

Self-managed Care - a co-operative approach



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Contents

Foreword	2
Background	4
Executive Summary	5
1. Introduction	8
2. Justification for the Programme	9
3. The Programme	10
4. The Pilots	11
5. Policies and Procedures Pack	14
6. Internet and Intranet	15
7. Workshops and Conference	16
8. The Cluster Model	18
9. Issues	20
10. Conclusions	24

Foreword

We are all going to be affected by the way personal care is delivered.

This does not just mean that as we get older we will necessarily need these services ourselves, but we may be involved on behalf of our parents, children or dependents. And if not for them, then as taxpayers the implication is enormous. This booklet outlines how the challenges of providing personal care in the future can be addressed using co-operative models.

We are all living longer and have higher expectations than our parents, not just about the quality of services we want, and about the level of control we have, but also when and where they are provided. We want services that are technically of the highest standard, but at the same time delivered in an individual way, to suit our unique preferences.

In the co-operative movement we've long been convinced of the idea that people working together for mutual support brings benefits way above the sum of the individual parts. Co-operatives are excellent vehicles to build community cohesion, be business-like in the way they work, encourage active citizenship and democratic participation. They are trading organisations with strong values, driven by the aspirations and values of the members, but moderated by the democratic process.

Personalisation and the introduction of individual budgets and self managed care take this whole agenda one stage further, but to really deliver choice for service users we will need to see far more, and very different sorts of provision. Simply opting for a traditional homecare agency at the point of assessment, because it is the only service with spare capacity when someone is leaving hospital, is user choice, but will not deliver the benefits that direct payments has, nor will it address funding.

With the introduction of registration under the Care Standards Act at the same time as

the expansion of direct payments, there are two apparently contradictory ways of thinking about quality running in parallel. On the one hand quality comes from staff trained to NVQ2 level, with quality systems, standard processes, supervision and record keeping. On the other, is the quality of how the service user wants it done.

Care work has always been part time, low paid and often seen as predominantly female oriented employment. In affluent areas, it can be difficult to recruit carers, in poorer areas, care employment may be critical to family income, or play a major role in sustaining communities.

Then there is the issue of profit. Whatever people's political views are, there is a strong sense that resources going into care should be spent on care, not be distributed to shareholders. After all there are hardly sufficient resources to meet people's needs now, let alone as demand grows in the future. On the other hand we do want organisations that are business-like, but have strong values, and strong connections to communities. We believe co-operative solutions offer a way to square this circle.

Our models may vary but all have the same characteristics:

- Staff are employed by the co-operative, so the responsibility for employment is shared.
- All the organisations have a legal form, that give limited liability to any individual.
- All have a democratic process that enables stakeholder view to be reflected. The balance or mix of stakeholder varies significantly between the models, but most have a majority of service users.
- Most create the opportunity for friends and supporters families to contribute expertise, towards the running of the organisation.
- All are democratic, encourage active citizenship and contributing to democratic renewal.

- Staff in clusters collaborate to share cover for leave and sickness, so that continuity of care is maintained.
- The co-operative structures include management resources that provide support to clusters.
- Tensions over charges, pay and performance can be managed collectively rather than individually.
- Constitutions generally restrict the distribution of profits.
- In rural areas clusters could diversify providing a wider range of services, and building cohesive local employment.

Multi-stakeholder direct payment co-operatives offer a real alternative to other forms of service provision. By bringing stakeholders together, some of the tensions of cost, staff working conditions and service levels can be addressed.

Our approach offers a different way of thinking about user led services, by developing models where users manage their own services, not just choose between providers. It offers to extend the benefits achieved through direct payments to whole groups of people who are not able,

willing, or prepared to use direct payments, or become individual employers of their own carers. It does this by a simple expedient. People collaborate together: service users; families and carers; paid care staff; and other people from their communities. The service user has direct and individual control of their care; they decide who comes, what they do, when and how they do it. The mutual organisation is the employer, provides training, quality standards, insurance and administration. Small clusters of service users and carers, collaborate in self managing provision in localities or to communities of interest. Groups of clusters form a co-operative.

This booklet describes co-operative approaches to the personalisation agenda that are an innovative and practical response. These approaches provide the potential to meet many of the aspirations of self managed care and widen access to these benefits for people who don't wish to do this on their own. Co-operatives that care.

Ed Mayo
Secretary General
Co-operatives^{UK}

Background

The programme was managed Co-operatives^{UK} and delivered by Mutual Advantage. It was funded by the Department of Health (Section 64, Voluntary and Community Sector Partnership Team).

The aim of the work was to

- Raise awareness of the benefits of participation by service users and carers in service development
- Build the capacity of the social enterprise sector to identify, respond to and support the development of stakeholders in care
- Support approaches which empower service users, staff and communities.

Specifically in relation to older people's care we looked to

- Promote the creation of co-operative social enterprise care providers in meeting the needs of older people.
- Support the approaches which empower older people, staff and communities, enabling them to take a direct role in managing the delivery of their own care, and developing high quality care to meet their needs.

Mutual Advantage is an independent co-operative consultancy practice which supports the development of co-operative, social enterprise and mutual solutions; working with local authorities, NHS bodies, government, social enterprises, sector support organisations, communities, user groups and staff teams to

develop practical solutions for public service improvements. Mutual Advantage is a member of Concilium, a consortium of social enterprise support organisations.

Mick Taylor is a partner in Mutual Advantage, he is a member of the Social Enterprise Coalition Council, chairs the Phone Co-operative, and lives in East London.

Sipi Hämeenaho is a partner in Mutual Advantage, is member of the Commissioning Joint Committee, the Department of Health National Strategic Partnership Reference Group and was a founder member of Social Enterprise London.

Co-operatives^{UK} is the member owned and led trade association for all types of co-operative enterprise throughout the UK. It is the strategic voice for co-operation, works to increase awareness and understanding of co-operative values and principles, supports the development and growth of new co-operatives and helps existing co-operatives to achieve high performance levels and good governance. It is a focal point for the sector and a forum for innovation and best practice. Co-operatives^{UK} represents co-operative enterprise throughout the United Kingdom of Great Britain, Northern Ireland, the Channel Islands and the Isle of Man.

The work arose from the long-standing interest in health and social care by the Co-operative Business Development Panel (formerly New Ventures Panel).

Executive Summary

1. Introduction

This project was established by Co-operatives^{UK} following earlier work, which had identified the real benefits that direct payments can deliver when services users are able to control their own care. It also removes the potential problems of the direct employment model for many people, including older people.

It sets out to establish the viability of mutual models where direct payment recipients join a co-operative, retaining individual control over their own care, but collectively share the responsibilities of employment, insurance, training, recruitment and other organisational burdens, with a view that these models would increase access to the benefits of direct payments to a wider group of people.

These are models that allow people not able or willing to take up direct payments individually, by collaborating to gain all the benefits that come from service user management of care. The collaborative or co-operative structure allows risk and administration to be shared and provides relatively easy access to people who are only receiving care for short period, are good employers and are registered under the Care Standards Act.

Whilst originally envisaged to take advantage specifically of direct payments, these models are well suited to delivering the personalisation agenda and utilise emerging individual and personalised budget regimes.

2. Implementing the programme

The development period for the pilots was longer than anticipated due to the work involved identifying them and negotiating local partnership arrangements. Planning also took longer than anticipated and with the slower development rate resulted in the programme overrunning by 6 months.

The programme was delivered within budget and levered in other significant resources.

The major success of the programme was the development of a practical and viable model for the mutual self-management of care by service users and carers, even though the focus shifted during the programme from direct payments to personalisation and other income streams.

The organisational model developed during the programme, reflects the aspiration to facilitate mutual support between service users and carers; provide a flexible structure so that service users can really control, who's coming and when; and maintain or improve working conditions for paid carers. A small group of services users, carers, and PCAs work together in a cluster to manage and deliver their own care, supported by a dedicated Cluster Support Worker. A group of these clusters form a co-operative which provides, systems, support, supervision, training, and accreditation, and employs a manager.

3. Meeting the programme outputs

1. An innovative organisational form has been developed, and model legal forms prepared, for the collaborative self-management of care by groups of service users or their carers.
2. A model set of policies and practice documents has been prepared that can be used by small mutual care organisations to achieve Care Quality Commission (CQC) registration.
3. The target to establish five pilot projects has been met. Six pilot projects have been supported, one has obtained registration and is trading, and four remain in development with a local partner; one left the programme. All acquired some local resources and all but one exceeded the target of 100% matched funding, some by a significant amount.

4. Advice has been provided to a wider group of organisations, although the balance of the project has been in supporting the pilots.
5. Both web and intranet resources are in place and will survive the programme by at least two years, and may well be sustained longer if the pilot projects continue to network.
6. The target number of workshops and dissemination conferences were held successfully.

4. Issues in developing the pilots

1. Financial

Whilst the model appears to be financially viable, local direct payment rates which do not include the cost of achieving CQC registration are too low. Viability is dependent on achieving local Agency rates, or recruiting private paying clients. The implementation of personal budgets is likely to provide the opportunity.

2. Development Support

The length of time needed to establish the new organisations took longer than anticipated, and development support needs were higher. Given that pioneer group participants are often service users or carers this should not have been unexpected.

3. Regulation and the Care Quality Commission

A critical barrier that constrains the development of these co-operatives is the need to be registered under the Care Standards Act. The direct payment rate does not cover the associated costs, and whilst issues of documentation, policies and qualification for staff have predominately been resolved, concerns remain over the cost of the manager and the length of the period leading up to registration.

4. Partnerships

Forming local partnership was critical to the success of the pilots but where these were made

with voluntary sector bodies, the benefits are balanced by the need to retain the independence of the new co-operative.

5. Conclusions

1. At the heart of issues over the viability of these models is a contradiction. As care providers they are required to meet the full costs associated with agencies ensuring quality care, particularly the policy and process costs, the level of supervision and other requirements necessary to achieve CQC registration.
2. The programme has shown that these models are viable, can be established and can meet the registration requirements of CQC.
3. Commercial viability is dependent on the difference between the rates paid to care staff - Personal Care Assistants (PCAs) - and the rate available in local marketplace for care hours. The wider the difference between these two rates, the higher the likelihood of viability.
4. Direct payments rates, in the main, do not reflect the full organisational costs associated with ensuring quality care, particularly the policy and process costs, the level of supervision and other requirements necessary to achieve CQC registration.
5. The aspirations of services users and families towards good employment practices and payment rates that reflect both the demanding nature of the job, and the labour market for care staff (PCAs) all increase the cost base, but have the potential to deliver a stable, satisfied employee base, a pre-requisite for quality care.
6. Whilst the direct payments model was the original motivation for developing this approach, the pilots have looked for ways to increase income, by top-ups, privately funded

clients or achieving agency rates.

7. This approach, of service users mutually managing their own care, is highly suited to the aspirations underpinning the personalisation agenda, and the implementation of individual budgets. These small, service user led organisations are more likely to be viable in the complex local markets that will result, and will contribute innovation and diversity to local service capacity. They have capability to offer highly specialist services for small groups of people with specific needs whether these derive from care requirements, location, community, culture, age, ethnicity or some other reason.
8. The development period necessary to establish a viable organisation is longer than anticipated. The pilots required considerable development support over one to two years, although this was shortening as the programme progressed. This required public funding, and cannot be recovered from future profits.
9. Registration with CQC can be achieved by these types of organisations, although they are very small compared with the full range of organisations inspected by CQC. There are particular problems in development

linked to the need to register, particularly the high costs of management during the pre-registration period, when personal care services cannot be delivered. This must be publicly funded, or a light touch regulatory framework developed for community-based or user led organisations.

10. Where these organisations are developed with the support of community or voluntary organisations, which can be an effective way to provide low cost development support over long periods, there were particular issues of achieving practical independence. Whilst there is commitment in this sector to social enterprise development, these models can only deliver the quality of care aspired to if they are genuinely user led, are allowed to operate independently in the market place, and it must be accepted that the potential to return profits to supporting organisations is extremely low.
11. Whilst none of the pilots has developed to the point where accurate assessments of the quality of care can be made, and they are at varying levels of development, five very different pilots have been established, all have a local partner and all are working towards CQC registration and business viability.

1. Introduction

The Self-managed Care project was delivered by Co-operatives^{UK} for the Department of Health during the financial years 2006/07, 2007/08 and 2008/09. Funded under Section 64, the project took longer than expected to gain momentum, and as a result overran by 6 months; however, it was delivered within the original budget.

The project aimed to increase the take-up of direct payments by under-represented groups, by developing a co-operative or social enterprise approach, which gives service users greater control over their care, promotes good employment practice and delivers good quality care and value for money.

It aimed to:

1. develop in detail a series of collaborative models for direct payments, including operational, governance, constitutional and legal arrangements, and evaluate development pathways.
2. prepare a model set of systems, standards and processes to assist the new organisations to achieve the National Minimum Standards and achieve registration under the Care Standards Act (responsibility for registration passed

from CISCI to CQC during the project - for clarity CQC is used during the remainder of the report).

3. support and evaluate four pilot projects and where possible obtain match funding or other matched resources.
4. offer an initial advice and support service to VCS, groups of direct payment users, social enterprise support organisations and local authorities.
5. develop a networking infrastructure (web resources, intranet facility) for the pilot projects, interested VCS organisations, users' groups, local authorities and others, creating a self-sustaining learning community.
6. promote this approach through conferences, magazine articles, a website and contributions to publications.

The programme was managed for Co-operatives^{UK} by Mutual Advantage, with significant contributions from Social Enterprise Services, Co-operative and Mutual Solutions, and Sunderland Home Care. Local partners and funders are listed in Section 4.

2. Justification for the Programme

The project aimed to support the achievement of the Department of Health's Priority 4 - Older people & Disability: Support the extension of direct payments and the development and use of individual budgets including ensuring their take up by underrepresented groups.

Whilst take-up of direct payments is increasing, it still remains extremely low, even though the benefits are widely reported. The Joseph Rowntree Foundation reports that direct payments recipients identified the benefits derived from this approach as:

- employing whom they choose;
- determining the hours of employment;
- determining the tasks they require the personal assistant to undertake; and
- the flexibility of the relationship, which allows them to vary their routines and activities with more ease.

The programme aimed to develop models where individual service users retain personal control over:

- who comes;
- what they do and how they do it; and
- what time they come.

Through a co-operative, possibly also involving their informal or paid carers, and others from

their community, they collectively:

- employ the paid care staff;
- supervise and train paid care staff;
- support informal carers; and
- run the business.

Whilst service users can maximise the quality of care each individually receives by direct personal control, emulating the benefits obtained by direct payments recipients, the organisation can manage quality through standards, training, and supervision, bringing individual service-led quality within the framework operated by the Care Quality Commission.

As staff and families are also involved in the running of the organisation, this approach has the potential to:

- operate efficiently, drawing on community and volunteer resources;
- attract charitable funding;
- help them become good employers;
- attract 'non typical' employees into the care labour market;
- develop community or culturally specific services; and
- develop expertise in particular client groups.

3. The Programme

The programme was based on six work streams:

1. The establishment of five pilot projects.
2. The preparation of a resource pack to assist with registration under the Care Standards Act.
3. A website for public access, an intranet site for networking between the pilot projects and access to shared resources.
4. Advice and support to the pilot projects and others.
5. Three workshops and a conference.
6. Evaluation and publication.

4. The Pilots

By far the largest work stream in the programme was the development of the local pilots (this was the primary focus of the advice and support work), the internet capacity and the three workshops.

At the completion of the programme in the summer of 2009, five pilot projects had been established. This is the target number set in the original funding agreement.

The aim was to establish independent co-operatives or social enterprises that:

- are registered under the Care Quality Commission;
- are led by stakeholders: services users, families and carers; paid carers and partners or a community of interest;
- are flexible in operation with service users controlling their own day to day care;
- employ care workers and have good employment practices; and
- minimise overheads and share administration.

The pilots developed during the programme were:

1. Caring Support based in Croydon;
2. Life Choice Care in partnership with West Sussex Independent Living Association;
3. Oadby and Wigston Direct Payments Support Group in partnership with Leicestershire County Council;
4. Barking and Dagenham Age Concern (did not proceed);
5. Sunshine Care based in Rochdale; and
6. Melton Care in partnership with Leicestershire County Council and Melton Borough Council.

Only one, Caring Support, had by the time of this report obtained CQC registration and was trading independently. All the others were at various stages of development, but all have a locally

established partner. Detailed plans including negotiations with partners were developed for six pilot projects, but one withdrew at a late stage. Programme bursaries were provided to five pilot projects.

4.1. Support and advice

The process to establish the pilots and the support provided varied between projects, but followed a methodology established early in the programme based on:

- promoting the concept at meetings, conferences and through other channels;
- identifying potential pilot projects;
- contributing to local briefing meetings for potential participants;
- reviewing the feasibility of potential pilots;
- identifying local support providers and other local resources;
- negotiating with local partners;
- supporting the development of local pioneer group;
- preparing a proposal for a pilot project and supporting the preparation of a development plan;
- supporting the preparation of a pilot development action plan including a budget for the programme bursaries and identification of potential local matched funders;
- approving and allocating the bursaries; and
- supporting development, business planning and relationships with partners.

Advice was also offered in response to general enquiries and presentations made to a number of regional and national conferences, in both England and Wales.

4.2. Matched funding

All the pilots achieved local funding, sometimes independently of the programme, at other times directly in response to the bursary allocation. These leverage rates are shown in the table at the bottom of this page.

4.3. Caring Support

Caring Support was established by service users and carers from a pioneer group that predated the programme. It has been established as a multi-stakeholder co-operative with the legal form of an Industrial and Provident Society. Services users are the largest group on the board. It has over 30 members, has obtained CSC registration and is now trading. It is based in Croydon and has developed using a cluster-based operational model, but with a single office.

4.4. Life Choice Care

Life Choice care has been developed in partnership with the West Sussex Independent Living Association (ILA) and is based in Worthing.

The ILA provides administrative support to local direct payments recipients and will do so for the new organisation. Whilst Life Choice Care will have a membership, some directors will be nominated by the ILA, with whom any profits will be shared. This development grew from some previous work done by the ILA in developing other models for co-operatives that support people in receipt of direct payments.

4.5. Oadby and Wigston Direct Payments Support Group

Initially a pilot project, this was proposed by Leicester West Carers, a worker-controlled care co-operative, part of the regeneration strategy for Branston in Leicester. An action plan was prepared and initial partnership discussion held with Leicestershire County Council and Oadby and Wigston Carers Group. Unfortunately as work progressed, LWC ceased trading. A new pioneer group was established with the carers' group; the project is now being led by a secondee from the County Council, and is developing a multi-stakeholder model.

Sources and value of matched funding			
Pilot	Source	Value	Leverage
Caring Support	London Borough of Croydon	£15,000	400%
	Co-operative Community Fund	£950	
	Ross Harding Fund	£3,000	
	Help the Aged	£8,890	
	Esmée Fairbairn Foundation	£30,000	
	Private donations	£2,250	
Life Choice Care	West Sussex ILA (2/3 of a development worker post for 12 months)	£18,000	120%
Oadby and Wigston	Leicestershire County Council- part time secondee for 1 year, and office facilities	£17,250	115%
Sunshine Care	Rochdale Council - Grant	£30,000	200%
Melton Care	Leicestershire CC – Development worker 1 day per week	£6,900	46%
	Melton Borough Council – office resources		

4.6. Barking and Dagenham Age Concern

Barking and Dagenham Age Concern had an existing home care service, part of a group of services offered to older people. Committed to a client-led approach, flexible employment and collaborative working, they proposed to establish a pilot based on developing and implementing a marketing strategy to significantly increase the take up of direct payments by older people. If successful they would have reviewed the legal and organisational structure of the project, giving consideration to establishing an independent co-operative.

They participated in the project, and took part in two of the workshops; however, at a late stage they decided to withdraw. This coincided with a wider review, national merger with Help the Aged and staff changes within the organisation.

4.7. Sunshine Care

Sunshine Care was established by group of care workers leaving local authority employment in Rochdale, following a restructuring of the in-house service. With the support of the local authority, some in-house clients for whom the newly focused service is no longer appropriate will shift to direct payments and may obtain services through the co-operative. They have registered a legal entity, opened an office, are delivering some practical care and are en route to achieving registration with CQC.

4.8. Melton Care

Melton Care, working in partnership or with the support of both Leicestershire County Council and Melton Borough Council, was the last pilot to join the programme, and is therefore the least developed. It aims to establish a multi-stakeholder co-operative based on people living in sheltered accommodation currently owned by the Borough Council.

5. Policies and Procedures Pack

Sunderland Home Care prepared for the programme a model set of fifteen policies, with practical guidance notes that address the standards required for the Care Quality Commission registration as a home care agency. This included a model services user guide and additional operational documents.

A hard copy of these resources was made available to each pilot and also in electronic format on the pilot's part of the intranet site.

This resource was critical to the speedy achievement of registration; pilots amended policies to suit their particular circumstances.

This resource will remain available through Co-operatives^{UK} for co-operatives and social enterprises in the future needing to register under the Act.

6. Internet and Intranet

A web site was established at <http://cscp.webeden.co.uk> for the duration of the programme. It will remain in place for an additional two years. This is a fairly simple site, aimed at signposting enquiries either to the programme or to the pilot projects. It contains:

- a description of the programme and contact details;
- a description of each of the pilot projects;
- some resources on direct payment and self directed care; and
- information on the workshops and conference.

The site received a total of 4,400 hits over the last year.

An intranet site at <http://dp-pilots.webexone.com> was also established, with access restricted to members of the pilot projects. This had two objectives: to enable resources to be easily shared and accessed as the pilots developed, and to encourage networking and peer support between the pilots. The site contains:

- announcements;
- a diary for arranging meetings;
- a discussion forum;
- a set of links to key internet sites;
- links to guidance and policy documents;
- an area containing all the key documents on each pilot; and
- a private area for each pilot to use for their own purposes.

The site has been used by all the pilots with Life Choice Care and Oadby and Wigston making extensive use. Clearly it has been more valuable for those developing later in the programme.

7. Workshops and Conference

7.1. Pilot workshops

The original project plan included three workshops. All were delivered, although slightly later in the programme than planned, to support the development progress of the pilots.

These practical workshops were held for the pilot projects, members of pioneer groups, partners or supporting organisations. The first workshop drew on a wider group of partners and supporting organisations, as only two pilots were at that time in development.

The remaining two workshops were focused more directly on the progress issues of the pilot projects, facilitating experience sharing and peer learning, practical problem solving, sharing and debating development, organisational, business and care management issues.

The workshops were held as follows:

1. OXO Tower, 15th May 2008, pilots and partners, 27 people
2. Avonmouth House, 22nd of October 2008, 4 pilots
3. Avonmouth House, 17th of March 2009, 4 pilots

Topics covered included:

- Development issues
- The Cluster Model
- Ensuring good quality care in practice
- Meeting registration standards
- Wage rates and fees
- The intranet site
- Financial viability issues
- Business plans

A fourth workshop is planned to take place after the end of the programme, organised by the pilots themselves.

7.2. Dissemination conference

The main dissemination conference “Mutual Responses to Personalisation” was held on 11th June 2009, at the Coin Street Neighbourhood Centre in London. Chaired by Dame Pauline Green, the key note speaker was Frances Hasler, Head of User and Public Involvement at the Care Quality Commission. The conference was attended by over 60 participants from:

- local and national voluntary and community organisations representing older people, those with physical disabilities or mental health problems;
- local authority social services commissioners, policy officers and those with responsibility for supporting independent living or developing personalisation;
- social enterprise support organisations; and
- Care Trusts, the Department of Health and representatives from a housing association, a political party and a university.

The timing of the conference just as the implementation of the personalisation agenda shifted from the pilot authorities to the mainstream, along with a widening of focus within the pilots from direct payments to income streams created through personalisation, suggested the twin themes of:

- a platform for the pilot projects to present themselves and their successes and our learning from their experiences; and
- the impact of the implementation of personalisation on self-directed support.

This is summed up in the strap line used in the conference materials:

“Communities and service users setting up their own care providers in response to the direct payments and personalisation agendas.”

Each pilot made a presentation, and other speakers included:

- Clive Newton - National Development Manager, Age Concern and Help the Aged.
- Sonia Bray - Partnership Liaison Manager, Caring with Confidence.
- Jacquie Bickers - Self Direct Support Implementation Lead, West Sussex County Council.
- Mick Taylor - Mutual Advantage, Project Leader CSMCP.

The evaluations collected from participants were extremely positive, and a number of enquiries both from participants and those not able to attend have been received since the conference.

Caring Support were interviewed and an article appeared in the national press describing their progress in the period running up to the conference.

8 The Cluster Model

8.1. Principles

A principle underlying the programme and all the pilot projects is the mutual self-management of care. This is the idea of group of service users, their carers, families and communities and the paid care staff all working together in supporting the management of the day to day delivery of care. Management and organisational arrangements must be in place to support this aspiration.

Making this work in practice became the determiner for the size of a delivery unit. Hours of care received by any group of clients can vary widely and at the extremes are very large complex packages with a large number of paid care staff, against very small packages delivered by one person.

The size of delivery units is therefore limited by the number of people who can in practice work together to build stable and effective personal and organisational relationships. The variations in the size of care packages and the needs of service users makes it impossible to define a precise optimum size for these delivery units, and a practical range may only emerge from the practice of wider groups of projects.

The project researched and developed an organisational and management structure based on a traditional hierarchal approach used in most care agencies, but the majority of the pilots opted for a cluster-based model of delivery.

This model divides responsibility for care delivery into three bands which underpin the organisational and management structure developed in different ways by each of the pilots. The three bands are:

Delivery

Services users and their carers managing the day to day provision of an individual care package. This level focuses on practical care and support, who comes, what time they come, what they do

and how they do it, the practical achievement of quality care and the development of services and provisions in response to an individual's needs.

Cluster

The delivery of a group of care packages being managed by a cluster support worker, working for and with a group of services users, carers, families and paid care staff. At this level the focus is on the organisation of care delivery: staffing, recruitment and rotas; cover and emergency response; first level supervision and development; the implementation of policies and procedures; user focused administration; and financial data.

Organisation

A slim corporate level, providing support, systems, resources and supervision to clusters and delivery, made up of a paid manager and a voluntary board of directors elected from the members. The focus at this level is on sustaining organisational capacity: developing and monitoring the implementation of policies, procedures and practices; skill development and human resource management including supervision; and financial systems along with business development.

8.2. Practicalities

The implementation of the principles underpinning the cluster model varies significantly between the pilot projects. Typically, a group of service users manage a group of Personal Care Assistants (PCAs) to provide the care they require. A number of clusters form a co-operative, which has a manager and perhaps administrative or financial management resources. A board of directors runs the co-operative, typically elected from and representing a mix of the four key groups of stakeholders: service users, carers, paid carers (PCAs) and the community of interest or partners.

Cluster may be based on a locality, minimising

travel times for PCAs, or on types of service users, enabling the development of specialist services or workforce.

Each cluster has a Cluster Support Worker, perhaps working part-time. This role varies, but may be a generic role that provides support to services users and their families, as well as organising and being first-level supervision to the PCAs. They may support recruitment or organise training, as well as service user facing administration and data capture.

PCAs are employed by the co-operative and predominantly work in a single cluster, although they can be available if they choose to provide cover or back up to other clusters. They may have zero hours contracts, or be on basic hours guaranteed hours plus additional availability. This allows the level of flexibility needed to mirror the PA direct employment model.

Service users can select their own PCAs, and have control over timings, but have to do this within the organisational arrangements of the cluster and the employment requirements of the whole co-operative.

Overheads and start up costs can be reduced to a minimum by cluster support workers, or the

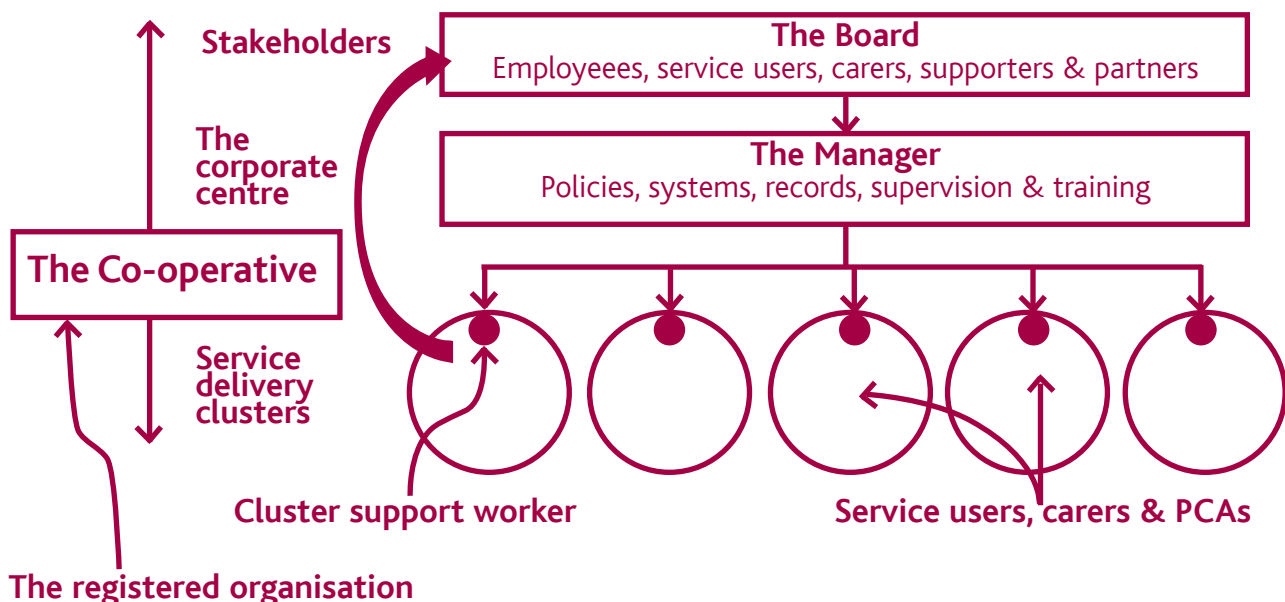
manager working from home or being provided with low cost facilities through a partner organisation. The registration requirements for a registered office, the security of data and meeting training facilities must be met.

The co-operative can grow by developing new clusters.

8.3. The structure

This diagram shows a typical structure for a cluster-based care provider. All the pilots that are following this model have variations. The key elements are:

- local or client-specific clusters of service users and care workers (PCAs), each with a cluster support worker;
- a group of clusters forming the co-operative, with board of directors and a manager;
- the members of the co-operative being the service users, care workers and families or carers;
- the board being elected by the members; and
- the co-operative as a whole being registered with CQC.



9. Issues

9.1. Financial issues

Financial costs, income and cluster size will vary from locality to locality. Critical to viability is the difference between the hourly direct payment rate paid by the local authority and the hourly pay rate (plus on costs) paid by the co-operative to its care staff.

Where this difference is narrow, viability is difficult. Nearly all the pilots looked to widen this gap with:

- local authority top-ups;
- privately funded top-ups;
- differential charging for private funded clients;
- specialist services at higher rates; and
- agency rates.

This model has very low start-up costs. If office costs are kept to minimum, or provided by a partner, and some Cluster Support Workers work from home, then, setting aside development support, the initial capital cost for the co-operative including the first cluster may be less than £15,000, with £2,000 or £3,000 capital for each cluster established after that.

There will be cashflow requirements, but if the main source of income is direct payments, these are paid in advance. By agreeing that members pay the co-operative in advance, and wages are paid in arrears, cashflow can be positive.

Overheads can be kept to a minimum by controlling office costs. CQC registration requires an office address and training facilities, otherwise Cluster Support Workers can work from home, keeping them close to the cluster they support.

Local clusters minimise travel time.

Most of the pilot projects using this model are based on clusters in the region of 130 to 150 care hours per week, perhaps 12/15 direct payment recipients or other clients.

With a half time manager, this scale of organisation might breakeven with 5/6 clusters. If the management cost (i.e. paid time) could be graduated to match the number of clusters, then breakeven might be achieved sooner.

9.2. Development time and support needs

The development period for these types of projects is much longer and more intensive than anticipated. Client groups (older people/those with physical disabilities etc) have specific support needs. It is a major task for people in receipt of care, or who are informal carers who may already be stretched in terms of their responsibilities, to take on the establishment of even a small organisation. Where people's capacity is limited, attending meetings, preparing business plans or funding bids can be a significant additional responsibility.

The length of time need to achieve CQC registration, as well as its complexity, adds to the time needed to get started.

Even when funded development support was made available, the time from pioneer group to trading varied from more than 2 years to less than 1 year.

Development support needs include:

- building and sustaining a pioneer group or early membership;
- supporting the understanding of business principles and preparing a business plan and establishing business systems;
- understanding the needs of CQC registration and care management policies and building the confidence of key members to take part in the registration process, and other preparation for the first inspection;
- support in developing a democratic culture, appropriate process and agreement on a

- constitution and legal form;
- help with planning implementation, establishing operational systems and the recruitment of key staff; and
- holding potential members, whose primary priority is their own care, in place and active whilst the business is being developed.

9.3. The Direct Payments rate

At the heart of issues over the viability of these models is a contradiction. As care providers they are required to meet the full costs associated with agencies ensuring quality care, particularly the policy and process costs, the level of supervision and other requirements necessary to achieve CQC registration.

Most of the authorities in whose areas the pilots are operating have a direct payment rate that is significantly lower than the rate they pay for equivalent homecare provided by agencies.

Broadly speaking, the direct payment rate and other payments to direct payments recipients are calculated on a cost recovery principle: put simply, this may have three elements:

- the local hourly rate paid in the marketplace to PCAs;
- employment on costs (recruitment/insurance/holidays etc); and
- employment administration – PAYE, paper work, accounts tax etc.

There is no element for the management of the PCAs, for example organising rotas etc, supervision or record keeping.

The difference between the direct payment rate and that paid to agencies can be significant; in one area for example, £7.50 against £12 per care hour.

This difference can be critical to the viability of these co-operatives. They carry the cost of

delivering quality and obtaining accreditation, but do not receive the payment necessary to do so.

The pilot projects adopted a number of approaches to this problem, listed in par 10.1., most enabling them to increase the fees charged for each care hour. As the practical implementation of personal budgets developed during the life of this project, it became clear that this may well be achieved by funding streams in the personalisation process, rather than direct payments.

9.4. Regulation and CQC

A critical barrier that constrains the development of these co-operatives is the need to be registered under the Care Standards Act.

There are five main areas requirements that the pilots have had to meet:

1. The documentation of policies, processes, systems and standards

This has been to a large extent resolved by the preparation of the pack, although it is still a significant task for these small organisations to amend the policies to suit their particular situation.

2. Achieving the qualification standards for care staff

On the whole, training for care workers is now relatively readily available. Some pilots used the Train to Gain scheme, Caring Support organised specialist courses, and one pilot had a waiting list of qualified care workers. As good employers, with care worker involvement in running the business, these organisations are likely to be attractive to care workers in the labour market.

3. Having a manager in post who is at the least in training to NVQ 4.

This is very high cost burden for small organisations. Five operation clusters can sustain half a manager's post. Three approaches have

been considered by the pilots to overcome this problem:

- Using the bursary or local matched funding to pay for development support from someone who becomes the manager at least for the first inspection interview, and the initial growth period.
- Making a partnership with a local organisation, who has an existing staff member who has the qualifications, and takes on the manager's role.
- Finding someone who is prepared to take on the manager's role, paid only in proportion to the number of clusters in operation.

4. The innovatory nature of the organisations

This does not fit into the expected pattern typical of other care agencies and so necessitates negotiations with local inspectors, including:

- The registered person not being the owner, but perhaps a carer, volunteer or service user, supported by a board of directors who are members;
- Cluster Support Workers, being both the first point of contact for service users, and supervisors of care staff;
- A user-led approach to the supervision of care staff, including in various roles service users, the Cluster Support Worker and the Manager;
- Control and management of client data, with an emphasis on computers and secure data storage and transfer rather than physical files; and
- The open nature of the organisations, which may have a central office but have staff working in their clusters.

5. The period from the formal application to CQC to first visit, and registration being approved

All policies, procedures and operation systems need to be in place and tested before an application for registration is made, and there is then an undetermined period from application to interview and notification of successful registration. During this period no personal care can be provided, yet the organisation needs to be operational. For small new organisations like those in the programme this is major barrier to becoming established. It is also difficult to hold pioneer groups, volunteer supporters and potential service users in place for this extended time.

A number of strategies have been adopted by the pilots:

- Obtaining public or charitable funded resources to pay staff time and operational costs during this period.
- Negotiating with a partner organisation to provide resources and undertake a "holding role".
- Delivering practical care only for this initial period.

9.5. Relationships with partners

Two types of partnership relationships have developed between the pilots and local voluntary and statutory organisations during the programme.

- Firstly, a supportive, but fairly hands off approach, providing funding, expertise, direction and access to systems, people and buildings, typically by a local authority.

- Secondly, a much closer relationship, typically with a voluntary sector body, where the partner sees the new organisation as a long term partner, a way to achieve its own service delivery aspirations, or aims to provide a real financial contribution at some time in the future.

These local partnership relationships have been critical to the successful establishment of all the pilots. Funding, access to members and local credibility have all been enhanced.

In response to the requirement for CQC registration to have the manager in place early and the practical requirements of the registration process, particularly its duration, we encourage the programme to look for local voluntary sector partners who could act as incubators for projects. This could be an effective route to fairly quickly duplicate successful pilots. Whilst this approach has been successful in addressing these issues, this approach has not been without its problems, including:

- Slowness and complexity of decision making.
- Balance of risk between the partner and new co-operative.
- Challenges to the voluntary body created by the business-like and user-focused nature of the new co-operative.
- The route to real independence for the new co-operative.

10. Conclusions

The programme has shown that these models are viable, can be established and can meet the registration requirements of CQC.

Commercial viability is dependent on the difference between the rates paid to care staff - Personal Care Assistants (PCAs) - and the rate available in the local marketplace for care hours. The wider the difference between these two rates, the higher the likelihood of viability.

Direct payments rates, in the main, do not reflect the full organisational costs associated with ensuring quality care, particularly the policy and process costs, the level of supervision and other requirements necessary to achieve CQC registration.

The aspirations of services users and families towards good employment practices and payment rates that reflect both the demanding nature of the job, and the labour market for care staff (PCAs) all increase the cost base, but have the potential to deliver a stable, satisfied employee base, a pre-requisite for quality care.

Whilst the direct payments model was the original motivation for developing this approach, the pilots have looked for ways to increase income, by top-ups, privately funded clients or achieving agency rates.

These models can fit directly into the complex local markets that are emerging from the implementation of individual budgets; however, they will have limited capacity to enter competitive processes where this remains a pre-requirement for access to independent budget funding streams.

The development period necessary to establish a viable organisation is longer than anticipated.

The pilots required considerable development support over one to two years, although this was shortening as the programme proceeded. This required public funding, and cannot be recovered from future profits.

Registration with CQC can be achieved by these types of organisations, although they are very small compared with the full range of organisations inspected by CQC. There are specific problems in development linked to the need to register, particularly the high costs of management during the preregistration period, when personal care services cannot be delivered. This must be publicly funded, or a light touch regulatory framework developed for community-based or service user led organisations.

Where these organisations are developed with the support of community or voluntary organisations, which can be an effective way to provide low cost development support over long periods, there were particular issues of achieving practical independence. Whilst there is commitment in this sector to social enterprise development, these models can only deliver the quality of care aspired to if they are genuinely user led and are allowed to operate independently in the market place, and it must be accepted that the potential to return profits to supporting organisations is extremely low.

Whilst none of the pilots has developed to the point where accurate assessments of the quality of care can be made, and they are at varying levels of development, five very different pilots have been established, all have a local partner and all are working towards CQC registration and business viability.

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