



SOCIAL ENTERPRISE GUIDE TO  
**Health & Social Care for the Elderly**



Social Enterprise London is the regional agency tasked with the job of promoting social enterprise in London and increasing the scale of the social economy. Our work is divided into three broad areas: improving understanding of social enterprise, improving business support and ensuring access to finance.

## • Our Vision

SEL aims to be the centre of excellence and knowledge for social enterprise in London, developing a significant, vibrant business sector that contributes to the wealth, empowerment and well being of the capital.

## • Our Mission

To promote, support and develop sustainable social enterprise solutions through:

- Leadership
- Lobbying
- Definition and recognition
- Innovation
- Facilitating practical support
- Branding
- Mainstreaming
- Access to finance

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Social Enterprise London  
1a Aberdeen Studios  
22-24 Highbury Grove  
London N5 2EA

Telephone 020 7704 7490  
Fax 020 7704 7499  
E-mail [info@sel.org.uk](mailto:info@sel.org.uk)  
Website [www.sel.org.uk](http://www.sel.org.uk)

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## Introduction

This booklet aims to describe and support the development of social enterprises working with and for older people to provide social care and health services, or meet social care needs.

In this country there is a long tradition of community involvement in the provision of health and social care. Before the NHS was established, many communities built and managed their own hospitals. Charities and voluntary organisations have always funded and provided vital services for older people, and they still do. In recent years government strategies have encouraged diversity of provision, and the development of the independent sector. At the same time organisations in the public sector have focused more on the commissioning and procurement of services, leading to the externalisation of many services previously delivered in-house.

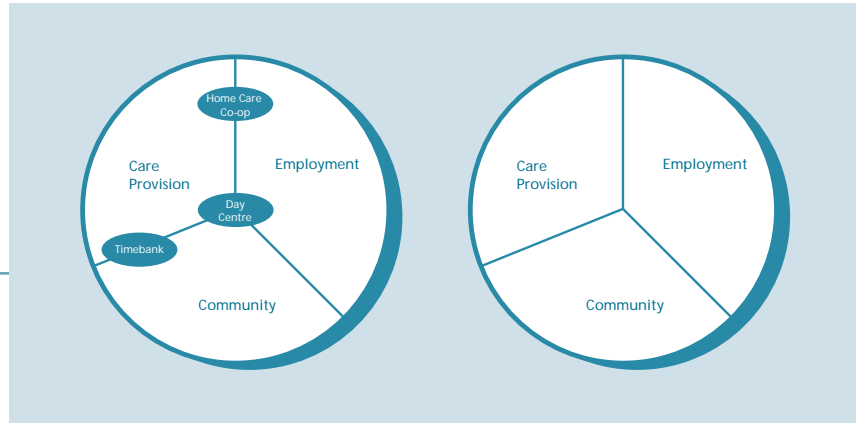
With these changes has come a new generation of organisations, which are entrepreneurial, democratic and sensitive to users and communities. They operate in the market place, but have many of the characteristics of the public sector.

The range, diversity and scale of organisations involved, and the variety of roles that they play, complicate the analysis of social enterprises involved in this sector.

The range of organisations involved includes:

- development trusts
- community businesses
- LETS and time banks
- credit unions
- voluntary organisations delivering contracts
- workers' co-operatives
- multi-stakeholder co-operatives
- housing associations and housing co-operatives

Some earn all their income from trading; others survive on a mixed income. They may have contracts with local authorities, receive grant aid or charitable donations, or charge fees to people who receive a service. Equally some have highly trained employees and professional managers, whilst others rely on a mix of employees and skilled and supported volunteers.



### Social enterprise motivation

Social enterprises are involved in care and health for a mixture of three reasons:

- to provide care
- to provide employment
- to build the strength of communities

One or another of these three motivations may predominate, or they may be balanced. All three are nearly always present. It all depends on why people wish to work in this way, and what they are trying to achieve.

A workers' co-operative delivering home care may be predominantly about creating more employment or better quality of employment for home care workers, but will also be concerned with the quality of care, and widening the choice open to those who need it.

A time bank, bringing community resources to support older people in practical tasks, and valuing older people's contribution to communities, is not primarily concerned with delivering intensive complex social care. It is about building communities, as well as providing a key resource that enables older people to live longer and more independent lives. It may create little or no employment.

A development trust running an extra care centre for older people is interested in the development and sustainability of the community it represents, creating employment in that community and enabling older people to receive care within the community in which they live.

A small local community organisation running a day centre for older people with dementia, under contract to a local authority, may primarily be concerned to ensure that a high quality service is available and accessible for those that need it. However, through its local membership, advocacy and campaigning roles, it is also likely to be concerned with building acceptance and understanding of dementia within the local community. It may use volunteers to assist in the centre, or for help with transport.

## Defining social enterprise

SEL defines social enterprises as businesses that trade in the market in order to fulfil social aims. They bring people and communities together for economic development and social gain. They have three common characteristics:

### Enterprise oriented

They are directly involved in the production of goods and the provision of services to a market. They seek to be viable trading concerns, making a surplus from trading.

### Social aims

They have explicit social aims such as job creation, training and provision of local services. They have ethical values, including a commitment to local capacity building. They are accountable to their members and the wider community for their social, environmental and economic impact.

### Social ownership

They are autonomous organisations with governance and ownership structures based on participation by stakeholder groups (users or clients, staff, local community groups etc.) or by trustees. Profits are distributed to stakeholders or used for the benefit of the community.

Some definitions place more emphasis on empowerment, both as a social aim and as a requirement for democratic structures. Empowerment and engagement of users and staff are critical issues when social enterprises are involved with the delivery of social care.

## Benefits of social enterprise

The market for social care in the UK is well developed. Much provision remains in the public sector, although in 2002 for the first time more than 50% is in the independent sector. Health care is much more strongly focused on public provision, although this too is starting to change.

Why should you be considering social enterprises?

## Achieving quality care

Effective commissioning,  
purchasing and contracting

Quality  
systems

Confident  
users

Empowered  
care staff

Firstly, social enterprises in general occupy a particular place in the market. They bridge the gap between public and private provision. As organisations, they can have all the entrepreneurial energy and organisational creativity that many people think characterises the private sector. They are responsive to the market place, enabling users and customers to drive service improvements.

At the same time they are firmly in the social economy, having at their core a set of social values and aspirations in common with the public sector. These values – about equality, access, empowerment and quality care – are integral to social enterprise, not bolted on for marketing reasons. Social enterprises are often *not for profit*, their surpluses being reinvested in the service or used for the benefit of the community.

If users and their families are included in the structure, then social enterprises become directly accountable to those in receipt of the service, and have the sensitivity to individual needs, only usually found in direct payment schemes.

The empowerment element of social enterprise offers the potential for critical quality improvements. Many staff work without direct supervision, and the situation often constrains users from being specific about their needs. Four conditions may be necessary for quality services:

- a successful commissioning and contracting framework
- management and quality systems to support practice
- well trained and empowered staff, confident in their skills and limitations
- empowered and engaged users, confidently able to ask for the things they need

Social enterprises have a built-in capability to empower users and staff – immediately delivering two of the conditions for quality service.

Whatever the structure adopted or the model used, one issue is of paramount importance in the delivery of social and health care. This is the quality of the care delivered. When older people are being supported at home in the community or in residential or hospital premises, their quality of life is critical. It is the key issue in choosing structures or providers: Is this the best way to improve the quality of older people's lives?

Social enterprise solutions have another advantage. Being close to and often representing communities, they work to community priorities. They also have a better understanding of local market conditions as they are rooted in the communities that they serve. They have the ability to actually deliver joined-up services to a real community agenda.

When they give staff a stake in the ownership of the enterprise, as some models do, they gain the ability to address another issue. Staff participation in management can lead to the introduction of flexible working, improved pay, respect for professional capability and challenges to discrimination – all of which make for a more attractive workplace. Recruitment and retention problems are common in many types of employment in the sector. This may be one route towards resolving them.

Social enterprises also create employment and skill development opportunities for local people, who may be disadvantaged in the labour market. They thus contribute directly to regeneration and health improvement strategies. They play a major role in delivering and developing culturally sensitive services.

### Using the booklet

This booklet is divided into three parts:

- The **first section** is a general review of the market, describing some of the current issues affecting the way social enterprise could deliver social care and health services for older people.
- The **second section** describes a series of opportunities that may be available to establish and develop social enterprise solutions for the delivery of health or social care.
- The **third section** considers some issues involved in **business planning** for the sector.

An **appendix** with some practical advice, a list of references and other useful information sources, some contact addresses and a glossary of terms completes the booklet.

To show what is possible, a series of **case studies** with contact information are included throughout the booklet.

Care can be purchased or paid for by:

- local authority social services departments
- Health Trusts or Primary Care Groups
- Charities
- individuals using their own savings
- individuals using state benefits or direct payments

It can be provided by:

- local authority in-house providers
- independent sector providers

The independent sector includes:

- commercial, large scale providers – essentially care PLCs
- small private sector providers, typically owner-managers
- national voluntary organisations, charities or housing associations
- local voluntary organisations or other community providers
- social enterprises

This section reviews issues in the delivery of health and social care from the perspective of current or potential social enterprises.

### The market for social care

The NHS and Community Care Act made a series of significant changes to the way that social care was organised and paid for. Its primary aim is to enable older people to live independently in homely settings in the community with care tailored to their individual and specific needs. Following the Act, many social services departments restructured to separate assessment or purchase from provision. They also establish a commissioning function to plan the development of services.

Local authorities were provided with transitional funding, most of which had to be spent in the independent sector. At this time there was a well-developed independent sector for residential care, but very few independent providers of home care. This funding stimulated a new care market.

The independent sector is sometimes divided into the *for profit* sector and the *not for profit* sector. Social enterprises sit across these two sectors, some being *not for profit*, others distributing profits to members.

In order to manage care purchase, local authorities have introduced contracting arrangements. These vary widely between localities, but have generally resulted in local fixed prices for residential, nursing and home care. Most authorities have introduced an approved provider list, often with local accreditation schemes. Experiments have been made with banding schemes, in an attempt to reward quality providers.

Contracts may be:

- **Block** – a fixed term contract with an approved provider for an agreed number of places.
- **Spot** – an individual purchase negotiated with an approved provider for a specific person.

Block contracts can guarantee payment to the provider irrespective of take-up, or be call off contracts where payments are only made when places are taken up.

Spot contracts give flexibility to providers and enable new providers to enter the market and gradually build up business. Most now want block contracts as they guarantee a level of work to both providers and their staff.

Some people have argued that the contracting process has led to a level of payment from local authorities to providers that is insufficient to cover the real cost of providing the quality of care that is desired. The numbers of residential homes closing is high. There is a view in the industry that fees will have to rise, to cover both the increased costs of regulation and the higher wages that will need to be paid to recruit and retain staff.

There is a particular problem with specialist services. How can a small local voluntary sector provider produce a culturally specific meal for a small number of people at the same price that a multi-national company produces frozen meals for six authorities?

Having gone through a process of stimulating and encouraging a diversity of providers in home care, some authorities are realising that this has led to a wide range of standards and very high contract monitoring costs. They are now looking to reduce the number of providers with whom they contract, even though they may retain a small number of specialist or minority community providers.

For new start proposals, this market poses another difficulty. Commissioning or planning new services is often separated from direct purchase. Social workers or care managers, in area offices or hospitals, undertake assessment and search for places for individuals with needs. Service developments may be planned or commissioned by specialist teams within social services departments, or jointly with colleagues in health. There is no presumption that a planned service, even one established with the direct intervention of commissioning teams, will be taken up by purchasers.

The government has recently agreed a framework with the independent and private sector in order to encourage a more strategic, inclusive and consistent approach to capacity planning at a local level. In *Building Capacity and Partnership in Care*<sup>1</sup>, the government recognises that funding must be adequate to resource the right level of service. It also recognises that commissioners have used their position in the market to drive cost down below the level at which a quality service can be provided, and that this is in conflict with the policy of best value.

*Fee setting must take into account the legitimate current and future costs faced by providers as well as the factors affecting those costs, and the potential for improved performance and more cost-effective ways of working. Contract prices should not be set mechanistically but have regard to providers' costs and efficiencies and planned outcomes for people using services.*

## Building Capacity and Partnership in Care

### Trends

A simple model<sup>2</sup> for predicting future social care and health trends is shown in the next diagram.

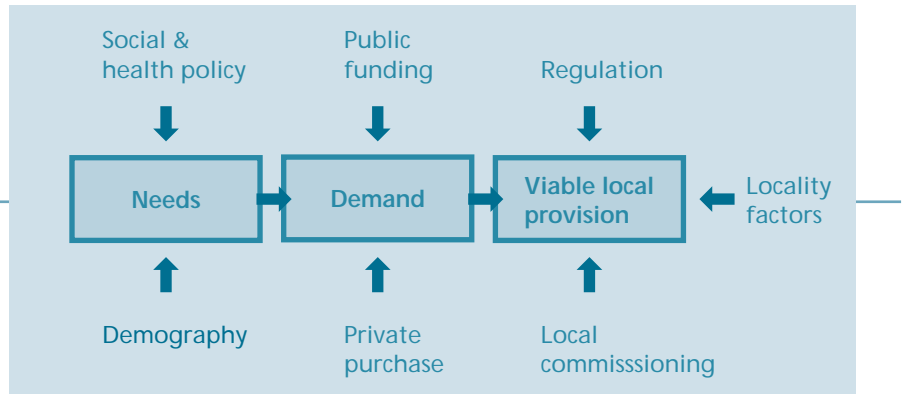
- The volume of needs is generated by demographic change.
- The effectiveness of health interventions affects the absolute level of need, and influences the types of service provided to meet those needs.

<sup>1</sup> *Building Capacity and Partnership in Care* DoH 2001

<sup>2</sup> *Co-operatives in Care* Mick Taylor unpublished paper for Co-operative Union 2002

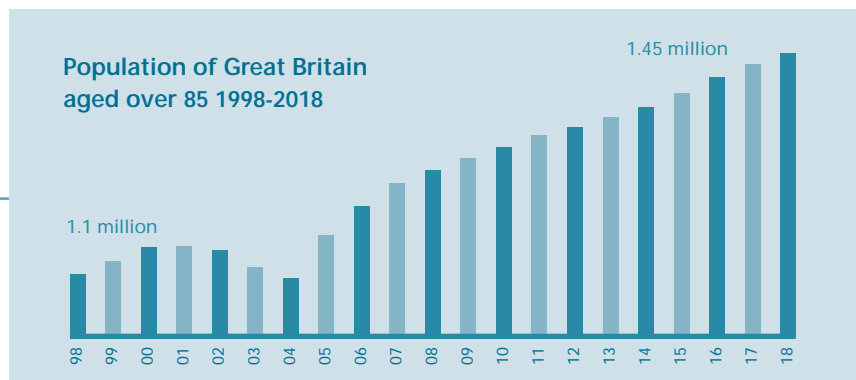
- Needs are only converted into demand when there is funding to purchase a service.
- The kinds of service purchased depend on the local commissioning priorities and user choice.
- The quality of services, and to some extent their cost, is now determined by regulation.

### The market for services for older people



There are two kinds of funding for purchase of care and health provision: public and private. Markets are local, as are demographics, commissioning strategies and the labour force. Whatever the national picture, what happens in your local area may be different.

### Demographics



The key age group for predicting social care and health needs for older people is the over-85s. Most of the people receiving significant amounts of care are the very elderly. The demography of this age group is interesting. The long-term national trend is for significant growth. The Office for National Statistics indicates that the number of people aged over 85 will rise from 1.1 million in 1998 to 3.3 million by 2056. This is a rise from 1.9% of the population to 5.2%. However, these projections show a dip in growth between 2001 and 2004 as a result of the drop in birth rate associated with the First World War. Because of this dip, and the current oversupply of residential care, Laing and Buisson suggest that:

Resurgence in demographic driven demand will not take place until at least the middle of the next decade.

Laing & Buisson – Laing’s Healthcare Market Review 2000-2001<sup>3</sup>

There are two views of the way medical advances will impact on need. Will they lengthen life without impacting on disability, leaving people dependent for long periods at the end of their lives, or will they reduce the period of dependency without significantly effecting lifespan?

Resurgence in demographic driven demand will not take place until at least the middle of the next decade.

Localities can have significantly different demographic structures and therefore population trends for older people. Some inner city boroughs have declining numbers of older people, even as the rest of the UK population grows. This is a result of people moving out of cities on retirement, or older people moving to live near children as they become frailer and more dependent.

Over the last century, migration driven by employment has been significant, creating very different population structures. New and expanding towns have demographic profiles that reflect their periods of growth; they may have few older inhabitants now, but what happens when all those migrant families reach old age together?

It is critical to look at demography on a local basis.

One area of growth that suffers from specific and proven under-provision is among minority communities. The age structure of these communities is linked to the period of migration, and family development suggests significant growth over the next few years. Research has identified that existing provision does not meet their ordinary and special needs. Specialist provision has increased, but there are still likely to be unmet needs. The needs of individuals and small communities are particularly hard to address.

Public funding for social care has been restricted for a significant time. The government has not accepted the Royal Commission’s recommendation that all social care needs should be met from public funds. However, spending on social services has been increased and the government is committed to maintaining that increase of 3.4% p.a. in real terms for three years.

Currently, most care is purchased from public funds, but there is a significant and growing market for private purchase. Many people in residential homes contribute through the sale of their family home. Continual raising of the eligibility criteria for home care means that more and more people have to buy privately until their savings are reduced. Predicting future private purchasing of care is difficult. Although few people in this country have private insurance schemes, the Royal Commission<sup>4</sup> predicts that pensioners will become more affluent compared to the rest of society. However, this is in the context of a growing divergence between those dependent on state benefits and those with private pensions and property.

Most commentators take the view that society will have to find the resources to pay for the care of the increasing number of older people, whether it is from public or private funds.

<sup>3</sup> Laing’s Healthcare Market Review 2000-2001 Laing & Buisson

<sup>4</sup> With Respect to Old Age Royal Commission on Long Term Care HMSO 1999



## Supporting people

The government is changing the arrangements that, until now, have funded housing related support services for vulnerable people. Under the Supporting People programme it is implementing a single framework for all of this type of funding. By 2003, the government expects local authorities to set up Local Housing Partnerships. These may include Housing and Neighbourhood Renewal, Community Safety and Health and Social Services.

To cover the period until the full implementation of Supporting People, the government in 2000 introduced Transitional Housing Benefit. This amends Housing Benefit Rules to allow for some new support costs to be met by Housing Benefit. This is available to people living in sheltered, semi-sheltered and extra care accommodation and for those with private landlords, who have had a community care assessment. This benefit cannot be used to supplement social services budgets but it can be used to pay regularly occurring support costs, such as rent. Local Housing Benefit Officers will make the final decisions, but may include:

- general counselling and support, calling the GP, liaising with Social Services, shopping or running errands, arranging social events etc.
- cleaning rooms and windows, where the resident or their family cannot do this themselves
- help with minor repairs, changing light bulbs, unblocking sinks etc.
- an emergency alarm system

Support can include informal day-to-day advice, regular reminders about the need to take medication, non-specialist counselling and emotional encouragement.

Personal care, for example help with eating, dressing or using the toilet, is specifically excluded.

These arrangements will affect the provision of extra care and sheltered accommodation, and may create a market opportunity to provide benefit-funded assistance to people living in private rented accommodation.

## Prevention and rehabilitation

Older people form the single largest group of NHS patients; they make up over 40% of emergency admissions. The NHS Plan<sup>5</sup> sets out a series of initiatives and funding proposals. Their focus is to promote independence through active recovery and rehabilitation. There are concerns that older people are admitted unnecessarily to acute hospitals, that they stay in hospital too long, and that hospital admission creates dependency. Older people are not to be seen as a burden but a priority for the modernisation programme. By 2004 the government proposes to make available an extra £1.4 billion a year for older people's services, with the aim of extending years of healthy life and promoting dignity, security and independence.

In 2001-02, the plan introduces a new grant, Promoting Independence<sup>6</sup>, worth £296 million in its first year. It replaces earlier prevention grants and

5 NHS Plan DoH [www.doh.gov.uk/hhsplan](http://www.doh.gov.uk/hhsplan) 2000

6 Promoting Independence Grant – 2001-02  
Guidance DoH 2001

The government proposes draft legislation that will change the way it offers assistance to homeowners for the renovation of property.

funding for Winter Pressures. The vast majority of this funding, 97%, must be spent on additional community care services, and the grant aims to promote new patterns of service, providing care closer to home in order to:

- prevent unnecessary hospital admissions
- improve discharge arrangements
- give better rehabilitation after hospital treatment
- help people to live independently
- respond to emergency pressures

Government strategies place considerable emphasis on partnership arrangements between the NHS, local councils and the public and independent sectors. This will result in pooled budgets, with some services purchased from the independent sector.

Arrangements will vary between localities, as well as budgets and the type of services purchased, but they are likely to include a range of initiatives in the community:

- intermediate care beds in residential or nursing homes
- active rehabilitation in a homely setting
- fast response, 24 hour or emergency home care
- intensive rehabilitation services, providing both home care and therapeutic interventions

Some authorities and trusts may already have developed these services and allocated their portion of the funding. However, a recent Audit Commission Report, *The Way to Go Home*<sup>7</sup>, identified major gaps, so other localities may well be looking for innovative responses from the independent sector.

### Property, practical tasks and independence

If older people are to stay at home longer, then the condition of their homes becomes a critical factor. Larger repairs and conversions have in the past been funded through a complex and sometimes restrictive system of grants. The government proposes draft legislation that will change the way it offers assistance to homeowners for the renovation of property, and in December 2001 issued a consultation paper. This proposes to:

- bring all powers to give grants or loans together
- enable authorities to assist disabled people to meet their contributions
- provide assistance to buy a property if this is a better option than improvement

Small repairs can be a definite problem. Often difficult and costly for large organisation to arrange, the completion of small practical tasks can make a home a less risky place to live. A trip on a loose carpet resulting in a fall and a broken hip can place someone in hospital and in need of home care for the rest of their life. Some estimates suggest that the cost of a fractured hip to the NHS may be over £12,000.

7 The Way to Go Home DoH

8 Practical Tasks and The Preventative Agenda  
Gowland Taylor Associates  
unpublished report for Nottinghamshire County Council  
2000

Nottinghamshire County Council<sup>8</sup> interviewed older people when considering social enterprise solutions to this problem. They identified eleven specific activities that would help them remain independently living at home, or increase their quality of life and independence. They were:

- befriending
- help with odd jobs, for example putting up shelves
- help with shopping, particularly food, presents and clothes
- transport, particularly wheelchair-accessible transport for social visiting
- gardening
- walking dogs and other pet care
- decoration
- improvements to public transport, including the ability to cope with wheelchairs
- cleaning
- window cleaning

Interestingly, this survey did not identify cost as a barrier. Most people said they would be prepared, and were able, to pay; the problem was finding someone whom they could trust.

## Well and Wise in Camden

Well and Wise in Camden is a Healthy Living Centre. It currently operates under the aegis of Age Concern Camden, but has a dedicated steering group who have been working together to set the project up. It is about to enter a partnership agreement with 14 other local groups concerned with older people, including the statutory authorities. It may then move to become a company limited by guarantee, with partners having equal rights and an equal say.

The project grew out of the development of a Quality of Life Strategy for Camden and the Vulnerable Older People's Project. Well and Wise will be delivering a significant part of the Strategy.

Not yet delivering a service, Well and Wise in Camden intends to work through other organisations that will deliver the services for

older people. It aims for example to develop health information and training projects, sports and dance projects (working with a local Sports Development Team), projects to help develop better services for stroke victims, and projects to provide more relevant information (with CAB). It does not intend to become a huge project in its own right; it will facilitate other organisations' activities and fill gaps in provision through the work of other groups.

Future users have been involved in the project's development through public events at each stage. People have been invited to come and talk about the quality of life in the area and what activities they would like to see. Surveys and focus groups were also used.

The partners include Camden Active Health, Arts & Tourism (LA),

Social Services, Vulnerable Older People Project, Healthy Schools Initiative, Health Improvement Programme, CAB, a community centre, Good Neighbour Scheme, Age Concern, African & Caribbean Elders Association, Camden Carers Centre, Camden Forum for the Elderly and the Elderly Person's Liaison Committee.

Funding so far is approximately £1.8m. The New Opportunities Fund is providing £1m over 4 years, and over £0.5m is being provided in the form of secondments, space, training, audit and insurance from Age Concern Camden and the Local Authority. The project has an annual target of £60,000, which will need to be raised for a Community Fund.

### Contact

Well and Wise in Camden  
Age Concern Camden

Warmth is critical for older people. *Keep Warm Keep Well*<sup>9</sup> is part of the National Service Framework for older people. The energy efficiency scheme has been repackaged as the Warm Front Scheme. This provides a grant of up to £2,000 to people aged over 60 for help with insulation, draught-proofing and improvements to central heating. This is an area in which social enterprises have a significant track record.

The government has made it clear that it sees adaptable and safe housing as an essential component of good quality of life for older people. It wants to see those commissioning services considering the contribution that can be made by home improvement agencies and home insulation services, as well as more traditional health and social care providers.

### **Inspections, best value and externalisation**

Over the past ten years a large number of local authorities have externalised residential care homes, some to trusts, some to the private sector. On occasions this has been as an alternative to closure. Home care services, too, have been externalised, both directly and through a gradual drift towards independent sector purchase, reducing budgets for the in-house provider.

Research by a number of organisations has identified the difference in pay levels between in-house and independent sector providers. There are still major regional variations although it has been suggested that the gap in basic pay levels is narrowing. TUPE (the Transfer of Undertakings [Protection of Employment] Regulations) provides some protection to externalised staff, but research by UNISON shows that both pay and employment conditions for newly recruited workers are poorer.

A number of Joint Inspections of social services departments have raised the issue of higher in-house costs, linked to pay and conditions. The best value regime requires that authorities compare provision, and only retain services in-house where they can be shown to provide best value.

Best value, budgetary pressures and the increased costs that may occur from the implementation of single status suggest externalisation may continue. For residential care, there is a more explicit driver. New regulations specify room sizes, facilities and occupancy that local authorities with older homes will find difficult to achieve. With many homes, renovation is as expensive as re-provisioning. Current capital rules make in-house re-provisioning unlikely. Authorities will be looking to establish partnerships with providers able to raise capital and run newly provisioned homes, where closure is not an option.

At least three authorities are currently (January 2002) considering a social enterprise solution to this issue. These may involve setting up new multi-stakeholder co-operatives, or partnerships between care co-operatives and housing co-operatives or other registered social landlords.

Business plans and contract arrangements must be negotiated to insure that employee remuneration is retained at a level that reflects the nature and responsibilities of the job, and ensures recruitment and retention. Social enterprise



approaches have the potential to provide practical solutions to this issue, engaging with employees and service users in local providers.

### Labour market

Many providers face serious difficulties in recruiting and retaining care workers. The UKHCA (United Kingdom Home Care Association)<sup>10</sup> reports that 76% of its membership replying to a survey in 2000 had difficulty with recruitment. Staff turnover was estimated to be 26% a year. In local authority in-house teams this turnover figure is 12%.

In areas where economic growth is strong there is an increasing number of alternative employment options for women wanting flexible and part time work. Pay rates in the leisure and retailing industries are comparable, and the work appears more attractive and carries far less stress and responsibility.

At the same time, the care workforce is older than the whole UK labour force: 56% of independent home care workers are aged over 40, and 31% over 50.

Care labour markets are local, with low pay, unsocial hours, shift working and in-home care involving short visits, often without payment for travel time.

Career opportunities for care staff are few, and in the past many workers in the sector stayed at the same level for most of their employment. There is some suggestion that care staff trained in the social care sector are recruited into health for improved pay and working conditions.

The Low Pay Commission<sup>11</sup> identified the care sector as one of the main areas of low pay in the UK. Other reports have argued that there are two labour markets in care. The first is typified by local authority providers with a relatively stable long-term workforce, better though still low basic rates of pay, but with good conditions. In-house workers typically get pensions, unsocial hours payments and do their training in paid time. The independent sector is typified by lower pay, only the best providing unsocial hours or overtime rates. The poorest payers in home care for example will not pay travel time between clients.

A number of projects have been exploring strategies that use regeneration funding to attract and train new entrants to the care market. Sunderland Home Care runs a very successful project of this type. Regulation now requires that at least half of care workers at any provider are qualified with an NVQ or equivalent. In areas where recruitment and retention are very difficult, linking training strategies of this type to provision could be a very attractive business strategy for social enterprise care providers. This could also open the way to recruit from non-traditional labour markets.

### The Care Act and regulation

The government is currently changing the regulations and inspection arrangements for both residential care and home care. It is unifying all local inspection units into a national service, the National Care Standards Commission, and establishing the same inspection regime and standards for all providers.

10 Domiciliary Care Markets Growing and Growing Up Brian Hardy Nuffield Institute 1998

11 The National Minimum Wage Low Pay Commission 1998

The regulations for residential care homes have been approved, and those for home care are currently under consultation. The government aims to approve them by July 2002.

For residential care<sup>12</sup> providers the regulations cover:

- home management
- care planning and record keeping
- assessment and admission arrangements
- facilities and services with the home
- staffing, recruitment, supervision, training and qualifications
- the home itself, communal space, room sizes and facilities
- financial issues

Home managers will have to be qualified to NVQ level 4, and at least 50% of care staff qualified to level 2. Homes will have to provide 4.1 sq. metres of communal space per resident; new homes to have en suite facilities, and single rooms, of at least 12 sq. metres of floor space. Existing homes must provide single rooms with 10 sq. metres of floor space by 2007.

For domiciliary care<sup>13</sup> agencies the regulations cover:

- user focused services
- personal care
- protection
- managers and staff
- organisation and running the business

Once again agency managers must be qualified to NVQ level 4 and at least 50% of home care staff must have NVQ level 2 within five years of the approval of the standards. The regulations will apply to care provided within extra or supported living schemes.

For both services, all staff must have a police check, and references taken up before appointment.

### **NHS Plan**

*The NHS Plan*<sup>14</sup> is the government's response to the Royal Commission on Long Term Care. The government objectives are that:

- people have faster access to care, with readily available information about the services on offer
- they are assessed as individuals, promptly and in a co-ordinated way
- services are related to needs, have clear objectives, are of guaranteed quality and are provided seamlessly by the different agencies involved
- any contribution people are asked to make to the cost of their care is fair, predictable and related to their ability to pay

New regulations are being introduced so that the government will now be funding nursing care, wherever and whoever provides it. These arrangements are complicated, but it is likely that people will be assessed into three bands, and funding provided accordingly.

<sup>12</sup> Care Homes for Older People – National Minimum Standards DoH 2001

<sup>13</sup> Domiciliary Care – National Minimum Standards, Consultation Document DoH 2001

<sup>14</sup> NHS Plan DoH [www.doh.gov.uk/hhsplan](http://www.doh.gov.uk/hhsplan) 2000

It is not clear that the funding levels provided will match the real cost of providing nursing care for people in residential or nursing homes. The government predicts that these changes will reduce the cost of a year's stay in a nursing home by £5,000.

The government is also changing the regulations so that when people move in to residential care, there will be an initial period of three months before the issue of selling a family home to pay for care is raised. Given the shorter time that people now spend in residential care, this may significantly reduce the number of older people who have to sell their house to pay for care.

### Direct payments

The direct payments system provides that, rather than purchasing care on behalf of someone, the local authority makes an assessment, and then provides the budget directly to the person in need. They are then assisted to purchase care they feel is appropriate to meet practical day-to-day needs. This system has worked very effectively for younger adults with physical disabilities. It gives them direct control over the care provision, enabling them, for example to change the times when a carer visits, to recruit carers themselves, and to be in complete control of the kinds of work the carer does, the way they do it and when it is done.

In practice the direct payments scheme usually provides a central resource of some kind, which helps people to recruit carers, advises on employment law and other practical issues, and undertakes accounting and PAYE administration where this is necessary.

This scheme has now been extended to older people aged over 65.

## Swindon GP Co-operative and Medic-Link Ltd

Swindon GP Co-operative is an out of hours GPs' co-operative, but all the non-medical part of the service is provided for the co-operative by Medic-Link, which is a conventional limited company. There are about 100 GPs in the co-operative, representing 30 practices.

The service provides:

- out of hours home visits
- an out of hours surgery
- telephone advice
- an out of hours nurse service

The service liaises closely with the Community Health Council and the local NHS walk-in centre. It takes

about 40,000 calls a year. It is based in a modern unit close to the town centre, but on a small business estate. This has car parking, is close to a pharmacy, and has no close neighbours to disturb at night.

Income comes from three main sources:

- the out of hours development fund – 25% approx.
- night visit revenue – 25% approx.
- from the GPs in fees – 50% approx.

GPs in the area joined together as a co-operative in 1994. The group was not large enough to support the

infrastructure to administer the service, so they 'sub-contracted' this to the Reading centre. After two years the co-operative had grown enough to sustain its own provision. The structure means that GPs do not have to worry about running the business, or providing the capital and managing the finances, but they are still able to be a GP co-operative.

### Contact

Robert Charles  
Swindon GP Co-operative and  
Medic-Link Ltd  
Telephone 01793 541111  
admin@medic-link.co.uk  
<http://www.medic-link.co.uk>

This creates opportunities for older people to group together and set up social enterprises following the model adopted by the disability community. They could contract collectively to a single care provider, they employ a group of care workers or individually employ individual care workers. The direct payments scheme could be used to give residents in extra care housing direct control over the management of day-to-day care that is provided. The collective management, employment, and recruitment of care workers could remove from frail, older people the practical difficulties of managing care workers themselves, whilst leaving them in direct control of day-to-day provision of their own care.

### **Primary Care Groups and Care Trusts**

Primary Care Groups have now replaced Health Authorities. These are gradually being converted into independent Primary Care Trusts. Led by GPs, with representation from other groups, PCTs will be responsible for commissioning all the primary care in their localities.

There have been calls for the Health Action Zones to be integrated with PCTs.

The next step in the government's thinking is the establishment of Care Trusts. These will enable even closer working between health and social services departments. The legal framework for Care Trusts was set out in the Health and Social Care Act. The aim is to broaden the range of options for health and social services, and deliver integrated care that gives the best service to the people who depend on both.

Care Trusts<sup>15</sup> are currently being developed, and government may approve the first in April 2002. Models will respond to local needs, and so may develop different structures. Guidance describes some of these:

- Focused strategic commissioning with primary care teams and partners developing a wide range of service delivery options.
- Integrated health and social care teams providing care management assessment and service delivery.
- Multi-disciplinary teams with a single budget, created from NHS and local government resources, and a single management structure and information system.
- Integrated provision with sheltered housing.

### **Grants or contracts**

In recent years there has been a shift in the way many voluntary and community organisations are funded. Authorities have moved from providing grants to contracting. Some have introduced Service Level Agreements, which are often a half-way-house between the two. These terms are not always used in exactly the same way, but generally speaking a contract requires a direct link between activities and payment. A grant is paid irrespective of the number of users, or care hours or people attending. SLAs bridge the gap in that they provide a fixed level of funding with specific output targets or requirements.

This change may have converted many small and medium sized voluntary organisations into social enterprises. This is the case if their contractual relationship can be defined as trading, and it makes up a significant part of their income.



This change has required a response in that organisations have had to learn a whole range of new skills, including:

- contract management
- business planning
- marketing
- financial control

Many have become more entrepreneurial, and looked for other forms of earned income, expanding to offer services to other funders, or to develop new projects. This has often created a cultural change within the organisation, and made them more responsive to users and clients and more practical in their approach to service delivery.

### **New proposals for NHS reform**

As this booklet is being prepared, a whole range of new proposals for the operation and management of the NHS are being announced. These include:

- the delegation of 75% of the NHS purchase budget to Primary Care Trusts
- increased freedom to select acute and community health providers
- new ways to manage poorly performing NHS Trusts, including *not for profit* organisations
- additional freedom for some trusts to be involved in entrepreneurial activities

### Introduction

This section describes 12 areas where opportunities may exist for social enterprises to develop, and where social enterprise models may be particularly appropriate. Like other businesses, social enterprises are market led.

Opportunities exist where:

- people or organisations, including the government, have needs or priorities
- funding is available to pay for services to meet those needs
- social enterprise models have the capability to deliver, or have some advantage over other business forms

The markets for health and social care are highly local. There will be variation between localities in:

- their demography
- the nature and character of communities, and informal caring
- the development and structure of health and social care public organisation
- the capacity and character of provision
- budgets and wealth
- the existing social enterprise community
- health and social care priorities
- support provision

In considering opportunities, it will be vitally important to understand the local situation. It may be necessary to do some initial research in order to evaluate whether the opportunities we suggest exist locally. Not all the opportunities we have identified will be appropriate. In some cases other forms of provision may have already occupied the gap in the market. In other cases, the infrastructure may not be present or have the capacity to facilitate the developments that we suggest. Local needs may not warrant provision, funding may not be available or other barriers may make certain types of development inappropriate.

Initial feasibility studies may be required, at a level of detail and at a scale appropriate to the opportunity. Many opportunities arise from partnership development, and partnerships can take some time to establish. Other opportunities happen quickly with funds available only for a limited time, so it may be necessary to build capacity and plan in advance, to be ready when the opportunity arises.

In most cases in-depth business planning will be necessary to obtain grants, raise finance and convince potential members or partners. General business planning issues are addressed in section 3.



### Introduction

Government strategies now make the connection between poverty, the physical environment and lifestyle choices in determining everyone's individual health.

Social enterprises are the perfect vehicle to respond to this agenda. They:

- retain wealth, from both pay and surpluses, in the communities they serve
- can service communities by providing otherwise unavailable facilities, or can sell services outside impoverished communities, increasing local wealth
- directly reflect the aspirations and goals of local communities
- embody government priorities as regards partnership and joined-up working
- have the enterprising character of the private sector, within a public sector value base
- can be established and survive on a low market base, trading to create the capacity to grow

### The market

A recent publication from the King's Fund, *The Regeneration Maze Revisited*<sup>16</sup>, listed 27 government initiatives that could provide support or funding for projects linking health and regeneration. Some are area based and only available in specific localities. Others are generally available. Objectives and targets describe all. However, funding regimes are prone to change; they may be replaced or their remits, priorities or detailed frameworks amended. For example, SRB 6, a major funder in the past for these types of schemes, is currently being replaced.

These initiatives include:

- SRB 6 – currently being replaced
- New Deal for Communities
- action zones (health, education, employment and sports)
- European Community initiatives
- public service improvement programmes
- local strategic partnerships
- New Deals
- learning and education initiatives
- small business and community development support
- the New Opportunities Fund

### What could be provided?

The range of initiatives possible is wide and eclectic, as communities and individuals respond to local priorities, capability, markets and opportunities.

<sup>16</sup> *The Regeneration Maze Revisited*  
Teresa Edmans and Grisel Tarifa  
The King's Fund 2001

These initiatives must build on existing community strengths, not replace them. They could include:

- **Time banks** – informal exchange networks sometimes called Time Dollars schemes. A central computer records all the volunteering time contributed to the community by members, who can then obtain the same time from others in the scheme. All time is valued equally. Time banks are an excellent vehicle to assist older people with many of the practical tasks that are so difficult otherwise. They also validate older people's contribution to communities. It is exchange, not charity.
- **Practical tasks** – accredited services that will do low level practical and building work for people in their own homes. These could be:
  - gardening – regular maintenance rather than one-off clearance
  - small building jobs
  - electrical equipment and white goods – maintenance and repair
  - insulation and draught proofing
  - pet care, and emergency short term pet sitting or respite
  - security – door and window locks
  - installation of adaptations, in particular grab handles

## Rushey Green Timebank

The Rushey Green Timebank was set up with the help of the New Economics Foundation who provided a development worker. The time bank is based in the Rushey Green GP practice. The long-term intention is to institute a management committee and become a charity.

Approximately 60% of the members are older people. There are 58 individual members, and nine organisation members. One full-time and one part-time development worker provide administrative support and assistance with the recruitment of new members. The bank has space within the practice, its own computer and phone, and uses time bank software (it started with a hand-written system!).

The organisational members provide resources, rooms for meetings, plants and use of telephone, in exchange for the volunteer time of individual members.

This is the only time bank in a GP practice or health care setting, and came about because of the interest of the GPs. They knew that there were social rather than medical solutions to some of the problems that patients were presenting. Ill health and anxiety grew from feelings of social isolation. People didn't know their neighbours or were too frightened to go out. Many of the families and older people need help, but for the small things. Members are regularly doing visits, dog walking, baby sitting, shopping, or anything from writing poetry to helping with the shopping. The scheme is expanding into DIY so that members can also

get small but vital practical repairs done. The doctors regularly prescribe the time bank!

Many people want to do things for others and find it difficult to think what they want others to do for them. It is sometimes difficult getting people to use up their time credits. But then the project is as much about befriending as getting jobs done.

It is too soon to be precise about the impact on local health, but the South London and Maudsley Health Trust is convinced, and plans to roll out the time bank to their institutions.

### Contact

Rushey Green Timebank  
Rushey Green Group Practice,  
Canadian Avenue  
London SE6 3AX  
Tel: 07946 411177

These services could be provided by:

- community business or small workers' co-operatives
  - LETS schemes or time banks
  - voluntary organisations
  - development trusts.
- **Complementary medicine** – facilitating access to complementary or alternative therapies, and assisting people to train and gain employment through their provision. These might include:
    - homeopathy
    - chiropractic
    - osteopathy
    - therapeutic massage.
  - **Healthy Living Centres** – whilst the main funding driver for Healthy Living Centres, the New Opportunities Fund, has shifted its priorities elsewhere, setting up and developing similar facilities using other funding sources must remain an option.
  - **Practical support** – for older people in their own homes. Most authorities have withdrawn from funding or providing practical or domestic support for people in their own homes. Some research suggests that even people on low incomes are still prepared and able to pay for some of these services, but have difficulty finding trustworthy and appropriate providers. These include:
    - cleaning – regular and spring
    - transport
    - help with pensions and other finances
    - shopping
    - cooking
  - **Translation services** – many people still have to attend doctors, hospitals and other health practitioners who cannot speak the patient's first language, and few provide an effective translation service. The use of family members, in particular children, can often be inappropriate.
  - **Support for specific health issues** – developing community based facilities or teams to support people living in the community with specific health issues, not always addressed by Community Health Trusts.
  - **Training and recruitment** – there are severe shortages of nurses, PAMs (Professionals Allied to Medicine) and care workers. There are already a small number of social enterprises running successful training programmes for care workers, and that could be emulated nationwide. There could be a role for social enterprises in addressing the recruitment issues for the other caring professions. Community based recruitment, flexible employment, and local specialist agencies are all possibilities.
- Opportunities also exist to establish intermediate labour market businesses, training care staff and earning additional income from their deployment in the delivery of care services.



- **Credit unions** – there are clear links between poverty and ill health, and one route to addressing this issue is through the establishment of credit unions. SEL has taken part in a health evaluation of the impact of credit unions.
- **Meeting the prevention agenda** – helping older people to live healthy lives. A whole range of initiatives are possible, many of them formalised into Healthy Living Centres, but including:
  - clubs, networks and social organisations – reducing isolation and improving the quality of life
  - improvements to diet and better food through co-operatives and box schemes
  - better access to information, particularly about facilities, drugs and behavioural health impacts
  - access to sports and leisure facilities.

A number of other health issues are addressed in Opportunity 2, which looks specifically at intermediate care.

### The Hull Healthy Living Centre

The Hull Healthy Living Centre, which opens early in 2002, is a new innovative facility in the centre of the town. The building houses:

- a restaurant
- a charity shop also providing living aids/adaptations
- rooms for the Primary Care Trust and alternative therapies
- hairdressing facilities
- breast screening facilities
- a gym
- a sports hall, with sprung floor
- a wet room, with hydrotherapy pool, steam bath and jacuzzi

The centre is open to people aged over 55, and members get a 10% discount. Some activities are run by the Centre, others by other organisations such as the Osteoporosis Society, Adult Education and local, private keep fit providers.

The range of classes and activities is extensive, including gym, dance,

exercise, relaxation, indoor sports, crafts, health education and screening, podiatry, hairdressing, reflexology, aromatherapy and insurance services.

Part of Age Concern Hull, the Centre is a charity, with a trading arm that covenants its profit to the charity. Users were extensively involved in the design and building process, including the disability community as well as older people's groups. Users and members form the basis of an active volunteer group.

Within a week of opening, the membership list of 500 was full, and the Centre already has a waiting list. There are 17 staff and about 70 volunteers. The volunteers are just as important as the paid staff, and all are treated as an equal part of the team.

The Centre has been planned for 10 years, and has been the realisation of a dream for some

members of Age Concern. It was funded by a package of over £860,000 from the city council and over £900,000 from the New Opportunities Fund. The remainder of the over £2 million budget was raised from other trusts and general fundraising. £500,000 still has to be found.

The success of the centre has been based on real partnerships, consulting extensively with people in the planning process, building what the community wants. They worked hard to make sure that plans and projections were as accurate as possible. Hull now has an excellent centre, the first completed, building-based Healthy Living Centre.

#### Contact

The Hull Healthy Living Centre  
Age Concern, Bradbury House,  
Porter Street, Hull HU1 2RH  
Tel: 01482 324644

### Which types of social enterprise?

- Development trusts could play a major role in facilitating, funding and establishing many of the proposals described in this section. They could also form partnership vehicles with the public sector to respond to specific health-focused initiatives.
- Some services, particularly those with some funding, but also dependent on charges to users, will lend themselves to **community businesses** or **workers' co-operatives**.
- There is also a role for **credit unions**, **LETS schemes**, **ILMs (Intermediate Labour Market schemes)** and **time banks**.
- Community or voluntary organisations moving into trading could add these services to complement grant-funded activities.

### What to do next?

Most of these opportunities depend on linking need at a local level to a specific funding or support opportunity, and individuals with the capacity to initiate proposals or deliver local services.

Where development trusts or other well-developed, broadly based community regeneration organisations exist, then they will play a major role in bringing funding, ideas and individuals together. Equally, proposals could be initiated by local voluntary bodies or campaigning individuals. The key is the link between funding bodies, communities and individuals:

1. Build partnerships between funders, commissioners and local communities so that strategies reflect the needs of local communities, and communities know this.
2. Identify the range, remit and objectives of local funding or support opportunities.
3. Make links between funding support and individuals that can champion projects at a local level.
4. For each possible project, prepare an initial feasibility study. If this looks promising, move on to the full business plan. The level of detail should reflect the size and scale of the project and the level of risk involved.

### Introduction

For a number of years governments and policy makers have been recommending a range of services aiming to keep older people out of hospital, and equip them to return home without increased dependency.

These policies achieve two aims. They improve the lives of older people, and may reduce the long-term support cost of keeping people living at home. Secondly, they reduce NHS costs and remove pressure on beds by moving older people out of acute hospitals into lower cost, more homely environments.

Older people form the largest group of NHS patients, making up over 40% of emergency admissions. The NHS Plan sets out a series of initiatives and funding proposals. Their focus is to promote independence through active recovery and rehabilitation. There are concerns that older people are admitted to acute hospitals unnecessarily, that they stay in hospital too long, and that hospital admission creates dependency. Older people are to be seen not as a burden but as a priority for the modernisation programme.

### Partnership working

Intermediate care is a focus for the government's objective to integrate health and social care provision with many of the services that people use when they move between hospitals, nursing homes and home. Services are planned and delivered in partnerships between health, social services and the independent sector. Until now the majority have been delivered by co-ordinating statutory provision. This is now changing: policy development, increased funding and lack of capacity mean that far more of these services may be purchased from the independent sector.

This creates an opportunity for social enterprise development.

*Most people agree that there is a yawning gap in the range of health and social care services for older people. An expansion of intermediate care services will fill that gap.*

Jan Stevenson, Community Care<sup>17</sup>

Partnership structures between health and social care at a local level are developing at different speeds. In some places Primary Care Trusts are established, in others they have yet to be approved. Proposals for Social Care Trusts are well developed in a few areas. Some authorities share chief executives, some are moving to pool budgets, whilst others have set up other types of partnership structures. In most places, Intermediate Care Co-ordinators are now in post, with a remit to facilitate the commissioning and delivery of intermediate care.

<sup>17</sup> Singing From the Same Hymn Sheet

Jan Stevenson Community Care 29 March 2001

Some examples of intermediate care services, delivered in partnership with voluntary or independent sector providers:

- Home from Hospital  
**Bath Age Concern**
  - Nurse led units – therapeutic care in sheltered accommodation  
**Action for Health Older People, Newcastle**
  - Resource centre, respite, assessment OT and Physiotherapy  
**Ambleside Bank Older Peoples' Resource Centre, Wigan**
  - Residential 'halfway house', planned programme of rehabilitation  
**Community Rehabilitation Unit, Sheffield**
  - Rapid Response Team  
**South London NHS Trust partnership with the voluntary sector**
  - Home from Hospital Service  
**British Red Cross**
  - Community based resources to facilitate early discharge from hospital  
**Challenge Fund, Scunthorpe**
- Intermediate Care Models in Practice** The King's Fund 1999

## The market

By 2004 the government proposes to make available an extra £1.4 billion a year for older people's services, with the aim of extending years of healthy life and promoting dignity, security and independence. Of this, £900 million is designated for Intermediate Care Services by 2003-04<sup>18</sup>.

The plan introduces a new grant, Promoting Independence, worth £296,000 in 2001-02. It replaces earlier prevention grants and funding for Winter Pressures. The vast majority of this funding, 97%, must be spent on additional community care services, and the grant aims to promote new patterns of service, providing care closer to home.

It is intended that by 2004 intermediate care facilities will provide:

- 5,000 beds and 1,700 places for recovery and rehabilitation
- rapid response services helping 70,000 more people each year
- additional home care and other support for 50,000 more people living at home
- 50% more people benefiting from community equipment services
- carer's respite services to benefit a further 75,000 carers

Quoted in *Intermediate Care, Journal of Community Nursing*, June 2001<sup>19</sup>.

Whilst it is likely that the vast majority of these services will continue to be provided by the statutory sector, issues of undercapacity and the emphasis on partnership working means that a significant proportion may well be commissioned from the independent sector. The Audit Commission Report, *The Way to Go Home*<sup>20</sup> identified major gaps in service provision, so localities may well be looking for innovative responses from the independent sector.

## What could be provided?

Intermediate care lends itself to innovation in service provision<sup>21</sup>. The vast bulk requires partnership working, which lends itself to some types of social enterprise. It is likely that many of the services developed will follow the patterns already laid down, which include:

- **Rapid response teams** – providing emergency assessment, diagnosis, nursing treatment or home care in someone's home to avoid admission to hospital.
- **Hospital at Home services** – providing health care, nursing or other care, that would normally require hospital admission, in someone's own home.
- **Day rehabilitation** – intensive therapy in a day centre to increase someone's ability to live independently or avoid long term admission to hospital or residential facilities.
- **Supported discharge** – services that enable someone to be discharged from hospital, but complete their recovery at home or in a nursing home where continuing nursing care, with therapeutic input, continues alongside home care.
- **Home from Hospital** – low level interventions to support the transfer from hospital to home.
- **Residential rehabilitation** – a period of intensive rehabilitation, often in a nursing or residential home, aiming to equip someone to live independently in their own home.

18 Promoting Independence Grant – 2001-02 Guidance DoH

19 Intermediate Care Journal of Community Nursing Sue Thomas June 2001

20 The Way to Go Home DoH

21 Intermediate Care Models in Practice Vaughan & Lathlean The King's Fund 1999

### What are the barriers?

Many of the services needed to meet the intermediate care agenda will be professional health interventions, frequently linked to social care. They will be delivered by nurses, therapists and care staff. Unless your organisation already has this capability, developing it just to take these opportunities will be difficult. It is important to play to your strengths. Think carefully about which parts of the agenda can be delivered effectively by a social enterprise.

Recruitment of staff may be difficult. There are well-known recruitment difficulties for nurses and occupational therapists. A similar situation is also developing for home care staff. Some of these services require staff to work unsocial hours, in the evenings, nights and weekends. A smaller independent social enterprise may have some advantage in the labour market by offering more flexible or family-friendly employment, and a working culture that is empowering and non-discriminatory.

Pay rates and profitability will be dependent on the level of funding.

Many of the services will require providers to be accredited under the Care Standards Act.

Some existing independent providers have not wished to respond to similar opportunities in the past because of the investment needed, the risk involved and the lack of certainty of continuing purchase.

### Cumbria Direct Payments Advice and Information Service

The winner of the older people, intermediate care category in this year's Community Care awards was the Cumbria Direct Payments Advice and Information Service. It is a registered charity, and the trustees are local people, most of whom are users of the service. The involvement of people using direct payments was crucial to its success.

The centre facilitates people's access to direct payments to purchase their own care by employing care workers themselves.

It helps people to identify and select appropriate care providers, to

make the arrangements and recruit staff, and also provides support in managing the finances and making monthly returns.

The service has about 100 clients; all are disabled adults, and many are elderly. Some make contact every week, and in the early stages of switching to the direct payment option clients have daily contact, as they need to produce a care plan, identify their care needs and how they will meet these, and work out what money is needed before making an application. There are four part-time staff

members and administrative support in five locations.

User control is really important. The organisation gives people the opportunity to be really independent – this promotes the feeling of self-worth that comes from being in control of one's own life.

#### Contact

Fred Wilenius  
Cumbria Direct Payments Advice and Information Service  
Tel: 01228 674882 and 818555  
Fwilenius@aol.com

By becoming a player in the partnerships you will not only be seen as an organisation that can deliver provision, but will start to be able to influence the way services are designed and procured.

### Which types of social enterprise?

This situation suggests opportunities for three types of social enterprise:

- Those that **already have facilities** to run businesses or deliver services, and have the capability to develop additional intermediate care services:
  - housing associations or co-operatives running sheltered or extra care facilities
  - existing providers of residential, day or home care services for older people
  - those providing specialist services for Black and Ethnic Minority clients

These organisations should already have the capacity to train and manage staff, and they should be on the way to achieving the accreditation requirements under the Care Standards Act for their existing services. They are more likely to have the capital, track record and management skills to convince commissioners that they can deliver.

Even so, opportunities are likely to be restricted to existing capability. Residential or housing providers could take on residential reablement, or provide step down beds. Existing home care providers may be looking at rapid response or night or emergency services for people at home.

- There is a role for **voluntary sector** organisations already working with older people in the community, and newer community based organisations, for example development trusts, looking to strengthen their role with older people. Home from Hospital schemes are specifically identified as likely to be delivered by the voluntary sector, and could be undertaken by social enterprises.
- **New partnership organisations** set up specifically to respond to particular local intermediate care proposals. They may bring together the statutory sector, community, voluntary and campaigning organisations as well as employees and older people themselves. The community basis and the independent sector positioning may increase the availability of additional resources, particularly regeneration funding. This type of multi-stakeholder social enterprise is an excellent vehicle to reflect the partnership character of intermediate care, and facilitate real joined-up provision without being dominated by any one partner.

### What to do next?

The majority of these opportunities will come from participation in ongoing partnership arrangements with health and social care commissioners. This may be a long and gradual process, but by becoming a player in the partnerships you will not only be seen as an organisation that can deliver provision, but will start to be able to influence the way services are designed and procured. Partnership membership also provides timely information on anticipated changes to service plans. The steps are:

1. Identify and engage with the local Intermediate Care Co-ordinator.
2. Obtain the local plans that describe the services that are still to be procured.
3. Review the strengths and capability of your organisation, what do you do well, where do your strengths lie? Do they match any of the proposed provision? Be aware of the danger of over-reaching.
4. Gain access to the local partnership, or build partnerships with other local social enterprises to influence the direction of service planning and procurement.

5. If there is a relevant opportunity, prepare an initial feasibility study to see if you can deliver within the proposed pricing or funding structure.
6. Clarify the procurement arrangements: is independent sector provision a genuine option? Will the service be tendered, delivered by a partnership or negotiated with a preferred provider?
7. Prepare a detailed business plan. Identify the support you need and where it may be available. Is there a local support organisation for social care providers, a CDA or social enterprise development agency, a development trust or the local Small Firms Service. See section 3 for details on the business planning process.



Specialist home care providers in East London:

- Majlish (Bangladeshi)
- Tawakal (Somali)
- Shebadan, St Hilda's East Community Centre
- Apasenth (Bangladeshi)
- Chinese Association
- Vietnamese Community of Refugees
- Jewish Care
- Bikur Cholim (Jewish Orthodox)
- Turkish Cypriot Cultural Association
- Hackney Chinese Community Services
- Christian Community Centre
- North London Muslim Centre
- Subco (Asian meals)
- Dekhabhall (a community training partnership)

**Mapping of Home Care Services in East London Boroughs, Baker Brown Associates, 2002**

### Introduction

There is general acceptance that in many localities there is under provision of services for older people from the Black and Minority Ethnic Communities, and often low take-up of existing facilities or programmes.

Participants at seminars organised by the Royal Commission on Long Term Care<sup>22</sup> argued that there is lack of provision in terms of both the range and choice of services and the quality of services. Quality relates to meeting people's basic needs, but also those specific needs that are part of culturally appropriate services, including:

- appropriate ordinary daily care
- food
- access to religious and spiritual facilities
- communication

Not only should we, as a community be providing a choice of culturally specific services and facilities, but where people through choice or circumstances use mainstream services, then their culturally specific needs must still be met.

Communities do have different family and social structures that support older people in different ways. These are changing as communities develop over time, but this fact is insufficient to explain the low take-up of services.

There is some evidence that people from Black and Minority Ethnic communities have poorer health than the general population of the same age. That is to say they need health and social care interventions at a younger age than the remainder of the community of older people. Frailty and ill health can be linked to poor economic circumstances and bad housing conditions. There is an argument that communities and individuals suffer from the combined impact of discrimination by race, age and social class<sup>23</sup>.

Some communities are dispersed and the problems of isolation for small numbers or even single older people can be acute. Attention has been drawn to the lack of services for older asylum seekers, who may have specific needs. Changing patterns of migration and dispersal policies create the danger that needs may be missed or ignored.

The 1976 Race Relations Act has now been amended. This new law outlaws discrimination by any public authority in carrying out any of its functions, and imposes a duty of positive racial equality. Health Trusts, PCTs and social services departments are all covered by this legislation. They should be undertaking a policy impact assessment, which will look at the way race equality is promoted and inequalities are being addressed, to identify good practice and challenge poor practice. This may result in identification or provision of resources, and therefore additional services.

<sup>22</sup> *With Respect to Old Age* Royal Commission on Long Term Care HMSO 1999

<sup>23</sup> *Future Imperfect?* Melanie Henwood The King's Fund 2001

## The market

For a range of reasons, Black and Minority Ethnic Communities tend to live in specific localities, and over the past ten years some specialist services have developed to meet their culturally specific needs. A range of community organisations have responded to the opportunities provided by the general development of the independent sector to build small specialist residential homes and day centres and to establish culturally specific home care providers. A recent SEL survey<sup>24</sup> of six London boroughs and the City of London identified 14 culturally specific or community-led specialist home care providers. Whilst organisations are concentrated in the areas of highest population, within this area there are localities with significant minority communities, which nevertheless have little or no cultural provision.

Changes in purchasing strategies and more importantly increased accreditation burdens are likely to increase costs for smaller providers and may threaten their profitability. Culturally specific providers already face higher costs than mainstream providers. In some places this problem has been resolved by strategies that support providers or encourage collaboration between providers.

As well as existing under-provision, demographic projections suggest a significant growth in the numbers of Black and Minority Ethnic older people. In 1991, only 5% of the Black community were aged over 65, compared to 19% of the White community. The percentages for those aged 45-65 are much closer, 15% and 19% respectively<sup>25</sup>. This means a significantly higher growth in the numbers of Black older people, at a time when projections

24 Mapping of Home Care Services in East London Boroughs Baker Brown Associates SEL 2002

25 Future Imperfect? Melanie Henwood The King's Fund 2001

## Carib Care

Carib Care is an independent voluntary organisation, registered as a company limited by guarantee. The members and the management committee are drawn from the local community. Many people who receive services are also members, and take part in the AGM which elects the management committee.

The service grew from a critical inspection of the local social services department, which identified the lack of appropriate provision for minority ethnic communities. As a result they approached local churches to access these communities. Developments were encouraged and a home care project started through the auspices of the Huddersfield Afro Caribbean Council of Churches, but progress

was difficult because of a lack of available people with experience and skills to write business plans, negotiate etc. There was a need to identify the key players, be persuasive, do research and put forward real demographic evidence.

Carib Care now provides 500 hours of home care per week. It provides personal and practical care, and runs a befriending scheme. It is about to open a day care centre and has a contract with Kirklees Social Services to provide 40 places a week. The centre intends to provide 'traditional' activities and meals but within an Afro-Caribbean cultural context. It will link in with an internet and computer training facility and the local Healthy Living Initiative.

Work is also taking place on developing housing with care through a housing association. It is intended this will cater for residents with varying care needs and to have a care team based there. A bid has been submitted to the Housing Corporation, a site has been identified and development is expected to take about two years. The intention is to include a purpose-built day centre and move the existing day centre activities to this venue.

### Contact

Carib Care Scheme  
c/o New Testament Church of God  
Great Northern Street  
Huddersfield HD1 6AY

show high growth in the general population of older people. Figures for other ethnic groups vary in detail but are broadly similar.

### What could be provided?

This analysis suggests three areas of need:

- **New culturally specific services**, where gaps exist and communities are sufficiently large to sustain provision.
- Support for **existing providers** to ensure survival and accreditation, and to encourage the development of alternative provision.
- The development of **support services** that assist mainstream providers to meet culturally specific needs, and that provide information and facilitate access to existing services for potential users.

There may be needs in a whole range of areas of service provision:

- specialist services to support people with dementia
- residential or extra care provision for specific communities
- culturally specific home care and meals on wheels
- day care
- 'low level' support both in the community and in health provision
- services providing information and access
- organisations addressing specific health needs

In some key localities there may be opportunities to develop formal partnerships or collaborative approaches with a range of providers working together to facilitate accreditation, recruit, train and develop care workers, and negotiate with public commissioners to ensure appropriate and sustainable provision. Regeneration funding can be used to establish and sustain this infrastructure support.

### What are the barriers?

Many barriers are the same as those faced by any social enterprise in this field, but there are two that are specific to this specialist area.

Firstly, justifying that need is real. Low take-up of existing facilities by people from Black and Minority Ethnic communities can be used to argue that there is no real need for specialist provision. Accurate mapping data with exemplars from other places can be used to counter this argument, but it often takes campaigning to gain recognition.

New projects may be replacing existing capacity, which is not meeting needs, and so is underused. This in itself is a barrier. It is not easy to remove budgets from existing services, even to fund new, more effective provision. The result may be loss of provision for another group of people. In this situation, new independent sector provision in a social enterprise may be replacing existing in-house provision. As in many areas there are pay and conditions differences between the sectors, and it is important to ensure that this process does not result in people being paid less. This could have problematic results if staff are recruited from the minority communities, and locked into a low pay environment.

### Which types of social enterprise?

- Existing **voluntary organisations** developing the capability to deliver specific services to their users or members, moving into a contracted, trading-based operation. These are likely to be unincorporated associations or companies limited by guarantee, and following either the service or single stakeholder models.
- Existing **social enterprises** developing new services, either by growth or by facilitating a new local provider. These may be single stakeholder or multi-stakeholder enterprises.
- New **multi-stakeholder social enterprises** establishing themselves as providers to address specific needs.
- Wider area-based **partnership organisations**, a second level group of social enterprise and community-based providers.

### What to do next?

These opportunities are likely to arise from one, or a combination of two, sources. Firstly, campaigns by existing organisations or individuals aware of the level of need and the frustration with existing provision, and secondly by proposals from commissioning or service planning groups in health or social care. In the past, these might have been service managers with responsibility for this area, or joint commissioning groups. In the future it will be Primary Care Trusts or Care Trusts. Development trusts and/or social enterprise support bodies may bring people together to facilitate these developments.

1. If it has not already been done, the first step is a **mapping exercise**:
  - What localities and services do culturally specific providers already cover?
  - What unmet needs do communities, organisations and individuals identify?
  - A demographic analysis of the communities: How many older people are there? Where do they live? What are the predictions for the future?
  - What concerns have been raised about existing facilities and services? What is the uptake by the community in question?
2. This analysis should help to **identify gaps** in provision and give a sense of the potential level of take-up. The gap analysis will suggest the types of project or service that are needed and will be viable. Look for good practice exemplars, whose ideas and experience can be transferred to your locality.
3. Identify the opportunities for **funding or purchase**.

Who is likely to pay for or fund the proposal? Will capital be needed, and are there ways to obtain it? Will the service be grant funded, or purchased? What financial contribution will users make? If there is a gap where might additional funding come from?
4. **Review the proposal with commissioners** or service planners. Does it fit with the Community Care Plan or Joint Investment Plan? Is it likely to be supported and purchased? Will local politicians and community leaders support the proposal?
5. Prepare a **feasibility study**. Given local conditions, is it likely to work?
6. If this is positive, prepare a fully detailed **business plan**. You may need help from a development agency or the Small Firms Service, or have to find some funding.

At the heart of these changes was the development of a range of services aiming to help people to live independently in their own homes for longer than had previously been the case.

### Introduction

The social enterprise market for home care and day care is already well developed. A recent report by the UKCC<sup>26</sup> identified over 50 co-operatives delivering home and day care, predominantly to older people.

Following the Community Care Act, strategies to support older people changed radically, although the rate of change varied widely between authorities. At the heart of these changes was the development of a range of services aiming to help people to live independently in their own homes for longer than had previously been the case.

- Home care shifted from practical or domestic services to personal ones. Traditional home help services – shopping, fire lighting, cleaning – have virtually disappeared from the publicly funded sector unless they are part of larger packages of care. A recent survey by UNISON described this shift in responsibility. Five years ago 43% of care workers felt that the majority of their work was domestic or practical; now only 5% do.
- The size and intensity of home care packages has changed from a large number of short visits to more intensive care. The number of hours of care provided has grown dramatically whilst the number of people or householders receiving care has not. In England in 1992 for example, only 11% of care packages were intensive; by 1998 this had increased to 30%.
- There has been a massive shift in the ownership of provision. In 1999-2000 for the first time the number of hours of care provided by the independent sector exceeded that provided by local authority in-house providers. This is a radical change from 1993-94 when less than 10% of care was provided by the independent sector. However, in Scotland and Wales the majority of home care, over 80%, is still provided directly by in-house providers.
- Day and respite services, which are also critical in assisting people to remain at home, have developed, but not to the same extent.
- A large amount of care is still provided by unpaid carers, usually family members. Respite care, which aims to support the carer, is of two sorts. It can be residential, in which case the older person spends time in a residential or nursing home to provide a break for their carer. On the other hand it can be domiciliary, in which case home care is provided, but to support the carer.

### The market

The independent sector market is diverse with a large number of small providers, and a small number of large providers. The majority (76%) of independent providers deliver over 1,000 hours per week. However, most (54%) only work for one local authority. Only 11% of providers work for more than four authorities. In England and Wales around 500,000 people receive home care, of whom 84% are aged over 60<sup>27</sup>.

<sup>26</sup> Co-operating In Care ICOM UKCC 1998

<sup>27</sup> Domiciliary Care Markets 2000 Laing & Buisson

In most localities, the policy shift from residential to home care provision has been completed. Where this has not happened it is generally identified in inspections, and councils are encouraged to change practice. In those remaining localities with more than 50% in-house provision there will still be opportunities for growth in the local independent sector. This may be by the transfer of budgets, or by direct externalisation of in-house services.

However the growth in new home care providers that occurred over the past ten years, driven by funding policy, is over. Markets are consolidating as commissioners start to see the disadvantage, and high contract monitoring costs, of a large number of small providers.

### Sunderland Home Care

Sunderland Home Care grew out of two other co-operatives in Sunderland, Sunderlandia and Little Women. Initially set up as Little Women Household Services, it traded by providing services to people who used benefits to cover the costs. When the Community Care reforms were introduced, and the local authority started to look for independent sector providers for home care, the co-operative, with the help of Job Ownership Ltd, put together a bid. In 1993 they won an initial contract for 450 hours a week.

The co-operative now employs over 110 people, and provides over 2,500 hours of care a week to over 500 elderly clients. It provides personnel care, helping people get dressed, helping with meals, bathing etc. It also has a separate, smaller team which provides practical care such as shopping, housework and laundry. Virtually all the turnover of over £850,000 a year comes from purchases by the social services department.

Originally a classic workers' co-operative registered under ICOM's blue rules, the constitution has recently been amended by setting

up an employee benefit trust with a profit sharing scheme. This allows the co-operative to distribute surpluses by giving members shares in proportion to their length of service. It is a way to start to address the issue of low pay, which is prevalent in the care industry.

The employee ownership structure has been critical in retaining staff, and encouraging recruitment. Staff turnover is considerably lower than other equivalent independent sector providers. Care workers are more committed to the organisation, and provide a better quality of service. The organisation has a strong local reputation as it is not seen to be exploiting the local community. This results in a greater feeling of security for clients.

A major success has been the new training programme developed with the Care Consortium, a group of local independent care providers. This is funded by the social services department and the European Social Fund. Links with Social Enterprise Sunderland have been critical in establishing this project. There is a rolling programme of training, with ongoing reviews for all workers, an NVQ programme and delivery of training on a wide range of topics,

for example first aid, health and safety, abuse awareness, counselling and advanced care. The programme is available to all local independent sector providers, who are now in a much stronger position to meet training requirements in the new accreditation standards.

The co-operative is now planning a major development. Feasibility funding has been obtained to research the potential to establish a Centre of Excellence. The plan is to establish an extra facility where residents have their own flats, but care is provided by a dedicated staff team. This allows 24 hour care if necessary to be provided in people's own homes. The structure facilitates a much higher quality of life, with people living independently with their own furniture, without having to move as they get older or frailer.

Needless to say the new centre would be run as a co-operative with tenants, owners, residents as well as staff being involved in owning and running the complex.

#### Contact

Sunderland Home Care  
Associates Ltd  
44 Mowbray Road  
Sunderland SR2 8EL

The Blakelock Day Centre is a workers' co-operative in Hartlepool which provides day care for frail older people on two sites in the town.

The co-operative was set up when the local authority, then Cleveland County Council, decided to stop providing these day care services themselves, and put them out to competitive tender. Cleveland CDA submitted a bid, and won. It then recruited members to take on the contract as a co-operative.

It is now the only day care service in the area provided by an independent sector provider. It is far more economical than the original facilities, and provides a better quality of service at a lower cost. More people are using the service than when it was in council ownership.

When the co-operative took over the service, it had to work hard to bring some of the staff on board. Both staff and users, in particular the older people, were resistant to change.

A major change has been the freedom to recruit staff more flexibly. The co-operative now employs 12 people, but also encourages some users to work as volunteers. There are 230 registered users at Blakelock and 80 at Abdiel.

Both sites cater for frail older people. The social services department assesses potential clients and then refers them. Blakelock also provides social facilities for people who are more able.

People who use the centres do not get involved in the business. Staff encourage the users to suggest

activities or programmes, but their attempts to sustain a users' group have failed.

The co-operative's annual turnover is £200,000, about 75% of which comes from a contract with the social services department. Users pay £2.50 per day for morning coffee, a two-course lunch and afternoon tea and biscuits. The enterprise makes a small surplus each year, and since 1994 has accumulated enough to buy a minibus.

#### Contact

The Blakelock Day Centre  
Blakelock Gardens, Hartlepool,  
Cleveland TS25 5QW  
Tel: 01429 265815

## The Blakelock Day Centre

The Royal Commission<sup>28</sup> predicts increasing affluence in old age for some people, and Laing and Buisson have identified some increase in private purchase. It may be that in those areas where better off older people are living, the future will see further increases in the private purchase of home and day care. This may be particularly the case where councils raise eligibility levels, excluding more people from the public funded sector.

The development of day care provision has not kept pace with other policy developments. In many localities, day care is organised as an adjunct to residential care, whereas the service is critical to keeping people at home.

The Carers Act, which gives carers the right to an assessment in their own right, should stimulate demand for respite and other support provision.

### What could be provided?

Once again, opportunities depend on the local situation:

- Where a significant percentage (over 50%) of home care remains in-house then there may still be occasional opportunities to establish **new home care providers**. Where regulatory, set-up and training costs can be funded through regeneration initiatives, then a major barrier will have been removed. However, if the medium-term market is private, then it is unlikely except in particular circumstances that regeneration funding and the private market will coincide.

Where authorities are committed to social care provision but want the operational freedom of independent sector positioning, social enterprise solutions may prove very attractive.

- Best value, inspection regimes, the establishment of Care Trusts and the focus on intermediate care may stimulate more **direct externalisations** of in-house home care and day care. Where authorities are committed to social care provision but want the operational freedom of independent sector positioning, social enterprise solutions may prove very attractive.
- **Collective direct payments schemes.** Membership organisations for older people or their families that directly employ care staff, providing home care. Funded using benefits and direct payments, these schemes could be established independently or as a franchise from an existing social enterprise provider<sup>29</sup>.
- **Specialist day care,** particularly community-based provision for people with dementia, as long as funding reflects the real cost of delivery. Where community-based regeneration strategies are repositioning community facilities then the inclusion of day care for older people with other community activities provides an excellent opportunity for integration.
- The development of **respite and other support services** for carers where needs and funding exceed current provision.
- In appropriate localities, major opportunities exist to use regeneration funding mixed with care purchase to develop specialist **care employment training** provision. There is a significant need to develop good practice in recruitment strategies for non-traditional labour markets.
- The establishment of local **partnerships** to provide central services to smaller social enterprises and to develop support for accreditation, training, quality and human resource management. These partnerships may include PCTs or work closely with them in developing the capacity to innovate and improve services.

### What are the barriers?

There is a sense in the market place that the barriers to establishing or developing new provision have recently been raised.

- The **new regulations** under the Care Standards Act will make it hard for new providers to become established, as it appears likely that they will need to meet regulatory standards immediately they start to trade. Staff, including managers, will need to be qualified, and systems and record-keeping in place. It may be difficult for undercapitalised social enterprises to meet the financial qualifications necessary.

This barrier could be overcome by initial grant funding or other development support, or by franchising accreditation and systems from other successful social enterprises.

- The move away from spot to **block contracts** gives stability, but again makes entry harder. Purchasers are likely to increase their demands on providers for information, and may in future require IT systems which call for more investment.
- Whilst it is predicted that prices for both these services will rise, developing a **financially sustainable** operation may not become easier. Smaller social enterprises operating in a mixed economy with earned, grant and charitable income may find this task easier than larger providers.

<sup>29</sup> Community Care Direct Payments Act 1996, Policy & Practice Guidance DoH [www.doh.gov.uk/scq/ccdp.htm](http://www.doh.gov.uk/scq/ccdp.htm)



- **The labour market.** Care labour markets are local and many providers are already suffering from recruitment and retention difficulties. It may be that in some places, where this problem is at its worst, those that control the labour market will get to provide the care. However, recruiting sufficient, trained staff may be a major barrier for new providers, unless they are involved in regeneration-funded training provision.

#### **Which types of social enterprise?**

- **Voluntary or community organisations** developing trading and contracting capability to take on new services in a mixed income economy.
- **Worker-led or multi-stakeholder social enterprises** developing new services in both the public and privately funded sectors.
- Collective **direct payments** scheme.
- **Secondary partnerships** of existing social enterprise and independent sector providers.

#### **What to do next?**

Whether you are thinking of establishing a new enterprise or developing a project from an existing one, the process is similar, and it is described in detail in section 3.

### Introduction

The time when residential care was seen as the normal way for older people to live has gone. Current policies aim to encourage people to live independently in their own homes for as long as possible. People now tend to enter residential care at the very end of their lives, when they are very frail, and remain for quite a short time, often less than one year.

There are two exceptions to this situation:

#### 1. Extra care

Sometimes referred to as Part 2.5, or very sheltered, this is sheltered accommodation where people live in their own flats or flatlets, but with an on-site care team available. Individual care packages are amalgamated to pay for the care teams, who can provide 24-hour cover. Independence

### The Extra Care Charitable Trust

The Extra Care Charitable Trust wants us all to change the way we think about getting older. It set out in 1987 housing people from the closing NHS geriatric wards, by providing fairly traditional residential care. But, stimulated by visits to the USA and other leaders in provision for older people, they started to challenge the traditional standards for residential care. Privacy, independence and security are what we want when we get older, and as Extra Care's publicity says, if we ask older people, that is what they want too.

"We believe passionately in a way of life for older people which offers choice and opportunity, where people live for today and look forward to tomorrow. We encourage a lifestyle that challenges what most people see as 'getting older' and we believe that age and frailty needn't be a barrier to achievement."

The charity now has a turnover of £25 million a year. It has 1,400 staff, 1,200 volunteers and 1,700

residents, and manages 34 housing or care schemes.

Their vision is the care village – a community of self-contained flats, each with its own front door, and a village centre with an extensive range of facilities open to everyone living in the scheme. In most villages there is a shop, library, IT area, craft workshops, hairdressers, fitness gym, garden, greenhouse and a community space, used amongst other things for bowls, dancing, amateur dramatics and social events. Whilst there is professional help, most activities are run by the people living in the village.

The charity provides a 24 hour, seven day a week expert care service. Care packages are designed to suit people's individual needs, and can be extended as people become frailer or their needs change. Friends, visitors and families just drop in as they would to anyone's home, and the trust encourages large numbers of volunteers.

The villages are built-in partnership with local authorities and a housing association. The funding package shows the partnership nature of the schemes. For Berryhill Village in Stoke on Trent, Extra Care funded 20% themselves, the Housing Corporation provided 20%, the local authority provided 17% and 40% came from private sources. A typical village may cost £15 million to build, and have 200 flats or bungalows on a six-acre site. Residents can be tenants supported with housing benefits, or they can buy their own flat. Social services pays for the home care of those that meet its eligibility criteria.

#### Contact

The Village Life Team  
The Extra Care Charitable Trust  
Abby Park, Humber Road, Coventry  
CV3 4AQ  
Tel: 024 7650 6011  
betterlives@extracaretrust.org.uk  
www.extracare.org.uk

Eldonia House is a residential care home owned by the Eldonia Development Trust. The trust itself grew out of the Portland Gardens Housing Co-operative.

The organisation grew up in response to local demands to redevelop a site formally part of the Tate and Lyle refinery in Liverpool. Housing was provided in Eldonian village. About 11 years ago, the community opened the purpose-built residential home in response to the needs of older residents. In this way, people can remain in their own community as their needs change. This releases housing stock for younger people. The home is part of a close-knit community; residents have lived very locally, and their friends and relatives continue to drop in on a daily basis as if they were at home.

The managers of the care home report to the management committee of the Eldonian Village.

The home has 30 residents, 90% of whom come from the Eldonian Village or surrounding area. Many were born in the area. All have a single en suite room. The home usually has 100% occupancy. There are approximately 30 staff.

The local social services department funds all residents, and the home makes a surplus that is reinvested in equipment and furnishings.

The close relationship between the home and the development trust is critical to its success. This enhances its reputation, and enables the residential needs of the whole community to be met by the same organisation. Staff turnover is low and the pay is reasonable compared with the rest of the sector.

It can be difficult to start a care home within the confines of a small community. People have expectations, for example as to the availability of employment, that

may not be realisable. Care workers have to be trained, and the new accreditation regulations require that 50% of the staff have NVQ level 2 in care.

It has been important in developing the facilities to take a long-term view, and to budget to replace equipment and allow refurbishment. In designing new care homes, it is important to consider such factors as space needs, the quality of the building, maintenance costs and energy conservation, as well as the homeliness. The new standards will increase costs.

#### Contact

Eldonian House  
The Tony McGann Centre,  
7 Eldonia Way, The Eldonian  
Village, Liverpool L3 6JL  
Eldonian House: 0151 298 2989  
Development Trust: 0151 207 3406

## Eldonia House

is maintained, but high levels of care can be provided as people become frailer. This avoids people having to be moved to more intensive care as their needs change.

Extra care facilities are not residential homes, residents are tenants or licensees, pay rent, and have in the past received housing benefit. It is argued that the quality of care can be as high as residential care, without any loss of independence. At the same time the cost to local authorities is considerably less than traditional residential care. The funding of this type of care will fall within 'Supporting People'.

### 2. Dementia or EMI care facilities

People with dementia or who are classified as EMI (elderly mental infirm) need specialist care. More staff may be needed, and homes need to be specifically designed or adapted to provide the right facilities and levels of security. There is a general shortage of specialist facilities and many care managers report difficulties finding placements. There is no direct link between dementia and morbidity, and people may enter residential care as relatively young older people and live there for some considerable time.

Between 1996 and 2001 there were 760 fewer residential homes and approximately 20,000 fewer places. This shrinkage has been driven by the Care in the Community reforms.

### The market

The number of places provided in residential care has been dropping steadily for a number of years. Between 1996 and 2001 there were 760 fewer residential homes and approximately 20,000 fewer places. This shrinkage has been driven by the Care in the Community reforms, which have resulted in people who in the past would have entered residential care staying at home with larger and more intensive packages of home care. The independent sector residential care market faces difficulties:

- projections suggest an overall reduction in the numbers of places needed
- occupancy rates can be lower than needed for profitability
- many privately owned homes are for sale
- a number of schemes that provide capital to the private sector have failed, with home owners struggling to finance the buildings
- regulation has set standards for the size of rooms, facilities and communal space that some older homes will not be able to meet

Many private sector homes are currently for sale, owner managers finding trading circumstances difficult with capped public sector fee levels and low occupancy rates. Some lease-back schemes that provided capital funding for home purchase are in serious difficulties.

Some commentators feel that this situation is about to change. With homes closing, the balance between demand and supply will shift. Health purchase of nursing home beds will increase as the NHS tries to reduce the length of time older people stay in hospital and purchases intermediate and step down care. The cost of large packages of home care can be higher than residential home fees, which may reverse the trend towards home care. Well run, full residential care homes can make significant returns on capital.

One area of potential growth is the development of extra care or very-sheltered accommodation. A number of local authorities are transferring or considering transferring existing stock to registered social landlords (RSLs) with a view to conversion or re-provisioning as extra care facilities. Between 1995 and 1999, local authorities reduced their stock by 36%, whilst RSLs increased their stock over the same period by 11%. Laing and Buisson, in their review of the sector, report that there is an oversupply of sheltered housing, but an undersupply of extra care:

*(a) ... shortfall of 56,000 units nationally of very sheltered, with an oversupply of 200,000 sheltered.*

Assisted Living Market 2000 – Laing and Buisson<sup>30</sup>

The provision of extra care offers opportunities for social enterprises in both the provision of buildings and the care provided within them. Building provision may be attractive to housing associations or co-operatives, particularly if their current tenants are elderly. Research suggests that once people are over 75-80, less than half want to move house, and then not more than four miles from their current home. Building extra care close to, or part of, existing housing scheme keeps people in their communities and would free up underused properties.

<sup>30</sup> Assisted Living Market 2000 Laing and Buisson

## What could be provided?

Three opportunities have been identified in the current market.

- **Employees buying private residential care homes**

Many owner managers are looking for buyers for their residential care homes. Given the current sentiment in the market, homes are not selling that well, which means that owners may be prepared to consider alternatives, and the sale price may not be prohibitive.

This creates the opportunity for staff in the home to purchase it, and convert a private home into a social enterprise. As long as the home can

## West Midlands Co-operative Society

The West Midlands Co-operative is a retail co-operative society, owned by its customers. It owns three care homes, The Willows in Codsall, and Castle Meadows and Nether Crest in Dudley. There are 140 places in the three facilities, and Nether Crest has a nursing wing with 40 places. All were bought from the private sector.

The homes are established as a trading division of the co-operative society. Any customer of the society can be a member, and this includes staff, residents and relatives of clients in the care homes. Members elect the board members at the AGM; eight are from the community and four are staff representatives. The Deputy Chief Executive of the Society is Head of the Care Division, and operational management is in the hands of a Head of Care Homes.

The society originally become involved in care when the opportunity arose to buy a home which also blocked a retail competitor from developing a site. This encouraged the society to develop the care business, and it is now seen as a substantial part of the whole portfolio of service to their members.

The majority of income is derived from social services departments, with less than 5% coming from residents. Currently, turnover is about £2.25m. As a group, the homes trade profitably, but individually their performance is mixed. The best make a high rate of return on capital invested, whereas more recently purchased homes require improvements and renovation to meet quality and accreditation standards. At the moment under-occupancy during the building period is depressing profitability. Surpluses all go towards the development of existing homes, but in the future, expanding the network of care homes will be a priority.

Some of the homes had poor reputations, low occupancy and staffing difficulties when they were purchased. The society has worked hard to resolve these issues, improving terms and conditions, introducing training, renovating and expanding buildings and improving furnishings and equipment. Once these changes impact on the quality of care, the reputation of the homes will change and occupancy rates improve. Only when quality is consistently assured will the homes be badged as part of the society.

It is still early days, but the improved homes are getting a name amongst potential residents – and are full.

The homes are traditional residential or nursing homes, but with administration and development provided through the core co-operative retail business. Placing the homes within the society creates significant business synergy. The society already has extensive experience in human resource management, property development and management, all of which become available to support the development of the care homes. There are also trading opportunities with the society as it owns and runs local post offices, chemists and undertakers. So far, direct food purchase between the retailing and care arms has not been a practical possibility.

The society is now actively supporting other retail societies considering entering the care market, and has taken a leading role in a working group set up under the New Ventures Project.

### Contact

West Midlands Co-operative Society  
Tel: 01922 659277

With the collapse of sale and lease-back schemes, and the sales by owner managers ... this is a good time to be buying this type of property.

meet the new regulations on buildings, facilities and room sizes, the long-term market for good quality, well run residential care looks good.

- **Consumer societies buying private residential care homes**

Many consumer co-operative societies are looking for ways to widen their trading portfolios. Care homes have a natural synergy with other activities, and they fulfil the societies' objectives about serving the whole community. With the collapse of sale and lease-back schemes, and the sales by owner managers already described, this is a good time to be buying this type of property. Consumer co-operative societies can take a long-term view, and have access to the capital to invest to ensure that homes are of the highest standards. Management expertise can deliver high quality care and, where it is successful, significantly higher returns on capital than are currently achieved in retailing.

- **Extra care facilities**

Opportunities exist to build new extra care facilities and to convert existing property. For the right organisations this will need a package of funding, perhaps including land or buildings at a peppercorn rent as part of a regeneration strategy or planning gain. This opportunity may be open to existing home care social enterprises, or community organisations looking to provide specialist care for older people from Black and Minority Ethnic Communities.

### **What are the barriers?**

The development or acquisition of buildings involves a number of issues:

- their availability in the market at an affordable cost in the right locations
- the ability to raise funding for purchases and renovation
- the risk that earnings will not sustain repayments in the long term
- the ability and funding to manage the development and ongoing maintenance

Access to regeneration funding may ease the way, and will be a key resource. For others, acquiring a development partner with a track record and skills in raising capital and developing homes will be necessary. Housing associations and co-operatives often have this capacity, and a long-term partnership between them and a care delivery social enterprise may prove an effective vehicle.

For employees trying to buy homes from the current owner, one critical barrier must be overcome. Banks may lend up to 70% of the capital needed, secured against the buildings, as long as they trust the management and the business plan stacks up. However the rest of the capital would have to be secured in some other way, and this will be difficult given the low pay levels of most care workers. A block contract with a local authority would help. Another option might be deferred payment to the vendor.

### **Which types of social enterprise?**

- **Multi-stakeholder social enterprises or workers' co-operatives** may be involved in buying care homes from their current owners.
- **Development trusts** may facilitate the establishment of new extra care facilities.

- Existing **voluntary organisations and charities** may set up new social enterprises to take on residential care provision, either on their own or in partnership with existing housing associations or co-operatives.
- **Consumer co-operative societies** may purchase care homes or establish new developments in extra care, residential care or nursing homes.

### What to do next?

This type of opportunity requires considerable capital investment, and a long-term commitment to the service.

1. Consider what kind of care people will want in future. How do you want to live when you are older? Develop or select an **appropriate model of care** that is likely to meet the needs of older people in your community for the next 15 years.
2. Review the **local property market**. What sites or buildings are available? Are any local care homes on sale? What kind of price? Where might a public sector organisation provide free land as part of a package, or might planning gain be possible?
3. Prepare an outline **capital development strategy**. What will be the cost of purchase and development, where might funding come from? What will the revenue cost be, or the return on investment?
4. Develop an outline **business plan**. Will revenues be sufficient to cover the cost of capital? What risks are involved over the life of the funding?

### Introduction

The last ten years has seen a major shift of services from local authorities to the private or independent sector. Both budget cuts and political dogma have driven this process. There has been a perception that the private sector is better able to improve the quality of services. There have been some major service improvements as a result of this process, but there are also concerns that competitive tendering has driven the price down below the real cost of delivering quality services.

Efficiency improvements have reduced some costs, but the majority of savings have been achieved by reducing pay and conditions for care workers. In social care this is a serious issue, as pay is already low. Trade unions have campaigned against externalisation for this reason, as well as a substantive belief that some services should be delivered in the public sector.

Externalisation can happen in two ways: directly by transfer or competitive tendering, or indirectly by displacement. A service can be externalised by running down the in-house budget, and increasing budgets or creating new budgets for purchase in the independent sector.

Externalisation has occurred by direct transfer of homes to existing independent sector providers, and by setting up new organisations, sometimes Trusts, to run them on the authority's behalf.

It is estimated that the predicted reduction in demand for residential care places in 2002 will be matched by the continuing closure of local authority homes.

### The market

Some local authorities may retain a small number of specialist facilities. However, they are unlikely to retain portfolios of traditional residential homes. Three issues are driving this next phase of externalisation:

- best value
- the new residential care regulations
- changing care strategies

There may also be a feeling in some social services departments that, with the changes to Care Trusts, and the general closer working with health, they should no longer be in the business of direct service delivery.

Authorities which, up to now, have shown a strong commitment to retaining and protecting in-house services are the ones which are now likely to be considering externalisation. Labour authorities may well see social enterprise solutions as a real alternative to in-house provision, and a way of retaining locally owned provision in the social sector.

A similar situation is facing those who still have substantial in-house home care provision. Joint reviews of social services have frequently stressed the higher unit costs of in-house home care. They have also been critical of some of the

It is estimated that the predicted reduction in demand for residential care places in 2002 will be matched by the continuing closure of local authority homes.

inefficiencies they have identified in the worse-managed services. Where the balance of provision between purchased and provided home care favours the in-house service, market management arguments have been used to reduce the proportion of in-house care.

Local authorities that have retained in-house residential care face particular problems if their homes do not meet the new standards or are in poor physical condition. Government rules on capital spending mean that few authorities can raise the capital needed to reprovise homes. The design of older homes with a predominance of double rooms makes conversion to meet the new regulations almost as expensive as rebuilding, and would often produce smaller homes with higher unit costs.

With home care the focus on intermediate care has resulted in authorities adopting a strategy of separating care into three broad bands:

- Practical care – delivered predominantly by the voluntary sector or paid for by users themselves
- Intensive interventions – with an emergency or rehabilitation focus, provided for a fixed time after a crisis or leaving hospital, and delivered by in-house specialist teams
- Long term provision – once a stable level of need has been established purchased from the independent sector, but volumes restricted by higher eligibility criteria

It is likely that any authority with more than half its home care still provided in-house will be looking to reduce the amount significantly, potentially by transferring services and people to the independent sector.

Authorities that still manage in-house residential care, particularly where care homes may not meet new registration standards, will be looking to find partners to help reprovise. This may be done through the Private Finance Initiative, or by public private partnerships. On the other hand, opportunities and vehicles exist to take a social enterprise route.

#### **What could be provided?**

- residential care
- reprovise building-based care services
- home care

#### **What are the barriers?**

Externalising large services of this type is a major exercise. It can only be successfully completed if a whole range of stakeholders agree. These include:

- care staff
- provision management
- departmental management
- councillors
- trade unions

Users and families will also have to be consulted and brought on board.

Where homes do not meet new standards, or care strategies require re-provisioning, a significant development programme may be necessary. This might involve placing residents temporarily in alternative accommodation, while the existing premises are demolished and new facilities are built. In the best cases, sites will be available on which to build so that demolition only happens after residents have been transferred to the new facilities. Disruption is very problematic for frail older people, and needs to be minimised.

A re-provisioning process makes externalisation considerably more difficult. The new social enterprise will need to:

- raise large sums of capital
- manage a complex rebuilding programme
- manage residents through a decanting programme
- base business plans, not on current costs but on unknown costs in new buildings
- manage staff through the change process, which may involve changing roles or jobs, and the break-up of well established work groups

Staff must approve the transfer. They will do so both through their trade unions and by a series of ballots. Without their approval, it is not possible to establish an employee-led social enterprise. Workers' commitment and empowerment is at the heart of social enterprise. Some local government trade unions have campaigned actively against externalisation and have in practice not seen mutual or social enterprise vehicles as being significantly different from other forms of ownership.

Working closely with local trade union members and officials will be critical, initially avoiding direct opposition and working to gain their confidence and approval. Strong campaigns led by trade unions but involving local communities have changed externalisation decisions. It is likely that direct support will only be obtained once the decision to close or externalise has been irrefutably made.

In many transfers, staff will be protected by TUPE. The council will take advice on whether TUPE applies once practical arrangements are clarified. TUPE rules are complex, but in principle mean that pay and conditions of employees cannot be changed during the transfer process, and have some protection following transfer.

Arrangements will also have to meet strict value for money criteria. There will need to be evidence that the solution proposed delivers best value. If it can be shown that proposals are in the best interests of the council and the client groups, then proposals can avoid some procurement requirements.

### **Which types of social enterprise?**

The requirement for a vehicle that enables public sector services to be delivered by an enterprising organisation that is motivated by a strong value base, and does not extract profits, has led to the development of multi-stakeholder social enterprises. These are social enterprises that use



traditional legal formats amended to ensure representation for the key stakeholder groups. These are usually:

- clients or their families and advocates
- staff, including management
- the community

### **What to do next?**

The process for major externalisations is complex and difficult, and as it covers a number of opportunities, it is described separately in section 3.

### Introduction

As with other types of business, planning is critical to the development of an effective social enterprise. The structure of the market for social care and developments in the health service involving commissioners, public and private purchasers and a wide range of funding opportunities, make this type of planning more difficult than usual.

It is not always easy to establish or develop a social enterprise, and you will need all the help that you can get. The assistance that is available varies from place to place but you may have a local support organisation, perhaps a:

- development trust
- co-operative development agency
- social enterprise development agency
- branch of the Small Firms Service

This section can only describe planning in outline, but one of these organisations should be able to help you with a specific plan for your enterprise.

### The Plan

A good business plan for a social enterprise in social care will describe a proposal that:

- sets out a strong, but realistic, **vision**
- has a core or **pioneer group** with the skills, commitment and determination to make it work, and with the flexibility to respond to real opportunities
- clearly identifies target **markets** in terms of both users of the service and those who will pay for the service
- presents robust evidence that the population of the target market is large enough to convert to **sufficient take-up** to justify the proposal
- makes a realistic and evidence-based assessment of take-up, price and purchase, to generate sufficient **earnings to cover costs** and, in time, generate a surplus
- shows how the quality of the service on offer and the promotional strategy planned have the potential to **attract and retain users** and purchasers. It should have the potential to develop an appropriate profile, and build a set of long-term relationships with the community, carers, local authorities, health trusts, and health and other professionals



- includes **sufficient skilled and able staff** to deliver the service, meet quality and accreditation requirements and manage the business. The financial projections should contain a realistic budget for salaries that will attract the calibre of staff required
- has **systems** in place to ensure that quality, performance, financial, and market information are available to both staff and managers
- has **sufficient capital** available to equip the business, and cover any predicted cashflow deficit based on realistic assumptions about local authority payment delays
- includes **financial projections** that break-even within currently available resources, and have a reasonable potential to achieve operational self-sufficiency, or generate a marginal surplus with permanent grant aid, and predictable earnings

### Marketing

Between 1992 and 1995 the Department of Health ran an innovative programme called the Caring for People Who Live at Home initiative. Its aim was to stimulate the development of day and domiciliary services for older people. It provided funding for feasibility studies, consultancy assistance with business planning, training and funding for an initial period. It took place in the best market conditions, just as the independent market was opening up, and authorities had funding to purchase new services.

By the end of the programme, the failure rate for some types of initiative was as high as 50%, particularly in home and respite care, where employment was significant and spot purchase necessary.

The other reason for failure was the presumption that because a service had been encouraged by commissioners and supported by the Department of Health, purchasers would buy it.

*Services failed mainly because they could not develop or sustain the continuity of level of purchases needed to be viable. There was little doubt that inadequate initial assessment of the demand or need was responsible for some service failures.*

*The social care business is one in which difficulties fast turn into failure, and cash flow problems, especially for small and medium-sized business, arising from poor uptake of the service or delay in payment, can be crippling.*

Perkins and Allen – Creating Partnerships in Social Care 1997<sup>31</sup>

There are two lessons to learn here, first to make sure that you fully understand the complexities of the public funding regime, if that is who is paying for your services. Secondly, not to underestimate the value of financial projections in determining the viability of your proposal, and that of robust financial management in the early years to ensure its survival. Make sure that the terms of your contract with the purchasers include early payment.

With the advent of Care Trusts, some of the complexity of health and social care purchasing may be reduced; however, the fundamental problem for new providers will remain. Users may identify a need, commissioners may promote

<sup>31</sup> Creating Partnerships in Social Care  
Elizabeth Perkins and Isobel Allen  
Policy Studies Institute 1997

services to meet that need, but unless care managers or individual purchasers make the decision to place clients and provide the funding, the initiative will struggle. With constrained budgets, this always means reducing spending elsewhere. When short-term new funding is provided, initiatives bloom; the difficulty for innovative providers is access to core budgets when short-term funding finishes.

It is relatively easy to show that people have needs and that those needs are important. It is harder to identify funding or payment that will convert those needs into demand. Only then will the social enterprise succeed. This is summed up in 'A Good Job in Care?':

*"Too often we assume that needs will translate into demand, and then into purchase. There is often a strong and genuine commitment inside social services departments and within the campaigning voluntary sector to users and their rights to services. This identification with the needs of service users can cloud perceptions of the real demand for services. Only when sufficient service users identify that a service will satisfy their needs, can demand be established. Only when funding matches demand will it be translated into purchase."*

SEEDS – A Good Job in Care?<sup>32</sup>

Market research is crucial to quantify the real level of fundable demand and clarify the complexities of the way placement purchase decisions are made.

The plan must be based on:

- a realistic estimate of the volume of work that is likely to be obtained
- realistic targets for the price likely to be obtained, either from public or private purchase
- a practical view of the delays in payments which are likely to occur

### Promotion

Promotional activities must be focused on three key targets:

- **Potential clients and their families**, at the point of decision-making. How will they find you? What will their first impression of your service be? How will you give them information about the way things work, and the practical arrangements? Why should they choose your service rather than another?

Tools that you might use include:

- brochures
  - information leaflets and other materials
  - signposting, signs, yellow pages and other directories and lists
  - location
  - the appearance and ambience of buildings, and people
- **The community in which you operate.** How will your reputation for the quality of care and the sensitive way that you work with people be established and maintained? The target is that everyone says, "Yes, that's who I would like to look after my mum or dad". Some tools include:

<sup>32</sup> A Good Job in Care?

Diane Gowland and Mick Taylor SEEDS 1999

- enhancing word of mouth
  - open days
  - good communication with families and friends
  - open access for individuals and the community
  - taking part in, and contributing to, community activities
  - good pay and conditions, satisfied and caring staff, with a low turnover
  - proactively encouraging volunteering from people of all ages
- **The professionals who make referrals** – social workers, care managers, GPs etc. At the point of assessment, health and social care professionals have considerable influence on user choice. Tools include:
    - good inspection reports
    - high quality service, trained staff, professional and competent management
    - welcoming professionals at any appropriate time, working to develop a good, professional relationship
    - good paper work, completed on time
    - proactive visits
    - invitations to events
    - brochures
    - availability and accessibility
    - participation in partnership bodies

### Staffing

Staffing costs account for the major part of expenditure over which the social enterprise has control. However, staff are critical in delivering a quality service, in gaining business and in sustaining the enterprise. The business plan must:

- show a staffing forecast that meets accreditation requirements
- provide a level of staffing and skills that will ensure a quality service is delivered at all times
- ensure that staff are trained at the very least to the minimum standards, but also provide the opportunity for all employees to develop skills and access career paths
- include strategies that ensure people are available when care is needed, and that remuneration reflects the flexibility that the job entails

The business plan may need to include reasonably sophisticated spreadsheet models showing how rotas are organised. If pay packages include enhancements for unsocial hours, then these must be reflected in the spreadsheets so that the real costs are clear.

### Capital

Social enterprises may need capital for buildings, training and accreditation, and for working capital. Many sources of capital are available, and their appropriateness depends on the nature of the proposal. Commercial loans will need security, often a problem for smaller social enterprises. The issue of capital for residential or extra care has been discussed in section 2, as has some of the regeneration funding that may be available in section 1.

Other potential sources of finance include:

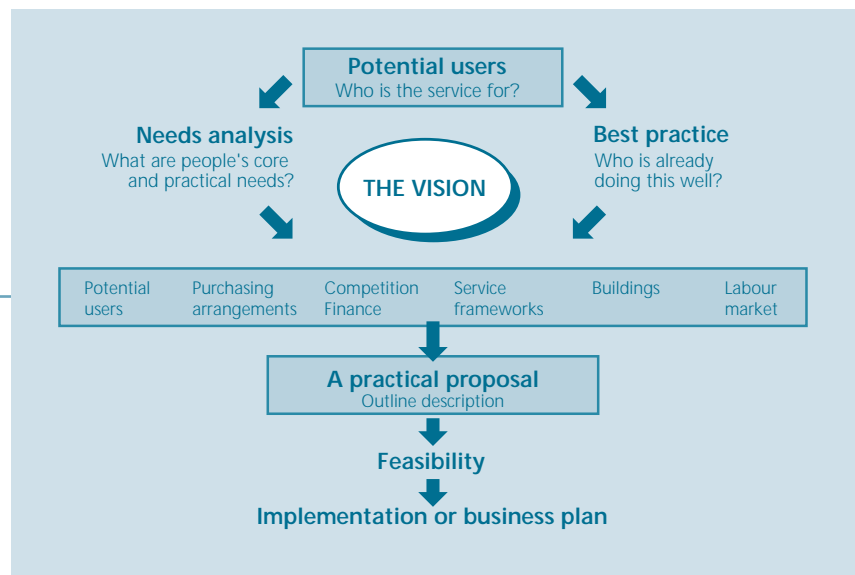
- community finance initiatives, such as London Rebuilding Society
- member investment and member loans
- local authority grants
- the Co-operative Bank, which has an earmarked fund for loans to care businesses
- charitable trusts
- European funds
- lottery funds
- government grants
- the Ecology Building Society (for loans to renovate old properties)
- Industrial Common Ownership Finance
- Local Investment Fund
- Triodos Bank
- CIS Co-operative Community Grant

### Planning new starts and developing new services

#### The process

**Stage 1** Identify the people that will use the service and engage with them  
Who are they, what are they like, where do they live? Early engagement with the people who may use the service in future will improve the planning process, and ensure that the details of the service really do reflect their needs. Set up a group to help with key decisions, and bring real understanding to decision making on the project. Better still, hand the project over at this stage, and work to support and facilitate service users to plan and develop their own project.

Social enterprise in care  
The feasibility process



#### Stage 2 Needs analysis

Do detailed research into the needs of the client group. Interview people, set up some focus groups. Where do older people meet locally who might be future service users, which are their favourite cafés, day centres, post offices, or religious centres? Find out and go and talk to them. Interview local campaigning and representative organisations.

- What needs do people have?
- Why are they not being met already?
- Do different kinds of people have different kinds of needs?
- Think about the core needs, but also the practical needs, for example:
  - transport
  - location
  - timings
  - duration
  - security
  - access
  - furniture
  - help with medicines

This is also the time to start thinking about local champions. Who will lead and drive the project? Who will give it the right backing, support and credibility?

### Stage 3 Good practice

Research good, or best, practice in this area. Try to find research reports, magazine articles or other reports about the sector, the service users or type of service that you are considering. Interview national representative or campaigning organisations: do they have relevant policy positions or good practice statements? Talk to local specialists in social services departments, health or voluntary organisations. Search the internet, visit university or college libraries or, if you can get to London, visit The King's Fund Library, which can help you search databases and periodicals.

Who is already doing this, or something similar, well? Arrange some interviews or visits. You do not have to re-invent the wheel; learn as much as you can about what works and what doesn't. People may be very generous with information and data that can really save you time and effort later on.

### Stage 4 Your vision

Build your vision of the new social enterprise. If the pioneer group share a common vision, then it is more likely to be achieved. Do not just copy the good practice examples – think about transferability. Just because something works in one place, with one group of people, that does not mean that exactly the same thing will work for you. Focus on the needs analysis – apply that to the good practice. What can you learn that will help you think about services that would really meet local people's needs? Encourage the pioneer group to innovate.

### Stage 5 Local research

In order to convert your vision into reality you need to understand:

- the people who may use the service
- competitors or alternative providers
- who will pay
- potential employees or volunteers
- the opportunities or barriers in the local environment

This research needs to give you a good picture of the local situation, but it is not detailed social or market research. Get as much factual data as practical to give a broad overview, and talk to people who you think know about each issue.

At this point research the regulations that apply to your service; generally these are readily available on the internet. The regulatory environment for both home care and residential care has already been reviewed. However, do not forget that a number of other regulations may be involved – it all depends what you are planning to do. There are regulations about food handling, COSH (the Control of Substances Hazardous to Health regulations) regulates the use of chemicals perhaps used in cleaning, and there may be health and safety issues. As well as regulations, a number of organisations publish advice or guidance on the best way to do things, for example work with volunteers.

Talk to those people who are planning or commissioning services for older people in your local community. If your plans fit into their plans, then you will have a much higher likelihood of success. Discuss your plans with local commissioning staff – their agreement will not guarantee success, but it will help.

Identify the key issues that will determine the success of your vision. These will depend on the service that you are planning, and your locality. Key issues for the research may include:

Key issue	Possible information source
<b>Potential users</b>	
Numbers of people and trends	Population data from public plans or the ONS
Likely take-up	Other similar projects
Service needs	Needs assessment
Practical needs	Needs assessment and good practice
Barriers to use	Interviews and good practice research
<b>Purchasing arrangements</b>	
Changes to numbers and types of service purchased	Local service plans, interviews
Local contracting arrangements	Interviews with purchasers and providers
Local accreditation requirements	Interviews with purchasers
<b>Competition or alternative providers</b>	
Number and size of alternative providers	Local plans and interviews
Marketing or development strategies	Interviews or published information
Spare capacity	Informal research
Prices, funding or charging structure	Interviews, funders reports and informal research
Possible response to your project	Interviews and informal research
<b>Service framework</b>	
What is likely to work	Interviews and good practice
Optimum size or arrangements	Interviews and good practice
Practical issues	Interviews and good practice
Regulations and standards	Regulatory bodies
Good practice	Good practice research and interviews

## Key issue

## Possible information source

### Financial

Possible funding level

Purchasing plans and interviews

User ability to contribute

Needs assessment and interviews

Possible costs or budget

Good practice research

### Buildings

Space needs

Good practice and regulations

Buildings available

Local research

Capital available

Funder interviews and reports

### Labour market

Current pay rates

Interviews – other providers

Potential recruits or volunteers

Interviews – other providers, local organisations

Training

Local research

## Stage 6 A practical proposal

Use the information you have collected to draft an outline practical proposal.

This could include:

- description of the service
- objectives or outcomes, needs being met
- quality standards
- target users – numbers and frequency (% of the potential market)
- staffing arrangements, pay levels and recruitment
- regulatory requirements and approaches to meet them
- fit with commissioning or purchasing plans
- user engagement and empowerment
- management arrangements and legal structure
- likely or potential buildings or location
- training
- funding and charging arrangements
- broad outline budget or costings
- potential source(s) of capital

## Stage 7 Feasibility

Evaluate your proposal against a set of criteria; this is to make sure that it will work before you invest a lot of time and effort in researching and planning.

The criteria could include some questions like:

- Are you likely to attract the number of users that you have projected?
- Is the service the best way to meet the needs you identified?
- Will you be able to recruit good skilled staff at the pay rates and times of day that you need them? Will you be able to find the number of volunteers you have projected, and train and support them?
- Will service users, employees or people from the community be ready to take part in the management or running of the social enterprise?
- Will you be able to find a building or location at the cost that you have projected?



- Have you identified all practical barriers and found ways to overcome them?
- Are funders really going to purchase the service at the volume and rate you have projected?
- Will users make the level of contribution you have projected, or will charges reduce attendance?
- Can you raise the capital you need to start? Will the project be financially viable, and is income from all sources likely to be higher than costs?

If the plan does not appear to be viable, what can you change? Go back and review the areas that do not work and see how to make it practical.

### **Stage 8 Detailed planning and implementation**

For smaller projects without a large number of employees or large amounts of capital, this level of planning may be sufficient. It may simply be necessary to flesh out some of the details and prepare an implementation plan.

This describes how you will go about making the project happen. Who is going to do what, and by when:

- Set out the target dates or milestones.
- Draw up a list of all the work that needs doing.
- Arrange the tasks in an appropriate order, given what needs doing first, and what depends on another piece of work being completed first.
- For each task, agree who is going to be responsible, and when it needs to be completed.
- Larger projects will need to prepare a fully-costed business plan. The larger the amount of capital invested or the more critical the service, the more detailed and accurate the plan will need to be. Assumptions included in the plan must be sustained by evidence backed up by research or data. Projections should be evaluated using both sensitivity and risk analysis.

There are innumerable business planning manuals on the market that describe in detail how this type of plan is prepared.

### **Planning externalisations**

The last ten years has seen a major shift of services from local authorities to the private or independent sectors. This process has been driven by both budget cuts and political dogma. There has been a perception that the private sector is better able to improve the quality of services. There have been some major service improvements as a result of this process, but there are also concerns that competitive tendering has driven the price down below the real cost of delivering quality services.

Externalisation can happen in two ways. Directly by transfer or competitive tendering, or indirectly by displacement. A service can be externalised by running down the in-house budget, and increasing budgets or creating new budgets for purchase in the independent sector.

### Indirect externalisation

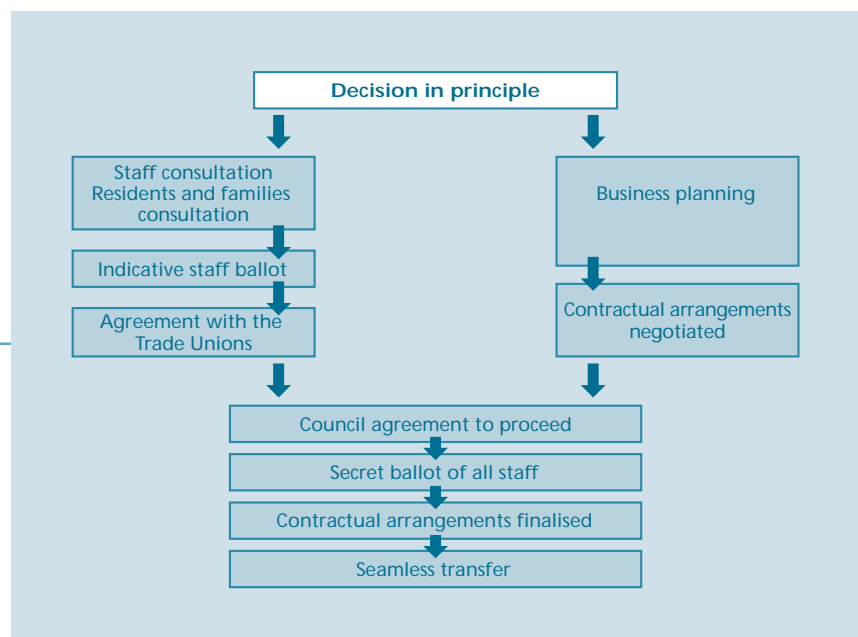
Be very careful that your new project is not an indirect externalisation. Ensure that pay and conditions in your new social enterprise are as good as, if not better than, those in-house. Beware of the danger that you are displacing better-paid jobs in the in-house service, in favour of poorer-paid ones in the independent sector. You may feel that the quality improvements you can offer will balance out this problem, but low pay leads to disillusionment and high staff turnover. Neither is good for quality. High overheads and inefficiencies often inflate the cost of in-house services. You should be able to offer comparable or lower costs in a social enterprise without reducing real pay levels. This is not to say that you should not look at ways to improve flexibility in the way people work. It is quite possible to remove some of the rigidity in employment contracts, enabling people to work in a more family-friendly way. Make sure though, that you have the staff around when the clients need care. Many in-house employees have enhancements for weekend or unsocial hours, and you may want to negotiate their removal or limit their use, and compensate by increasing the basic pay rate.

### Buildings

The new regulations for residential care homes set standards for room sizes, facilities and communal space. Existing homes not meeting these standards in the set timescale will fail their registration and eventually close. Many people think that few, if any, of the current in-house stock of homes are likely to meet these new regulations.

The budgets available for the maintenance of residential homes have often not been sufficient to keep them in good condition. Even if homes being transferred meet new standards, they may have a backlog of maintenance requirements and need substantial refitting. Make sure that you have proper surveys to ensure that you understand the real condition of buildings, plant and equipment.

### Care externalisation A possible decision-making process



Building developments require another whole range of skills and expertise, including putting together a capital funding package, costing the draft specification and developing an outline project brief.

### Staff

Staff must approve the transfer. They will do so both through their trade unions and by a series of ballots. Local government trade unions have campaigned actively against externalisation and have in practice not seen mutual or social enterprise vehicles as being significantly different from other forms of ownership. Working closely with local trade union members and officials will be critical.

In many transfers, staff will be protected by TUPE. The council will take advice on whether TUPE applies once practical arrangements are clarified. TUPE rules are complex, but in principle mean that pay and conditions of employees cannot be changed during the transfer process, and have some protection following transfer.

### The process

Large-scale externalisations are difficult. They require high-level skills, considerable resources, patience and determination. The process is political as well as technical and practical. Resources will be necessary to support it, including:

- feasibility and business planning support
- specialist care business expertise
- project planning for the in-house team
- mentoring and support for key individuals
- training for the service management team
- training and awareness building for staff
- development work with other stakeholders
- practical development work with councillors or key players
- development work with new directors, board members or trustees

Building developments require another whole range of skills and expertise, including putting together a capital funding package, costing the draft specification and developing an outline project brief.

The formal council decision-making process will depend on the structure of the authority. Formal decisions will be made in cabinet, or an appropriate committee, but informal debates and decisions may well be made in political groups in advance of the formal decision-making process.

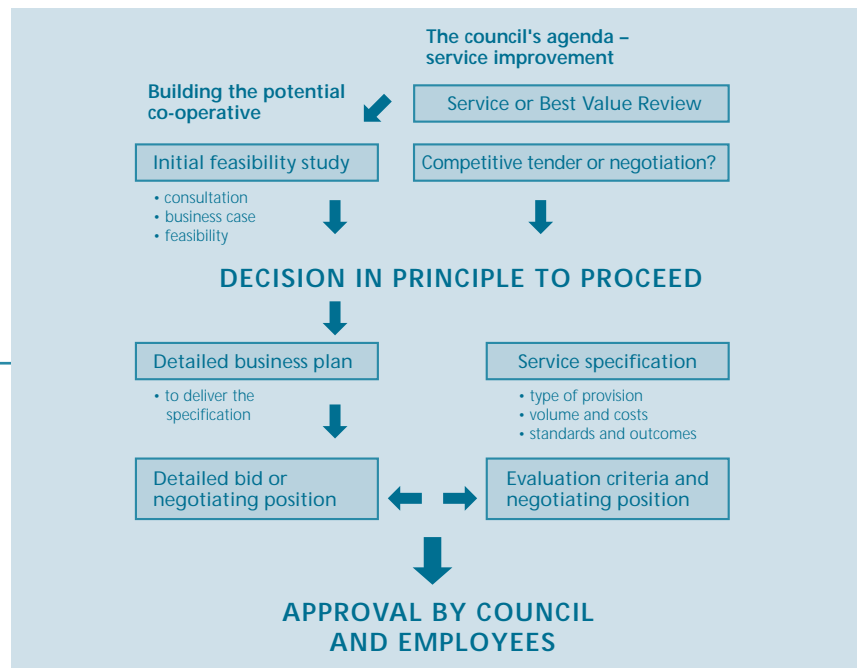
For the process to succeed, the service department management, the council, the trade unions and the employees must all be broadly in agreement.

This requires:

- initial consultations
- an indicative ballot of staff
- a negotiated proposal
- the council's formal agreement
- a final ballot of employees

In the final ballot, employees are agreeing to the transfer arrangements as well as approving the finally negotiated agreement with the council.

Care externalisation  
A planning process



### Stage 1 Initiation

Proposals for externalisation may have come from the social services department or directorate, or be a political priority. At the moment, change in local government is often driven by Best Value Reviews or Joint Inspections. The process may be initiated by a service review, which recommends major changes to the kind of service that the council wishes to see in place. Best Value Reviews prepare action plans. These are formal documents that are approved by the council and inspected. They may address both the type of service, and the way it is provided. If major changes are a possibility, then the department may prepare a service strategy. This lays out in principle how the council sees the service developing in the future.

### Stage 2 The initial feasibility study

The initial feasibility study aims to establish if the social enterprise option is viable.

- Is it practical?
- Are there any easily identified issues that will stop the idea proceeding?
- What are the employees' initial views?
- How do the unions stand?
- What is the view of service users, their families or carers or advocates?
- What is the view of other stakeholders? Are there individuals who could form part of the board?
- Are there ways for the new social enterprise to obtain investment capital and working capital?
- What is the initial view of the business case? Does it look realistic?
- What is the quality of the service like? Are accreditation requirements met? Will the social enterprise need to invest in staff, training, buildings or other resources to bring quality up to the required standards?
- How do purchasers see the service and react to the new development? Will they continue to purchase?

- Will there be sufficient demand and purchasing capacity to meet take-up targets?
- What is the quality of the management? Is there a key individual or small group who can give leadership to the transfer and the new social enterprise?

#### Negotiation or competitive tendering?

It is not possible at this stage to be specific that the new social enterprise will be viable. This depends on the negotiations in stage two. The key question to be answered is: does this option appear practical, is it worth further investigation?

At the same time, the council will need to consider how it intends to procure this externalised service. The legal situation for the procurement of social care is different from other public purchase. It appears to be possible to proceed by negotiation without a direct competitive process if the council feels that it, and the client group, will be best served by this approach. This is a critical legal issue on which internal advice should be sought at an appropriate stage.

If the council decides to proceed by negotiation, it declares that the emerging social enterprise is its preferred partner.

#### Stage 3 The specification and the business plan

The council must now start to separate those officers who will decide on the social enterprise's proposal from those assisting the in-house team.

A project group or similar will lead the assessment and negotiations for the council. This may include legal, financial and property management expertise. Whilst the team may report to a senior officer who has responsibility for the service, it must be separate from service management involved with the transfer.

This group will prepare or approve a service specification. This describes in detail the type of service the council wishes to see, and also defines variables including:

- target clients – the kinds of people who may receive the service
- the character and nature of the service to be provided
- the range of choice available
- quality standards
- buildings, facilities, equipment etc.
- outputs from the service, numbers of people, times of day, frequency of visits etc.
- the desired outcomes: what should the quality of life for older people be like?

Some specifications focus on outputs, the activities, and the things you will have to do. Others prioritise outcomes, the results of the work that has been done. Tender documents may also require levels of inputs, people, money, time etc. When this type of contracting first appeared, most specifications were based on outputs; however the government is encouraging local



authorities to move to outcome specifications. They are much shorter, and focus on the results that should be achieved. However they are often seen as difficult to prepare, and difficult to enforce, allowing contractors too much freedom. It is relatively easy to monitor staff hours or choice of menus. But how do you measure quality of life or independence?

Simultaneously, a second project team group needs to be established to prepare a business plan or business case for the new social enterprise. This can be an in-house team with external expertise, or an external group working with the in-house management and employees.

Whilst the project team will be occupied with day-to-day work, one task will be to start to establish a steering group. Initially this will be made up of people co-opted or volunteering, and it should include representatives of the relevant trade unions. As work progresses, some may be replaced or confirmed by elections or nominations from stakeholder groups. The steering group will make the key decisions that underpin the business plan.

Business plans for care providers follow the lines of most other business plans. However, the plan must ensure that the new care business will:

- provide the care that the council wishes to see
- meet, and improve on, the quality standards set in the specification
- meet accreditation requirements
- provide, maintain and, if necessary, replace buildings to the specified standard
- recruit, train, retain and pay staff, ensuring skilled capable staff are always available to the levels required
- raise capital to take on the service, and expand and improve provision
- be financially viable, and sustain provision in the longer term

The business plan will include:

- A human resource and staffing strategy and pay policy, to provide the levels of trained staff and the care hours to meet and exceed accreditation standards, provide the quality of life and meet the service standards in the specification, within the cost budgets in the plan.
- A quality strategy to ensure that training, standards, recording, information and monitoring systems are in place.
- A user engagement strategy, ensuring service users are well informed, have direct influence over their own care, have access to redress, and are supported in taking as active a role as possible in the running of the enterprise.
- A marketing strategy to ensure that the service reflects the needs of users, purchasers and commissioners, and that promotion ensures take-up and income targets are exceeded.
- A management strategy that provides leadership to the new enterprise, builds the democratic structures, and ensures day-to-day quality of care.
- A buildings development strategy that ensures buildings are maintained to the appropriate standards, in the right locations, and are developed to meet changing needs and accreditation standards.

- A financial strategy, based on costings that ensure income matches costs, and financial projections and cashflow forecasts showing that sufficient surplus is generated to sustain the business in the long term, reward staff for their efforts and enable future developments.
- A development strategy that sees the enterprise responding to changes in the market, users' needs and service developments, ensuring long-term high quality service provision, and business sustainability.
- A legal structure that reflects the agreed representation of stakeholders and a strategy for building and sustaining democratic participation.

#### Stage 4 Negotiation or competitive tender

If the council is proceeding by preferred provider status, then extensive negotiations will take place during this stage. These aim to ensure that all the practical arrangements can be agreed between the steering group, the unions, the social services departments and the council. These arrangements must ensure that:

- the council obtains best value from its procurement of care
- the social services department is confident that the specification will be delivered
- the employees are satisfied with the transfer arrangements, including those regarding pay and conditions and trade union representation
- the social enterprise is confident that the price and purchase arrangements will allow it to trade successfully and deliver the quality of care in specification

These arrangements will include:

- pensions and employee transfers and the costs associated with meeting TUPE requirements
- leases and the transfer of buildings and costs associated with maintenance deficits
- training and accreditation requirements
- the level of current overhead costs or central recharges transferred to the new organisation's budget
- the transfer of senior managers or support staff
- the length and type of contracts: the unit price, rectification, variation and other contracting arrangements
- contract monitoring procedures, access, inspection and information provision
- practical transfer issues, timing and costs associated with transfer

If the service strategy includes reprovisioning, then agreements must be made to cover this process and also:

- the costs of transferring people between facilities
- the cost of demolition and site clearance
- loss of revenue due to high vacancy rates in the period prior to closure
- the ownership of the new buildings

If the council decides to proceed by competitive tender, this follows a fairly formal process. This will vary but will have some of these stages:

- consultation with potential suppliers
- advertisement or approach to potential providers
- initial assessment by questionnaire to establish a short list of potential bidders
- invitation to tender – detailed bids against the service specification
- presentation, interview, visits or further enquiries
- tender evaluation against specification criteria
- negotiation on details or changes to the bid with the selected provider

In considering their decision the council can now take notice of 'workforce matters'. These include pay and conditions<sup>33</sup>. It will normally provide selected tenders with information about the in-house service on which to base their bids.

The principles by which the council must proceed in a competitive tendering situation are:

- equality of treatment – same information, same time to respond, minimise advantage to existing providers, and by using predetermined objective criteria
- transparency – written records, and document appraisal including points allocated on a score-based assessment system
- best value – best quality services for the money spent. The winning bidder must be the best value option, not necessarily the lowest price

Following the tender evaluation, the council may decide to negotiate detailed arrangements with the best provider.

### Stage 5 Approval

The finally negotiated agreement will be approved by the council in its normal decision-making process. As part of that approval it will consider the views of staff, expressed through their indicative ballot.

Once the council has agreed the terms of the transfer offer to staff, it will hold a ballot of those staff likely to transfer, to confirm their approval of the arrangements.

33 Making the Workforce Matter

Best Value and Procurement  
UNISON & LGIU 2001

Third Sector Care  
Roger Spear, Aude Leonetti and Alan Thomas  
Open University 1994

Investing in Health SEL 2001

Social Enterprise Solutions to Public Policy Goals  
Andrea Westall IPPR 2001

Care and Equality Jane Foot LGMB 1998

## Glossary

<b>Best value</b>	The current arrangements for reviewing the effectiveness, efficiency and economy of public sector services, and the measure of value for money in public sector procurement.
<b>Block contracts</b>	Arrangements where purchasers or commissioners agree to purchase to a guaranteed level, for instance a fixed number of beds, or hours of health or care provision.
<b>Care Trusts</b>	Local multi-purpose bodies enabling closer integration of health and social services. They will be able to commission and deliver primary and community health care as well as social care for older people and other client groups.
<b>Carer</b>	We have used carer to mean someone who looks after a family member, relative or friend who is not a paid employee. We have described paid employees as care workers.
<b>Commissioners</b>	People or organisations that plan service provision and negotiate with providers to ensure delivery capacity and quality. They also purchase block contracts.
<b>Community care plans</b>	Publicly available plan for each local authority area outlining or updating its community care provision or strategy.
<b>Competitive contracting</b>	Arrangements for procuring services which involve tendering by more than one provider. Tenders are assessed against best value criteria, balancing quality with cost.
<b>Direct payments</b>	A scheme whereby, after the assessment, the value of the care package is given directly to the client. They can use the funding themselves to recruit and employ their own carers.
<b>Domiciliary care</b>	Health care, personal care or practical care provide in someone's own home.
<b>EMI or EMF</b>	Elderly Mentally Infirm or Elderly Mentally Frail – people with dementia or similar infirmity or frailty.
<b>Externalisation</b>	The transfer of in-house services, currently delivered by publicly employed staff, to the independent sector.
<b>Extra care</b>	Building-based care for older people, based on renting with dedicated home care. Variations are called very sheltered, close care or Part 2.5.
<b>Funding package</b>	A package of care designed to meet the needs of someone who has been formally assessed by a social services department.
<b>Health Improvement Programme (HImP)</b>	Plans to achieve health improvement targets for the local population.
<b>Home from Hospital</b>	Time-limited service to facilitate transfer from hospital to home, which does not usually involve health care professionals.

Hospital at Home	A service that delivers a planned programme of active treatment by health care professionals for a limited period in someone's home.
Inputs	The resources available to deliver a service: staff, budgets, quality systems etc.
Intermediate Care Co-ordinator	Specific posts in each local area, with a remit to facilitate the commissioning and delivery of intermediate care.
Joint Investment Plan (JIP)	A plan of the action being taken to improve continuing and community care.
Not for profit	' <i>Not for profit</i> ' organisations do and should make a surplus from their trading activities. They just do not distribute it. Surpluses are reinvested in their activities or used for the benefit of the community, their charitable objectives or social aims.
Outcomes	The benefits (or disbenefits) that result: quality of life, independence, better health, increased mobility, confidence etc.
Outputs	The quantifiable results of activities: a number of bed nights, visits, occupancy rates, people attending or registered etc.
Personal care	Services of a personal nature provided in someone's home to assist them to live independently – help with dressing, washing, getting up, going to bed, using the toilet etc.
Planning gain	Land, buildings or other facilities provided by a developer as part of the conditions for gaining planning consent to a development.
Practical care	Sometimes called domestic care, practical care is a range of support provided in someone's home that will help them to live independently. It used to be delivered by Home Helps, and often includes cleaning, cooking, shopping and help with pensions.
Primary Care Groups & Primary Care Trusts	The main local commissioning bodies for primary care, replacing Health Authorities.
Procurement	The means by which public sector organisations make arrangements for the delivery of services. It includes the commissioning process, in-house provision and contracting.
Purchasers	People who buy services. With spot contracts, purchasers select a provider for each individual person who is receiving public funded care.
Rapid Response Teams	A service that reacts to an event that could otherwise have precipitated an A & E admission of an older person.

<b>Registered Social Landlords (RSL)</b>	More commonly known as housing associations, they are independent non-profit organisations registered with the Housing Corporation.
<b>Rehabilitation or reablement</b>	The provision of intensive therapy, at home or in a residential setting; the aim is to assist someone to regain mobility, abilities or confidence that may have been lost following an acute crisis.
<b>Reprovisioning</b>	Replacing care services with new provision.
<b>Respite care</b>	Care provided either at home, or by short-term visits to a residential or nursing home, to give a carer a short break.
<b>Service level agreement (SLA)</b>	An agreement detailing the activities or outputs that should be provided or achieved from the provision of funding. SLAs are a halfway house between grants and contracts.
<b>Service specification</b>	The description of a service that is needed. Specifications can be activity-based, describing what has to be done or provided, or outcome-based, describing the results of delivering the service. Specifications are part of the procurement process.
<b>Single status</b>	The merging of local authority officer and manual grades.
<b>Spot contracts</b>	Arrangements made between purchasers and providers for one care package.
<b>Supporting people</b>	New arrangements for publicly funded support, provided alongside, or as part of, housing. Supporting people will eventually replace housing benefits for this group of people.
<b>Therapists</b>	Sometimes referred to as PAMs (Professions Allied to Medicine), therapists include physiotherapists, occupational therapists and others working alongside nurses and doctors.

## Sources of Support

### Health & Social Care: sector contacts

#### Age Concern

Age Concern England, Astral House,  
1268 London Road, London SW16 4ER  
Tel: 020 8765 7200 [www.ageconcern.org.uk](http://www.ageconcern.org.uk)

#### Care & Repair England

3rd Floor, Bridgford House, Pavilion Road,  
West Bridgford, Nottingham NG2 5GJ  
Tel: 0115 982 1527

#### Department of Health

Richmond House, 79 Whitehall,  
London SW1A 2NL [www.doh.gov.uk](http://www.doh.gov.uk)

#### The King's Fund

11-13 Cavendish Square,  
London W1G 0AN  
Tel: 020 7307 2400 [www.kingsfund.org.uk](http://www.kingsfund.org.uk)

#### National Care Standards Commission

Richmond House, 79 Whitehall,  
London SW1A 2NL  
Tel: 020 7210 4850 [www.doh.gov.uk/ncsc](http://www.doh.gov.uk/ncsc)

#### National Electronic Library for Health

[www.nelh.nhs.uk](http://www.nelh.nhs.uk)

#### TOPSS UK (The National Training Organisation for Personal Social Services)

TOPSS England, 26 Park Row,  
Leeds LS1 5QB  
Tel: 0113 245 1716 [www.topss.org.uk](http://www.topss.org.uk)

#### The United Kingdom Home Care Association (UKHCA)

42b Banstead Road, Carshalton Beeches,  
Surrey SM5 3NW  
Tel: 020 8288 1551 [www.ukhca.co.uk](http://www.ukhca.co.uk)

#### Winter Warm Advice Line

Tel: 0800 085 7000 (Text phone 0800 085 7857)

## General contacts

### Association of Local Co-operative Development Agencies

c/o Co-operative Union, Holyoake House,  
Hanover Street, Manchester M60 0AS  
Tel: 0161 246 2900 [www.co-opunion.coop](http://www.co-opunion.coop)

### Avon CDA

The Coach House, 2 Upper York Street, Bristol BS2 8QN  
Tel: 0117 989 2536

### Business Link (business advice service)

Tel: 0845 600 9006 [www.businesslink.org](http://www.businesslink.org)

### Cambridge CDA

Alex Wood Hall, Norfolk Street, Cambridge CB1 2LD  
Tel: 01223 360 977 [www.colc.co.uk/cambridge/ccda/](http://www.colc.co.uk/cambridge/ccda/)

### CDA Dorset

56 Dorchester Road, Lytchett Minster, Poole BH16 6JE  
Tel: 01202 620 050 [www.cda-dorset.com](http://www.cda-dorset.com)

### CDA Luton

The Innovation Centre, Adelaide Street, Luton  
Tel: 07092 224 889

### Co-active Ltd

25 Wolseley Close, Plymouth PL2 3BY  
Tel: 01752 500 888

### Confederation of Co-operative Housing

Unit 19, 41 Old Birley Street, Hulme, Manchester M15 5RF  
email contact: [info@cch-uk.org](mailto:info@cch-uk.org) [www.cch-uk.org](http://www.cch-uk.org)

### Co-operation Black Country

Social Economy House, Victoria Street, West Bromwich B70 8ET  
Tel: 0121 553 2620 [www.socialeconomy.org](http://www.socialeconomy.org)

### Co-operative Assistance Network Ltd

12 Bellevue Road, Southampton SO2 0AE  
Tel: 023 8071 0622 [www.co-op-assist.co.uk](http://www.co-op-assist.co.uk)

### Co-operative Bank

New Century House, Manchester M60 4ES  
Tel: 08457 215 215 [www.co-operativebank.co.uk](http://www.co-operativebank.co.uk)

### Co-operative Solutions Limited

Denmar House, River Way, Harlow CM20 2DP  
Tel: 0845 458 1137

### Co-operative Union

Holyoake House, Hanover Street, Manchester M60 0AS  
Tel: 0161 246 2900 [www.co-opunion.coop](http://www.co-opunion.coop)

**Coventry & Warwickshire CDA**

Doe Bank Building, Doe Bank Lane, Spon End, Coventry CV1 3AR  
Tel: 024 7663 3911 [www.cwcca.co.uk](http://www.cwcca.co.uk)

**Cymru-Wales Co-operative Development Association**

Baltic House, Mount Stuart Square, Cardiff CF10 5FH  
Tel: 029 2046 2222

**Development Trusts Association**

2-8 Scrutton Street, London EC2A 4RT  
Tel: 08454 588 336 [www.dta.org.uk](http://www.dta.org.uk)

**Employee Ownership Scotland**

Robert Owen House, 87 Bath Street, Glasgow G2 2EE  
Tel: 0141 554 3797 [www.eos-online.co.uk](http://www.eos-online.co.uk)

**Greenwich CDA**

2nd Floor, The Forum@Greenwich, Trafalgar Road, London SE10 9EQ  
Tel: 020 8269 4880

**Hackney Co-op Developments Ltd**

2 Beechwood Road, Hackney, London E8 3DY  
Tel: 020 7254 4829 [www.hced.co.uk](http://www.hced.co.uk)

**Harlow CDA**

Latton Bush Centre, Southern Way, Harlow CM18 7BL  
Tel: 01279 446 446 [www.harlow.gov.uk/business/cda/cda/htm](http://www.harlow.gov.uk/business/cda/cda/htm)

**Humberside CDA**

57a Chanterlands Street, Hull HU5 3ST  
Tel: 01482 449 877

**Industrial Common Ownership Movement (ICOM)**

Holyoake House, Hanover Street, Manchester M60 0AS  
Tel: 0161 246 2954

**Lancashire CDA**

Charter House, 20 Winckley Square, Preston PR1 3JJ  
Tel: 01772 203 692 [www.lcda.org.uk](http://www.lcda.org.uk)

**Leicester & County CDA**

New House, 94 New Walk, Leicester LE1 7EA  
Tel: 0116 222 5010 [www.lccda.co.uk](http://www.lccda.co.uk)

**Local Government National Training Organisation**

Layden House, Turnmill Street, London EC1M 5LG  
Tel: 020 7296 6600 [www.lgnto.gov.uk](http://www.lgnto.gov.uk)

**Mutual Aid**

48 Osborne Road, Brighton BN1 6LQ  
[www.co-op.org/mutualaid/home\\_map.htm](http://www.co-op.org/mutualaid/home_map.htm)

**New Economics Foundation (NEF)**

Cinnamon House, 6-8 Cole Street, London SE1 4YH  
Tel: 020 7089 2800 [www.neweconomics.org](http://www.neweconomics.org)

**Northamptonshire CDA**

214a Kettering Road, Northampton NN1 4BN  
Tel: 01604 259 700 [www.ncda.demon.co.uk](http://www.ncda.demon.co.uk)

**Oxford, Swindon & Gloucester Co-op**

New Barclay House, 234 Botley Road, Oxford OX2 0HP  
Tel: 01865 249241 [www.osg-co-op.co.uk](http://www.osg-co-op.co.uk)

**Sheffield Co-op Development Group Ltd**

Aizlewood's Mill, Nursery Street, Sheffield S3 8GG  
Tel: 0114 282 3100

**Social Economy Agency**

45-47 Donegall Street, Belfast, Northern Ireland BT1 2FG  
Tel: 028 9096 1115 [www.socialeconomyagency.org](http://www.socialeconomyagency.org)

**Social Enterprise London**

1a Aberdeen Studios, 22-24 Highbury Grove, London N5 2EA  
Tel: 020 7704 7490 [www.sel.org.uk](http://www.sel.org.uk)

**Social Enterprise Sunderland**

44 Mowbray Road, Hendon, Sunderland SR2 8EL  
Tel: 0191 565 0476 [www.hendon-hub.org.uk](http://www.hendon-hub.org.uk)

**South East Hants & Wight CDA**

c/o 44 High Street, Fareham, Hants PO16 7BN  
Tel: 023 9235 0035

**Southampton Area CDA (SACDA)**

12 Bellevue Road, Southampton SO15 2AY  
Tel: 023 8023 0529 [www.co-op-assist.co.uk/sadca/](http://www.co-op-assist.co.uk/sadca/)

**Tower Hamlets CDA**

Business Development Centre, 7-15 Greatorex Street, London E1 5NF  
Tel: 020 7247 1056

**UNISON**

1 Mabledon Place, London WC1H 9AJ  
Tel: 020 7388 2366 [www.unison.org.uk](http://www.unison.org.uk)

**Wales Co-operative Development & Training Centre**

Llandaff Court, Fairwater Road, Cardiff CF5 2XP  
Tel: 029 2055 6153

## Co-operative websites

### **CDA Anywhere** [www.cda-anywhere.inuk.com](http://www.cda-anywhere.inuk.com)

This is a website that was developed from a collaborative project amongst co-operative support organisations (CSOs). It contains a wide range of information that is primarily intended as a resource for CSOs. Much of it, however, would be useful to anyone wanting to set up a co-operative in a part of the country in which no specialist support is available.

### **Co-Active** [www.co-active.org.uk](http://www.co-active.org.uk)

Co-active is an economic development organisation in the South West of England, providing business support to social enterprises. The range of services includes business consultancy, specialist development work, incorporation and governance advice, accredited training across the spectrum of social economy activities, and advice and support for practitioners, co-operators and social entrepreneurs.

### **The Co-operative Union** [www.co-opunion.coop](http://www.co-opunion.coop)

The Co-operative Union is the national federation of co-operative societies in the United Kingdom. The Union's role is to co-ordinate, inform, advise and influence member co-operatives and act as their national spokesbody. The Union also represents, promotes and protects the interests of its members through its affiliation with such bodies as the International Co-operative Alliance, and it liaises directly with Government on behalf of the movement.

### **Communicate Mutuality/Mutuo** [www.mutuo.co.uk](http://www.mutuo.co.uk)

Communicate Mutuality is a project that brings together the different wings of the mutual sector, consisting of consumer co-operatives, building societies, mutual insurers and friendly societies.

### **Confederation of Co-operative Housing (CCH)** [www.cch-uk.org](http://www.cch-uk.org)

Its aims are to promote co-operative and tenant-controlled housing as a viable alternative form of tenure, to represent the interests of housing co-ops and other tenant-controlled housing groups, and to provide a forum for networking between housing co-ops nationally.

### **Industrial Common Ownership Finance (ICOF)** [www.icof.co.uk](http://www.icof.co.uk)

ICOF, the sister organisation of ICOM, was created in 1973. It manages a revolving loan fund, to which money is repaid and lent again, to assist in the development of common ownership co-operative enterprises. It also provides back office services.

### **Industrial Common Ownership Movement (ICOF)**

#### [www.co-opunion.coop/ICOM.htm](http://www.co-opunion.coop/ICOM.htm)

ICOM, the worker co-op federation, provide a range of services to members designed to enhance their performance both as co-operatives and as businesses. The site comprehensively describes these, plus provides pointers and guidance for new start-ups and conversions from a conventional business to a co-op.

**Lancashire Co-operative Development Agency** [www.lcda.org.uk](http://www.lcda.org.uk)  
Lancashire CDA offers a range of development and support services to co-operatives and community businesses in the North West of England.

**New Sector** [www.newsector.co.uk](http://www.newsector.co.uk)

This is the site of the New Sector magazine, 'The Magazine of Community and Co-operative Enterprise', of workers' co-operatives and community-owned businesses in the UK.

**Plunkett Foundation** [www.plunkett.co.uk](http://www.plunkett.co.uk)

The Plunkett Foundation is an educational charity based in the UK, which supports the development of rural group enterprise worldwide.

**Social Enterprise Institute, Heriot-Watt University**

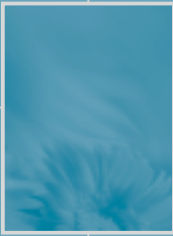
[www.som.hw.ac.uk/socialenterprise/](http://www.som.hw.ac.uk/socialenterprise/)

The business of the institute is the provision of research, training, business planning, education and consultancy practice for the social or '*not for profit*' economy in Scotland.

**www.coop**

.coop is the brand new Top Level Domain (TLD) exclusively for use by the co-operative sector, launched on 30 January 2002, making domain name registration available to all co-operatives worldwide.





The 'Social Enterprise Guide To' Series is a series of booklets that have been designed by SEL to provide practical help in developing social enterprises in a variety of sectors including Childcare, Housing, Health and Social Care for the Elderly, and the Environmental Recycling sector.

The Health & Social Care for the Elderly Guide is aimed at social entrepreneurs, community groups and organisations, voluntary sector organisations, and public sector organisations. Indeed, they are for anyone who is considering starting up, undergoing a process of transition, or in the early phase of developing a social enterprise in this sector.

This Guide provides practical case studies of social enterprises operating in the Health & Social Care for the Elderly sector, as well as a sector analysis, an exploration of the market opportunities, and business planning tips.

#### **Social Enterprise London**

1a Aberdeen Studios  
22-24 Highbury Grove  
London  
N5 2EA

Telephone 020 7704 7490  
Fax 020 7704 7499  
E-mail [info@sel.org.uk](mailto:info@sel.org.uk)  
Website [www.sel.org.uk](http://www.sel.org.uk)

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