectives. Japan does not have a law for worker co-operatives, so the Seikatsu Co-operative network and other groups in Japan have used other legislation to develop the worker collectives as an equivalent organisation to worker co-operatives in other countries.

53 Nobumasa Kitajima (2009) 'Health Care Co-operatives in Japan and the Nagano Health Co-operative' in Catherine Leviten-Reid *The Role of Co-operatives in Health Care – National and International Perspectives*, report by the Centre for the Study of Co-operatives, University of Saskatchewan, June 2009.

54 Jean-Pierre Girard and John Restakis (2008) 'To Life! – Japan's model of co-operative health care and what it means for Canada', *Making Waves* Volume 19, number 1.

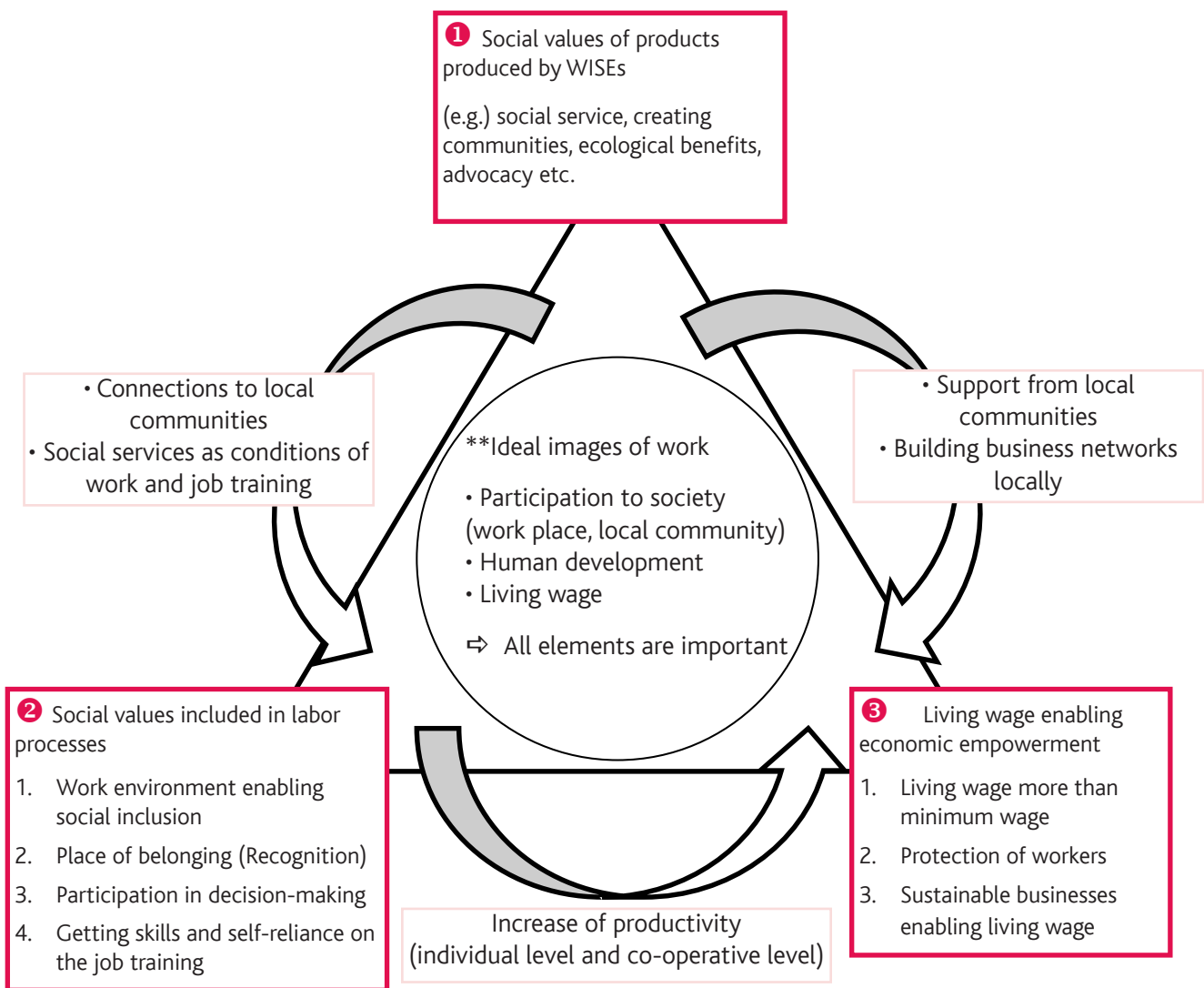
55 Johnston Birchall (1997) *The International Co-operative Movement*, Manchester University Press.

The Seikatsu consumer co-operatives used their capital to invest in land and the building of care facilities during the 1990s. There was no comprehensive social care legislation in Japan until a national law was passed in 2002. The development by Seikatsu of the infrastructure to provide care before then has enabled the worker collective model to expand strongly over the past decade.

In Tokyo and other metropolitan areas in this region, including Yokohama, the Seikatsu worker collectives provide 148 local home care services, 95 services for the disabled, 95 child care nurseries, 78 healthy living centres, 26 residential care homes, 22 day care centres and 6 home nursing services.

Seikatsu today provides care for 64,700 service users with an aggregate annual turnover within the Seikatsu group of 40 billion yen.⁵⁶ Below is a diagram of their strategy for the future.

Three elements of social aims in WISEs



56 Information has been provided by Yuko Wada, policy and research manager of the Seikatsu Club Co-operatives in Japan.

Seikatsu has continued to study the cultural ideas and practices of the Social Solidarity Economy in both Italy and Quebec closely for years and has been introducing these into Japan by building upon the han system and tradition, that is similar in nature. Following a visit to Italy in 2004 to study closely the Type B social co-operatives, Seikatsu has over the past ten years introduced these workforce integration co-operatives for a growing number of disabled and marginalised people.⁵⁷

Spain – Integrated Co-operative Health System

In Spain a similar integration of co-operative health services has been developed with some similarity to Japan. Service delivery typically involves both a consumer co-operative that owns and runs a hospital, and worker co-operatives of doctors that operate health clinics and facilities through a jointly owned health insurance co-operative. When operating in collaboration, the consumer and worker co-operative networks are called an 'integral health co-operative system.'

A good example is in the metropolitan area of Barcelona where a health co-operative of 170,000 members owns a hospital that collaborates with 5000 doctors in jointly running both the hospital's health facilities and local clinics.⁵⁸ An even larger worker co-operative of 20,000 doctors owns a Spanish health insurance company that controls and operates the largest network of non-public hospitals and treatment clinics in Spain.

Nationally the Espiritu Foundation supports the development of these health co-operative services. This was set up in 1989 to provide strategic support for the widespread promotion of co-operative health care and to conduct both shared research and the dissemination of findings through publications, seminars and conferences.

57 Atsushi Fujii (2013) Social Inclusion in Japanese Workers' Collectives – Actual situations and conditions, EMES-SOCENT Conference Selected Papers, no. LG 13-04

58 Dr. Jose Carlos Guisado del Toro 'Health Co-operatives in Spain: An Overview' in Catherine Leviten-Reid The Role of Co-operatives in Health Care – National and International Perspectives, report by the Centre for the Study of Co-operatives, University of Saskatchewan, June 2009.

Summary of lessons from international experience and the governance challenge

The evidence gathered from interviews and literature available on multi-stakeholder models indicates that six common factors have been key to ensuring success in the strategic development and growth of the co-operative care sectors in Italy, France and Quebec. These ten elements of good practice are:

- (i) Advocacy for the multi-stakeholder model by a strong and growing group of co-operative practitioners.
- (ii) The development of a clear definition in law of the multi-stakeholder model.
- (iii) The agreement with government of financial incentives and/tax relief benefits linked to specific policy objectives that can be measured.
- (iv) The successful development of partnership working between the co-operative movement in each country and also with public sector bodies at local authority and national/provincial levels.
- (v) Negotiated agreements between the trade union movement and the co-operative movement to give assurances that the new co-operatives will not threaten existing public sector jobs.
- (vi) Co-operative financing systems to provide access to co-operative capital for start-ups, for development and for risk funding.
- (vii) Co-operative intermediary organisations ranging from Co-operative consortia in Italy to regional co-operative development bodies in Quebec to reduce operational costs and provide training and other shared services for primary co-operatives.
- (viii) Co-operative education to engage an informed membership and commissioners.
- (ix) Toolkits – to enable local co-operators to get on with the job.
- (x) The role of strategic thinking, research and collective intelligence to drive innovation.

A key issue and practical challenge commented on by the international experts is the governance challenge in the co-operative sector when moving from a single stakeholder to a multi-stakeholder model. This is especially tricky where the stakeholders include both worker members and consumers, with one group typically seeking higher pay and the other wanting lower prices. Trade-offs are not straightforward. In Italy, as we have seen, volunteer members are widespread among social co-operatives while user members have a lower profile. But in other countries, such as Japan in the han system, service users play a central and very active role.

Multi-stakeholder co-operatives are clearly an emergent form of new co-operative provision. They also exemplify a wider and growing global interest in moving to more inclusive forms of democracy and governance actively involving citizens in the practice of 'daily democracy', 'associative democracy' and 'strong democracy.' Ecological economists Herman Daly and Robert Costanza have described what 'strong democracy' would look like in practice.⁵⁹

59 Benjamin Barber (1984) *Strong Democracy – Participatory Politics for a New Age*, University of California Press and Herman Daly, Thomas Prugh and Robert Costanza (2000), *The Local Politics of Global Sustainability*, Island Press.

'In a strong democracy, people – citizens – govern themselves to the greatest extent possible rather than delegate their power and responsibility to representatives acting in their names. Strong democracy does not mean politics as a way of life, as an all-consuming job, game, and avocation, as it is for so many professional politicians. But it does mean politics (citizenship) as a way of living: an expected element of one's life. It is a prominent and natural role, such as that of "parent" or "neighbor".'

Girard stresses the culture change involved in such an institutional transformation. He emphasises that new forms of co-operative education are essential for all staff and stakeholders involved in any shift from a single stakeholder organisation to a multi-stakeholder model. This applies equally strongly to those making the shift within the co-operative movement from, say, a worker co-operative to a multi-stakeholder form of ownership and governance.

In Quebec the effective development of Solidarity Co-operatives requires the cultivation of a new mindset among the stakeholder groups. As Girard explains:⁶⁰

'Deliberative democracy means engaging members, in every category, in an open discussion where respect for each other is maintained and produces enlightened and socially-validated choices. Equitably addressing diverse and possibly competing interests is not easy. Replicating the governance model used for sole member co-operatives – or worse, private enterprise – is not useful.'

Roger Spear points out that multi-stakeholder co-operatives could succeed in overcoming these problems by carefully cultivating a team culture. This requires the development of a self-management ethos among the key stakeholders. By contrast, allowing a delegate culture to emerge and dominate can be highly problematical and in governance terms can lead to tugs-of-war in opposing directions.

Bob Cannell, a UK board member of CICOPA, the World Federation of Worker Co-operatives, has commented that the multi-stakeholder innovation of social co-operatives in Italy, Spain and Japan is closer to second nature in the culture of those countries, which have a longstanding tradition of mutual aid. In southern Europe and Quebec, they call this the Social Solidarity Economy, a concept which is foreign-sounding in the UK and the USA. He also considers that 'the social co-operatives have sprung out of a stronger sense of community and indeed communities less accepting of wage labour as a norm not to be questioned that is a mind-set here'. He stresses that the lack in Britain today of a 'social solidarity' ethos is a key barrier that will inhibit genuine social co-operatives emerging unless we build upon community bonds where they can be found.

60 Jean-Pierre Girard (2012) 'Multi-stakeholder co-operatives (MSCs): The challenge of combining institutional and organisational innovation' – presentation. Without training and orientation, Girard's research is finding that there is a tendency to revert to conventional top down delivery and the hierarchical thinking that goes with single stakeholder companies. Co-design and co-production effectiveness for MSCs requires a new form of engaged and participative governance.

5. Towards a co-operative model for the UK: new collaborative economy pathways

Finding gaps in the market to develop co-operative care services in ways similar to what has been achieved internationally will be especially challenging in today's mature market in the UK and especially with such dominance by the private sector.

The current move within commissioning to personal budgets provides a major opportunity and arguably gives customers the chance to have a better relationship, choice and continuity with the people who provide services. Existing infrastructure is weak but digital and smart technology offers cost-saving pathways that could radically transform the provision of services.

But is there both a gap in the market and a margin in the gap? Do new structures and patterns of work in the 21st century provide insights on where this 'sweet spot' may lie to enable co-operative models to succeed? This section explores these issues and the innovation opportunities.

As Robin Murray argued in *Co-operation in the Age of Google*, new business models that are decentralised and networked are undermining traditional centralised business models introduced by Henry Ford a century ago.⁶¹ Apple's iPod and the iTunes revolution brought about the insolvency of HMV in 2012 due to the latter's dependency on the compact disk market. As Murray argues, the future of business and other service provision is about 'tools and relationships'.

As Shoshana Zuboff puts it, the decentralised and networked business model of the future is tailored to service user circumstances and is thematically about what do you need and how can we help? This is an inversion of many business models that are primarily about what do we have and how can we flog it to you?⁶²

Co-operative consortia methods have tested and developed practical and collaborative structures for network governance and network co-production. Interestingly, Amazon is a superb example of network co-production but, as Zuboff indicates, its governance is hierarchical and centralist.

Zuboff points out that weaknesses of the large private sector health and social care providers are increasingly rooted in their concentrated centralised control, overpaid senior management and investor ownership. All these factors have a tendency to load costs into the pricing equation and thus favour high cost solutions that are not prevention-oriented.

As Ivan Illich observed in the *Medical Nemesis*, this structure favours the opposite of health – namely an increasing industrialised system in the services sector where harm can outweigh good.⁶³ This has become evident today in the growing number of scandals in the health and care services that can be expected to rise with growing cost pressures in the public sector.

61 Robin Murray (2010) *Co-operation in the Age of Google*, Co-operatives UK.

62 Shoshana Zuboff (2011) 'Creating value in the age of distributed capitalism' in the McKinsey Quarterly for members.

63 Ivan Illich (1974) *The Medical Nemesis*, Calder & Boyars. In his analysis, Illich introduced the term iatrogenesis or diseases brought about by the actions of a health service provider.

The privatised paradigm appears structurally flawed as high rates of profit appear to be sustained by reducing wages, by sacrificing quality and by trying to reduce competition with price undercutting. A study of care services in 1994 revealed rates of pay for home carers of £4 to £6 per hour.⁶⁴ Pay in the sector since then has not kept pace with inflation. The minimum wage of £6.19 is today pervasive in the sector, a significant fall in real terms.

A glaring and growing crisis is underway - driven both by public sector austerity cuts and the fact that alternative models are not well enough positioned and resourced to offer something better and entirely different. Co-operative economic solutions, both worker co-operative and multi-stakeholder, appear therefore potentially to hold the keys to solving this problem for the state, social care workers, service users and taxpayers.

The biggest threat lies mostly in the welfare sector. People who buy their own care, namely the majority, could behave very differently. A problem in the UK and in other countries is a false perception of a universal welfare system. In fact, given the historic split between NHS statutory and universal provision and means-tested local government care services, we never did. Although in the past the latter was more generous than it is now, most people never used social welfare for social care and still do not.

Thinking more widely several new opportunities can be seen. Mutuality in health care provision has an important history that could be reclaimed. Indeed, before the NHS was established there were some 19,000 mutual friendly societies providing forms of co-operative health care.⁶⁵ One notable example of good practice and collaborative methods was the Peckham Health Centre in south London, that demonstrated from 1935 how to improve working class health through an integration of public health measures, leisure facilities, good food and the social involvement of citizens in health education.

The Beveridge report in 1942 on the welfare state recommended that the NHS be structured to use approaches like this by incorporating the mutual friendly societies as local delivery structures. Unfortunately the Labour government in 1946 did not implement this recommendation. Elbaek and Lawson contrast the social contract established almost 60 years ago with the need today for a new, more actively democratic social settlement that could and should be forged.⁶⁶

'The NHS, full employment and cradle to grave welfare provision were all done to people by well-meaning but elitist technocrats. Democracy was something you did for a second once every four years and participation was the silent receipt of whatever you were 'lucky' to get. Such elitist means could never sustain egalitarian and democratic ends.....[Today the] cultural shift on a flat earth could become permanent because equality and democracy have become both means and ends.'

In the UK, there are 6.3 million unpaid carers, more than ten times those in paid home caring roles. Social co-operatives, as Italy has demonstrated, offer diverse ways in which paid and unpaid carers can collaborate through localised co-operative systems. For social co-operatives, membership is socially inclusive and equality and democratic provisioning can become both means and ends.

In Japan there has been superb integration between co-operative health care and public health services and along the lines of that proposed in the Beveridge report. Additionally the involvement of volunteers can assist in bringing unpaid carers into paid professional work.

64 Roger Spear, Aude Leonetti, and Alan Thomas (1994) op. cit.

65 <http://hansard.millbanksystems.com/commons/1944/nov/07/friendly-societies>

66 Elbaek and Lawson (2014) op.cit.

The Japanese health co-operatives focus primarily on prevention rather than cure by mobilising the active involvement of members. Nurses, social workers, doctors, physiotherapists and other health care professionals participate as collaborative partners in a community-led model of integrated health and home care services. The Han groups providing mutual aid by members peer -to-peer show how public health services and co-operative systems can be co-developed in complementary ways.

These multi-stakeholder social co-operative practices would appear to be pre-figurative of a wider and deeper new social settlement that needs to be negotiated and agreed upon.

6. Social co-operatives: Digital technology solutions and social currencies

The multi-stakeholder model for developing new forms of horizontal economic democracy would appear to be generative but today's approach will require more than this alone for success. Other worker co-operative models in countries from Japan to Spain offer guidance and can complement methods well where member involvement is optimised, as in the Japanese Han system. The use of digital technology offers significant and growing potential for the new, more localised and decentralised forms of care that social co-operatives can provide.

In any strategy for the UK, ensuring both good pay and conditions in the co-operative care sector and the maintenance of high quality services will require the use of the latest information and communication technology (ICT). This will be essential to secure high co-production efficiencies with collaborative methods. Research by new economics foundation (nef) has found that being able to co-design one's own care plan not only tailors provision to needs but increases the well-being of the person cared for, because they feel at the same time valued and empowered.⁶⁷

An impressive example of how this can be achieved in a rural area is Elder Power (EP) in Maine; this is a social enterprise providing home care services that demonstrate dynamic ways to limit the rising costs of institutional forms of care in the USA.

EP is inspired by the fundamental belief that people and social capital are a wasted resource. It develops its approach by recognising that, in many if not most circumstances, over 90 per cent of care is provided by family members and friends. From this starting point EP has found diverse and better ways cost-effectively to mobilise and deploy social capital. This radical methodology can become very sound economics if systems of good ICT and co-production can be democratically structured. EP work is showing precisely how the co-delivery of services can be efficiently and effectively co-ordinated.

Robin Murray has summed up the success in terms of service quality and the potential for real cost-savings through dynamic forms of co-operative co-delivery, linked with other total-systems approaches to distributed models of social care.

In Hilary Cottam of Participle's words, the starting point for 'the Circle' is not needs but capacities. It is people supporting themselves collectively in many different ways, within a wider web of support. The digital spine is another element, as is the use of under-used resources (the rooms they rent for those who have recently left residential care). But what we are talking about is a system of distributed and personalised support that can replace residential care - this is where the large economies are. It does not replace residential care but seeks to make it more punctuated. Residential care becomes merely one part of a wider system that includes also the GPs and other primary care services, all of which would ideally be included in a single budget so that savings in one area can be fed through to others and to support the social network.

Some key figures highlight the economics and the results achieved by EP.⁶⁸

67 Nic Marks (2008) Five ways to well being: the evidence, new economics foundation.

68 Ibid.

24-hour home care in Maine costs about \$24,000 a month, nursing care charges are about \$7000 a month and assisted living or what we call sheltered housing comes in at \$4000 a month. By recruiting and training a personal advocate and by mobilising care from family members, from other friends in the community, from a portion of paid staff and by utilising a network system of co-design and co-delivery, Elder Power has shown how to curb the demand for institutional care costs. Through the setting up of digitally integrated and distributed home care systems and through their prevention-oriented approach, EP has demonstrated practically how charges can be reduced to rates as low as 10 per cent of the monthly nursing home charge.

Another barrier EP has had to contend with, that also applies to the UK, is that service provision in rural areas is more costly because of travel time for paid workers and the rising cost of fuel. In Maine and other rural regions of the USA this increases care delivery costs by 20 to 35 per cent.

EP's solution has been to organise creative forms of social reciprocity and befriending and to reward this work through the implementation of a social currency that is widely accepted by merchants and local businesses in the rural areas of Maine in which EP care services are provided. The EP target has been for every 1000 care recipients to recruit 40 to 50 volunteer service providers from family, friends and neighbours. The volunteers all earn the social currency co-developed by EP with local sponsors and including meal vouchers, discounts on cinema tickets and discounts on petrol.

Digital technology facilitates both co-production and complementary currency integration. Social care currencies and time banks have been developed successfully in the USA, the UK⁶⁹ and in Japan. The largest scheme of this kind is the Japanese Health Care Currency, 'Fureai Kippu'.⁷⁰ It is a time bank system in which carers build up time credits for care that they can save for future use by themselves or donate to friends and relatives.

Over 380 time bank systems for health, social and personal care (including shopping and housework) operate in Japan and many increasingly use smart card technology. Each member has a savings account from which they can save or trade the hours of service they provide. The system pays overtime of 1.5 hours for each hour of care time provided outside normal business hours. To assist the system to get established in the 1990s, the Japanese government invested \$10 million a year to run trials in different parts of the country. nef report that 12 million volunteers are involved with this social care currency.⁷¹

However, since the national legislation in Japan created a right to social care, the Fureai Kippu social currency has been experiencing a degree of decline and a number of challenges.⁷² The time banks have lost financial support to pay for their administration while the expansion of home care professional services has been on the rise. Moreover, as in the UK, pensions have declined in value requiring older people to work longer and this has reduced the number of active volunteers among those in retirement, while on the other hand the number of very old people continues to rise. Consequently there is a growing gap between service demand and volunteer supply.

69 <http://www.timebanking.org/>

70 Robin Murray, Julie Caulier-Grice and Geoff Mulgan (2010) *The Open Book of Social Innovation*, NESTA and the Young Foundation.

71 Lucie Stephens (2014) *The Carebank pilot review*, forthcoming Spring 2014.

72 <http://ijccr.files.wordpress.com/2012/08/ijccr-2012-hayashi.pdf>

Inspired by the success in Japan and by the Time Dollars systems in the USA, Time Banks have been introduced and successfully promoted by new economics foundation (nef) in the UK. Links have been made by nef with many forms of co-production, especially in the fields of care services, community education and public health promotion. The Southwark Circle, for example, was co-designed by 250 older people and sponsored by Participle.⁷³ Members pay £10 to join and can employ Neighbourhood Helpers who are background checked and live locally. There are now 900 members and about one in four give their time for free and the others save up time credits for spending to meet their needs from other members or to give their time credits as tokens to other people as they choose.

Age UK branches are working in some areas of the South East to move from a traditional volunteer support scheme to time banking.⁷⁴ Age UK Bromley set up a Community Volunteers Timebank in 2003 with a Big Lottery grant and it now continues to operate this as a core service. Volunteers who do not save time credits can put them into a separate fund called the Helping Hands Community Bank. This enables those in need of care to access support without any pre-savings.

Age UK Bromley workers provide older people a Support, Planning and Brokerage service that includes a mixture of paid care services that could be paid for by social services or the older people themselves, which can be complemented by the time-banking services. Since 2012 Age UK Isle of Wight has developed a similar time bank with 300 members who have banked 14,000 hours collectively and are supporting 450 older people.

There are other areas of digital innovation in relation to Care and Repair services. For example, fuel poverty is a major cause of higher mortality rates and the UK has the highest levels of fuel poverty among northern European countries in the EU.

Older people and many disabled people have almost twice the energy needs of households in work. A key reason is because they spend more time at home and do not benefit from the '9-5' heat and electricity provision that employers deliver to their workforce. This inequality, combined with poor housing conditions, contributes significantly to premature winter deaths among the elderly.

London Rebuilding Society (LRS) is a mutual, community development finance institution (CDFI) operating in seven boroughs of east London and providing group of services through a home improvement agency. It has been working on new smart technology wired to the home that provides advice services for vulnerable people to enable income to be maximised, household budgets to be managed more easily, decisions to be made on cost-saving improvement measures to reduce energy costs, fuel poverty to be curtailed and low-cost and flexible finance to be delivered. This SHIMMER system has been piloted successfully with the support of the Energy Saving Trust and the Technology Strategies Board.⁷⁵

The SHIMMER platform has been extended and now includes the following three services and smart technology solutions:

- Income maximisation and welfare benefit service.
- AMP: next generation, appliance level smart home energy management system
- IPTV PayWise: the money management system with an online, 'near' bank account

73 Stephens (2014) op.cit.

74 Stephens (2014) op.cit.

75 Data and information about London Rebuilding Society and SHIMMER is from a presentation made by Warren Garrett, their innovation manager, at the Deliberative Inquiry on 11 July 2012 in Birmingham.

The digital services can be used via a TV, home computer, laptop, tablet or a smart phone. The AMP pilot run by LRS has demonstrated average household energy savings annually of 20 per cent. Other pilot data is showing an average aggregated savings of £590 a year with an investment payback of five months on the smart technology applications.

AMP has the ability to collect energy data and the capability to collect health and other data; it can also deliver money advice, assisted living, alerts and support early interventions, coordination of services and social networking of both the carers and the cared for. Exploiting big (and real time) data to provide services to the very vulnerable is one of the potential benefits of this smart plug system. Better intelligence should lead to better services for reducing waste and duplication, identifying and filling gaps and providing better coordination of support and a more personalised and tailored service for care recipients.

Filling the data gap through AMP should result in evidence-based interventions and solutions. Monitoring of health and well-being need not be intrusive and can provide an added sense of security rather than a dread of being under surveillance. Technology can be low-cost, affordable and generate savings and new revenue streams from energy-saving to collective switching and purchasing. Feedback loops can provide people with alerts and advice to help them better manage their health and wellbeing and alert carers and health practitioners when necessary. Digital inclusion can connect people to service providers in new ways - for example via emergency sensors capable of telling the fire brigade in which room a fire is raging and its intensity.

New dynamic social co-operative ownership and governance systems, and major breakthroughs in convivial technology like these are complementary jigsaw pieces for a socially inclusive restructuring of social care provisioning. What are the new business models that these resources could propel?

7. UK good practice: Social co-operative opportunity areas

Clear guidance is needed to pave the way effectively to develop a movement of strong social co-operatives in the UK that reflects the needs and aspirations of collaborative partnerships. It will be important that potential member / service users recognise and are engaged in shaping how values are agreed and maintained in co-operative organisations.

The Public Services (Social Value) Act requires all public service commissioners to factor in social value. This means that local authorities and government-funded organisations will need to consider how the services they commission can improve the social, economic and environmental well-being of localities. If scaled up, John Craig of the Innovation Unit, an independent social enterprise, estimates that co-production social enterprises could save the NHS £4.4 billion and radically improve health outcomes through innovation measures.⁷⁶ Social co-operatives are ideally placed to develop and provide this triple-bottom line added value.

Most UK Care Co-operatives are worker co-operatives, Some either do or are seeking to involve service users as members and in the governance. A number have operated successfully for 20 to 30 years including Sunderland Home Care Associates, Care Co-operatives in Brighton and Hove, Wrekin Home Care in Telford, Bridgnorth Home Care Co-op in Shropshire.

Highland Home Carers in Scotland is fully employee-owned, with 300 worker owners. The care service was privately owned until 2004 but the owner wanted to transfer ownership to the employees. Existing good will, a strong relationship and block contracts with the local authority were a key asset along with an excellent management team. These factors put them in strong position to attract the finance needed to achieve the ownership transfer.

On the Co-operatives UK member list there are about 25 social care co-operatives or care support organisations. This would appear to be under 1 per cent of the national market. However additionally there are other forms of mutual and social enterprise provision from which to draw good practice and strategic guidance in order to develop the latent potential of the co-operative care sector. A number of these are reviewed below and a number have a mutual structure. Some are introducing innovative member ownership and governance systems. So the care co-operative sector has the potential to expand and recruit new members from existing organisations moving in this direction.

In the consultation, Dan Gregory of Social Enterprise UK pointed in particular to the health services sector and the '50 odd social enterprises, often with co-operative principles', that have emerged since 2008 out of the Labour government and the Department of Health "Right to Request" scheme, which enabled PCT staff to convert their services to mutuals. He stressed that, many of these organisations are trading as 'Community Interest Companies with one member, one share, and significant employee ownership and participation.'

Mick Taylor of Mutual Advantage sees several strategic opportunity areas for social care co-operatives to be cultivated from existing practitioners. He describes five broad pathways in the table below.

76 John Craig 'It's time for people-powered health services' 3 September 2013, New Start.

Pathways	Description	Challenges to overcome
1. Contracting	Open and competitive process led by a procurement body	Difficult process Opportunity and risk High cost
2. Externalisation	Negotiated process to transfer staff and service to a co-operative	TUPE Culture and management Re-configuration
3. Partnership	Set up by a charity or voluntary body for the community as a co-operative service	Ability to trade Culture change Hard to let go
4. Society venture	New business set up by a co-operative society	Poor return Risk to the core brand No appetite
5. New start	Started by stakeholders such as carers, activists and community backers	Regulatory hurdles Time and effort Hard decisions

The implementation by Government of some version of the Dilnot report will raise the local authority financial assistance eligibility threshold from an asset ceiling level for individuals of £23,500 to £123,000. Thus in the years ahead the demand for better quality care will grow with the aging population and these voters will increasingly matter politically. These changes could enable more models of social care co-operatives to find niche and potentially expanding market opportunities. There is some encouraging evidence of this already beginning to happen.

The deliberative dialogue event held with Co-operatives UK members and stakeholders carried out a SWOT analysis in small groups that appraised the existing social care co-operatives in the UK. The findings are summarised in Appendix 2.

Six strong points of the co-operative and mutual sector were felt to include:

- A range of high quality services, good practice and innovation in some areas
- A range of care option choices and user involvement among some services
- Worker co-operative good practice and some multi-stakeholder expertise
- Somewhat better pay and conditions albeit under relentless competitive pressure
- Services that meet popular demand for more say and fairness through mutuality and solidarity
- Member involvement and economic democracy that provide additional good governance safeguards

There were a number of identified weaknesses in the sector including:

- Lack of strategic leadership and national profile
- Lack of a strong body of evidence of good practice and success
- Gaps in management expertise for many services - including tendering capacity for big contracts
- Isolation and a lack of communication between dispersed organisations
- A lack of awareness by commissioners of the co-operative option and solutions

- Few social financing systems to support start-ups and enable development – though the Social Enterprise Investment Fund (SEIF) operated by the Department of Health has been important as a source for development finance.

The following market niches and specialist providers emerged from the social care review. The organisations profiled illustrate both the five pathways summarised by Mick Taylor from Mutual Advantage. The eight profiles are indicative of the application areas and the wide potential for social co-operatives. Additionally they cover both established models for worker ownership and emerging markets for multi-stakeholder co-operative development.

1. Sunderland Home Care Associates and CASA – Employee ownership model

Founded as a social enterprise in 1994 by Margaret Elliot with a small grant of £10,000 from Sunderland Council, Sunderland Home Care Associates became an employee owned business in 1998. From its early days as a service with 20 carers, it operates today as a larger mutual with 600 worker owners delivering over 10,000 care hours per week. The organisation is not a worker co-operative but an employee ownership firm. They provide home care for the elderly as well as adults with a range of disabilities.

To develop a social franchise for this model, Care and Share Associates (CASA) was developed as a larger mutual to bring together a growing range of care providers that are replicating the model. Thus far, CASA social franchises have been developed in Newcastle-upon-Tyne, Manchester, North Tyneside, Halifax, Leeds and Knowsley.

CASA's approach in recent years has moved from their social franchise model to a larger consolidated employee owned business. They found this to be necessary because of the minimum asset requirements specified by care commissioners. In practice the locally based CASA firms will operate as semi-autonomous mutuals but legally they have become sub-divisions of a larger national scale worker ownership business.

They also report low turnover of staff of only 6 per cent compared to an estimated national turnover range annually of 25 per cent to 50 per cent among private sector care providers. Guy Turnbull, the business development director has described the economic benefit directly arising from employee ownership.⁷⁷

'Because our employees have a share in the business our staff turnover is much lower than the private sector and overall our business model yields significant benefits on performance. This is crucial in health care as you aim to have continuity of support, as you want to have the same person toileting you every day. Plus as we have no external shareholders we can reinvest our surpluses in staff development and training.'

The new larger and unified business structure will increase the worker ownership stake to 90 per cent.⁷⁸ CASA also recognises trade unions and 80 per cent of their worker owners are reported to be members of a trade union.

77 Simon Birch 'Is the future of healthcare co-operative?', The Guardian, 3 September 2012.

78 Robin Murray, 'Notes on Health and Social Care pathways for social co-operatives', unpublished paper, April 2013.

2. GP and Health Centre co-operatives

When the NHS was founded in 1948, GPs resisted becoming members of staff and negotiated to operate as independent contractors. Part of this national agreement was a duty for each GP to provide out-of-hours health care services to each of their patients. In 1995, changes were introduced to allow for group rotas for out-of-hours provision. To arrange and ensure delivery of these services, the amended contract allowed payments to GPs (inclusive of other staff) of £6000 a year plus a further £3000 per GP to develop innovative delivery systems.⁷⁹ These changes kick-started a rapid growth of local and regional Co-operatives among GPs to handle out-of-out hours services provision mutually.⁸⁰

The co-operatives introduced a triage of service provision involving telephone screening and advice, out-of-hours centre surgeries and home visits. This innovation achieved efficiency savings and led to a major reduction in the proportion of home visits.

A national review of provision in 1996–97 profiled case studies of seven GP co-operatives operating across England and covering 16 sites with centres of population ranging from 45,000 to over 400,000. The expansion thereafter of co-operatives was meteoric and in 2004 the National Association of GP Co-operatives had more than 300 co-operatives in membership with over 30,000 doctor owners and widespread coverage across the UK.⁸¹ By then co-operatives had secured dominance in the market with three in four GPs in membership of co-operatives providing out-of-hours services.

However in 2004 a policy change and a new national GP contract shifted the out-of-hour services responsibility away from doctors and to Primary Care Trusts (PCTs). Relieved of service responsibility, the co-operatives rapidly lost membership in many areas. The new PCTs decided to bring many services back in-house and additionally from 2008 to commission services, and increasingl, from the private sector.

Rural areas were the worst hit by these changes, often driven by price. Kernowdoc, the exemplar GP co-operative for Cornwall, saw its contract passed to Serco. The GP co-operative in Buckinghamshire was reportedly forced out of business almost overnight when private sector Harmoni secured the contract.⁸² In other areas GPco-operatives have mutated into social enterprises offering more than simply out-of-hours provision. This was the transition path taken by Devon Doctors. Northern Doctors set up as a GP out-of-hours co-operative but converted into a Community Benefit Society following the 2004 policy changes. It provides out of hours and other health care services to 1.5 million people with 600 staff across North East England.

By 2013, social enterprises and a smaller number of co-operatives accounted for 42 per cent of out-of-hours market, the private sector 33 per cent and the NHS covered the remainder.⁸³ Formed out of seven former GP out-of-hours co-operatives, Local Care Direct is now an expanded social enterprise providing services on commission for the NHS urgent and primary care services and in areas across both West and North Yorkshire. They describe themselves as a community mutual, employ 800 people and have a yearly turnover of £20 million.

While GP co-operatives have declined steeply, they are still viable in some large urban areas. South East London Doctors' Co-operative (SELDOC) is good example and provides a service for the boroughs of Lewisham, Southwark and Lambeth.

79 Dr. Eric Rose, Blog posted on 10 May 2013 'The True History of GP Out-of-hours Services'.

80 <http://www.population-health.manchester.ac.uk/primarycare/npcrdc-archive/archive/ProjectDetail.cfm/ID/27.htm>

81 Tim Smedley (2013) 'GP co-operatives mutate into out-of-hours social enterprises, The Guardian, 20 September 2013.

82 Dr. Eric Rose op.cit.

83 Ibid.

Set up in 1996 with a base in Dulwich hospital in Southwark, SELDOC has used consortia methods successfully to expand its membership from 20 GPs to more than 600, providing services for more than 125 practices and delivering out-of-hours services for a population of 900,000.⁸⁴ GPs own the co-operative as a single group of stakeholders and have built up an organisation with 250 staff covering a wide diversity of jobs and with NHS pensions.⁸⁵ 70 per cent of the workers are members of a trade union and the consortium services cover joint purchasing, car rentals secured at special rates, and the co-ordination of the provision of locum services at attractive rates.

Willow Bank Partnership CIC is an innovative multi-stakeholder co-operative that grew in 2006 out of a former PCT-run surgery in a poor area of Stoke-on-Trent. Two GPs and the surgery health staff founded the co-operative, and membership includes the workers as well as the patients and community organisations. Other founder members include Gingerbread, a local group for homeless single parents and CTP – a social enterprise of former NHS managers committed to new models of distributed community health care. The GPs and health staff are all salaried members of the co-operative. The patients have two board places, one of which is designated as the chair.

3. Multi-stakeholder mutuals for Community Health Services

Community health services operate in the space between services provided by GP surgeries and the acute services of NHS Foundation Trust hospitals. These services account for 10 per cent of NHS expenditure and include health visitors, midwives, community and specialist nursing, physiotherapists, speech therapists and rehabilitation services. The evolution of PCT commissioning over the past ten years has seen a rise in service provision by social enterprises. The changeover from PCT to GP commissioning is underway and Community Health Services offer a major opportunity area for multi-stakeholder mutuals to emerge.

In the White Paper, *Equity and Excellence: Liberating the NHS*, the Coalition government has announced the aim 'to create the largest social enterprise sector in the world'. Arising out of PCT and GP commissioning (since 2012), Mutuo reports that 47 social enterprises have been set up, involving in aggregate 25,000 NHS staff, who have opted to restructure their operations as a social enterprise.⁸⁶ Many are big, with annual turnover in excess of £50 million. Many are in the South West, including SEQL in Swindon and Peninsular Community Health in Cornwall.

Services provided by the third sector now account for 10 per cent of staff involved in community health services, 11% of NHS provision and a combined annual turnover of £900 million.⁸⁷

Mutuo has been working on multi-stakeholder legal structures that have some similarities to the social co-operatives in Italy and the Solidarity Co-operatives in Quebec. Since 2011, four large community health service mutuals have been established along these lines. Together they provide services for almost a million people and with an aggregate staffing level of 3600. The four new mutuals include Anglian Community Enterprise CIC in North East Essex, Medway Community Healthcare CIC covering Medway, Swale and West Kent, Your Healthcare CIC in Kingston-upon-Thames and Richmond, London and Care Plus Group in North Lincolnshire.

84 <http://www.seldoc.co.uk/seldoc>

85 Robin Murray (2013) *op. cit.*

86 Cliff Mills and Chris Brophy (2011) *Community Health Services: Made Mutual*, Mutuo, October 2011.

87 Since March 2011 the new Right to Provide system gives NHS Trust staff the right to take the initiative to become an independent social enterprise.

Care Plus Group is a good example. Set up in 2011 as a Community Benefit Society, it employs 700 staff and has an annual income of £23 million. Its services include home care, community nursing, intermediate care, meals on wheels, employability and other care services. Its operational area in North Lincolnshire is densely populated but geographically isolated and straddles the Humber estuary. A pathfinder GP Commissioning Consortium has awarded its contract.

Care Plus Group's multi-stakeholder ownership and governance is innovative. The mutual has a two-tier board comprising a Council of Governors responsible for the strategy of the mutual and a board of directors responsible for the operations. All workers are members of the mutual and they elect eight staff governors. Two further governors are appointed by the local authority, two governors by GPs and three governors by community group members. The board of directors includes four non-executives (one of whom is the chair) and three executive directors including the chief executive of the mutual. The Council of Governor is the body that both appoints and removes the chair of the board and the other non-executive directors as well. A Community Forum recruits members from service users, carers, volunteers and other local health community people.

Cliff Mills and Chris Brophy confirm that all four mutuals have an asset lock with local accountability and control.⁸⁸ Care Plus Group and the other mutuals are facing a culture shift that Mills and Brophy describe this way:

'The culture change is not just in terms of engagement as members and via the representative body. It also involves becoming aware that there is not simply an entitlement to an annual pay increase for continuing to do the same job. If the business is to prosper, pay increases need to be based on an element of performance, cost and efficiency savings. There are already indications of progress in this, providing a basis for the message to travel through the work-force by peer-pressure, rather than from management.'

The NHS ethos is embraced in their respective mission statements and all of the mutuals are not profit-distributing; all trading surpluses being retained within the business and invested for community benefit.

4. Lessons from The Foster Care Co-operative – the potential for the Externalisation through Public-Social Partnerships

The Foster Care Co-operative (FCC) was established in 1999 as a mutually owned foster care agency. It currently supports children and young people placed in foster care from more than 50 local authorities in England and Wales. Its success in securing public sector support in the UK is noteworthy and it is the only registered co-operative in the foster care sector. The Foster Care Co-operative in Scotland has recently opened and there are plans for expansion in London, Northern Ireland and in Ireland. The turnover was £6 million in 2012.

There are 50 staff who are full members plus 250 foster carers (mostly couples) who are associate members. The regulations in England and Wales do not currently allow foster carers to be full members as they are not allowed to control or manage the agency for which they foster. To seek ways to overcome this barrier, the FCC has written into its memorandum of association an explicit commitment to consult both foster carers and social workers at support meetings every six weeks.

88 Cliff Mills and Chris Brophy, op.cit.

The FCC has expanded steadily and its democratic ethos is seen as a superb fit both with the shared values of local authorities as public service providers and with trade unions. The asset lock and common ownership structure of the co-operative, together with the reinvestment of surpluses for community benefit, are all attractive aspects. High quality training and agency support for all staff and foster carers has been key to success. A free legal advice service to update members and associates is part of the support system.

Laurie Gregory led the work to found and develop the FCC and he sees big opportunities to develop a similar model for home care co-operatives. The strategic opportunity and the unique selling point would be a multi-stakeholder co-operative model with the extension of full membership and democratic rights to service users.

Gregory sees two options for local authorities. The first would be the outsourcing of the service to a co-operative that could be co-developed with the local authority and staff transfers negotiated with the trade unions. The second option would involve 'in-sourcing' as a halfway house that would preserve a strong degree of local authority control.

Scotland is currently testing a 'Public Social Partnership' model that could provide a vehicle for the second pathway. This arrangement would be similar to the Arms Length Management Organisations (ALMOs) used over many years for attracting private sector investment and well-developed in England in the context of the regeneration and modernisation of public sector housing. Essex Cares operates in this way and was set up in 2009 by Essex County Council as a Local Authority Trading Company (LATC) for adult social services. It employs over 1000 staff running home care, day centres, community support services and training services for disadvantaged people.

A number of these methodologies could fit well with a model like the Social Co-operative system in Italy where local authorities can participate as members among other stakeholders. Gregory summarises the key benefits of a close partnership between local authorities and the co-operative movement in co-developing a mutual model as follows:

- (i) Costs would be reduced, compared with a local authority service, through a reduced management overhead and a flatter operational structure;
- (ii) Revenue can be attracted from a variety of sources - including new income streams generated by private payer households. Differential pricing would enable a much wider market to be developed;
- (iii) Social investment could be attracted along with other forms of capital;
- (iv) Multi-stakeholder membership for staff and service users would provide democratic participation in new and unique ways through the co-operative;
- (v) Voting rights for service users and care workers would extend power to the recipients of the service and those who provide their personal care;
- (vi) The democratic ethos would create a culture completely different from any other form of service provision.

This model is attracting growing interest from local authority politicians and senior managers of councils in the West Midlands, the North of England, parts of Wales and elsewhere. Gregory remains hopeful and some local authority advocates do appear to be beginning to emerge.

For example, Edinburgh is a Co-operative Council that has launched a strategic co-operative development programme in the fields of social care, health, childcare and education. Their programme has five elements:⁸⁹

- A Co-operative Development Team to support the growth of health and social care co-operatives
- A two year Innovation Fund of £400,000 to provide venture funding of up to £50,000 for the development of employee-owned health and social care co-operatives
- Support for the Edinburgh Development Group Care Co-operative to address the special needs of adults with severe learning disabilities and to include parents and family members in the management
- A service level agreement to develop the Out of School Care Sector into a network of co-operatives
- A Co-operative venture to standardise the induction and training of all health and social care workers in Edinburgh, regardless of their employer (voluntary or private sector)

Another example is in Lancashire. Danielle Proctor, a senior manager of Oldham Council, attended the Co-operatives UK Deliberative Inquiry. She is currently leading the work to transform the Council's social care services into a co-operative. Their business model is building upon existing Council funding for home care and connecting this with reablement funding from the NHS. This ambitious work on a co-operative model has involved hundreds of Council employees. To assist the transformation they have set up a helpline to consult service users and joint planning is in progress with a wide range of stakeholders including council staff, commissioners, the Central Commissioning Group, trade unions, local authority sponsored care services outside the council and other private carers.

5. Ex-cell and a new criminal justice model for Social co-operatives in the UK

Co-operative and Mutual Solutions (CMS) and Ex-cell have worked together throughout England over three years to promote and stimulate social enterprises, co-operatives and Public Mutual spin-offs within the prison and probation services. They are strongly in favour of co-operative models that promote desistance.

Desistance is a criminological term for effective measures to stop re-offending behaviour. This joint work has been inspired by the success of Type B social co-operatives in Italy. The shared objective being pursued goes beyond a narrow interpretation of desistance. Fundamentally the mission is about individual and collective flourishing that includes financial reparations to victims of crime.

Inspirational forms of mutuality in prison operate well to resettle Italian offenders and to maintain desistance. Pausa Café, for example, was set up as a social co-operative in Turin's main prison. It provides a guarantee of paid work both in prison and a job on the outside. Prisoner members of Pausa Café roast and package a wide range of coffee beans in the prison and then work outside the prison on release with a growing chain of coffee bars.

Another Type B co-op example is Exodus, which fabricates doors and window frames in prison that ex-offenders fit and install on building sites. Another social co-operative has been established as a microbrewery within Saluzzo prison. The real ale produced has become so successful that it is now exported to many countries across Europe.

89 Phyllis Stephen 'Edinburgh Council spearheading the Co-operative Council approach', 22 September 2013.

Ex-cell was set up in 2009 in an attempt to replicate such success in England. After a false start as a project, with the assistance of CMS, it was transformed into a democratic business. Today it operates as a worker co-operative for ex-offenders and their families in Manchester.⁹⁰ The partnership work between CMS and Ex-cell has led to a shared understanding and a common strategic interest in developing work beyond just social enterprises and into social co-operatives that extend ownership and democracy to prisoners, ex-offenders and their families by operating on both sides of the prison gates.

The “Transforming Rehabilitation” reforms introduced by the Ministry of Justice have led to some limited opportunities to explore mutual solutions in the probation context. With the support from the Cabinet Office via the Mutuals Support Programme, a small number of worker groups at Probation Trusts are taking this forward. Anthony Collins Solicitors, working with CMS, Ex-Cell and others, has led one such project that has been collaborating with the team from the Kent and Surrey / Sussex Trusts, where there has been significant interest in embedding the principles of co-production in service re-design and governance. There are also a number of other social enterprise pilots that Ex-cell has current involvement with.

At HMP Styal, a horticulture project has been established within the prison that works in partnership with Manchester Veg People, who purchase the produce to supply university catering facilities in Manchester and in Salford. At Kent prison, a social enterprise has been established that operates both as a catering business and as an employment agency. These ‘Through the gate’ social enterprise experiments are also at different stages of development within Wormwood Scrubs and Glen Parva prison and the services are involved in cleaning, grounds maintenance, catering and construction.

As a rule the prison and the probation service are the key purchasers of services from large contractors (with large capital reserves). In the view of Gareth Nash of CMS:

‘It is likely (or possible) that ‘smaller organisations will get a slightly better bite of the cherry as Tier 2 or 3 (more likely) sub-contractors in the Transforming Rehabilitation ‘revolution’.’

The programme of action by Anthony Collins, CMS and Ex-Cell to develop social enterprise into social co-operatives services is contracted to push out the envelope in Kent, Surrey and Sussex. There is strong support from managers and staff within the probation services. There are, however, major concerns about the nature of the Government’s agenda and whether or not a broader vision has any real chance of being fully pursued.

For example, the view of the Cabinet Office about what constitutes a Public Service Mutual for the purposes of procurement is not apparently based on a definition of democratic member control or recognition of co-operative principles but more upon considerations of organisational assets and balance sheets.⁹¹ During the consultation, the comment was made that a mutual, in the view of the Cabinet Office, can be a ‘joint venture with just a dose of employee participation.’ A dose of 25 per cent employment ownership is deemed to be enough, one commentator said, because in the view of the Cabinet Office ‘this amount of shareholding means that employees must be listened to by the board of directors’.

90 One linked venture supported by Ex-cell is Recycle IT, an ex-offender co-operative that repairs and recycles computer and IT equipment. In 2011 CMS and Ex-cell worked with the Warwickshire Probation Service to set up Ubique, which employs ex-offenders in a social enterprise. Ubique does not, however, involve ex-offenders in either the ownership or governance of the business.

91 In the Government view, a mutual, as defined for the purposes of tendering for a public services contract, need only meet a threshold of a minimum of 25 per cent member ownership. Thus private sector controlled bodies with only a minority stakeholder share (e.g. former public sector workers and/or a proportion of service users with voting shares) could easily meet this definition

In relation to Cabinet Office primary concern about balance sheet size, the emphasis in the recent pre-tendering documents issued by NOMS for screening prospective contractors for the delivery of probation services is heavily on corporate financial capacity and proven bank cash assets of sums in the region of half the value of any contract.⁹² However despite this major obstacle for small co-operatives, Ex-cell and CMS believe that problems like this could be overcome by a change in policy and they are encouraged by the strong and genuine interest among many staff and managers, both in the prisons and in the probation services.

6. Home Improvement Partnerships - regional co-operative networks for community finance

A key area for making cost-savings for the state is preventing older and disabled people having to go into institutional care. Home Improvement Agencies were set up in the 1970s to help vulnerable homeowners carry out essential repairs and home improvements, ranging from safety features for baths and showers to roof repairs, window and door replacements, improved heating systems and insulation. Grant funding was the main source of this work until ten years ago, but this funding has become more and more restricted.

Community Development Finance Institutions (CDFIs) are not-for-profit local and regional lending organisations. Over 50 operate across the UK and they make loans that banks and building societies would decline – either because they are commercially unattractive due to low margins or deemed high risk. CDFIs tend to make larger loans than credit unions and many of them are mutually owned. Most focus on the provision of loans to small businesses and social enterprises but a handful have diversified lending into home improvement over the past ten years. Their target market has been the clients of home improvement agencies and their track record with such lending has been excellent, with over £100 million in aggregate advanced to date and with no bad debt or arrears problems.

Wessex Home Improvement Loans (WHIL) is an exemplar CDFI that has developed an extensive co-production partnership over the past eight years with 20 local authorities, and a similar number of home improvement agencies across the southwest from Wiltshire to West Devon and from North Somerset to West Dorset. They have made over £7 million in loans to over 1300 households.⁹³ WHIL has led the regional development of a practical co-delivery service by themselves as lender with home improvement agency staff managing as local partners the tendering and contracting of the builders carrying out the repairs. The partnership system is underpinned by a partnership agreement. Service user satisfaction levels are rigorously monitored and this has achieved an 88 per cent level of excellence.

The savings to the state of this linked service between CDFI mutual finance and Care and Repair services is considerable. A hip replacement for an elderly person who slips and falls getting out of a bath without handrails runs to almost £30,000 for the NHS. Many times hospital discharges are impeded and bed blocking incurred because of the poor state of repair of a patient's home, as they cannot be released until emergency improvement work is carried out.

WHIL takes referrals from its network of partners and from other advice bodies like Age UK. However it has found that there are a number of gaps in the advice services network, so in order to meet these it has expanded its work beyond lending to provide welfare rights advice, some counselling and other support to both service users and other family members. All services are now part of Wessex Resolutions CIC – a community interest company. Wessex Home Improvement Loans remains a trading name of Wessex Resolutions CIC.

⁹² So without working with other organisations that have the necessary financial strength (typically private sector providers), the opportunities for social co-operatives, like those in Italian prisons, would appear to be non-existent to secure this work.

⁹³ Data and information about Wessex Home Improvement Loans is from a presentation made by Andrew Wallace, the managing director, at the Deliberative Inquiry on 11 July 2012 in Birmingham.

For low- to moderate-income homeowners and their families, borrowing is a big concern. There is a gap in the market to develop a social co-operative service to involve service users more fully and give them a democratic voice in the co-production system of Home Improvement Partnerships.

There is strategic scope to connect the work of the small but growing network of regional home improvement CDFIs to other carbon- and energy-saving providers. Social co-operatives and co-operative consortia are key innovations that could creatively integrate the co-design and co-delivery of these social economy innovations. Support to link up a full supply chain of co-operative elements might be secured from Co-operative Energy and from regional co-operative societies.

7. A model for Co-operative Retail Societies to invest and develop Home Care

The support for social care co-operatives has had a mixed history among larger co-operative retail societies. Mid Counties Co-operative is succeeding well with childcare co-operatives but, on the other hand, Midlands Co-operative Society decided to pull out of residential care homes because of the impossibility of maintaining good standards of care and living wages for care-home workers. So any model to secure strategic and financial backing from a major co-operative retail society or even a smaller one would have to be premised upon a compelling business case. But what might this look like?

Robin Murray has described the state of the care services market as a gathering 'scissors crisis' with needs rising on the one hand and public sector spending falling on the other. This adverse environment has triggered a reduction in services and expedited greater levels of privatisation. There has been an evident and growing decline in service quality that an innovative approach could tackle, especially if developed by the co-operative sector.

Murray points to research carried out by Carr Saunders on the economics of co-operative retailing that showed in the 1930s that established co-operative societies hold key cost advantages over smaller private sector firms and that this holds even in comparison with some larger firms.⁹⁴ The advantages include lower cost logistics, access to lower cost capital, land and property ownership, which can be provided, and administrative infrastructure.

The related cost-savings aspects in Murray's analysis could be used 'to develop a model of care where co-operative costs are decisively lower and the standards of care higher, so that co-operative care out-runs the private equity [care] chains.' He argues that there are seven ways that a co-operative retail society could deliver cost savings to assist social co-operatives to develop:

- (i) Use of back office services
- (ii) Use of shops and premises as care hubs
- (iii) Use of training facilities and access by care workers to employee benefit schemes
- (iv) Use of marketing and advertising services
- (v) Access to lower cost transport and energy
- (vi) Supply of trusted pharmaceutical services at modest margins
- (vii) Provision of good quality food and other inputs at reasonable prices

94 Information describing this model has been provided by Robin Murray including unpublished documents.

Murray argues that these savings can enable carers to be paid more, the service quality to be enhanced and a virtuous circle to be facilitated. Co-operatives can also drive up quality because they uniquely involve workers as key stakeholders in the governance of the service. Fundamentally, the innovation in design must put the service users first and 'assemble a group of services around them, customised to their requirements.'

However, as Murray makes clear, this approach requires higher pay for the carers to incentivise the development of quality. While this revenue can come from savings elsewhere as indicated, this would not be sufficient to enable a trading surplus to be made in order to attract the interest and the investment of co-operative societies. This is the showstopper challenge. Going it alone by a large co-operative society is not the only way forward. There is the issue of comparative financial returns and reputational risk that might hold back testing out this way forward. A co-operative partnership model could, however, be a viable solution.

Many social co-operatives in Italy use paid and unpaid workers for service provision and do so through forms of co-production that is backed financially by co-operative banks. Many co-operative retail societies in the UK have existing links and some partnerships with credit unions. Among the smaller credit unions, these frequently involve a mixture of paid and volunteer workers. So there are precedents for these collaborative economy models in the UK operating between larger and smaller co-operatives.

Murray argues that technological innovation and the creative use of volunteers are, as Elder Power in Maine demonstrates, key to stakeholder inclusion, to maximising quality and for securing a margin to attract co-operative societies into the market. As an alternative to the large private sector payout to shareholders, a social co-operative trading surplus achieved by this strategy could be reinvested in staff in order to maintain quality and to improve and develop services.

Murray also agrees with Laurie Gregory that there is a need for differential pricing of services using cross-subsidy by those able to pay privately, to deliver lower-cost services to the public sector, and achieve this by competing on quality in the open market through a redesigned 'Co-operative advantage'. This 'new concept of comprehensive, trusted support' could be delivered through wider and creative co-operative partnerships between larger and smaller mutually owned businesses.

8. New Start: The Oxfordshire Wheel – a multi-stakeholder social and health care co-op

The Oxfordshire Wheel is a path-finding multi-stakeholder care co-operative with a mission to develop a broad range of service provision for and with disabled people and their carers.⁹⁵ As a majority of its organisational members are disabled people, it is a user- and stakeholder-led organisation supported by institutional founding members like Headway Oxfordshire and Oxfordshire Family Support Network.

Work has been ongoing in recent years to develop the co-operative and with a heavy emphasis from the outset on a 'user-led organisation'. Oxfordshire County Council has been a supporter and legal and technical guidance has been provided by Co-operative Futures of Mid Counties Co-operative.

The Oxfordshire Wheel mission is the promotion and development of self-directed support that ensures that its service-user members have choice and control of the support and help they need in their daily lives. Such support is about enabling disabled people to arrange care based on their priorities including: a) staying in their home; b) being involved in determining their own care plans; and c) managing help from family and friends.

⁹⁵ Information for this case study has been provided through an interview of Yvonne Cox, a leading Oxfordshire Wheel founder and from additional material in the co-operative's 2012-13 annual report.

Launched in 2010, the company is registered as a multi-stakeholder co-operative. Its board of directors is elected from three categories of membership: a) individual service users; b) user-led organisations for disabled people in Oxfordshire; and c) organisations representing people with disabilities and other service users.

At the heart of the co-operative's vision is the development of the ways and means to assist disabled people into paid work. The challenges are formidable as many of their members have learning disabilities or severe injuries and have been out of work for 15 to 20 years. To move things forward, Oxfordshire Wheel has been developing the infrastructure to provide a range of key services linked to their mission. The services include:

- Information and advice provision to members
- Brokerage referrals
- Training and accreditation for brokers and personal assistants
- Support services for carers
- Quality assurance
- Advocacy
- Research
- Consultation services

A major focus of the work of Oxfordshire Wheel is to help disabled members to devise and set up their own Care Plans and to link these to a personal budget that ensures the plan is affordable. Key criteria underpinning any plan is that it should be lawful, effective and within the financial means of the member. Each plan needs to be carefully checked and approved before it is implemented. As a supporter of the service but at arms' length, the local authority maintains its safeguarding and duty of care roles including risk management responsibilities and other statutory obligations.

For two years, Oxfordshire Wheel worked as a start-up without a permanent base. In December 2012 the co-operative opened up its own office in Banbury and has established a growing services programmes including:

- (i) **Support with Confidence:** this is a project under contract with Oxfordshire County Council to train and ensure the maintenance of professional standards for Personal Assistants who are working in adult social care. A disabled administrator recovering from a brain injury has been supported to take on the central co-ordinator job. Prior to this, she had been out of work for six years following her injury. Thus far 84 Personal Assistants have been trained and qualified and 72 others are undergoing training.
- (ii) **Community Learning Programme:** a growing range of courses developed and provided have now been fully accredited and validated by the Open College Network. These include training under four separated modules including: Self-directed support, Direct Payments, Personal Assistant induction and Brokerage support, How to recruit and pay staff.
- (iii) **Community Independent Support Service:** launched in early 2013, this surgery provides one-to-one support to members of the public in relation to claiming a full range of welfare benefits, employment support allowance, personal independence payments and pension credit.

- (iv) **Aspire and Achieve:** this is a collaborative programme that has been co-developed with the co-operative's two institutional founding members to co-deliver support to help those with brain injuries under one targeted project and to assist individual family carers to return to work under a second project.

Much of this type of work is operated by charities across the UK. Oxfordshire Wheel's innovation is to redesign and pioneer democratic ways for these services in future to be delivered through multi-stakeholder co-operatives that give voice and power to its service-user members but also work closely on co-delivery with other institutional and voluntary- sector members of the co-op. This Oxfordshire Wheel model is refreshingly unique and appears to be a pathfinder, though additional resources and ongoing investment are clear needs.

8. Review findings: Social Co-operative Sector Strategy and policy framework

Social co-operatives are an expanding breed of co-operatives in Europe and North America. Other integrated health care co-operative models, such as those in Japan, indicate very effective ways of involving volunteer carers. The Italian and Japanese models appear to be succeeding because they are structured through multi-stakeholder membership and governance and an active role for the members as volunteers.

As Bob Cannell of CICOPA pointed out, across Europe there are a growing number of mutuality innovators embracing the co-operative commonwealth and common ownership action at a local level. So perhaps the time for social co-operative action by diverse stakeholders in the UK is ripe? Cannell highlighted encouraging trends evidencing the growth of a social solidarity economy ethos in rural areas.

'In the UK, the Plunkett Foundation's village shops ['community-buyouts'] renaissance harnesses members as active volunteers, ditto the American food co-ops currently undergoing a huge increase with some 200 new starts on the stocks and similar to the Plunkett model.'

These community ownership structures have the potential to be radically transformative because of the ways both service providers (paid and volunteer) and service users (and their families) can collaborate creatively in detailed aspects of the design, development and delivery of services.

Key preliminary findings from telephone interviews and from the Deliberative Dialogue were circulated among the interviewees, the event participants and a wider group working in social care services and in the social finance and co-operative movement. This consultation led to considerable feedback and additional information. A consolidated list of findings was then developed.

Based upon the feedback from the Social Care sector consultation, information drawn from relevant policy literature and additional inputs from other interviewees and commentators, the twelve key findings from this review are as follows:

1. Ownership and governance: from Co-production to Social Co-operatives

Social co-operatives provide a democratic governance system for responding to the growing policy and practical interest in a wider co-production of social, health and advice/educational services. Co-production ideas and practices have been supported by new economics foundation, Nesta, the Social Care Institute for Excellence, All in this Together in Wales and others in recent years. A growing range of good practice has emerged.

However, there is an evident gap in the market in which to build upon this success by introducing co-operative ownership models to improve the democratic accountability and stakeholder management systems for co-production services. This novel structuring could assist co-production partnerships to expand and diffuse their operations. The Han system in Japan and EP in the USA demonstrate different forms of innovation and there is untapped potential in the UK to implement similar methodologies.

The opportunity to put many co-production services on a stronger legal foundation through social co-operative solutions is evident. Beyond England, leadership on the ground is moving forward positively and practically and working out ways to adapt and implement the Italian and Quebec models

In Wales, for example, the main promoter of legal rules for social enterprise is The Wales Co-operative Centre. Their advisory staff work to promote models where the ownership is clearly and directly by stakeholders on an inclusive and democratic (one member, one vote) basis. Glenn Bowen of The Wales Co-operative Centre pointed out that this due diligence practice appears less widespread in England, where many Community Interest Companies have been set up as social enterprises with a very small and restricted membership and in ways that do not evidence social ownership, let alone democratic control by a strong group of active members.

The attraction of the social co-operative model is that it fosters solidarity and empowers service users and other stakeholders through active membership and ownership of not-for-profit organisations and other social enterprises. This vision is gaining support in Wales. A Social Co-operatives Development Forum (SCDF) was set up in Cardiff in 2012 and has been lobbying the Welsh Government to include provision for social co-operatives in the implementation of the new Social Care legislation over the next two years.⁹⁶ The SCDF recommendations have been supported by the Welsh Co-operative and Mutuals Commission report.⁹⁷

'The Commission considers that there is a compelling case for a greater role for social care co-operatives because of the added value they can bring to social care services, including: High-quality services that are based on co-operative values and principles and not on private profit; Services that are responsive to people's needs, as they are citizen directed, giving a much stronger voice and greater control to service users and carers; Greater contestability in a market dominated by large, private providers.'

The Welsh Local Government Association and the Association for the Directors of Social Services in Wales have supported social co-operative innovation. The Welsh government has responded positively to social co-operative thinking and refers to this model in the Social Services and Well-being (Wales) Act.

2. The information gap and the strategic need to promote co-operative solutions

The workshop on community engagement at the consultation day and the follow-up interviews suggests anecdotally that the work to develop co-operative and multi-stakeholder models of care is still very embryonic.

The consultation day and some follow-up with those attending the event in Birmingham has revealed a growing interest among local authorities in the potential of social care co-operative solutions. Powys Council in Wales has shown an interest, as have Hull, Calderdale and local authorities in the West Midlands and the North East of England.⁹⁸

⁹⁶ Members of the SCDF includes The Wales Co-operative Centre, Co-operatives and Mutuals Wales, Wales Progressive Co-operators, Cartrefi Cymru, Disability Wales, Wales Council for Voluntary Action, the Welsh Institute of Health and Social Care, Older People's Advisory Group and Neath-Port Talbot Community Voluntary Council. Adrian Roper at Cartrefi Cymru has chaired SCDF.

⁹⁷ Report of the Welsh Co-operative and Mutuals Commission, February 2014, see this at: <http://wales.gov.uk/docs/det/publications/140221coopreporten.pdf?lang=en>

⁹⁸ The case profiles in Section 7 of CASA and others highlight co-operative care models and newer experiments underway in Edinburgh, Oldham and in Oxfordshire as well as to some extent through the Home Office pilots.

An in depth empirical study of current innovation in the social care sector should carry out more detailed mapping. Such potential future research could be undertaken on a comparative basis with reference to services in Italy and Quebec and should seek to understand and appraise:

- (i) What is happening, including the role of outreach and community development
- (ii) How organisations engage their members and other stakeholders
- (iii) How co-operative values are embedded in organisations
- (iv) What care sector co-operatives and mutuals are achieving and what are the metrics and the evidence
- (v) What challenges are being faced and being overcome
- (vi) How organisations currently link with the mainstream co-operative sector and other co-operatives in their sector

As several people commented in relation to questions (i) and (ii), there is a vast amount of ignorance among local authorities and other public service commissioners about what a co-operative is, let alone what a care co-operative would look like and might deliver.

The same problem of lack of awareness and understanding is pervasive in the voluntary and charitable sector.⁹⁹ Laurie Gregory of the Foster Care Co-operative commented that there is a lack of any basic literature to pass to these stakeholders to give them a clear idea of what social co-operatives have done in other countries and they could achieve here if given the right, supportive environment.

Bob Cannell made the point that the 'British inability to think that someone else has probably tried this and we should look outside the UK' reflects an astonishing level of insularity while at the same time 'our European cousins are frustrated at our refusal to work with them to reinvent the Co-operative wheel in forms in fact that conform to standards agreed by everyone else in the world.' He pointed to the available CECOP (CICOPA Europe body) video, 'Together', on their website which tells the story of how co-operatives across Europe, including social co-operatives, have been expanding since 2008.¹⁰⁰

3. Lessons from international experience and the elements of success

From the lessons that can be gleaned from international social co-operative practice and other data gathered through this review, the following ten action points are each important to guide UK development work on social co-operatives.

1. The promotion of a new concept in meeting member needs – the multi-stakeholder co-operative among a growing group of practitioners
2. The importance of an agreed Social Co-operative legal definition
3. Tax reliefs and incentives from central government linked to policy objectives that can be measured
4. The successful development of public-social partnerships between co-operatives and public sector bodies at local authority and national levels
5. Negotiated agreements between the trade union movement and the co-operative movement to give assurances that the new co-operatives will not threaten existing public sector jobs

⁹⁹ Experience in Wales initiated by Wales Progressive Co-operators and supported by a wider network of bodies including The Wales Co-operative Centre has highlighted that once these social care co-operative models are presented and explained, the interest from third sector organisations, local authorities and health service professionals is very high indeed.

¹⁰⁰ See the Together video at this link: <http://www.together-thedocumentary.coop/>

6. Co-operative financing systems to provide access to co-operative capital for start-ups, for development and for risk funding
7. Co-operative consortia to reduce operational costs and to provide training and other shared services for social co-operatives
8. Co-operative education to develop an informed membership and informed commissioners
9. Toolkits – to enable local co-operators to get on with the job
10. The role of strategic thinking, research and collective intelligence to drive innovation

CiCOPA, the ICA sectoral organisation for worker co-operatives has drawn upon legal models for social co-operatives and produced an international standard that the EU has recognised.¹⁰¹

4. Social co-operatives and market opportunity areas identified

This review highlights the potential of social co-operative models in a number of key areas where services are already underway in specific markets. The eight market areas that emerged from this social care review as existing or emergent can be summarised as:

- Home care co-operatives from local authority staff transfer using an employee ownership model of good practice like CASA or a multi-stakeholder co-operative or a mutual
- Health Service Mutuals set up as public sector spin-outs like the Care Plus Group or from GP out-of-hours co-operatives or as social co-operatives like Willow Bank Partnership
- Resettlement/rehabilitation and job creation social co-operatives for ex-offenders, those recovering from addiction and other disadvantages
- A social care co-operative model for home care developed in innovative ways by a Co-operative Retail Society that could be replicated nationally - like for example the Child Care Co-operative or the Foster Care Co-operative
- Social care co-operative models that could provide cost-saving alternatives to residential care through methods like the Han system in Japan and EP in Maine
- Care and repair services linked to Home Improvement Partnerships and community finance that could be improved through the use of co-operative consortia for co-delivery and a social care co-operative for their staff and service users
- Voluntary sector care service organisations and social enterprises seeking ways to transform themselves or part of their operations by becoming social co-operatives
- User led co-operatives for co-delivery of services or through a co-operative consortium to provide regional advice, support and training for start up multi-stakeholder co-operatives like the Oxfordshire Wheel

The above service provision areas are not mutually exclusive. A number could be developed collaboratively under a public-social partnership with a local authority and a government body and with the support and regional assistance of a co-operative consortium.

101 CiCOPA (2009) World Standards of Social Co-operatives

5. Conversions from social enterprise to social co-operatives – the culture shift needed

Social enterprise in the UK has a history going back to the late 1970s and has developed a model for working that is distinctive from that of charities. Over this same period, social co-operative models have emerged steadily in Europe and with an inclusive community and democratic ownership structure. Since 2005, more and more social enterprises are embracing increasingly mutual or co-operative principles and practices in how they recruit members and involve them in the social ownership and governance of the business.

Social enterprise development in Italy pursued a co-operative road from the outset and has embedded an economic democracy and mutual aid culture as Bob Cannell, Robin Murray, Henry Tam and many others have emphasised. This unique multi-stakeholder ownership and governance model has spread to a growing number of other European countries. Inspired by Italy, the solidarity co-operative model developed in Quebec is beginning to spread to other Anglophone provinces of Canada and to the USA.

In the USA and Canada the 'Social Solidarity Economy' (strong in southern Europe) is growing as an inclusive and democratic concept of connected organisational networks for transformative change. Could this mutual aid ethos and approach emerge more widely here? The emergence of the Social Economy Alliance may augur well for this opportunity.

The work in other jurisdictions in the UK beyond England, such as the leadership emerging for transformative change through social co-operatives in Wales could become generative.¹⁰² From discussions in Wales, many charities also want to diversify and to convert some of their services into a social co-operative. Perhaps existing legislation could be amended to enable this in ways that the French appear to have done with the SCIC model.¹⁰³

Legal structures for multi-stakeholder co-operatives have been developed and include adapted forms of Community Benefit Society legal rules and specialist rules. Somerset Co-operative Services and a set of co-operative consortium model rules developed by Co-operatives UK have developed these forms.¹⁰⁴ A new set of model rules, FairShares, has been developed to promote a cultural shift to a co-operative system of multi-stakeholder co-operatives.¹⁰⁵ The FairShares model is a company limited by shares.¹⁰⁶

But as Bob Cannell stressed, a change in legal structure would not necessarily be transformative. He pointed out that as a matter of principle, Co-operatives UK, the Co-op Enterprise Hub and Co-operative and Community Finance raise questions and challenge Community Interest Companies (CICs) with a restricted and small membership and practices that do not extend economic democracy to workers and other stakeholders as voting members.

102 From feedback on the consultation day in Birmingham, from the interviewees and other commentators, there would appear to be a significant market that could be developed to assist many social enterprises to become social co-operatives through changes to their legal structure to facilitate the development of multi-stakeholder governance.

103 In Powys, a number of voluntary sector organisations have been investigating the potential of social co-operation including organisational change. Developing out of a year of ways to transform themselves into social co-operatives and holding countywide events hosted by Cartrefi Cymru, in Mid Wales. In March 2014 a commitment from 15 organisations to form a Mid Wales social co-operative consortium was agreed in March 2014.

104 Further information on the 'Somerset Rules' for multi-stakeholder co-operatives can be found at: <http://somerset.coop/somersetrules>

105 <http://shura.shu.ac.uk/7503/>

106 http://www.fairshares.wikispot.org/FairShares_Employee-Owned_Social_Enterprise

Gareth Nash of CMS agreed that culture change is critically important. He argued that a gateway could be created to enable social enterprises and voluntary organisations to be assisted to convert to social co-operatives in the way that Ex-cell has demonstrated as a pathfinder.¹⁰⁷

The Han system in Japan, if better understood in the UK, could be helpful as a locally based way to involve co-operative members in the planning, co-designing and evaluating of advice and care services, and as the Oxfordshire Wheel is doing without the benefit of a supportive public and social policy environment.¹⁰⁸

6. Associative democracy: Implementing multi-stakeholder governance

The concept of stakeholder corporations and stakeholder governance has been promoted for about 25 years. There is a growing literature about corporate social responsibility (CSR) towards stakeholders of a firm. The stakeholders vary widely from employees to customers to suppliers.

While the mainstream literature on CSR is now dominant in business schools, multi-stakeholder ownership and governance requires a much deeper approach. This transcends the weak nature of representative democracy based on individual rights by moving towards engaged forms of deliberative democracy based upon a broader and clearer sense of the mutual rights and responsibilities of citizens. Benjamin Barber described this shift as Strong Democracy, whose mission is a 'participatory politics' for a new age.

Multi-stakeholder co-operatives are forms of associative democracy and represent a qualitative departure from any surface level concept of stakeholders, because the model involves direct empowerment of members in aspects of service design and, where volunteers are concerned, the co-delivery of what is produced and provided.¹⁰⁹ Chris Pienaar of Oxfam pointed to similarities between multi-stakeholders in India that have been achieving remarkable success in rural areas and the lessons from social co-operatives in Italy.

'These stakeholder co-operatives are transformative by nature as they are driven by shared values rather than by the profit motive. Governments against a tide of rising austerity cannot afford to continue to pay high returns on investment to shareholder owned businesses. Social co-operatives obviate this by providing a clear alternative. Moreover the way they actively volunteers helps with recruitment, quality training and furthers organic growth.'

107 Nash observed that the partnership developed between Co-operatives UK and Locality to co-develop community share issues is work that could be extended into this emerging area of mutuality in the UK.

108 Yvonne Cox, a former CEO of an Oxfordshire NHS organisation and one of the developers of Oxfordshire Wheel said that the rhetoric about empowering service users from Government is not backed by investment in the process necessary to make this happen. She also said that Oxfordshire Wheel regard co-operatives as the only genuine way to empower service users and to help User Led Organisations to grow and flourish.

109 The consultation in Birmingham concluded that language is important for fostering community engagement and participants stressed that there is a lot more time needed for events like the Co-operatives UK Deliberative Dialogue to begin a realistic conversation on ways to develop collaboration among service users, those in the co-operative sector plus other key stakeholders in local government, in the NHS and among social landlords. Participant Moyra Riseborough pointed to relevant research findings on the effective methods for community engagement and user control that Joseph Rowntree Foundation, the Beth Johnson Foundation and the Housing LIN have published. As efforts to develop social co-operatives evolve, research funding might be secured from bodies like this.

Henry Tam stressed the need for any social enterprise or charity that wants to convert to a multi-stakeholder ownership and governance system to be made well aware of the full implications and the fundamental need to build inclusive communities as the changeover is implemented. Otherwise any managerial elite, accustomed to vertical command and control systems, will operate no differently than they already do in most single stakeholder or shareholder structures where economic democracy is not cultivated.

'I think that while some with a managerial perspective may see multi-stakeholder as something they need to get their heads around, from a co-operative-communitarian point of view, all inclusive communities must inherently embrace multiple interests and facilitate their mutually respectful collaboration in order to steer their collective direction. Using a concept which has grown out of the co-operative tradition would add even greater strength to the thinking on how to cultivate multi-stakeholder solidarity.'

Roger Spear of the Open University pointed out that disability organisations in the UK have pioneered service redesign across many services and developers of multi-stakeholder co-operatives could learn from that well-documented work and good practice .

7. Co-operative education and knowledge transfer

Strategically, there is a major need to provide co-operative education on an ongoing basis for all new social co-operative members. As the pioneering work of Oxfordshire Wheel has shown, it is crucial not to underestimate the resources needed to enable multi-stakeholder members to experiment and find out by doing how to direct, co-design and manage their affairs effectively.

Service managers and workers, paid and voluntary, also require training and support. Work has begun in Wales to begin to frame, design and develop a programme of social care co-operative training courses. The Oxfordshire Wheel's four accredited courses and other similar ones should be linked up with other similar training in the social care sector. Considering ways to consolidate educational services for the sector is an obvious area for strategic consideration at a national level in England, Wales, Scotland and Northern Ireland.

Girard emphasised the importance of adapted training programmes for board members and executive directors in order to develop their skills for diversity management. Girard set out the practical challenges of switching to a multi-stakeholder governance system in this way:

'Clearly it is a good idea to give power to different stakeholders (users, workers, etc.) BUT the board members need to think not only about their members' group interest; BUT also about the general interest of the co-op. Otherwise the board meeting could become a boxing ring! In this sense, the board chair need also to follow closely the guidance of training programme in order to know how to manage the deliberative democracy process during the board meetings. Reliance mainly on wishful thinking would be a big mistake!'

Girard's strategic guidance and message, while noting the pitfall areas, is both clear and positive. While it is not easy to manage effectively and efficiently a multi-stakeholder co-operative, it can most definitely be done well with the appropriate tools.¹¹⁰

110 Girard's words of warning are based on many circumstances in Quebec where the training of the stakeholders was not invested in. The adverse consequences he reports are several including dysfunctional multi-stakeholder co-operatives and characterised, for instance, by the isolation of some groups of stakeholders, who are alienated from the board of directors, feeding suspicion, leading to lots of informal meetings, breeding permanent toxic tension, and in the worst cases, leading to the collapse of at least one co-op after a few years of infighting like this.

Cannell felt this would be a real challenge in the UK with a mentality he described as ‘the boxing ring problem’ rooted in:

‘the British ideal of a board member as a gruff fighter for what they individually believe to be right. So you get a bunch of people all pushing their pet interests (usually nit-picking the budgets) while the CEO is secretly manipulating the organisation into a merger where s/he can command a bigger salary.’

For Cannell a real culture change is required to advance genuine co-operative economic democracy with wider participation by members and stakeholders. This challenges current practices in the mainstream co-operative movement, as well as within the wider social enterprise sector.

8. The need for Co-operative Consortia to empower local and distributed provision

The review considered the use of co-operative consortia methodologies for implementing and reducing the costs and overheads of social co-operative service provision. Such methods are essential to achieve economies of scale while maintaining both a human scale and effective member engagement within and between individual social co-operatives. The Italian ‘strawberry patch’ methods show how this can be done.¹¹¹

There has been some development of this methodology in the UK over the past twenty years, on which Co-operatives UK has reported. This includes two examples of consortia services in the care and health services sectors – Wrekin Care Co-operative in the West Midlands and SELDOC, the GP co-operative that provides out-of-hours medical services in south London.¹¹²

However there does appear to be a problem in advancing the Co-operative Consortia methodology and systems nationally. Bob Cannell of CICOPA feels that this is due to the ideology that has become dominant about social franchising. As he pointed out, the Italian and Spanish approach is not about some privatisation of intellectual capital and resale in the social economy sector. It is about collaborative sharing and open source knowledge transfer.

Robin Murray echoed the need for the latter in the UK. The Mondragon co-operatives promote what they do in Spain as well as how they do it and invite others to copy and fill the gaps with their enterprise ideas. So how might open source collaboration and this ethos be advanced?¹¹³

Ben Hughes of the Community Development Finance Association (CDFA) commented that good examples of community finance partnerships like the work of Wessex Home Improvement Loans in the South West are indicative of how co-operative systems linked hand in glove with local authority partners can provide collaborative and networked co-delivery with high social impact.

111 This is an ingenious method to enable local and human-scale social co-operatives to be formed with a maximum membership of 100. Each established social co-op agrees a social solidarity pledge to invest time and effort to support another social co-op to be formed by ‘putting out a runner’. This is the ‘strawberry patch’ principle for establishing, developing and maintaining a decentralised and federated social co-operative network.

112 Co-operatives UK (2008) Trading for Mutual Benefit – A Guide to Co-operative Consortia

113 The social co-operative work developing in Wales could mark a turning point and sea change for the third sector and Social Solidarity Economy strategic coming together in peer-to-peer collaborative economy ways that aim to empower the smaller local organisations, not just boost the position of the bigger players in the social economy.

'These and other community banking partnerships are great examples of home based lending and the positive impact this can have on social care and financial returns (improvements/savings). But I see it as going beyond this in that lending to low income/excluded communities for both personal and enterprise purposes we know achieves significant social impact, and so direct benefit in terms of secondary social care.'

In Mid Wales, after 18 months of discussions and meetings, 15 co-operatives, social enterprises, charities and voluntary organisations jointly agreed in March 2014 to set up the first co-operative consortium to co-develop care services in the UK,. Both The Wales Co-operative Centre and Co-operatives UK are assisting with the development of the model legal rules.

9. The need for redesigning services for added value and quality provision

In relation to the question of how successfully to develop social care businesses, the experience of investment by Co-operative retail societies and their involvement in the sector to date is not encouraging. The care sector is widely known as a high volume and low margin undertaking. Margins in the 3 per cent to 6 per cent range are average but many service areas lose money. Wage rates of £6 to £7 an hour attract a casualised workforce with a high staff turnover rate. Some specialist niche areas such as the treatment of those suffering Alzheimer's disease have better margins but the provision is fiercely competitive.¹¹⁴

Residential care is increasingly becoming a fraught and high risk field. For example, Midcounties Co-operative sold off all their residential care homes because they were fed up with "reducing the quality in order to balance the books." The lesson that can be drawn is that other market segments are where success for co-operatives services is to be found.

The approach of both EP in Maine and Ex-Cell with Type B social co-operative development shows how to provide unconventional and collaborative solutions that demonstrably save costs and empower members.

The family-based service, Shared Lives, matches a carer with an adult in need of support. They do this by identifying common interest areas. One mutual exchange arrangement provides accommodation for the carer in the service user's home. Another exchange may provide day support through activities in which they both share an interest. Like EP in the USA, Shared Lives is working with the latest digital technology to facilitate mutual exchange systems. Nesta has awarded Shared Lives funding to introduce and trial Tyze networks that have been developed in Vancouver, Canada.¹¹⁵

Home Share services operate in a similar way and the savings are significant. The transfer of a care user from a residential home to care in the community generates an average savings of £13,000 a year for each Shared Lives user.¹¹⁶

Respondents to the consultation reported on the savings being made by a reduction of sickness leave that innovative social enterprises and social care co-operatives are reporting. Danyal Sattar of Esmée Fairbairn commented on patterns of sick days among both local authority and some private sector care services of an average of 35 days a year -and among some local authority services of 42 days a year. These figures are close to one day per week per full-time carer lost through sickness. As Sattar commented: 'Essentially staff were informally compensating their low pay with extra holiday time.'

114 There are 800,000 sufferers of Alzheimer's disease and severe dementia in the UK. This is forecast to treble over the next 20 years. One-quarter of hospital beds are occupied by those suffering with this condition. The cost of care is £23 billion annually, which is twice the budget for treating cancer and three times the cost of treating heart disease. Some innovative but expensive social enterprise solutions have been pioneered in the Netherlands - see Jon Henley 'The village where people have dementia – and fun', The Guardian, 27 August 2012.

115 <http://giving.nesta.org.uk/project/tyze/>

116 Alex Fox 'What older people need is not choice, but companionship', The Guardian, 11 June 2013.

Sattar pointed to two examples of innovative social enterprise models that have almost eliminated patterns of worker sick leave.

'A charity provider took on two such homes in Sandwell, and reduced sick days to 0.7 per worker on average (with no change in the terms and conditions of the workforce or eligibility for sick days and allegedly, no change in underlying sickness). Driver for the change was a change in culture in the new structure, sessions with care recipients explaining the impact of not having their regular care givers on their lives. Similar stories out of a care cooperative in Scotland.'

The charity provider is Sandwell Community Caring Trust. Taking on a home care contract from the local authority, they not only reduced sick leave days over three years from 22 a year to less than one day; they also reduced staff turnover from 40% a year to about 7%.¹¹⁷ Geoff Walker, the services manager, highlights both the cost and quality double bottom-line impact. The changes they made 'save huge amounts in training and recruitment. Those two things also really improve quality of care because services are reliable and consistent.'

Big Issue Invest has provided social finance for Sandwell Community Caring Trust to expand and they pointed to the IT back office system they operate that enables them to monitor carefully the quality of care for efficiency while at the same time ensuring high levels of staff and service user satisfaction.

10. Personal budgets, direct payments and integrated co-operative solutions

As a result of the Lansley reforms, there is a shifting of public health responsibilities from the NHS to local authorities and a transfer of funding of £2.7 billion a year.¹¹⁸ Local authority public health teams have a responsibility to seek out healthy living solutions that can save costs to the NHS. Nesta's 'People Powered Health' programme has been testing public health solutions in six different localities in the UK.

Self-help and user led groups are widespread nationally - but generally below the radar screen and thus not taken seriously by commissioning bodies. This is beginning to change in some areas. Community Catalysts CIC is a dynamic example in Nottinghamshire and operates as a network of micro-providers (with typically two to five staff), each delivering services in different areas of the county to provide flexible, localised and personalised support to help people with budgeting and direct payments in effective ways that make choice meaningful. Care is provided through the development of the Shared Lives scheme and Home Share programme.¹¹⁹

Community Catalysts continue to explore co-production and co-operative themes with the creation of local models to support individual care providers as well as the creation of micro-enterprise specific quality assurance standards that can be recognised by local authorities. They also are researching micro-providers to identify what proportion are co-operative in form.

The problem of lack of capacity is an underlying issue that Oxfordshire Wheel is seeking to solve. Social co-operatives can play a major role in addressing this formidable challenge.¹²⁰

117 Victoria King 'Could co-operatives be the future of care?', BBC News Politics, 24 August 2011.

118 John Craig 'It's time for people-powered services', New Start, 3 September 2013.

119 For more information on Community Catalysts see: <http://www.communitycatalysts.co.uk/>

120 Yvonne Cox pointed to the complementary nature of new user led co-operatives like Oxfordshire Wheel and efforts by Laurie Gregory and others to develop Home Care Co-operatives. Both efforts need to be joined up. The Japan integrated health and care model shows precisely how this can be done.

Up2us, based in Kensington and Chelsea, is a group of people in receipt of personal/ individual budgets who are pooling their money to do things together and buy things collectively. Like Oxfordshire Wheel, they are a multi-stakeholder co-operative co-directed by people with learning disabilities. New economics foundation has been evaluating their work as part of a wider project looking at people pooling individual and personalised budgets.

The forthcoming roll-out of Personal Budgets provides a major opportunity. NHS patients will be able to work with their GPs and other services like Oxfordshire Wheel to decide how the money should be spent, and partnerships will be developed with local authorities. The Government has seen personal budgets and choice as the key way forward. Alex Fox of Shared Lives argues that this focus on demand only is one-sided and for many, if not most, service users will not work unless supply side measures are also implemented to develop relational goods that empower people.¹²¹

Co-operatives UK has been investigating ways to create a co-operative consortia model to facilitate the updating of personal budgets and overcome some of the legislative and contractual challenges of individuals directly employing their care support.

Mutuo is exploring the possibilities of creating co-operative and mutual enterprises based on the innovative management of personal budgeting and direct payment funding streams. They see the major challenge and opportunity as with 'health and social care integration which is so problematic because of the institutional divide between NHS and local government.'

The current system provides a statutory right to health services but not prevention-oriented services in the community that could achieve major savings nationally if health and social care budgets were integrated. Shadow Health minister Andy Burnham has referred to social care as the ultimate postcode lottery.¹²²

Mutuo is appraising the potential for personal budgets and direct payments to make a radical difference in the opportunity for real co-operation. Responding to the consultation, Cliff Mills explained their approach.

'As I see it, the main impediment to effective mutualisation of our public services is the lack of an economic relationship between the service-user/customer and the provider. The dynamism of co-operation is (in my view) fundamentally based on the engagement of the individual in an economic enterprise, and where the individual is not spending any money, that engagement is necessarily more limited. So I see the extension of personal budgets and direct payments as potentially remedying this problem. Not only does it provide the individual with an incentive to get more for their money/budget, but as we know from nearly 200 years of history this tends to result in the creation of pro-social relationships which tend to encourage the individual to collaborate with others and share the benefits of trade for the wider public benefit.'

Disability Wales and The Wales Co-operative Centre have co-produced a report with guidance on how co-operatives can be established to support personal budgets and to manage direct payment arrangements by the service user or with family member support.¹²³ The report highlights emerging good practices in the UK as well as from Sweden and Norway.

121 Alex Fox (2013) Putting People into Personalisation: Relational approaches to social care and housing, Res Publica Green Paper, produced for Hanover Housing's 50th anniversary debate, June 2013.

122 Patrick Wintour, 'NHS patients should have the right to see records online, says Andy Burnham', The Guardian, 1 December 2013.

123 <http://www.cooperatives-wales.coop/wp-content/uploads/2013/08/direct-payments-report-eng.pdf>

11. Co-operative venture funding and a social financing framework

In Italy and a growing number of other countries in Europe and North America, social co-operative networks have developed effective co-operative financing mechanisms that can enable the provision of services to be scaled up. In Italy, Banca Etica Popolare was co-developed by the non-profit sector, the social co-operative movement, environmental organisations and a number of local authorities. It has become a specialist provider of social finance. Other social co-operative finance specialists in Italy include ETIMOS, and MAG (Self-Help and Mutual Associations) and the mutual guarantee funds operated by the Italian co-operative federations through national consortia.¹²⁴

Notoriously low margins in social care make it difficult to build reserves to fund expansion and to develop assets for leveraging capital. Accessing social finance and co-operative venture funding will be essential. John Restakis points to the two-way partnerships in Italy, in which the municipality finances the construction of hardware (e.g. a new care facility) and the social co-operatives deliver the 'economic democracy' provision and the inclusive forms of care.

To become viable within two years, CASA estimates that a care co-operative needs start-up capital of at least £250,000 and a contract commitment of two or more years from a commissioner. John Restakis points out that in Italy social co-operatives began partnerships with local governments on short-term contracts of only one to two years but this now been extended to terms of up to ten years.

Social venture capital fund members of the Community Development Finance Association (e.g. Bridges Ventures, Big Issue Invest and CAF Venturesome) should be engaged in the discussion. Bridges Ventures has played a key role in helping CASA to expand by providing loan capital from their social venture fund that can be converted into preference, non-voting stock.

Many members of the CDFA responded positively to this consultation. Big Issue Invest has supported both co-operative care organisations and other social enterprise care providers. Their investments have ranged from conventional repayment loans with a fixed interest rate, to interest only with a bullet repayment of capital at the end of the loan term, to equity investments through preference shares.¹²⁵ They indicated a range of weaknesses they encounter with social care organisations seeking social finance. They were attracted to the co-operative consortium innovation of the Italian social co-operatives as this and a system of mutual guarantees could help address a number of the weaknesses below that lead to loan and investment rejections.

- Gaps in management expertise for many services – including tendering capacity for big contracts
- Isolation and a lack of communication between dispersed organisations
- Lack of strategic leadership and national profile
- Assets to support access to finance
- Short length of contracts
- Lack of substantial back office support to help reduce costs and provide efficient reports for delivery, CRM (customer relationship management) and financial reports.

124 Antonio Thomas (2004) The rise of social co-operatives in Italy, *Voluntas*, Vol. 15, No. 3 September 2004.

125 This review has not had the scope to conduct an overview of the available social financing mechanisms, but this should be done during a further stage of research and development.

Tracey Axten of Big Issue Invest stressed the importance of an emerging social co-operative movement to advocate the development of public-social partnerships that support multi-stakeholder models as a preferred option and 'include the requirement for longer-term and a diversity of contracts'. It is the successful negotiation of longer-term contracts, she added, that is key to securing social finance on an enabling basis. She pointed out that a barrier to social co-operatives and simply care co-operatives generally is certainly a widespread lack of awareness by service commissioners of the co-operative option and solutions.

Neil Hewitt, manager of the social and cultural team of Triodos Bank advised that they have an investment portfolio of about £70 million for social economy organisations in the health and social care sector. A significant area of their lending is property and asset backed finance which extends across the whole range of range of health and social care services. Hewitt described the demand for social finance from Triodos.

'Given the funding and operational changes that we are seeing in the National Health Service, we are seeing the creation of more specialist areas such as dementia, autistic and high dependency care, which we are keen to support. There is also the growing sector of extra care that provides people a choice of tailored services, to help them live independently within their community. Over the past 18 months we have funded a number of these projects that are typically purpose built facilities, through the initial development phase and then onto the longer term operating loan.'

In addition to its defined care sector lending, Hewitt was keen to point out the valuable contribution made by community organisations, faith groups and housing associations, to the health and social care sector. Health and caring for the individual's well being has formed a significant part of the Triodos UK customer portfolio over the past 16 years, and is directly aligned with the Bank's values and mission of using money to support the quality of life, and ensuring that the preservation of human dignity remains at the very core of our society.

Robin Murray pointed to the Welsh Co-operative and Mutuals Commission and the strategic need for a Co-operative Finance Initiative – a CFI alternative to the failed and tragically flawed PFI.¹²⁶ Murray argued for the need to establish an 'acceleration fund' that could perform the same co-operative venture financing functions that the Caja Laboral Popular co-operative bank provided for the successful growth and development of the Mondragon network of worker co-operatives.

Danyal Sattar, Social Investment Manager of Esmée Fairbairn Foundation, found the tax incentives for social co-operatives in Italy and other countries a key element but stressed the need for further work to tease out the public policy case in order to highlight the benefits of co-operative models. He also felt that a strong impetus for introducing social co-operatives could be achieved through a focus on getting mutual guarantee funds up and running in the UK. He appraised the strategic opportunity concisely.

'In general, guarantee approaches seem under-utilised in the social investment sector and have some potential advantages to the likes of us – we can leave our funds invested (earning a return) while carrying risk for an entity less able to carry it. The logic of making a guarantee would be

- *In an area where the problem is uncertainty (you do not know what the risk is)*
- *Our hypothesis is that the risk is in fact a low one, so the guarantee unlikely to be called*
- *Function of the guarantee would be to prove the actual level of risk*

Where we would be a bit more reluctant would be where there is a permanent risk problem (say, SME finance) where you already have a fair idea of what the likely loss rate is.'

126 Robin Murray (2013) op. cit.

Malcolm Hayday, a co-founder and former chief executive of Charity Bank echoed the Sattar appraisal.

'I recall social co-ops and [social finance organisations] like MAG [in Italy] and have never really understood why it has not taken wider hold. I know there has been some cultural resistance in the UK. Perhaps through ignorance? Guarantee funds are a key element and I like the Italian and Canadian ways of developing those funds.'

Hayday felt that the timing for this could be good and that 'armed with this report' there was a clear need for Co-operatives UK to consult with the social banks (e.g. the Co-operative Bank, Charity Bank, Unity Trust and Triodos) and the Community Development Finance Association on how social solidarity financing mechanisms like these and mutual guarantee schemes like those in Italy could be introduced and co-developed.

Innovation Funds like the one launched to support health and social care co-operatives in Edinburgh will be needed in other sub-regions of the UK. Ben Hughes felt that there was a strategic opportunity for creative collaboration between Co-operatives UK and the CDFA to work together on the social financing framework. He saw scope for co-working on:

- Community share issues, peer-to-peer and crowd funding methods for raising capital
- Tax incentives to expand the scope of Community Investment Tax Relief (CITR)
- Co-operative consortia and 'Sharing without Merging' methodologies for partners
- Mutual guarantees and possible links to the Enterprise Finance Guarantee
- Community banking and community finance partnerships to support social co-operative innovation and development locally and regionally
- Co-operative capital: a patient capital fund, not a loan fund¹²⁷

Hughes added that Co-operatives UK should work with Social Enterprise UK to include social co-operatives as a category of social enterprise in the development of Social Investment Tax Relief (SITR) that will be introduced in April 2014.

Co-operatives UK has produced a think piece on the concept of 'co-operative capital' from Mark Hayes, a co-founder of Fairtrade social finance specialist, Shared Interest.¹²⁸

12. Governance tools and measuring social economic impact

There are a number of management and governance tools that could be adapted to develop a UK framework for multi-stakeholder co-operatives which would reduce their complexity. One is the Viable Systems Model (VSM) pioneered by Stafford Beer, which has been adapted by Jon Walker for co-operative enterprises. Some commentators found the model of sociocracy helpful, which was developed by the Dutch educator, Kees Boeke, as well as the Circular Organising methods that have been further advanced by Gerard Endenberg.¹²⁹

127 While any development of 'co-operative capital' would require widespread consultation in the co-operative sector, Hughes felt there could be scope to develop such patient capital a sub-set of a national CDFI fund and added that this idea is attracting growing interest from different parts of Government.

128 Mark Hayes (2013) *The Capital Finance of Co-operatives and Community Benefit Societies*, Co-operatives UK, July 2013 <http://www.uk.coop/sites/storage/public/downloads/capitalfinance.pdf>

129 <http://www.sociocracy.info/> and see also Kees Boeke (1945) *Sociocracy: Democracy as it might be*.

Bob Cannell stressed the need for a radical ethos as fundamentally important. He recommended a return to the 'Self-Help by the People' ideas of George Holyoake that promote 'self-organisation and an emergence of organisation from the participation and co-operation of the participants'. As an example he pointed to the Japanese 'Hans' that are self-reproducing because they provide the needs of their participants.'

Chris Pienaar argued that to support social co-operatives to forge ahead in the UK there is a need for a set of measuring tools and proxy indicators. These are key to tackling the 'race to the bottom' pressure to pay lower wages that is manifestly reaping what has been sown, leading to a damaging public mistrust in care services.

'Caring individuals were previously carrying out those roles but have been replaced with less caring workers on minimum wages. What is the commercial value of someone genuinely caring for you? If this had had a physical value, the drop in services/caring levels would have been financially apparent and reflected in performance indicators against service delivery agreements. The elderly and those with special needs are particularly vulnerable as they are less likely to be heard and they value the visits by someone who cares more due to their restricted social networks.'

There are a number of tools for valuing what matters. Known as LM3, the Local Multiplier Impact innovation of new economics foundation (nef) continues to evolve and is being promoted by Anthony Collins Solicitors in partnership with LM3 Online. They point out that the 'introduction of the Public Services (Social Value) Act while catalysing interest in the area has added confusion.' They observe that 'the Act places a duty on Commissioners to consider Social Value, but neither defines the meaning of Social Value nor supplies guidance in its measurement.' Both partners have tailored and developed LM3 as a specific measuring tool to plug this gap.

Roger Spear questions the value of social return on investment (SROI) as a tool for measuring social impact because existing methods are very resource intensive and expensive. He recommends simpler methods that can be used by stakeholders themselves. The Prove It system developed by new economics foundation (nef) can work well and so can the Balance Scorecard developed by Social Enterprise London.¹³⁰ nef research has found that these stakeholder-driven methods unite both means and ends because being involved and valued for your opinions and guidance has been found to be an intrinsically high indicator of well-being.¹³¹ Ben Hughes of the CDFI indicated that their new community development finance impact tool to be launched in 2014 could work well with social co-operative development and collaborative efforts.

130 <http://www.proveandimprove.org/>

131 Nic Marks (2008) Five ways to well being: the evidence, new economics foundation.

9. Conclusion and sector review recommendations

Since the 19th century most co-operatives in the UK, have been single stakeholder. The social co-operatives in Italy and the solidarity co-operatives in Quebec are reframing co-operative provision in dynamic ways for the 21st century. Their ethos described as the 'Social Solidarity Economy' strategically fosters inclusive communities. This approach has been spreading beyond southern Europe and francophone countries to western Canada and the USA. This strategy deserves to be more widely understood in the UK.

Multi-stakeholder co-operatives provide a new model for social care that should be strategically developed in the UK. However, as Italy has shown, worker co-operatives are also a key delivery system and in the care field can be seen as social co-operatives. These are key conclusions of this sector review. With their support, existing UK worker co-operatives in the social care sector should be included in a national definition for social co-operatives that is inclusive of both worker and multi-stakeholder options.

The scope for a social co-operative agenda needs debate and discussion. This is strategically important as social co-operative models in both France and Quebec have respective missions that encompass the social enterprise sector very widely indeed, including areas related to environmental action. This could be relevant as is the example of the care and repair bodies reviewed in this report highlights. London Rebuilding Society provide care-related services while also tackling fuel poverty through additional insulation and energy efficient heating systems. Environmental action is a major area of the multi-stakeholder co-operatives in francophone countries.

Jonathan Bland, a founder of Social Enterprise UK, has been a strong advocate of social co-operatives since his early days with Social Enterprise London. In 2011 he observed:¹³²

'There's nothing hugely different, culturally, which means the co-operative model couldn't work here, but big changes are needed to legislation and attitudes. At the moment we're in the rhetoric phase – there has to be a lot more work to actually build capacity and there's a vital role for government in taking the lead. People need building up the skills, they need access to capital, tax breaks, and so on. Councils have to change their thinking too because if they just keep on procuring from the same big supplier, small co-operatives will never get a look in.'

Bland summarises well the sea change in attitudes and action needed to go down the social co-operatives road. He also lists the key ingredients for success. Many commentators on the sea change required, such as Cannell and Tam, stressed far more the cultural change barriers to develop inclusive forms of participative democracy for social co-operatives.

Evidence of innovation from social enterprises who are members of Social Enterprise UK was crucial for gaining a wider understanding of the needs beyond the current practices of members of Co-operatives UK - either within the specific community health services sector where multi-stakeholder models are growing or among social enterprises providing home care.

¹³² Victoria King 'Could co-operatives be the future of care?' BBC News Politics, 24 August 2011.

This review has also identified a strategic market opportunity for the Co-operative movement to collaborate with other stakeholders in the public sector, the voluntary sector and the social enterprise sector in the development of specific, well designed multi-stakeholder models for social care. Creative partnership with co-operative and community development finance organisations will be needed to design a social financing system. The democratic involvement of workers (paid and unpaid) and service users is a challenging but potentially generative area for the development of effective solutions. The international evidence gathered and summarised in Section 4 confirms this.

Looking at the challenge in one way, this opportunity would appear to be an impossible mountain to climb as the public sector funding environment continues to deteriorate. Gregory of the Foster Care Co-op summed up the turning point that lies ahead this way:

'All the demographic evidence suggests a massive growth of dependent adults and it is clear that the self-paying service users are very much part of this growth pattern. The position with those depending on state financial support is currently unsustainable, and it can only be a matter of time before Central Government is forced to provide extra finance within a carefully controlled and monitored system free of abuse and excessive profiteering by a range of "for profit" agencies. When the environment changes there will be opportunities for a greater and more viable involvement with those dependent on state financial support.'

In Gregory's appraisal, this means that the kick-starting of home care services through social care co-operatives will require a mixed pricing system and a targeting of a wide spectrum of care service users in ways that enable some services to be run on a break-even basis for lower-income users and other services provided by self-funding and relatively better-off service users that will enable social co-operatives to trade positively.

Timing to move forward with a social co-operative model is opportune as the shift of funding from the NHS to the local authority sector and the devolution of a public health budget opens up strategic opportunities to engage public health teams and other commissioners. Policy related social investors including charitable foundations are also likely to be attracted to an invitation to assist in this innovative opportunity to co-develop a more inclusive and democratic model for empowering service users, paid carers and volunteers.

Other GP co-operatives and potential strategic partners like SELDOC and the Willow Bank Partnership CIC in Stoke-on-Trent are emerging. Co-operative consortia could unite a broad range of worker co-operatives, multi-stakeholder co-operatives and community health service mutuals in a national advocacy and delivery network that is democratic, decentralised and distributed.

Danyal Sattar pointed to the strategic opportunity for a radical but democratic redesign of social care services on a multi-stakeholder basis.

'It may well be the economic potential for a "fair" structure like a Co-operative is in practice, high, even if in theoretical terms, an economic benefit may not look like it would be there.'

As so many other respondents to the consultation have indicated, the obstacles are widespread ignorance, policy prejudice and a lack of practical experimentation with a generative new frontier that other countries are demonstrating. This applies to the best models in the UK, which have been highlighted in this review.

Robin Murray summarised the opportunity for social co-operative models to demonstrate how to secure 'economies of co-operation'.¹³³

'The promising areas for substantial savings are:

- (i) *Replacing residential care with domiciliary care*
- (ii) *Integrating care with other services such as health care and housing*
- (iii) *Integrating care within a package of well-being services that generate their own income streams*
- (iv) *Integrating informal voluntary help and finance with formal professional based services*
- (v) *Making use of the rapidly developing digital tools and infrastructure to support the above*
- (vi) *Developing collaborative back office services to reduce the overheads for autonomous front-line service providers.'*

With these ingredients for success in mind, this review has found that there are several interconnected ways of driving forward the development of social co-operatives nationally, with the caveat that these will need to be adapted to the different legal jurisdictions of the UK.¹³⁴

The twelve recommendations below are proposed as an action list.

1. **Briefing materials:** ignorance about the potential for multi-stakeholder co-operative solutions is profound across Government, within local government, across the NHS and in the third sector. Well-designed briefing documents are needed as a high priority. To make a start, this report should be published and a summary of key findings and other elements disseminated by Co-operatives UK. There is also a need for shorter, focused and topical documents providing targeted information about social co-operative legal structures, business models and income streams, as well as areas for cost saving through the co-operative methodologies highlighted in this report.
2. **Legal recognition and incentives:** Legal structures and model rules for social co-operatives are available and there are already a wide range of good practices. Wider understanding in the UK of the international definition of social co-operatives is needed. This promotional work should be led by Co-operatives UK to exemplify current good practice and to clarify the core mission, membership categories and to make improvements as necessary in the existing sets of model rules. Careful consideration should be given to the scope of the mission and a national strategy for development. As in other countries, fiscal incentives may be needed and justifiable to assist the social care co-operative sector to expand, to thrive and to secure its strategic potential. Co-operatives UK should take a lead role in investigating this matter and advocating for the enabling changes needed from Government. Collaborative work with Social Enterprise UK and the Government should ensure that social co-operatives are included as a category of social enterprise for Social Investment Tax Relief (SITR) in 2014.

¹³³ Robin Murray (2013) op. cit.

¹³⁴ A number of points in this list have been developed from consideration of a forward strategy that emerged out of discussions held between Robin Murray and Laurie Gregory and documented in an unpublished paper dated 10 November 2011.

3. **Design work:** the review has highlighted key innovators in the co-production field where social co-operative solutions could provide a more effective governance and ownership model. Some design work is underway on the delivery by social co-operatives of home care and the development by social co-operatives of employment for ex-offenders and for disabled people. Areas of care and health service needs should be identified by Co-operatives UK and sources of innovation funding for detailed business modelling in niche and wider markets should be explored, with a focus on the redesign of service delivery by social co-operatives. This work should utilise user-centred design methods and incorporate new technology.
4. **New technology:** securing 'economies of co-operation' is crucial for the development of high quality services that can reduce transaction costs, co-ordinate the co-delivery of paid and unpaid care services and facilitate direct payments. Digital technology is essential and innovation in this area must be a high priority for action by Co-operatives UK with other partners. Lessons should be learned from best practice in the social care and related fields.
5. **Consortia:** Further investigation by Co-operatives UK is needed to identify where shared cost savings lie and what functions can be pooled and developed, including back office, training, market research, technology solutions and advocacy specific to the co-operative care sector. The work in Italy to develop specialist 'real service' centres for the sector (such as in Trentino) should be considered for guidance and good practice. Input and relevant expertise in relation to NHS spin-outs from Social Enterprise UK, Mutuo and the CDFA should be sought.
6. **Advocacy:** The design work needs to feed into a series of policy reports by Co-operatives UK on key social and health care service need areas. This work should document and provide a critique of existing forms of service and set out a vision of the alternative, using working examples based on existing practice but also incorporating new design work showing specific areas for innovation. Specific areas for further research and development should include cost savings that could be generated through social co-operative methods and holistic approaches with evident economic benefits including job creation, return to employment by disadvantaged groups, reduced clinical support and medication and other identifiable impacts. Gathering comparative data from the Care Quality Commission and other sources to contrast private sector performance with co-operative and innovative social enterprise providers would be a key starting point.
7. **Social finance:** Work needs to be undertaken to design the social financing mechanisms and framework for mobilising development capital to support a diversity of social co-operative pathways including start-ups, public sector spin-outs, non-profit conversions and co-operative partnerships. Social finance organisations with expertise in care services and other relevant social economy sectors should be approached to explore the development of a Co-operative Finance Initiative (CFI). Co-operatives UK's work on mutual guarantee societies and co-operative capital should be advanced in partnership with the Community Development Finance Association. This work on financing frameworks needs to draw in and involve other sources of capital including the social banks, mainstream banks, Government, foundations and equity providers.

8. **Education:** A task group needs to be established by Co-operatives UK to appraise existing training materials developed for care co-operatives, and to develop a bespoke, modular training programme that can be extended as the social co-operative sector expands and diversifies. Given the diverse needs of stakeholders, the design of this curriculum and the modules needs to be done with optimal flexibility, and range from a basic workshop format to fully accredited courses and professional qualifications. Particular attention should be focused on governance, the training needs of elected board members and ways and means to adapt legal structures, advance the cultural aspects of multi-stakeholder management and stakeholder participation, and further the economic democracy of social co-operatives.
9. **Knowledge transfer:** Peer-to-peer learning will be essential to expedite development. Knowledge transfer systems need to be established by Co-operatives UK and other partners efficiently to spread high-quality and cost-effective ways of working. A Community of Practice Network and Action-Learning Set are recommended for early adopters and pathfinder social co-operatives in emergent market segments.
10. **Open source information:** Sharing documents, disseminating good practice, developing case studies, recorded short talks and videos need to be brought together by Co-operatives UK and other partners as a common resource. The respective roles of Co-operatives UK, local social co-operatives and Consortia organisations need to be considered strategically and a system that works at both local/ regional and national level should be tested and adapted until a viable system emerges.
11. **Valuing what matters:** Social co-operatives need to develop a system of metrics that values what matters. Well-being indicators need to be given the highest priority and the design should be stakeholder led. Care Quality marks need to be co-developed and assessment mechanisms agreed with local authorities and the public sector, as is the case in Italy. It will be necessary to negotiate other cost-saving metrics with procurement bodies. Low-cost social accountancy systems, such as Prove it and the Balanced Scorecard, offer helpful tools. The Seikatsu Co-operative self-regulatory systems operating in Japan and actively involving members in inspections should be investigated. Emerging networks and consortia should take a lead and work in close partnership with Co-operatives UK.
12. **Branding and trademarks:** As with the evolution and development of Fair Trade, work on brand development and trademarks, a recognition of trust and a focus on quality will be important as work gets underway and evolves. As this research shows, quality assurance at a just price is the key to success. Further work on this challenge should be considered by Co-operatives UK as part of a national strategy programme for supporting the collaborative development of social co-operatives.

Appendix 1: Deliberative Inquiry methodology

The research and consultative work in review has been produced using a deliberative dialogue approach that has involved practitioner stakeholders in England and Wales in a staged process as follows:

Stage 1: involved some joint work with Co-operatives UK plus some contact with care sector co-operatives and other care sector organisations to develop a list of target practitioner organisations to invite to the deliberative dialogue meeting. Lists of invitees were prepared with Co-operatives UK from current and past members. These organisations were given priority. Additional invitations were sent to some care organisations with innovative or relevant social enterprise expertise.

Stage 2: the deliberative dialogue event was held in Birmingham on 11 July 2013 and sponsored by Anthony Collins Solicitors.

Stage 3: in-depth telephone interviews were undertaken to develop an understanding of best practice, operational aspects and barriers to development. The interviews included leaders of Social Co-operatives in Italy and Solidarity Co-operatives in Quebec, Canada as well as a number of UK organisations engaged in the development of innovative models. Additional material was sourced from international experts on social care and health co-operatives in Japan and France. That evidence informed the sector review and the work on case study profiles. The interviews have also been important in developing the review's sector strategy recommendations.

Stage 4: Production of a Co-operative Care Sector Strategy draft report and its circulation for comments and feedback. Revision work and production of the final report.

Appendix 2: Deliberative dialogue and market review

In a consultation event for members of Co-operatives UK and other stakeholders for this review, participants were asked to break into groups and consider the status of different market players.¹³⁵ As background information, a presentation was given to the participants of the co-operative care models in Italy and in Quebec. Two groups were asked to review the position in the market place of the private sector providers of social care and two other groups were asked to do an appraisal of the co-operative care sector.

The second set of groups included a number of participants working on social co-operative ideas and this fact influenced the discussions. Each of the groups was asked to use a SWOT (strengths, weaknesses, opportunities and threats) assessment as a framework for their respective appraisal discussions.

Private care sector appraisal

- The strong points of the private care sector were regarded as:
- Bankability and access to debt (and often equity) capital plus the ability to 'sweat assets'
- Dominant market position and political influence
- Management: professional skills and capacity to win large contracts
- Ability to deliver a low-cost, tight margin and high volume service
- Scale and ability to fill gaps and be responsive
- Some good practice and quality provision (but generally this was either from smaller niche specialist providers and more lucrative market segments)

The weak points of the private care sector were assessed as:

- Variable quality provision and lack of person centred care
- Poor working conditions and extremely low pay for care staff
- A perceived under-investment in training for the workforce
- Over-stretched and inflexible services
- Accountability to shareholders not stakeholders¹³⁶
- A perception that there is a trend away from smaller local businesses to global corporations

An ageing population is providing an expanding market and growing demand for services but their demands and needs are not necessarily being met by current provision. The private sector is in a strong position to secure new business from new forms of NHS commissioning and from the continued expansion of outsourcing as public sector cutbacks increase.

¹³⁵ The Deliberative Dialogue event was held in Birmingham on 11 July 2013 and sponsored by Anthony Collins Solicitors – an associate member of Co-operatives UK who is currently working with CMS and other colleagues in relation to the social co-operative programme being developed with the prison service and the probation services.

¹³⁶ Some participants commented that this applies to the voluntary sector in a different way as workers and service users are not part of the governance system. This will also be the case for most social enterprises that do not provide membership and voting rights to stakeholders.

The private sector also appears to be embedded in the NHS commissioning bodies with some groups of doctors operating as businessmen with medical qualifications.

The threats to the private sector are from deteriorating quality of provision, an ongoing range of scandals in the press, the financial precariousness of a number of providers and a tide of future large-scale collapses arising from insolvency and fiercer competition. Similar scandals have been reported within local authority services and the NHS.

Co-operative care sector appraisal

The strong points of the co-operative and mutual sector were felt to include:

- A range of high quality services, good practice and innovation in some areas
- A range of care option choices and user involvement among some services
- Worker co-operative good practice and some multi-stakeholder expertise
- Somewhat better pay and conditions but under relentless competitive pressure
- Services that meet popular demand for more say and fairness through mutuality and solidarity
- Member involvement and economic democracy that provide additional good governance safeguards
- Inclusive stakeholder provisioning and a redistribution of surplus for community benefit
- The 'co-operative difference': social mission and a focused expenditure on care where the service is serviced user centred

A number of weaknesses were identified in the sector including:

- Lack of strategic leadership and national profile
- Lack of a strong body of evidence of good practice and success
- Gaps in management expertise for many services - including tendering capacity for big contracts
- Isolation and a lack of communication between dispersed organisations
- A lack of awareness by commissioners of the co-operative option and solutions
- Few social financing systems to support start-ups and to enable development – though the Social Enterprise Investment Fund (SEIF) operated by the Department of Health has been important as a source for development finance.

It was pointed out that there is no national directory of co-operative services to promote existing co-operative care providers and to attract the interest of public sector organisations and service users

The opportunities for the co-operative care sector to deliver a dynamic new approach were widely regarded as timely. A multi-stakeholder model appeared to participants as an ideal solution if implementation and development could be handled effectively. The potential to involve paid staff, service users, volunteers and families in a fully inclusive system could deliver significant added value. Time-banking and complementary currencies could be co-developed as a system to encourage social reciprocity and to attract and reward volunteers.

A pattern of fragmentation and isolation was perceived by participants as an impediment to progress. Participants highlighted a strategic need to increase collaboration and partnership with the aim to grow the regional density of co-operative care provision. The use of co-operative consortia methods could support the development of a federated national model that could facilitate co-operative knowledge transfer regionally and enable economies of both scale and scope to be achieved.

There are major opportunities for public sector services to become co-operative providers through ownership transformation pathways and collaborative partnerships. However political parties are not yet alert to this option. Ignorance is a major barrier. On the other hand, if the staffing remains the same, this changeover could be just a name change.

The threats are formidable as the trading environment will continue to get tougher for co-operatives and smaller businesses as the severity of public service cutbacks increases. Stakeholder involvement has cost implications. Maintaining 'the co-operative difference' and indeed business integrity in a low-margin, high-volume marketplace will require extraordinary levels of innovation.

Appendix 3: Deliberative Inquiry Participants

First Name	Last Name	Organisation
David	Alcock	Anthony Collins Solicitors
Anna	Betz	School of Commoning
Mick	Brown	Robert Owen Community Bank
Tony	Carr	Leading Lives
Pat	Conaty	Common Futures
Yvonne	Cox	The Oxfordshire Wheel
Warren	Garrett	London Rebuilding Society
Tracy	Giles	Capsticks
John	Goodman	
Laurie	Gregory	The Foster Care Co-operative
Neil	Hampson	
John	Harrington	Cae Post
Martin	Hockly	Street UK
Anne	Hubbard	Leading Lives
Andrew	Hutchinson	
June	Jones	Co-operative Cyrmu
Patricia	Juby	Midcounties Co-operative - Elected Member
Nick	Matthews	Co-operatives UK - Board Member
Katy	Murray	Local Food (& More) Co-operative
Dave	Nicholson	Ex-Cell
Chris	Norwood	Co-operatives UK
Danielle	Procter	Oldham Council
Moyra	Riseborough	RRCA, Empowering Citizens
Adrian	Roper	Cartrefi Cymru
David	Smith	Wales Progressive Co-operators
Rebecca	Stanley	Community Catalysts
Jon	Stevens	CDS Co-operatives

Mick	Taylor	Mutual Advantage
Andrew	Wallace	Wessex Resolutions CIC
Linda	Ward	Co-operatives UK - Board Member
John	Waters	Cartrefi Cymru
Conrad	Watkins	Cyrenians Cymru
Matthew	Wort	Anthony Collins Solicitors

Appendix 4: Research interviewees and consultation respondents

First Name	Last Name	Organisation
James	Angel	new economics foundation
Tracy	Axten	Big Issue Invest
Leander	Bindewald	new economics foundation
Alex	Bird	Co-operatives and Mutuals Wales
Glen	Bowen	The Wales Co-operative Centre
Bob	Cannell	Cicopa
Sarah	Forster	Big Issue Invest
Jean-Pierre	Girard	University of Quebec, Montreal
Renate	Goergen	Associazione Le Mat, Italy
Dan	Gregory	Social Enterprise UK
Malcolm	Hayday	
Neil	Hewitt	Triodos Bank
Ben	Hughes	Community Development Foundation
Chris	Johnson	
Heather	Laird	Ontario Nonprofit Network, Canada
Pierre	Liret	CG Scop, France
Valerio	Luterotti	ConfCooperative, Italy
Sarah	Lyall	new economics foundation
Robin	Murray	London School of Economics
Bob	Paterson	Resonance / Community Land & Finance CIC
Enzo	Pezzini	ConfCooperative, Italy
Chris	Pienaar	Oxfam
John	Restakis	British Columbia Co-operative Association
Hugh	Rolo	Locality
Danyal	Sattar	Esmée Fairbairn Foundation

Taka	Sawaguchi	Seikatsu Co-operatives, Japan
Roger	Spear	The Open University
Lucie	Stephens	new economics foundation
Henry	Tam	Cambridge University
Ian	Taylor	Co-operative and Community Finance
Yuko	Wada	Seikatsu Co-operatives, Japan

Co-operatives UK

Co-operatives UK works to promote, develop and unite co-operative enterprises. It has a unique role as a trade association for co-operatives and its campaigns for co-operation, such as Co-operatives Fortnight, bring together all those with a passion and interest in co-operative action.

Any organisation supportive of co-operation and mutuality can join and there are many opportunities online for individuals to connect to the latest co-operative news, innovations and campaigns. All members benefit from specialist services and the chance to network with other co-operatives.

www.uk.coop





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